The contribution of Religious health networks in Systems Strengthening through Innovations in Community Health Financing – The case of Community Health Insurance in Uganda – successes and challenges

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Introduction

Innovation means the introduction of new ideas / techniques or the application of better solutions that meet new requirements, unarticulated needs, or existing market needs. It also means having more effective products, processes, services, technologies. Whatever is being introduced should be something new and original coming to that market. In some instances, however, the idea might not be new but being tried in a new context. In that case the trial of the idea in a new context is itself an innovation to the originators of the idea or technology; the old idea or technology is also an innovation to the users in the new context.

The World Health Organisation (WHO 2000) defines health financing as Function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system." The purpose is to make funding available, and to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care. Community financing is one of those known mechanisms for health financing.

In September 2000 UN (Heads of States) made the Millennium Declaration "to improve social and economic conditions in the world's poorest countries by 2015" Three out of 8 MDGs directly related to health. They are:

3. To reduce child mortality rates
4. To improve maternal health
5. To combat HIV/AIDS, malaria, and other

The others impact on health through other mechanisms.

In April 2001 African Union Heads of States made the Abuja Declaration setting a target of allocating at least 15% of their annual budget to improve the health sector. They also urged donors to fulfill their target of 0.7% of their GNP as official Development Assistance (ODA) to developing countries.

Health Financing in Uganda

Table 1 shows the on-budget financing to the health sector in Uganda over a period of 13 years.

Table 1: Trend of Health Sector Financing in Uganda

Year	GoU Funding (U Shs bns)	Donor Projects and GHIs (U Shs bns)	Total (U Shs bns)	Per capita public health exp (UGX)	Per capita public health exp (US $))	GoU health expenditure as % of total government expenditure
2000/01	124.23	114.77	239.00	10,349	5.9	7.5
2001/02	169.79	144.07	313.86	13,128	7.5	8.9
2002/03	195.96	141.96	337.92	13,654	7.3	9.4
2003/04	207.80	175.27	383.07	14,969	7.7	9.6
2004/05	219.56	146.74	366.30	13,843	8.0	9.7
2005/06	229.86	268.38	498.24	26,935	14.8	8.9
2006/07	242.63	139.23	381.86	13,518	7.8	9.3
2007/08	277.36	141.12	418.48	14,275	8.4	9.0
2008/09	375.46	253.00	628.46	20,810	10.4	8.3
2009/10	435.8	301.8	737.6	24,423	11.1	9.6
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.4

Source: MoH: Annual Health Sector Performance Report 2012/13

A comparison of Uganda and six other countries in the same region (WHO Health Statistics 2012) shows that nine years after declaration of the MDGs and 8 years after the Abuja declaration Uganda's total expenditure on health at 9% of its GDP (2009) and total expenditure at US dollar 52 per capita for the same year was only second to Rwanda's. However, Uganda government's expenditure of own money on health as per cent of total expenditure was the lowest in the region at 7%.

Table 2: Total Expenditure on health

Table 8: Regional Comparison – Total Expenditure on Health
Sources: World Health Statistics 2012; Mortality indicators for Uganda are from DHS 2011

Countries	Total Expenditure on Health as % of GDP (2009)	Total Expenditure on Health per capita (USD) (2009)	Government expenditure on health as a % of TGE (2009)	Under 5 Mortality rare (2010)	Maternal mortality rate (2010)
Tanzania	5.5	27	12.9	76	460
Zambia	6.2	63	15.7	111	440
Malawi	6.7	25	14.2	92	460
Mozambique	5.4	23	12.2	135	490
Kenya	4.8	36	7.3	85	360
Rwanda	10.1	52	20.1	64	340
Uganda	**9.0**	**52**	**7.0**	**90 (2011)**	**435 (2011)**
Ghana	5.0	54	12.4	74	350

Source: WHO Health Statistics 2012

From the above statistics, with the second highest per cent GDP expenditure on health and second highest per capita expenditure on health in the region, Uganda did not post the second best health indicators in the region. Referring to figures of 2010, the infant mortality rate (IMR) and Maternal Mortality Rate (MMR) were not only the 3rd and 4th highest in the region respectively but were simply not acceptable.

Even more glaring is that Kenya spent only 4.8% of its GDP (about half of Uganda's 9%) and only US dollar 36 per capita on health in the same period. However, these made 7.3% of its total expenditure, (almost same as Uganda). It means in relative terms Kenya spent less on health but posted better health outcomes with IMR of 85 and MMR of 360.

Looking at these figures, a few questions cross the mind. For example,
(1) Why would Rwanda whose total expenditure on health as per cent of the GDP is only slightly higher than that of Uganda and whose total expenditure on health per capita was the same as Uganda have better health outcomes as signified by the above two indicators of IMR and MMR? (2) Why would Kenya with less Per cent GDP and per capital expenditure levels on health also post better health outcomes?

One may argue that other than spending directly on health, Rwanda may be spending better than Uganda on the other non-health / social determinants of health, for example education especially of mothers, water and sanitation, infrastructure that improve access to health services etc. However, given that the equal per capita expenditure (which rules out the population volume factor) were the same, for Rwanda that translated into 20% of its total expenditure while for Uganda it was only 7% means the total expenditure for Uganda was actually higher. So what was or is the problem with Uganda.

The above statistics imply there are certain things Kenya and Rwanda are doing differently from Uganda. Uganda does not necessarily need to copy from but would definitely do well by also looking for innovative means of having effective financing of the health of its citizens, even if that means copying some of their aspects.

A few factors could be at play. Is it an issue of allocative efficiency, thus more resources going onto things that do not have much effect on the health outcome? Is it an issue of utilisation / implementation efficiency, thus being wasteful even when actually allocated to the right interventions? Here a number of factors play out like corruption, bureaucratic bottlenecks? Is it a question of how readily available the money is (to the country and eventually to the end user) when it is needed for what is needed? Related to efficiency, is it possible that the funding mechanisms in use are themselves inherently promoting those inefficiencies?

There is no doubt; Uganda needs more money to the health sector. This is even more urgent now as we look into the Universal Health Coverage in order to achieve the Sustainable Development Goal on health. However, whatever the case, Uganda and other African countries in similar scenarios need some innovation in financing health.

Could Uganda leverage some of the strategies seen to have produced positive results. An example is the evidence that partnership with the Private-not-for-profit (PNFP) subsector has helped the country not only to provide services widely across the country, but that also to make available relatively good quality services. But all these have been possible because of the national Religious Medical Bureaus (umbrella organisations) having made systems strengthening of the member health institutions and regional or diocesan health coordination a core function. Without these all support by government and other interventions by donors or other partners in the health institutions would not have given the same results. It means that sustaining the gains of the partnership also means deliberate effort in supporting and sustaining these indigenous coordination and systems support structures, the Medical Bureaus. Therefore spending more money on PNFP umbrella bodies and their networks is one way of improving the gain on health investment.

However, for now this paper will move to and focus on the role the end-side / demand side (the community) can play in improving health financing as one of those innovations. We note that in Uganda a lot of the experience related to community health financing has been linked to communities working with faith-based health facilities, and mainly those accredited to Uganda Catholic Medical Bureau (UCMB) and Uganda Protestant Medical Bureau (UPMB). This again goes further to demonstrate the importance of these religious umbrella bodies as centre for innovation in the country and the need to support them as a way of supporting innovations for the national health system.

Community Health Financing

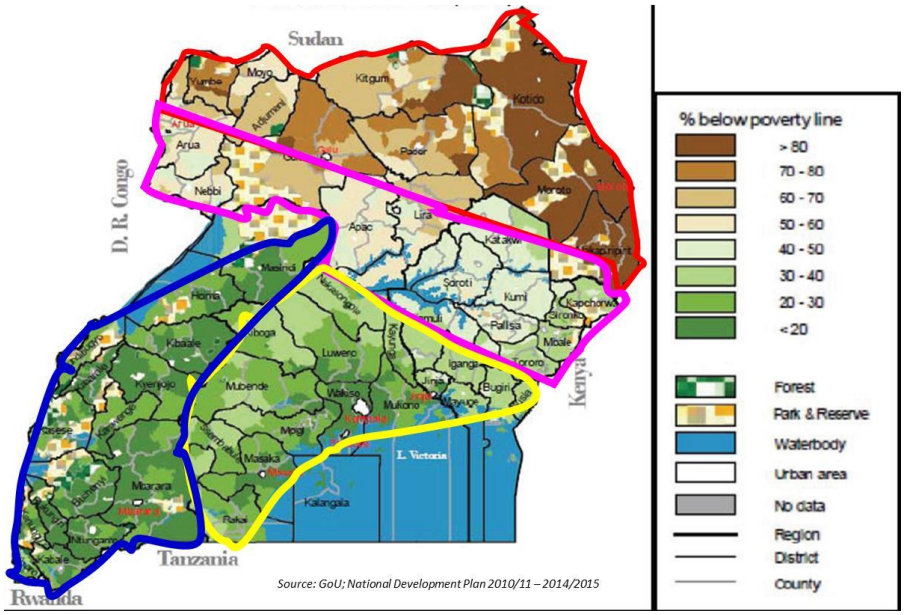
The community financing their own health is a practice in many countries around the world although it takes various forms and it is indeed being considered as part of Uganda's innovation in the health financing strategy. This article at this point is not a detail analysis of the Community Health Insurance experience in Uganda.

Innovation in Community Health Financing should aim at increasing funding for health care while reducing the burden on the individual or family (**Financial protection**) by keeping cost-sharing and user fees low especially for the poor. It should also aim at increasing **population coverage** and reducing social exclusion, and also increasing the quality **service package** covered. These are in line with the WHO's box model of Universal Health Coverage. Further, the innovation should provide appropriate financial incentive to provide health care by enabling health providers break even or have surplus in order to be able to

reinvest to improve on quality of their services. The population should be seeing an increase in their voices and control over health care. Finally there should be sustainability of the financing mechanism

This article simply aims to briefly share with readers the experience of community health financing in Uganda. Among factors influencing success or providing challenges is the economic status of the society. Without going into the current wealth or poverty distribution and availability of expendable cash, linkage is made to the poverty map as contained in the National Development Plan of 2010/11 – 2014/15. From this map one can see four major economic zones or blocks with Uganda as marked by this author below. However it will not try to subject the CHIs to test whether some of the factors possibly affecting effectiveness of health financing above have also affected it, for example allocative efficiency, management efficiency etc.

Four main economic zones



Community Health Insurance in (CHI) Uganda

Again it is important to recognize that CHI in Uganda has mainly been practiced in areas served by Religious health facilities under UCMB and UPMB. Whereas there are other forms of community health financing practiced to varying levels of complexity or simplicity, this article will only (and only briefly) reflect on the experience with Community Health Insurance. Could scale up of community health insurance (CHI) in a country like Uganda with the above economic distribution be one of those innovations that will improve health financing?

In Uganda community health financing has been practiced for over a decade now but mainly in western and south-western Uganda, having originated from the "burial groups" who used to collect money for burial of members. They instead decided to convert to collecting money to prevent burial by using it for health care of the sick. It was mainly among the rural poor but also joined a by some working class in those rural areas with membership being voluntary. The practice has now been replicated in a few more parts of the country but essentially still in south-southwest and central regions. These are regions with relatively higher level of wealth in the country, as compared to the northern block and the block that cuts across the country from the east, through the middle to the north-west (West Nile).

Players in the Community Health Insurance

Like for any health insurance scheme, there are the subscribers, the insurer, and the service provider. In Uganda the providers under all these schemes so far have been non-state health facilities, mainly under the umbrella of the Uganda Catholic Medical Bureau (UCMB) and the Protestant Medical Bureau (UPMB).

There are three models with which CHIs are being implemented.

- Provider-based or Provider-managed CHIs

All the schemes started as Provider-based or Provider-managed schemes. Under this arrangement members pay premiums to the facility / provider. The provider is able to use the money in advance to procure medicines and supplies ("trade with it"). It has some element of a pre-payment scheme. The challenge is that it depends a lot on the integrity of the facility managers or leaders at the time because it can provide a situation of abuse where providers can make high claims to absorb the money collected. Some providers can also set high management costs. To avoid such scenarios UCMB advised against providers managing the schemes and the practice was stopped in UCMB facilities in 2007.

- Community-managed schemes

Since 2007 all CHIs linked to UCMB facilities are managed by the respective communities. Some other schemes linked to UCMB facilities are also managed by the communities. The challenge of this model is the risk of some schemes not paying in time for members treated. It is not easy for the provider to force the money out of them. In a review done by UCMB and Cordaid in 2009 it was noticed that there were more cases of health facilities subsiding for scheme members, the CHIs thus paying less than the poor who could not subscribe to the scheme.

- Independently managed CHIs

This is where the community pay premium to an independent organisation, usually voluntary agencies who also help to build the capacity of the communities to eventually manage their own funds. They have no interest in building profit for themselves but for the community. That is what makes it different from paying into a prvate commercial health insurance company

Benefits experienced from Community Health Insurance Schemes

From both the UCMB/Cordaid review in 2009 and other interactions with them, the Communities report reduction in catastrophic health expenditures in households enrolled in schemes. Members do not delay in seeking medical care when sick reflecting better health seeking behaviours among CHIs members. The relationship between communities and health service providers reported is also reported to have significantly improved with more participation of the community in health facility decision making through representation by the scheme leaderships. In general there are reported to be relatively reduced rates of patients escaping from hospitals, hence better completion of payment for treatment.

Challenges of Community Health Insurance Schemes

1. Inadequate political will.

This is manifested in a lack of local or in-country support to provide subsidy to the schemes The schemes have largely and for long been heavily donor dependent especially in meeting the management cost. This is because of the inability of communities to match premium with increasing costs of services and management. They resist any rise in premium level; hence premiums often do not covering operational and administrative costs like costs of community mobilisation, staff salaries, office costs etc. The financial coverage rate (including administration cost) is below 100% but a bit better without the administrative costs.

In the draft National Health Insurance Scheme (NHIS) plan, CHI is included simply as one of the schemes making up the NHIS. Whereas government plans to give a matching fund of the 4% salary deduction towards insurance of civil servants (from government coffers including taxes from the poor and meant also for the poor) and others in formal employment having their employers paying the same, there is no plan for government to support the poor who will be trying to pay up into the various Community Health Insurance Schemes.

2. The most poor not able to join the schemes.

Replicability in absence of external support to bridge operational costs appears difficult especially in regions of higher poverty levels (North and East). UPMB reports that some

facilities in the east-central part of Uganda accredited to it have introduced CHIs without external funding, these facilities are still within the relatively better economic zone. It is still not easy to see how this would play out in the northern zone and the middle zome (east-northeast stretch).

3. Lack of costing studies to guide reimbursement claims and setting of premiums

Many health facilities subsidize for CHIS members without knowing, especially where the scheme is managed by the communities.

4. Poor enrolment rates / penetration rates

This is largely a result of poor population understanding and appreciation of health insurance. The country is operating in a "free health care" policy environment with provision of "free" health services in government facilities even if this may only mean having a free consultation without actual access to the other services. It has led to reduced willingness pay for health care and even to and even to join insurance schemes especially among the rural community.

5. Potential threat from the upcoming National Health Insurance Scheme (Even though CHI is part of it)

The formal employed sector will mandatorily contribute to the Social Health Insurance Scheme. Rural contributors (teachers, nurses etc) whose salaries will have been mandatorily deducted and do not have enough subscribe to more than one scheme (dual subscription) may find it difficult to continue with CHIs . This is likely to lead to lowering of subscriber numbers. Yet the strength of any insurance scheme is in the number of subscribers.

What innovations may we have in community health insurance in Uganda?

Community Health Financing is itself an innovation for most of Uganda amidst inadequate government funding of health care. The other possible innovations to improve on it may include:

- Introduce performance-based-financing (PBF) in it. PBF has already been successfully tried in Uganda (Jinja diocese by Cordaid and UCMB and in Northern Uganda by DFID (Montrose)). PBF is likely to make it more responsive to priorities agreed between providers and scheme members.
- Encourage members to form / join community saving and lending schemes

Conclusion

Religious health facilities mainly accredited to Uganda Catholic and Uganda Protestant Medical Bureaus have championed the starting of Community Health Insurance Schemes in Uganda. The Medical Bureaus mainly play the role of systems strengthening of the facilities in order to allow the landing and running of various programs, including the CHIs.

Community Health Insurance increases involvement of the members in mobilising resources for their health care. While having to guard against abuse in terms of over use and adverse selection, it seems to improve on health seeking behaviours. It however appears easier to scale up in communities with more expendable money if it should remain sustainable in absence of donor support or any other external support. Its success so far indicates that if supported by the national governments it could be more replicable to other parts of the country as well.

Finally once more, supporting programs including Community Health Insurance Schemes without supporting systems that cover a sector or a big sub-sector, the PNFP, will not lead to sustainable benefit in the communities and the country.