UGANDA

Health Financing Issues

To be addressed in the proposed

Health Financing Strategy

Draft, version 2

24 October 2011

Content

I. Health financing Strategy development

The GOU/MOH foresees to develop an overarching Health Financing Strategy, which has been on the agenda for the National Health Assembly, Joint Review Mission (JRM), and figures also on the agenda during the 24-26 October 2011 JRM. Such development seems to be an opportunity to embed the discussion and further shaping of health financing modalities in the framework of a comprehensive health financing strategy for which already a lot of ground breaking work has been done in the various policy papers and reviews, e.g. in the National Health Policy I & II and others[1],[2],[3],[4],[5],[6].

The appearance of the latest draft Health Insurance Scheme Bill makes it even more urgent to develop a health financing (HF) strategy and for the GOU/MOH and development partners to set out on a roadmap for drafting such strategy as soon as possible to provide an appropriate reference framework for the new draft Bill. The JRM of October 2011 could be the starting point for this action.

The ***Objective of this paper*** is to further the dialogue on developing a draft HF strategy and discuss some of the implications of the recently proposed new draft Health Insurance Scheme (HIS) Bill. To this effect, various elements in the following sections will help to bring the various current work streams together and synthesize the findings and proposals of the aforementioned papers into a contribution to a Ugandan Health Financing Strategy.

Uganda has been attempting for some time to improve its health financing system to achieve equal access to essential health services for its entire population, with a particular focus on preventing impoverishment due to the use of necessary health services. In addition to the existing multitude of funding sources for the health sector, the wider introduction of health insurance has been considered as a means to tap into the current high level of out of pocket paid funds and changing this into prepaid systems. This would expand coverage among the population, improve access to care, widen the possibility of cross-subsidization, preventing acute financial strain for the patients at the moment of service need and create better options for effectively and efficiently managing funds and achieving efficiency in services delivery by introducing purchasing functions and purchasers.

Besides turning OOPS into a prepaid system with predictable costs per person and improving access to care, the GOU agenda also includes creating more fairness in financing and efficient use of resources: "*Government with support from development partners shall provide adequate resources*

[1] Okwero, Peter et al. Fiscal Space for Health in Uganda. World Bank, Working Paper No. 186. Washington, 2010

[2] The Republic of Uganda, Ministry of Health and WHO. 2009/2010 Health Financing Review. Kampala July 2010

[3] Ministry of Health Uganda. Health Sector Strategic & Investment Plan, Promoting People's Health to Enhance Sociao-economic Development 2010/11 – 2014/15

[4] Devillé, Leo et al. Joint Assessment of Uganda's Health Sector & Investment Plan (HSSIP). Kampala, 31 January 2011

[5] P4H. The proposed National Health Insurance Scheme and promotion of Social Health Protection in Uganda. Final Report of a visit of P4H Partners 4 to 14 August 2009. Geneva, March 2010

[6] P4H. Health Financing Reform & Social Health Protection, Specifying the options. Follow up visit and dialogue between Uganda Stakeholders and a P4H Team, 17-19 February 2010, Kampala, 21 March 2010.

to the health sector. Efforts for improving health financing in Uganda shall be guided by the concepts of Universal Coverage and Social Health Protection[7]."

An important element of the overall approach would be bringing the various elements together in a comprehensive strategy, which addresses the complementarity of schemes and other financing sources, reduction of administrative waste, encourages the efficiency of health financing implementation and of health services itself, and are feasible to implement given the administrative and managerial capacity in Uganda.

To ***develop a Comprehensive Uganda Health Financing Strategy*** the following steps are proposed:

1. agree on:

- ***Vision, goals and objectives set the direction of such a strategy…***
  These should guide the strategy, ensuring that reforms are driven by their expected influence on the system-wide objectives rather than merely focusing on implementing one or several "schemes". The goals/objectives should be derived from the National Health Policy/HSSIP.
- **…though the starting point for reform is the system as it exists today**
  It is essential to have a good understanding, in functional terms, of how the system is currently organized as well as its strengths and shortcomings. This requires a functional approach: understanding the existing arrangements for revenue collection, pooling of funds, purchasing of services, and policy(ies) with regard to how the entitlements of the population are rationed. Even though all countries want to move in the direction of improved equity of access, financial protection, etc., the specifics of how to get there depend critically on where a country is starting from.
- **And a realistic approach requires a good understanding of contextual constraints**
  Context conditions both what can be achieved and what is feasible to implement. Key aspects of context that have to be considered are Uganda's fiscal situation (e.g. what is the scope for increasing public spending on health), its structure of public administration (e.g. the specifics of the way that decentralized decision-making manifests in the country), and the political priorities of the government as well as any health financing reform proposals that are already well developed. This understanding of context is essential for ensuring that a reform agenda is designed that is not only aimed at best meeting the **needs** of the Ugandan population, but also what can realistically be done within the given resources.
  Some aspects are reflected upon in more detail in section II.
- ***Comprehensiveness is a necessary condition for a strategy to be considered good***. It should not only aim at universal coverage/SHP, but should ensure that it encompasses all funding sources and schemes. Thus, within the strategy, there is a need to effectively link and to create **synergies among the different approaches** and work streams (e.g. reform of supply-side [HSSIP]; and development of demand-side approaches [NHIS]), where possible, or to consider exclusion of some that may contradict the overall approach. Thus, for example, there should not be separate discussions about the UNMCP and the NHIS benefit package. How can duplication be avoided, e.g. when different working groups are addressing all the building blocks of the health system separately?

[7] Government of Uganda, Ministry of Health. National Health Policy: Promoting People's Health to enhance socio-economic development. Kampala July 2010

- the approach to developing the strategy: developing a road map?

2. After having this sorted out, then the content of the strategy and priority areas will come up. Some suggestions are made in section III, based on identified health financing issues.

3. The next question would be: how to create an enabling environment or conditions for successful introduction/sustaining of health financing modalities as identified in the strategy.

4. Finally, instruments for implementation will need to be explored.

For items 2, 3 & 4 a ***systematic approach to Capacity Development*** will be needed. The transition to universal coverage is a complex and often lengthy process, in particular for low-income countries. Whatever strategic option Uganda will choose, there needs to be sufficient capacity to analyse and adapt the system to current and future challenges, as well as to effectively manage change in inclusive stakeholder involvement beyond the borders of the health sector. The capacity requirements should be systematically assessed and addressed as part of the strategy process.

II. Vision, Goals & Objectives of a health financing strategy

The GOU has stated its guiding concepts and overall objectives re the health sector: Every step in health financing reform and every proposal in a new health financing strategy would need to be reviewed against the ***concepts***: Universal coverage/social health protection (SHP) and against the ***objectives*** that are embodied in or supported by these concepts in the Ugandan context: ensuring equity, efficiency, transparency and mutual accountability[8].

GOU's intentions are also laid down in a number of social values: Solidarity; Equity; Respect of cultures and traditions of the people of Uganda; Professionalism, integrity and ethics; Client's responsibilities and Accountability[9].

Besides these general objectives and values, ***sub-level objectives or intermediary goals*** would need to be identified that act as additional yardsticks. These can be related to various elements or building blocks of a health system and also reviewed in relation to a new Health Financing strategy.

The National Health Policy II describes a number of strategies to achieve its policy objectives. However, these sound more like intentions and are sometimes rather vaguely formulated. The HSSIP is more concrete, containing targets and planned investments for major policy implementation steps, although it does not plan for the implementation of new health financing arrangements. The Joint Assessment of HSSIP[10] states that ***"The health financing strategy (mentioned as an activity in year 1) needs to be developed as a matter of urgency, including elements of health insurance and covering both domestic and non-domestic resources. Both the health financing strategy and the proposed National Health Insurance Scheme (NHIS) should indicate a clear focus on access for the poor and protection against catastrophic health expenditure."***

[8] Government of Uganda, Ministry of Health. National Health Policy II: Promoting People's Health to enhance socio-economic development. Kampala July 2010
[9] National Health Policy II
[10] Devillé, Leo et al. Op Cit

Vision: MOH National Health Policy II envisions "a healthy and productive population that contributes to socio-economic growth and national development. It sees as its mission to provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels in order to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life".

For the purpose of a health financing strategy these general health sector related vision, goals and objectives would need to be translated into a more specific health financing vision, goals and objectives.

MOH has further indicated social values and guiding principles in its National Health Policy, which would need to be taken into account (see Annex I)

A fundamental question seems to be: ***What are the health services needs of the Ugandan population and what can be provided within the current means, i.e. how does the system need to be designed to best respond to these needs within the given and potentially available resources and what functions would need to be fulfilled?***

The design of a HF strategy would obviously depart from the current system and try to overcome its identified problems, weaknesses and shortcomings. These will be discussed hereafter, also pointing at possible aspects that could figure in the content of an HF strategy.

III. Issues to be addressed in the Health Financing Strategy

The suggestions and comments in this section are based on the earlier referenced papers. Questions demanding an answer as part of HF reform are outlined, as are topics that might go into a HF strategy and thus possibly contribute to its content.

The ***priority problems*** in the performance of the system seem to be:

- Financing the system:
    - Lack of equity in financing of the system
        - Limited overall financial resources
        - High direct contributions from households and OOPS; herewith connected
            - Low level of cross-subsidization
            - Limited pooling of resources, in turn leading to limited purchasing power
        - Impoverishment due to services use
    - Fragmentation of funding, multitude of financiers and of purchasers
- Inequity in access to services,
    - Especially for the poor
    - Due to
        - Absenteeism of staff
        - Skewed distribution, dis-favoring remote and rural areas.
        - OOPS
        - Transport and other opportunity costs

        - Inadequate health facilities and equipment
    - Limited benefits package
- Inefficiency, thus wasting scarce resources, indicating fiscal space for health
    - Human resources management
        - Dual practicing due to low staff pay and lack of oversight
        - Absenteeism of staff
    - Inadequate procurement and distribution of drugs and supplies
    - Limited development of purchasing function and tools
    - Lack of control of investments
- Stewardship
    - Governance
    - Procurement, financial management and audit follow up: implementing the rules
    - Decentralization, in light of planned national health insurance systems

The above problems are almost all inter-linked.

Some of the performance issues of the health sector and its financing system are outside the direct influence of MOH. However, these ***Contextual factors play an important role.*** These factors are referred to in the following section III A. and listed in section III B.

A. Performance Challenges

In this section, problems and challenges in achieving important objectives of a health financing system will be discussed and related to a future health strategy: equity in finance, equity in access to care and efficiency in the organization of the financing system and in health services

1. Achieving Fairness in financing

Current financing is not fair, mainly because of the high out of pocket payments (OOPS) and the limited cross-subsidization between high and low health risk persons and rich and poor people. The large amount of money, paid out of pocket at the point of services and the apparent need for many poor people to sell assets or take loans with sometimes high interest rates from commercial micro-financiers points at lack of equity and fairness in financing of health services. However, perhaps not all OOPS are made for essential, appropriate and effective care because of the lack of a third-party purchaser, many poor are possibly left with high payments for unnecessary medical interventions. The relative high amount of OOPs for medicines supports the suggestion in the Fiscal Space paper to further look at drugs procurement and distribution, although the appropriateness of prescriptions may also be an issue.

Tax funded public services offer more equity than OOPS. However, the tax system, its revenue mobilization potential, and its fairness are obvious issues. VAT is the least fair system because it taxes the consumption of the poor equally as that of the rich, but in countries with economies similar to that of Uganda, they tend to be the main source of government revenue because they are relatively easy to collect. Access to publicly paid services, included in the UNMHCP, does not require copayment.

Not-for-profit NGO's get some of their services subsidized by the government to lower the copayments in order to make their services accessible for the poor though the poorest of the poor have still difficulty accessing the services they need.

Not much is known about the financial aspects of private for profit health care providers.

Impoverishment

An estimated 4.8% of the households in Uganda are experiencing catastrophic payments for health, 2.3% are pushed into impoverishment. ***How would evolving financing arrangements reduce such catastrophic payments and impoverishment, and contribute to achieving equity?***

Beyond the user fee exemption policy

User fees/copayments have been abolished for the UNMHCP, which as such has contributed to better access to care. However this has not contributed to more equity in funding: the rich had their copayments also being waived.

If they can be implemented effectively, income-dependent copayments, possibly waiving these for the poorest, could improve equity in financing (and possibly allow for a wider package of benefits and improve cross-subsidization when preventing the rich to opt out). However, doing this accurately would pose major implementation challenges to Uganda's administrative capacity, and it may also be politically difficult to withdraw an entitlement previously given, even to the non-poor. However, selective use of copayments could contribute to efficiency in health services delivery e.g. for reducing self-referrals to higher levels of services than necessary for dealing with the patient's condition.

Is it administratively feasible to introduce income-related copayments in Uganda?

Can copayments be introduced selectively to improve efficiency in service delivery by imposing a charge on those who self-refer to specialists?

Cross-subsidization

This can be done within schemes and between schemes of health financing and it is a common method to increase fairness in financing. It can take place via:

a. Contribution side

- a progressive tax system (in a tax funded health system),
- an income dependent contribution scheme of health insurance,
- income dependent copayments (allowing for a bigger benefits package, accessible for the poorer parts of the population)

b. Pooling side

- subsidizing a relatively poor scheme by a richer one (e.g. a private scheme pays a percentage of its revenues into social or community based schemes)
- subsidizing a poor insurance scheme from tax resources

The extent to which the modalities of the evolving health care system can contribute to improving fairness in financing and reducing the OOPs for especially the poor might be seen as an important objective and as a main test for the desirability of the new modalities and the way these are being shaped or the way existing forms of financing can be adjusted. Determining the level of cross subsidization between schemes could be an important aspect of the new HF strategy.

Sources of funding and distribution of resources

There may be further ***scope for increasing public fundin***g. To actually achieve this could be an objective but even if it reaches the 15% of the total government budget the country aspires for, there would still not be sufficient resources to cope with increasing health services needs, qualitatively and quantitatively, of a rapidly increasing population. So, the funding of the health care sector from other sources is most welcome and very much necessary to fill the gap of 50-60% of health sector financing left after public financing is exhausted. ***So, next to increasing public funding, the HFS should look at tapping into other sources, among these the current OOPS.***

Actually available resources for investment and recurrent costs may come from various sources. Besides increasing the inflow of more resources, increasing the efficiency of existing resource use seems an attractive one because it does not ask for money on top of the existing resource envelop. Some of the realized savings will go into pursuing the activities, measures and enforcement of new ways of working, remaining savings can be reinvested into the care sector and permanently increase the funds for direct care payments. ***How will a new financing strategy and health financing modalities support more efficient resource use ad therewith increasing useable resources?*** (See also section on efficiency).

This section could include an overview of how financial resources are currently distributed over levels of care, over Districts and Sub Health Districts, over public and private providers and what would be available per capita in the geographic entities.

Pooling of resources

The funds from the different sources (see hereafter) are fragmented over ***many risk pools*** with household member's OOPs being the most fragmented, i.e. having no risk pooling, thus not profiting from pooling advantages. Government funding is pooled on the national and district levels. Other risk pools are found in private health insurance, community health insurance, community based banking and NGO based community insurance. All non-public financing resources are divided over many relatively small pools, thus limiting their resistance against incidental high costs and limiting their purchasing power. A good step seems to be the attempt of trying out a consortium model to integrate various community-based schemes.

Would the creation of bigger risk pools, as to achieve more fairness in financing, be an objective of the HF strategy and if so, how to realize?

Multitude of financiers and financing mechanisms.

The Health Financing Review paper provides a detailed and systematic overview of the current financing mechanisms, their strengths, weaknesses and performance, and it identifies the critical challenges ahead, accompanied by a description of the required institutional arrangements. It

notices that Uganda has "*three distinguishable institutional mechanisms viz., direct purchasing, insurance and banking that are in operation in Uganda to channel financial resources from six primary sources of health financing viz., government, donors, employers, households/communities, philanthropists, and NGOs. Each health financing channel has its strengths (and weaknesses) and target population. Part of the challenge lies in the identification and better use of unorganized resources and their health financing mechanisms. More specifically, household, NGO and philanthropic resources and their channels of flow are not well documented or planned. This is also true, to a limited extent, to employer/corporate and donor resources."* (See Table 1)

However, given the already existing many different financiers, is it possible to consolidate these or a number of them in a lesser number of schemes or have these possibly working under the umbrella of some national system? This could perhaps be explored for the community insurance systems and other community based initiatives.

Table 1. Institutional mechanisms through which health financing channels operate in Uganda

FINANCING SOURCES USED	FINANCING CHANNEL	INSTITUTIONAL MECHANISM	KEY INSTRUMENT
Government budget	Government	Direct purchasing	MoH budget
External resources			Hospitals
Household resources (payment ward)			Districts
			Demand side financing (cash transfers)
Government budget (subsidies)	NGOs	Direct purchasing	Hospitals
External resources			
Household resources (user fee)			
Philanthropic resources			
NGO resources			
Household resources	Community-based	Insurance	Community-based
NGO resources (subsidy)			Provider-based
Government budget (indirect through subsidies to NGOs)		Banking	Community-based credit
Employer resources	Private	Insurance	Provider-based insurance
			Formal insurance
Household resources			Micro insurance
		Direct purchasing	Employer-run facilities
		Banking	Micro-credit

Source: Health financing review paper

2. Equity in utilization

Health services delivery

Public funded health facilities are not equally geographically spread over the country, despite a gradual increase in their numbers. Many facilities are in a state of disrepair and lack basic equipment and medicines. It is acknowledged that access to the more specialized services and hospitals is

difficult for the poor. Lack of adequate transport aggravates the access problem. Absenteeism of staff in public facilities is another factor reducing access.

Private for profit services are mainly found in urban areas and mainly accessible for the upper wealth quintiles. It is not known what exactly the capacity (beds & staffing) and services of this sector entails.

Absenteeism of staff (37% of public staff on average) is caused by low pay for staff, lack of appropriate oversight and the opportunity for dual practicing, i.e. in the public sector and in private practice. It is leading to diminished access for especially the poor who cannot afford the private services and to financial waste for the public system, estimated to be equivalent to U Sh 26 Bilion per year[11].

Most of the poor only use the health centres, while the richer quintiles of the population are making more (than the poor) use of hospital based services. This begs the question of equal access to effective care in case of need. Geographic distribution of people, categorized in the poor quintiles, and of health care facilities will play a role, next to transport and other opportunity costs which impede access for the poor to more specialized services on the higher levels of care.

Differences in benefits packages between different financiers also may lead to inequity in access and thus to inequity in utilization.

The GOU aims at offering the Uganda National Minimum Health Care Package ***(UNMHCP).*** It is not clear what exactly the stated services include, i.e. whether a more detailed list of medical interventions and entitlements exists, e.g. for the categories "Non-communicable diseases" or "Integrated Essential Clinical Care". And if so, ***whether the listed services are equally available*** in all Districts, assuming that patients can afford the visit. Further research may be warranted to uncover this. The UNMHCP is offered by public health facilities and by not for profit NGO's.

Other financial agents offer different benefits, perhaps in addition to the UNMHCP and/or with access to private providers which supposedly offer better quality of the also UNMHCP covered services as well as offer non-covered services***. An inventory of these various other benefits packages does not exist but may be useful to survey as input into the further discussion about the future health financing strategy.*** It can be concluded that not all residents have access to the same package of benefits. However a uniform package, more extended than the current UNMHCP and accessible for the whole population is probably hard to reach although with using available fiscal space (see conclusions of that study) and improving the efficiency and effectiveness of health services delivery and health financing mechanisms, one can probably get some improvements.

So, actual coverage providing access to available care is not equally spread among the population. Thus, how will the new financing modalities contribute to a bigger uniform package and how will it be made equally accessible for the whole population and improve equity in utilization?

[11] Fiscal space study. Op Cit

3. Efficiency in resource use

Fragmentation of funding, fragmentation of purchasing and absent of insufficient use of purchasing and of effective purchasing tools can all contribute to inefficiency in the organization of health financing and in health services delivery. But there is more:

Main points for improving to inefficiency:

> *"While Uganda needs to continue exploring ways to mobilize funding for health it needs to improve the efficiency of its Health spending to maximize the health benefits for its population. Uganda could reap significant savings by improving management of human resources for health; strengthening procurement and logistics management for medicines and medical supplies; and by better programming of development assistance for health. Besides, Uganda needs to take proactive steps to mitigate growing pressure to increase health spending." (Fiscal Space study)*

These various points are all related to health financing:

- Absenteeism to payment of staff
- Procurement to overall purchasing
- Development assistance to investment and recurrent cost funding

With respect to health financing modalities and instruments, the overall question arises: would the development of ***new financing modalities and financial tools be seen as an objective in order to contribute to more efficient organization of health care financing and of more and more cost-effective health services, delivered in an equally accessible way***?

Purchasing

The many currently operating risk pools may lead to many and many different purchasers of care, except in provider-based based health insurance and in case of the use of reimbursement systems as in private insurance instead of cashless or in kind benefits payment systems where no independent purchaser operates. Fragmentation of the risk pool leads to ***fragmentation of purchasing***, diminishing the potential for guaranteeing access to services and getting value for money, i.e. ***reducing efficiency in the system of health services delivery and in health finance.*** A single payer, representing a big volume of people has more clout vis a vis the providers to negotiate reasonable fees and has better options for performance review[12].

Would strengthening the purchasing function, advancing towards o single payer system be an objective of the evolving health financing arrangements and of reshaping of the overall financing system?

The earlier mentioned consortium model for CHI would make purchasing more effective and efficient.

---

[12] WHO. The world health report - Health systems financing: the path to universal coverage. Geneva 2010

Effective purchasing requires a split between payer and provider. The public funded health services do not have such a split at the moment. To check on care provided and public finances being used, a number of internal and external financial and some quality controls are being used. ***Will the new financing arrangements allow for such purchaser-provider split and accept its consequences, such as the possible reduction of capacity and/or of specific activities and corresponding available funds because the purchaser can contract better quality and lower prices in the private sector or he does not need all services in the available volume?***

The question how investments will be funded is related to this split and is discussed earlier.

Purchaser functions

Getting value for money and avoiding payment for unnecessary and/or inappropriate care is the role of a purchaser. This role cannot effectively be exercised by the individual when paying directly OOP at the point and at the moment of services. Since 50% of THE is coming from households for a variety of services, if these are not channeled via a pre-paid mechanism, they are not scrutinized for need and appropriateness and patients may get inappropriate services or far too expensive care. Those financiers that use a reimbursement system, e.g. private insurers, and their clients do not profit from the potential efficiency and quality gains of a purchasing function. ***How can cashless or benefits in kind systems be expanded in an evolving health financing system to strengthen the purchasing power and capacity?***

Other tools a purchaser can use are setting or negotiating the payment system and the remuneration, tariffs and fees (see next section). Such payment system can be included in a contract with the particular provider in which mutual rights and obligations are included, sometimes together with an arbitration possibility to solve conflicts more easily and cheaper than via court procedures. ***Will the HF strategy intend to provide purchasers with the option to set payment systems and fee levels?***

Provider performance review.

Another important tool, which can be agreed in more detail in a contract is the review of performance of the provider. To do this, yardsticks would be needed such as clinical practice guidelines, minimum services delivery standards or clinical pathways. Benchmarking services providers can be a potent tool for performance review. Confronting them with statistics on e.g. prescription, lab-test ordering, admission rates, average length of stay, operation mortality and showing where they are located in the statistic is an effective tool. It can lead to adjusting provider behavior by using the acquired info for feedback and peer review as well as for use by the purchaser for discussion with providers of the reasons for being an outlier in the statistic.

To conduct such reviews effectively and efficiently, the status of ***health information systems*** (HIS) is very important. Not only as regards the availability of hardware, applicable software and staff that can use the systems (computer literacy of health staff?) but also re clinical information systems with agreement on definitions, coding etc as well as on financial admin aspect for reviewing claims and making payments. ***The status of such HIS systems and its availability on the various levels of the UG health system and its distribution over the country are not known, i.e. not further explored in this paper***.

Selective contracting is another powerful tool the purchaser can use to stimulate provider competition to enhance quality and optimize payment schedules. This means that the provider, dependent of the available care suppliers (i.e. some oversupply is necessary) can choose which provider to contract or which services in what volume from a particular provider and can make a choice between public and private providers.

It is currently not known to what extent these purchasing tools are being applied in Uganda. So, it might be useful to see how purchasing and its tools can be used more effectively and efficiently be in light of the evolving health financing mechanisms to improve value for money and would the HF strategy intend to allow for effective and efficient provider performance review by the purchaser of services?

Funding investments

Separating the responsibility for investment funding from the payment of running costs may lead to conflicts of interest between the investor and the purchaser. The investor, for whatever reason (e.g. political, technology push or pull, donor driven) may invest in health facilities and/or medical equipment in places where they are not of most urgent need (if at all), while payer of the running costs, i.e. the purchaser of services sees no need for it or has no resources to pay recurrent costs.

Investments are currently funded by the government, NGO's, including the for-profit ones, and donors. The government can control its own public investments and anticipate the subsequent running costs, for which it also pays, at least until now. Public investments are carefully vetted for individual need, cost-effectiveness and financial feasibility in the framework of universal access.

Government has however no influence over e.g. donor funding of investments of which the recurrent costs may become a burden for the public budget. (The realization of new hospitals and the instalment of high tech equipment and fostering the introduction of high tech and high risk interventions may raise expectations among the population to makes these services available to all or to at least guarantee the funding of running costs in case the investment funders will not do this. So it has sustainability, efficiency and equity in access aspects) The size of this problem is not known. ***The fiscal space study argues for a system to capture donor inputs to prevent unsustainable and not well located investments!***

Even quality of care reasons can be considered to support explicit decision making by government or by a government designated authority to foster concentration of high risk medical interventions to achieve better outcomes.

Developing nationally oriented health insurance schemes, or more generally creating a purchaser/provider split, with the freedom for selective contracting of providers and which are not responsible for investing in health services but only for financing operating costs, may lead to tensions between the investing authorities on the national and District levels and these schemes. (national and district politicians may want to gather political support by building shiny well equipped health facilities for which e.g. an insurer sees no need and therefore does not want to contract.

So, from a financial sustainability, equity in access and efficiency point of view, what would be the financial and other mechanisms to guide or control investments?

Paying the providers of health services

Payment systems can influence the productivity and quality of services provided: neither too much nor too little care and stimulating achieving optimal quality. The Government and District authorities can just set the salaries although they will reckon with the actual needs for staff in their decisions about remuneration and other benefits as to contribute to adequate distribution of staff and covering areas not very much wanted by staff. Other purchasers will have to negotiate fees or remuneration, or can give a take or leave salary offer. Current public remuneration systems are not results oriented. ***The general question is how can the financiers and purchasers best calibrate their payment systems for the various levels of care and health staff at those levels as well as for the different activities to get just the optimal results for a reasonable price?*** The Fiscal space study points at the need to especially adjust payment and other incentive systems to attract and retain staff in remote and rural areas. It further opts for exploring output based payments.

Adequate payment mechanisms and financial incentives can provide a conducive environment for delivering quality care and gradually further improving it. However, it is not the only factor. It is beyond this short paper to discuss the other quality improvement options and factors that co-determine the outcome of the care process during the patient's career through the health system.

Provider autonomy

Separating payers from providers and subsequently strengthening purchasing needs to be complemented by some level of autonomy for health services providers to optimize their own resources use. Private providers are supposed to have this freedom. The issues of autonomy include the ability of public facility managers to shift between budget lines, hire and fire staff, set incentive structures for their staff, substitute equipment for staff or raise additional revenues. ***This area would need to be addressed in a HF strategy***

4. Stewardship

Overall steward of the system is MOH, which plays a role in Budget formation, the setting of the regulatory framework for the specifics of the health sector and provides tertiary level care health services. Besides this, general regulations are generated from other ministries such as on public finance management and accountancy, the judiciary, civil service etc. The decentralized health system delegates to Districts the authority for running the public health facilities in their territory up to the level of District hospitals. They do also the oversight over private providers in their District. ***One of the questions for the evolving health financing system will be: how to match the mandate of possibly national working health insurance arrangements with the mandate of Districts to avoid confusion of roles or mutual weakening of options for the implementation of these different mandates and thus reducing effectiveness and efficiency?*** E.g. will a national insurer who represents an important volume of services and accompanying money be allowed to sometimes not contract a public health care facility but go to a private one because of better quality services and preference of his insured? This question is connected to the separation of investment and payment responsibilities, aforementioned in this paper.

Good governance

Clear responsibilities, transparency and accountability are key ingredients of good governance, feeding trust of the population at large and of external financiers in particular:

> *"The overall health sector budgetary process, including planning execution and monitoring, could benefit from a number of actions. These measures include: (a) reducing earmarking and giving more flexibility to spending entities, (b) improving recording and monitoring donor expenditures, (c) linking budgets to sector programs and outputs, and improving overall sector financial management. These measures require action by various government ministries and various development partners in order for the MoFPED to clarify off budget expenditure and develop instruments for monitoring it. Mechanisms for both improved governance and anti corruption are essential if Fiscal space from external financing is to be expanded. One of the key reasons behind fluctuations in donor financing was the scandal involving GFTAM and GAVI grants, which suggests that direct and sustained attention to improve governance and anti corruption measures is critical given Uganda's dependence on future external resources. The health sector needs to develop a "good governance" and anti corruption strategy."*
>
> Source: Fiscal Space for Health in Uganda

Improving governance is also important to reduce waste and thus have more resources available for patient care. ***Question towards the planned health financing strategy is therefore: will the introduction of new players, e.g. in health insurance, lead to an increase in chances for corruption given the limited administrative and financial management and auditing capacity in the country? Or, will the new strategy has as objective to consolidating schemes, simplify administration and make better use of scarce available admin and audit capacity?***

Administration.

The multitude of financing agents leads also to multiple administrations which all need their own administration systems, geared to their needs. These multiple systems will also lead to multiplying of admin costs. ***Total health sector administration costs are not known. It might be useful to survey this and have a reference point that will show how will the evolving health financing system will facilitate the simplification of administration and free up resources to cover direct health care needs.***

The capacity, capacity expansion needs and performance of the current public and private administration systems are also not known. However, financial management reviews and audit reports of the public system point at shortages of competent staff and high turnover of staff.

Financial management rules and auditing requirements and tools are reviewed to be up to standard. It is the following of the rules and sticking to the requirements that generates questions while enforcement is weak and accountability is not guaranteed. ***How will the financing system and its possible extension with new players generate sufficient capacity (HR and business support systems) to cope with administrative and accounting requirements given the already existing shortages? What options would there be to use any new developments to streamline administration and***

accounting while reaping the benefits of e.g. new financial resources and possible economies of scale?

B. Contextual factors

Several contextual factors play a role in health sector financing, which are mostly outside of the mandate or power of MOH. These are only being mentioned here because these have been discussed, intertwined in the previous section on Performance challenges, or could not e further explored due to limited time available for drafting this paper:

- Financial economic situation, co-determining the level of government funding though not necessarily the % of the public resources spent on health.

- Decentralization of government to Districts, including aspects of health services delivery.

- Civil services, including public health staff: regulations and remuneration.

- Uncertain donor contributions, influencing planning and budget execution

- Absence of influence for GOU on some donor investments.

- Overall governance, procurement, auditing and administrative regulations and capacity in the country

- Infrastructure

    - Transport system

    - Electronic communication

- Personal security, especially in the North-West of the country

- Regulation of private business with an eye on promoting economic development which could undermine health services cost containment and quality, e.g. in selling and distribution of medicines and medical equipment as well as in the regulation of private health care providers.

IV. Next Steps

MOH, possibly together with DP's and other stakeholders, may want to depart on agreeing on the approach to develop a HF strategy, agreeing of main problems to be solved in achieving universal coverage and improved social health protection, stating the connected objectives and subsequently on the content of the strategy, not only looking at issues that are in the realm of MOH but if and were warranted also paying attention to contextual factors outside the mandate of MOH and jointly with DP's and other stakeholders addressing these.

Roadmap

Would a road map for the further development of health financing need to be designed and agreed to show that the objective of a new National Health Insurance Scheme "To ensure financial access to affordable, equitable and quality healthcare services progressively to all residents in an efficient manner through health insurance." will be achieved via a pro-poor development and timing of introduction of new or adjusted financial modalities, reducing the wealth gap in access to health services instead of widening it, with defined milestones?

V. Annexes

Annex I

From MOH National Health Policy II:

Social values

This policy puts the client and community in the forefront and adopts a 'client centered' approach and it looks at both the supply and demand side of health care. The following social values, as detailed in the Constitution of the Republic of Uganda and Uganda's Patients' Charter, will guide the implementation of this policy.

The right to highest attainable level of health: The Constitution guarantees rights of access for all people in Uganda to basic health services.

Solidarity: Government will give due consideration to pursuit of national solidarity in its attempt to achieve health related MDGs, with special focus on social health protection for vulnerable groups.

Equity: Government shall ensure equal access to the same health services for individuals with the same health conditions.

Respect of cultures and traditions of the people of Uganda: Stakeholders shall respect promotive health aspects of cultures and traditions of the peoples of Uganda. Negative practices and behaviours shall be discouraged.

Professionalism, integrity and ethics: Health workers shall perform their work with the highest level of professionalism, integrity and trust as detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.

Client's responsibilities: Individuals are ultimately responsible for lifestyle decisions they adopt. Clients have the responsibility of seeking care, adhering to treatment and mutual respect for health providers.

Accountability: A high level of efficiency, effectiveness, transparency and accountability shall be maintained in the development and management of the national health system. The health service will be accountable for its performance, not only to the political and administrative system, but, above all, to its client communities.

Guiding principles

The national policy on health shall be guided by the following principles:

Primary Health Care: PHC shall remain the major strategy for the delivery of health services in Uganda, based on the district health system, and recognising the role of hospitals as an essential part in a national health system. Greater attention and support shall be given to health promotion, education, enforcement and preventive interventions as defined in the UNMHCP. Individuals and communities shall be empowered for a more active role in health development. Communities shall be encouraged and supported to participate in decision making and planning for health services provision through VHTs and HUMCs.

Decentralisation: Health services shall be delivered within the framework of decentralisation and any future reforms therein.

Evidence-based and forward looking: The implementation of the NHP II shall be evidence-based, forward looking and take into account emerging trends.

Gender-sensitive and responsive health care: A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.

Pro-poor and sustainability: This policy shall provide a framework to support sustainable development. In order to address the burden of disease in a cost effective way, GoU, PHPs and PFNPs shall provide services included in the UNMHCP with special attention to underserved parts of the country. GoU shall also explore alternative, equitable and sustainable options for health financing and health service organisation targeting vulnerable groups.

Partnerships: The private sector shall be seen as complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.

UNMHCP: In order to address the burden of disease in a cost-effective way, public and private providers shall offer services that are included in the UNMHCP.

Integrated health care delivery: Curative, preventive and promotive services shall be provided in an integrated manner.

Mainstreaming of health in all policies: Health shall be mainstreamed in all relevant policies. MoH shall guide other government ministries, departments and the private sector on health issues.

Uganda in the international context: In order to minimize health risks, GoU shall play a pro-active role in initiating cross border initiatives in health, adherence to International Health Regulations and health- related issues. The NHP shall follow the principles of the Sector wide Approach, the Paris Declaration and the Accra Agenda for Action through the IHP+ in the interaction and collaboration with national and international development partners.

Annex II

Criteria for reviewing health financing modalities

Financing

- Is paying into the system according to the ability to pay
- Are copayments allowed
- Are income-differentiated (poor exempt) copayments possible to allow for a larger package of benefits (BP)
- Will there be a backup system for small scale and thus more financial risk prone schemes (such as community health insurance and banking systems)
- Can payment and benefits packages into the system be tailored to regional differences in services availability
- Will the new arrangements clearly identify what needs to be continuously paid from the budget, e.g. public health and health promotion
- Would the new systems have to have cross-subsidization, via contribution/tax systems and/or via pooling systems:
    - Between rich and poor,
    - healthy and sick,
    - small and big families
- Will new financial players be allowed to reduce equity in funding and in access to care via:
    - risk rating
    - community rating
    - exempting pre-existing disease
    - refusing high risk people
- Will it solve existing investment problems, i.e. lack of funds and lack of direction (donor funding) and priority setting, especially in the private sector, to better contribute to equal access
- Will investment decisions be governed and related to responsibility for subsequent recurrent costs.
- Can off-budget funds be better tracked in an evolved new system and will these funds become more predictable
- Will new finance modalities contribute to more equitable spreading of investments and resources for running costs while favoring disadvantaged areas

Organization:

- Is fragmentation of financiers and purchasers reduced.
- Efficiency and effectiveness in collection and pooling of resources can be sustained and enhanced, e.g. via.
    - Combining collection of health insurance contributions with tax collection
    - Adequate auditing of employers in case of employer contributions in social health insurance, possibly together with the tax office and relying on external certified accountants

- Pooling at the treasury instead of at a commercial bank. the latter always provide some risk while pooling at the treasury may lead to using the funds for other government purposes. In both cases: good governance and transparency is key.

- Efficiency and effectiveness in financial administration, contract implementation and performing purchasing functions. E.g. using modern, HIS supported, systems combined with provider performance criteria and yardsticks
- The new financial arrangements reduce fragmentation of administration and reduce admin costs
- Capable management and staff, including financial management staff and auditors, will have been trained and are available to implement new financial arrangements.
- New financing mechanisms reduce the strain on the already insufficient HMIS and make well-functioning HMIS available, also forthe poorest schemes.

Coverage:

- Do the proposed financing arrangements improve coverage of the population and if so:
  - Across all social strata
  - Across the whole country
  - Irrespective of income level
  - Irrespective of gender
  - Irrespective of nationality
  - Irrespective of religion
  - Does it close the wealth gap in access to care.
- Will enrollment in a national scheme be mandatory or voluntary
- Will people or categories of the population have the possibility to opt out of a national scheme
  - If so, will there be financial compensation for the missing of possible contributions from the relatively rich and relatively healthy
  - What level of cross subsidization would there be required between schemes to guarantee universal coverage
- Is portability guaranteed for people enrolled in a regional scheme

Benefits:

- Do the BP's of various schemes entail all essential and cost-effective services to achieve the constitutional rights to health services
- Do the new financing arrangements narrow the wealth gap in depth and breadth of the BP to which different social strata, formal sector and informal sector workers have access
- Are the benefits unambiguously formulated to avoid misunderstanding and denying rights of beneficiaries at will, i.e. will there be a clear demarcation between various benefits packages
- Will the BPs anticipate the growing burden of non-communicable diseases and cater also for the family planning needs
- Will the BP act as entitlements list that can be enforced by patients or their relatives, pre-supposing transparency and public availability of information about these entitlements.

- Is there a working judiciary or arbitration system that allows for fast decision making about entitlement conflicts between patient and payer, especially in case of life threatening health conditions
- Will it allow for explicit decision making about changes in the BP, based on results of CEA or HTA, including benefits that are generated by donor investments in high tech.
- Will schemes have to offer outpatient and inpatient care, to avoid inefficiency in services delivery and duplication in medical interventions, shifting care to another level to avoid payment by one scheme and have it done by the other?
- Can BP's be tailored to differences in regional health needs
- Can BP's be tailored to differences in services availability
- Where transport is a major factor for accessing necessary health facilities, would the new schemes provide for this, especially for the poor

Purchasing

- Will the new schemes allow for selective purchasing of services, supported by
- Introduction of purchaser-provider split in publicly funded health services
- Will it allow for results oriented payment of providers

Services delivery

- Will new financial arrangements bring more effective services delivery, enhance efficiency and foster cooperation between providers
- Will they help to redress the skewed distribution of medical staff over the country and especially improve staff availability in rural areas
- Will medicines become more equally accessible across the country
- Will the external quality of health services assessment activities take into account the different stages of development of health care facilities to actually allow for the establishment of new facilities and for an improvement path

Health impact

- Will the new schemes be pro-poor to reduce the wealth gaps in mortality and morbidity
- Will they contribute to more speedily achieving of health and poverty related MDG's

Governance

- Will the new schemes simplify governance, stewardship and management
- Will it improve governance, via e.g.
    - Increased transparency
    - Accountability,
    - Enforcement of existing regulations i.e. taking corrective action towards functionaries in the system in case of deviation.
    - E-government
    - Involvement of consumer representatives
- Will there be independent oversight, reviewing financial and functional performance

- Will the new arrangements reduce the auditing burden for participants in the schemes by integrating auditing activities as much as possible to avoid duplication and reckon with limited and expensive staff availability.
- Will the responsibilities of District-wise organized publicly funded and implemented health services be matched with nationally working schemes as in insurance. To allow for effective purchasing and efficient investments and deployment of staff
- Will new schemes reduce or increase the reporting burden for purchasers, managers and providers of services, leading to more accurate and timely reporting of data, essential for financial and disease management
- Will it improve coordination between providers, geographically and of various levels of care to enhance quality and efficiency
- Will private payers have to go through a licensing system with explicit criteria for e.g. solvency, board composition etc.
- Will new schemes reduce absenteeism of staff and dual practicing
- Will new schemes guarantee confidentiality of patient health and disease data
- Will new health financing mechanisms be accompanied by adequate regulation of the private sector providers, allowing also for reducing dual practicing and absenteeism
- Will it be facilitated by appropriate public-private partnership regulations allowing the schemes for effective use of PPP arrangements to improve access to care and to more advanced services.