Republic of Uganda

Health Financing Reform & Social Health Protection

Specifying the options

Follow up visit and dialogue between Ugandan Stakeholders and a P4H Team

17 – 19 February, 2010

Draft of 21 March 2010

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List of abbreviations

BP	Benefits package
BBP	Basic benefits package
CHI	Community Health Insurance
CMI	Community Medical Insurance
DFID	Department for International Development
GOU	Government of The Republic of Uganda
HI	Health insurance
HMIS	Health management information systems
HMO	Health Maintenance Organization
LTFQ	Less than fully qualified practitioner
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labor and Social Development
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
OOP	Out-Of-Pocket Payment
P4H	Providing for Health Initiative
PFP	Profit for profit
PHC	Primary Health Care
PNFP	Profit not for profit providers
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
WHO	World Health Organization

I. Introduction and summary

An intense dialogue and its reflection in "The proposed National Health Insurance Scheme and promotion of Social Health Protection in Uganda"[1] has led the Uganda Ministry of Health and the Task Force on Social Health Insurance to rethink its original proposals for the introduction of social health insurance and to consider a number of alternative options. This was discovered during a follow up visit of a small P4H team (Annex 1) and in meetings held with its Ugandan counterparts (Annex 2) from 17 to 19 February, 2010, in Kampala.

The MOH has shifted its thinking to embracing the concepts of social health protection and of universal coverage. It now wants to make sure that from its start a new health financing regime will also expand coverage and improve access to quality care for poorer categories of Uganda's population without them running the risk of impoverishment by offering financial protection. The MOH sees these categories as a priority for the initial implementation of social health protection and towards universal coverage. The P4H Team has therefore agreed with MOH and other stakeholders:

1. To provide more details on the alternative options as regards their potential influence on a number of important aspects, like coverage and OOP's , and on the pros and cons of each option.

2. That MOH in the further process and as part of its stewardship mandate will intensify its dialogue with the stakeholders and together review and consider the alternative options in light of the Ugandan health sector, its socio-fiscal-economic and cultural context and its core values.

3. That MOH will, in a shift to a more strategic approach to health financing and social health protection, develop a Road Map for health financing reform, indicating the steps and decision points, the institutional and administrative arrangements as well as the topics for which it would like to have inputs from P4H partners.

4. That MOH will also consider doing a social assessment of the consequences of a proposed new health financing system, together with measures to mitigate these consequences as far as necessary.

5. That MOH will also draft legislation to foster financial autonomy of hospitals to allow for more efficiency in health care delivery as a necessary complement to the introduction of selective purchasing as part of health financing reform.

6. To communicate and further exchange views, clarifications and technical aspects, as related to these options via e-mail or otherwise, not necessarily waiting for another P4H formal visit, as to speed up the process of decision making on Health Financing Reform.

7. That MOH will take as soon as possible a preliminary decision on its principles and direction, based on which further details of a new health financing system, its codification and its roll out can be discussed and designed.

[1] Report of a visit of P4H Partners, 4 to 14 August 2009, readied on 7 October 2009

8. To make, as much as possible, use of existing capacities and the availability of representatives of the P4H partners in Uganda and in the region via existing contacts and arrangements, in an organic and streamlined way.

9. To avoid as much as possible the need for explicit and separate P4H missions but instead align and integrate the P4H approach in the country's health financing reform processes within the social protection framework, e.g. to have P4H partner representatives from outside the regions, if necessary, participating in regularly scheduled events not specifically dedicated to their visit, which will also lighten the burden of Uganda official and staff of MOH and other ministries and their agencies and staff.

Hereafter follows a description of the developments to date, including some follow up actions since the visiting team had left, a description of the options, of a possible way forward and the eventual contributions of development partners. Some of the recommendations of the October '09 Report will be reminded. Terms of reference for the February 2010 of the P4H Team, as agreed with MOH can be found in Annex 3. Annexes 4,5 and 6 contain a briefing note for Development Partners in Uganda, a Summary of the October 2009 Report on slides and a set of slides for a presentation to MOFPED respectively.

Last but not least, it has to be mentioned that the follow up visit was nicely prepared by the staff of MOH and hosted by this Ministry.

The visit coincided with the 50th conference of the East, Central and Southern African Health Community, during which the State Minister of Health of Uganda gave a keynote address on health insurance, reflecting also on the recent Ugandan experience and the relation with P4H and social health protection. The Team was pleased to hear these reflections during such an important conference.

II. *Developments to date*

After the August '09 visit of the P4H team and its subsequent report (see a short summary of the recommendations in Annex 7) the MOH has:

1. Reflected on the dialogue held and on the report provided by the P4H partners

2. Decided to broaden its focus of health financing reform and to incorporate the poor and vulnerable informal categories of the population from the very beginning of a social health insurance system and therefore now welcomes the further dialogue with the P4H partners as to receive their technical advice to make informed decisions. The MOH and subsequently the social health insurance agency will need a good instrument for social targeting, i.e. to designate those who will not be able to pay the insurance contributions for themselves and their families. Such an instrument could also indicate those in the informal sector who are able to pay insurance contributions and the amount they should pay. This would form the basis for whatever premium subsidies are provided.

3. Amended the August '09 draft Social Health Insurance Bill and submitted this to the Ministry of Justice's Parliamentary Council for legal advice. This advice was not yet available during the February '10 visit. When available the Task Force will receive it and further review the Bill in light of foreseen policy developments and choices of the Government of Uganda, i.e. codification will come at the end of the policy preparation process. In this process, the Task Force will reflect on the broader picture for health financing reform. The deadline for MOH to submit a new Bill is April 2011.

4. Sent extensive comments from the Task Force on Health Insurance (TF) to the P4H team (see hereafter).

5. Advised that the GOU has established an Inter-ministerial Committee on National Health Insurance, chaired by the Hon. Minister of State for Health (General Duties) and further composed of the Honorable Ministers of State for Public Service; Gender, Labor and Social Welfare; and Finance, Planning and Economic Development..

   This committee was taken for a study tour of the Social and Community Health Insurance schemes in Rwanda and Tanzania. Currently the committee is concerned with addressing the issue of incorporating the informal sector about (87%) of population in the scheme from the start.

   The Secretariat is redesigning the initial plan to include community health insurance schemes using district based schemes to be implemented in four traditional regions of the country and requested P4H for support to establish these schemes.

   The plans of the National Social Security Fund to also offer its insured financial access to health services can also be coordinated via this Committee into an overall framework for health financing reform as to avoid adverse effects of separate targeting of population categories and creating multiple schemes. This Committee has also brought up the idea to eventually try out some schemes in some of the Districts.

6. Decided to continue its sensitization of the general population on the idea and features of health insurance. Eight regions have been covered so far.

Further developments

Unfortunately, the planned ILO supported actuarial study for the NSSF has not yet taken place due to unavailability of the actuaries.

The MOH and WHO supported, ***Uganda health finance review*** was not yet finished but the team was provided with a partial draft. Some issues were indicated in this draft as in need of further and more in-depth study, such as:

1. The impact of health sector decentralization on health sector performance and ways to improve allocative efficiency at the District level

2. The impact and prospects of Community health insurance

3. Vertical program financing, its sustainability and impact of the rest of the sector

It is expected that the review will be soon finished.

III. Comments on the October 2009 Report

The P4H team received very valuable comments and some suggestions from the TF, requesting to:

1. Provide more details on how the proposed scheme could address the poorest of the poor.
2. Provide a comprehensive background paper on human resources issues related to HF reform.
3. Elaborate on the issue of pharmaceuticals in relation to services delivery in an NHIS.
4. Assist in a thorough review of the benefits package (BP), in costing out the proposed BP and in analyzing the trade-offs between OOP's and the size of the BP.
5. Propose modalities of NHIS into the broad social protection strategy, including aiming at poverty reduction.
6. Propose a model for structural dialogue between top leadership and stakeholders, and on how to engage with local governments and support building up their capacity.
7. Ascertain more efficiency and reliability in the allocation of donor resources

A response on the more detailed comments was provided to MOH by the P4H team, written in into the TF comments (Annex 8), including some suggestions on the above item 6.

The requests as mentioned in the above number 2., 3. and 7. are outside the immediate scope of the current P4H focus on social health protection but are certainly worth further exploring by MOH in its contacts with development partners. The other requests will be taken up by MOH with support of the P4H partners, starting with a further elaboration of the alternative options for health financing reform while addressing the poorest of the poor and using NHIS as contributing to a social protection strategy (see hereafter).

IV. Options for health financing reform

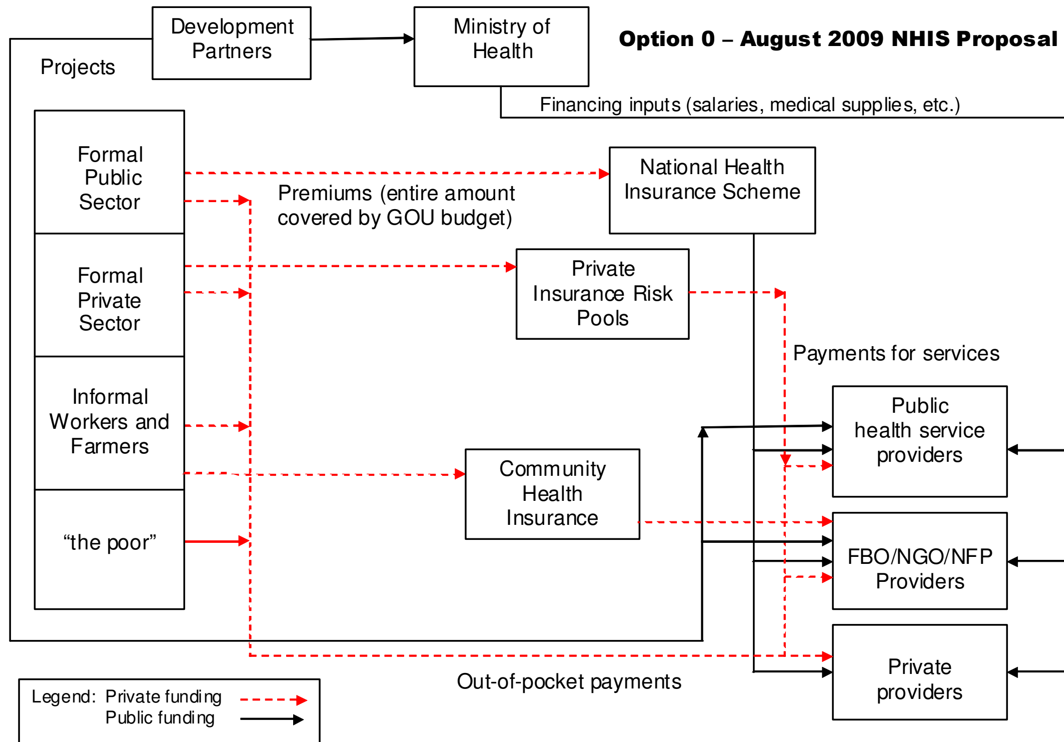
The zero option

The P4H October 2009 Report concluded that the original proposed NHIS and its planned implementation posed some serious risks:

- The poor could be worse off 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.
- 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 can further decrease due to the creation of a parallel funds flow, the absence of increased pooling of funds and the increase in administration costs.

- It does not contribute to the creation of a strong purchaser, which could use its clout for selective contracting of efficient quality health care services of public and private providers.

The following chart illustrates the schematic flow of funds of the proposed NHIS draft bill 2009



The above flow chart has in the 4 boxes on the left side the categories of workers and their dependents as well as the poor. Only the formal public sector pays into the NHIS, as proposed in August 2009. Some in the formal private sector pay into a (company based) private health insurance scheme. Community insurance, where it exists, is paid from the contributions of the informal sector and the farmers. The others pay directly out of pocket to the health services providers that also are financed by MOH and donors. The boxes on the right hand side show the various categories of providers. The chart shows the fragmentation of risk pools and finance flows.

Proposed alternative options

Observing the above mentioned risks, the P4H team suggested a number of alternative options for further consideration and discussion:

1. Multiple options under a single insurer
2. Beginning SHI with the Informal Sector and the Poor, using the increased budget
3. Free care in different format
4. Expanding the budget funded scheme and over time moving to NHIS

5. Big bang, transferring all budgetary resources for curative care to the NHIS and add the revenues from contribution s

Compared with the original MOH NHIS proposal, all these alternative options are aiming to at least:

1. Improve access to health care for the poor, i.e. offer coverage for a wider population
2. Prevent impoverishment due to the consumption of necessary health care services, this means that also the direct out of pocket payments would decrease; therewith
3. Contributing to achieving the Governments health and social objectives.
4. Provide better chances to improve the overall quality of the health care services
5. Pay attention to the role of the Districts in funding which diminishes in most of the alternative options. But where the funding role of the District would diminish, unjustified regional variation in availability of funds and in the supply of services may also reduce. The Districts may also continue and strengthen their role in supportive supervision of the health services providers.

However, it has to be realized that all options, including the originally option proposed by MOH will require Budget transfers to cover the poor and informal sector.

The options differ in the extent to which they provide coverage, strengthen the purchasing function, demand administrative infrastructure and resources, have impact on the role of the Districts and on the role of community health insurance.

It has further to be realized that the introduction of mandatory health insurance will initially decrease the market opportunities for private health insurers, dependent of the breadth and width of the benefits package of the mandatory scheme. However, that is a small price for the overall improvements for a lot of Ugandans. The company based private health insurance can still offer supplementary health insurance to cover the health services not provided as part of the mandatory scheme. This way, employees will also not see their entitlements shrink as a consequence of the introduction of mandatory social health insurance.

The alternative options include a line on out of pocket payments (OOP's) which are meant to indicate that regardless of the options chosen, there will still be some services which will be paid directly out-of-pocket, even if there are no formal (or informal) user fees. It may also include formal user fees that are set for those who do not use the formal referral system (i.e. self-refer) or user fees from which the poor are exempted and meant to expand the benefits package for the insured an provide possibilities for cost control and quality assurance.

The MOH requested P4H to provide more details on the proposed alternative options, and the TF also asked that a sixth option be included which included multiple insurers of the Basic Benefit Package, including private sector insurers.

The options are further elaborated hereafter, starting with the schematic funds flow in the August 2009 MOH model, allowing for comparison with the alternatives[2]:

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[2] NB: in all schematic representation of the various options it should be realized that community financing in Uganda has both insurance and credit options. OOP, of which the poor should be exempted, can be part of all schemes and there can be some co-payment or additional payment for some chosen services outside the basic

1. 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. If the scheme requires a uniform premium contribution for all subscribers, the care received would vary between the urban and rural areas due to differences in the level of available health services. Insured persons in urban areas may thus have access to a variety of health care services of relatively high quality while rural areas may get inferior substantially less access to care (including choices with respect to providers) or relatively lower services despite also being insured.

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 many people. However it is not known if this is intentionally or due to unavailability of services and/or unbearable costs, including opportunity costs. This reality needs to be taken into account while devising health financing strategies to reach qualified health care to the doorsteps of all Ugandan citizens and residents.

A perfect financing scheme and equal contribution levels combined with an imperfect and unequal health care delivery system may not be acceptable to the people.

The **rationale** for this option is that it may be more acceptable to have a multi-tier insurance system supported by budget transfers, which is sensitive to the available health care options and with the scope for gradually improving towards a higher quality of care and over time equal contributions. Equity could be achieved through progressive premiums, adjusted to income levels and capacity to pay, e.g. with free insurance for the poor and the highest premiums for the rich, taking into consideration the area where they live and where they will use health services. residents could be backed up with cash transfers for transport to ensure access to the most appropriate health care facility.

Targeting the poor under any system is expensive. But, targeting geographic areas is relatively easy and inexpensive. Therefore, this option could include 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)[3].

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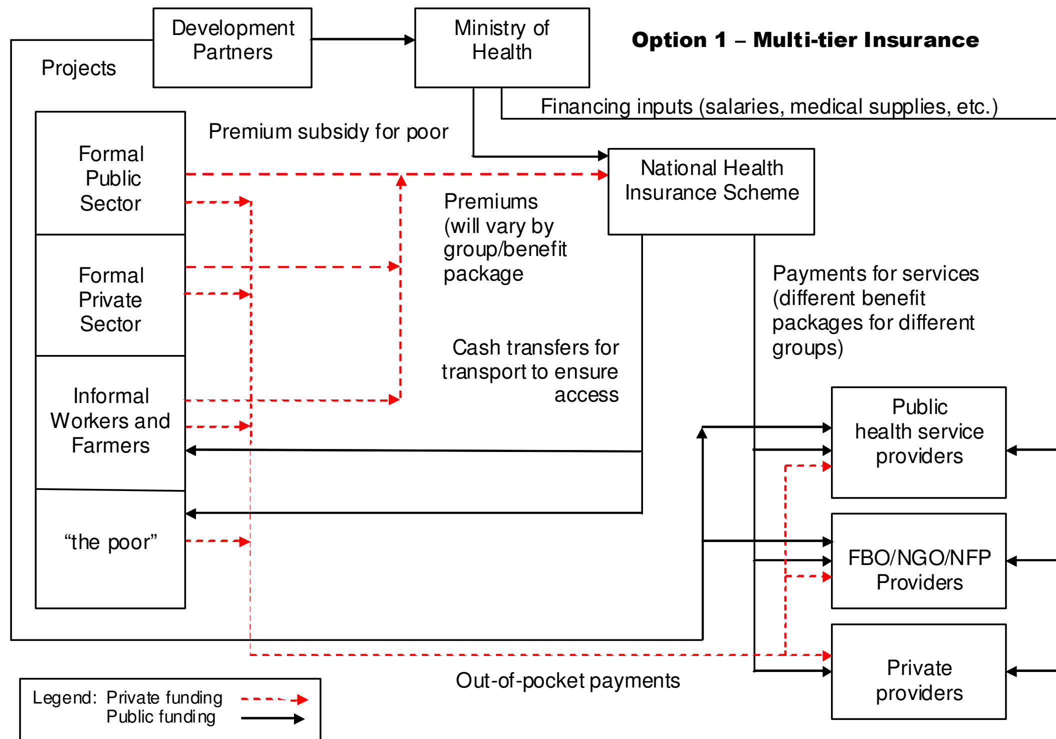
benefits package (BBP). Further, to keep the flow charts readable, not included are: microfinance, which is widely prevalent at least in urban and semi urban areas and some philanthropic resources or voluntary contributions flowing mainly to NGO facilities or to individuals as cash transfers from private agencies or individuals.

[3] The poor, living in urban areas would be offered the urban package of services, free of charge. This means that in urban areas some sophisticated targeting of urban geographic areas or neighborhoods will need to be done to prevent people who can pay contributions getting a free ride. Otherwise, social targeting tools may be necessary to support compliance with contribution payment obligations.

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.

Schematic funds flow:



The chart shows the contributions of the non-poor and the MOH into the NHIS, which in turn is one of the payers of providers. The number of risk pools is diminished in this proposal as compared to the 0-option and paying the providers is less fragmented.

In sum: This option takes into account the existing regional differences in health care services availability and the quality and level of the services, i.e. this option offers different benefit packages with matching contribution rates, poor people being exempted from paying premiums, and health insurance revenues complemented by Budget transfers.

The **advantage**s of this option are that:

a. There is a direct link between the contribution level and the entitlements and/or availability of services

b. It is relatively easy to target the poor, based on geographic areas, as compared to using a complicated individual poverty assessment tool

c. The benefits package will be expanded and available to insured persons who have the advantage of living in an area with a wider variety of services.

d. Informal OOP will be eliminated

The **disadvantage**s of this option are:

a. The poorer categories of the population will receive relatively lower levels of services, although free of charge, until more and better health services will be available in their areas or within easy reach due to upgraded and free transport facilities.

b. Substantial administrative capacity is necessary to offer the various benefits packages and to administer the different contributions.

c. Inequity remains. Thus, this option should be seen as temporary and not distract from creating universal coverage and equal access to quality services.

In this option the role of the Districts in health care financing will disappear. Private insurers will likely have reduced business and CHI's may lose members.

2. Beginning SHI with the Informal Sector and the Poor, using the increased budget

This option is based on the following rationale:

- The poor and the informal sector of the economy are left out of the SHI program for a long time under the original model. So, a solution is needed on how to reach those sectors with social health protection;
- For the time being, there are substantial unresolved issues with respect to the inclusion of private sector formal employees (e.g., opting out, contribution levels and their impact on competitiveness ;
- 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, since public sector unions have maintained that the Treasury should increase the wages of public servants in an equivalent amount to cover the "employee" contribution;; and
- Unresolved questions regarding the impact of "private wings" on the broader public health service delivery system as regards equality in access to quality services, and the availability of human resources for the non-private parts of hospitals..

In recognition of these issues, this option would advocate a focus initially on the provision of health insurance to the informal sector and the poor followed by the inclusion of the formal sector. Once the outstanding issues are resolved. 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.

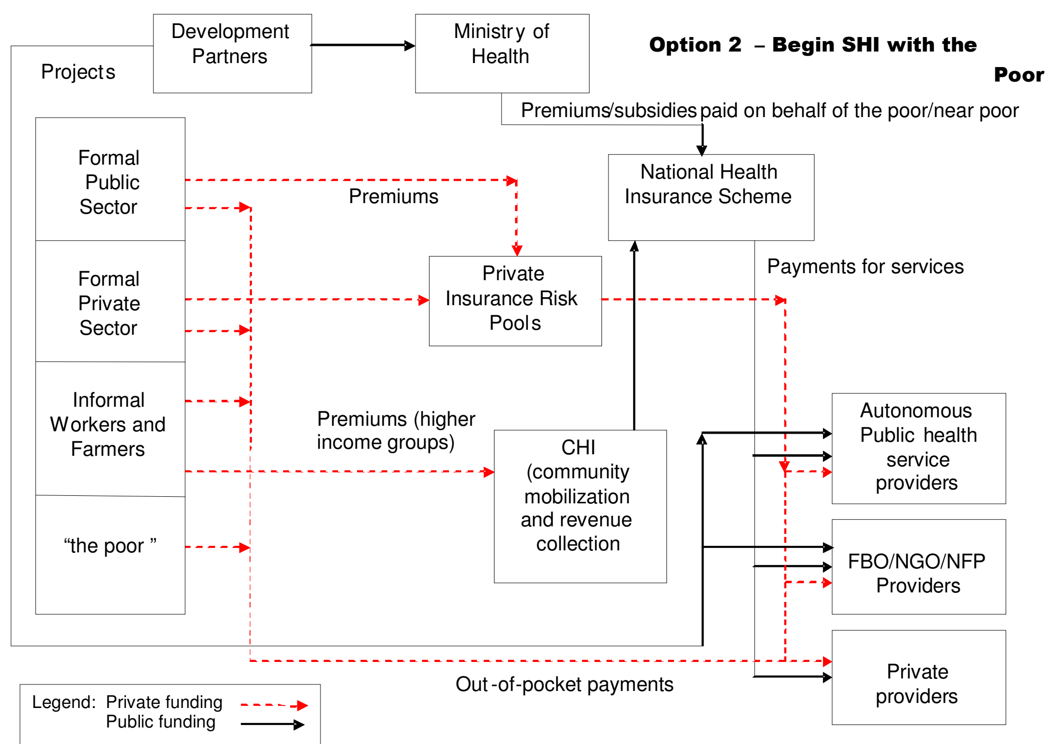
The question might be asked why people who presumably get free health care anyway would sign up for health insurance. A new to be established health insurance agency will exercise its purchasing mandate via contracting a number of health services providers, selected on quality, reliability and price. So, the main inducement would be that subscribers to this health insurance would get access to all contracted health care providers in the NHIS network, including public, and private, for profit and not-for-profit. This means that public providers indeed would need to deliver attractive health services in a forthcoming way in order to keep their patients. With money following the patient, there would be a clear incentive to do so.

Distinct from existing community health insurance schemes, there would also be a portability of health insurance 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 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, e.g. would be able to hire and fire staff according to needs and to use their financial resources in a flexible and efficient way.

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 National Health Insurance Fund.

Schematic funds flow:



This flow chart shows the NHIS, funded from the Budget, from which the providers are directly paid for services to the poor. Community health insurance plays a role towards the NHIS, as shown in the CHI box. Shown are also the multiple risk pools and fragmented paying of the providers.

In summary, the **advantage**s of this approach are:

a. It would address the issue of the substantial delay associated with the originally proposed start of SHI with the public formal sector and allow the addition of substantial resources with even relatively low premium levels, i.e. it prevents the poor and informal sector from being long time left out.

b. In line with SHP objectives, this option would reduce the OOP at the point of services, especially for the poor.

c. It provides time to solve issues around the private sector formal employees and conflicting opinions of employers and employees on NHIS and to sort out the impact of private wings in public hospitals

d. It avoids starting with budget funded civil servants health insurance

e. It adds resources even with low premiums, and avoids a two tier system and fragmenting resources

The **disadvantage**s of this approach would be:

a. The formal private sector will not pay premiums into the NHIS, so that revenue will be lost in the short to medium term

b. Administrative costs would go up, however not more than in option 1

This option will have a limited or a positive impact on the business prospects of private health insurers. CHI may see more members but the CHI bodies will not continue do claims processing but will focus on community mobilization and revenue collection for the NHIS. This will also allow the NHIS to keep the administrative costs of the scheme to a reasonable level.

3. Free care in different format

The original MOH proposal to sustain 'free care' alongside insurance till full coverage is achieved under the NHIS is unlikely to work unless the quality of the services offered via the NHIS contracted providers is clearly distinguishable and detachable from the 'free care'. Giving NHIS the possibility of selectively contracting of services could advance this. If not, why should people pay for the same health care service if it could be obtained for free? Probably for this reason, paid services such as beds in public institutions will be under-utilized while free services are overcrowded. The original MOH proposal with its dual system of providing services will also introduce new administrative challenges. Dual practice may also lead to the artificial creation of waiting lists and waiting times or suboptimal behavioral and medical standards in the public sections in order to push people towards the private wings.

Given this context, it may be more effective and efficient 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 or even graded according to the socioeconomic or geographic status of the card holder (geographic targeting is easier than income targeting). The card would entitle the holder similar health care services irrespective of socioeconomic or geographic status. However, actually getting the benefits in full may be dependent of the area where the card holder lives and the services available in that area or within reach; there would be a difference only in terms of how health care is being financed or in the amount of the contributions paid by or for the individuals, however not in terms of health care benefit. In this way, disadvantaged people would have better access to care.

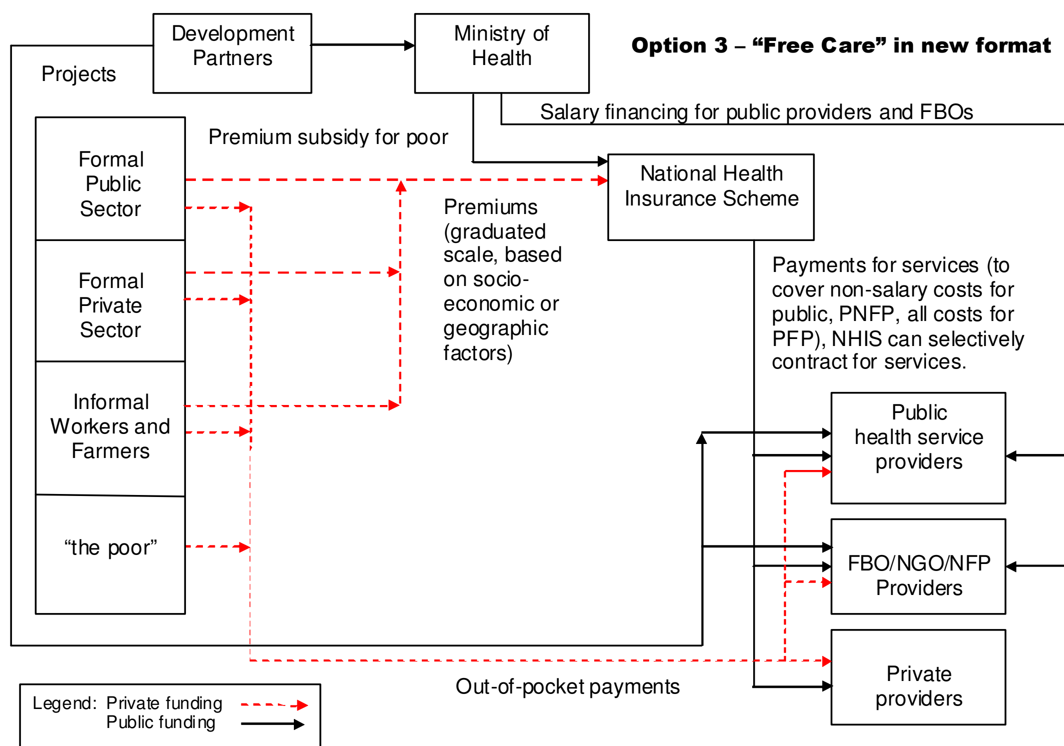
The card allows collecting, compiling and storing of certain valuable socioeconomic, health, and health care data of the entire Ugandan population.

In order to finance disadvantaged people under this option, it is proposed to split the government health spending into two - salary and non-salary. While the salary bill could go to the public facilities 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, the reimbursement to private facilities will be inclusive of salary cost. Thus, from the point of view of the NHIS, public facilities will have a comparative price advantage over private facilities. This may not be perceived as fair competition by the private providers, but public providers likely will need some guaranteed funding until they are full able to compete with private providers on a level playing field. However, over the long term, splitting salary from non-salary costs will not be helpful for the creation of a strong purchasing function and improved provider autonomy, especially with respect to staffing, so this should be seen as a short-term option only. Further, in this option, the NHIS should also be allowed to do selective contracting.

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

Schematic funds flow:



This graph shows the NHIS as single purchaser of health services.

In **sum**, this option's advantages:

a. Insures every citizen

b. Offers the same package of benefits to all citizens

c. Hands out insurance cards to everyone and charges premium according to ability to pay and/or geographic area

d. Allows NHI agency to selectively contract from public and private providers while creating a level playing field for them

e. Cross-subsidizes disadvantaged people

Its **disadvantages**:

a. Administrative costs will go up

b. Substantial capacity required

c. . Negative reactions from private providers are likely because their salary costs are not directly funded from the budget like happens to the public providers.

d. No contribution to the development of a strong purchasing function.

This option will lead to reduced business for the private insurers and the CHI's will possibly see a reduction in members.

4. Expanding the budget financed scheme and moving over time toward NHIS

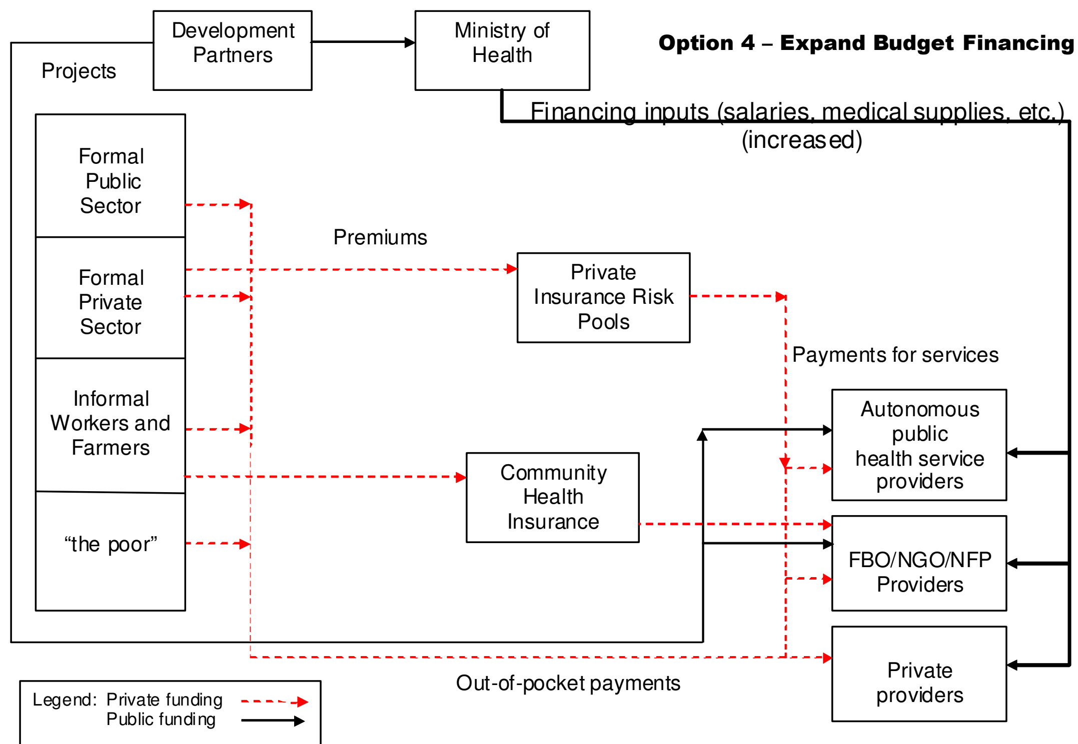
To achieve universal coverage the simplest solution is to expand the current budget funded system and make the existing system more effective and more efficient. **The rationale** for this option can be summarized as: Is it really necessary to establish a health insurance system and to further fragment the already fragmented health financing system and enter into a new financing scheme with all its extra administrative costs and unavoidable learning curve effects once the introduction starts? As the World Bank fiscal space study highlights, there are still significant possibilities to improve efficiency and to direct the saved monies to other needs[4]. Have all options to improve the current system been exhausted?

To fund such an expansion of budget resources, the 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. It is important to note that the August 2009 MOH proposal, would have been paid fully from general tax revenues in its first stage of implementation owing to the position of the public sector unions as described above. Thus, in any event it would be necessary for the GOU to increase taxes or improve tax collection.

[4] World Bank: Fiscal Space Study, 2009

The GOU could therefore 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 to 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.

Schematic flow of funds:



This graph shows, as compared to the 0-option, only the increased input financing from the Budget.

In sum, the advantages of this approach:

a. Simple to implement

b. Prevents further fragmentation

c. Will not require substantive capacity increase, i.e. prevents increasing administrative costs and staffing allocated to administration of the NHIS

d. Expands coverage

e. Improves equality in access to services

f. Potentially reduces OOP (explicit actions needed in this regard)

g. Gives time to improve efficiency in care delivery

h. Gives the possibility to already create an independent purchaser (later called NHI Board) and to already autonomize public hospitals in a necessary parallel action

Disadvantage:

a. No creation of an independent purchasing function

Conditions to make this approach work are:

a. Improved tax collection

b. Addition of sin taxes

c. Making the equivalent of the planned 8% of the civil service wage bill (planned in the August 2009 MOH proposal) available for improved health services

d. Eventually charging a solidarity tax from company based HI

Contrary to all other alternative options, in this approach the role of the District authorities in health financing will not decrease or be abolished but instead will increase. Private insurers may have less business and CHI's will likely see a reduced scope of activities . as publicly financed services become more widely available and accessible.

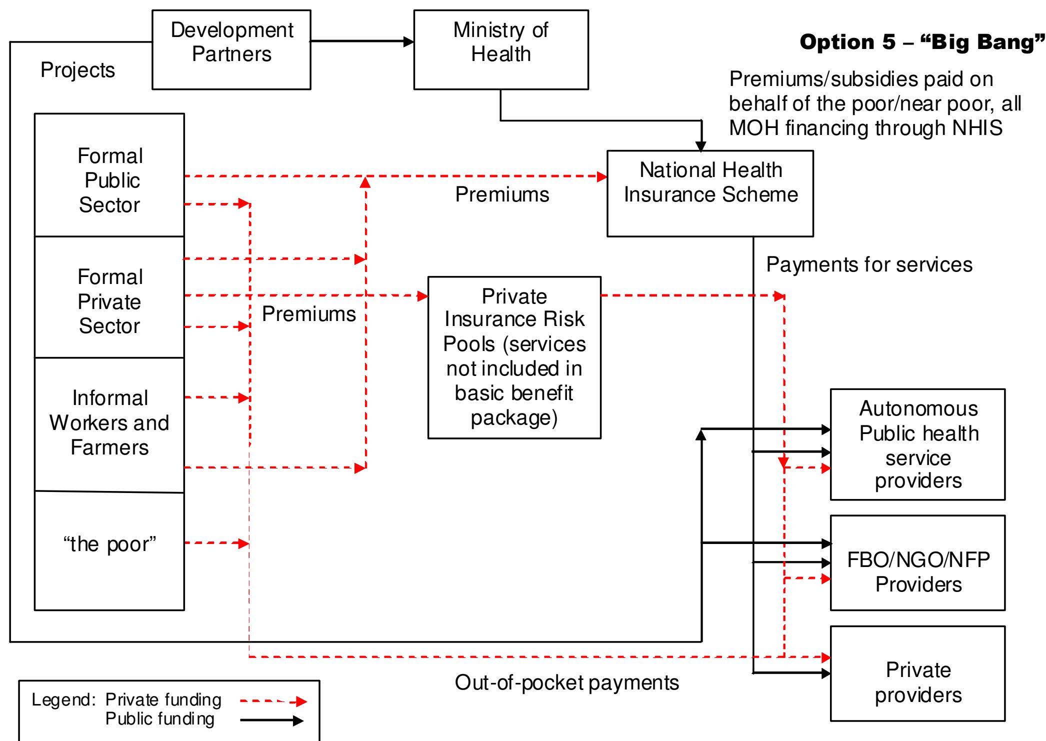
5. Big Bang towards NHIS

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.

Schematic funds flow:



This graph shows the simplification of paying the providers: only one main purchaser (the NHIS) while the private insurers offer coverage of services not included in the NHIS.

In sum: the **advantages** of this option as compared with the August 2009 proposal are, it:

a. Offers universal coverage and offers a broader package from the start.

b. Includes formal and informal sectors from onset

c. Eliminates informal OOP

d. Creates a single purchaser, with advantages for costs & quality assurance

e. Prevents a two-tier system

However this system takes time to prepare, i.e.

a. T o figure out the revenue basis

b. To determine the breadth and depth of the benefits package which, of course depends on the available initial revenues

c. To establish capacity to run the system.

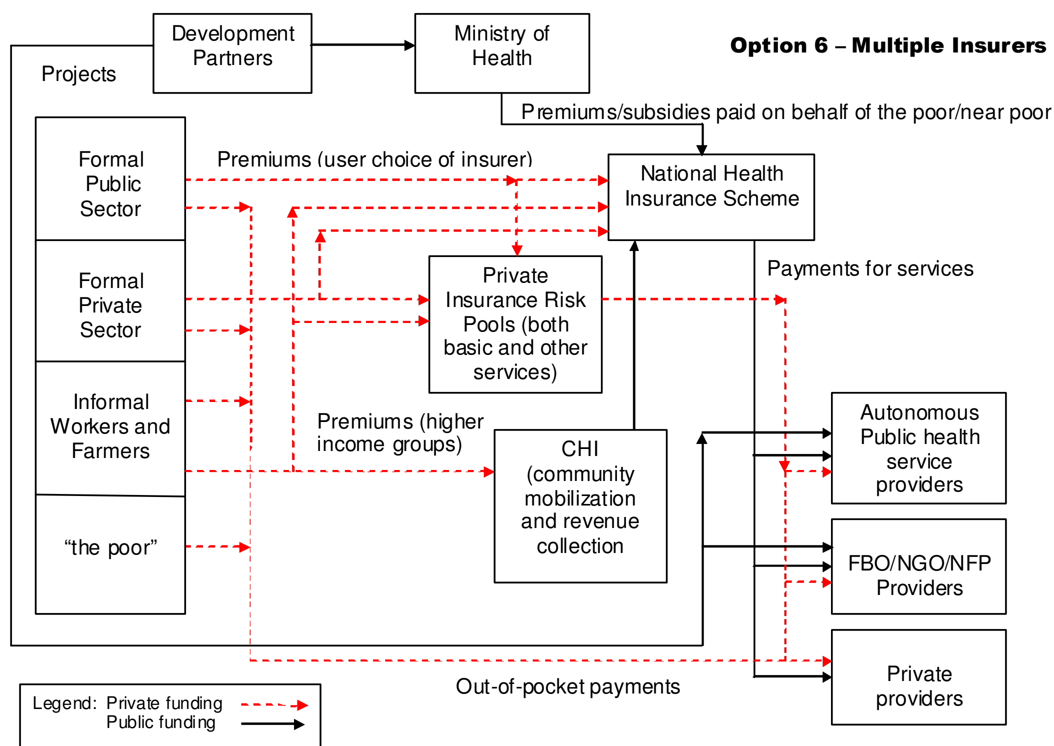
This approach will reduce the role of the Districts in terms of funding, but with increased activity, could enhance their role with respect to supportive supervision. It may also reduce business of

private insurers to the extent that they are currently covering services which might be expanded under this option. The CHI's may get more members but have reduced activities.

6. Multiple insurers

This option was proposed during a discussion with the Task Force, suggesting that the public health insurance system could be implemented by private insurance companies, eventually in competition with a public health insurance agency. However, there is no evidence that a system with competing insurers contributes to cost control or to quality improvement, i.e. that it would be of increased benefit for the Ugandan citizens, but this may be seen as an appropriate trade-off for private sector support. Among the issues that would need to be resolved would be the mechanisms for collecting and distributing premium revenue between public and private insurers. There would also be a need for a strong, independent regulatory body that would license and monitor insurers, define the benefit package, and set tariffs for those services covered under the benefit package. If private insurers were included, this would likely need to be more independent from government compared to a system where there was only a public insurer for the BBP.

Schematic flow of funds :



The **advantages** of such system would be:

a. for the existing private insurers to keep their current market share and volume of risks and to further expand this volume.

b. For the citizens to have a choice of insurer

c. Equal access to care

d. Elimination of informal OOP

The **disadvantages** of this system:

a. High administrative costs for running multiple insurers

b. High administrative costs for running and supervising the overall system :

   i. To prevent cream skimming or risk selection by the insurers,

   ii. For ascertaining the acceptance of any insured irrespective of his health risks and pre-existing medical conditions for the same contribution as charged to all others (i.e. no premium differentiation or risk rating)

   iii. Regards the establishment and running of a risk equalization mechanism which will require sophisticated health management information system and in depth detailed auditing of insurers while a good system would take years to establish.

The role of the Districts would be diminished in this system while the CHI's may see more members but have fewer activities (no claims processing)

7. Option X

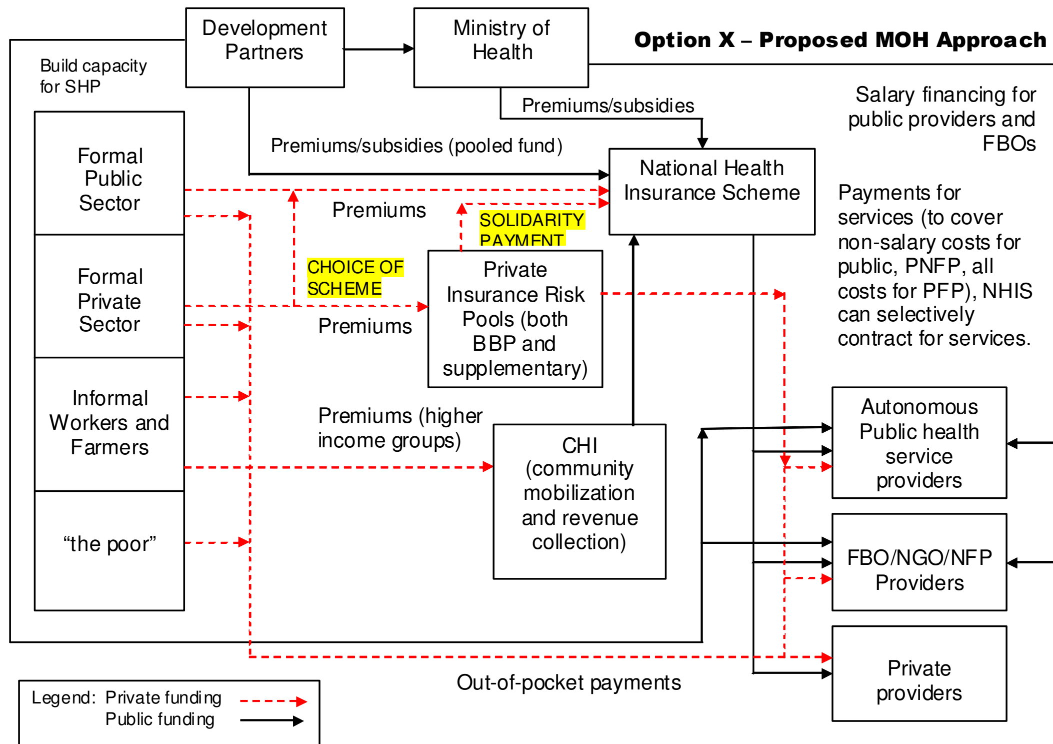
After the departure of the visiting team, one of the team members, Dominic Haazen, returned to Kampala on request of MOH to further discuss the options, leading to a seventh option, having the preference of MOH. This option is a variant of option 6 (Multiple Insurers). The differences are as follows in Option X:

- No separate category for the poor, because the informal workers and farmers can also be poor.
- The funds from development partners flow directly into the National Health Insurance Scheme (instead of via MOH)
- A choice of scheme and of insurer will be given
- Private insurers will be obliged to pay a solidarity contribution into the NHIS
- Salaries are paid directly by MOH to the public providers and FBO's (like currently is done).

- The NHIS will pay non-salary costs for public providers, private not for profit (PNFP), all costs for private for profit providers (PFP).

- NHIS can selectively contract for services.

Schematic flow of funds :



The advantages and disadvantages are the same as in option 6, except:

Added advantage:

- Solidarity payment of private insurance into the NHIS

Added disadvantage:

- continuation of salary payment by MOH, which reduces the option for the management of the providers to influence their fixed costs. However, it may secure the employment of staff albeit at the cost of efficiency.

- This option will further fragment the purchasing function and reduce the options for the NHIS.

In option X, it could also be possible to offer all the three options (NHIS, Private Insurance and Community-based financing) to every section of the population so that they could opt for one of these. Option X would offer the freedom of choice of contracted providers by subscribers. This would be essential to induce subscribers who currently nominally get free care, to join the scheme. Other options can also offer such choice.

Private insurers would be able to offer the BBP but only at rates that are the same as for the NHIF. This would give people freedom to choose BBP providers on a cost-neutral basis. Given that those opting for private insurance would likely be younger and healthier, private insurers would be required to make a "Solidarity Payment" to the NHIF as compensation for this fact. The payment should be set so that the "actual cost of care" plus the "solidarity payment" is equal to the premiums collected. This would of course need to be actuarially determined. The bottom line is that there should be no subsidization (positive or negative) between the BBP policies and the supplementary non-BBP policies. Private insurers could compete on service, "one-stop shop" convenience and other benefits.

The following table summarizes the options and their characteristics.

Comparison of Social Health Protection Options

	Option 0 NHIS initial roll-out	Option 1 Multi-tier Insurance	Option 2 Begin with the Poor	Option 3 "Free care" in new format	Option 4 Expand Budget Financing	Option 5 "Big Bang"	Option 6 Multiple Insurers
Coverage by NHIS							
Formal Public	X	X		X	N/A	X	Choice by subscriber
Formal Private		X		X	N/A	X	Choice by subscriber
Working Poor		X	X	X	N/A	X	Choice by subscriber
Informal/Farmers		X	X	X	N/A	X	Choice by subscriber
Poor		X	X	X	N/A	X	X
Benefit Package							
Formal Public	Based on 8% of salary	More services		Basic package	Financing of inputs	Basic package	Basic package
Formal Private	No change	More services		Basic package	Financing of inputs	Basic package	Basic package
Working Poor	Reduced access	No change	Basic package	Basic package	Financing of inputs	Basic package	Basic package
Informal/Farmers	Reduce access	No change	Basic package	Basic package	Financing of inputs	Basic package	Basic package
Poor	Reduced access	No change	Basic package	Basic package	Financing of inputs	Basic package	Basic package
Premium Levels							
Formal Public	8%	Higher		Higher	None	Based on income	Based on income
Formal Private		Higher		Higher	None	Based on income	Based on income

Working Poor		Lower	Based on ability to pay	Lower	None	Based on ability to pay	Based on ability to pay
Informal/Farmers		Lower	Based on ability to pay	Lower	None	Based on ability to pay	Based on ability to pay
Poor		Lowest	Paid by GOU	Lowest	None	Paid by GOU	Paid by GOU
Source of Funding							
Formal Public	100% GOU	100% GOU		100% GOU	100% GOU	100% GOU	100% GOU
Formal Private		Employer/ employee		Employer/ employee	100% GOU	Employer/ employee	Employer/ employee
Working Poor		Employer/ employee + GOU subsidy	Employer/ employee + GOU subsidy	Employer/ employee + GOU subsidy	100% GOU	Employer/ employee + GOU subsidy	Employer/ employee + GOU subsidy (if NHIS chosen)
Informal/Farmers		Self + GOU subsidy	Self + GOU subsidy	Self + GOU subsidy	100% GOU	Self + GOU subsidy	Self + GOU subsidy (if NHIS chosen)
Poor		100% GOU	100% GOU	100% GOU	100% GOU	100% GOU	100% GOU
Out-of-Pocket - BBP							
Formal Public	Eliminate informal	Eliminate informal	No change	Eliminate informal for package covered	Eliminate informal	Eliminate informal	Eliminate informal
Formal Private	No change	Eliminate informal	No change	Eliminate informal for package covered	Eliminate informal	Eliminate informal	Eliminate informal
Working Poor	No change	Eliminate informal	Eliminate informal	Eliminate informal for package covered	Eliminate informal	Eliminate informal	Eliminate informal
Informal/Farmers	No change	Eliminate informal	Eliminate informal	Eliminate informal for package covered	Eliminate informal	Eliminate informal	Eliminate informal
Poor	No change	Eliminate informal	Eliminate informal	Eliminate informal for package covered	Eliminate informal	Eliminate informal	Eliminate informal
Impact on Private Insurers	None	Reduced business for BBP services	None, or increased business	Reduced business for BBP services	Reduced business for BBP services	Reduced business for BBP services	Increased business and numbers

Impact on CHI	None	Possible reduction in members	More members, but reduced scope of activities (no claims processing)	Possible reduction in members	Possible reductio n in members	More members, but reduced scope of activities (no claims processing)	More members, but reduced scope of activities (no claims processing)
Impact on health financing mandate Districts	No change	Mandate restricted to supervision	Mandate restricted to supervision	Mandate trestricted to supervision	Increase d activities	Mandate restricted to supervision	Mandate restricted to supervisio n
Capacity requirements and impact on admin costs	Substantive	Substantiv e	substantiv e	Substantiv e	Limited	Substantiv e	Big

V. Conditions

Regardless of the option MOH and GOU would prefer, it will be necessary to strive for:

- Increased autonomy for public health providers. This is essential to allow them to compete with non-public providers, once the funding of providers changes from input-based to performance-based, and the "money follows the patient").
- Development of a provider accreditation system, irrespective of ownership status or of a contract with the health insurance agency. Such development is advised to be placed in the framework of a more comprehensive health care quality improvement strategy
- Starting with capacity building immediately for both running and regulating health insurance. Capacity for shaping and reshaping provider payment systems related to cost and quality control will be one of the essential features
- Improving the efficiency of public health providers
- The development of mechanisms for engaging development partners in direct funding the SHP mechanism

VI. Some further general comments on the options.

In all options, for all the three variants of insurance (NHIS, private insurance and community financing), people could be given a choice as long as there is an appropriate link between each one of them, such as including some solidarity payment from private insurance to the other schemes to strengthen solidarity. Such mechanism would optimize the relation between the paid premium and covered and accessible health care services, i.e. a differential premium and care. This may not be ethically acceptable on the long run. But, that is the way it is in now in Uganda.

Public (and private) health care infrastructure is strong in urban and semi-urban areas. People living in these areas are likely to receive better care and therefore, may be willing and able to pay higher premium. But, at the same time, people in rural areas lack access to good infrastructure, particularly for inpatient care and therefore, may not be willing and able to pay higher premium. Even if the government accepts to pay premium on their behalf, it may not mean anything to them in terms of health care. Rather, government could top up their insured benefits by providing additional facilities such as an ambulance in health centres-2 so that rural people could be linked with hospitals for inpatient care.

Only then, insurance will have some meaning to the population in rural areas. This can be furthered by organizing outpatient care financing around community financing with the government toping up with additional premium for a group insurance linked to the NHIS and additional facilities to ensure health care at all levels. Micro-finance could also be explored, although this would be an aid for people to pay their premiums, rather than a specific financing mechanism.

Three levels of premium will appear: High. Moderate and Low. The highest premium will be for private insurance as it is for-profit and also it will cover high-cost health care options, although these services would not be part of the NHIS program. These services can be included in voluntary supplementary programs.

However, under Option X, The NHIS premium will be moderate because it will include government health care institutions, whose cost are not entirely premium based and it will offer relatively low-cost care. The NHIS would also offer the BBP, and will include formal sector workers, whose premiums (in aggregate) should more than cover the cost of their care, as well as informal sector and the poor, whose premiums would be subsidized or covered from other sources (Development Partner funds or MOH subsidies).

The community health financing way could be the cheapest of the three as this now covers mostly basic essential care. However, in the proposed option communities would focus on community mobilization and revenue collection and would feed into the NHIF system. Thus the package of benefits would not be different from those who register through the NHIS directly.

The community option could be organized around the health centers while the HNIS option would be around hospitals, but this has proved to be an ineffective strategy in Tanzania, where the potential benefits of having only coverage by health centers are perceived as less than the costs of CHF coverage. So, the better way is need to provide the same BBP to everyone, including hospital care, with premiums based on ability to pay.

In case the community option will nevertheless be included in the scheme, than the facilitator for the community option could be the district health committee which includes representatives from the government, NGOs and the community. Communities could pay subsidized premium to NHIS for inpatient care while they take care of the outpatient care locally. In this way, there will be a link between all the three options with the possibility of cross-referral between the three. However this could lead to multiple payers which may create inefficiencies. This option would eventually need to be further explored and the problems addressed during the detailed design process.

The facilitation and regulatory process could be designed accordingly.

VII. Regulation of the NHIS in Option X

The Ministry of Health has later on in the process, after the P4H team already had left , given some further thoughts to how its preferred health insurance scheme could be regulated:

a. Health Insurance

- A single regulator should be established for both public and private health insurance, focusing on financial stability, consumer protection and business related issues (including contracting, claims processing/adjudication, etc.);
- MOH would recommend to NOT include this NHIS regulator within the existing overall financial services/insurance regulatory authority;
- The regulator should be financed through GOU budget, with contribution from those being regulated (through the Solidarity Fund);
- All stakeholders should be represented on the governing body of the regulatory body;
- The regulator could be possibly housed in Ministry responsible for social protection under the Social Protection Regulatory Authority.

b. Health Providers

- Initial licensing and re-licensing of providers should be done by the MOH, with input from the councils of health professionals;
- Investigation of complaints would be done by professional councils, with oversight by the MOH (possibly leading to action on the status of the license if necessary)
- Regular assessment of quality of care (minimum standards) would also done by the MOH, with input from the health professional councils.

c. Basic Benefit Package and Payment Tariffs

- Establish a "Health Benefits and Tariffs Board" to define the basic benefit package (BBP), and to develop appropriate tariffs which all insurers should pay for insured services;
- Because of the mix of public and private health insurers, semi-autonomous bodies will be needed to regulate benefit package and tariff issues;
- The tariffs established should be used for compensation of all providers who are contracted by either the NHIS or private insurers with respect to services within the BBP. By contract, no "balance billing" will be allowed.
- Should be financed through GOU budget, with contribution from those being regulated (through Solidarity Fund);
- All stakeholders should be represented on the governing body of the regulatory body;
- Possibly housed in Ministry responsible for social protection under the Social Protection Regulatory Authority.

d. Accreditation

See "Accreditation Toolkit"[5] for key issues and options.

[5] ISQUA: http://www.isqua.org/isquaPages/Accreditation/ISQuaAccreditationToolkit.pdf

- Preference for independent organization under the MOH, independence established and protected by act of Parliament;
- Include multi-disciplinary, respected senior professionals on governing board, no more than 2 terms;
- Ensure stakeholder involvement in developing the process, independent implementation of the process;
- Accreditation should be done periodically (annually or less frequently depending on outcome of previous accreditation);
- Should aim to develop highest quality standards of health care and to promote continuous quality improvement for all providers irrespective of their eventual acceptance as a provider of care to insured patients
- Accreditation can be seen as a necessary condition but may not be sufficient for a payment relationship with the NHIS
- Should cover the entire health sector (public, PNFP, PFP)
- Should be guided by international best practice.

VIII. Comments from the P4H team on the regulation of option x

If indeed the GOU prefers to introduce Option X than the above mentioned Regulator would be essential. Such regulator will require a firm legal basis and enforcement capacity and a lot of sophisticated capacity building at the regulator as regards human resources and health management information systems (HMIS). If this is not timely done and if it is not possible to attain transparency in operations of the various schemes, than this option creates risks for consumers as regards risk selection and risk rating. It poses also problems for the public scheme if the payment of solidarity contributions is avoided and if private insurers will do risk rating of the insured. This latter policy may lead to dumping all bad health risks at the public scheme, making this scheme unsustainable.

Although an independent regulator is a good idea, close cooperation with other bodies, e.g. with the general insurance regulator will be necessary. Private insurers will not only offer health insurances but also other insurances. Enforcement of solidarity contributions will require transparency in operations and the numbers of privately insured per insurer need to be known. The simplest form of such solidarity contribution will be a nominal flat fee per enrolled individual.

The investigation of complaints as referred to in the provider section will be about medical care, i.e. not about benefits or insurer behavior. This latter function may be ascribed to the regulator (as to avoid the tedious process of going to a Court and using the regular judicial system.

Districts could also play a role in the quality of care assurance process, next to professional councils.

Instead of creating separate benefits package and tariffs boards, this function can also be taken by the general health insurance regulator, albeit in an advisory role because of the health and fiscal impact of benefits decision. So, MOH and the government as such should play a role. Prudence will be required in such set up because of the dual role of MOH, which is also a health services provider.

If tariffs are set on a uniform level by a tariffs board than this will undermine competition between providers, which as such will only happen where there is relative oversupply of providers, i.e. only in the cities. The use of maximum tariffs can be considered as to give insurers room to negotiate.

It is assumed that “the highest quality standards” will have to be interpreted as the highest possible quality standards, related to affordability.

IX. The way forward

The continued efforts of the Task Force, the establishment of an inter-ministerial committee and the orientation towards Social Health Protection create an enabling environment for the transition process towards Universal Coverage. Future progress and sustainability will depend on

- strong ownership and stewardship on the Ugandan side
- a strategic and inclusive stakeholder process
- effective integration in the health sector reform process
- linkage to the Social Protection framework process
- strengthening the capacity to facilitate, manage and implement the discussions and decisions regarding the possible health financing options
- aligned and harmonized support of external development partners.

P4H is offering continued tailored and demand oriented support. It has been proposed to take the cooperation to another level, moving away from bigger periodic missions to a more flexible and integrated mode of delivery. In this context, it has been suggested to develop a road map for the transition process, including clarifications on roles and responsibilities, milestones and division of labor among different partners.

X. Next steps

Below a summary of discussions and agreements on the next steps:

It was acknowledged that the options presented are neither complete nor exhaustive: other options or variations of the options above are clearly possible, including the structures and funds flow within each option. However, the options are indicative of the kinds of considerations which need to be reviewed in coming up with an appropriate long-term health financing approach. The MOH and its Task Force agreed to consider the above options in light of the Ugandan health sector, its socio-fiscal-economic and cultural context and its core values . In case of questions and a need for further clarification, P4H partners would be happy to search for answers together with MOH.

However, MOH is advised to make a choice between the offered alternatives as soon as possible. Thereafter more detailed elaboration of the chosen option would need to be done. In case MOH would seek support of the P4H partners, it would be best if this support could also lead to

capacity building at MOH and other agencies as to allow for future adjustments of the chosen system.

The MOH will update the Road Map on the proposed National Health insurance scheme with clear milestones on technical issues like regulation and accreditation, indicating the steps and decision points, the institutional and administrative arrangements as well as the topics for which it would like to have inputs from P4H partners.

Further, the MOH will regularly update Providing for Health of the major issues arising out of the Task Force meetings, and will seek to integrate the proposed National Health Insurance Scheme as part of the entire Social health protection Program

MOH will also consider doing a social assessment of the consequences of a proposed new health financing system, followed measures to mitigate any negative consequences.

That MOH will also draft legislation to foster financial autonomy of hospitals to allow for more efficiency in health care delivery as a necessary complement to the introduction of selective purchasing as part of health financing reform.

The contributions of development partners, including P4H

It is very much up to the GOU/MOH to formulate its needs for cooperation and involvement of P4H partners and development institutions. P4H partners have agreed with MOH that it can request for clarification and advice to be provided by representatives of P4H partners in Uganda or in the region, from remote by P4H partners or their experts from outside of the region.

Regular activities of P4H partners in Uganda could also be used as vehicle for dialogue and assistance on health financing reform. This approach would prevent separate missions and an extra burden for the Ugandan officials and their staff.

Final

P4H partners have herewith provided MOH and others with their impressions of the follow up visit to Uganda and would very much welcome the feedback and proposals of MOH and other counterparts in Uganda as to better be able to partner with them in their effort towards broad social health protection.

XI. Annexes

Annex 1. P4H team composition

Michael Adelhardt, Team Leader, P4H Coordinator WHO, Geneva

Juliet Bataringaya-Wavamunno, Health Economist, WHO Uganda Office

Dominic Haazen, Lead Health Policy Specialist, World Bank Africa Human Development Department

Marc Lejars, Regional Health Advisor, Embassy of France in Kenya, Nairobi

Jan Bultman, Consultant Health Systems, GTZ

Annex 2. List of persons met during February 2010 visit

Nduhuura Dr. Richard,	Minister of State for Health (GD)MOH
Runumi Mwesigye, Dr.Francis	MOH Commissioner Health Services (Planning)
Basaza, Dr. Robert K.	MOH.Principal Health Planner
Saweka, Dr.Joaquim	WHO Country Office for Uganda
Nyanzi, Emily	MOH
Christine R. Mubiru	Policy Analysis Unit (PAU)- MoH
George .S.Okotha	Deputy Commissioner Technical Uganda Insurance Commission. TF member
Frederic Makaire	Uganda Community Based Health Financing Organization
Christopher Karhirita	Chairman Central Organization of Free Trade Unions, Direcor NSSF, TF member
Mrs.Rosemary .N. Ssenabulya	Executive Director – Federation of Uganda Employers (FUE), TF member
11.Robert .J. Mawanda	Uganda Manufacturers Association, TF member
George Serunjogi	MOFPED, TF member
Patrick Luwanga	Rep. HMO, Head Doctor TF member
Morris Seru	MOH, Pharmacy Section
Jonathan Katumusiime	CES MNFE, TF member
Ms.Namitala Lindah	Uganda Insurers Association, TF member
Mudiba Hassan	Central Organization of Free Trade Unions
Emmanuel Barigana	National Organization of Trade Unions, TF member
Kaitiritimba Robinah	UNHCO (Civil Society)
Lambda, David	NSSF, Social Protection Specialist

Lukwata, Dr. Hafsa	MOH -TF Member
Tumwesigye, David L.	NSSF, Performance Intelligence Manager
Denis Owens Ochieng	Chief Risk Officer, NSSF
Francis Baryahabwa	Ag. Chief Operations Officer, NSSF
Dirk Mueller	KFW
Martin Schmidt	KFW
David ?	KFW consultant

Annex 3. Terms of Reference P4H Uganda visit 17-19 February 2010

Background

A P4H team comprising WHO, Germany and France attended a national **health policy workshop** on 15-18 June 2009. The concept of SHP and the role of the Ministry of Health as steward in the transition towards universal health coverage have been included in the national health policy 2010-2020.
From 3-14 August 2009, P4H conducted its **first mission** to Uganda with a team of 10 experts from WHO, Worldbank, ILO and Germany as well as external consultants. The mission focused on the proposed National Health Insurance Scheme, in particular its role towards achieving universal coverage and SHP, its links to health reform and broader social Protection, but also operational design issues. A report including possible options on the way forward has been forwarded to Uganda and is being discussed at various levels.
A planned subsequent ILO actuarial study needed to be postponed and results may only be available mid 2010.
A **health financing review** has been carried out by MoH/WHO from 11-22 Jan 2010.

Purpose of the visit

Continued P4H support to Uganda in the transition process towards Universal Coverage (UC) and better Social Health Protection (SHP).

Specific objectives and tasks of visit

1. Follow-up on previous visits and analytic work

- Presentation and discussion of the results of the health financing review (Jan 2010);
- Meetings with relevant stakeholders to receive feedback on the P4H report submitted in 2009 and to discuss the outlined health financing options.
- Update and discussion on the consequences for the proposed National Health Insurance Scheme

2. Health Financing Strategy

- Discussion of P4H involvement in the development of a health financing strategy

3. Capacity Development

- Development of a Capacity Development plan for the transition process towards Universal Coverage.
- Update and discussion about the possible launch of a Ugandan health economics institute.

4. Future P4H collaboration

- Clarification of the roles of P4H partners and their involvement in the transition process, including the role of local, regional and international level
- Integration of various work streams related to SHP and SP in the health reform process.

Annex 4. Briefing note for MOH and Development Partners

Uganda Health Financing Reform

Meeting MOH, Uganda Development Partners and P4H Team

Kampala, 17 February, 2010 at 3.30 PM

Objective

The objective of the meeting is to (i) receive the views of Development Partners on health financing reform in Uganda, taking a comprehensive approach from a social health protection and health systems perspective, (ii) discussing options as eventual alternatives for the MOH developed National Health Insurance System (NHIS) and (iii) exploring areas of work where DP's could contribute to the further development of a health financing strategy and could support capacity building.

Terms of reference P4H team

In General: to provide **c**ontinued P4H support to Uganda in the transition process towards Universal Coverage and better Social Health Protection

More Specific:

To **follow-up** on previous visits and analytic work via (i) presentation and discussion of the results of the health financing review (January 2010); (ii) meetings with relevant stakeholders to receive feedback on the P4H report submitted in September 2009 and to discuss the outlined health financing options; (iii) update and discussion on the consequences for the proposed National Health Insurance Scheme; (iv) discussion of P4H involvement in the **development of a health financing strategy;** (v) to start the making of a **Capacity Development** plan for the transition process towards Universal Coverage, including an update and discussion about the possible launch of a Ugandan health economics institute; and (vi) to discuss **future P4H collaboration** by (a) clarification of the roles of P4H partners and their involvement in the transition process, including the role of the local, regional and international levels and (b) the integration of various work streams related to SHP and SP in the health reform process.

P4H September 2009 Report

In summary: the then **proposed NHIS** and its planned implementation poses some **serious risks**:

a. The poor may be worse off 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.

- 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 can further decrease due to the creation of a parallel funds flow, the absence of increased pooling of funds and the increase in administration costs.
- It does not contribute to the creation of a strong purchaser, which could use its clout for selective contracting of efficient quality health care services of public and private providers.

A number of **alternative options** was suggested for further consideration and discussion:

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

See Annex for more details of HNIS alternatives.

The **P4H Report recommended** the following:

- Reconsider the current proposal & draft NHI bill and engage in further discussion and review of alternatives to advance social health protection.
- Strengthen the process of engagement and dialogue with stakeholders, including improved inter-ministerial coordination within the Government itself.
- Organize guided public debates on advantages and disadvantages of various financing options outlined in this report.
- Revise the draft Health Insurance Bill, taking into account the comments and revisions proposed by the P4H team.
- 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.
- Develop an independent accreditation system, separate from health financing reform, as part of a systemic quality assurance system/framework for all health facilities irrespective of sources of payment
- Start capacity building for health financing reform implementation
- Consider
    - Introduction of a purchaser-provider split,
    - Greater autonomy of public health care institutions, including financial
    - Development of capacity for effective purchasing of health services, including the development of a system of contracting of providers.
    - Increasing efficiency via:
        - Health workforce management & performance
        - Strengthening procurement and logistics management for drugs and supplies
        - Creating a referral system
- 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).

- Do not allow for opting out, i.e. for company based health insurance, of an otherwise mandatory scheme because it undermines sustainability of the overall system

- Carefully choose the systems of provider payments that allow for cost-containment and quality assurance even while staying within the overall available budget envelope.

- Coordinate via the Cabinet of Ministers:

    - To align, coordinate and unify MOH and NSSF plans for health/medical

    - To prevent further fragmentation of the health care funding system, while

    - NSSF could play a useful role in the collection of contributions.

Comments received from NHIS Task Force

The P4H team received very valuable comments and suggestions from the TF, some of which could be **taken up by the Development Partners**, like:

8. Provide more details on how the proposed scheme could address the poorest of the poor.

9. Provide a comprehensive background paper on human resources issues related to HF reform.

10. Elaborate on the issue of pharmaceuticals in relation to services delivery in an NHIS.

11. Assist in a thorough review of the benefits package (BP), in costing out the proposed BP and in analyzing the trade-offs between OOP's and the size of the BP.

12. Proposing modalities of NHIS into the broad social protection strategy, including aiming at poverty reduction.

13. Proposing a model for structural dialogue between top leadership and stakeholders, and on how to engage with local governments and support building up their capacity.

14. Ascertain more efficiency and reliability in the allocation of donor resources

Besides in the above areas, there may be a need to support

1. The development of a comprehensive health care quality improvement strategy, including an accreditation system.

2. Te development of capacity for the implementation of a new HF strategy and preparing a plan for such development.

Annex to Development Partners Briefing Note:

Details on Alternative options for the proposed NHIS

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

    a. Takes into account the regional differences in health care services availability and quality, i.e. offers different benefit packages with matching contribution rates, poor people exempted, and complemented by Budget transfers

    b. Pro: Relatively easy to target the poor, based on geographic areas

    c. Con: inequity remains, thus

    d. Should be temporary and not distract from creating universal coverage and equal access to quality services.

2. **Beginning SHI with the Informal Sector and the Poor, using the increased budget**

    a. Prevents the poor and informal sector from being long time left out

    b. Provides time to solve issues around the private sector formal employees and differing opinions of employers and employees on NHIS and

    c. To look at private wings in public hospitals

    d. Avoids starting with budget funded civil servants HI

    e. Pro: adds resources even with low premiums, and avoids a two tier system and fragmenting resources

3. **Free care in different format :**

    a. Insures every citizen

    b. Same package of benefits

    c. Hands out insurance cards to everyone and charges premium according to ability to pay and/or geographic area

    d. Allows NHI agency to selectively contract from public and private providers while creating a level playing field for them

    e. Cross-subsidizes disadvantaged people

4. **Expanding the budget funded scheme and over time moving to NHIS**

    a. Pro: simple to implement

    b. Prevents further fragmentation and increased admin costs

    c. Gives time to improve efficiency in care delivery

d. Conditions: improve tax collection and add sin taxes

e. Add 8% of the civil service wage bill (planned for NHIS)

f. Eventually a solidarity tax from company based HI

g. Create independent purchaser (later called NHI Board) and autonomize public hospitals

5. Big Bang towards NHIS

a. Includes formal and informal sectors from onset

b. Pro: universal coverage and

c. Single purchaser, advantage for costs & quality

d. No two-tier system

e. Takes time to prepare, i.e.

f. revenue basis?

g. Breadth and depth of benefits package?

Annex 5 Summary slides of October 2009 P4H Report

Annex 6 Briefing slides for meeting with MOFPED

Annex 7. Recommendations of October 2009 P4H Report

P4H September 2009 Report

The **P4H Report recommended** the following:

- Reconsider the current proposal & draft NHI bill and engage in further discussion and review of alternatives to advance social health protection.
- Strengthen the process of engagement and dialogue with stakeholders, including improved inter-ministerial coordination within the Government itself.
- Organize guided public debates on advantages and disadvantages of various financing options outlined in this report.
- Revise the draft Health Insurance Bill, taking into account the comments and revisions proposed by the P4H team.
- 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.
- Develop an independent accreditation system, separate from health financing reform, as part of a systemic quality assurance system/framework for all health facilities irrespective of sources of payment
- Start capacity building for health financing reform implementation
- Consider
    - Introduction of a purchaser-provider split,
    - Greater autonomy of public health care institutions, including financial
    - Development of capacity for effective purchasing of health services, including the development of a system of contracting of providers.
    - Increasing efficiency via:
        - Health workforce management & performance
        - Strengthening procurement and logistics management for drugs and supplies
        - Creating a referral system
- 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).
- Do not allow for opting out, i.e. for company based health insurance, of an otherwise mandatory scheme because it undermines sustainability of the overall system
- Carefully choose the systems of provider payments that allow for cost-containment and quality assurance even while staying within the overall available budget envelope.
- Coordinate via the Cabinet of Ministers:

- To align, coordinate and unify MOH and NSSF plans for health/medical
- To prevent further fragmentation of the health care funding system, while
- NSSF could play a useful role in the collection of contributions.

Besides in the above areas, there may be a need to support

3. The development of a comprehensive health care quality improvement strategy, including an accreditation system.
4. Te development of capacity for the implementation of a new HF strategy and preparing a plan for such development.

Annex 8. Comments of Task Force on Health Insurance on October 2009 P4H report and reply (R) by P4H team (under the specific comments)

Comments on the report by Providing for Health provided by the NHIS TF

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. 42, 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 12).

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

B: Specific issues

(page 5 and 6)

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 6)

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 88). A consideration could be to leave this to private pockets, because traditional medicine has always been financed that way.

Page 8: Social health protection

The recommendation on page 47 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 11: 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 13

(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

Page 16

2. Political environment

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

i. 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.

Page 40 Options for SHP Universal coverage

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

5 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 45, 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

3.Demand creation: This will be harmonized with option 5 (a).

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 organisation 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 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 18

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

Page 19

- 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.

Page20

- Clarify on 1st 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 21

- There is a need for adequate planning.

Page 22 - 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 23 - 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 25-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 NIHIS. Indeed, it requires the attention of the Cabinet of ministers

Page 26

- 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 27

- 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 28

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

Organisational issues of the NHIS

- Recommendations made have been noted.

Page 29

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	
ORGANISATIONAL ISSUES OF THE NHIS		
1. Preconditions Political Will/ Conesus Economic . Labor Market . Issues of 11th August 09	There is to an extent – e.g Inter-ministerial Committee till Executive Pronouncement -Sensitivity to stakeholders, business cost. Corruption, Public confidence. Awareness of community 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** In agreement	
2.IMPLEMENTATION PLAN- P 29		
a)Prerequisite . **What are these steps referred to as having not been implemented?**	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	
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	Agree Changed from Zonal and Regional	
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 External & Internal	Agree	
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