ISER
Facilitating Social Justice
INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

THE NATIONAL HEALTH INSURANCE BILL, 2019

SUBMISSION TO THE HEALTH COMMITTEE OF PARLIAMENT

20 NOVEMBER 2019

POLICY BRIEF No. 9

Presented by: Allana Kembabazi, Program Manager, Right to Health Program, ISER

Brian Kiira, Program Officer, Right to Health Program, ISER

I. About the Organization

The Initiative for Social and Economic Rights (ISER) welcomes the opportunity provided by the Health Committee to take submissions on the National Health Insurance Scheme (NHIS) Bill, 2019. ISER is a Non- Governmental Organization (NGO) that was established in 2012 to promote the effective understanding, monitoring, implementation, accountability and full realization of social and economic rights. ISER holistically works on social economic rights but in its day to day operations has five programs: the right to health; the right to education, Business and Human Rights, Citizen Participation and Social Accountability; Economic Inclusion and Fiscal Policy. It uses community engagement, research to support system reform, evidence based advocacy, and strategic litigation to realise these rights.

ISER is an ardent advocate for the adoption and use of a human rights based approach to healthcare service delivery and has actively engaged in advocacy for the right to health especially for vulnerable groups including the poor, and Persons with Disabilities (PWDs). ISER's right to health program focuses on universal health coverage and governance and accountability for health, with a particular focus on vulnerable groups and marginalized areas. ISER sits on the country's interministerial committee developing a road map to achieve Universal Health Coverage in Uganda. In 2015, ISER conducted research on national health insurance entitled, "***Getting it Right: Uganda's Proposed National Health Insurance Scheme (2015)"***. ISER conducted consultations with communities in Uganda on the proposed National Health Insurance Scheme, particularly in the North and Central. ISER has worked with the Ministry of Health, Ministry of Gender, Labour and Social Development, Uganda Bureau of Statistics and Equal Opportunities Commission on how to develop criteria to identify the poor and vulnerable for the National Health Insurance Scheme.

II. Brief Overview

Target 3.8 of Goal 3 of the Sustainable Development Goals (SDG) in Agenda 2030 clearly articulates that all countries should provide Universal Health Care (UHC), including financial risk protection by ensuring "access to quality health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." UHC is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying

for the services.

The definition of UHC embodies related objectives;

- Equity in access to health services – everyone who needs services should get them, not only those who can pay for them.
- The quality of health services should be good enough to improve the health of those receiving services.
- Fairness and equity are central considerations in achieving UHC. Fair representation requires primarily expanding coverage for low-income groups; rural populations; other groups disadvantaged in terms of health service coverage.[1] ((WHO, Making Fair Choices on the Path to Universal Health Coverage, 2014 (*hereinafter* WHO 2014)

Although National Health Insurance Schemes are not the only way to achieve UHC and there is no single best path for reforming health financing arrangements, a National Health Insurance Scheme has been hailed as a key tool in the move towards achieving Universal Health Coverage (UHC)[2].

Expanding financial risk protection and social protection through national health insurance is high on the national policy agenda. Uganda's National Health Policy II and Health Sector Development Plan 2015/16 – 2019/20, Health Financing Strategy 2015-2025 focus on accelerating the movement towards UHC by committing to a National Health Insurance Scheme as way to ensure households have equitable access to basic health services and to protect households from the financial risk associated with high out of pocket health care payments. Similarly the Uganda Vision 2040 and National Development Policy II, National Social Protection Policy reiterate the need to establish a National Social Protection System which defines social protection to mean public and private interventions to address risks and vulnerabilities that expose people to high financial risk including affordable national health insurance as one of the seven priority interventions. Uganda

[1] World Health Organisation (WHO) (2014) Making Fair Choices on the Path to Universal Health Coverage.
[2] The World Health Organisation, in its 2010 World Health Report indeed noted that there is no single best path for reforming health financing arrangements to move systems closer to Universal Health Coverage. See also, Joseph Kutzin, *Anything goes on the path to Universal Health Coverage? No*. at https://www.who.int/bulletin/volumes/90/11/12-113654/en/

also made this commitment during the 2005 African Union Health Ministers Meeting: Universal Health Care by 2015, Universal Periodic Review 2011 & 2016.

In Uganda, out of pocket costs for health are 41%, the highest in the East and Southern Africa region, far above the World Health Organisation recommended 15% and resulting in catastrophic expenditures for health.[3] Uganda has a low proportion of people on private health insurance. The Ministry of Health estimates only 1% of the population have private health insurance. [4] According to the Uganda Bureau of Statistics 2016 Uganda Demographic Health Survey, 94% of women and men aged 15-49 years have no coverage.[5] Among this percentage, only 0.7% of women aged 15-49 have privately purchased health insurance, 1.7% of women aged 15-49 have community based health insurance and 3.4% with other employer based insurance. For the men, only 0.8% have private insurance, 1.2% community based health insurance, and 3.3% other forms of insurance. Among the lowest income quintile, 0% of men within this quintile have private insurance compared to 1% in the highest income quintile. [6]

According to the World Health Organisation, countries must advance towards UHC in at least 3 dimensions:

- expand priority services
- include more people
- reduce out-of-pocket payments.

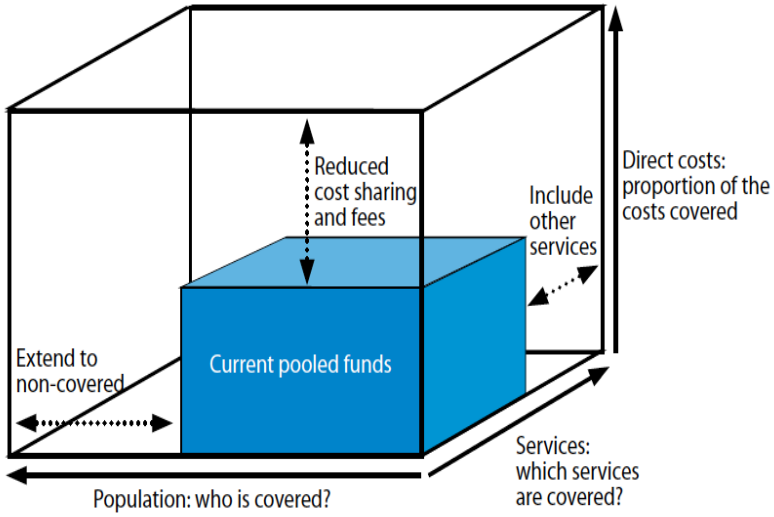
[3] Ministry of Health, Mid Term Review Report for the Health Sector Development Plan 2015/16-2019/20, http://library.health.go.ug/publications/annual-quarterly-performance-reports/mid-term-review-report-health-sector-development

[4] Ministry of Health (2018), Mid Term Review Report for the Health Sector Development Plan 2015/16-2019/20, http://library.health.go.ug/publications/annual-quarterly-performance-reports/mid-term-review-report-health-sector-development

[5] Uganda Bureau of Statistics (2018), Uganda Demographic Health Survey, p.66 https://www.ubos.org/wp-content/uploads/publications/07_2018UDHS_2016_FInal.pdf

[6] Uganda Bureau of Statistics (2018), Uganda Demographic Health Survey, Table 3.9.2, p67 https://www.ubos.org/wp-content/uploads/publications/07_2018UDHS_2016_FInal.pdf,

Figure 1:



Source: WHO, 2014.

III. Policy and Legal Framework for the Right to Health.

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. At a domestic level, Uganda is bound by obligations under the country's legal and policy framework to ensure realization of the right to health. Similarly, Uganda is a signatory to a number of conventions and treaties at both the regional and international level, which guarantee the enjoyment of the highest attainable standard of health. The adoption of the International Covenant on Economic, Social and Cultural Rights (ICESCR) by the United Nations General Assembly in December 1966 was the first formal international recognition of the right to health; with Article 12 compelling signatory states to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," and to ensure "conditions which would assure to all medical service and medical attention in the event of sickness."

The Right to Health has four overarching elements:

- **Availability**: Functioning healthcare facilities must be provided in sufficient quantity. All underlying determinants of health, like safe drinking water, as well as well-trained medical

personnel and well-equipped hospitals and clinics, should be present.

- **Accessibility**: Accessibility involves physical accessibility, economic accessibility, and information accessibility. Accessibility also implies non-discrimination in delivery of health services. Additionally, Article 14 of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) specifically obligates States to ensure that rural women have "access to adequate health care facilities, including information, counseling and services in family planning."
- **Acceptability**: Healthcare facilities, goods and services must respect ethics and the culture of individuals, minorities, and other communities. Healthcare providers must uphold confidentiality and be sensitive to needs of the patient in all aspects.
- **Quality**: Health facilities, goods and services must be scientifically sound and administered by trained medical personnel. Drugs and equipment should be unexpired and functional, and all standards of sanitation should be followed.

Beyond these expected services, governments have immediate obligations in relation to the right to health including providing at minimum certain services including essential primary health care. The government is required to enforce non-discrimination in the exercise of health rights ensuring health facilities, goods and services are accessible to all. Using a rights based approach, ISER will examine the NHIS.

IV. The National Health Insurance Scheme Bill, 2019

The starting point in this analysis is the objective of the bill. Who does it seek to cover? What does it seek to address? The policy rationale for the scheme as indicated in section 1 of this position paper was to reduce out of pocket costs and contribute to strengthening social protection. The scheme, which is hinged on the principle of solidarity and cross subsidization[7] seeks, among other objectives, to develop health insurance as a mechanism for financing healthcare in Uganda; facilitate the provision of efficient, equitable, accessible, affordable and quality healthcare to all residents of Uganda and to ensure quality of healthcare services, equity, appropriate utilization of services and patient satisfaction in the provision of healthcare.[8] It does not explicitly mention social

[7] Meaning that the rich subsidize the poor, the healthy subsidize the sick and the young subsidize the elderly.
[8] Clause 4 of the proposed Bill

protection. The objectives are central since they present the yardstick against which the scheme will be measured. The Bill presents a number of shortcomings which, unless addressed, will leave the country trailing in UHC advancement. These shortcomings are discussed below.

ANALYSIS

1. Overarching Considerations.

1.1. Cover the Poor and Vulnerable from the Onset

Ensuring the coverage of the poor and vulnerable is paramount. The human rights approach, particularly, the principle of equality and non-discrimination, exclude any trade-offs which would result in or exacerbate unequal and discriminatory outcomes, e.g., giving priority to the more affluent parts of society, rather than to the most disadvantaged and marginalized groups. The World Health Organisation's Consultative Group on Equity and Universal Health Coverage, in its guidance to States on national health insurance notes certain trade offs are unacceptable and it is necessary from the onset to expand coverage of high priority services to everyone and to ensure that disadvantaged groups are not left behind. [9] This will often include low income groups and rural populations.[10] Section 2 of the Bill defines the indigents as; poor orphans and other vulnerable children, poor older persons, poor persons with disabilities, poor destitute and poor refugees who are registered as such under section 26. Clause 26 further states that the scheme shall determine and register persons who qualify as indigents. The Bill does not however state when the coverage of indigent persons under the Scheme shall commence; nor does it explicitly state that Government shall cover such indigents.

It is therefore recommended that an independent clause be inserted as clause 27 to read as follows;

Coverage of the indigent.

1) *Government shall provide for benefits cover of all identified indigents.*
2) *The above mentioned cover shall be afforded to all indigents from the onset.*

[9] World Health Organisation (2014), Making fair choices on the path to Universal Health Coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage, https://www.who.int/choice/documents/making_fair_choices/en/ (last accessed 18 November 2019).

[10] World Health Organisation (2014), Making fair choices on the path to Universal Health Coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage, https://www.who.int/choice/documents/making_fair_choices/en/ (last accessed 18 November 2019).

3) *The Scheme shall, as may be prescribed by the regulations made under this Act, determine and register persons who qualify as indigents and notwithstanding anything in this Act, a person registered as an indigent shall have access to the benefits specified in Schedule 1 of this Act."*

Equally, clause 2 on the definition of indigents should be revised as;

'Indigents means orphans and other vulnerable children, poor older persons, persons with disabilities, destitutes and refugees who are registered as such under section 27.'

1.2. Conspicuous absence of Government Contribution to the scheme to subsidise the poor.

Part V of the Bill, which addresses contributions under the scheme makes no mention of whether Government will contribute to the scheme or have any mechanism in place to ensure that the cost of accessing healthcare for the most vulnerable poor is subsidized. To avert the looming prospect of a section of Ugandans being left unattended, the Government should set up a Fund where general revenues (such as those from consumption taxes) are collected to subsidize citizens that cannot afford contribution to the scheme.

Ghana for example has set out a range of sources of money for its National Health Insurance Fund.[11] These not only include contributions by members of the scheme but also an instituted National Health Insurance Levy charged at a rate of two and half on each supply of goods and services made or provided in Ghana, each importation of goods and supply of an imported service.[12] The large pool of resources therefore makes it possible for vulnerable categories of citizens such as children, differently abled persons, persons classified as indigents and older persons to be exempted from making contributions to the Fund.[13]

Similarly, it is recommended that the Government widens the sources of revenue to the scheme by levying a charge on select non-essential goods and services such as cigarettes, and alcoholic beverages to enable subsidization of the most vulnerable. A number of countries have charged what is often considered a sin tax and directed that money towards national health insurance, for

[11] Section 41 of Ghana's National Health Insurance Act, 2012 (Act 852)
[12] Ibid, Section 47
[13] Ibid, Section 29.

example Ghana, the Philippines devote proceeds from a tobacco tax towards national health insurance.

Curbing illicit financial flows and making sure corporations pay their fair share of taxes is also something that should be addressed since doing so would widen the revenue base and ensure government has more sources of revenue to direct towards social services and in this case the National Health Insurance Scheme.

Conclusively, for the scheme to be sustainable, Government contribution should be reflected by revising the Bill and inserting as clause 25 the following;

25. Contribution by Government

(1). Notwithstanding the above sections, for purposes of subsidizing health care under the health insurance scheme, the Government will make contribution towards the fund in the following ways;

(a) Imposition of a national health insurance levy of 2 percent on tobacco and alcoholic beverages and/or any other supplies and goods that the Ministry, in consultation with the Ministry responsible for Finance, may determine.

(b) Monies that are approved for the Fund by Parliament.

1.3. Set out criteria to identify the Vulnerable.

The focus on vulnerable groups is commendable. The Bill however is silent on the criteria to determine who qualifies as an indigent, leaving it to be prescribed by regulations that are yet to be made under the Act.[14] ISER's research and its engagements with the Ministry of Health, Ministry of Gender, Labour and Social Development, Equal Opportunities Commission and Uganda Bureau of Statistics on criteria[15] to identify the poor found that "Poor' is a highly fluid qualifier and the Bill should therefore consider using the word 'vulnerable' instead. Of the existing criteria used by

[14] Under Clause 26 (5)

[15] ISER (2018), Report from Stakeholder dialogue on criteria on Identification of Indigents for the National Health Insurance Scheme, February 2, 2018, Royal Suites Hotel Bugolobi; ISER(2019) Report from Second Stakeholder dialogue on Identification of Indigents for the National Health Insurance Scheme on July 22, 2019, Royal Suites Bugolobi

government to identify the poor, the Equal Opportunities Commission criteria which holistically focuses on vulnerability is the most comprehensive.

1.4. Increased Role Of The Private Sector In Delivery Of Health Necessitates Stronger Regulation

The Bill notes that private health insurers will be providers and will have to meet accreditation requirements. There has been an increasing proliferation of private actors in health in Uganda. Currently private health providers are 49% of the total health providers in the country. The government is yet to put in place adequate regulatory, supervisory and monitoring frameworks for the burgeoning private sector involvement in health. Less than 30% of Public Private Partnership desk units within districts are operational. Research conducted by ISER entitled "Achieving Equity in Health, Are Public Private Partnerships the Solution?" found that the country's inadequate regulation of the burgeoning private sector in health has resulted in discrimination and limited access because services are not affordable particularly for vulnerable groups.[16] It also found other rights violations like failure to provide patient's access to information, limited transparency and fraud, failure to hire qualified staff and issues with data reporting.[17] While the private sector will play an increased role in the delivery of healthcare through national health insurance scheme, the government must put in place adequate regulation. The Government retains stewardship of the health system. It must strengthen the public health system, which still remains first point of call for poor and vulnerable.

In order to curb the threats that come with unregulated private sector involvement in health service delivery, it is advised that the Accreditation Committee be constituted as the Accreditation and Oversight Committee. To this end, clause 39 would be revised to read as follows;

[16] ISER (2019) Achieving Equity in Health: Are Public Private Partnerships the Solution?

[17] Medical Council Speaks Out on Health Insurance Fraud, DAILY MONITOR, Friday November 8,2019, https://www.monitor.co.ug/News/National/Medical-Council-speaks-out-health-insurance-fraud/688334-5341968-9u9g75/index.html
(last accessed 17 November 2019) citing a 2018/19 fraud survey by Insurance Regulatory Authority that found widespread fraud with hospitals submitting fictitious claims and bills to insurance companies for clearance. Some of the facilities include the International Medical Centre, Marie Stopes, AAR Health Services.

*39. **Accreditation and Oversight Committee**.*

1) There shall be a committee of the Board to be known as the accreditation and oversight committee to accredit and undertake continuous monitoring of health care providers of the scheme.

2) The members of the committee shall be appointed by the Board and shall include;

a) two members of the Board one of whom shall be the chairperson of the committee;

b) six other members who shall include a Ministry official, an expert in health insurance, a specialist in health services administration, an expert in health systems management and a representative of the professional health councils and boards, as well as a community representative.

3) Save for the community representative, a person appointed under sub section 2(b) shall have experience of ten years in the relevant field.

4) A member of the committee shall hold office for three years and may be reappointed for one further term.

5) The Committee shall be responsible for ensuring compliance of private health insurance providers with this Act and taking any action incidental to this purpose as shall be prescribed by the regulations under this Act.

6) Notwithstanding any provision in this Act, the existence of this Committee does not negate the state's primary duty to monitor health care providers.

7) The criteria and requirements for accreditation shall be prescribed by regulations made under this Act.

1.5. Provide for a More Comprehensive Benefits Package.

Any bill should have descriptions of priority services people are entitled to and information on how these services will be financed, particularly if out of pocket payments will be incurred.[18] In line with equity, total benefits should be maximized for all people in society.

Although the bill in schedule 1 has a benefits package,[19] it leaves out a number of essential services like palliative care, coverage for diseases that predominantly affect certain groups like the elderly,

[18] World Health Organisation, (2014) Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage.
[19] Schedule 1, of the NHIS Bill

for example cancer. Yet there has been a 38% increase in the number of cancer patients seeking treatment over the last five years.[20] Mental health is not explicitly covered. Yet the Mental Health Act requires that mental health services should be provided at the community level.

The benefits package needs to be comprehensive covering curative, preventative, palliative care, rehabilitative services like mental health. Other countries have shown it is possible to do so. Ghana's benefit package is extensive covering 96% of health problems including female reproductive health.

The certificate of financial implication notes that Ministry of Health will have the discretion to draw up benefits package that will be defined in the scheme and schedule 1 will be regularly reviewed. [21] However, at minimum, a benefit package in line with Uganda's Minimum Health Care Package including palliative, rehabilitative and preventative care services should be defined in the bill.

Clause 26(4) notes that when the cost of healthcare offered exceeds amount prescribed by regulations under the Act, the patient will cover the extra amount. It is not, however, clear on how these costs are determined.

1.6 Non-inclusion of people in the informal sector.

Clause 21 of the Bill provides that all persons who have attained the age of 18 years and are ordinarily resident in Uganda shall be liable to contribute to the scheme. It further qualifies such persons to include persons whose income is derived from salaried employment and persons who derive their income from self-employment.

The Bill does not include the informal sector whose activities are not taxed or monitored by the Government and yet these form the larger part of the economy. The scheme should be adjusted to be all inclusive. It is not clear from the Bill how the informal sector pool will be tapped into. Will the informal sector, for instance be treated as a homogenous group, as the Ministry of Finance, Economic Development Certificate of Financial Implication had implied? The uncertainty that surrounds inclusion of the informal sector if not rectified will impede the accessibility of benefits of the scheme from one class of people. To easily tap into the informal sector, the scheme should

[20] UBOS, Statistical Abstract 2016 at page ix.
[21] Ministry of Finance, Planning and Economic Development, Certificate of Financial Implication at page 3.

be decentralized as is done in Ghana to foster accessibility as well as appreciation of the concept of resource pooling for health. To this end, grass root structures in the form of District Health Insurance Schemes should be established.

The Bill should therefore be revised, inserting as clause 21 (2) (c), the following;

(c) In the case of a contributor whose income is derived from informal employment, such an annual contribution as prescribed by the Board in consultation with the District Health Insurance Scheme.
i) Rules regarding the operation and constitution of the District Health Insurance Schemes shall be prescribed by regulations made under this Act.

1.7 Conspicuous Absence of Nature of Deductions/Contributions.

Clause 21 notes that contributions to the NHIS Fund will be mandatory for those who are above 18 years and ordinarily resident in Uganda. For the formal sector, a deduction will be made from a monthly deduction of the wage by the employer and a contribution by the employer.[22] The self-employed will pay an annual contribution.

The Bill, however, is silent on the nature of contributions, leaving that discretion to the Minister in form of regulations but noting it shall depend on the total income of the person.[23] The Act needs to be clear on the nature of contributions.

The failure to address the contribution in the current bill raises concerns about whether they will be affordable. As ISER had submitted to the Ministry of Health during repeated engagements on the scheme, communities consulted repeatedly raised concerns about the affordability of the contributions/premiums. Before they receive their salary, the average worker has to remit Pay As You Earn 30% deduction, and 5% contribution to the National Social Security Fund. If the premium was for instance 4% as intimated earlier, this would deplete the meager resources left. A more feasible alternative would be to harmonise NHIS deductions with those from the National

[22] Clause 21 & 22.
[23] Clause 21(3).

Social Security Fund like a number of countries have done. This would be an opportune time to reflect on this given the discussions around amending the National Social Security Fund Act.

The certificate of financial implication issued by the Ministry of Finance assumes pensioners will contribute 1% of their salary. The elderly should not be mandated to contribute to the scheme. Pensioners due to their fixed income have been exempted from taxation. Countries like Ghana have exempted pensioners and those above 70 years from contributions.

1.8 Number of dependants to be registered.

The Bill is silent on the number of dependants that will be registered under a contributor. At best, it states under clause 26 (1) that *'Every contributor and a spouse and child of a contributor are entitled to all the health care benefits specified in schedule 1.'* This suggests that there is no cap to the number of children and or spouses a person can have enrolled under their insurance policy as dependants. This should be commended and is alive to the Ugandan family reality where the average number of children born to a woman is close to six (6) according to Uganda DHS 2016 statistics.[24] To limit the number of dependants would exclude and therefore inhibit access to health care.

1.9 Unjustified discrepancy in penalties for default on payment of contribution

The Bill, in clause 22, prescribes a penalty for an employer who fails to make deduction in time or does not remit it, a fine not exceeding fifty currency points. Clause 23, prescribes a penalty equal to two times the amount of the contribution in the case of an employer who fails to make the required contribution on or before the day on which the payment is due. Similarly, clause 24 prescribes a penalty for a self-employed person in case of such default save for the fact that in this instance, the penalty is five times the amount of the person's contribution. Unlike in clause 23 where the penalty is borne by an employer, clause 24 punishes an individual contributor excessively without sufficient clarity on the rationale behind different punishment for the same offence. Lessons can be gotten from Kenya where the penalty imposed on an employer for default

[24] Uganda Bureau of Statistics (2018) Uganda Demographic and Health Survey 2016 p.13; https://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/Uganda_DHS_2016_KIR.pdf: Also see https://www.ubos.org/wp-content/uploads/2019/03/Womens-Day-Brochure-2019.pdf pg. 6

on making a standard contribution is the same as that imposed upon a self-employed person for failing to make their special contribution to the fund.[25]

It is thus recommended that the penalties for default by any contributor should be made uniform in order to avoid resistance from a class of contributors that are bound to feel discriminated by the disparate excessive penalty.

1.10 Invest in Public Sensitization on Benefits of Health Insurance

While the bill sets out clauses, it does not pay adequate attention to sensitization of the public on health insurance, its benefits and provide them with a penalty free enrollment window. Yet there is limited understanding of health insurance. In its latest Demographic Health Survey, the Uganda Bureau of Statistics found only about one quarter (23.5%) of women 15-49 have heard of health insurance with only 7.3% of those in the lower income quintile having any knowledge of health insurance while approximately one third (34.4%) of men aged 15-54 had any knowledge of health insurance and only 13.6% in the lower income quintile. Lessons learnt from other countries conducting health insurance is that intensification of public education on the NHIS is key.[26]

To ensure mass sensitization and increase in awareness of the benefits of health insurance, one of the key roles of the schemes must be to conduct such campaigns. The Bill should therefore be revised, inserting the following after clause 5(d) to read;

'conduct sensitization and awareness campaigns at district level.'

1.11 Strengthen Accountability

The Bill on a positive note contains safe guards and institutional arrangements for accountability that will ensure that the money provided is used efficiently and accounted for correctly.[27] This includes the power of the Board to require a healthcare provider to produce records, documents, reports, inspect premises of a healthcare provider and act upon complaints by beneficiaries and providers.[28] The Scheme will also be subject to the audits of the Office of the Auditor General which shall be presented to Parliament. Provisions on remedial mechanisms in the form of regional

[25] Kenya NHIF, Sections 18 and 19
[26] For example see NDPC (2009) Citizen Assessment Study of Ghana's National Health Insurance Scheme.
[27] Clause 34 and 35
[28] Clause 13

health insurance appeals tribunals[29], audit, [30] Parliamentary scrutiny of audited accounts[31] and acceptable accounting are much lauded and needed for the integrity of the scheme. This is a big positive inclusion especially in the face of the notorious likelihood of corruption. However, Uganda's recent scandals within health insurance particularly around drugs necessitates Uganda pays more attention to governance. Lessons from other countries like Ghana necessitate that we proactively think through how to avoid challenges like delays in reimbursements and over billing when designing the scheme.

1.12 The Scheme will only Work Within Context of Broader Strengthening of Health System

While National Health Insurance Schemes are a critical component of UHC, they are not the silver bullet that will meet that aspiration for the country. The government must continue to invest in the health sector. ISER's research "Are We Failing to Progressively Realise the Right to Health? An Analysis of Health Sector Budget Trends" found current financing levels to the health sector grossly insufficient and for the span of NDP II until 2018, the average budget of the health sector out of the total budget is 6.45%.[32] The need for government to adequately finance the public health sector therefore remains prime.

For example, given that public health facilities will not be subject to accreditation, Government should guarantee that quality healthcare is delivered by public healthcare providers enrolled on the scheme. To do this, public health facilities ought to be adequately financed to meet the required standard.

Clause 37 should therefore be amended, explicitly inserting as clause 37 (2), Government's commitment. The clause will read as follows;

37. Health care providers

(1) All Government hospitals and health centres shall be health care providers under this Act.

[29]Part X of the Bill
[30] Clause 35
[31] Clause 36(2)
[32] ISER (2018) Are We Failing to Progressively Realise the Right to Health? An Analysis of Health Sector Budget Trends", https://www.iser-uganda.org/images/downloads/health_budget.pdf (last accessed 18 November 2019).

(2) Government shall ensure that all Government hospitals and health centres meet the requisite standard to optimally deliver health services under the scheme.

(3) A privately owned health unit and a non-governmental health unit may be a health care provider.

(4) The Board shall prescribe the level of care to be provided by the hospitals, health centres and health units.

(5) The Scheme shall enter into a contract with a health care provider which shall have terms on the pricing, payment mechanisms, design and implementation of the administrative and operating systems and procedures, financing and the delivery of health care services by the health care provider

2.0. Commentary on Overarching Provisions.

Clause	Contents of the Clause	Comment	Proposal
Clause 2 and 26 (5)	Covering the poor and vulnerable (indigents)	The two clauses do not explicitly state whether the indigent will be covered from the onset and by who. This leaves the fate of those most exposed to financial risk uncertain and yet they need the protection most. It is advisable that the Government specifically be marked as duty bound to cover the indigent and that this coverage is to be ensured from the onset.	Clause 26 (5) should be severed and redrafted as a new and independent clause 27 as such; '27. **Coverage of the indigent**. 1) Government shall provide for benefits cover of all identified indigents. 2) The above mentioned cover shall be afforded to all indigents from the onset. 3) The Scheme shall, as may be prescribed by the regulations made under this Act, determine and register persons who qualify as indigents and notwithstanding anything in this Act, a person registered as an indigent shall have access to the benefits specified in Schedule 1 of this Act.'

			By necessary implication, clause 2, which defines indigents, shall be revised to read as follows; 'Indigents means orphans and other vulnerable children, poor older persons, persons with disabilities, destitutes and refugees who are registered as such under section 27.'
Clause 21 / Part V	Contributions and Benefits	Clause 21 does not reflect how contributors in the informal sector will be tapped into and yet these form the largest part of the country's economy. To streamline and increase uptake of individuals in the informal sector, the National Scheme should be decentralized into District Health Insurance Schemes to coordinate, operate and mobilize the informal sector easily at the grass root level. Ensuring proximity of the scheme to communities as is in Rwanda and Ghana will help foster community participation and mobilization for health, thereby	It is therefore advised that clause 21 be revised, inserting as clause 21 (2) (c), the following; (c) In the case of a contributor whose income is derived from informal employment, such an annual contribution as prescribed by the Board in consultation with the District Health Insurance Schemes. i) Rules regarding the operation and constitution of the District Health Insurance Schemes shall be prescribed by regulations made under this Act.

		empowering communities in health as well as heightening their involvement in decisions affecting their own health. These district schemes would operate closely under the supervision of the regional health insurance offices. Part V does not provide for any deliberate government contribution to the scheme. Part V should be revised to add Government contribution. This can be done through imposition of a national health insurance levy on goods and supplies that are considered hazardous to health and any other goods as may be determined. Additionally, Parliament can ear mark funds for the scheme as is done by Ghana. To increase the pool of funds –which in effect increases the scope of coverage and aids subsidization - it is advised that Government contribution	Insert as Clause 25 under the title **'Contribution by Government'** the following; 25 (1). Notwithstanding the above sections, for purposes of subsidizing health care under the health insurance scheme, the Government will make contribution towards the fund in the following ways; (c) Imposition of a national health insurance levy of 2 percent on tobacco and alcoholic beverages and/or any other supplies and goods that the Ministry, in consultation with the Ministry responsible for Finance, may determine. (d) Monies that are approved for the Fund by Parliament.

		be explicitly reflected in the Bill.	
Part VII – Health Care Providers	The Part addresses concerns of heath care providers as well as accreditation and monitoring of private health care providers.	It is to be noted that whereas private health facilities are to be subjected to accreditation, Government facilities are not. This therefore calls for the need for Government to ensure that its facilities meet such standards as are required to operate under the scheme. To this end, an explicit commitment ought to be inserted in the Bill as clause 37 (2). In as much as the Bill gives lee way to the Board to constitute committees under clause 15 for purposes of executing Board functions, there is need to specifically constitute an oversight committee to ensure proper monitoring and regulation of private health insurance care providers. Although Clause 40 obliges healthcare providers to have in place programmes that	Clause 37 should be revised, inserting Government's commitment to ensure that public health facilities meet the required standards, to read as follows; '**37. Health care providers** (1) All Government hospitals and health centres shall be health care providers under this Act. (2) Government shall ensure that all Government hospitals and health centres meet the requisite standard to optimally deliver health services under the scheme. (3) A privately owned health unit and a non-governmental health unit may be a health care provider. (4) The Board shall prescribe the level of care to be provided by the hospitals, health centres and health units. (5) The Scheme shall enter into a contract with a health

		ensure quality assurance and monitoring of utilization of health care services, self-regulation will not suffice. Clause 39 should be revised and the Accreditation Committee be reconstituted as the **'Accreditation and Oversight Committee'** to perform the duty of accreditation as well as continuous external monitoring of the healthcare providers. This committee would be akin to Ghana's Private Health Insurance Oversight Committee	care provider which shall have terms on the pricing, payment mechanisms, design and implementation of the administrative and operating systems and procedures, financing and the delivery of health care services by the health care provider.' It is further recommended that clause 39 be drafted as below; 39. **Accreditation and Oversight Committee**. 1) There shall be a committee of the Board to be known as the accreditation and oversight committee to accredit and undertake continuous monitoring of health care providers of the scheme. 2) The members of the committee shall be appointed by the Board and shall include; a) two members of the Board one of whom shall be the chairperson of the committee;

			b) six other members who shall include a Ministry official, an expert in health insurance, a specialist in health services administration, an expert in health systems management and a representative of the professional health councils and boards, as well as a community representative. 3) Save for the community representative, a person appointed under sub section 2(b) shall have experience of ten years in the relevant field. 4) A member of the committee shall hold office for three years and may be reappointed for one further term. 5) The Committee shall be responsible for ensuring compliance of private health insurance providers with this Act and taking any action incidental to this purpose as shall be prescribed by the regulations under this Act. 6) Notwithstanding any provision in this Act, the

			existence of this Committee does not negate the state's primary duty to monitor health care providers. 7) The criteria and requirements for accreditation shall be prescribed by regulations made under this Act.
Commentary on Specific Provisions.			
Clause 2: Definition of a child.	A child, in relevant part, is defined to mean a child of a contributor who – (b) having attained the age of eighteen years – i) has no income of his or her own and is living with the contributor; (ii) is a person with a disability who is wholly dependent on and living with the contributor.	Clause 2(b) (i) is too indefinite in as far as it suggests that any child who is above eighteen but has no source of income and is living with the contributor should be considered a child. There should be an age cap lest even thirty year olds with no income and still residing with their parents be categorised as children. The Kenyan example can be adopted wherein a similar provision qualifies a child as one 'having attained the age of eighteen, but not the age of twenty one years has no income of his own and is living with the contributor.'	The clause should be drafted to read; 'Child means a child of a contributor including a posthumous child, a step child, an adopted child and any child to whom the contributor stands in loco parentis, who – a) Has not attained the age of eighteen; or b) Having attained the age of eighteen but not the age of twenty one years has no income of his own and is living with the contributor c) Is undergoing a full time course of education or other type of qualification in

		Further, clause 2(b)(ii) defines a child as a person with a disability. The qualification of a child as a person with a disability is outright unnecessary and should be struck out. Also generally, the entire clause's definition of a child is not alive to the reality of Uganda's family context where families are largely extended and blended in nature and usually include children of other relatives (that may be dead or unable to effectively take care of these children) who may not necessarily be legally adopted but rather under de facto guardianship.	a trade or profession and is not in receipt of any income other than a scholarship, bursary or other similar grant or award.
Clause 5: Functions of the Scheme	It lists the roles to be played by the Scheme	The clause omits the critical role of sensitization and awareness among citizens to increase uptake by the masses. Leaving this duty to the discretion of the scheme officials under the guise of clause 5(e) which empowers the scheme to perform any	It is recommended that the following be inserted after clause 5(d) to read; 'conduct sensitization and awareness campaigns at district level.'

		other necessary function is too vague to foster compliance.	
Clause 8: Board of Directors	Defines who can be on the board of the NHIS	While it commendably includes members from different sectors like medical professional, insurance experts, people with experience in entrepreneurship, accountant/economist, advocate, social worker, it lacks representation from the health consumer perspective.	It is advised that clause 8 be revised to read, in relevant part, as clause 8 (2) (j) and (k); 8 (2) The Board of Directors shall comprise eleven members who shall include; ….. (j) a community representative (k) a representative from the local government.
Clause 25: Identification Card	Issuance of Identification card for verification while accessing health services under the scheme	The clause does not disclose recourse in instances where a contributor loses the identification card. Instead, it absurdly states in clause 25(3) that one cannot access benefits under the scheme without the issued card. What then happens in instance that a contributor has lost his card pending re-issuance? The Ghana experience may be adopted where one can not only apply for replacement of a card, but also latitude is	Advisedly, the clause should be redrafted, striking out clause 25(3) and replacing it as follows; 3) in the event of loss, the card shall be replaced on payment of a prescribed fee. 4) Notwithstanding any other provision in this Act, the Board will accept the use of a National Identity Card or any other identity card authorized under an enactment to be used

		given for usage of any other authorized identity card – which in Uganda's case can be the National Identity Card	for all purposes of identification in the country.
Clause 26: Benefits under the Scheme.	26 (1): Every contributor and a spouse and a child of a contributor are entitled to all the health care benefits specified in Schedule 1.	Information regarding a contributor's benefits is only to be found in the law. This inhibits access to information and may foster abuse due to ignorance. More so, the contributor's rights/obligations at the point of enjoyment of these benefits are not made known. Uganda should take lessons from Ghana[33] and issue a booklet containing membership rights, obligations and privileges; a list of healthcare benefits available under the scheme; and a list of accredited health care providers/facilities.	It's recommended that the clause be revised to insert, after clause 26(1), the following provision; '26(2) In addition, upon issuance of an identification card, the contributor will be issued with the following materials; a) a booklet containing membership rights, obligations and privileges b) a list of the healthcare benefits available under the scheme, and c) a list of accredited health facilities.'
Clause 29	Advance to a healthcare provider. The Board when satisfied that a healthcare	What are the safeguards in place to ensure this is the best use of the board's money?	The clause should be drafted to include safeguards by

[33] Section 95 National Health Insurance Act, 2012 of Ghana. Notwithstanding the fact that this provision is made regarding operation of private health insurance schemes in Ghana, it is important that information flow in the scheme is seamless.

	provider located in an underserved area is financially viable may advance money to the healthcare service provider to improve the facilities. The Minister will prescribe underserved areas through regulations.		including consultation with the Ministry of Health. "29(1) The Board, in consultation with the Minister, shall, where it is satisfied that a health care provider located in an underserved area, is financially viable, advance money to the health care service provider, for the improvement of the health care facilities and services of the health care provider."
Clause 36(2),(3)	Minister shall "lay the annual report of the scheme together with the audited accounts of the scheme before Parliament" and "every three years present to Parliament, the actuarial valuation of the Scheme."	Parliament should be more involved from a governance perspective. It is not clear from the phrasing if the annual report of scheme and audited accounts are reviewed by Parliament every year. The clause is open ended. The Minister should present the annual report and audited report to Parliament annually in addition to presenting actuarial valuation of the scheme every three years	Clause 36 (2) should be drafted to read; "The Minister shall lay the annual report of the Scheme together with the audited accounts of the Scheme before Parliament for review every year."
Clause 42(3)	Prescribes what regional health insurance offices do	While it explicitly states the regional health insurance	Before (b) explicitly state that;

		office shall receive contributions, they should also be involved in sensitization on importance of health insurance, and be involved in periodic monitoring of service providers	"regional health insurance offices will conduct sensitization and be involved in periodic monitoring of providers."

3.0 Conclusion

The National Health Insurance Bill is undoubtedly a positive step towards the realization of the right to the highest attainable standard of physical and mental health and is timely as the country aspires to achieve UHC and is in the process of designing its UHC roadmap. However, in order to effectively and meaningfully realize the noble UHC aspirations, particularly to ensure everyone can receive healthcare regardless of ability to pay, ISER urges this Committee to ensure the Scheme is well designed, prioritizes the vulnerable, is sustainable and regulates private actors/providers of health to avoid detrimental effects on the right to health. ISER appreciates the opportunity to contribute to the dialogue underway to bring those concerns to the fore and looks forward to participating in the continuing exchanges.

About the Initiative for Social and Economic Rights

ISER is a registered Non-Governmental Organization (NGO) in Uganda founded in February 2012 to ensure full recognition, accountability and realization of social and economic rights primarily in Uganda but also within the East African Region.

Initiative for Social and Economic Rights

Plot 60, Valley Drive, Ministers' Village, Ntinda

P.O Box 73646, Kampala- Uganda

Email: info@iser-uganda.org Tel: +256 414 581 041

Website: www.iser-uganda.org

Follow us on: Twitter @ISERUganda

Facebook @ISERUganda