For the Ugandans, nearly the last four decades have been years of hope, conflict and resilience in a myriad of contexts for healthcare reform. The health insurance system in Uganda has no legal framework and provides benefits not to the entire national population. In Uganda, community-based health Insurance is prevalent for the informal sector while private medical insurance is with employees from the work places and agencies. The 2019 National Health Insurance scheme Bill was passed in 2021. If the President of Uganda assents to the National Health Insurance Bill it will be a compelling policy in health and health for all policies. But, this Bill has several drawbacks. In this perspective, we aimed to provide the intricacies and mix of challenges and opportunities for the health sector in Uganda.

Key words: Health Insurance Scheme, Community Based Health Insurance, Universal Health Coverage, Uganda

INTRODUCTION

The National Health Insurance Scheme (NHIS) Bill 2019 highlights value of adequate investments in health as Uganda undergoes key transitions. It provides fascinating evidence on need for a “new social contract” between state and people. In spite free public health care, services are poor. Subsequently, majority of prefer private sector based on out-of-pocket expenditure at 29% [1]. This contract is key for realization of universal health coverage for all by 2030 through execution of Public Health Act, National Insurance Act, National development plan and strategies for health. The Bill makes health insurance mandatory for entire population. Other contents of the bill, the informal sector will contribute a fixed flat rate annually (i.e., USD 28.6) and formal sector monthly deductions of 4% employee’s salary and additional 1% of the employee’s salary by employers. Pensioners will contribute 1% of their monthly pension payment. The indigents will be contributed for by Government subsidies and refugees by donor agencies. Only, 10 percent of indigents will be enrolled per year for 10 years. Private Health Insurance Schemes will continue to co-exist with NHIS in provision of packages not covered under scheme. Dependents under 18 years shall be covered for free. Benefits shall be derived from the Uganda National Minimum Health Care Package [2]. The share of Community Health Insurance (CHI) 0.2% and private health insurance 5% suggest limited affordability. [3]. However, 77.5% Ugandans are willing-to-join the scheme [4].

Growth of the health sector is occurring within context of rapid urbanisation, structural transformation proposals, and private sector development. There is also a continental push for integration of markets across Africa with digital services as the main driver of financial and health inclusion [5]. Nearly 31.3 million people who own a mobile phone with an average addition of 690,000 new subscribers annually use digital wallets for healthcare. Though this may revolutionize health insurance legal frame works are still lacking [6]. The government’s position is expressed in the scheme design which is built on 3 sub-schemes: Social Health Insurance (SHI), Community Health Insurance (CHI), and Private Health Insurance (PHI) which will be implemented concurrently. The scheme is expected to enroll 25% of 45 million people in its initial stage. Currently, 7.5% of the population is insured by CHI and PCHI.

Reflecting on Uganda’s free-enterprise economy and health care delivery 4 tier system the country has a mix of public, private-for-profit, and private-not-for-profit providers as well as traditional and complementary medicine. The 4-tier system under NHI reform will be a co-existence relationship. All health facilities shall be accredited to provide services, which in effect is expected to increase service utilization. Government shall continue funding public health interventions and health system investments but at a reducing scale as coverage by scheme and contributions to the scheme increase. Uganda is proceeding with NHI and not solely SHI scheme as such in Korea. This may be due to fear of backlash to supply adequate better health services to a minority of the population and ignoring the rest which may have serious social-economic and political consequences. Additionally, NHI is thought to increase resource envelope and improve health equity. The health expenditure per capital is estimated at 38.4 USD. And, health expenditure as a share of Uganda’s GDP is projected at 0.97% far low to 5.2% for sub-Saharan Africa and global average at 9.9% [7]. Though in SHI and NHI schemes formally employed members make mandatory contributions, in an NHI scheme packages will be delivered to the whole population. In contrast, SHI caters for only those who have paid (and their dependants) will be the beneficiaries, paid for by their contributions. This implies individuals in the lower income quintile will be able to access more health services than they would have if they had to pay out-of-pocket at the point of consumption.
The establishment of NHI began in 1987 as a Social Health Insurance model when it was recommended by the health Policy Review Commission after the 5-year civil war. Then was reviewed in 1997 and 2001, resulting to the current proposed NHI. Unfortunately, NHI Bill does not explicitly mention improving equity to the vulnerable. The Bill only proposes to the catastrophic nature of out-of-pocket expenditures on health. In the case of Korea along with industrialization has come National health insurance. Though Korean model is not the best ideal model for the Ugandan NHIS the challenges are not unique to Korea. South Korea has virtually never chosen NHI and was mired in controversy at the start, but 12 years of coverage to the entire population by 1989 since its introduction in 1977 is an outstanding success scheme [8]. The Korean model’s influence is most notable in 3 areas: the administrative structure of the system, regional based expansion of health insurance and policy for mobilizing financial resources for the system [9].

In 2009, Kwon [9] proposed structural changes in labour market and existing laws as a must be amended to realise the scheme of this nature. Evidence suggests that elite negotiation and prioritisation of structural changes with pragmatic political settlements are critical constituents to allow the country to make a viable post-oil economy that prioritizes adequate health financing. Besides, consistent health spending that addresses unmet needs of the population tends to boost political capital. In Uganda, design and development of the scheme is still tied up in legal, political and socioeconomical mix. Doetinchem et al. [10] study of 2006 contend that it is impossible to introduce such a scheme without political support and interest groups. Several key stakeholders have expressed varying positions. Private sector concerns include accreditation of facilities, sustainability mechanisms, model blend operating alongside private insurance operation, implementation of risks including skilling of health workers and inflation. The reason for private sector positions is skepticism of returns on their investments. But the scheme will incentivize health sector and investors be assured through payouts from scheme. Considering the envisaged contribution of employers to the scheme, trade organizations, including the National Chamber of Commerce implied that the perceived increase in the cost of doing business in the country may discourage prospective foreign direct investment into Uganda. Given that, formally employed persons already contribute towards social security, a percentage of their monthly contribution could be diverted to the health insurance scheme to avoid an excessive burden on employers and employees who constitute the largest group of taxpayers in the country. However, Uganda cannot wait for all challenges surrounding the proposed NHIS to be resolved before rolling out the ambitious programme. As such, Uganda will avoid pitfalls associated with implementing NHIS by drawing sufficient lessons from several countries that have successfully implemented a national health insurance including Ghana, Kenya, Nigeria, Rwanda, Tanzania, and Thailand among others. Thus, the government’s position is that these concerns should not delay implementation - consultations can continue even as NHIS is rolled out. This will help identify any emerging issues or challenges that may require strategic resolution.

In conclusion, different countries developed and have followed their own different pathways. Korea’s National Health Insurance scheme is regarded a success and no precedent worldwide. Uganda may need to learn numerous lessons from Korea to introduce its NHI scheme. Thus, have more equity in health financing, greater financial risk protection and equal access to health care.

Ethics Statement
This paper is a perspective, so it did not need ethical approval.

CONFLICT OF INTEREST
The authors have no conflicts of interest associated with the material presented in this paper.

FUNDING
None.

ACKNOWLEDGEMENTS
None.
AUTHOR CONTRIBUTION

Conceptualization: EO, JN. Data curation: EO, JN. Funding acquisition: None. Writing - original draft: EO, JN. Writing - review & editing: EO, JN.

ORCID

Emmanuel Otieno https://orcid.org/0000-0002-8879-2414
Josephine Namyalo https://orcid.org/0000-0002-7567-3627

REFERENCES

10. Doetinchem O, Schramm B, Schmidt JO. The benefits and challenges of social health insurance for developing and transitional countries. Financing Health Care-a Dialogue Between Southeastern Europe and Germany. 2006; 18:27-43