Perspective

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The Paradox of the Ugandan Health Insurance System: Challenges and Opportunities for Health Reform

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For nearly four decades, Ugandans have experienced a period marked by hope, conflict, and resilience across various aspects of healthcare reform. The health insurance system in Uganda lacks a legal framework and does not extend benefits to the entire population. In Uganda, community-based health insurance is common among those in the informal sector, while private medical insurance is typically provided to employees by their workplaces and agencies. The National Health Insurance Scheme Bill, introduced in 2019, was passed in 2021. If the President of Uganda gives his assent to the National Health Insurance Bill, it will become a significant policy driving health and universal health coverage. However, this bill is not without its shortcomings. In this perspective, we aim to explore the complex interplay of challenges and opportunities facing Uganda's health sector.

Key words: Health Insurance Scheme, Community based health insurance, Universal health coverage, Uganda

INTRODUCTION

The National Health Insurance Scheme (NHIS) Bill of 2019 underscores the importance of adequate investments in health as Uganda undergoes significant transitions. It presents compelling evidence for the need of a "new social contract" between the state and its citizens. Despite the availability of free public health care, the quality of services is lacking. As a result, the majority of people prefer the private sector, which is largely funded by out-of-pocket expenditures, accounting for 29% [1]. This contract is crucial for achieving universal health coverage for all by 2030, in line with the Public Health Act, National Insurance Act, National Development Plan, and health strategies. The Bill mandates health insurance for the entire population. According to other provisions of the bill, the informal sector will contribute a fixed flat rate annually (US$ 28.6), while the formal sector will see monthly deductions of 4% of an employee's salary, with an additional 1% contributed by employers. Pensioners will contribute 1% of their monthly pension payment. The government will subsidize contributions for the indigent, and donor agencies will cover refugees. However, only 10% of the indigent population will be enrolled each year over a span of 10 years. Private health insurance schemes will continue to operate alongside the NHIS, offering packages not included in the scheme. Dependents under the age of 18 will be covered at no cost. Benefits will be aligned with the Uganda National Minimum Health Care Package [2]. The current share of community health insurance (CHI) at 0.2% and private health insurance (PHI) at 5% indicates limited affordability [3]. Nevertheless, 77.5% of Ugandans are willing to join the scheme [4].

The health sector is experiencing growth within the context of rapid urbanization, proposals for structural transformation, and private sector development. Additionally, there is a conti-

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nental effort to integrate markets across Africa, with digital services serving as the primary catalyst for financial and health inclusion [5]. Nearly 34.3 million mobile phone owners, with an average of 12% increase of new subscribers each year, utilize digital wallets including healthcare transactions. While this has the potential to revolutionize health insurance, the necessary legal frameworks are still underdeveloped [6]. The government's stance is reflected in the design of its health insurance scheme, which is based on three subsidiary schemes: social health insurance (SHI), CHI, and PHI. These will be implemented simultaneously. The scheme aims to enrol 25% of the 45 million people in its initial phase. At present, CHI and PHI insure 7.5% of the population.

Reflecting on Uganda's free-enterprise economy and its four-tier healthcare delivery system, the country offers a mix of public, private-for-profit, and private-not-for-profit providers, as well as traditional and complementary medicine practitioners. Under the National Health Insurance (NHI) reform, these different tiers are expected to coexist. All health facilities will be required to obtain accreditation to provide services, which is anticipated to lead to increased service utilization. The government will continue to fund public health interventions and invest in the health system, although this funding is expected to decrease as coverage by the scheme expands and contributions to the scheme increase. Uganda is moving forward with the implementation of NHI rather than adopting an SHI scheme similar to that of Korea. This decision may stem from concerns about providing adequate, better health services to only a minority of the population, potentially leading to serious socioeconomic and political repercussions. Furthermore, NHI is believed to have the potential to increase the resource pool and improve health equity. The health expenditure per capita in Uganda is estimated at US$38.4. Moreover, health expenditures as a share of Uganda's gross domestic product are estimated at 0.97%, which is significantly lower than the 5.2% average for sub-Saharan Africa and the global average of 9.9% [7].

Although both the SHI and NHI schemes require mandatory contributions from formally employed members, an NHI scheme provides packages to the entire population. In contrast, SHI benefits only those who have contributed (and their dependents), with services financed by these contributions. Consequently, individuals in the lower income quintile will have access to more health services than they would if they had to pay out-of-pocket at the point of service.

The establishment of NHI began in 1987 as an SHI model, following a recommendation by the Health Policy Review Commission after the five-year civil war. It underwent reviews in 1997 and 2001, leading to the current proposed NHI. Unfortunately, the NHI Bill does not explicitly address improving equity for the vulnerable. The Bill focuses solely on mitigating the catastrophic nature of out-of-pocket health expenditures. In the case of Korea, national health insurance emerged alongside industrialization. Although the Korean model may not be the ideal archetype for Uganda's NHIS, the challenges it faces are not unique to Korea. Korea did not initially embrace NHI and faced considerable controversy at its inception. However, achieving 12 years of coverage for the entire population by 1989, since its introduction in 1977, represents an outstanding success [8]. The Korean model's influence is most evident in three areas: the administrative structure of the system, the regionally based expansion of health insurance, and the policy for mobilizing financial resources for the system [9].

In 2009, Kwon [9] proposed that structural changes in the labour market and amendments to existing laws are essential for implementing a scheme of this nature. Evidence suggests that elite negotiation and the prioritization of structural changes, along with pragmatic political settlements, are crucial elements in enabling the country to transition to a viable post-oil economy that prioritizes adequate health financing. Moreover, consistent health spending that addresses the unmet needs of the population can enhance political capital. In Uganda, the design and development of the scheme are still entangled in a complex web of legal, political, and socioeconomic factors. Doetinchem et al. [10] argued in their 2006 study that introducing such a scheme is impossible without political support and the backing of interest groups. Various key stakeholders have expressed differing viewpoints. Concerns from the private sector include the accreditation of facilities, sustainability mechanisms, the integration of the model with existing private insurance operations, and the implementation of risk management strategies, such as the training of health workers and managing inflation. The private sector's stance is rooted in scepticism about the returns on their investments. However, the scheme is expected to incentivize the health sector, with investors being reassured through payouts from the scheme. Considering the anticipated contributions from employers to the scheme, trade organizations, including the National Chamber of Commerce, have suggested that the perceived increase in the cost of doing business in

Uganda may deter prospective foreign direct investment. Given that formally employed individuals already contribute to social security, a portion of their monthly contributions could be redirected to the health insurance scheme. This approach would help to prevent placing an excessive financial burden on employers and employees, who represent the largest group of taxpayers in the country.

However, Uganda cannot afford to delay the rollout of the proposed NHIS until all challenges are resolved. To avoid common pitfalls associated with implementing NHIS, Uganda will learn from the experiences of countries that have successfully established national health insurance systems, such as Ghana, Kenya, Nigeria, Rwanda, Tanzania, and Thailand. The government maintains that these concerns should not postpone the implementation; consultations can proceed concurrently with the rollout of NHIS. This approach will facilitate the identification of any emerging issues or challenges that may necessitate strategic solutions.

CONCLUSION

Various countries have developed and followed their own distinct pathways. Korea's National Health Insurance System is considered a success without precedent worldwide. Uganda could benefit from learning numerous lessons from Korea's experience in implementing its NHI scheme. This could lead to more equitable health financing, enhanced financial risk protection, and equal access to healthcare.

Ethics Statement

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

NOTES

Conflict of Interest

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

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Author Contributions

Both authors contributed equally to conceiving the study, analyzing the data, and writing this paper.

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