ADITUM
Enrich your Research

International Journal of Epidemiology and Public Health Research

Research Article

Health Financing and Policies in The Transition to Universal Health Coverage – Uganda as A Spotlight

Emmanuel Otieno[1,2*], Togo Yaya[3], Josephine Namyalo[4], Rachael Alira[5]
[1]School of Public Health, Gudie University Project, Kampala, Uganda;
[2]Uganda Peoples Defense Forces, Kampala, Uganda;
[3]Department of Public Health, University of Sciences, Techniques and Technology of Bamako, Mali,
[4]Department of Public Health, Faculty of Public Health, Nursing and Midwifery, Uganda Christian University, Mukono, Uganda;
[5]Centre for International Health Education & Biosecurity, Nairobi, Kenya.

Article Info

Received: April 06,2024
Accepted: May 01, 2024
Published: May 20, 2024

***Corresponding author:** Emmanuel Otieno, School of Public Health, Gudie University Project, Kampala, Uganda.

Citation: Emmanuel Otieno (2024) "Health financing and Policies in the transition to Universal health coverage – Uganda as a spotlight". International Journal of Epidemiology and Public Health Research, 5(1); DOI: 10.61148/2836-2810/IJEPHR/061

Abstract:

The problem of the uninsured has been a major focus of health policy debate for decades all over the World. The call for drastic change in the health sector has never been so urgent today than ever before. Humanity faces enormous crises and health related challenges. Before the pandemic the global economy was staggering and fragile; the consequent recovery has increased inequalities in access to health needs. Consequently, creating societies that may be unproductive and unsustainable. This requires transformative health reforms based on health financing and policy aspects. Yet the sector's mainstream persists in doing business as usual, with no meaningful impact to global aspirations set out in the 2030 Agenda for Universal Health Coverage. The purpose of this perspective is to lay out a framework for policymakers to think about how policy reforms might fit to context of universal health coverage in low- and middle-income countries. The future of health insurance and the pursuit of innovative health financing approaches that we need to know to achieve implementation of National Health Insurance Scheme in Uganda.

Keywords: Health financing, Health policy, Universal health coverage, Uganda

Introduction:

Universal health coverage is a reflection on human rights and its universality seem an insuppressible right which flows by simply having a virtue of being human. The underlying question is whether or not, policy aspects can be considered integrated, or better yet, how to context the concept of "universality" to policies. Though policies must work within the limitations and needs of human finitude. Policy does not always prefer defecting over universality. Thus, its capabilities need to shift as time moves on and contexts of health and health systems change. Although a demanding and all-embracing process for ensuring that all people receive the health services, they need without suffering financial hardship. The UHC was a much sought-after and collective effort that would be referenced for decades to come. UHC is defined as 'the goal that all people receive the health services when and where they need them, without financial issues [1]. It is estimated that 40% of the world's population lack social protection. And 400 million people have no access to essential healthcare [2].

The vision of UHC is rapidly becoming a reality, in some countries through

National Health Insurance. Yet for many, in the developing world particularly, sub-Sahara Africa it remains a far-fetched vision. Even among those with it, UHC has become a battle of narratives difficult to rationalise. The assumption that UHC is entrenched in Uganda's vision 2040 and the National health policy is no guarantee of its realization. But rather enters into force among governments that are accountable to the population beyond signing of the "international agreement." [3] In Uganda Universal health coverage has become a reliable appeal to a fundamental yearning in health policy, nonetheless, is finding it hard to claim the mantle. So, once the National Health Insurance Scheme (NHIS) law is enacted all Ugandans will be required to contribute to the government scheme. Those on the private scheme will have to drop their schemes and enroll for government. However private health insurers will continue to deliver health care services not covered by the government scheme. One of the risks with complementary insurance is, on the one hand, the quality of care and services covered by the public sector leads to all care being "complementary". In fact, it generates fraud among patients in complicity with providers who will make minimum prescriptions for care covered by public insurance to obtain the right to benefit from the supplement. To the contrary, there are risks of adverse selection and moral risks with seriously ill people (people with chronic illnesses) who will be in very large numbers among the subscribers of complementary insurance, thus favoring an inflation of care and risks of bankruptcy of complementary (private) insurance. The UHC is interlaced to health system strengthening [4]. While UHC isolation alone may not suffice, it places important constraints on a health system's strategic decision-making by invigorating the Alma-Ata Declaration 1978 ''health for all to all for equity.'' It's an important crucible for development of the primary health care concept. Despite principles for attaining UHC being well known, the varying uncertainties and complexity of health systems in each country requires context specific solutions.

First, the greatest challenge is that some governments do not view health as a key policy priority [2]. Yet so may benefits come with a healthier population for increased productivity, social development, and increased equity. The complexities of UHC policy so demand attention not from different actors but the political will to materialize, a redistributive policy such as UHC. It will be a political victory when UHC is realized less by 2030 in developing countries, and still more so that it has any veneer of social solidarity for national service.

Second, knowledge of universal health coverage (UHC) for inclusive and sustainable development is critical at the heart of this debate to ensure universal coverage and access to needed health care services though most of the population seem particularly the healthcare professionals indifferent to healthcare policy [5]. Notably, there might be a need to translate health insurance information in the indigenous languages well understood by people. This strategy could be an asset for Uganda in relation to the adherence problems that some countries encountered when starting their health insurance scheme.

Third, achieving UHC will require domestic health financing innovations aimed at increasing fiscal space for health. These can be generated through increased domestic revenue mobilization for health and reversing all forms of illicit finance flows (IFF). In Mali, the national policy is based on contributory, non-contributory schemes, and the free healthcare system. The contributory mechanisms consist of public insurance (compulsory health insurance – AMO –) for public employees; private insurance for contractual employees in the private sector and mutual insurance for the informal sector covering nearly 78% of the population. The non-contributory scheme called medical assistance scheme (RAMED), with 100% free coverage, covers 5% of the population made up of indigent people, nuggets of the State and the Nation, war wounded and prisoners. Free healthcare concerns certain illnesses for specific segments of the population (malaria for children under five and pregnant women, cesarean section, etc.). The Malian system is focused on budget reprioritization in favor of the health sector, and due to a desire to give the social protection policy engaged in a guarantee of universality. Despite significant efforts, 60.98% of the financing of the health system is provided by direct household payment; 32% by public administration schemes and compulsory contributory health financing schemes and 6.62% by voluntary private healthcare payment schemes [6]. In Mali, the national policy is not based on contributions. But is focused on budget reprioritization in favor of the health sector and is funded entirely by the government. Due to a desire to give the social protection policy engaged in a guarantee of universality [7]. In Ghana, premium exemptions financed by subsidies from the earmarked portion of the value-added tax [8].

At the centre of health expenditure-revenue gap is the excessive revenue leakages through IFFs, tax avoidance, tax evasion, tax exemptions and incentives. It is estimated that about 51 per cent of GDP is generated from the informal economy in Uganda and loses 40 per cent of GDP annually due to tax evasion because of immense size of the informal sector. More so, UGX 1 trillion lost annually to tax exemptions [9]. There is need to reduce the size of the informal sector, simplify administrative processes, digitise and harmonise both business registration and tax processes such as closing illicit financial flows. This could ease the burden and motivate informal firms to formalise. Thus, unlocking the potential of the informal sector for UHC.

Investments in the health sector are a proven driver of economic growth. The rising productivity and economic growth tend to facilitate increased demand for health through the markets, politics, and climatic change. Globally the experiences of health financing indicate more than 5% of GDP have been associated with easier attainment of UHC [10]. In many low-and middle-income countries not yet achieved the UHC reflects the mechanisms and historical patterns entrenched in social systems that lead to social inequities and health disparities.

Uganda with a GDP growth rate at 4.4% will require it to mobilize political leadership for investing in human capital and financing UHC to improve administrative efficiency policies. This could streamline easier operation and establishment of health insurance societies. The need to expand the tax base by tapping into harm tax regimen for commodities like sugar are desirable. Not to mention, raising spending on health by easing the stringent targets on monetary and fiscal policy with support from international technical and financial partners. Furthermore, setting an ambitious

target of USD 90 per capita on health, in line with the recommendations on the path to UHC must be prioritized [11]. Similarly, the influences of climate change are indispensable drivers demanding policy attention in the transition to universal health coverage. Contemporary policy concerns are inclined with strong paradigm shift from the traditional democracy ideologies to social welfare irresistible popularism.

The scaling up of insurance mechanisms will generate additional pressure on the health system through an increase in demand from insurance members. As result, and in addition to political commitments UHC requires significant investment in infrastructure and above all a sufficient facilitated numbers of well-trained and motivated staff to succeed. But, as in many LMICs, this is in regard of a pseudo constricted labour market which is a ‘’shortage in the middle of abundance’’, as large pool of licensed professionals, who endure unabsorbed and out of the labour market dynamics. The WHO's global strategy on HRH for 2030, outlines that health systems can only function when they have a formidable health workforce. The WHO recommended patient – healthcare workers at 4.45: 1,000 people to achieve UHC [12]. Uganda’s healthcare workforce density of 1 per 11 000 Uganda [13]. Consequently, health policy must prioritize HRH aspects especially competence and loyalty to the health system under wide circumstances to orient, induce and expedite the transition to UHC. Furthermore, during the implementation of compulsory health insurance in Mali, certain problems emerged including long queues which considerably damaged the confidence of certain segments of the population [14]. Despite political commitments, the results of universal health coverage therefore remain mixed in certain countries including Mali or Senegal regarding health indicators [15].

Based on Uganda’s strong demand for medical services and the government’s poor tax policies for health sector, National health insurance policy remains a social development opportunity for the country. There is no national health insurance coverage, but there are twenty-eight community-based health insurance schemes and private health insurance provided by five insurance companies [16] [17]. Some organisations also run their own health insurance schemes. Uganda does not require employers to contribute to employment health insurance. Nevertheless, employers often provide it as an employee benefit. This is a missed opportunity for tax revenue generation. A policy for establishment and operationalization of Health insurance societies based at the employer level for private sector (employer-based insurance), integrated in the household NHI for the indigents and civil servants might be needed. This can be supported with digitalization of health services policy integrated with the social security and tax systems to ease premium collections and operational efficiency. Similar to CBHI, the Health insurance societies will mobilise and intermediate savings among their members, under the co-operative employer regulatory frameworks in promotion of their health interests. Not only will these institutions fast track coverage but stimulate the economy and development.

This article contests that healthcare is a “need,” rather than a “commodity” to be traded freely on the market. It posits that when healthcare is treated as a commodity – especially with a focus on profitability, it harms people. Those with money can buy ‘health,’ and those who cannot suffer the burden of catastrophic expenditure. To solve the challenges plaguing the health system healthcare must be considered a communal good and not distributed on the free market. However, when healthcare is subjected to the ideals of UHC healthcare ceases to belong in the free market and out of pocket expenditure tend to decrease. It is a need that everyone should have a fulfilled care in Uganda due to our ability to provide it and our responsibility to one another. Considering this aspect, it is a moral and civic duty of any government to provide Universal Health Coverage to its citizens [18].

Conclusion:

Globally, UHC is not only a critical prerequisite for exercising the right to health for all people but a social justice and responsibility to meet. Despite the right to health being enshrined in the country’s supreme law, the state of healthcare in the in Uganda remains a national crisis, one in which the Uganda’s competing values of freedom, equality, justice, and autonomy are distorting healthcare policy and inhibiting collective action. It is recommended that countries without schemes like Uganda expedite the passage of the National Health Insurance Scheme Bill arguably the most ambitious social reform proposed to minimise the exposure of the population to the exorbitant cost of health care and resolve to improve the complex healthcare delivery question. The political power must expedite the ratification of the National Health Insurance Scheme Bill. Uganda should also draw inspiration from the experiences of other countries such as Mali to better face the challenges of technical capacities and human resources generated by reform and new orientations.

Conflict of Interest:

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

Acknowledgements: None

Funding sources: None

References:

1. WHO 2024, Universal health coverage (UHC), October 2023.https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
2. Chen S, Cao Z, Wang Z, Wang C. The challenging road to universal health coverage. The Lancet Global Health. 2023 Oct 1;11(10):e1490-1.
3. Greer SL, Méndez CA. Universal Health Coverage: A Political Struggle and Governance Challenge. Am J Public Health. 2015;105 Suppl 5(Suppl 5): S637-S639. doi:10.2105/AJPH.2015.302733
4. Paul E, Ndiaye Y, Sall FL, Fecher F, Porignon D. An assessment of the core capacities of the Senegalese health system to deliver Universal Health Coverage. Health Policy OPEN. 2020 Dec 1; 1:100012.

5. Tung FL, Yan VC, Tai WL, Chen JH, Chung JW, Wong TK. Nurses' knowledge of universal health coverage for inclusive and sustainable elderly care services. Revista Latino-Americana de Enfermagem. 2016 Mar 4;24:e2670.
6. Institut National de la Statistique (INSTAT). (2019). Cellule de Planification et de Statistique Secteur Santé-Développement Social et Promotion de la Famille (CPS/SS-DS-PF), ICF. Enquête Démographique et de Santé au Mali 2018: INSTAT, CPS/SS-DS-PF and ICF Bamako.
7. Touré L, Ridde V. The emergence of the national medical assistance scheme for the poorest in Mali. Global Public Health. 2022 Jan 2;17(1):55-67.
8. Cashin C, Dossou JP. Can national health insurance pave the way to universal health coverage in sub-Saharan Africa? Health Systems & Reform. 2021 Jan 1;7(1):e2006122.
9. Unlocking the potential of the informal sector in Uganda through business formalization. https://eprcug.org/blog/unlocking-the-potential-of-the-informal-sector-in-uganda-through-business-formalisation/
10. Evidence for Universal Health Coverage indicators. Appendix 4. https://www.jstor.org/stable/pdf/resrep15878.12.pdf
11. Tracking universal health coverage:2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017. https://thedocs.worldbank.org/en/doc/265221524514363896-0090022018/original/UHCFlagshiponepagerFINAL.pdf accessed 27 March 24.
12. WHO, 2020. Global strategy on human resources for health: Workforce 2030 https://www.who.int/publications/i/item/9789241511131.
13. Ajari EE, Ojilong D. Assessment of the preparedness of the Ugandan health care system to tackle more COVID-19 cases. Journal of global health. 2020 Dec;10(2).
14. Goita, S. O. (2018). The difficulty of implementing compulsory health insurance in Mali: The case of higher education teachers. Revue francaise des affaires sociales, (1), 199-204. https://www.cairn.info/revue-francaise-des-affaires-sociales-2018-1-page-199.htm
15. Deville, C., Hane, F., Ridde, V., & Touré, L. (2018). La Couverture universelle en santé au Sahel: la situation au Mali et au Sénégal en 2018 (Doctoral dissertation, Working Papers du Ceped).
16. Uganda National Household Survey 2019/2020 Summary Report. Uganda National Household Survey 2019/2020 Summary Report.
17. O'Hanlon B, Nakyanzi A, Musembi V, Busulwa I, Husband R, Okumu R, et al. 2016. Exploring Partnership Opportunities to Achieve Universal Health Coverage: Uganda PSA 2016
18. Muthuuri JM. Demystifying the concept of Universal Health Care: A review. East African Orthopaedic Journal. 2020 May 21;14(1):30-5.