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Start, support health insurance to save Ugandans from poverty

The long awaited national health insurance plan should be started. Ugandans have waited for nearly three decades, since the Prof. Owori report of 1987. The Owori report recommended a national health insurance plan to protect Ugandans from falling into poverty due to health-related catastrophic expenditure.

Noteworthy, this is the fourth manifesto of the NRM that promised a health insurance scheme.

Therefore, the time is ripe to deliver on this social contract to Ugandans as we embrace the *hakuna mchezo* era.

Thankfully, in April 2017, the Ministry of Finance issued a certificate of financial implication to trigger Parliament to enact this policy; something we *basawo* have waited for since 2012 when the health insurance Bill was first crafted.

There has been a sharp increase of fundraising activities to save ordinary Ugandans from life threatening illnesses.

These costs would ordinarily be met by families, which are forced to sell property with the hope of saving a loved one from death. People are desperate with the escalating costs of private health care, amidst an economic downturn and a free public health system "free of services".

In fact, stories of patients being detained in private health facilities are common, which raises ethical dilemmas for medical professionals. It should not surprise Ugandans that our health sector budget has stagnated between 6% and 9% in the past five years; which calls for innovative alternatives to urgently mobilise resources to strengthen our weak health system.

Although Uganda is party to the 2001 Abuja declaration by African leaders that recommended 15% of direct government budget allocation for health, President Yoweri Museveni has often cited that Uganda spends over and above the Abuja mark. Indeed since 1986, Uganda's health sector budget has grown over three fold from about 3% to below 10% of the national cake.

President Museveni argues that Uganda expends over 25% on health considering the investment in infrastructure such as dams for electricity or roads or schools, all of which are important social determinants of health.

To this extent the President is in order, since good roads improve access to health facilities, a fact corroborated by the Uganda Demographic and Health Survey of 2016, that about 70% of women deliver in hospitals today, compared to 57% five years ago. In turn, this has resulted in significant reduction of maternal deaths in Uganda from 438 to 336 per 100,000 live births. Still, these maternal deaths remain unacceptably high compared to the average of the developed countries reporting only 12 women deaths per 100,000 population related to pregnancy and child birth.

Policy concerns with Uganda's health insurance Bill of 2012

Uganda is the only country without a national health insurance plan for its citizens among the East African sister states, except conflict ridden South Sudan.

Uganda's overall health insurance

penetration was less than 1%, as per the 2013 Insurance Regulatory Authority report. Rwanda learned and perfected from the over 20 community health insurance schemes in western and central Uganda including that of Kisiizi hospital, which started in the 1990s. Ironically, Uganda Government experts have severally visited Rwanda to benchmark their successful insurance scheme whose coverage in over 90% of the population.

In fact, a common joke is that soon Uganda's ministry of health officials may visit South Sudan to learn from its yet to be conceptualised health insurance scheme. Further, various Government departments benefit from private health insurance schemes paid for by tax payers including Parliament, Cabinet and Uganda Revenue Authority.

This contradiction compromises Uganda's strategy to achieve Social Development Goal number 10 on equitable access to social services and wealth.

So why has Uganda's health insurance scheme taken 30 years without implementation? Among the key policy concerns we researched about at the African Centre for Systematic Reviews and Knowledge Translation at Makerere University are: a high premium proportion of 8% of salaries, split at 4% each between employers and employees was perceived as additional taxation that would grind manufacturing with loss of jobs or further strain the already low salaried employees.

Secondly, this scheme was perceived to exclude the informal sector, whose tax compliance culture raises concerns and the rural folk who are the majority of Ugandans. Labour unions complained of being targeted as low hanging fruit, whilst politicians labeled the scheme elitist.

Further, lack of trust in the governance of the health insurance fund, given the past corruption scandals in the health sector, including that of the "Global Fund" and "GAVI". Additional important considerations were lack of a single information system for Ugandans and quality assurance of health services.

Lastly, the scheme proposed eligibility of four dependents yet at that time Uganda recorded one of the highest fertility rates of about seven children per woman.

Policy considerations and moving forward; what are the low hanging fruit?

Foremost, common sense prevails that we should start this national health insurance scheme "yesterday"!

In Ghana, it was a pending election in 2003 that triggered a policy shift to kick-start their model insurance scheme in a matter of weeks.

Uganda is not naive to major health sector reforms. In the 2001 electoral process, President Museveni tactfully neutralised his contestants by abolishing user fees in public health facilities. Nevertheless, Ugandan women continue to pay user fees under the table or even openly as they are forced to buy medical supplies for life saving procedures such as caesarean section.

What is needed, therefore, is to regularise these payments, well before hand and pool the risk and resources within Ugandan communities.

We should adopt interventions to improve democratic decision-making, accountability and trust in the scheme. Key to successful policy change is effective stakeholder engagement as enshrined in Uganda's 1995 Constitution.

Cabinet's certificate of financial implication dropped employer's contribution to 1% from 4%, a move that will improve acceptability by the manufacturers.

It would be important to assure effective representation of workers and ordinary citizens on the proposed board structure of the health insurance authority. As it is today, there are more Government ministries represented than workers.

The ordinary rural folk should have a voice too, as research shows community participation positively impacts on health outcomes.

Expanding to multiple sources of revenue would help ease the strain on the already overstretched narrow tax base. It should be noted that health insurance is an addition to the existing health financing mechanisms.

The state would not relax on allocating health expenditure in its annual budget. Ghana imposed a 2.5% share on VAT for health insurance. Heritage taxes from Uganda's growing oil and gas sector or tourism would be vital, whilst leveraging on the NSSF to enroll informal sector contributors and extend a health package makes business sense.

President Museveni's Government has already put in place resources from which the health insurance scheme should hit the ground running. These include the national identification project, the new and rehabilitated hospitals, the national ambulance services and the district health information systems.

In any case, this scheme should prioritise women and children, targeting major reductions in Uganda's child, neonatal and maternal mortality.

Last, but not least, the spirit of solidarity should pervade the health insurance scheme. Certainly with the rich paying for the poor, the productive paying for the indigent and the high disease risk prone paying for those at lower risk.

As it stands today in Uganda, it could be argued that the poor are paying for the private health insurance schemes of the rich either via Government taxes for public officials or profits in the private sector.

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