

6<sup>th</sup>

# NATIONAL COMMUNITY HEALTH FINANCING CONFERENCE

24<sup>th</sup> – 25<sup>th</sup> November, 2022

Golf Course Hotel, Kampala



## CONFERENCE REPORT



*"Community solidarity for quality health"*

## CONFERENCE HOST



*“Community solidarity for quality health”*

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Ministry of Gender,  
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## Acronyms

|         |                                                                 |
|---------|-----------------------------------------------------------------|
| BftW    | Bread for the World                                             |
| CBHI    | Community Based Health Insurance                                |
| CHF     | Community Health Financing                                      |
| CHI     | Community Health Insurance                                      |
| EHIS    | Ethiopian Health Insurance Service                              |
| FUE     | Federation of Uganda Employers                                  |
| ICT     | Information Communication Technology                            |
| ILO     | International Labour Organisation                               |
| IRAU    | Insurance Regulatory Authority of Uganda                        |
| MEACA   | Ministry of East African Community Affairs                      |
| MGLSD   | Ministry of Gender, Labour and Social Development               |
| MOH     | Ministry of Health                                              |
| MPs     | Members of Parliament                                           |
| NHI     | National Health Insurance                                       |
| NHIS    | National Health Insurance Scheme                                |
| NITA-U  | National Information Technology Authority - Uganda              |
| NPA     | National Planning Authority                                     |
| OOP     | Out-of-Pocket                                                   |
| PCHI    | Private Commercial Health Insurance                             |
| PDM     | Parish Development Model                                        |
| PPD-ARO | Partners in Population and Development – Africa Regional Office |
| SHU     | Save for Health Uganda                                          |
| UCMB    | Uganda Catholic Medical Bureau                                  |
| UHC     | Universal Health Coverage                                       |
| UIA     | Uganda Insurers Association                                     |
| ULGA    | Uganda Local Governments Association                            |
| UPFSP   | Uganda Parliamentary Forum on Social Protection                 |
| UPMB    | Uganda Protestant Medical Bureau                                |
| WHO     | World Health Organisation                                       |

## FOREWORD

On behalf of Save for Health Uganda (SHU), I am glad to share with you a report of the 6<sup>th</sup> National Community Health Financing Conference we hosted on 24<sup>th</sup> and 25<sup>th</sup> November, 2022 at Golf Course Hotel, Kampala. This conference was another great milestone in our advocacy for community health insurance (CHI) and a fair National Health Insurance Scheme for Uganda.

The conference objective was to enhance support for fast-tracking the establishment of an inclusive National Health Insurance Scheme (NHIS) for Uganda. Discussions focused on scaling up private health insurance, building synergies through public private partnerships, and available options for universal coverage in preparation for the NHIS. At the end of the two days, participants resolved that it was important to have regulations for CHI schemes, harmonise divergent views on the NHIS, invest in equal distribution of healthcare services across the country, get approval for Luwero district CHI scheme ordinance, and show penetration of the informal sector with information, communication technology.

I sincerely appreciate the 144 guests who fully participated in the conference for two days and those that followed online. I am grateful to the chief guest, the keynote speaker, presenters, panelists, session chairs and everybody who played a special role that made the conference a great success. In a special way, I thank the Members of Parliament for turning up and participating openly in the discussions. They demonstrated commitment to supporting introduction of a universal national health insurance scheme as part of the efforts to address the challenges in financing Uganda's health sector.

I sincerely thank the following partners for making generous contributions towards the success of the conference:

- Bread for the World (BftW)
- Ministry of Health (MOH)
- Ministry of Gender, Labour and Social Development (MGLSD)
- Smart Applications International
- Uganda Insurers Association (UIA)
- Health Partners
- Federation of Uganda Employers (FUE)
- Airtel Uganda
- Uganda Protestant Medical Bureau (UPMB)
- Ishaka Adventist Hospital
- Uganda Catholic Medical Bureau (UCMB).

I also extend sincere appreciation to the Organising committee that gave shape to the conference through sharing ideas, important contacts and volunteering in different ways. The committee members were:

- |                                  |                                                   |
|----------------------------------|---------------------------------------------------|
| 1. Mr. Makaie Fredrick           | Save for Health Uganda                            |
| 2. Dr. Kasyaba Ronald            | Uganda Catholic Medical Bureau                    |
| 3. Mr. Walimbwa Aliyi            | Ministry of Health                                |
| 4. Mr. Zephaniah Ogen            | Ministry of Gender, Labour and Social Development |
| 5. Mr. Badru Bengo               | Uganda Insurers Association                       |
| 6. Ms Peace Uwor                 | Smart Applications International                  |
| 7. Ms Logose Evelyn              | Federation of Uganda Employers                    |
| 8. Mr. Brian Alex Kiira          | Initiative for Social and Economic Rights         |
| 9. Ms Labira Sumaya Musoke       | Initiative for Social and Economic Rights         |
| 10. Ms Nnamulondo Proscovia      | Save for Health Uganda                            |
| 11. Ms Juliet Nazibanja Kibirige | Save for Health Uganda                            |
| 12. Ms Asio Veronica             | Save for Health Uganda                            |
| 13. Mr. Kabaale Robert           | Save for Health Uganda                            |
| 14. Mr. Friday Moses             | Save for Health Uganda                            |
| 15. Ms Josephine Kemigisha       | Save for Health Uganda                            |

Last but not least, I wish to thank the rapporteurs, Mr. Kabaale Robert, Project Monitoring and Evaluation Officer, and Mr. Kitenda Samuel, Union Technical Manager, Munno mu Bulwade Union of Schemes Organisation who summarized conference outcomes and worked with Ms Nnamulondo Proscovia to produce this report.

Thank you all for making the conference enjoyable, informative and successful!

*Makaie Fredrick*

Executive Director



*"Community solidarity for quality health"*

**Vision:**

Healthier families with simplified access to quality healthcare

**Mission:**

To enhance the quality of health of Ugandans through self-managed Community Health Financing (CHF) schemes

**What we do**

1. Promote Community Health Insurance (CHI) initiatives and organize communities to actively participate in running the formed schemes.
2. Advocate for a fair National Health Insurance Scheme law that favors the informal sector workers and guarantees subsidies for the vulnerable.
3. Support vulnerable and low-income families to acquire vocational, business and financial management skills and access low-interest loans.
4. Promote Patient centered care practices at partner health care facilities for delivery of quality health care services.

## CONFERENCE HIGHLIGHTS

The 6<sup>th</sup> National Community Health Financing (CHF) conference was held on 24<sup>th</sup> and 25<sup>th</sup> November, 2022 at Golf Course Hotel, Kampala. It was intended to build upon numerous achievements realised from the five conferences held earlier which included: recognition of CHF at various levels; support for CHF from local government leaders; public calls for health insurance for all; expansion of CHF to more parts of the country particularly the north and east; and technological innovations to advance CHF. The theme of the conference was ***'Building synergy for universal health insurance coverage for a healthy and productive population in Uganda'*** while the objective was ***to enhance support for fast-tracking the establishment of an inclusive National Health Insurance Scheme for Uganda***. The conference was structured in PowerPoint presentations, round table and panel discussions which focused on three sub-themes and eight topics shown below:

1. Scaling up private health insurance schemes (Community Health Insurance and Private Commercial Health Insurance) in preparation for the national health insurance scheme (NHIS).
  - Enrolment of informal population segments in the proposed NHIS: The critical role of private commercial and community health insurance schemes.
  - The legal and regulatory framework for micro health insurance in Uganda.
  - The role of local governments (decentralised system) in scaling up private and public health insurance schemes.
2. Practical linkages between government, NHIS and private insurance schemes for universal coverage
  - Scaling up micro-insurance under the current legal and regulatory framework.
  - The experience of Ethiopia with Community Based Health Insurance (CBHI) – successes, challenges and prospects.
  - The role of local governments (decentralized system) in scaling up private and public health insurance schemes.
3. The journey to universal health insurance coverage in Uganda: available options to reach all citizens.
  - Preconditions for successful universal health insurance schemes: perspectives from implementing countries.
  - The role of key stakeholders in fast-tracking the introduction and implementation of the NHIS.
  - Scaling up coverage of CBHI schemes in Uganda.
  - Leveraging existing technology platforms and advancements to facilitate introduction and rollout of the NHIS in Uganda.

The expected outcomes of the conference were:

- (i) The role of private health insurance schemes in the implementation of the NHIS streamlined.
- (ii) The NHIS bill reintroduced in Parliament and passed into law.

The expected outputs were:

- (i) Participants appreciate the role private health insurance schemes can play in reaching the informal sector and support their inclusion in the proposed NHIS.
- (ii) Participants appreciate the benefits of the proposed NHIS and give recommendations to finalize it.
- (iii) Information communication technology (ICT) providers commit to generate evidence on the viability of rolling out their systems to the informal sector to support the NHIS.

A total of 144 participants from 15 districts attended the conference physically while others followed through online live streaming. Participants included six members of parliament (MPs), seven representatives of government ministries and agencies, four representatives of international agencies, one international guest, 22 local government leaders, 33 civil society representatives, 26 private sector players, 32 representatives of healthcare providers, four leaders of CBHI schemes, 12 members of the press and a support team of 18.

The conference was officially opened by Dr. Charles Olaro, Director Clinical Services, Ministry of Health (MOH) on behalf of the Minister of Health. He reiterated the commitment of the ministry to achieve the target of 25 percent health insurance coverage in Uganda by 2025. It was officially closed by Mr. Prosper Muhumuza, Commissioner for Elderly and Disability Affairs, in the Ministry of Gender, Labour and Social Development

(MGLSD) on behalf of the Permanent Secretary. The keynote address was delivered by Dr. Marios Obwona for the Chairperson of the National Planning Authority and discussed by Hon. Joel Ssebikaali, the Deputy Chairperson of the Health Committee of Parliament.

### **Key issues and resolutions**

- (1) It was observed with concern that Uganda remains one of the few countries in the East African Community **without** a National Health Insurance Scheme. It was further observed that there was a continued delay by the Ministry of Health to return to Parliament and cabinet the NHIS bill, which had been passed in March 2021 into an Act 2021.

**Resolution:** a) *Explore the option of the Ministry of Health issuing guidelines / regulations to guide operations of Community Based Health Insurance Schemes due to the delay to introduce the NHIS.*

b) *The Ministry of Health should fast-track the process of reintroducing the NHIS bill in parliament and start preparations for its implementation.*

- (2) The low number of people covered by private (CBHI and Private Commercial Health Insurance Schemes – PCHIS) health insurance schemes at 3.9% of the population due to absence of a supportive regulatory framework.

**Resolution:** *The Insurance Regulatory Authority of Uganda working together with CBHI promoters and other stakeholders including Ministry of Health should develop and issue appropriate regulations for micro health insurance to facilitate their growth and sustainability.*

- (3) The role of Community Based Health Insurance and Private Commercial Health Insurance not streamlined in the previous NHIS bill 2019. Experiences from Ethiopia, Rwanda, Ghana and others show that CBHIs provide a foundation for NHIS.

**Resolution:** *CBHI schemes should be recognized in the proposed NHIS to play the roles of promotion, distribution, marketing and collection agents for the NHIS.*

- (4) The Non-approval of the Luwero District Community Health Insurance Scheme Ordinance by the Solicitor General in anticipation of the NHIS, which does not yet exist. The District scheme was designed to provide a legal framework for CHI at that level as well as a pilot for implementing the NHIS.

**Resolution:** *Luwero District Local Government to resubmit its Community Health Insurance Scheme Ordinance to the Attorney General through the Ministry of Local Government.*

- (5) The wide spread negative perceptions about health insurance which the public holds cause resistance to the idea of the NHIS.

**Resolution:** *Private Commercial Health Insurance Schemes to address negative perceptions about their services through raising awareness on health insurance.*

- (6) The existing disparities in the scope, breadth and quality of healthcare services undermine the principle of equity and may make the NHIS unattractive especially in rural areas.

**Resolution:** *The Ministry of Health should harmonize concerns of various stakeholders and invest in reducing disparities in the distribution and quality of health care services across the country in preparation for equitable access to services under a universal NHIS.*

- (7) Whereas participants were convinced that there are sufficient ICT platforms and providers to support the scaling up of health insurance in the country, it was not very clear how much of such technology had reached informal sector segments for easy enrolment of families into the health insurance schemes.

**Resolution:** *ICT providers to share evidence on their coverage of the informal sector on various platforms to guide the roll out of a universal NHIS covering even hard-to-reach population categories.*



## **Uganda Insurers Association**

Is an umbrella body for all Insurance companies in Uganda whose purpose is to promote the development and expansion of sound insurance and reinsurance in Uganda.

### **What we do.**

1. Promote awareness of Insurance.
2. Policy and Advocacy.
3. Consumer Protection.
4. Market Research.
5. CSR.
6. Industry Capacity Building

### **How we do this.**

We work to advance the interests of insurance and reinsurance companies by adopting a common strategy that encourages and promotes close cooperation, the exchange of business among members, builds on knowledge through research, influences the enactment of favourable legislation and represents the views of membership to Government, quasi – government and Private bodies.

### **Our Membership.**

An Aggregate of 36-member companies that include;

- 21 Non- Life/ General Insurance
- 8 Life Companies
- 2 Micro Insurers
- 4 Re Insurers.

## CONFERENCE PROCEEDINGS

DAY 1: 24<sup>TH</sup> NOVEMBER, 2022

### Session 1: Welcome remarks, keynote address and official opening

#### 1.1 Welcome remarks

Mr. Makaire Fredrick, Executive Director, Save for Health Uganda (SHU), welcomed all participants and recognized key guests particularly Hon. Joel Ssebikaali, Deputy Chairperson, Health Committee of Parliament, Dr. Marios Obwona, the keynote speaker from National Planning Authority (NPA), Dr. Muluken Haile Argaw, Deputy Director General, Ethiopian Health Insurance Services (EHIS), Ms Martha Akurut, Inspection Officer, Insurance Regulatory Authority of Uganda (IRAU) and Dr. Leticia Nakimuli, Chairperson, Board of Directors, SHU. He emphasized SHU's commitment to convening annual CHF conferences to promote CHF as one of the viable options for financing healthcare. He said SHU was advocating for scaling up of CHF initiatives to protect people from high out-of-pocket expenditure on health. SHU's work focused on two objectives: 1) to improve financial access to quality and affordable healthcare services and, 2) to rationalize health seeking behaviors of the people.



Mr. Makaire said SHU, the conference convener, was also advocating for fair national and local level laws and policies that guarantee access to affordable healthcare services for the informal sector and the vulnerable. He noted that although parliament had incorporated community health insurance (CHI) schemes in the NHIS bill of 2019 which the President did not assent to, it remained unclear how both CHI and private commercial health insurance (PCHI) schemes would operate alongside or as part of the NHIS. He reminded participants about key national statistics such as 41 percent out-of-pocket (OOP) expenditure by households on healthcare; 15 percent households impoverished due to paying for health care; about 10 million people living below the poverty line and only about 3.9 percent of the population covered by some form of health insurance. He said these statistics provided the background to the CHF conference. He said the vision of CHI promoters was an NHIS that is universal, fair, a single pool with members accessing benefits according to their needs regardless of their contribution.

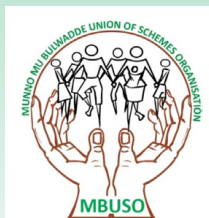
He challenged participants to think about the following issues and formulate plausible answers during conference deliberations:

- Is a health insurance premium a contribution or a tax?
- Is it a contribution people should make according to what they can afford or according to need?
- Will government funding stop, reduce or increase when the NHIS is introduced?
- Will private health insurance schemes cease to exist with the introduction of the NHIS?
- Why is it so hard for Uganda to pass the NHIS law and implement it?

He appreciated all partners that contributed towards the success of the conference. They included: Bread for the World (BftW), MOH, MGLSD, Smart Applications International, Uganda Insurers Association (UIA), Health Partners, Federation of Uganda Employers (FUE), Airtel Uganda, Uganda Protestant Medical Bureau (UPMB), Ishaka Adventist Hospital and Uganda Catholic Medical Bureau (UCMB).

## Community health insurance schemes supported by Save for Health Uganda

The five active Community Health Insurance Schemes supported by Save for Health Uganda operate as federations, bringing together several sub schemes. Four are member-managed and one is third party managed



**MBUSO** operates in Luwero, Nakaseke and Nakasongola districts. It is a member managed scheme that brings together 76 sub schemes



**CRUMBS** is a third party managed scheme that targets families mainly in the semi urban areas and corporate groups. The scheme operates in Luwero, Nakaseke, Nakasongola and Masaka with 10 sub-schemes.



**MSCOM** operates in Mityana and Kassanda districts. It is a member managed scheme that brings together 12 sub schemes



**WATSA** operates in Bushenyi, Sheema and Mitooma districts. It is a member managed scheme that brings together 20 sub schemes



**BURATS** operates in Iganga, Bugweri and Mayuge districts. It is a member managed scheme that brings together 20 sub schemes.

**SHU** is currently supporting the formation of Greater Nebbi Community Health Insurance Scheme in the districts of Nebbi, Pakwach and Zombo which is Health Provider Managed.

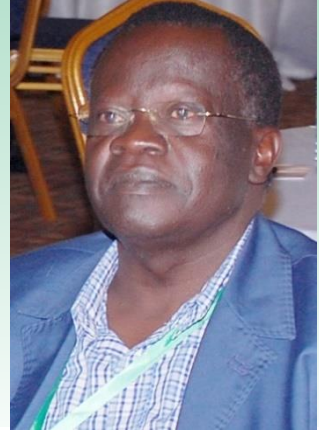
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## 1.2 Key note address: Building synergy for health insurance schemes to achieve universal coverage for a healthy and productive population in Uganda

Dr. Marios Obwona delivered the keynote address on behalf of the chairperson, NPA. He informed participants that NPA took matters of national health insurance (NHI) seriously because it was hinged in Uganda Vision 2040 and Agenda 2030 for sustainable development, which aimed to transform the country from a peasant to a modern society. He said the conference theme provided an opportunity to look beyond health insurance as an expense but rather as an anchor of growth. He added that Universal health insurance was one way to leave no one behind, and labour productivity was highly dependent on the health of the human capital. He described health insurance as a strong bargaining tool for employers and a sure way to improve productivity.



Dr. Obwona said health financing should focus more on preventive than curative services since majority of common illnesses were preventable. There was a need to design and operationalise parish level health promotion programs to counter preventable diseases. He pointed out that the emergency of COVID 19 and Ebola haemorrhagic fever exposed the fragility of the country's healthcare system. He observed that up to 1.5 million people in Uganda were trapped in poverty due to healthcare expenditures hence the need to build a stronger and more resilient healthcare system as a strategy to respond to the needs of citizens.

On designing a fair NHIS, Dr. Obwona said inclusive health was based on two main principles: equitable access and full participation. He noted that universal health coverage (UHC) required equitable financing schemes such as prepayment systems based on tax or compulsory contributions, though tax compliance was intricately linked to strong social contract and transparency. He observed that in countries like Uganda which was dominated by a large informal sector, there was a need to increase fiscal contributions by government to reach everyone. He emphasised the role of the private sector in healthcare services delivery and the need to establish strong public private partnerships to achieve UHC.

He advised that the immediate and short term interventions to accelerate towards UHC should include fast-tracking the enactment of a universal NHIS and ensuring that all Ugandans would contribute and benefit from health insurance to reduce the health financing burden that households faced. He committed that NPA would continue to plan and cost strategies and interventions that support CHF which was key in attaining human capital development outcomes and targets. He urged participants to renew efforts towards national insurance and CHI schemes by placing them at the centre of the primary healthcare system.

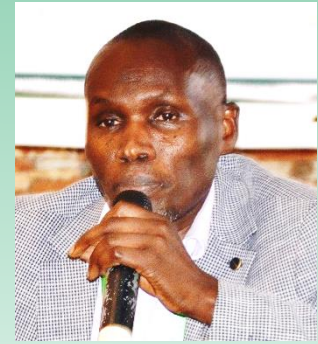
### 1.2.1 Remarks by the Deputy Chairperson of the Health Committee of Parliament



Hon. Joel Ssebikaali expressed concern that the issue of health insurance had been discussed for 20 years and featured in three national development plans but not much had been achieved. He mentioned that members of Parliament (MPs) laboured a lot, benchmarked in various countries in Africa and beyond, and passed the NHIS bill 2019 but all was in futility. He revealed that members of the 11<sup>th</sup> parliament had once again planned to visit three East African countries in preparation for the debate on the NHIS. He noted that citizens who would advance economically were languishing due to high OOP healthcare expenditures that force them into distress sale of family assets. He decried the unsystematic and inconsistent implementation of government programs which was sometimes driven by selfish interests. He cited Parish Development Model (PDM) program whose implementation started very fast with a lot of money yet the NHIS would be cheaper but continued to be shelved. Ssebikaali added that even funds sent to communities for development programs would not yield much because they would be diverted by household heads to meet immediate needs including healthcare. He advised participants to engage key stakeholders and influencers to drive the agenda of achieving UHC. He appealed to responsible officers in MOH to expedite the process of introducing the NHIS before the next national elections.

### 1.3 Status of the proposed National Health Insurance Scheme

Mr. Walimbwa Aliyi, Principal Health Economist, MOH, addressed participants on the various reforms that government was undertaking to improve healthcare services delivery, achieve equity and sustainable health financing systems. He shared milestones in the NHIS trajectory indicating that since the NHIS bill was returned to MOH, more consultations with stakeholders were held, a new draft bill was ready by October 2022, and costs and contribution scenarios were updated. He said the next steps would be to present the bill before cabinet for approval and later table it in Parliament for enactment. He noted that there was a need to maintain a delicate balance between political, economic and technical factors. He emphasized the need to continuously engage stakeholders through advocacy and resource mobilisation to create awareness and build acceptance of the proposed NHIS. He called upon all participants to support the process and committed, on behalf of MOH, that the bill would be fully processed. He added that discussions around government funding for healthcare when the NHIS is introduced and the place of CHI in the NHIS were healthy and should continue for purposes of building consensus among stakeholders.



### Session 2: Official opening ceremony



Left-right: Dr. Leticia Nakimuli, SHU Board Chairperson, Dr. Timothy Batuwa, Shadow Health Minister, Dr. Olaro Charles, Director Curative Services, MOH, and Mr. Makaire Fredrick.

#### 2.1 Speech by Board Chairperson, SHU

Dr. Leticia Nakimuli, thanked MOH and the chief guest for recognising the work of CHI schemes and listening to their proposals whenever there was an opportunity to dialogue. She explained that SHU's desire in hosting CHF conferences was to create a platform where CHF promoters, policy makers, healthcare providers and other stakeholders could share ideas on making access to healthcare affordable to all categories of the population. She revealed that since the previous conference, SHU had expanded operations to the eastern region specifically in Iganga, Mayuge and Bugweri district. SHU was also providing technical support to local players in West Nile in order to promote CHI in the three districts of Nebbi, Zombo and Pakwach. She recognized Luwero district leaders for continuing with efforts to create a district CHI scheme despite the frustration they experienced when the Solicitor General did not approve their ordinance in anticipation that the NHIS would soon be introduced.

Dr. Nakimuli said the theme of the conference was selected because organisers believed that if all healthcare financing mechanisms (government, donors and households) in Uganda were amalgamated and resources put into one pool, the country could easily achieve universal health insurance coverage. She appealed to the government to establish more safety nets to protect people from impoverishing healthcare expenditures and other catastrophes, citing lessons from the experiences of victims of COVID who faced hardships in paying huge healthcare bills.

## 2.2 Remarks by Shadow Minister of Health, Parliament of Uganda

Dr. Timothy Batuwa, Shadow Health Minister and Jinja West MP, emphasized the need to balance availability of critical diagnostic equipment across the country to guarantee access to timely diagnosis and treatment. He added that matters of equity could not be appreciated in a situation where services were not equally distributed across all regions including rural settings. He was concerned that the cost of drugs was so high due to the procurement protocols, hence the need to invest in drug manufacturing in the country. He said there was a need for more investments in the health sector.

On the proposed NHIS, Dr. Batuwa noted that it was important to discuss whether the NHIS must be mandatory or not and whether enrolled members would continue to experience some form of OOP expenditure. He emphasized that citizens needed to be convinced that they would actually access the services after paying premiums. He warned that if issues of concern around the NHIS were not fully addressed, the NHIS bill might delay further and not be approved. He said aspects of the obligations of government under the NHIS, level of pooling and accreditation criteria for health facilities had to be clearly stated in the bill. He concluded that the opposition in parliament would support the bill once all key concerns of stakeholders are addressed.

## 2.3 Opening speech by Chief Guest

Dr. Olaro Charles, Director Curative Services, MOH, opened the conference on behalf of the Minister of Health. He appreciated SHU and partners for convening the conference and congratulated SHU upon attaining 20 years of existence. He noted that instead of policy makers going out of the country to benchmark for health insurance, they should visit CHI schemes since they had been in existence for more than 20 years. He said there were so many savings schemes in communities for various social events other than health, which called for a mindset change. He said the return of the NHIS bill 2019 to MOH enabled them to consult further and build consensus with different stakeholders. He hoped that the bill would not face any resistance because almost all key stakeholders had given their input. He assured participants that MOH was still committed to introducing the NHIS and plans were underway to resubmit the bill to cabinet and Parliament. Dr. Olaro revealed that MOH was, in the meantime, strengthening the healthcare system to prepare for the NHIS and would continue to invest in infrastructure, equipment, human resource and health information systems. He called upon all people to support health insurance initiatives adding that what was most important was a decision to start and improve along the way. He called upon MPs to allocate more funds towards healthcare services so that MOH could focus more on improving quality of services and holding everybody accountable.

## 2.4 Key issues from the session

- The need for increased funding to the health sector
- Concerns over the delay by the Ministry of Health to table the NHIS bill in parliament for debate.
- Commitment by Members of Parliament to pass the NHIS law.
- The need to lobby stakeholders in public and private sectors to support the introduction of the NHIS.



Left-right: Dr. Ronald Kasyaba, the master of ceremonies and UCMB Assistant Executive Secretary, Mr. Makaire Fredrick and Dr. Muluken Haile from EHIS.



### Smart Applications

International is a leading ICT solutions provider delivering a wide variety of world class technological business solutions.

Fondly known as ‘Smart’ within the industry, the company was founded to provide innovations for secure, high tech solutions in Africa and beyond. We have presence within 11 African countries stretching from East African region (Kenya, Uganda, Rwanda, South Sudan, DRC, Tanzania) and beyond (Zambia, Somalia, Cameroon, Malawi) and beyond the seas over Mauritius

The Smart system has revolutionized the management of medical schemes using biometrically controlled contactless Smart card and cardless technology. We continue to serve over millions of medically insured members with access to over 5200 medical facilities installed with the Smart system. Through partnership medical insurance providers and medical health facilities, the system has enabled maximum efficiency in terms of member identification using biometrics, benefits management, accuracy of data capture, real time monitoring of member access, real time transmission of e-claims from the medical health facilities to the insurance providers (scheme administrators)

Smart has continued to dominate the healthcare space through constant innovations that has shaped the medical industry with one of the most recent being the Smart Virtual Access, Electronic Data Interchange (EDI). The EDI platform has enabled transmission of full electronic claims from the medical health facilities to the payer (scheme administrator), the platform acts as a portal of communication between the two parties hence shortening the claims reconciliation cycle. We have also enabled the capture of clean medical data and record keeping through our HMIS (Smarthealth+) and not forgetting the Business Analytics platform which has enabled visibility of information at a click of a button providing real time dashboards on medical trends.

Smart Applications International Uganda Ltd has partnered with some of the CHI schemes in provision of automation for the

management of the medical schemes. The major CHI promoters currently using Smart products include Save for Health Uganda (SHU), Uganda Protestant Medical Bureau (UPMB), Kiwoko Hospital and Ngora Hospital. This automation has helped in terms of member identification before accessing medical services, implementation on restrictions regarding member access and services to be accessed. With the Smart platform the scheme administrators are able to receive reports on real time basis i.e reports on scheme expenditure and the scheme performance at large. As Smart, we envision full adoption of technology by the CHI schemes around Uganda and also adoption by the Ministry of Health for the proposed National Health Insurance Scheme (NHIS) as we inspire convenience in terms of access to healthcare services.

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### OUR FOOTPRINT IN AFRICA



## Session 3: Scaling up private health insurance schemes in preparation for the NHIS

Dr. Byamukama Agaba, District Health Officer, Nakasongola, chaired the session. In his introductory remarks, he wondered who was supposed to pay for healthcare since it is recognized as a human right. He was concerned that while communities had safety nets for social events like weddings and burials, the issue of contributing towards healthcare was always ignored. He pointed out that workers' salaries needed to be enhanced to enable them contribute comfortably towards health insurance. He emphasized the need to mobilize resources and ensure that quality of healthcare services are provided.



### **3.1 Enrolment of Informal population segments in the proposed NHIS: the critical role of community health insurance schemes**

Ms. Juliet Nazibanja Kibirige, Program Manager, SHU, used the International Labour Organisation's (ILO) definition of informal sector workers as people or groups of people engaged in the production of goods and services with the primary objective of generating own employment and incomes. She said 75% of all the people employed in Uganda were informal sector workers. She added that while the NHIS bill 2019 mentioned that self-employed persons would make an annual contribution to the scheme, it was not clear how the contributions would be collected. She said CHI schemes, which are groups of people voluntarily formed with the aim of pooling funds to meet the cost of healthcare, had the potential to enroll informal sector population segments into the NHIS. The schemes, which were 44 at the time across the country with a network of 67 healthcare providers, could serve as marketing and distribution channels for NHIS through mobilizing communities, creating awareness, registering members, collecting premiums and transmitting feedback. She concluded that if CHI schemes were regulated, supported, and their role clearly defined, they could facilitate universal coverage of the informal sector by the NHIS.



### **3.2 Enrolment of informal population segments in the proposed NHIS: The critical role of private commercial health insurance schemes**



In his presentation, Mr. Badru Bengo, Manager Life, Medical Insurance and Pension at UIA, noted that health insurance cover was an enabler for workforce productivity. He said medical insurance was contributing about 20 percent of insurance services in the country. He observed that many insurance companies were experiencing high loss ratios due to impersonation by proxies of clients, unethical practices of some healthcare providers, manual claims, declaration of a waiver on the pandemic clause, and high costs of drugs and other services.

On extending health insurance services to the informal sector, Mr. Bengo said many insurers were not venturing into the informal sector because information about it was scanty. He, however, added that some insurers had started providing other benefits such as hospital cash reimbursement on admission although such products were characterized by frequent payment of premiums e.g. daily, monthly or quarterly. He added that some insurers were diversifying into other markets like covering older persons up to 80 years of age.

Mr. Bengo pointed out proposals of private insurers for the NHIS which include: liberty for an individual to choose a scheme of their preference as long as the benefit package is not inferior to the one prescribed in the law; piloting the scheme with the public sector; a mandatory contribution of one percent of the salary of formal sector workers to the NHIS; IRAU to supervise the scheme; government to make a contribution to the scheme; revolving of surplus funds; and separation of roles of the fund holder and purchaser. He said UIA was advocating for inclusion of PCHI as a component of the NHIS.

### **3.3 Plenary discussion**

There were four contributions during plenary which emphasized the need to deal with misinformation and misconception about health insurance so as to build public trust. Other submissions focused on the best

approaches that could be used to enroll the rural informal sector into health insurance, the viability of premium loans, challenges of sustainability of CHI schemes and their relevance under the NHIS. It was observed that mobilizing communities to pay premium was very expensive yet if health insurance was tagged to other services such as credit facilities in finance institutions, it would reduce operational costs. Premium collection had to be customized to enable target insurance clients contribute premiums at their convenience using the easiest payment modes such as mobile money transfers. It was noted that one of the sustainability strategies for CHI schemes was to link them to the NHIS.

### **3.4 Key issues from the session**

- The need for a regulatory framework for CBHI to address limitations in its promotion.
- The need to provide more support supervision to health Insurance providers through agencies like Insurance Regulatory Authority of Uganda (IRAU).
- Recognition of private health insurance providers as key stakeholders in the NHIS process that can play various roles such as marketing, distribution and collection agents.

## **Session 4: Practical linkages between private insurance and the NHIS for universal coverage**

### **4.1 Scaling up Micro-insurance under the current legal and regulatory framework**

The session was chaired by Mr. Douglas Opio, Executive Director, Federation of Uganda Employers (FUE).

Ms. Martha Akurut, Inspection Officer, IRAU, introduced IRAU as a government body created under section 14 of the Insurance Statute of 1996 which was later amended into the Insurance Act of 2017. IRAU is mandated to ensure effective administration, supervision, regulation and control of the business of insurance in Uganda. It regulates insurers, intermediaries (insurance brokers, banc assurance and agents), loss assessors and loss adjusters. She said the insurance industry hit the one trillion target in 2021 but penetration remained low at 0.8 percent.



She described micro-insurance as the protection of low-income earners against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. She said IRAU issued interim Micro insurance guidelines in 2016 and accompanying regulations were in process. The interim guidelines contained details of capital requirements, governance matters, licensing and product approval. There were only two licensed micro insurance companies running in the country at the time – Age Micro and Grand Micro. She cited a report commissioned by Financial Sector Deepening in Uganda on the needs and gaps faced by small and micro enterprises during the COVID 19 outbreak which indicated that many people did not have trust in insurance players. It also showed that many insurance products did not respond to the needs of the people. She shared proposals on what could be done to scale up micro insurance which included: formulating products that meet the needs of the target market; harnessing the distribution channels; investing significantly in educating customers and potential customers; and engaging at aggregator levels such as farmer groups, cooperatives and unions. She urged insurers to deliver services as per the contracts with their clients to build trust in the insurance industry.

For CHI schemes, Ms Akurut recommended that they could leverage on the commercial insurance companies' capacity by having reinsurance packages for their schemes and taking advantage of already existing structures. She said IRAU was aware of the existing gaps in the operations of CHI schemes and the risks that characterized operating in an unregulated field. She added that IRAU was already considering proposing regulations for CHI schemes. In her conclusion, she emphasized that the NHIS agenda concerned everyone in terms of contribution and awareness to achieve universal coverage.

#### **4.2 The experience of Ethiopia with Community Based Health Insurance – successes, challenges and prospects.**



Dr. Muluken Haile Argaw, Deputy Director General, EHIS, shared on the experience of Ethiopia with CBHI, the lessons learnt, challenges faced and prospects. He said Ethiopia had a population of about 115 million people, OOP expenditure was about 30 percent and per capita expenditure on health was USD36.4, which was below both the continental average (40USD) and the recommended amount for essential services (86 USD).

Dr. Muluken explained that Ethiopia undertook numerous reforms in the healthcare system to prepare for introduction of health insurance. The reforms included:

- Allowing revenue retention and utilization at the health facility level,
- provision of a fee waiver system for the poor,
- standardization of exempted health services,
- evidence-based revision of user fees,
- establishment of a private wing in public hospitals,
- outsourcing non-clinical services at public hospitals e.g. cleaning, security, and,
- establishment of health facility governance boards.

Dr. Muluken said the Ethiopian health insurance system was designed to have both CBHI and social health insurance (SHI) but the later was delayed due to resistance by the formal sector. SHI was intended for formal sector employees (19 percent of the population) while CBHI was designed was for the informal sector (81 percent of the population). SHI was supposed to be mandatory with a single national pool while CBHI was initially voluntary with district level pools until July 2022 when it was made compulsory. Both schemes were solidarity based backed by the principle of equity and the unit of enrolment was a household.

He explained the roadmap starting in 2005 that led Ethiopia to roll out CBHI in 2012 and reach coverage of 67 percent of the population (8 million households) in 84 percent of districts (894 districts) with a renewal rate of 83 percent by 2022. Up to 52 percent of the target indigents (1.7 million households) had been covered. The reasons for introducing CBHI were to: remove financial barriers, enhance equity, reduce catastrophic OOP, increase health service utilization, and improve quality of care. He said CBHI was introduced in a phased manner starting with four regions out of 11. The factors that facilitated introduction of CBHI were: Health sector development plan 1997/98 – 2014/2015 which improved physical access to health care facilities (many health centers were built); Health financing reforms; and Fee waiver system for the poor and exempting maternal healthcare services.

Dr. Muluken said CBHI had two categories of members, that is, contributors who pay annual premiums and indigents whose premium is paid by local governments. Revenue came from subsidies for indigents from districts and 25 percent contribution from federal government. Premium contributions ranged from 6 to 13 USD for rural settings and 10 to 33 USD for urban dwellers. The benefit package included outpatient care, inpatient care, delivery services, surgical services, diagnostic tests and generic drugs.

##### **Lessons learnt**

- CBHI was widely accepted by the population
- Per capita health service utilization increased from 0.36 to 2.05 for enrolled households
- Reduced OOP by 50 percent hence decreased financial hardships
- Contributed to improvements in quality of healthcare services through: increased flow of more predictable resources to health facilities, and more active engagement of the community.
- Poor households reached by CBHI realized improved equitable health services utilization
- Empowered women to utilize healthcare services whenever needed without having to wait for their spouses.

### Major challenges

- Inconsistent leadership commitment
- Inadequacies in the quality of healthcare services (drug stock outs and inadequate human resources)
- Fragmented and small size CBHI pools with no cross subsidization
- Some schemes became insolvent due to lack of financial sustainability
- Flat rate membership contribution (inequitable) with no capping system
- Manual operation and reporting system
- Inadequate financial and technical support from development partners

### Future plans for EHIS

- Expand CBHI to all districts
- Modernize contribution collection from manual to mobile / electronic.
- High level pooling
- Introduce sliding scale contribution.
- Engage the private sector to participate in provision of healthcare services because it constitutes 24 percent of healthcare service providers in Ethiopia
- Create a modern health insurance information system.
- Strengthen strategic health purchasing functions.
- Capacity building to EHIS and regional and district level health insurance work force.
- Finalize preparatory tasks and resolve pending issues to launch SHI.

### 4.3 Plenary discussion

Four participants raised a number of issues. One observed that even if CBHI would widely be adopted in Uganda, local governments would not be able to contribute premiums for indigents because Uganda Revenue Authority was collecting taxes right from small businesses in rural areas, leaving local governments without any local revenue. He also wondered why OOP remained high in Ethiopia at 30 percent yet health insurance coverage was high. It was clarified that OOP was high because the formal sector was not insured and a section of the informal sector remained uncovered (33 percent of the eligible households). Another issue was about coverage of only 84 percent of districts in Ethiopia. The reason for this was that CBHI roll out depended on willingness of local governments to implement it. Majority of districts in pastoralist areas had not implemented the first generation reforms and CBHI due to low commitment of local leaders. For a scheme to start, 50 percent of eligible households must be enrolled which was not easy to achieve. Efforts were being targeted at the uncovered regions and the proclamation of July 2022 made it mandatory for all regions to start CBHI.

Another participant asked why coverage of indigents stood at 52 percent yet there was a policy to cover everybody. Dr. Muluken responded that Ethiopia was still a poor country and local governments did not have financial resources to pay for all eligible persons. He added that the country had a large informal sector (81 percent) and a tax-based scheme could not work. However, the federal government was meeting running and administrative costs of EHIS and public healthcare facilities including staff salaries. CBHI premiums covered only medical treatment and related costs.

A question was raised about whether CBHI had caused any improvement in the quality of healthcare services and the country's health indicators. In response, it was revealed that health facilities in areas where CBHI was being implemented improved the quality of services because of increased resources although there were challenges in procuring drugs due to escalating costs. CBHI also increased utilization of healthcare services. One participant wondered how the general public could access information about insurance from IRAU and he was informed that the organisation's website had all relevant information and more was being channeled through the mass media.

### 4.4 Key issues from the session

- There was a need for IRAU to engage concerned stakeholders at the earliest opportunity to develop a legal and regulatory framework for CBHI schemes.
- IRAU needs to provide more support to insurance promoters regardless of their size.
- Universal health insurance schemes must be fully backed by government to succeed and be sustainable. The most important decision was to start and improve along the way.



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## Health Cooperatives

### A LOCALLY DRIVEN SOLUTION BRINGS AFFORDABLE CARE AND BETTER OUTCOMES

In Uganda, high out-of-pocket (OOP) health costs deter many from seeking care, resulting in poorer health outcomes. They also result in increased poverty: In 2010, high OOP expenditures drove poverty rates in the country up more than 17.5%.<sup>1</sup> This has given rise to health cooperatives, an innovative solution to improve access to affordable care

### How health cooperatives work

Care providers sign agreements with member groups who prepay premiums that enable members to seek care when they need it. Healthy members offset the costs for those who fall sick. Providers usually see a small budget surplus at the end of the year, which they reinvest to improve care quality.

Members are free to change providers if they are unhappy with their care, which further drives quality improvement. In addition, a member-elected board of directors oversees the partnership, and their costs are covered by a small fee paid by both the members and providers.

### Incentives are built in

Since members prepay premiums directly to care providers, there are little, if any, third-party managed care costs. This helps providers understand that if they keep administrative costs low, they will make more money. They also learn that, by covering a wider pool of members and keeping them healthy, they will be more profitable.

In addition, because members prepay their premiums, they are more likely to seek care early so they are less expensive to treat. This enables them to recover faster and miss less work or school.



### The Impact

**Health cooperative membership<sup>2</sup> has:**

- **Improved disease-prevention behaviors:** Members are 22% more likely to have hand-washing stations in their homes (80.4% coop vs 66% non-coop) and 38% more likely to sleep under bed nets.
- **Fostered earlier intervention:** Members are 12% more likely to get treatment for diarrhea and 5% more likely to seek treatment for fever.
- **Provided protection from high health care costs:** Members are about 50% less likely to pay for care on credit or have to borrow or sell assets to pay for care.
- **Improved cost recovery:** Providers recover an average of 6.38 USD per coop member treated vs losing an average of 0.50 USD treating non-members, largely due to patients' inability to pay.

### The Cooperative Difference

- **Local control and ownership:** Governance structure empowers members to own their health care decisions and outcomes.
- **Financial sustainability:** Prepayment and shared risk means fewer patients pay on credit or abscond without paying.
- **Quality:** Members have a collective voice and bargaining power to demand quality care.
- **Investment:** Directly paid premiums reduce administrative overhead, enabling providers to invest in and retain quality staff and maintain drug supplies.
- **Earlier treatment seeking:** Prepayment encourages members to seek care early, which reduces the overall cost of care and improves outcomes.
- **Health education:** Healthy behaviors drive better health and lower treatment costs, so providers are more likely to offer health education to keep members healthy.

## The Role of HealthPartners

With a vision to increase access to quality care while improving health outcomes, HealthPartners helps build local capacity to manage health cooperative financing and to enable continuous health care quality improvement from the village to the national level. As part of this effort, HealthPartners provides training and support to cooperative providers and boards and has created a toolkit for organizations to pilot cooperatives in their own countries.

#### References:

1. Zikusooka, CM, et al. 2014.
2. HealthPartners Impact Assessment, performed by consultants from Makerere University, June 2015.

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#### **4.5 The role of local governments (decentralized system) in scaling up private and public health insurance schemes**

The session was chaired by Mr. Douglas Opio, Executive Director, Federation of Uganda Employers. In his introductory remarks, he observed the important role local governments in Uganda play in delivering services to the people at the grassroots. He noted that while there were concerns about financial resources available at the local government levels, the leadership structures set up placed them at the frontline of service delivery. He then introduced the panelists who were:

- Mr. Andrew Moses Awany, Vice President, Uganda Local Governments Association
- Dr. Nkonwa Herbert Innocent, District Health Officer, Luwero District Local Government
- Mr. Kaggwa Andrew, Principal Assistant Secretary, Ministry of Local Government



The chair asked panelists the roles they were playing as local government leaders in the NHIS process and what more they could do in future to promote uptake of health insurance. He also asked them to comment on their readiness for the NHIS and how the indigent could be identified to benefit from the scheme.

Mr. Awany said leaders were mobilizing people in their areas, encouraging them to plan for their healthcare and to get information about health insurance. He added that leaders also created an environment for people to dialogue about health care service delivery and make recommendations. In addition, they allowed private insurance companies to interface with district leaders and educate them about health insurance as a way of marketing their products. On identification of vulnerable people, Mr. Awany said the different programs under the community development department kept data which could be used to identify the different categories of people in the district. He said all districts had focal persons for each special interest group.



Dr. Nkonwa noted that the healthcare system in Uganda was facing various challenges including inadequate supplies and there was need for interventions that would help people to access services whenever they needed them. He said there must be deliberate efforts to invest in health care system to improve the infrastructure and distribution of services. He said promoting health insurance was one of the interventions Luwero district was using and political commitment was crucial in pushing it forward. He added that health indicators were better in areas that had running CBHI schemes but a lot was yet to be done to increase the number of members in CBHI. He said the District Council passed an Ordinance to create a district CBHI scheme but it was halted by the Solicitor General in anticipation of the NHIS. However, the district leadership was continuing to explore how to promote CBHI with or without a legal framework.



On what local governments could do to scale up existing CBHI schemes, Mr. Kaggwa said they would focus on community mobilization aiming at mindset change on health insurance and passing supportive bylaws under the existing legal framework. Mr. Kaggwa said there were efforts to upgrade existing health facilities to ensure equitable distribution of services across all districts. He added that parish chiefs had been recruited in at least 85 percent of parishes and the minimum academic requirement upgraded to a diploma for them to be able to mobilise communities, collect data, store and use it. A parish information system was established under the parish development program and the personnel at various levels had the potential to support implementation of the NHIS. He said the elaborate local government



structure was helping to bring everybody on board in development programs. He concluded that structures were 98 percent ready for NHIS but infrastructure was at 50 percent.

#### **4.6 Plenary**

A participant asked what the Ministry of Local Governments was doing to support districts to secure approval of their ordinances by the Solicitor General. He added that even the act of rejecting Luwero District CHI scheme ordinance basing on speculation was illegal because the NHIS law was not in place. Mr. Kaggwa guided that ordinances should be submitted through the Ministry of local government so that lawyers could refine them before they are forwarded to the Solicitor General. He suggested that Luwero submits its ordinance again through the Permanent Secretary of the Ministry of Local government, adding that the reason given earlier for its rejection by the Solicitor General was illegal.

Another participant wondered how local governments could subsidize indigents to enroll into health insurance. In response, Mr. Kaggwa proposed that individuals who could afford should contribute premium for their indigent relatives. Dr. Nkonwa said mobilizing as many people as possible makes it possible to bring on board vulnerable people because of the pooling effect. In addition, some programs that support vulnerable people such as the elderly could be integrated into health insurance with subsidies from government and development partners.

Mr. Awany said budgeting by local governments was being dictated by the central government. He was concerned that the Public Finance Management Act disempowered local governments because even the local revenue collected was being sent to the central government instead of being used to tackle local priorities. He said local governments had no autonomy to determine their priorities. He recommended that the legal and regulatory framework for health insurance should enable every stakeholder to play a role in promoting it.

#### **4.7 Key issues from the session**

- Luwero District leaders should be supported by the Ministry of Local Government to secure approval of the District CHI Scheme Ordinance from the Attorney General.
- Local governments were disempowered by laws that require them to transfer all revenue to the central government, hence neglecting local priorities.
- Local governments had the structures for rolling out the NHIS but the infrastructure was underdeveloped.



*Mr. Gabula Ezra, Iganga District Chairman, contributing to the discussion.*



*Mr. Abdu Mazinga, Speaker and Ms Christine Nakamanya, the Vice Chairperson of Luwero District.*

## DAY 2 – 25<sup>TH</sup> NOVEMBER, 2022

### Session 5: The journey to Universal Health Insurance coverage in Uganda: available options to reach all citizens.

#### 5.1 Preconditions for a successful universal health insurance scheme: perspectives from implementing countries. Panel discussion

The objective of this session was to generate practical lessons and evidence that could be adopted for NHIS implementation in Uganda. It was chaired by Ms Nnamulondo Proscovia, Communication and Advocacy Officer, SHU. The panelists were:

- Dr. Muluken Haile, Deputy Director General, EHIS
- Ms Christabel Abewe, Health Financing Specialist, World Health Organisation (WHO), Uganda Country Office.
- Ms. Hoehler Shana Fabienne, Technical Officer, Social Health Protection for Refugees and host communities, International Labour Organisation (ILO)
- Mr. Sebina Edward, Commissioner Social Affairs, Ministry of East African Community Affairs, Uganda



Left – right: Ms Nnamulondo Proscovia, Mr. Sebina Edward, Dr. Muluken Haile and Ms Christabel Abewe.

The session chair asked panelists to talk about the factors that enabled some countries to start and finance national health insurance schemes, the size of their benefit packages, involvement of stakeholders in the running of such schemes and coverage of indigents.

Ms Abewe observed that no health insurance model was fit for all countries because of differences in socio-economic status, cultural diversity and others. She noted that some countries made mistakes from which others could learn. She said the key factor that enabled some countries to start was funding for the scheme, which should be adequate, sustainable and equitable. She said governments had to subsidise schemes to enable them run smoothly. She observed that Uganda's NHIS bill 2019 did not suggest government contribution to the scheme but partners were advocating for a change. She said the second factor was resource pooling where countries establish big pools of insurance funds to facilitate cross subsidization and avoid fragmentation. The third factor identified was strategic purchasing arrangements that are based on data to monitor use and avoid abuse of schemes. Other important factors were: transparency and accountability structures to build trust in the scheme and avoid leakages; strong political commitment to the scheme; and good quality services offered.

On determining the benefit package, Ms Abewe said WHO recommends a cost effective and affordable benefit package that maximizes health gain. It must address the burden of disease to the highest degree possible. She

said an appropriate benefit package for Uganda must maximize the goals of the health sector premised on the dimensions of equity. People and groups that are vulnerable should be prioritized e.g. pregnant women, children under five and older persons above 60 years of age. She said it would not be possible to initially have a package that covers everything but tradeoffs should be identified and managed well with a focus on interventions that promote primary healthcare.

Citing examples from Ethiopia, Dr. Muluken identified stakeholders of CBHI to include federal government, regional governments, district, community, religious leaders, elders and healthcare providers. He said the commitment of government as a major stakeholder was crucial for CBHI to take off. The Ethiopian government took full responsibility for starting CBHI, promoted it and issued rules and regulations to support implementation. The local governments made contributions towards CBHI schemes by providing staff, creating awareness, mobilising communities and contributing premiums for indigents. He mentioned that community, religious leaders and elders played a great role in introducing NHIS and dealing with negative perceptions. Health extension workers would go to each household to teach basic health services e.g. maternal health, child health, family planning, sanitation and educate people about CBHI benefits. Healthcare providers supported CBHI through good customer care practices. International and local partners played roles in creating capacity, training individuals, giving resources for support supervision, awareness campaigns, review meetings and hiring experts to support the local team.

Dr. Muluken shared about strategic purchasing which involves determining the package to buy, the providers and how to pay for services. Strategic purchasing makes sure that resources are allocated to the prioritized conditions in an efficient way. He said EHIS was still practicing passive purchasing but schemes were trying to redesign the benefit package basing on cost effectiveness analysis and equity principles. The major payment mode was fee for service but capitation was being piloted. EHIS was purchasing services from public facilities only but there were plans to engage the private sector to create competition. The challenge was that there were no private facilities in some areas and claims management was still manual.

Ms Shana, who joined the conference online from Nairobi, observed that countries use different sources of funding to establish successful health services delivery systems. He added that although health insurance was being considered key in improving access to healthcare services, there were countries like Malaysia which provided free health services for all. There were also others that were moving towards UHC through contributory schemes and extending risk pooling such as Palestine. She said Thailand was a classic example of countries that are highly subsidizing their citizens with 75 percent of the population covered through public/tax financing - only civil servants make contributions. In some countries, primary health care is publicly funded while tertiary care is funded through contributory schemes. Countries that had made mistakes of starting small pools of funds had to amalgamate them. She said some success factors included having a strong legal framework, mandatory coverage, considerable domestic financing and subsidies for sections of the population.

On inclusion of vulnerable people in health insurance schemes, Shana observed that many countries were grappling with the challenge of covering a large informal sector. She said there were various identification mechanisms for social protection programs which could be used to identify people considered poor e.g. Kenya's single registry. She said people move in and out of poverty frequently and mechanisms should be in place to make periodic updates to the registry. She added that governments need to plan to subsidise a large section of the population with domestic resources and make people aware of their entitlements without being stigmatized. She concluded that it was important to think about the population as a whole.

Mr. Sebina shared insights on plans by member states of the East African Community to introduce and expand health insurance. He revealed that in 2018, Heads of States agreed on a 10 - year health sector investment priority framework with ten priorities. Priority seven was expansion of health insurance coverage and social protection. The main goal of the priority is to reduce out of pocket expenditure on health and improved financial risk protection while accessing essential healthcare services. He recognized that tax-based financing of healthcare services was inadequate but contributory schemes expanded opportunities for mobilizing additional

resources. He recommended that any health insurance scheme being designed for Uganda should consider portability of benefits across the east African region.

### **5.1.1 Plenary**

There were seven contributions from participants. The issues raised focused on enforcement of mandatory CHI schemes, negative socio-cultural norms, cost effectiveness of benefit packages, success factors for countries like Rwanda, introducing health insurance under a free healthcare system, and the tendency of patients to prefer private health care providers. The responses of panelists indicated that mandatory health insurance must be backed by law as the case was for Rwanda. In Ethiopia, CBHI premium was attached to the land tax which was essential for households. In Rwanda, CBHI coverage is a performance assessment area for leaders which makes them work harder to enroll everybody. In Ethiopia, the negative perceptions were addressed through countering practices such as those that were promoting burial groups. Religious leaders may also help to deal with negative perceptions. On the tendency of people to prefer private to public healthcare facilities, Dr. Muluken said it was a reality in urban settings but not common in rural areas. In many cases, private facilities refer patients back to public facilities. The most important issue is to ensure that the vulnerable who would not afford services in private facilities access them. Public facilities are able to refer patients to private pharmacies for drugs that may not be in their stock. On designing a cost effective benefit package, panelists stressed that when designing the package, a country has to consider needs of different population groups. Beneficiaries could participate in the processes through their associations. It is possible to introduce health insurance where there is a free healthcare system. For, instance, the high OOP expenditure in Uganda shows that people are spending money on health care and insurance would benefit them.

### **5.1.2 Key issues from the session**

- Each country should design a national health insurance scheme that addresses the actual needs of its citizens.
- Governments should avoid the mistake of creating fragmented health insurance scheme pools because they are not sustainable.
- Countries need strong legal frameworks that make health insurance mandatory so as not to leave out any population segment.
- Governments must allocate funds towards subsidizing the less privileged to access health insurance.



*Left – right: Mr. Samuel Kitenda and Mr. Robert Kabaale, conference rapporteurs.*



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*The Voice of Employers*

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## 5.2 The role of key stakeholders in fast-tracking and implementing the National Health Insurance Scheme. Panel discussion



The session was chaired by Ms. Gloria Nakajubi, Advocacy and Communication Specialist, Uganda Parliamentary Forum on Social Protection (UPPFSP). In her introductory remarks, she emphasized the need for the NHIS for Uganda basing on the high out of pocket expenditures and the number of people that fall into poverty due to paying medical bills. She observed that the low income levels of Ugandans further justified the need for health insurance because people had very little disposable income. She was concerned that the process of introducing the NHIS had dragged for over 20 years. He asked panelists to share updates on the status of the NHIS, the roles of their institutions in fast tracking it and the opportunities for its quick introduction.

The panelists were:

- Dr. Alima Hilary, Director Health Systems Strengthening, Uganda Protestant Medical Bureau (UPMB).
- Mr. Walimbwa Aliyi, Principal Economist / NHIS Desk Officer, MOH.
- Mr. Kiwanuka Achilles, Program Officer, Partners in Population and Development – African regional Office (PPD-ARO)



*Dr. Alima Hilary, Mr. Walimbwa Aliyi and Mr. Achilles Kiwanuka.*

Mr. Walimbwa said he had been part of the NHIS process for 10 years. He said health insurance was a complicated issue because of resource pooling and different contributory mechanisms. He, however, said the most important issue was to achieve the desired goal. He noted that the design of the NHIS for Uganda had been changing over time to avoid leaving out of any category of the population. He said the delays were partly due to the desire to avoid making mistakes that other countries made which led to slow progress with NHIS. He cited comparative population targeting experiences of Kenya and Ghana whereby Kenya, which started in the 1960s focused on the formal sector and had very low coverage while Ghana focused on everybody and reached about 60 percent of the population within 10 years. He said the focus for Uganda was to have everybody on board and avoid fragmented pools from the start of the scheme with UHC being the ultimate goal. On the status of the NHIS bill 2019, he said history was made when parliament passed it although it was not signed by the president. He said the MOH had done its part and redrafted the bill awaiting cabinet approval. He appreciated all proposals given by stakeholders towards improving the technical design of the NHIS.

On the role of stakeholders in fast-tracking and implementing the NHIS, Mr. Kiwanuka said the first stakeholder to hold accountable for UHC was the government including ministries of finance, gender and health. He observed that the process of sending back the NHIS bill to MOH was illegal because it did not follow the stipulated

procedures. He said the government committed to Vision 2040 and a minimum healthcare package but little was being done. He added that the same government which has led Uganda for 35 years promised to introduce NHIS 15 years ago until it was removed from the manifesto in 2021. Uganda committed 10 years ago before the committee of health to pass the NHIS bill but there was no action until the Chairperson of the Health Committee in the previous parliament attempted to table a private members bill. He observed that the private sector was standing in the way of the NHIS because it alleged that the NHIS would increase the cost of doing business. He added that the civil society also had a big role to play especially in sensitizing the population about the NHIS.

Dr. Alima, said UPMB, which was implementing CBHI at 43 facilities with 96,000 members, was using different approaches such as encouraging affiliated institutions and faith leaders to pool resources for their healthcare. Faith leaders were important because of their stake in the communities they serve. He said UPMB had about 315 affiliated health facilities which it was targeting to scale up CHI. He noted that health promotion was very key in preparing people for health insurance so as to sustain the schemes. He said CBHI schemes had great potential to pave way for the NHIS but they were not regulated and their standards for compliance and quality assurance were not universal. Dr. Alima said there was need for inclusion and joint planning so as to involve everybody including the private sector. He added that government involvement in financing the NHIS was crucial because subsidies would reduce the cost of services. He observed the need for public sensitization to build acceptance and political will towards the NHIS.

On using the existing initiatives to prepare for NHIS, Mr. Walimbwa said patient satisfaction was seen to increase with insurance because people demand for quality. He added that the example of health facilities partnering with pharmacies to avoid disappointing insured clients due to drug stock outs was good to adopt. He emphasized that the results based financing (RBF) program where funding was based on results also helped to prepare health facilities to account for resources and focus on quality.

On capitalizing on current strengths, Mr. Kiwanuka said there was need to dispel fears on the side of government that it may not be able to finance the NHIS. He said there was need to strengthen the spirit of solidarity because with a pool that brings everybody together, the premiums could be kept low to enable everybody to belong to the scheme. He proposed that CBHI and PCHI should also be streamlined in the NHIS bill.

### **5.2.1 Plenary**

Three participants made submissions during plenary. One observed that all services at public facilities were being paid for by the people through illegal fees. Another said capacity building for human resource for health, infrastructure, equipment and data management was crucial in preparation for NHIS. He was concerned over the poor drugs management and usage in the country which allowed anybody to buy any drug without any prescription. The last one doubted the sustainability of the NHIS since a number of CBHI schemes started in different areas had collapsed.

In response to the above issues, panelists assured participants that no NHIS in any country had ever collapsed even though many faced challenges. The NHIS helps to improve accountability and the referral system as improvements are introduced along the way. Mr. Kiwanuka concluded that the sprouting of many CHI schemes was a positive development because it prepared the population for the NHIS. What was needed was sensitization of the people to know what insurance is and demand for it. There must be solidarity and cross subsidization.

### **5.2.2 Key issues from the session**

- Government is the major stakeholder in health financing and should be at the forefront in pushing for health insurance.
- Existing health insurance schemes should be supported to continue preparing the population for NHIS.

### 5.3 Scaling up coverage of community health insurance in Uganda

This topic was discussed in a parallel round table meeting for MPs, selected local government leaders and health insurance promoters. The meeting was chaired by Dr. Martin Ruhweza, Executive Director, Healthwise. The objective of the session was to mobilise support for CBHI and the proposed NHIS among MPs. The following MPs attended the session:

- Hon. Kakembo Micheal - MP, Entebbe Municipality
- Hon. Nakato Mary Ann – Woman MP, Buyende District
- Hon. Namukuuta Brenda – Woman MP, Kaliro District
- Hon. Auma Kenny – Woman MP, Kwanja District

The district leaders who attended the meeting were:

- Mr. Andrew Moses Awany, Vice President, Uganda Local Governments Association
- Mr. Kibirango Elasto – Luwero district
- Mr. Gabula Ezra – Iganga district
- Ms Jemimah Buhanda – Sheema district
- Mr. Tibagendeka Frank – Mayuge district

The meeting was addressed by:

- Mr. Makaire Fredrick – SHU
- Mr. Bengo Badru – UIA
- Ms. Christine Makobole – UPMB
- Mr. Johnson Andinda – Health Partners Uganda
- Dr. Muluken Haile - EHIS



*A parallel session for MPs, local government leaders and health insurance promoters at the conference.*

Mr. Makaire shared highlights on the coverage of CHI schemes in Uganda and stressed the challenges they were facing due to lack of a regulatory framework. He said the schemes were being promoted by volunteers and non-governmental organisations but scaling up was not easy because authorities at different levels lacked a legal framework under which they could support and promote CHI. He asked the MPs to consider alternative legal framework for CHI as the process of the NHIS was still ongoing. He cited examples of different countries which started with CHI before introducing national schemes. He stressed that CHI schemes had potential to prepare the population for universal health insurance and facilitate easy roll out of the NHIS. Ms Makobole echoed similar views suggesting that CHI schemes should be recognized even without the NHIS.

Mr. Andinda shared about the health cooperatives promoted by Health Partners. He said the first health cooperative was registered in 2000. There were eight active health cooperatives in Uganda with 21,000 members under 48 healthcare providers. He said there was a need for support to mobilise 5.6 million registered members of cooperatives to add a component of health insurance because they already had a saving culture.

Mr. Bengo appealed to MPs to ensure that private health insurance providers are not ignored in the process of enacting the NHIS law. He said some classes of people like the rich could be covered under private insurance. He added that private schemes should be allowed to continue running to cater for people who may need bigger benefit packages above what the NHIS might offer. He said it was important to cluster benefits and allow people to choose a scheme they may want to belong to so that no one is left out.

Dr. Muluken emphasized that the most important thing was for leaders to make a decision to start and CBHI schemes which were running provided a great opportunity for benchmarking. He said there were no perfect conditions to start a scheme. Ethiopia rolled out CBHI under a prototype directive without any legal framework but coverage was increasing every year and discussions were focusing on amalgamating the fragmented district pools. He said that even Uganda could start with district level schemes and pool upwards in future.

### **5.3.1 Discussion**

During the discussion, local government leaders emphasized the importance of creating awareness on health insurance for people to understand and demand for it. They also requested the central government to make health insurance a priority and equip local leaders with knowledge and skills to mobilise people to accept it. They proposed that health insurance should be integrated into other development programs such as the social assistance grant for empowerment (SAGE), the parish development model, village health teams and microfinance activities. They urged MPs to demand for the NHIS on the floor of parliament or consider introducing a private members bill.

The MPs were concerned that private insurance companies were not providing quality services to their clients which could jeopardise efforts to promote health insurance for all. They advised insurance providers to provide attractive packages and meet the standards that satisfy their clients. The MPs assured participants that they were committed to passing the NHIS bill but they needed to be sure that citizens would actually receive value for their money.

### **5.3.2 Key issues from the session**

- The Ministry of Health should deliberately address various stakeholders' concerns on disparities in distribution and quality of healthcare services.
- There is need for transparency in health insurance programs to encourage accountability to members.
- Health insurance providers should focus on the best interest of their clients to make them popular.
- There is need for a regulatory framework for CBHI to address the limitations in their promotion.
- Incorporating Health Insurance in other programs like Cooperatives, SACCOs, SAGE can increase its uptake.
- Continuous Health Insurance education is essential at all levels for citizens and leaders to appreciate its benefits.



# airtel

## money

## 5.4 Leveraging existing technology platforms and advancements to facilitate introduction and rollout of the NHIS in Uganda

The objective of the session was to assess availability, accessibility and appropriateness of existing technologies for universal coverage of the NHIS. The session was chaired by Mr. Mukasa Livingstone, Chief Executive Officer/Founder, Four One Financial Services. The panelists were:

- Mr. Brian Kiira, Program Officer, Business and Human Rights, Initiative for Social and Economic Rights (ISER)
- Mr. Andrew Rugamba, Head Product Development and Business Operations, Airtel Uganda
- Dr. Louis Kamulegeya, Digital Health Projects and Research Manager, Rocket Health
- Ms Peace Uwor, Business Development and Brand Manager, Smart Applications International
- Mr. Akandwanaho Joshua, Information Technology Services Advisory Officer, National Information Technology Authority of Uganda (NITA-U)



*Left-right: Mr. Mukasa Livingstone, Mr. Kiira Brian Alex, Mr. Andrew Rugamba, Dr. Louis Kamulegeya, Ms Peace Uwor and Mr. Akandwanaho Joshua.*

Mr. Mukasa, the session chair, started by asking each of the five panelists to share about their biggest medical bill ever and how they paid it. Four of them had their bills cleared by their insurers while one had sold an item. He then asked them to share about how technology firms could enable delivery of health insurance services.

Mr. Rugamba introduced Airtel Mobile Commerce Uganda Limited as a payment platform that enables over 10,500 entities (corporate entities, small and medium enterprises) to collect payments from their members. He said Airtel's role in the insurance sector had been minimal because attempts to work with existing insurance providers had not succeeded. He said Airtel's strength was a very strong grassroots distribution network with agents and mobile phone handsets widely distributed. Its role in the NHIS would be to act as an enabler, a mobiliser of communities through information sharing, support the payment of premiums and access to benefits by eligible members. Airtel was ready to provide the technology for NHIS implementation at affordable rates. Mr. Rugamba said tech centric entities could access the available platforms for integration to make their transactions easy and affordable. Airtel was ready to extend its platforms to any stakeholder to make all health insurance work easier and affordable through integration.

Mr. Rugamba said there were five areas that would be considered for collaboration:

- 2,800 airtel money branches country wide where potential NHIS members could be enrolled, registered and identified. Airtel would provide simcards at very affordable rates.
- Use the USSD channel for transactions (\*185#)
- Education and sensitization of communities through SMS platforms and a web-based application that disseminates information.
- Mobilisation of premiums in a simple, easy and convenient way e.g. mobile money especially to bring on board people in far to reach areas.
- Support payout of claims and collection of payments at health facilities

Dr. Kamulegeya said Rocket Health was leading in incorporating technology in the delivery of health care. The company was enabling insured patients to utilize healthcare services without visiting a health facility. This is done through a call centre to access services including consultation, diagnosis, laboratory tests, prescription and billing. Insurers are able to track utilization in real time. He said digital experience should be the first point of triage for the NHIS. He recommended that technology should be integrated into the design of the NHIS to maximize benefits and ensure efficiency at all levels.

Ms. Peace Uwor introduced Smart Applications International as an information technology company that provides a wide range of ICT solutions in 11 African countries. In Uganda, the Smart system had been installed in over 700 health facilities that included pharmacies, hospitals and clinics in 92 districts. Smart streamlines processes regarding identification of an insured client with instant transmission of the medical bill to the insurer. She said the system entails bio data and all services consumed. It makes benefit management easy because all information about the benefit package one is entitled to is shown in the system. The scheme administrator is able to monitor utilization, implement benefit conditions such as copayment and threshold. The members also have a mobile application which enables them to monitor their utilization of services. Ms Uwor said Smart was enabling automation that monitors all processes of a particular scheme because all information is available instantly to aid decision making. Smart operates a full time call Centre and has technical support teams across the country. It has an analytics tool for generating all kinds of reports. Smart is certified by NITA- U.

Mr. Akandwanaho noted that data management was still a big challenge in the country. He said the Data Management and Protection Act of 2019 required all data managers, companies, and government institutions that capture personal data to register with NITA-U which had mandate to scrutinize the modalities of how data is collected, stored, secured, integrated and shared. He said there were arrangements in policy and regulations regarding how data systems connect to each other to enable seamless data share. He added that NITA created a data integration platform called the UGHUB that integrated all data systems within government. He said there were 20 banking institutions already integrated onto the platform and 74 government institutions. The platform was open to private players like insurance companies and health facilities. NITA also established a National Data Centre that is certified. He said NITA could provide five support services:

- Connectivity through the national backbone infrastructure for fast internet,
- Awareness creation and accessibility: there is a USSD platform for government where all mobile enabled services are channeled regardless of the quality of phone set one holds,
- E-services development that helped government institutions to re-engineer their processes, have all services automated such that manual forms may be eliminated,
- Centralised hosting of platforms in the national data Centre,
- Data management service standards and compliance with laws for quality data sets,
- Working with innovation and incubation centres to build solutions to existing challenges.

On educating consumers to take up the various innovations enumerated by other panelists, Mr. Kiira said ISER was creating awareness about health insurance and advocating for a fair NHIS. He said the concept of insurance was still foreign to majority of Ugandans. He said ISER was also advocating for incorporating the national identification system into social services delivery but the challenge was that only 70 percent of the population possessed national identification cards. He suggested that other forms of identification that had been used before should continue until everybody gets a national ID card. He said the country needed ICT systems that could address the needs of the people and fit within the context. He observed that it was important to underscore the role of government as a service provider and regulator so that citizens are at the centre of all innovations.

#### **5.4.1 Plenary**

Five participants contributed to the discussion. One from Sheema complained that NITA cables stopped at Sheema district headquarters and other institutions could not access them. He added that Kitagata Hospital received computers but they were not being used for the rightful purpose because of lack of connectivity. Another participant complained about the high cost of internet. There were concerns about whether the technology talked about by panelists could be localized for particular geographical locations. Participants also

raised questions about fraud by hackers through mobile telephone networks and continuity of some technology providers in the market.

In response, Mr. Akandwanaho said there was a plan to connect all hospitals and HCIVs to the internet backbone. So far, 60 hospitals had been connected. The government was in the process of designing an infrastructure sharing policy so that all internet service providers could share infrastructure. Mr. Rugamba said Airtel was doing localisation either at the access point with the name of a scheme or at the second level for a pool. Reports and statements are also localized. Airtel provides technical integration free of charge. On the security of data and technology systems, Mr. Rugamba advised everybody to be vigilant and avoid sharing their national ID details because criminals were using them to register simcards.

#### **5.4.2 Key issues from the session**

- The existing technology platforms were enough to start implementation of the NHIS across the country.
- ICT providers were willing to partner for distribution of health insurance products.
- NITA-U was enabling integration of data to provide a one-stop centre for information for both public and private sector.



*Hon. Breanda Namukuta, Dr. Andrew Luwaga, Hon. Auma Kenny, Mr. Andrew Rugamba, Hon. Kakembo Michael and other participants at the conference.*



The Uganda Protestant Medical Bureau (UPMB) is a National Faith Based Not for Profit Organisation (NGO) that was established in 1957 as an Umbrella Organisation for the Protestant (Church of Uganda, Seventh Day Adventist) and Pentecostal Churches Founded Health Facilities. UPMB is a body corporate, registered under the NGO registration Statute, and the Trustees Incorporation Act. UPMB's Mission is To Empower Member Health Facilities To Provide Sustainable Quality Services For the Glory Of God and her Vision is To become the Preferred Christian Health Care Partner For Sustainable Services achieved through Coordination, Institutional capacity development, Advocacy and Technical support supervision of its Member Health Facilities (MHFs) and other health related activities in Uganda.

Currently, UPMB has a network of 311 MHFs including 19 Hospitals, 11 Health Centre IV's, 155 Health Centre III's and 126 Health Centre II's) and 16 Health Training Institutions.

## VISION

Preferred Christian Health Care Partner For Sustainable Services

## MISSION

Supporting Church Member Health Facilities to Provide Sustainable Quality Services for The Glory of God

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## SESSION 6: CLOSING CEREMONY

### 6.1 Conference resolutions

Before the official closing speeches, the rapporteur presented to participants the key issues and resolutions agreed upon at the conference. These were seven:

- (1) It was observed with concern that Uganda remains one of the few countries in the East African Community **without** a National Health Insurance Scheme. It was further observed that there was a continued delay by the Ministry of Health to return to Parliament and the cabinet the NHIS bill, which had been passed in March 2021 into an Act 2021.

**Resolution:** a) Explore the option of the Ministry of Health issuing guidelines / regulations to guide operations of Community Based Health Insurance Schemes due to the delay to introduce the NHIS.

b) The Ministry of Health should fast-track the process of reintroducing the NHIS bill in parliament and start preparations for its implementation.

- (2) The low number of people covered by private (Community Based Health Insurance Schemes -CBHIS and Private Commercial Health Insurance Schemes –PCHIS) health insurance schemes at 3.9% of the population due to absence of a supportive regulatory framework.

**Resolution:** The Insurance Regulatory Authority of Uganda working together with CBHI promoters and other stakeholders including Ministry of Health should develop and issue appropriate regulations for micro health insurance to facilitate their growth and sustainability.

- (3) The role of Community Based Health Insurance and Private Commercial Health Insurance not streamlined in the previous NHIS bill 2019. Experiences from Ethiopia, Rwanda, Ghana and others show that CBHIs provide a foundation for NHIS.

**Resolution:** CBHI schemes should be recognized in the proposed NHIS to play the roles of promotion, distribution, marketing and collection agents for the NHIS.

- (4) The Non-approval of the Luwero District Community Health Insurance Scheme Ordinance by the Solicitor General in anticipation of the NHIS, which does not yet exist. The District scheme was designed to provide a legal framework for CHI at that level as well as a pilot for implementing the NHIS.

**Resolution:** Luwero District Local Government to resubmit its Community Health Insurance Scheme Ordinance to the Attorney General through the Ministry of Local Government.

- (5) The wide spread negative perception about health insurance which the public holds. This perception is one of the reasons some people resist the idea of the NHIS.

**Resolution:** Private Commercial Health Insurance Schemes to address negative perceptions about their services through raising awareness on health insurance.

- (6) The existing disparities in the scope, breadth and quality of healthcare services undermine the principle of equity and may make the NHIS unattractive especially in rural areas.

**Resolution:** The Ministry of Health should harmonize concerns of various stakeholders and invest in reducing disparities in the distribution and quality of health care services across the country in preparation for equitable access to services under a universal NHIS.

- (7) Whereas participants were convinced that there is sufficient Information Communication Technology (ICT) platforms and providers to support the scaling up of health insurance in the Country, it was not very clear how much of such technology had reached informal sector segments for easy enrolment of families into the health insurance schemes.

**Resolution:** ICT providers to share evidence on their coverage of the informal sector on various platforms to guide the roll out of a universal NHIS covering even hard-to-reach population categories.

## 6.2 Remarks by SHU Executive Director



Mr. Makaire appreciated all conference participants for attending and actively participating in the deliberations. He gladly noted that all the conference objectives had been largely achieved. For instance, on the overall objective of enhancing support to fast track the establishment of Uganda's NHIS, participants demanded that the bill be reintroduced in parliament for consideration as soon as possible. In addition, the roles of CBHI and PCHI schemes in implementing the NHIS were well articulated. There was consensus that CHI schemes would act as distribution channels for the NHIS through mobilising the population in the informal sector, sensitizing them and reaching them with all the information from NHIS because they already had structures at the grassroots. He said it was

agreed that CBHI schemes should also act as collection agents for informal sector through CHI structures to which families could pay and transfer the premiums to the NHIS. This would enable all people to participate in the NHIS.

He added that participants recommended that all issues that blocked approval of the NHIS bill should be harmonised so that the scheme could take off. He said the support the previous parliament accorded the NHIS bill 2019 was a strong ground for the current parliament to moving forward. He added that providers of PCHI committed to continue diversifying their products to provide supplementary services in addition to the NHIS universal package as well as venture into micro insurance.

He informed the chief guest that Luwero district leaders were seeking for support to get approval for the ordinance to create a district CHI scheme in preparation for the NHIS and provide a learning ground for other interested districts.

He once again recognised the partners that supported the conference preparations. He announced that the 7<sup>th</sup> conference would happen in 2023 and invited more partners to join in.

## 6.3 Remarks by SHU Board Chairperson



*Dr. Leticia Nakimuli (centre) with Dr. Martin Ruhweza (left) and Mr. Ssekyanzi David (right) who are members of the Board of Directors.*

Dr. Leticia Nakimuli emphasized the need to build synergies in implementing health insurance initiatives. She appealed to participants to continue sensitizing the public on health insurance, building partnerships and strong advocacy teams. She noted that it was also important to continue strengthening the CHI schemes for sustainability. She urged district leaders to take lead in establishing health insurance initiatives in their respective districts to prepare the population for the NHIS.

#### **6.4 Remarks by Hon. Nakato Mary Annet, Woman MP, Buyende District**

Hon. Nakato Mary Annet, Woman Member of Parliament for Buyende District, assured participants that MPs were committed to passing the NHIS bill and were glad that it was soon going to be presented to cabinet. She said the health committee was working hard to realise the goal of the NHIS. She appealed to private health insurance providers to improve their responsiveness to the needs of their clients especially in emergency situations to avoid delays that could cost lives. She also appealed to them to improve the benefit packages to meet the needs of their clients.



#### **6.5 Closing speech by the Permanent Secretary, Ministry of Gender, Labour and Social Development**



Mr. Prosper Muhumuza, Commissioner Elderly and Disability Affairs, closed the conference on behalf of the Permanent Secretary, Ministry of Gender, Labour and Social Development.

He congratulated conveners and participants upon the successful conference held. He thanked the organisers and partners for making the discussion happen. He thanked SHU for constantly updating the MGLSD on health insurance issues through the social insurance and social protection technical working groups. He said the MGLSD developed the Uganda Targeting Mechanism for Indigents as a tool for identifying and enrolling indigents into the NHIS.

He noted that health insurance was a very important aspect of social protection. He was concerned that illhealth bears adverse consequences on the quality of life and livelihood of the population, and negative coping mechanisms for medical bills keep people trapped in the poverty cycle. He revealed that in Uganda, illhealth perpetuates vulnerability more than any other factor, adding that the impact of social protection programs would not cause any changes in the welfare situation of citizens if the problem of expensive health care was not addressed. He thanked MPs for committing to taking the discussion forward to the legislative agenda. He urged responsible stakeholders to implement the conference resolutions. He called upon participants to take advantage of existing health insurance schemes and be ambassadors that would prepare the population to embrace health insurance. He committed the MGLSD towards the cause for health insurance.



*A cross section of some of the conference participants*



# ISHAKA ADVENTIST HOSPITAL

& Health Training Institutions



Ishaka Adventist Hospital is located in the center of Ishaka town, Bushenyi district, Uganda. This hospital is owned and run by the Uganda Union Mission of the Seventh-day Adventist Church.

## Status:

it is a private not for profit hospital, teaching hospital, 120 bed capacity

## Vision:

Ishaka Adventist Hospital envisions itself as a leading Healthcare provider and training institutions of choice in Uganda.

## Mission Statement:

The hospital exists to "Provide a Christ centered healthcare to all; to improve the quality of life by caring for the physical, emotional, and spiritual needs of our clients.

## Services:

It offers a wide range of healthcare services that include but not limited to:

- Out-patient and in-patient services
- Maternal Child Health; ANC, Maternity
- Dental services
- Eye Care services
- Treatment of communicable and non-communicable diseases.
- Major and minor surgeries
- Immunization and Vaccination against killer diseases
- Radiological services
- Laboratory services
- Lifestyle and wellness centre



*Under the nutrition and gardening program, Mothers who come for ANC and PNC are taught how to make manure and gardening on small land with nutritional value crops.*

## Outreach programs:

We do perform community-based outreach programs in the following areas: Omukiyanga, Kashenyi, Katerera, Inshumi, Nkanga, Katimba, Kiyanga, Rutokye and Kyabakara. These outreach programs are intended to providing services to poor populations who are not able to come for services in the hospital.

## Specialized services:

Orthopedic surgery, Endoscopy, Colonoscopy, Urology, General surgery, Fertility medicine, Pediatrics, Neonatal care medicine, Emergency care medicine, HIV medicine, Ophthalmology, Dentistry, Palliative care, Physiotherapy

### Maternity care:

The hospital specializes in care for women during pregnancy and childbirth. For the last 2 years, no single maternal death!

### Chaplaincy department:

This department is very helpful to us. It offers comfort and support to patient families.



## Ishaka Adventist Health Training Schools:

We offer the following health training:

- Certificate Nursing
- Certificate Midwifery
- Certificate Medical Laboratory
- Certificate Medical Records
- Certificate Theatre Techniques
- Diploma Medical Laboratory
- Diploma Pharmacy,
- Advanced Diploma in Anesthesia
- Diploma in Clinical Medicine



School of Nursing and Midwifery



School of Nursing and Midwifery

## ANNEX: List of participants

| Name of participant           | Organisation                                                     |
|-------------------------------|------------------------------------------------------------------|
| <b>Kampala District</b>       |                                                                  |
| 1. Dr. Marios Obwana          | National Planning Authority                                      |
| 2. Dr. Olaro Charles          | Ministry of Health                                               |
| 3. Mr. Walimbwa Aliyi         | Ministry of Health                                               |
| 4. Ms. Christabell Abewe      | World Health Organisation                                        |
| 5. Mr. Prosper Muhumuza       | Ministry of Gender, Labour and Social Development                |
| 6. Mr. Kaggwa Andrew          | Ministry of Local Government                                     |
| 7. Ms. Martha Akurut          | Insurance Regulatory Authority of Uganda                         |
| 8. Mr. Edward Sebina          | Ministry of East African Affairs                                 |
| 9. Mr. Kiwanuka Achilles      | Partners in Population and DDevelopment – Africa Regional Office |
| 10. Mr. Andrew Moses Awany    | Kole District                                                    |
| 11. Mr. Akandwanaho Joshua    | National Information Technology Authority Uganda                 |
| 12. Mr. Bengo Badru           | Uganda Insurers Association                                      |
| 13. Mr. Omega Baingana        | Federation of Uganda Employers                                   |
| 14. Mr. Logose Evelyn         | Federation of Uganda Employers                                   |
| 15. Dr. Ronald Kasyaba        | Uganda Catholic Medical Bureau                                   |
| 16. Dr. Alima Hillary         | Uganda protestant Medical Bureau                                 |
| 17. Ms. Christine Makobole    | Uganda protestant Medical Bureau                                 |
| 18. Ms. Talemwa Esther        | Uganda protestant Medical Bureau                                 |
| 19. Mr. Mukasa Livingstone    | Four One Financial Services                                      |
| 20. Ms. Kensita Sharon        | Enabel                                                           |
| 21. Ms. Enyimu Ruth           | Uganda Catholic Medical Bureau                                   |
| 22. Dr. Luwaga Patrick        | Private consultant                                               |
| 23. Mr. Ivan Onyutta          | Uganda Healthcare Federation                                     |
| 24. Mr. Ivan Nimusiima        | Health Partners Uganda                                           |
| 25. Mr. Johnson Andinda       | Health Partners Uganda                                           |
| 26. Ms. Carolyn Natabona      | Health Partners Uganda                                           |
| 27. Mr. David Owere           | Health Partners Uganda                                           |
| 28. Mr. Alex Nkulanga         | Health Partners Uganda                                           |
| 29. Ms. Peace Uwor            | Smart Applications                                               |
| 30. Mr. Hadijja Omar          | Smart                                                            |
| 31. Mr. Fitz Wor Kagumire     | Smart                                                            |
| 32. Mr. Noel Gwambo           | Smart                                                            |
| 33. Ms. Joy Batusa            | UFAI                                                             |
| 34. Mr. Asiimwe John Bosco    | Kitojo Integrated Development Action ( KIDA)                     |
| 35. Dr. Samuel Mugisha        | Streamline Health                                                |
| 36. Ms. Jacqueline Katongole  | Streamline Health                                                |
| 37. Dr. Louis Kamulegeya      | Rocket Health Africa                                             |
| 38. Mr. Kiira Brian Alex      | Initiative for Social and Economic Rights                        |
| 39. Ms. Musoke Labila Sumayah | Initiative for Social and Economic Rights                        |
| 40. Mr. Andrew Rugamba        | Airtel Uganda                                                    |
| 41. Ms. Adongo Priscilla      | Airtel Uganda- Head office                                       |
| 42. Ms. Nalubowa Halima       | Airtel Uganda- Head office                                       |
| 43. Ms. Namwebya Mebra        | Airtel Uganda-Head office                                        |

| Name of participant                            | Organisation                                    |
|------------------------------------------------|-------------------------------------------------|
| 44. Mr. Mwesigwa Derick                        | Airtel Uganda                                   |
| 45. Ms. Leticia Nakimuli                       | Save for Health Uganda                          |
| 46. Mr. Douglas Opio                           | Save for Health Uganda                          |
| 47. Dr. Martin Ruhweza                         | Save for Health Uganda                          |
| 48. Mr. Fredrick Makaie                        | Save for Health Uganda                          |
| 49. Ms. Juliet Nazibanja                       | Save for Health Uganda                          |
| 50. Ms Asio Veronica                           | Save for Health Uganda                          |
| 51. Ms. Nnamulondo Proscovia                   | Save for Health Uganda                          |
| 52. Mr. Friday Moses                           | Save for Health Uganda                          |
| 53. Mr. Kabaale Robert                         | Save for Health Uganda                          |
| 54. Ms. Kemigisha Josephine                    | Save for Health Uganda                          |
| 55. Mr. Sekyanzi Badru                         | Save for Health Uganda                          |
| 56. Mr. Oromchan Samuel                        | Save for Health Uganda                          |
| <b>International Guest</b>                     |                                                 |
| 57. Dr. Muluken Haile Argaw                    | Ethiopian Health Insurance Agency               |
| 58. Ms. Hoehler Shana Fabienne                 | International Labour Organisation               |
| <b>Parliament</b>                              |                                                 |
| 59. Hon. Ssebikaali Joel Yoweeri               | MP- Ntwetwe county                              |
| 60. Hon Batuwa Timothy                         | MP Jinja East – Shadow Health Minister          |
| 61. Hon. Kakembo Micheal                       | MP Entebbe Municipality                         |
| 62. Hon. Auma Keddy                            | Woman MP Kwanja District                        |
| 63. Ms. Nakato Mary A                          | Woman MP Buyende District                       |
| 64. Hon. Namukuta Brenda                       | Woman MP Kaliro District                        |
| 65. Mr. Bwire Webby                            | Parliament                                      |
| 66. Ms. Irene Naitego                          | Parliament                                      |
| 67. Ms. Catherine Namuddu                      | Parliament                                      |
| 68. Ms. Nakigudde Prossy                       | Parliament                                      |
| 69. Mr. Alor Steven                            | parliament                                      |
| 70. Ms. Lillian Nabatanzi                      | Parliament                                      |
| 71. Mr. Bagaga Ronald                          | Parliament                                      |
| 72. Ms. Gloria Nakajubi                        | Uganda Parliamentary Forum on Social Protection |
| <b>Luwero, Nakaseke, Nakasongola Districts</b> |                                                 |
| 73. Dr. Nkonwa Herbert Innocent                | Luwero District                                 |
| 74. Mr. Kibirango Elasto                       | Luwero District                                 |
| 75. Ms Nakamanya Christine                     | Luwero district                                 |
| 76. Mr. Musisi Henry                           | Luweero district                                |
| 77. Mr. Mazinga Abdul                          | Luweero district                                |
| 78. Mr. Muwonge Joseph                         | Luweero district                                |
| 79. Dr. Byamukama Agaba                        | Nakasongola District                            |
| 80. Mr. Sekyanzi David Kitaakule               | MBUSO                                           |
| 81. Mr. Mangasi Moses                          | CRUMBS                                          |
| 82. Mr. Edema Jimmy                            | Bishop Caesar Asili Hospital                    |
| 83. Mr. Emudong John Bosco                     | St Luke Namaliga HCIV                           |
| 84. Sr. Adella Mary Nuwahereza                 | Holly Cross HC– Kikyusa                         |
| 85. Sr. Namusoke Beatrice                      | St Matia Mulumba Mulajje HCIII                  |
| 86. Mr. Langwa Andrew                          | St Kizito Natyole HCIII                         |

| Name of participant                           | Organisation                                       |
|-----------------------------------------------|----------------------------------------------------|
| 87. Sr. Maria Nannyunja                       | St Mary's Kasaala HCIII                            |
| 88. Sr. Achieng Racheal                       | Good Samaritan Health Centre                       |
| 89. Mr. Musiime Tadeo                         | St Francis Kijaguzo Health Centre                  |
| 90. Mr. Andrew Lubega                         | Kiwoko Hospital                                    |
| 91. Dr. Benard Okongo                         | Nakaseke Hospital                                  |
| 92. Ms. Namuleme Milly Eva                    | Nakaseke Hospital                                  |
| 93. Sr Nakiwala Rosemary                      | Franciscan Health Centre                           |
| 94. Ms. Naluyiga Jane Frances                 | Our Lady of Lourdes HCIII                          |
| 95. Mr. Ayebare Edward                        | St Mary's Mother of Jesus Kalule Health Centre     |
| 96. Mr. Mukasa Joseph Nantooke                | St Jerome Cove Health Unit                         |
| 97. Mr. Bazanye James                         | KALUDO pharmacy                                    |
| 98. Ms. Jeni Jackson                          | SHU Finance                                        |
| 99. Mr. Kitenda Samuel                        | Save for Health Uganda                             |
| 100. Ms. Nansubuga Dorothy                    | Save for Health Uganda                             |
| <b>Mityana District</b>                       |                                                    |
| 101. Mr. Muwanga Joseph                       | Mityana District                                   |
| 102. Mr. Mugisha Patrick                      | Mityana District                                   |
| 103. Mss. Musasizi Julian                     | St Francis Community Health Centre                 |
| 104. Sr. Janepher Kyosaba                     | Naluggi Health Centre                              |
| 105. Mr. Juuko Isaac                          | Save for Health Uganda                             |
| <b>Bushenyi, Sheema and Mitooma Districts</b> |                                                    |
| 106. Ms. Jemimah Buhanda                      | Sheema District                                    |
| 107. Byamugisha Sadic Mwemera                 | Mitooma District                                   |
| 108. Mr. Mwijukye Leonard                     | WATSA                                              |
| 109. Dr. Johnson Kabwishwa                    | Kitagata Hospital                                  |
| 110. Ms. Kihembo Jackline                     | Ishaka Adventist Hospital                          |
| 111. Mr. Bagyenzi Isaiah                      | Ishaka Adventist Hospital                          |
| 112. Sr. Monica Tuhaisemukama                 | Mushanga Health Centre                             |
| 113. Mr. Mutalina Naboth                      | Bitooma HC                                         |
| 114. Sr. Christine Nakanwagi                  | Nyakatsiro Health Centre                           |
| 115. Ms. Akatukwatsa Sonia                    | Save for Health Uganda                             |
| 116. Mr. Mujuni Wilfred                       | Save for Health Uganda                             |
| <b>Iganga, Bugweri and mayuge Districts</b>   |                                                    |
| 117. Mr. Gabula Ezera                         | Iganga District                                    |
| 118. Mr. Batuuka Samuel                       | Iganga District                                    |
| 119. Mr. Muluya Karim Mwebaza                 | Iganga District                                    |
| 120. Hajji Muziransa Shafi                    | Bugweri District                                   |
| 121. Dr. Muwereza Peter                       | Bugweri District                                   |
| 122. Mr. Nyende Ivan                          | Bugweri District                                   |
| 123. Bp Tibagendeka Frank                     | Mayuge District                                    |
| 124. Dr. Asuman Basembeza                     | Mayuge District                                    |
| 125. Mr. Osenya Patrick                       | Mayuge District                                    |
| 126. Mr. Naboola Ahmed                        | Busoga Region Association of Tweidhandhabe Schemes |
| 127. Sr. Nakate Mary Magdalene                | St. Francis Buluba Hospital                        |
| 128. Ms. Kadondi Rebecca Moureen              | Kiwanyi Health Centre II                           |
| 129. Mr. Elayu Anthony                        | Naluko Women's Hospital                            |
| 130. Mr. Moses Isabirye                       | Ibulanku Community Health Centre III               |

| Name of participant     | Organisation                  |
|-------------------------|-------------------------------|
| 131. Mr. Waiswa Kenneth | Save for Health Uganda        |
| 132. Ms. Mubeezi Docus  | Save for Health Uganda        |
| 133. Dr. Rubanga George | Nebbi                         |
| 134. Dr. Tugume Bernard | Angal Hospital - Nebbi        |
| 135. Dr. Omara Jammy    | Zombo                         |
| <b>MEDIA</b>            |                               |
| 1. Ms. Nakati Adiah     | UBC TV                        |
| 2. Mr. Eric Wakabi      | NBS TV                        |
| 3. Ms. Culton Scovia    | BBS TV                        |
| 4. Mr. Davis Mulumba    | BBS TV                        |
| 5. Ms. Ruth Nazziwa     | Bukedde                       |
| 6. Mr. Ddungu Davis     | Central Broadcasting Services |
| 7. Mr. Sam Wakhakha     | New Vision                    |
| 8. Mr. Derick Wandera   | Daily Monitor                 |
| 9. Ms. Peace Basemera   | UBC radio                     |
| 10. Ms. Nalusiba Halima | Bilal FM                      |
| 11. Ms. Esther Nakkazi  | HENJU                         |
| 12. Ms. Flavia Nassaka  | Uganda Radio Network          |

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