Uganda Health Reporter

The Uganda Health Communication Alliance

Vol. 1, No. 4 ugandahealthcom@yahoo.com August 11, 2008

National Health Insurance: The Debate Begins

The New Vision called it "one of the most far reaching and ambitious policy initiatives" the Ugandan Government has ever undertaken.

"It" is national health insurance. If the Ministry of Health has its way, it will become the way civil servants finance their health care next year, and it will grow to play that role for all Ugandans in 15 years. That would represent an altogether new way for Ugandans to relate to each other. Instead of relying on ourselves, our families or Government to pay for our care – approaches most people agree are no longer workable – it rests on what **Francis Runumi, Commissioner for Planning, Uganda Ministry of Health (right),** calls the principle of "social solidarity." Citizens will pool their resources so that there is enough to care for those unlucky enough to suffer medical emergencies.

Dr. Francis Runumi, Commissioner for Health Planning, Ministry of Health

That means the healthy will subsidise the sick, and those with low costs will subsidise those with high costs. And the rich will subsidise the poor, and the young may subsidise the old.

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Will Ugandans accept the concept? And will Government be able to make it work? On July 23, UHCA convened a group of experts to explore those and other questions. While Dr. Runumi and **Dr. Robert Basaza, senior health planner for the Ministry**, defended the plan, **Dr. Ian Clark, chief executive officer of International Hospital Kampala**, argued that too many details have yet to be worked out. He argued that the plan will increase an already stifling tax burden without addressing underlying problems – especially inefficiency in the current system and slow economic growth.

It promises to be a long debate: **Dr. Richard Alia, health specialist and consultant for the World Bank**, noted that while most countries – including Uganda's neighbors – have concluded that health insurance is the best way to meet rising health costs, it takes a long time to work out all the problems. The United Kingdom and Japan took 37 and 35 years, respectively, to perfect their systems. "If Uganda can do it in 15 years, that would be a welcome miracle," Dr. Alia said.

For an overview of the issue, see notes from Dr. Alia's presentation, which appear later on these pages. And keep watching for new developments: Dr. Runumi said the Ministry will be releasing the results of new studies by the end of this month.

Also in this Issue…

Health Promotion: The response of leaders to issues as varied as traditional birth attendants and the Hepatitis E outbreak in Kitgum shows that new approaches are needed to communicating with the public about health issues, a public health specialist says.

News Highlights: Planning for an influenza pandemic…Uganda wins praise for an innovative approach to treating mental illness…A study looks at which institutions are losing the most from the health care brain drain in the West Nile region… New research on children and malaria.

Health news highlights…

Planning for Pandemic: Ethicists, epidemiologists, academicians and other health experts from at least 15 African countries are meeting this week in Kampala (Speke Resort, Munyono) to develop a code of ethics to guide the public response to a possible influenza pandemic.

The meeting comes as public health agencies worldwide continue to watch closely the H5N1 virus, or avian flu, which has killed millions of birds and hundreds of people in Africa, Asia and Europe. Should the virus develop the capacity to spread from human-to-human, some studies put the potential death toll as high as 62 million people. The vast majority of deaths would be in Africa, where lack of access to medical care, inadequate infrastructure, poor nutrition, and pre-existing medical problems – including the HIV virus – leave people especially vulnerable to new diseases.

The **World Health Organization** is building a stockpile of vaccines that within three years could be sufficient to protect 25 million people from the avian flu. But that raises tough questions. At what point should the stockpile be tapped, and who should be vaccinated first? Should the emphasis be on protecting the most vulnerable individuals, or should authorities put a priority on protecting people who perform essential social functions? Also, since vaccinations alone are unlikely to be sufficient to control the spread of the disease, what other steps can authorities ethically take? To what extent, for instance, can they impose limits on public gatherings and population movements to slow the spread of the virus? And given the developing world's greater vulnerability, how can an equitable response between nations be devised?

This week's meeting is sponsored by **African Field Epidemiology Network (AFENET**), a non-profit organization and networking alliance incorporated in Uganda in 2005, in collaboration with the U.S. **Centers for Disease Control**. If you are interested in background materials on this important issue, contact UHCA: ugandahealthcom@yahoo.com.

The role of non-professionals in mental health: Uganda has won praise for taking an innovative approach to treating mental illness. **Vikram Patel**, a psychiatrist and senior lecturer at the **London School of Hygiene & Tropical Medicine**, writes for the *Science and Development Network* that interpersonal therapy, a psychological treatment that involves non-professionals, has been shown to be effective in treating depression. Such use of informal workers to address mental health problems is crucial, Patel says, because the shortage of trained professionals is acute and won't be resolved anytime soon. It is time to dispel the "myth" that African countries cannot afford to treat mental illness, he argues, noting that in many developing countries, the gap between the number of people with disorders and the number who actually receive evidence-based care is as high as 80%, according to Patel (www.scidev.net/en/opinions/mental-health-in-the-developing-world-time-for-inn.html).

Bottom of the food chain? A study of staff turnover in general hospitals in the West Nile region found that private not-for-profit institutions suffer the biggest "brain drain." They often lose trained medics to government institutions, according to the study, which attributed the losses to poor conditions of service, low pay and poor relationships between staff and managers. Most replacements come from training institutions. The study recommends that the Ministry of Health put more money into the health sector, including funds to offer well-managed monetary incentives to health workers who agree to work in rural areas, and that it invest more in training health service managers. The research was conducted by **Onzubo Paul, Medical Superintendent for Nyapea Hospital in Nebbi District** (http://www.bioline.org.br/abstract?id=hp07004&lang=en).

Children and malaria: Intermittent preventative treatment for malaria can reduce anaemia and improve attention span in children in malaria-prone regions, judging from a study of a malaria-prone region in Kenya. The study, carried out on children aged 5-18 in 30 schools in Bondo district in Kenya's Nyanza province and published in the British medical journal *the Lancet*, found that 50% of children in the area have the malaria parasite in their blood, though they have no current symptoms of malaria. (www.thelancet.com/journals/lancet/article/PIIS014067360861034X/fulltext).

Health Promotion: Threats or Dialogue?

By Dr. Freddy W. D. Oyat

In recent days, district leaders have made strong pronouncements in the media concerning the people's health in an attempt to protect their communities from communicable diseases or from practices perceived to be deleterious to good health.

The deputy resident district commissioner in Masaka is reported to have singled out traditional birth attendants for arrest should they continue killing women and babies during childbirths (*The New Vision*, 22 July 2008).

Similarly Kitgum district authorities have issued an order over Mega radio in Gulu, (26 July, 2008) effectively banning the brewing of a local popular beer, known as the kwete, and they say new by-laws will be enacted to make it a crime if children's faeces are found around one's compound.

All these extreme pronouncements are intended to improve the health of the people in the districts concerned. They may well be beneficial given current frustrations with maternal mortality and Hepatitis E, which are not about to go away.

But traditional birth attendants, the Kwete brewers and children's faeces around homes are all just drops in the ocean of health problems connected with maternal mortality and epidemics in Uganda.

While it can be shown that some women and neonates have died in the course of labour conducted by the TBAs, the same can be said of labour conducted by licensed doctors, nurses and midwives in health facilities across the country. Meanwhile, illegal abortion is responsible for about 40% of the maternal deaths in Uganda, and the rest can be assigned to a variety of reasons, including poor emergency obstetrics services and shortages of trained professionals and drugs. An RDC should devote time to these issues, and help find funds to retrain village health teams, of which TBAs should be members so that their actions can be monitored by the village health teams and not the police.

Health promotion cannot be achieved with threats. It requires a continuous dialogue built on trust.

In the case of the Hepatitis E, measures have included the distribution of free jerry cans, accompanied by instructions to stop using time-honored clay pots for storing scarce drinking water. People are told they must now wash their hands with water poured by somebody else, and not in the usual containers from which every member of the household can wash during meals time.

These strategies are frequently broadcast on the local FM stations, even though one can not be sure how many people in Kitgum actually listen to radio broadcasts. Meanwhile, there is not enough water to go round in Kitgum for hand washing in the prescribed manner.

Health promotion can not be achieved with threats. It requires a continuous dialogue between the health system and the community based on trust. And increased funding is needed for the health sector to deal effectively with these urgent problems. Health education that is insensitive and inappropriate, and that targets sections of society with punitive measures, is useless. It only serves to deflect attention from the real problems, and is a waste of scarce public resources.

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If you have another view on this issue, or would like to contribute something else to this newsletter, please contact us at ugandahealthcom@yahoo.com

Social Health Insurance: The Basics

Presentation of Dr. Richard Alia

To the UHCA Workshop on Health Insurance

23 July 2008

1. Health Financing – Overview

There are different mechanisms of health financing: tax-based; out-of-pocket payment; donors and nongovernment organizations; and health insurance – including Private Health Insurance (such as AAR & IAA in Uganda), Community Health Insurance (CHI) and Social Health Insurance (SHI). But:

- **Tax based** financing currently is not very effective because the health sector must compete with other sectors, and in end what it receives is not adequate. For example, the MOH requires 15% of national budget but receives only 9%.

- **Out of Pocket Payment** is difficult to implement because of equity issues (few people/households can afford).

- **Donors and NGO funding** are beneficial, but the major disadvantage is that it leads to dependence.

- **Private Health Insurance** in Uganda is regarded as a service for the rich.

- **Community Health Insurance** is being implemented in 10 districts in Uganda – for instance, Kinkiizi hospital in Western Uganda – but it leaves a lot to be desired.

Dr. Richard Alia, health specialist and consultant, the World Bank

Social Health Insurance, the financing approach favored by the Government of Uganda, has the potential of meeting health policy objectives: improving health status, equity, efficiency, acceptability (by providers and users) and sustainability.

2. Why Do We Need A New Health Financing Mechanism?

The costs of health care delivery have become quite high worldwide. Reasons for high costs include:

- Emerging diseases like HIV/AIDS; and re-emerging diseases like malaria

- Diseases of life styles -- what we eat/how we eat, how we move (we no longer want to walk). Diseases such as diabetes, hypertension, and heart disease are now rampant.

- High technology equipment such as MRI, CT-Scan, and Ultra-sound Scan are available but expensive.

- Modern type of drugs. Combination therapy – medicines that combine two or three drugs in one – reduce the frequency at which people have to take these drugs (once or twice a day instead of three or four times). But such comfort comes at a high cost.

- Population boom. At independence, Uganda's population was just 7 million. Now it is about 30 million: there are many more people to take care of.

- Awareness and high demand. Most people are now aware of the benefits of health care. Health care seeking behaviors have gone up tremendously.

Sickness is unpredictable! It doesn't tell you when it will strike, and whether you are broke or not, it will come anyway. The seriousness also is unpredictable. It may come like flu (which is manageable); or it may come in severe, life-threatening ("catastrophic") forms that require huge sums of money to treat.

3. What is health insurance?

Health insurance is a mechanism of health financing where the clients contribute as a group in advance for health services to ensure that they access health care, when need arises, without necessarily having to pay cash at the health facilities - regardless of the gravity of the sickness.

The principles of health insurance are **pooling of resources and sharing of risks**. Clients put their money in the same basket, and any time an eligible member is sick, regardless of the magnitude of the sickness, he/she will be treated using funds from that basket. It is particularly useful for severe diseases that would otherwise lead to selling of assets such as personal vehicles, land, or houses (i.e. catastrophic sickness).

"Being poor does not mean you are incapacitated; it's a matter of how you organize yourself."

--Robert Basaza, Senior Health Planner, Uganda Ministry of Health

The main difference between Private Health Insurance and Social Health Insurance is that **PHI is a voluntary scheme** – you join it at your wish depending on your income – while **SHI is established by law** (i.e. it is mandatory); hence whether you like Social Health Insurance or not, once the law is passed, you must abide by it.

Private Health insurance is not very popular even in the developed countries. In the developed countries, coverage is less than 10% of the population; it less than 1% in Uganda. Coverage for Social Health Insurance, however, is extensive in the developed countries (more than 90% of the population); it has great potential in the developing countries as well. (Americans have historically viewed PHI as the proper cornerstone of their health system. But about 17% of Americans are not insured; their needs must be met by charity or municipal hospitals.).

4. Why Health Insurance?

- To provide additional funds for health financing.
- To protect people from financial ruin when they become sick and incur high medical care costs due to catastrophic illness.
- To subsidize care for the poor social protection. It is the duty of every government to provide social protection for its citizens. Health insurance scheme, especially universal coverage will ensure that all citizens access health care when they need it.

Following the setbacks in the global economy in 1980s due to high energy price changes and unsustainable levels of debt, the World Bank put health insurance at the top of its list of recommendations for health reform.

5. Problems always encountered in health insurance and how to mitigate them.

Problem	Description	Mitigation measures
Adverse Selection	A situation where only those who know that they are sick with chronic conditions – for instance, diabetes mellitus, hypertension and heart disease -- will register. This means that they are always seeking treatment, and hence exhaust the resources quickly.	Carry out medical exam for those who want to join the scheme. Encourage group enrollment so that those who are always sick are compensated by those who are always not sick.
Moral Hazard	Situations where those who are insured behave carelessly -- getting injured or sick and seeking medical care frequently.	Build in *co-payment and/or deductibles. Establish a "ceiling"
Cost escalation	Collusion between the clients and health providers can lead to high costs of claims. For example, clients may negotiate for unnecessary procedures or even cash	Establish a "ceiling" Set up proper monitoring and verification mechanisms
Administrative costs	The costs of running a health insurance scheme can be quite high because there are many activities involved.	Set a ceiling. Many schemes choose to spend only 10% or less of the total insurance funds on administration.

* Co-payment is a nominal fee, paid by the insured person every time he/she seeks medical care at the health facility. It helps to reduce the problem of moral hazard.

6. Social Health Insurance (SHI) – Key Features

- **Solidarity perspective:** there is high level of cross-subsidization across the system between the rich and poor, low-risk and high-risk people, young and old, individuals and families.
- **Established by law** of the parliament.
- **Compulsory contribution** – based on one's income – a percentage of one's salary. Both the employer and employee make mandatory contribution.
- **Government may contribute as an employer for the civil servants.** However, it may also provide a contribution on behalf of those without ability to pay – for instance, students, the severely disabled, the unemployed, casual workers and the poor.
- **Benefit package**: There is a direct link between the payment of contributions to finance the system and the receipt of medical care benefits. Whether the country chooses to contribute 2% or 3% or 4%, will determine the quantity and quality of health services that individuals receive.
- **Sustainability**: Ideally, SHI is supposed to be solvent for about 25 years into the future. Government sometimes is called upon to provide the seed money. External aid and earmarked taxes are other sources of funding often used to subsidize SHI. Earmarked taxes are targeted to products that harm people's health – for instance, tobacco and alcohol – in order to reduce consumption.

7. Global perspective

- SHI systems have been established in more than 60 countries worldwide, beginning with Germany in 1883.
- 27 countries have reached Universal Coverage.
- SHI is particularly widespread among Organization for Economic Cooperation & Development (OECD) countries, but is also in found in developing countries, mainly in Latin America (including Argentina, Bolivia, Brazil, Chile, Costa-Rica, Ecuador, Peru), and to a lesser extent in other parts of the world, including Algeria, Tunisia, Nigeria and Ghana.
- In East Africa, SHI is being implemented in Kenya, Tanzania, Burundi and Rwanda

8. Roadmap to introduction of SHI

Stages: Usually, most countries go through two important steps, which may take several decades: First, formal sector workers (civil servants and/or industrial workers) are covered; and second, the whole population is covered ("universal coverage").

- This "incremental" process has been observed both in countries that have long used SHI as a way to provide universal coverage (for instance, Germany) and those that have done so more recently (for instance, the Republic of Korea).
- Starting with formal sector workers has the following advantages: This group can be enrolled relatively easily for the purpose of collecting premiums; are of middle to upper income, so ability to pay is not a major problem; tend to be located in and around cities or big towns so they can access services; and will spread information about SHI as they visit their villages in the rural areas. When the country gains experience and confidence from the formal sector program, the scheme can then be expanded to cover other citizens.
- It takes about 10 years to develop and launch SHI scheme in the developed countries. It can take even much longer in the developing countries. Tanzania did it in a record time of five years but it had help from the World Bank.

It has taken developed countries 50-70 years to reach universal coverage. If Uganda achieves universal coverage within 15 years, it will be a welcome miracle.

Prerequisites: For a system of SHI to be feasible; a number of administrative requirements must be met:

- The scheme must be codified into law that the country must be able to enforce.
- A mechanism must be established to collect contributions, with the level of contributions defined as a percentage from income/salary.
- An autonomous body with a board of directors is needed to handle funds.
- Capacity building (human resources) is needed for activities such as data collection and statistical analysis, claims handling, financial management, negotiation with providers and monitor to reduce fraud.
- Health infrastructure is needed to provide the legislated benefits. Accredited health institutions can be government or private (not for profit or for profit).
- The scheme should be designed in a way that keeps premiums low. Services covered by insurance should initially focus on relatively high-cost but low-frequency events (say in-patient services).

- A system for regulation and monitoring must be established. The law could mandate the insurance commission to take charge of that.

9. Models for implementing SHI schemes

There are different models of implementing SHI:

- Target civil servants initially. Thereafter, bring in employees of companies/industries, then informal sector workers and eventually the rest of the population. Tanzania is following this model.

- Target both civil servants and employees of companies (all formal sector workers) initially. Thereafter, move to informal and eventually the rest of the population.

- In some countries (such as France and Japan), the government makes insurance compulsory, but allows the consumer to choose among several private and public insurance plans. The government specifies a standard benefit package and actuarial standards with which these plans must comply. This model is referred to as the Bismarckian model.

- In other countries, insurance coverage is not universal. These countries tend to have "mixed" (pluralistic) schemes.

- SHI can be organized in such away that it provides universal coverage but is financed through the general tax revenues –for instance, the UK, Canada, Finland and Sweden.

10. Biggest challenges & pitfalls of SHI in developing countries like Uganda.

- **Lack of knowledge**: The majority of people do not know about SHI scheme. A study here in Kampala in 2003 found that only 7.3% of company employees and 12% of civil servants knew about SHI. In contrast, knowledge of private health insurance was good (68% of company employees and 78% of civil servants knew about PHI). A lot of efforts is needed to sensitize the public with regards to SHI (how it operates and its benefits, etc.) before the scheme is launched.

- **Poverty**: The majority of the potential clients are poor and already face high demands (school fees, rent, food, etc.). By the time they receive their salaries, they are already in debt, and do not see the need to pay for insurance after all that they are not sick. Besides, they are used to free medical services.

- **Other forms of deductions**: Potential SHI clients already face payroll deductions for pay as you earn (PAYE) and National Social Security Fund (NSSF), and would regard further deductions for SHI as an additional burden.

- **Poor medical services**: The current status of medical services leaves a lot to be desired. People cannot imagine a miracle over night for a better health service even when SHI is introduced.

- **High prevalence of chronic diseases**: Chronic diseases are now rampant. Will SHI scheme take care of all these (inclusions) or not (exclusions)? What will be the reactions of clients if they are excluded?

- **Corruption**: The level of corruption in this country gives a wrong signal that even SHI funds might not survive. The cost of information technology that could be used to fight coruption is so high that SHI management might not acquire them soon.

- **The small size of the formal sector**: The insured group must be large enough so that the risk of incurring high-cost health needs is sufficiently spread to keep premium low. But in countries like Uganda where most people are in the informal and agricultural sectors, SHI will not function easily. There are only 500,000 formal sector workers out of 30 million Ugandans.

- **Political support/commitment**: You need political support or commitment to push things forward. Fortunately, all political parties in Uganda included introduction of SHI scheme in their 2006 manifestos.

- **Culture**: Insurance is not in familiar concept in our culture, and problems with property insurance have not set a favorable precedent.

Every country that has developed SHI started with hesitation, fearing a lot of difficulties. But with commitment and determination, they have succeeded. The best approach is not to wait for an ideal condition to prevail – which is almost impossible. Start and improve on it as time goes by.

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