Private medical pre-payment and insurance schemes in Uganda: What can the proposed SHI policy learn from them?

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Executive summary

Over the last two decades there has been growing interest in the potential of social health insurance (SHI) as a health financing mechanism in low and middle-income countries. However, few countries in Africa have implemented SHI. Uganda is currently designing its own SHI scheme, in preparation for its imminent implementation. It is hoped that SHI will bring additional resources for the Ugandan health sector and that its introduction will improve equity in access. Very little was known about the Insurance market in Uganda before this study was undertaken, so one of our main objectives was to provide quantitative and qualitative data that could be used by the Ugandan Ministry of Health as a basis for designing this scheme and for future SHI policy-making. The research was undertaken as part of the in the Regional network for equity in health in east and southern Africa (EQUINET) fair financing theme work, co-ordinated by the Health Economics Unit at the University of Cape Town.

The insurance market in Uganda remains very small. By the end of 2006, there were only 19 licensed insurance companies in the country. Only one insurance company (Micro Care Insurance Ltd) offered health insurance and accident cover, while another organisation (East African Underwriters) offered health insurance and other life and non-life insurance services. In addition to standard health insurance firms, there are health maintenance organisations, or private service providers, that offer medical pre-payment schemes. In Uganda, **health insurance organisations** are involved in collecting insurance premiums from either individuals or companies in return for a specified health benefit package for those who are covered by insurance. The insurers are not involved in actual health service provision. In contrast, **health maintenance organisations** have a dual role that involves the collection of insurance premiums from individuals and/or companies on one hand, and the actual provision of health services to those who are medically insured on the other. It is still not clear how many of these providers are offering such pre-payment schemes. Anecdotally, we heard of about five of them and we were able to visit and collect data from two in Kampala.

All insurance companies in Uganda are regulated by the Uganda Insurance Commission (UIC), but there is a need for a formal body that regulates organisations that offer both health services *and* health insurance or pre-payment schemes.

Seventy-three organisations (employers) were approached, and 58 agreed to participate in the study. Results indicate that 50 of these 58 organisations have either private health insurance or some kind of health insurance arrangement, with differing benefits and arrangements. A number of employers who have not insured their employees have made other arrangements for their employees to access health services more easily, for example by having in-house clinics, designated clinics (where the employer picks up the medical bills) or a medical allowance added to the employee's salary.

A total of 261 employees were interviewed, but only 250 questionnaires were adequately completed and thereby valid for data analysis. Most employees (57%) were either currently insured or had a health benefit arrangement at the workplace, yet a significant proportion (43%) still had to pay out-of-pocket for health services each time they access services. Few of these employees (40%) had heard about Uganda's new SHI policy and those who had heard of it were usually misinformed or unaware of the objectives of SHI, the proposed benefit package, the suggested providers of the health services and the proposed management of the Fund. Only 48% indicated they would be willing to join the new SHI scheme. Clearly, education around these issues is required.

The improvement of equity *must* be stated as an explicit objective of the proposed NHI scheme in Uganda. The criteria for selection and accreditation of service providers should be well developed and made explicit to stakeholders, so that the process of accreditation is transparent. The SHI benefit package should include out-patient care, in-patient hospitalisation, antenatal care and basic dental services, with some exceptions for certain very expensive treatments and/or conditions. We

highly recommend that the suggested benefit package is costed before SHI is implemented. No co-payments should be introduced as part of SHI implementation. Care needs to be taken in computing the percentage contributions to be made by employers and employees. The decision about how much of an employee's salary can be deducted will require empirical evidence from an actuarial study that is conducted using the most up-to-date data on income, type of employment etc. No more than 5% of the salary should be deducted. Service providers could include both public and private providers, keeping in mind the issue of affordability of services provided by private providers.

All stakeholders (employees, employers and health insurers) believed that SHI would impact negatively on private health insurance/pre-payment schemes. The main concerns, raised by both employees and employers, were regarding the management of the SHI Fund and misgivings about corruption, and the poor quality of health services in public health facilities. Most would prefer a private institution or semi-autonomous institution to manage the SHI Fund, rather than any of the government ministries, because this is perceived to lower the risk of corruption. Most insurance companies were also concerned about the "manner in which the MoH is proposing to proceed with the policy" and the government is likely to meet resistance if they do not consult with them. Hopefully, the Task Force charged with designing the SHI policy will take all of their concerns into account.

We recommend that more research should be conducted on the various aspects of the SHI policy, so that future decisions are made on the basis of empirical evidence. A substantial amount of work still needs to be done to refine the policy before consensus among all stakeholders can be reached and before SHI can be implemented.

1. Introduction

In most developed countries, good health is regarded as a basic right for all people, as declared by the World Health Organisation (WHO, 1978) and their health sectors are allocated substantial financial resources by their governments, in addition to financing from health insurance schemes. This, however, is not the case in developing countries, where health services are chronically under-financed and resources are insufficient, inequitably allocated and inefficiently used. In the past, funding for the health sectors of these countries has come from general tax revenues, donor funds and private out-of-pocket household expenditure (through user fees). However, the funding from these sources is not enough to provide the basic right of good health for all in these countries, and many people do not have access to a minimum health care package.

Escalating health care costs, inadequate tax revenues and the unsustainable nature of donor funding have alerted governments of developing countries to the fact that their health sectors need money from sources other than conventional financing sources. Regrettably, the single largest source of financing for health services is out-of-pocket payments, which exceed 25% of total health care expenditure in more than 75% of sub-Saharan countries (McIntyre et al, 2005). Out-of-pocket payments are a very inequitable mechanism for health sector financing because they usually place a significant burden on households and present an obstacle to poor people who need to access health services. The consequences of out-of-pocket payments for health services can be *catastrophic* because the timing of such payments usually cannot be determined in advance and can threaten the livelihood of households (WHO, 2000).

The use of out-of-pocket payments as a financing mechanism has contributed to increased interest in health insurance mechanisms, as evidenced by the 2005 World Health Assembly resolution on sustainable health financing, universal coverage and social health insurance. Over the last two decades there has been growing interest in the potential of social health insurance (SHI) as a health financing mechanism in low and middle-income countries. SHI schemes exist in many countries in Latin America and have also been introduced across Asia in recent years. However, few countries in Africa have implemented SHI. Despite the sustained interest in SHI, there are growing concerns as to whether it will achieve equity and financial sustainability objectives (McIntyre et al, 2003).

What is social health insurance? Social health insurance consists of compulsory contributions into a health fund, made mainly by those who are formally employed, in return for a health care benefit package covering them and their dependants. SHI is sometimes considered to be a desirable health financing mechanism because of its nature of improving equity in access to health services. Because risk is pooled, more people are likely to access to health services that they would have not ordinarily been able to access (given their income levels). Normand and Weber (1994) note that SHI is a risk-pooling venture by people who have a mutual understanding that what they're doing is a good thing. If this understanding is missing, the introduction of SHI is likely to be met with resistance from some stakeholders.

In recognition of the potentially catastrophic consequences of out-of-pocket payments, and in the absence of SHI in many countries, some of the population in several African countries voluntarily join private health insurance or pre-payment schemes (e.g. in South Africa, Kenya, Uganda, Tanzania and Zambia). In other instances, community pre-payment schemes (i.e. community-based insurance schemes, where contributions need not be in monetary terms) have also been adopted in some countries, such as Zambia, Rwanda, Uganda, Burundi and Ghana. However, the amounts of funds generated from community-based schemes are relatively low because most of the funds from members depend on seasons (e.g. for farmers), and sometimes contributions are not in cash form. Also, in some countries, such as Uganda, the growth of community pre-payment schemes has been slowed down by the removal of user fees in public health facilities, especially where such schemes were mainly hospital based.
In some countries, SHI has been adopted mainly in the formal sector and with varying levels of success from one country to another. If an SHI is to succeed, it is important to establish and take

into consideration the views and attitudes of all stakeholders when designing it. In Uganda, an SHI needs to be acceptable to stakeholders if many already have private medical insurance or pre-payment schemes that are providing a reasonable benefit health care package. Therefore, this study offers views and attitudes from relevant stakeholders that may prove useful in designing or refining further SHI schemes for the country. The research was undertaken as part of the in the Regional network for equity in health in east and southern Africa (EQUINET) fair financing theme work, co-ordinated by the Health Economics Unit at the University of Cape Town.

1.1 Historical background of national health insurance in Uganda

Like many other African countries, Uganda is currently trying to find an efficient, equitable and sustainable health financing mechanism that will raise a substantial amount of funds for the health sector. For the period between 2000/1 and 2005/6, per capita public expenditure on health ranged between US$6 and US$10. This expenditure remains dismally lower than the estimated cost of US$28 of delivering the *minimum package* in Uganda (which notably excludes expensive interventions such as ACTs, ARVs, ITNs and Pentavalent vaccine). It is substantially lower than the US$34 target estimated by the Commission for Macroeconomics for Health. This big funding gap has been cited as a serious hindrance to effective delivery of the minimum package (MoH, 2005; MoH, 2006). It's clear that the gap cannot be closed by efficiency gains in resource allocation and use in the sector, so additional funding will be needed to enable the delivery of the minimum package and to meet the targets of Uganda's Health Sector Strategic Plan.

Recently, discussions in the health sector have moved away from the concept of social health insurance (SHI) to that of national health insurance (NHI). What's the difference between these two similar concepts? In both SHI and NHI systems, formally employed members make compulsory contributions, but the key difference is that, in an SHI system, only those who have contributed (and their dependants) will receive a health care package, paid for by their contributions. In an NHI system, the entire population will receive a health care package, not just the minority who contribute. It is not entirely clear why technocrats in Uganda have moved their position from developing SHI to developing NHI, but it may be due to the fact that supplying adequate better health services to a minority of the population and ignoring the rest may have serious political and social consequences. Policy makers believe that NHI will bring additional resources to the health sector and that its introduction will improve equity in access; in other words, those people in the lower income bracket will be able to access more health services than they would have if they had had to pay out-of-pocket at the time of consumption. Although public health services are provided free in Uganda, the quality of the service is poor, so large proportions of the population go to the private (formal and informal) sector, where they pay out-of-pocket costs at the time and point of consumption.

In the meantime, there is a proportion of the population that is voluntarily covered by private health insurance or pre-payment medical schemes, mainly in Kampala. Some of the insured individuals are covered by their employers at the workplace with health benefit packages of varying levels, while a much smaller number of people pay their premiums/medical cover themselves to health insurance agencies or health maintenance organisations. To date, no research has been done in Uganda to estimate the size of Uganda's private health insurance market, nor to describe the types of private health insurance available and the regulation of the market. Interestingly, despite the fact the SHI Task Force in Uganda has made significant progress in developing the SHI design, earlier versions of the Ugandan SHI proposal did not stipulate how private health insurance/pre-payment medical schemes would be managed, nor did it discuss the role of HMOs and other private health insurance agencies once SHI has been introduced. Obviously, the Task Force needs information on the size and nature of private health insurance and/or pre-payment medical schemes before it can debate their role in SHI implementation. Even more importantly, the Task Force needs this information because various groups of people (such as trade unions, employers, employees, HMOS and health insurers) have a vested interest and could potentially impede SHI implementation if their views are not carefully taken into consideration during the design stage of SHI policy.

Social health insurance first began in Uganda in 1987, when it was recommended by the Health Policy Review Commission. Having noted that the health sector was inadequately financed at that time (when the country was recovering from a long period of political turmoil), the Commission listed, among other alternatives, the introduction of SHI as a means of generating additional funding for the health sector (source: key informant interviews with MOH officials). Although SHI was not implemented immediately, some initial work on the SHI design/debate commenced. Specifically, the Ministry of Health (MoH) undertook some study tours in countries that had SHI policies in places. Later, in 1996, the MoH commissioned the first feasibility study on SHI. In the meantime, due to severe budget constraints and related difficulties in providing adequate hospital services, community health insurance or pre-payment schemes were introduced at some hospitals as a means of collecting additional funds. This led to the establishment of eight hospital-based community prepayment schemes, which had varying levels of success, but are currently facing severe challenges due to the removal of user-fees from all public health facilities.

Further discussions on SHI in Uganda were initiated in 1997 when a team from the MoH approached the National Social Security Fund (NSSF) with the idea of starting an SHI scheme. The SHI model suggested at that time was thought to be the most appropriate for Uganda and provided four criteria for the scheme:

- The scheme would cover the formally employed. It would be mandatory for all civil servants and their dependants and voluntary for private sector employees.
- The benefit package would only cover in-patient care (which was viewed as mostly 'catastrophic').
- The employer would not contribute because there was no scope for further contributions from employers, since the levy of 15% (towards NSSF) was already considered excessive.
- The scheme would be administered by competing insurers, one insurer or the institution that would be tasked to collect premiums.

There was some degree of silence on the SHI debate between 1997 and 2000, partly because key staff of the MoH had differences of opinion regarding SHI of and partly because of donor pressures. In 2001, however, the MoH commissioned a second study on the feasibility of SHI in Uganda, which was undertaken by lead consultants from Harvard University. Based on the results and recommendations of the study, discussions on SHI were revived around 2002 and policy makers proposed the implementation of the scheme in Uganda. In fact, the implementation of SHI was one of the important areas of the President's manifesto in 2006 and its implementation is currently being planned. A special Task Force has been given the responsibility of working the details of the SHI policy and to undertake the necessary activities leading to its implementation. Since 2003, the SHI Task Force (led mainly the MoH) has been heavily involved in developing and refining the SHI policy, sensitising stakeholders and developing consensus among them. The Task Force is still at the stage of refining the design of the SHI policy and debating with different interest groups, while at the same time preparing to table the proposal to the Ugandan Parliament.

The current SHI/NHI scheme proposed for Uganda is seen as one of the mechanisms for financing the health sector strategic plan (HSSPII) and it is expressly stated that one of the key objectives of SHI is to "raise additional resources for the health sector" (MOH 2006, Draft Proposal for Social Health Insurance). It has been repeatedly highlighted in the Draft NHI Bill and in the media that the other three East African countries (Kenya, Tanzania and Rwanda) have already implemented SHI in their countries, suggesting that Uganda is following suit in order "to be on par with other East African Community countries" (MOH 2007, Draft NHI/SHI Bill). Although the Draft NHI Bill alludes to the catastrophic nature of out-of-pocket expenditures on health, it does not explicitly mention that improving equity is one of the objectives of introducing SHI. One of the significant findings of this study is that the improvement of equity *must* be stated as an explicit objective of the proposed NHI scheme in Uganda.

It is proposed that initially the scheme will cover those who are formally employed in both the private and public sectors. Further, it is proposed that the SHI scheme should be established in phases and be expanded progressively to constitute one universal national health insurance scheme for the entire population. Other key features of the proposed SHI scheme include the following:

- Mandatory contributions must be made by all formal sector employees and their employers. The scheme will starting with central and local government workers, followed by big government parastatal organisations and later by private companies in Kampala. Eventually the scheme would gradually be expanded to cover smaller organisations and smaller towns.
- The scheme shall cover the principle member, a spouse and four dependants. It is anticipated that if all employees in the formal sector contribute premiums, about 10-15% of the national population will be covered by SHI.
- The SHI scheme must be administered by the SHI Corporation or the SHI Fund, or the SHI Formation Unit (SHIFU), which shall be a new institution created by an act of Parliament. It will have the status of a tax-exempt government corporation and will be attached to the Ministry of Health.
- Four percent of an employee's salary will be deducted monthly and employers will contribute an additional amount equal to 4% of the employee's salary.
- The health benefit package for the proposed SHI scheme will include primary health care, out-patient care, in-patient care and other health care services that the Corporation shall find to be appropriate and cost-effective. The benefit package excludes (except when the Corporation, after actuarial studies, recommends their inclusion) non-prescription drugs and devices, out-patient psychotherapy and counselling for mental disorders, drug and alcohol abuse or dependency treatment, cosmetic surgery, optometric services, alternative medicines, evacuation, ambulance services, wheelchairs, artificial limbs and private rooms.
- All health care providers (including public, private and private-not-for-profit) that have been operational for at least three years may apply for accreditation under SHI. They also have to meet minimum accreditation requirements, which include:
  - the availability of human resources, equipment and physical structures in conformance with the minimum standards of the relevant facility (as determined by the Ministry of Health);
  - the use of quality assurance and utilisation reviews, on behalf of the scheme;
  - the adoption of referral protocols and arrangements to share health resources;
  - the recognition of the rights of patients; and
  - the implementation of information management system requirements and the regular transferral of information.
- Providers may be paid on a fee-for-service basis, on a capitation reimbursement basis or both. In capitation reimbursement, a flat fee is paid to a provider (upfront) so that they can provide services for a specified number of people (usually within a geographic area) for a specified period of time (e.g. a year), regardless of the number of times these people will require medical care in that time period. The fact that the criteria for and the process of accrediting providers have not yet been developed will make it difficult to finalise the actual reimbursement mechanism suggested for SHI in Uganda.

So far, the MoH has been successful in working out substantial details of the design features of the SHI policy. The current SHI design has changed substantially compared to the SHI design previously suggested in 1997. Although it has taken a long time, the SHI debate is now very robust, and it is being prepared to be tabled to the Uganda Parliament and Cabinet for legislation. The SHI proposal has been presented at different decision-making fora (including the Ugandan Cabinet of Ministers), and the draft Bill for its enactment is currently being refined. The SHI Task Force/MoH has been successful in opening the debate on SHI through workshops with stakeholders and also through the media. However, the population's level of education on and sensitisation to the SHI policy is still inadequate and this is causing setbacks for the implementation of the policy. Various stakeholders argue that that MoH has not adequately consulted with all stakeholders to seek out their views and contributions to the design of the policy.

While the design and development of the SHI scheme is still ongoing, it is not clear what actions are being taken to harmonise the proposed SHI scheme with other existing laws such as the Workers' Compensation Act, the Insurance Act of 2000, the Motor Vehicle Insurance Act of 2000, the Employment Act of 1995 and the NSSF Act of 1985. The SHI scheme, in its current design, does not explicitly mention how vulnerable groups will be targeted. Specifically, it does not discuss how those who are not formally employed (which includes the unemployed and those who are informally employed) will be catered for as far as the provision of health services is concerned. It is implicitly assumed that such people will have access to the *free* health services from public facilities (financed through tax revenue) and/or they will seek care from private providers and pay for it out-of-pocket.

In conclusion, the debate on SHI shows that various stakeholders are unhappy about the suggested SHI design and, most importantly, about the speed at which the Task Force wants to implement the policy, because certain areas of the policy are not well defined and there is no consensus on specific issues. Clearly a substantial amount of work still needs to be done to refine the policy before consensus can be reached and before SHI can be implemented. In the meantime, some analytical work on SHI/NHI is currently being undertaken, including developing accreditation criteria, conducting economic analyses (impact on employment, taxation and cost containment etc), developing the benefit package and costing it, implementing provider payment mechanisms, making institutional arrangements and doing monitoring, evaluation and actuarial work.

Private health insurance or pre-payment schemes with providers in Uganda occupy a relatively small market in the Uganda. Until this study was conducted, very little was known or documented about private health insurance and medical pre-payment schemes in Uganda.

1.2 Objectives of this study

The overall objective of this study is to investigate the private health insurance market in Uganda and gather the opinions of various stakeholders on SHI to collect information that is relevant for guiding SHI policy refinement. Specifically, the objectives of this study are to:

- establish the number and type of private health insurance organisation in the market;
- examine how the private health insurance market is regulated in Uganda;
- explore the amount of money and/or proportion (%) of salaries that employees/employers are currently paying as insurance premiums to private health insurance schemes;
- explore the benefit packages that are being provided under private health insurance schemes.
- document the opinions of both employees and employers on the introduction of SHI;
- identify key issues and/or obstacles relating to private health insurance that may impede the successful implementation of SHI in Uganda; and
- provide recommendations to the SHI Task Force on the implementation of SHI in Uganda.

Results from this study will be of particular importance to the Ugandan MoH and specifically the SHI Task Force, which is currently tackling the evaluation of other fundamental issues relating to the introduction of SHI. Specifically, results from this study will inform the SHI/NHI Task Force in Uganda about:

- the number of employees who are currently covered by health insurance or who have private arrangements for pre-payment medical schemes, which will inform the debate around whether or not health insurance should be made mandatory; and
- the different types of stakeholders who are likely to be affected by the implementation of SHI and their opinions, which will inform the debate about the roles of different stakeholders in SHI.

Statistical information, especially about number of employers who are contributing to employees' health insurance, is urgently needed by the Task Force. For instance, the extent to which employers are currently contributing to their employees' health expenditures gives an indication of their interest in having healthy employees, and is thus indicative of the fact that they might be willing to contribute

to their employees' social health insurance. Also, knowledge about the benefit packages under private health insurance schemes would provide a useful guide for determining what could be included in the health benefit packages under SHI. Lastly, the opinions and perceptions of the key players in the health insurance market are of critical importance to policy makers. Specifically, this information will be helpful in determining the different areas that need to be addressed in the education, information and communication campaigns prior to the implementation of SHI.

2. Methodology

This exploratory study was carried out in Kampala, Uganda's capital city. Kampala was chosen as the area of study because it was the place most likely place to have a fair balance of health insurance agencies and HMOs, as well as employees and employers who have private health insurance schemes and those who do not. Given the financial constraints, it was not possible to include another city/town in the sample.

The research team consisted of two experienced health economists and two research assistants. The senior health economist designed three semi-structured questionnaires for data collection and, together with the second health economist, trained the two research assistants to conduct interviews with the different categories of stakeholders. For this study, interviews were conducted with three sets of respondents: insurance or health maintenance organisations, the employers/firms/organisations and the employees. The questionnaires were developed in English and interviews were conducted in English. The questionnaires were completed by the research assistants during the interviews. Interviews were conducted between September and November in 2006 and January and February in 2007. All data collection activities were supervised by the health economists throughout the period of data collection.

In total, information was collected from two insurance organisations, two HMOs, two private health service providers, 58 employers and 250 employees.

The entire population of employers and employees in Kampala could not be studied due to the limitations imposed by resources, so a representative sample was drawn from the population. Using the formula below, relevant sample sizes were calculated:

$$N = \left(\frac{ZS}{D} \right)^2$$

where: N = the required sample size; S = the standard deviation of the sample; Z = a z-value taken from the tables (corresponding to the given confidence level); D = the margin of error at the specified level of confidence.

Thus, with an error margin of 1.5 at the 95% level of confidence, and a standard deviation of 12, the required sample size for employees was calculated as: $N = [(2x12)/1.5]^2 = 256$. The size of the sample targeted for employees was 256 (N1 = 256). Similarly, using the above formula, with an error margin of 1.6 and a standard deviation of 5.5, the required sample size for employers was 47. The sample targeted for employers was 50 (N2 = 50), to be drawn equally mainly from the private and quasi-public sectors. Since the total number of insurance organisations and HMOs in Kampala was relatively small, the team aimed to include all of them in the sample.

Lists of organisations/firms registered to operate in Kampala were obtained from the Uganda Investment Authority (UIA) and also from Uganda Bureau of Statistics (UBOS). Stratified random sampling was used to select the organisations to be visited. First, the organisations were stratified according to the types of services that they offered, and second, they were stratified according to the number of employees they had. On the basis of these stratified lists, organisations were randomly selected from each stratum.

A two-stage random sampling method was used to select private sector organisations and employees. In the first stage, 35 private firms were selected, based on the size of the firm (in terms of the number of employees of these firms). The reason for selecting slightly more firms than required for the sample (i.e. 25 firms) was to take into consideration the possibility that some of the selected firms might refuse to be interviewed. The second stage involved drawing a random sample of four or five employees from each selected firm. The criterion for selecting employee respondents was mainly their willingness to respond to the interview. In each firm, employees were either identified by the head of the organisation or randomly approached by the interviewers (regardless of rank within the organisation).

Public/quasi-public sector organisations and employees were selected in the same way as for the private sector organisations and employees described above. The first stage involved randomly selecting 30 public or quasi-public organisations/institutions. The second stage involved randomly selecting four or five respondents from each of these quasi-public sector institutions.

The team obtained a list of all insurance companies in Uganda (including those that do not offer health insurance) from the Uganda Insurance Commission (UIC). The team was guided by the UIC on the organisations that provide health insurance. Since there were only six such institutions, the team included all of them in the sample. Since HMOs do not report to UIC, it was difficult to find comprehensive information about them. However, based on the experiences of the research team (and also through informal consultations with various colleagues in Ministry of Health), the team found out that there were four health service providers who provided some kind of pre-payment arrangement/insurance to corporate clients and individuals. All four were approached for interviews.

All data from the structured questionnaires was entered into MS Access and later transferred to STATA 8 by a statistician. Data entry and cleaning were supervised by a health economist, and checked and verified by the principal investigator. Data analysis was undertaken by a statistician, the health economist and the principal investigator using STATA 8.

3. Results of this study

In this section, we will first discuss the different types of private sector health insurance organisations found in Uganda, and then we will look at the role of the Uganda Insurance Commission, which regulates the insurance market in the country. We will conclude by presenting the responses of employees and their employers.

3.1 Health insurance organisations and the Uganda Insurance Commission

By the end of 2006, there were only 19 licensed insurance companies in the whole country. Only one insurance company, MicroCare Insurance Ltd, offers health insurance and accident cover, while another organisation, East African Underwriters, offers health insurance, as well as other life and non-life insurance services. In addition to standard health insurance firms, there are some organisations that offer medical pre-payment schemes. Most of these organisations are health maintenance organisations, which, in addition to offering pre-payment schemes, also offer health services. Until recently there were two main HMOs in Kampala, but several health providers are beginning to offer pre-payment arrangements, initially with their individual clients and later extending these arrangements to corporate clients. To date, it is not clear how many of these private health providers are offering such pre-payment schemes. We heard only anecdotes about five such providers, and we visited and were only able to collect data from two of them. We also found two insurance firms that offer general travel insurance (mainly for people travelling outside Uganda), part of which covers health care during travel. Health insurance that is part of travel insurance is outside the scope of this study, so insurance organisations offering only travel insurance were not included in this study. Jubilee Insurance and NIC Insurance reported that they had applied for licences to offer medical cover from the Uganda Insurance Company and were about to launch their

products on the markets. Details of the medical policy were not yet finalised at the time of the study, however.

Before we look at health insurance organisations, health maintenance organisations and other private health insurance providers with pre-payment schemes, let's point out the difference between health insurance organisations and health maintenance organisations for the sake of clarity. In Uganda, **health insurance organisations** are involved in collecting insurance premiums from either individuals or companies in return for a specified health benefit package for those who are covered by insurance. The insurers are not involved in actual health service provision. In contrast, **health maintenance organisations** have a dual role that involves the collection of insurance premiums from individuals and/or companies on one hand, and the actual provision of health services to those who are medically insured on the other.

3.1.1 Health insurance organisations

The two health insurance organisations in Uganda are East African Underwriters and MicroCare Insurance.

East African Underwriters started in 1993 and initially offered a wide range of insurance services, which was extended to include health insurance in 2005. The company covers clients from Kampala and a few other major towns in Uganda, offering mainly travel insurance (including health insurance) for clients travelling out of the country. In addition, they offer top-end health insurance cover for in-patient hospitalisation for senior executives and high net-worth individuals, including evacuation services. Few people have this type of insurance – about 20 people in total! Premiums for this top-end health insurance are paid annually, and range from US$400-3,000 per person covered per year. The insured people usually obtain health services from providers outside Uganda (mainly in South Africa), although they might sometimes require some initial care (for stabilisation) with providers in Uganda (particularly the International Hospital Kampala).

MicroCare Insurance, started in 2000, mainly offering services to community informal sector and later expanded to providing commercial health insurance to corporate clients in 2004. It has two main function areas: health management and health insurance. The management part mainly requires the management of health care funds for corporate clients, such as dealing with health service providers (on behalf of the client) on issues regarding their service provision, billing and reimbursements. In addition, MicroCare offers insurance cover for group and personal accidents and workers' compensation. Their insurance services are available for employees (and their families) of corporate firms throughout the country. MicroCare has about 20,000 people covered under the corporate insurance schemes and about another 20,000 people covered under the community schemes. For the informal community insurance cover, there are two main categories: Social Basic and Social Plus. For the formal commercial insurance cover offered to corporate clients, there are four categories of cover: Corporate Comprehensive Enhanced, Corporate Comprehensive, Corporate Standard Enhanced and Corporate Standard. The insured clients obtain services from several health providers throughout the country (with whom MicroCare has entered into agreements). To date, MicroCare has signed contracts with more than 100 service providers in the country, including hospitals, clinics, laboratories, optical and dental practitioners, and public health facilities. All providers are reimbursed the fee that they pay for service through claims. MicroCare has a very stringent system for identifying its insured members and for controlling fraud. Currently, it is not working with any health maintenance organisations in Uganda.

For both organisations, clients are not charged co-payments whenever they seek care.

3.1.2 Health maintenance organisations

There are two main health maintenance organisations (HMOs) in Uganda: International Air Ambulance (IAA) and African Air Rescue.

African Air Rescue (AAR) first started in Kenya in 1984 as a rescue organisation and later expanded into an HMO in response to local needs. AAR was the first HMO in Uganda, opening in 1994, mainly as a provider of health services that also offered pre-payment schemes and evacuation facilities to clients using the insurance approach. They are re-insured with Lloyds Insurance (a UK-based insurance organisation). AAR services and insurance schemes are available to both corporate and individual or family-based clients. The AAR health insurance schemes cover a total of about 25,000 people in Uganda, also providing health services to the general public, who pay cash to receive this care. To date, AAR has two clinics in Kampala (where all their Kampala-based clients seek care) and it has contracts with about 80 service providers in the rest of the country, who provide services for AAR clients outside Kampala. In addition, they have contracts with service international providers based outside Uganda. All providers who have entered into contracts with AAR are reimbursed on a fee-for-service basis, with some controls in place to contain over-servicing on the part of the providers. AAR offers two types of cover for its corporate clients: Basic Corporate (about US$100 per person per year) and Corporate International (about US$700 per person per year). For individual clients, the basic category has a premium of about US$150 per person per year. These premium contributions are normally paid annually, with some exceptions where corporate clients have negotiated other terms of payment. No payments are charged to insured patients; however, patients may pay a penalty if they fail to comply with some of the regulations/conditions in their contracts. Normally, this penalty will be about 20% of the total cost of treatment.

International Air Rescue (IAA) started in 2000, following the opening of their biggest facility, the International Hospital Kampala (IHK) in 1999. The initial motivation was to help those people who could not afford the cost of health care services as individuals, and they came up with the solution of pooling the resources of these individuals. The health insurance services were mainly targeted at companies/corporate firms. Since IAA is a service provider and at the same time offers health insurance, it fits in the HMO category. IAA has three clinics and one large hospital in Kampala, and a few other clinics in other parts of the country. It offers its services (health services, insurance and evacuation) to both corporate and individual clients throughout the country. It has a wide range of insurance cover categories, such as Executive Corporate, Corporate Gold, Corporate Silver, International, Family Cover, Personal Silver, Personal Gold etc. Each of these categories has a different premium and different benefit package. Premiums are normally paid annually but, in a few instances, premiums are paid monthly. Insured clients seek care from the IAA facilities or from the providers who have entered into contract with IAA to provide services for their clients. Such providers are normally based outside Kampala or are specialised public hospitals (e.g. Mulago hospital). The contract providers are normally reimbursed on a fee-for-service basis. No co-payments are charged to the IAA insured clients when they seek care.

3.1.4 Other private health insurance providers with pre-payment schemes

We identified five private health insurance providers with pre-payment schemes in Kampala, which insure their clients as individuals, families or as corporate clients. These providers are Case Medical Centre, Kadic Hospital, International Health Network, St Catherine's Clinic and Paragon Hospital. It is possible that there are actually more than these in Kampala and more in the rest of the country. However, since there is no special registration for them (apart from the usual registration as private health providers), there is no formal way of establishing the actual number in this category. These providers are not any different from ordinary private health care providers, except for the fact that they enter into some semi-formal pre-payment arrangements with some of their clients. The pre-payment amounts are calculated according to the client's previous utilisation of health services and the size of their family. It seems that the prepayments are also calculated on an ad hoc basis, depending on whether you go as an individual or as an organisation/company. Due to resource and time constraints, we were able to visit and conduct interviews with only two of these five providers in Kampala: Kadic Hospital and Case Medical Centre.

Kadic Hospital provides a wide range of private health services (out-patient and in-patient) and began offering pre-payment insurance schemes to their clients in 2004. They cover clients from all parts of the country, as well as from Sudan and Rwanda. They also offer health services to the general public on a cash basis. The pre-payment categories vary a lot and are tailored to specific clients, but the most common ones are MediPlus (UGX500,000 per person per year), MediSelf (UGX290,000-350,000 per person per year) and MediAid (UGX220,000-280,000 per person per year). (These calculations are based on an exchange rate of between UGX1,720 and UGX1,785 per US dollar.) About 90 individual/family clients have pre-payment schemes, while about 1,500 clients are covered as corporate clients. No co-payments are charged for patients who have pre-payment schemes. In addition to its health facilities in Kampala, Kadic Hospital has entered into contracts with other service providers in other parts of the country and also with specialised public health facilities, and they reimburse them on a fee-for-service basis.

Case Medical Centre (CMC) started as a private clinic mainly offering out-patient services with some limited in-patient care services, but they are currently building a full hospital that will provide a much wider range of health services. Over the many years that they have provided health they noted that a significant proportion of their patients had difficulties with paying for health care. So a simple pre-payment arrangement was started in 2004 with a few patients, mainly those who had been clients for several years and whose history was known. Initially, the pre-payment schemes were developed and priced on a case-by-case basis. Later, these pre-payment schemes were defined better and offered to individuals, families and corporate clients. These schemes were not considered to be strictly insurance, but purely pre-payment arrangements that allowed their clients to access services throughout the year. The Case Medical Centre does not see itself as an HMO, but a service provider that also offers pre-payment arrangements. CMC has only one facility in Kampala, but like many others has entered into contracts with other service providers to provide services for their clients who live outside Kampala. Based on the responses from the interview, about 20,000 people are covered as individuals or families and about 5,000 people are covered as corporate clients by these pre-payment schemes. Some of their contracted providers are paid on a fee-for-service basis while others are given pre-paid lump sums. No co-payments are charged to clients who have pre-payment schemes.

3.2 The Uganda Insurance Commission

All insurance companies in Uganda are regulated by the Uganda Insurance Commission (UIC). This means that East African Underwriters and MicroCare Insurance are formally regulated by UIC because they are registered as insurance companies that do not provide health services.

The main functions of the UIC are:

- to offer annual business licenses;
- to receive complaints from the general public about the insurance industry and make recommendations based on them;
- to write policies that regulate the insurance market; and
- to ensure that insurance companies are properly capitalised so that they can pay their claims.

In addition, all insurance companies must submit reports to the UIC, including annual returns on their accounts and annual reports on their performance. Every year, they must also submit annual financial statements and audit reports before they can register to continue business in the next year.

Other bodies that regulate Uganda's health services include the professional councils, such as the Medical and Dental Practitioners Council, the Nursing and Midwifery Council and the Allied Health Professional Council. While there is a body for regulating insurance firms and a body for regulating service providers, there is no body that regulates organisations that offer *both* health services *and* health insurance or pre-payment schemes. As noted earlier, health insurance is relatively new in Uganda, and its regulation seems not to have been considered of critical importance until recently, when the SHI/NHI debate gained momentum. Both the HMOs (African Air Rescue and International

Air Rescue) and both the providers that offer pre-payment schemes (Kadic Hospital and Case Medical Centre) reported that they were not regulated by any organisation with regard to providing insurance or pre-payment schemes. Clearly this is a major problem, and the Uganda Insurance Commission and other institutions have recently started investigating ways to regulate them.

3.3 Responses from employees and employers

In this section, the responses from employees and employers will be discussed according to their views and opinions on:

- the size of the health insurance market;
- premiums and size of contributions;
- health benefit packages;
- social health insurance (SHI);
- the impact of SHI on their health insurance schemes;
- their willingness to join or pay for SHI;
- SHI policy; and
- HMOs and insurance organisations.

3.3.1 Size of market: Who is covered by health insurance and pre-payment schemes?

Let's first look at the responses of employees before we turn to the responses of employers. Tables 1-3 provide a summary of the results from the employees. *Table 1* provides a summary of the demographic statistics of the respondents and whether or not they have belonged to health insurance within Uganda.

About 60% (149) of the 250 employees answered yes to the question, "Have you ever been covered by health insurance in Uganda?" This group includes those employees who are currently covered by health insurance and those who previously belonged to a health insurance scheme but are not covered now. Of these only 96 said they were currently insured (i.e. at the time of the interviews).

Table 1: Demographic description and previous insurance status of employees

	Details	Frequency (numbers)	Percentage (%)
Gender	Male	130	52
	Female	120	48
	TOTAL	**250**	
Age groups	20-24	14	6
	25-29	70	28
	30-39	110	44
	40-50	46	18
	Older than 50 years	10	4
	TOTAL	**250**	
'Have you ever belonged to health insurance in Uganda?'	YES	149	60
	NO	101	40
	TOTAL	**250**	
Insurer's name	AAR	59	40
	MicroCare	37	25
	IAA / IHK / IMC	33	22
	AIG	3	2
	Other (BUPA)	17	11
	TOTAL	**149**	

In *Table 2*, we can see that a total of 142 (56%) employees are either currently insured for health or they have some health benefit arrangement organised by their employers, leaving 44% of the employees with neither health insurance nor health benefit plan at the workplace. For the 96

employees who were "currently insured for health", their insurers were AAR (26%), MicroCare (29%) IAA (30%), AIG (2%) and others, such as the British United Provident Association (13%).

Table 2: Current health insurance status of employees

	Details	Frequency (numbers)	Percentage (%)
'Are you currently insured for health?'	YES (Insured) Some benefit scheme Not insured TOTAL	96 46 108 **250**	38 18 44
Name of current insurer	AAR Micro Care IAA / IHK / IMC AIG Other (BUPA) TOTAL	25 28 29 2 12 **96**	26 29 30 2 13
Total number of people covered by the insurance scheme:	Insured person (IP) alone IP and spouse IP, spouse and up to four children IP, spouse and all dependants TOTAL	40 22 32 2 **96**	42 23 33 2
Insurance status of the respondent	Primary insured Dependant TOTAL	90 6 **96**	94 6
Types of health insurance scheme	Corporate Gold Gold Basic Don't know TOTAL	42 3 25 26 **96**	44 12 26 27

Furthermore, on the basis of responses from 142 employees (i.e. the 96 employees with private health insurance *plus* the 46 employees with a health arrangement scheme), this study established that the care was sought from various providers as follows: private clinics and hospitals (52%) and insurer's facilities (47%) – in the case of health maintenance organisations (such as AAR and IAA). In addition, the majority of the insured employees (94%) do not pay any money (co-payments) whenever they access health services.

As reported earlier (*Table 2*), 46 employees said they had some kind of "health benefit arrangement at the workplace". Results show that these health benefit arrangements sometimes covered only the employee and in a few instances covered the employee and his/her family (see *Table 3*).

Table 3: Who is covered by the health benefit arrangement at the work place?

Who is covered?	Frequency (numbers)	Percentage (%)	Cum.
Employee alone	17	36.96	36.96
Employee, spouse and up to four children	17	36.96	73.91
Employee, spouse and all dependants	12	26.09	100
TOTAL	46		

Now let's turn to the responses of the employers, which differed from those of the employees in some respects.

Out of the 58 organisations interviewed, one was a public company, 23 were private companies, 18 were semi-autonomous and 16 were non-governmental organisations (NGOs). Fifty organisations (86%) had health insurance or some health benefit package given to their employees. Of these 50 organisations, 23 (46%) had private health insurance, while 27 (54%) had some kind of health benefit package. Of the 50 organisations with health insurance and/or health benefit package:

- two organisations had health insurance for only management staff,
- twenty-one had health insurance for all their employees;
- six organisations had an in-service clinic;
- sixteen organisations had the reimbursement system (i.e. employee seeks care and employer reimburses provider or the employee if they have paid out-of-pocket); and
- five organisations gave employees a medical allowance as part of their salary.

Of the 23 organisations with "health insurance", 11 (48%) organisations had subscribed with AAR, 5 (22%) with IAA, 3 (13%) with MicroCare, and the remaining 4 (17%) organisations were insured with other agencies/providers. For the 23 organisations with private "health insurance" packages, 17 (74%) had all employees in one health benefit package and only 6 (26%) had different packages for different staff categories.

Of the 23 organisations that had private health insurance, 19 organisations paid premiums on an annual basis, two organisations paid on a monthly basis and the remaining two paid on a billing system. The premiums were mainly paid in Uganda shillings. Different organisations paid different total amounts depending on the type and category of the insurance in place and the number of people insured. It should be noted that some organisations had more than two staff categories covered under different health insurance packages. Responses on the total amount of money paid as contribution for the employees were very difficult to obtain. Most organisations refused to reveal this information and more so to give specific expenditure figures. Given the very responses to this question, it was not possible to make valid and meaningful analyses and therefore these results have been excluded from the report.

3.3.2 Premiums and size of contributions

Of the 96 employees who were "currently insured", only 49 employees (i.e. 51%) knew the amount of money paid as annual health insurance premiums to cover them and their dependants. Given the fact that most employers pay the whole insurance premium for their employees, it is not surprising that a significant number of the employees did not know how much the premiums were. Based on the responses of the 49 employees who knew the premiums paid for them or by them, the annual premiums ranged from UGX222,000 (i.e. US$120) to UGX9,250,000 (US$5,000).

The reason for this wide range is due to the fact some of the people were insured alone (i.e. with no dependants) and hence had a low annual premium, while others had several number of dependants covered, in which case the annual premium for the entire family would be much higher. The median health premium was UGX1,184,000 (US$640) annually. The inter-quartile range was UGX425,500 to 2, 000,000, meaning that half of the population of those who answered the question paid annual premiums between UGX425,500 (US$230) to UGX2,000,000 (US$1,081). Of the 49 employees, 53% indicated that these premiums covered the whole family while 47% said that premiums covered individuals. On the basis of the responses of the 49 employees who knew the amount of money paid for insurance premiums, the ranges of the annual premiums covering both individuals and/or families is shown in *Table 4.*

Table 4: Amounts of Annual health insurance contributions (as reported by employees)

Annual premium	Frequency (numbers)	Percentage (%)
Less than UGX 1 million	23	46.94

UGX 1-5 million	19	38.78
Greater than UGX 5 million	7	14.29
TOTAL	**49**	

It is difficult to establish the validity of the information on premium contributions obtained from employees, especially in light of the fact that most of their premiums are paid in full by their employers. The wide range of annual premiums for health insurance services shown in Table 4 could be the result of different numbers of beneficiaries for different policies. If this assumption is correct, then the ranges of premiums reported in Table 4 are plausible. However, given the small number of respondents (49) for this question, it is difficult to estimate the significance of these results. Furthermore, since these contributions are absolute numbers that are not related to salaries or income, it is difficult to establish their relevance in light of the discussion around what percentage of an employee's salary should be deducted as an SHI premium. However, with this information, one can argue that, if employees and employers are willing to join SHI (and if they are allowed to move from private health insurance), they will be more willing to contribute the same amounts of money annually into the SHI Fund. So, if we were to consider the inter-quintile range (UGX425,500 to 2,000,000) for annual premium, it means that the monthly subscriptions would range between UGX35,458 for one employee alone and UGX166,667 to cover four dependants.

Interviews with the four main insurers showed that a minimum of UGX500,000,000 was collected annually (from all the 4 organisations) in premiums. However, due to the sensitive nature of this kind of information, it needs to be interpreted with caution if no further validations are done beyond this study. Most of the insurers were not willing to disclose their contribution rates or premiums per principal member/dependant, so this gap in the data remains.

A number of employers who have not insured their employees have made other arrangements for their employees to access health services more easily, for example by having in-house clinics, designated clinics (where the employer picks up the medical bills) or a medical allowance added to the employee's salary (see *Table 5*).

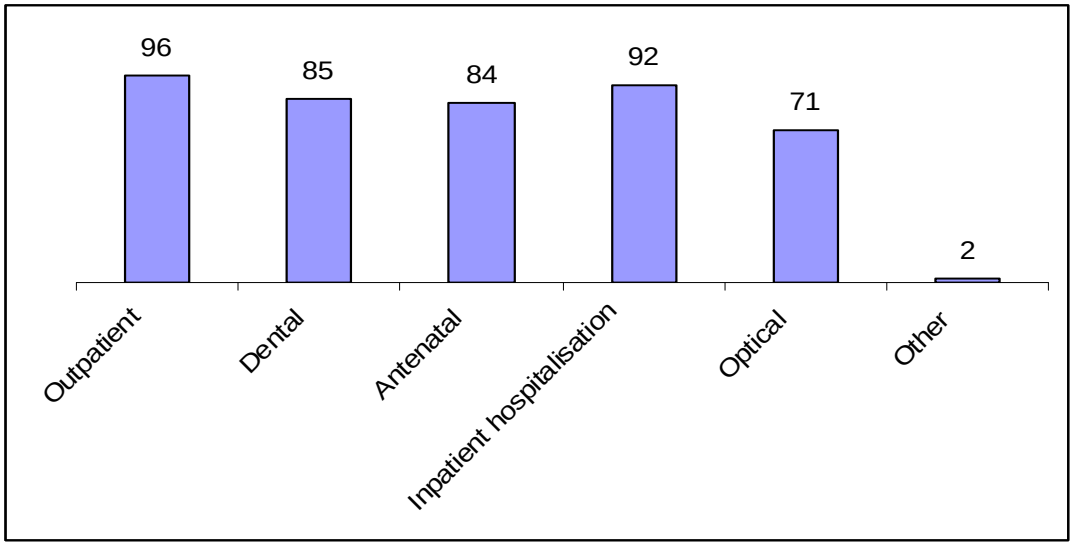
Table 5: A summary of different benefits for employees with a health benefit scheme

Benefits provided	Frequency (numbers)	Percentage (%)
In-house clinic/doctor	16	35
Out-patient care and organisation pays	2	4
Out/in-patient care and organisation pays	17	37
Employees pay for care and are reimbursed by organisation	3	7
Top-up medical allowance	8	17
TOTAL	**46**	

3.3.3 Health benefit packages

Respondents were asked questions relating to the health benefit packages that were available for those employees who were "currently insured" for health. Results in *Figure 1* show that a substantial proportion (over 92%) of the employees who are insured has a benefit package that includes both *out-patient* and *in-patient* services. In addition the health benefit packages for about 84% of those who are covered by health insurance include both *dental* and *antenatal* services.

Figure 1: Percentage distribution of health services coverage



About 86% of the 96 employees who were "currently insured for health" had their health insurance premiums paid by their employers, while only 7% directly paid their premiums themselves and only 7% had their premiums paid partly from their salary and partly by their employers. Of the 96 employees who are "currently insured", 79% said their premiums were paid annually, while 14% said their premiums were paid monthly. The rest (7%) did not know how their premiums were paid.

3.3.4 Opinions of employees regarding social health insurance

Only about 100 (40%) of the 250 employees had "ever heard about the SHI policy" that is being proposed by the MoH. Most had heard about it through the media. When asked whether or not "SHI is a good scheme", 73% of the 100 employees who had "ever heard about the SHI policy" said it was a good scheme, 26% of the 100 employees said it was not and 1% did not know whether it was good or bad.

Let's first discuss the 73 employees who said that SHI was "a good policy" and the reasons for their answers before we discuss those who reported that the SHI policy was "not a good policy".

Of the 73 employees, 28 said the policy was good because, if it were in place, it would not be necessary to have cash at the time of consuming health services. They argued that this factor was especially important because they received their salaries at either the beginning or end of the month, and were unlikely to have enough cash if they fell ill in the middle of the month.

A further 20 employees reported that the policy is a good one because it would improve the health-seeking behaviour of the people. They said that people did not go for check ups because they did not have money to pay upfront and this lack of preventive care had culminated in severe sicknesses. Can SHI help to reduce the financial barriers to accessing health services?

Fifteen employees reported that SHI would lead to an improvement in the health services offered by the government. This was based on the fact that it is a MoH initiative so it would be obliged to improve its services, especially in government-funded hospitals, like Mulago Hospital. This argument can be interpreted in two ways. First, it highlights the expectations of employees regarding quality of services once they are part of an SHI scheme, and also as a pre-requisite for the introduction of SHI. It shows that the quality of services in their current state is viewed as inadequate and needing improvement. Second, the argument highlights the critical function of SHI

in raising additional funds, part of which should be used to improve the quality of existing health services – which is one of the key objectives of the proposed SHI policy in Uganda.

Other reasons given by the respondents who supported the SHI policy are as follows:

- “In times when someone has lost a job or is retired, the policy would take care of their medical.” However, there were doubts on this issue because, under these circumstances, you would not be contributing to the fund, so these respondents requested the government to formulate the policy in such a way that would take care of these potential problems.
- Some noted that the SHI policy would help the insured people to “save money on expensive treatment, since they would be covered”. However, some respondents wondered how the SHI policy would cover expensive therapy like antiretroviral therapy, cancer and other complex diseases such as heart diseases.

Let's now discuss the 26 employees who said that SHI was "not a good policy" and the reasons for their answers.

Some said that SHI would “lead to corruption and embezzlement of funds, since the government does not put in place checks to fight corruption”. They recommended that the policy would be good if the private sector was entrusted with the mandate to run the policy. Others argued that the government health facilities were in dire need of repairs and old and faulty equipment needed to be replaced, which meant that they were not willing to contribute without being sure that they would benefit. Again, this confirms our earlier argument that potential contributors to the SHI see the improvement of the quality of health services as a prerequisite before the implementation of SHI.

There was also the perception that SHI was another tax replacing the government tax. They reported that they were already contributing towards NSSF and PAYE, which deducted close to 50% of their income, so they were opposed to another tax that would further reduce their take home pay. Others argued that SHI was “another tax to the employers that would further reduce the profit margins for the companies and thus the employees would be paid less”.

Some employees highlighted that SHI does not take into consideration the needs of those were unemployed. They argued that SHI would only favour those who have formal employment and that it should only be optional because there are employees already covered by private health insurance. Lastly, there were employees who were concerned that, under SHI, access to health services for the beneficiaries would be limited to the number of health facilities. They reported that this policy would restrict them to government-funded hospitals that were less equipped and yet crowded with patients.

Although 40% (99) of the total number of employees (250) interviewed said they had "ever heard about the SHI policy", we found that a very insignificant number of employees 8 (3%) said they had "a full understanding of the scheme" compared to 242 (97%) who did not. For the 3% who said they had a "full understanding of the SHI scheme", the following features of the SHI scheme were highlighted in their responses:

- Under the SHI scheme, 4% of your salary will be deducted.
- The SHI scheme will be compulsory.
- The SHI scheme will "offer all-time medical care", which means that you can access care at any time and not only when you have money.

3.3.5 Views of employees on the impact of SHI on their health insurance schemes

When employees were asked whether they would continue subscribing to their private health insurance schemes after they became members of the social health insurance scheme, 47% of the 96 employees (who currently have private health insurance) said they would still subscribe to their private health insurance schemes, 31% (30) said they would not and 22% (21) did not know. Unfortunately, no information was collected on employees’ different income levels or socio-

economic status, so this study cannot comment on how these factors affected differences in the responses. Those who reported that they would continue subscribing to PHI scheme gave the following reasons:

- The benefits of SHI are not yet known and government health service providers are not trusted.
- Poor facilities found in government hospitals are a disincentive for the people to willingly contribute to SHI, so respondents would still contribute to PHI since they would be assured of better quality services in the private clinics.
- Under SHI, there would be restrictions to use specific health facilities (i.e. the accredited ones). Further, they argued that, under SHI, they would not be free to go to clinics of their own choice, which could be a problem if they needed specialist help or already went to a clinic where they had satisfactory and personalised service.
- Private health care providers have better quality services.
- Funds remitted to government will not be used properly due to the poor management of public funds.
- Companies have already signed contracts with private health insurances/providers.

The 30 respondents who said they would stop subscribing to PHI when SHI is implemented argued that it would be a double cost if they subscribed to both schemes and they said that, since SHI was mandatory, they would have no choice but drop their PHI schemes. The respondents who were not certain continuing with PHI reported that this would depend on their employers' decisions, although most said that the employers would most likely drop the PHI in preference to the SHI, since it would be mandatory anyway.

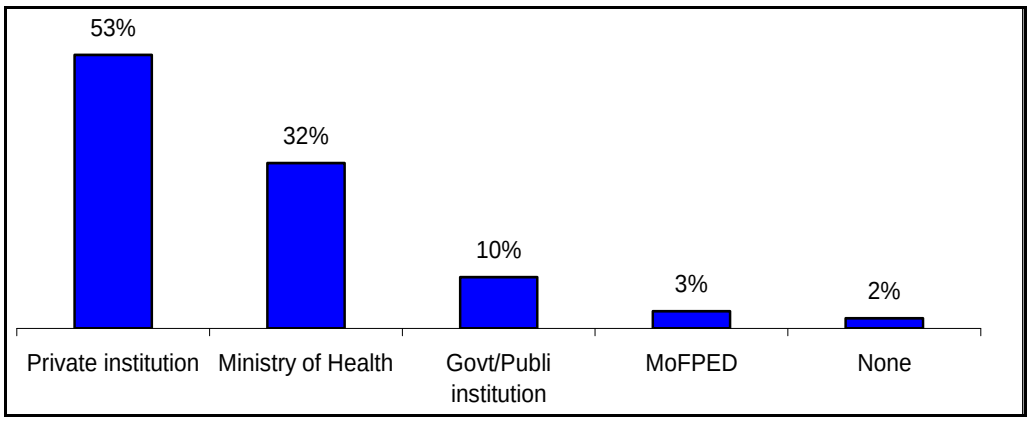
3.3.6 How willing are employees to join SHI and what do they think about SHI policy?

In this section, we will analyse and explain the relationship between different characteristics of employees and their levels of willingness to join SHI, with the aim to provide guidance on some key factors that are likely to influence employees' attitudes towards SHI.

Of all the 250 employees, 121 (48%) said they were willing to join SHI once introduced, 104 (42%) were not willing and only 25 (10%) were not sure. Among the respondents who said they were willing to join SHI, 3% was the median percentage they suggested ought to be deducted from their salaries. When they were asked questions relating to their expectations on the benefit package under SHI scheme, the majority (69%) of 146 employees (those willing to join plus those who were not sure) said that SHI should entitle them to all health services, which would include out-patient, in-patient, dental, optical, antenatal and evacuation. When asked for their preferences on health service providers, about 71% of these 146 employees said they would want a mix of public health care providers and private health providers, while 25% and 4% of the 146 employees said they would prefer private and public health care providers, respectively.

Of the 146 employees (those willing to join SHI plus those who were not sure), 143 (98%) said that SHI should cover the person contributing, spouse and children as opposed to 3 (2%) employees who said that SHI should cover only the person contributing. When asked who should manage the SHI fund, 53% chose a private institution. See *Figure 2*, which is based on responses from 146 employees.

Figure 2: Percentage distribution of who should manage SHI fund



3.3.7 Opinions of employers regarding social health insurance

Thirty-seven organisations (64%) of the 58 organisations (employers) admitted that they had "ever heard about SHI" and this was mainly through the media (newspapers). The majority 23 (40%) did not know whether SHI was good or bad. Of the remaining organisations, 18 (31%) said it was a good policy while 17 (29%) said it was not good. Of the 58 employers, 38% said that health insurance was good for those who are not covered by any insurance scheme because their employees would not be worried about having to pay cash every time they seek health care. Therefore it is good for those employees who do not have a scheme in place. They argued that SHI should be optional. When asked whether the employers had a full understanding of the Uganda SHI policy, thirty-seven organisations answered the question, of which only 7(19%) had a full understanding of the scheme, while 30 (81%) did not (see *Table 6*).

Table 6: Employers' opinions about SHI

'Is SHI good?'	Frequency (numbers)	Percentage (%)
Yes	18	31.0
No	17	29.3
Do not know	23	39.7
TOTAL	58	

Eleven percent of the 58 employers argued that SHI would encourage staff retention and motivation since it acts as a social welfare incentive to the staff. Other reasons given to support SHI were as follows:

- It caters for all the medical services.
- It brings about equity because it acts as a risk-pooling mechanism.
- It guarantees health care for all the employees in the formal sector.
- It improves health-seeking behaviours.
- Employees can also contribute to their own medical care.

Out of a total of 58, 17 employers said that SHI was "not a good policy" because:

- SHI is not good for employers who have a medical scheme because it's mandatory. They argued that those employers with existing medical insurance would have to pay double costs – for private health insurance and for SHI.
- Medical facilities under the SHI are in a very poor state.
- There will be mismanagement of funds (corruption) collected for SHI.
- SHI is a burden to taxpayers who are already paying PAYE and NSSF.
- SHI will have high premiums.

3.3.8 Views of employers on the impact of SHI on their health insurance schemes

According to the responses provided by the employers, it was clear that SHI would have some impact on private health insurance schemes. When asked whether employers would continue with PHI schemes for their employees after SHI is implemented, 18 of 50 organisations (36%) said they would continue subscribing to PHI schemes, 22 (44%) said they would stop subscribing and 8 (16%) employers were not sure of what they would do. The main reasons that were given included the following:

- 35% of the employers said that having both SHI and PHI would be a double tax/cost to the employer;
- 16% said that, with the introduction of SHI, organisations would incur high costs;
- 42% said that their employees would be restricted to assessing poor quality services offered by the public hospitals;
- 4% said that SHI would not cover specialised diseases; and
- 3% said that SHI would limit employees to a few clinics and hospitals.

3.3.9 How willing are employers to pay for SHI and what do they think about SHI policy?

When asked about their willingness to contribute to the SHI fund, on behalf of their employees, about 57% (33 of 58) of the organisations responded in the affirmative, 16 (28%) were not willing to contribute and the remaining 9 (15%) organisations were not certain. Half of the employers interviewed were willing to contribute between 3 to 6 percent, the median percentage being five. Of the forty-two organisations who either responded that they would join SHI or that they were uncertain about their willingness to contribute, the majority 22 (53%) suggest that the benefit package should include all health services (including out-patient, in-patient, dental, optical, antenatal and evacuation); 8 (18%) employers suggested that the benefit package should include out-patient, in-patient, dental and antenatal; 9 (21%) employers preferred out-patient and in-patient services only; and only 3 (8%) employers said it should cover only out-patient services.

The majority of employers (30, or 71%) suggested that the scheme should cover the employee, the spouse and the children. Only two suggested that it should cover only the employee, while 11 (26%) said that the scheme should cover the employee, the spouse, the children and any other dependants.

Most employers (23 out of 42) suggest that the SHI fund should be managed by a semi-autonomous firm. The majority (91%) also suggested that those covered under the SHI scheme should go to both private and public health care providers.

3.3.10 Final opinions on SHI from HMOs and insurance organisations

All six of the organisations included in this study said they had heard about the proposed SHI policy in Uganda. When asked whether they had a full understanding of the policy, all of them answered "No". Interestingly, when asked whether or not it was a "good policy", all of them answered in the affirmative. They noted that the policy was "theoretically good in principle" and highlighted its potential to reduce catastrophic expenditure as its most positive feature. Some also noted that it would allow some groups of people who have small income to access a wider range of services than they would have previously been able to afford. However, they had several reservations regarding the proposed SHI policy. The most-cited reservation was "the manner in which the MoH is proposing to proceed with it". As highlighted from the responses of the employers and employees, the health service providers/health insurers felt that the process was being rushed without adequate preparation for it. Similarly, they raised concerns about proposed management and corruption; the extent to which there were adequate health service providers in the rural areas of the country; the poor quality of health services in the areas outside the major towns; whether or not bureaucratic delays would affect timely payments to them as service providers, as well as possible "hidden agendas" of some SHI proponents. Interestingly, they noted that SHI is targeted at a relatively small

percentage of the population, which is already able to meet its medical care costs. They also feared that large numbers of people would congest the facilities, thereby lowering the quality of services.

In general, our conclusion is that this group of stakeholders, though relatively small, has important alliances with trade unions and the Federation for Uganda Employers, and together they have very strong and negative views about the manner in which SHI implementation is being proposed. They are a strong voice that is organised and that is likely to give the SHI Task Force some reasonable amount of difficulty if they are not handled properly and if their views are not taken into consideration during this phase of designing the SHI policy.

4. Discussion of results

4.1 Knowledge, perceptions and opinions about SHI

Results indicated that a significant proportion of employees (57% of the 250 who participated) have either private health insurance or a prepayment scheme or some kind of health benefit arrangement offered at the workplace. However, a rather significant proportion (43%) of employees pay out-of-pocket for health services each time they access services. Given this, it is not surprising that a sizeable proportion of employees (48%) were willing to join SHI once it is introduced.

A significant relationship emerged between employees' responses on willingness to join and their current health insurance status. Employees that were not currently insured were more likely to join SHI as when compared to those currently insured, and vice versa. In addition, although the sample size was relatively small, results showed that employees who are currently personally paying or contributing to the premiums for their current health insurance schemes were more willing to join SHI when compared to the employees for whom 100% of the current health insurance premium was paid for by their employers. Resistance to the introduction SHI is likely to come from employees who are already part of private health insurance/prepayment schemes, especially those whose premiums are fully paid by their employers. This makes logical sense because this group of people already has health insurance and access to relatively good quality health services. Also, health insurance premiums are paid by the employers, so they do not affect the employees' take-home salaries. The employees regard the introduction of SHI as unnecessary or unfair because part of their salaries will be deducted to pay the SHI contributions, thereby shifting the responsibility for contributing (to health insurance) from their employers to them. Employees do not know who the health service providers will be under SHI either. They assume that, since SHI is being designed by the government (MoH), they will have to attend public health facilities, with poor-quality service.

About 104 employees wanted a mix of public and private health service providers under the SHI policy. This finding is in line with the proposed structure of service providers once the SHI policy is implemented. Some of the most important issues to take into consideration while defining the criteria for selection of SHI service providers should be quality of services and ability to provide a wide range of services by a specific provider. This argument was also highlighted by Wagstaff and Claeson (2004), who noted that the quality of health services covered by a health insurance plays a decisive role in bringing about its acceptance among the population and a willingness of members to pay contributions in advance.

One of the main findings of this study was the lack of knowledge shown by employees about SHI. A substantial proportion (60%) of employees had never heard about SHI; even the small percentage that had heard about it had little information about it. Many employees are misinformed about various features of SHI and believe inaccurate facts about the SHI policy. Specifically, there is lack of knowledge about the objectives of SHI, the proposed benefit package, the suggested providers of health services and the proposed management of the Fund. This lack of knowledge informs negative opinions about SHI and makes employees unwilling to join the scheme.

Of the 58 organisations that were interviewed, 50 have either have private health insurance or some other kind of health insurance arrangement. When asked whether or not the "SHI policy was good", a significant proportion (40%) of the employers gave a non-committal response of 'don't know'. Perhaps this was because they didn't have enough information about the SHI policy or because they were concerned that responses would not be kept confidential. Several organisations were even hostile towards us because they thought that we were government spies sent to establish if they were against government policies! On a positive note, a significant percentage (57%) answered "Yes" when they were asked whether or not they were willing to join SHI.

Employees and employers raised similar concerns when asked for their opinions about SHI. The two main issues were regarding corruption and the management of the SHI Fund, and the poor quality of health services in public health facilities. They assumed that SHI would rely on public health facilities to provide the benefit package services.

4.2 Anticipated impact of SHI on PHI schemes

Employees and employers stated that SHI would impact greatly on their PHI schemes. It is clear that, once SHI is introduced, employers are more likely to drop the PHI for SHI. Our findings show that the majority of the employers (44%) and employees (65%) would stop subscribing to their PHI schemes once SHI is introduced. In fact, a significant relationship emerged between respondents' willingness to join and whether or not organisations would continue with PHI once they become members of SHI. This finding is consistent with McIntyre's (1997) argument that SHI is more likely to displace voluntary private health insurance than general tax revenue. Viewed differently, one could suggest that, even when SHI is implemented, it is still possible to have in place mechanisms that allow organisations offering private health insurance to work with SHI Fund management instead of competing with them. For instance, their expertise and experience in the insurance business may open mutually beneficial cooperation opportunities, such as subcontracting administrative or actuarial tasks to them (Bobadilla et al, 1994). Furthermore, organisations offering PHI could be allowed to offer top-up insurance packages for interested clients, to cover additional and/or specialised health services that are not covered by SHI.

The nature and regulation of private health insurance in Uganda is an important area for discussion. As noted earlier, a number of organisations/providers offer either health insurance or medial pre-payment schemes. For example, the HMOs and some health providers collect 'premiums' from their clients and at the same time provide health services to them. The dual role of collecting premiums and providing services is currently not regulated in Uganda, and this is a serious concern. It is highly likely that HMOs will be accredited to provide services under SHI (if they are willing), so we will need to understand how HMOs operate and how to regulate their activities. This is particularly important if they are going to be allowed to continue operating as they have been operating (i.e. taking 'insurance premiums' and providing services) while at the same time providing a range of services for SHI beneficiaries. It is necessary for the Task Force to work out exactly how SHI and PHI can co-exist and how they can work together to harness the synergies of collaboration.

4.3 Impact of SHI on service utilisation and quality of health services

Results from this study revealed that there wasn't a significant relationship between the service utilisation rates of employees and their families and the employees' responses on the willingness to join SHI. Key literature on social health insurance argues about the possibility of 'over-utilisation of health services' (sometimes referred to as 'moral hazard') once people are members of SHI (Shaw and Graffin, 1995). While there have been several studies on this subject in developing countries, there have been very little work done on it in developing countries, for the obvious reason that few developing countries have had SHI policies implemented. Theoretically, the notion of moral hazard is possible. However, one wonders the extent to which it is fully applicable in developing countries where major challenges to access already exist and where per capita utilisation rates are already 'low' from a relative point of view. The most important question is this: if implementation of SHI

resulted in increased utilisation of health services, would this be a good thing (i.e. improvement in access to health services) or bad thing (i.e. moral hazard)? This question remains largely unanswered because of the methodological difficulties that surround measurement of these variables. It is possible, however, that even with existing barriers to access in developing countries, some degree of moral hazard might be seen within some segments of the population (especially the higher and middle-income groups) than in others. The notion of moral hazard might be partially supported by our finding that there is a significant relation between employees' responses on current utilisation rates and their responses on the percentages of their salaries that ought to be deducted as SHI premiums. That is, the more money employees contribute, the more they expect to access a wider range of services.

Related to the issue of moral hazard is the suggestion that, in addition to SHI contributions, beneficiaries should be charged additional 'small' fees (co-payments) as a way of controlling frivolous use of services. Findings from this study showed that the majority of the currently insured employees do not pay any money whenever they access health services. This finding is important for the SHI policy design. For it to be acceptable, especially by the stakeholders that already have private medical schemes, the SHI policy should not introduce co-payments. We support this proposal by arguing that, since the concern with moral hazard is essentially one of cost containment, the designers of the SHI policy should aim to achieve this by having in place measures that relate to efficient provider behaviour. Furthermore, co-payments have been seen as sometimes ineffective in reducing moral hazard (De Geyndt, 1991) and incentives to providers appear to be much more powerful tools for containing costs (Kutzin, 1995).

A major finding of this study is that employers and employees are concerned about the quality of health services under SHI. The Task Force should consider these concerns very carefully when developing the accreditation criteria. For example, one of the conditions of the contracts with the service providers could be maintaining specified minimum levels of quality. If potential contributors and users of the scheme do not see any measures in place to ensure quality health services, they are very unlikely to 'buy into' SHI.

4.4 Service providers and type of management institution for SHI Fund

The majority of employers and employees prefer a private institution or semi-autonomous institution to manage the SHI Fund, rather than a government institution. It is also clear that stakeholders have very strong sentiments about the possibility of mismanagement of funds and/or corruption. Although the SHI Task Force should not rely entirely on these opinions when choosing the appropriate institution to manage the SHI Fund, they should try to allay the fears of stakeholders by explaining their choice, describing the expertise of this institution and pointing out its advantages over alternative institutions.

When it comes to the choice of service providers, stakeholders prefer a mix of public and private healthcare providers. Indeed, it makes sense to have providers from both public and private sector for various reasons. First, a mix of providers will ensure coverage of services in the country (for those who are insured) because there are health services offered in public facilities that are not offered in private facilities and vice versa. There are parts of the country with only either public or private providers, especially in the rural areas where there are very few private providers. If providers are restricted to either of one the two categories, some of the insured populations will have limited access to health services. Second, allowing both public and private providers will encourage healthy competition that is necessary to ensure high quality services. Hoare and Mills (1986) and Bachmann (1994) argue that if SHI is designed in such a way that health services are only offered by private providers, the quantity and quality of health services offered under SHI are likely to create a two-tier health system with inequitable access to health services.

4.5 Sensitisation as a major contributing factor to SHI acceptance

Results of this study showed that about 60% of the employees have never heard about the proposed SHI policy in Uganda. Similarly, the study found that the majority of the stakeholders did not have full understanding of the SHI policy. Employees and employers reported very little knowledge of the design features SHI scheme and in some instances some had been misguided by media reports that SHI was another tax. Furthermore, this study found a significant relationship between levels of knowledge of SHI and respondents willingness to join SHI. Results show that employees and employers who thought SHI is a good scheme were more likely to join SHI than those who thought SHI was bad. This finding underscores the importance of explicit sensitisation of the different stakeholders, not just about the fact that SHI will be implemented at some point, but about the actual details of the different features of the policy.

Related to the matter of sensitisation is stakeholder consultation and consensus building. This essentially means that stakeholders should not just be presented with the design of the policy when it's finished. No, their views and opinions need to be obtained *and* taken into consideration when refining the current SHI policy. Otherwise apathy and opposition can result. Here is an example of a comment from a stakeholder who has been invited to several SHI workshops conducted by MoH:

> *They just come to tell us about the policy and are not willing to hear our views and contributions about how the policy should be designed. They think they are the only ones with expertise in designing the SHI scheme and are not interested in consulting others. They inform us, they do not consult us.*

4.6 Key elements for successful implementation

Doetinchem et al (2006) argue that it is generally not possible to introduce a social health insurance system without the broad support of the population and political establishment. Major changes in the health sector are often met with resistance from entrenched interest groups. Indeed, this is likely to be the case in Uganda if appropriate consensus is not sought from all key stakeholders. Hsiao and others (2001) recommended at least three years of consultation, sensitisation and education of the public while laws are being reviewed and amended, accompanied at the same time by institutional creation, preparation and capacity building.

Introducing social health insurance is likely to require structural changes. Good governance standards and the ability to steer processes are as important as ensuring that new structures are equipped with the necessary skills and resources to fulfil their new tasks. SHI analysts argue that social health insurances have often started with covering only a part of population and then continuously extended the protection to other regions and societal groups until they reach universal or near universal coverage (in some instances). Doetinchem et al (2006) point out that the degree and the pace of the introduction of a social health insurance depends on the general economic situation of a country and especially the structure of its labour market. Countries, such as Uganda, with a large informal sector are likely to face challenges in the introduction of SHI. The larger the informal sector, the more complex it is to define the amount of contributions and how to collect them. Therefore many countries start by creating SHI for the formal sector first and expand coverage at a later time. Not surprising, a team of consultants in 2001 recommended that the Ugandan government should consider a step-wise implementation of SHI. The team envisaged that SHI would be achieved nationwide for the formal sector between 2011 and 2016. It is therefore not so much the question of whether a population can afford social health insurance but rather whether they are willing to spend on health through the mechanism of SHI.

International literature reveals that it is always a delicate and complex task to introduce SHI in any country. These challenges need to be balanced with advantages, such as flexibility, modularity and a design that is inherently based on solidarity. In order to improve the health status of their populations, different countries can develop and follow their own different pathways.

5. Conclusion and recommendations

5.1 Conclusion

Many employees currently have a private medical scheme (either a health insurance agency or health maintenance organisation), and a similar number of employees have some health benefit arrangement at the workplace to make access to health services easier. For these employees, the cost of services is met by their employers. However, a relatively big proportion of employees still pay out-of-pocket each time they access services.

A reasonable number of employees and employers are willing to join Social Health Insurance (SHI) once it is introduced. This study found that there was a significant relationship between willingness to join SHI (of employees and/or employers) and the following variables:

- employees' previous and current health insurance status;
- employees' and Employers' attitudes and perception of SHI scheme;
- whether or not employees or employers a relatively fuller understanding of SHI; and
- whether or not employees/employers will continue subscribing to PHI when SHI is introduced.

Clearly, the implementation of SHI will potentially have negative implications on private health insurance schemes, mainly because employers are likely to stop contributions to their private schemes once SHI is implemented. However, depending on the final SHI benefit package, there is potential for private insurers to offer 'top-up' insurance for highly specialised services and other services that are likely not to be included in the SHI benefit package.

Key factors that need to be addressed for SHI to gain the acceptance of by employers and employees in Uganda include the following:

- who the providers of services will be;
- the extent of restrictions over their choice of health service providers;
- the quality of services offered by the SHI service providers;
- the size of the benefit package;
- whether or not co-payments will be introduced as part of SHI; and
- what amount will be deducted from employee's salaries, and how much will be contributed by employers.

There is limited understanding of SHI among employees and employers. The most critical issue that needs to be addressed by the SHI Task Force is to ensure appropriate and adequate consultations with various stakeholders, as well as general sensitisation of the public about the specific details of the proposed SHI policy. Without this, the implementation of SHI will face firm resistance from several stakeholders.

5.2 Recommendations

On the basis of the findings of this study, the following recommendations are made to the SHI Task Force in Uganda to help develop and maintain an effective SHI scheme. These recommendations may be most effective in dealing with barriers to the successful implementation of SHI in Uganda:

- Consultation, consensus building and sensitisation must take place with stakeholders and the public.
- Get employees and employers to support the scheme.
- Ensure that management of the SHI Fund is accountable and honest.
- Monitoring the relationship between SHI and existing private health insurance/health maintenance organisations.
- Contain costs under SHI.

We will now consider each of these recommendations more closely and conclude with the implications for further research into SHI in Uganda.

5.2.1 Consultation, consensus building and sensitisation of stakeholders and the public

We highly recommend that the SHI Task Force adopt methods for effective consultation with key stakeholders and the general public, sensitising them to the relevant issues. Some issues to consider here include choosing the appropriate channels for broadcasting public messages about the SHI policy, as well as channels for obtaining contributions/opinions from stakeholders. Importantly, the Task Force will need to demonstrate that they are effectively taking the opinions of different stakeholders into consideration by giving them regular feedback on how their contributions have been incorporated in the policy design. Strong advocacy should be done within the stakeholder groups around how quality of care will be improved and how it will be maintained within the service providers under SHI.

5.2.2 Successful buy-in from employees and employers

To ensure successful buy-in from employees and employers, the following guidelines should be observed:

- Service providers should include both public and private providers.
- The criteria for selection and accreditation of service providers should be made explicit to stakeholders so that the process of accreditation is transparent. One of the criteria for accreditation should be related to some minimum level of quality of care. ‘Quality of care’ needs to be defined in advance. Once the providers have been selected, their contracts should have a clause on ‘quality of services offered to SHI beneficiaries’. Most importantly, the standards on quality of information should be made explicit to potential SHI contributors and other stakeholders.
- We highly recommend that the amount that should be deducted from an employee's salary as a contribution should be calculated by using empirical evidence from an actuarial study conducted with the most up-to-date data on incomes, employment, cost of the benefit package etc. By all means, the percentage should not exceed 5% of an employee's salary for either the employee or his or her employer.
- The SHI benefit package should include out-patient services, in-patient hospitalisation, antenatal care and basic dental service, with some exceptions for certain very expensive treatments and/or conditions. The suggested benefit package must be carefully costed before SHI is implemented.
- No co-payments should be introduced.
- Stakeholders need the Task Force to explain how the health services for the uninsured will be financed and what the potential impact of introducing SHI will be on public health services. We especially need to ensure that the poor, vulnerable and unemployed have adequate health services.

5.2.3 Management of the SHI Fund

Currently, government is proposing an autonomous corporation set up by an act of Parliament, but closely linked to Ministry of Health. On the other hand, most stakeholders prefer some kind of public-private institution (i.e. a private institution that is partially regulated by government). The Task Force needs to consider two key management functions: the collection of funds and the administration of the Fund. Should one firm carry out both functions? Do firms exist that have expertise in one of these functions so that they can essentially take up the role of either collection or administration? If no such firm exists, what is the best administrative structure for the management of the Fund? We highly recommend that a semi-autonomous institution is mandated to manage the Fund.

5.2.4 SHI and existing private health insurance/health maintenance organisations

Currently, the private health insurance industry is poorly regulated and monitored. We recommend that this area is addressed alongside other preparations for the introduction of SHI in Uganda. It is still not clearly stated what the relationship between private health insurers and SHI will be. Since

most ‘insurers’ also double-up as providers, if some of these HMOs are going to be accredited as providers for SHI, we highly recommend that the SHI Task Force explicitly works out how the private ‘insurance activities’ of these HMOs will run alongside the SHI scheme, if the HMOs are going to be providers of services for both groups (i.e. those with private insurance and those with social health insurance).

5.2.5 Cost containment under SHI

It is still not clear how the SHI Task Force proposes to ensure cost containment under SHI. Since we have already recommended that no co-payments should be introduced, we recommend that the Task Force achieve the cost-containment objective by developing appropriate provider re-imbursement mechanisms and designing a package with an estimated cost of delivery that does not exceed the anticipated revenue collections.

5.2.6 Implications for further research

We recommend that more research be conducted on the various aspects of the SHI policy, so that decisions are made on the basis of empirical evidence. Research areas for consideration include:

- the costing of a various components / services of different benefit packages;
- the evaluation of the quality of services in both public and private health facilities;
- the regulation of the private health insurance or pre-payment schemes market; and
- the commissioning of actuarial studies on the feasibility of SHI in Uganda, based on current information.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

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- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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