

What are the effective options to finance Private Not For Profit Health Units in Uganda?

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Key messages

Private Not For Profit health facilities (PNFP) provide care to a significant proportion of Ugandans. However, there are uncertainties about the better strategies to finance PNFPs by the Government of Uganda. This paper reviews the research evidence on this subject.

- The research evidence identified effects of four strategies of health financing (a) user fees, (b) pay for performance, (c) health insurance and (d) conditional cash transfers.
 - These interventions are not restricted to only PNFPs
- User fees generally caused a reduction in utilization of health services
- Performance Based Funding has inconsistent effects depending on the intervention and context.
- Rural (Community) Health Insurance may reduce sickness or injury or catastrophic health expenditure.



SURE
Supporting the Use of Research Evidence



Who requested this rapid response?

This document was prepared in response to a specific question from a decision maker in the Ministry of Health, Uganda.

! This rapid response includes:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in financing Private Not For Profit health facilities in Uganda.

X Not included:

- Recommendations
- Detailed descriptions

What is SURE Rapid Response?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems – is a collaborative project that builds on and supports the Evidence-Informed Policy Network (**EVIPNet**) in Africa and the Regional East African Community Health (**REACH**) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.

www.evipnet.org/sure

Glossary

of terms used in this report:

www.evipnet.org/sure/rr/glossary

Background

Private Not For Profit health facilities (PNFP) constitute nearly 40% of all health facilities in Uganda [1]. The Government of Uganda through its Ministry of Health has been supporting PNFPs including directly financing a proportion of their annual budgets. However, there are uncertainties about the better strategies to finance PNFPs in Uganda. This rapid response summarises the current research evidence from high quality systematic reviews on financial arrangements for health interventions except conditional cash transfers.

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

What the quality of evidence (GRADE) means

The quality of the evidence is a judgement about the extent to which we can be confident that the findings of the research are correct. These judgements are made using the GRADE framework, and are provided for each outcome. The judgements are based on the type of study design (randomised trials versus observational studies), the risk of bias, the consistency of the results across studies, and the precision of the overall findings across studies. For each outcome, the quality of the evidence is rated as high, moderate, low or very low using the definitions below.

⊕⊕⊕⊕

High: We are confident that the true effect lies close to what was found in the research.

⊕⊕⊕○

Moderate: The true effect is likely to be close to what was found, but there is a possibility that it is substantially different.

⊕⊕○○

Low: The true effect may be substantially different from what was found.

⊕○○○

Very low: We are very uncertain about the effect.

For more information about GRADE:

www.evipnet.org/sure

What we found from the research evidence

We found a total of 15 systematic reviews and one overview of reviews addressing; user fees [2]; pay for performance [3-8]; health insurance [9-13] and conditional cash transfers. This paper does not address conditional cash transfers [14].

A: USER FEES:

1. The evidence suggests that introducing or increasing user fees generally results in a reduction in the utilization of preventive and curative health services.

- There were 8 total studies which examined the impact of introducing or increasing user fees on preventive (2 studies) or curative (4 studies) health services.
- However, these studies were observational and of very low quality evidence.

User fees generally caused a reduction in utilization of health services

Population: Anyone using any type of health service in low- and middle-income countries

Settings: Burkina Faso, Kenya, Lesotho, Papua New Guinea.

Intervention: Introducing or increasing user fees

Comparison: No fees.

Outcomes	Impact: Relative change in utilization of health services	Number of studies	Quality of the evidence (GRADE)
Health Utilization – preventive care	A reduction of -15.4% immediately A reduction of -17% after 12 months. The two studies reported a drop in utilization of Ante-Natal Care and deworming drugs	2	⊕○○○ Very Low
Health Utilization – curative care	A reduction of -28% to -51% immediately A reduction of -9% to +8% after 12 months 4 out of 6 studies reported a reduction in OPD visits 2 out of 6 studies reported an increase in utilization. In these 2 studies, the introduction of user fees were accompanied with quality improvement of services.	6	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

2. The evidence suggests that removing user fees generally increases the utilization of preventive and curative health services.

- There were 8 total studies which examined the impact of removing user fees on preventive (3 studies) or curative (5 studies) health services.
- Noteworthy, these studies were observational and of very low quality evidence.

Removing user fees generally caused an increase in the utilization of health services

Population: Anyone using any type of health service in low- and middle-income countries

Settings: Kenya, South Africa, Uganda

Intervention: Removing user fees

Comparison: Previous user fees

Outcomes	Impact: Relative change in utilization of health services	Number of studies	Quality of the evidence (GRADE)
Health Utilization – preventive care	+1.3% to +249% immediately +5% to +92% after 12 months Findings not statistically significant	3	⊕○○○ Very Low
Health Utilization – curative care	+30% to +50% immediately +18% to +93% after 12 months Findings not statistically significant	5	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

3. The evidence suggests that decreasing user fees generally increases the utilization of preventive and curative health services.

- There were 2 total studies which examined the impact of removing user fees on preventive or curative health services.
- Noteworthy, these studies were observational and of very low quality evidence.

Decreasing user fees generally caused an exponential increase in utilization of health services

Population: Anyone using any type of health service in low- and middle-income countries

Settings: Colombia, Sudan

Intervention: Decreasing user fees

Comparison: Previous user fees

Outcomes	Impact: Relative change in utilization of health services	Number of studies	Quality of the evidence (GRADE)
Health Utilization – preventive and curative care	Number of children seen increased by 1% to 190% Number of pregnant women seen increased by +20% to +118% Number of new IUD users per month increased by +106% to +161%	2	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

B: PAY FOR PERFORMANCE:

4. The current research evidence on pay for performance is inconclusive.

- It is not clear if performance based financing increases or reduces health service utilisation and depends on the intervention (e.g. who receives payments, the magnitude of the incentives, the targets and how they are measured), additional funding, technical support, and organisational context in which it is implemented.

Performance Based Funding has inconsistent effects depending on the intervention and context

Population: Providers of healthcare services in low- and middle-income countries

Settings: Vietnam, China, Uganda, Rwanda, Tanzania, Democratic Republic of Congo, Burundi, Philippines

Intervention: Performance-based financing (PBF)

Comparison: No performance-based financing (PBF)

Outcomes	Impact: Change in utilization of health services	Number of studies	Quality of the evidence (GRADE)
Provider performance (quality of care)	1 study showed a small or no impact on tuberculosis case detection. 4 studies measured coverage of tetanus vaccinations among pregnant women, was inconclusive.	5	⊕○○○ Very Low
Ante-Natal Care	Immunization rates either reduced or increased across the 4 studies.	2	⊕○○○ Very Low
Institutional deliveries	Results are inconsistent with substantially larger increases without PBF, to a 2-fold increase with PBF.	4	⊕○○○ Very Low
Preventive care for children, including vaccination	Attendance for children's preventive services doubled. Immunization rates either reduced or increased across the 4 studies.	4	⊕○○○ Very Low
Number of Out-Patients	Out Patient Department visits may increase due to PBF. The evidence is inconsistent.	4	⊕○○○ Very Low
Patient outcomes	Evidence inconsistent on rates of wasting; self-reported general health; CRP levels; anemia.	1	⊕○○○ Very Low
Unintended effects	Curative services may squeeze out preventive care.	2	⊕○○○ Very Low
Resource use	PBF increases facility revenues & staff pay. PBF impact on wider resource use indicators e.g. other funding sources, patient payments & efficiency of service provision are not yet established.	8	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

C: HEALTH INSURANCE:

5. The current research evidence on Social (National and Community) Health Insurance in Low and Middle Income Countries is ambivalent.

- There is wide variation in enrolment into health insurance schemes ranging from as low as 3% to nearly 100%.
- The evidence suggests a general increase in utilization of health services.
- The evidence suggests a general decrease in out of pocket expenditure.
- Very few studies suggested better health outcomes.

Social Health Insurance may increase health service utilization and reduction in out-of-pocket expenditure

Population: Providers of healthcare services in low- and middle-income countries

Settings: India, Indonesia, Egypt, Georgia, Nicaragua, Colombia, Mexico, Costa Rica, the Philippines, Ghana, Egypt, China and Vietnam.

Intervention: Social Health Insurance (Community Based or National). Premium was either “completely free” or co-payment or subsidised by the National Government.

Comparison: No Social Health Insurance (Community Based or National).

Outcomes	Impact:	Number of studies	Quality of the evidence (GRADE)
Enrollment into the insurance scheme	Enrollment mostly ranged from as low as 3.5% for CHI up to 96% for the NCMS of China. Enrollment influenced by higher level of education and correlated with households with higher per capita expenditure.	9	⊕○○○ Very Low
Utilization of health services	Increased in 18 out of 28 studies. Increase varied in type of service: outpatient, inpatient, laboratory tests etc. No effect in 6 out of 28 studies. Increased among the poorest in 7 of 13 studies.	28	⊕⊕○○ Low (2 RCTs)
Out-of-pocket expenditure	Reduced in 16 out of 28 studies. This varied in terms of actual decrease or increased protection. Reduced among the poorest in 7 of 13 studies.	28	⊕⊕○○ Low (2 RCTs)
Health outcome	Better health outcomes in 3 out of 5 studies - Higher rate of control of diabetes among the insured - Lower levels of infant deaths - Fewer birth complications at delivery	5	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

6. The current research evidence on a Rural (community) Health Insurance scheme in China is inconclusive.

- In 2011, the New Cooperative Medical Scheme (NCMS) covered more than 96% of the rural population in China.
- There is no clear evidence that NCMS improves the health outcomes or decreases the alleviating catastrophic health expenditure of the China's rural population.
- Noteworthy, this evidence is of very low quality from 12 observational studies done in China.

Rural Health Insurance may reduce sickness or injury or catastrophic health expenditure

Population: Providers of healthcare services in low- and middle-income countries
Settings: China.
Intervention: “New Cooperative Medical Scheme” (NCMS)
Comparison: No “New Cooperative Medical Scheme” (NCMS)

Outcomes	Impact:	Number of studies	Quality of the evidence (GRADE)
Sickness or injury in the past 2 – 4 weeks	Reduced sickness or injury in 8 out of 10 studies with NCMS compared to without NCMS. No difference with NCMS compared to without NCMS in 2 out of 10 studies.	10	⊕○○○ Very Low
Self-reported health	No significant effect on self-reported health in 2 out of 5 studies.	5	⊕○○○ Very Low
Catastrophic health expenditure	NCMS reduces incidence of catastrophic household expenditure in 2 out of 4 studies. NCMS increases incidence of catastrophic household expenditure in 2 out of 4 studies. NCMS showed no effect on incidence of catastrophic household expenditure in 1 out of 4 studies.	4	⊕○○○ Very Low

GRADE Working Group grades of evidence (see bar on the right)

Relevance of the research to the question being asked

→ Findings

▷ Interpretation*

APPLICABILITY

→ **Studies on health financing were conducted in LMICs similar to Uganda.**

▷ *Findings apply to Uganda, a low income country. However, mobilisation of resources and the masses to embrace interventions such as health insurance is required.*
▷ *With widespread poverty, PNFPs abolishing user fees may go a long way in increasing health service utilisation. However, for purposes of sustainability the GoU could compensate PNFPs through subsidies and direct funding.*

EQUITY

→ **The evidence addresses inequity of health financing, catastrophic health expenditure & user fees.**

▷ *Health insurance may alleviate catastrophic health expenditure among the poorest persons. Whilst removal of user fees increases health service utilisation, and the poorest persons are likely to benefit most. There is no reason to believe otherwise in Uganda.*

COST CONSIDERATIONS

→ **The evidence provided information about costs for health insurance schemes and user fees**

▷ *Indeed health insurance requires payment of premium fees by the end users. This may be shared by government and or employers subsidising the premium fees particularly for the lower income brackets.*

MONITORING & EVALUATION

→ **Evidence on health financing strategies is of low quality. There are not many robust randomised designed studies.**

▷ *The existing financing strategies in Uganda should be systematically monitored to generate operations data for decision making. There is need for more feasibility studies in Uganda, for example health insurance interventions. And synthesis of evidence from local Ugandan studies.*

*Judgements made by the authors of this response based on the findings of the research and consultation with others (see acknowledgements). For additional details about how these judgements were made see: www.evipnet.org/sure

About the research underlying this Response

Types of	What we searched for	What we found
Interventions	Health Financing, Performance Based Funding, Budget Support, Health Insurance, User Fees	Health Financing, Paying for Performance, Paying for results, Conditional Cash Transfer, Social or National or Community Health Insurance, User Fees,
Participants	Private Not For Profit Health Facilities	Public Health Facilities, General Population
Settings	Low and Middle Income Countries	Low and Middle Income Countries
Outcomes	Health outcomes, Health services utilisation, Health expenditure	Health service utilisation, Catastrophic health expenditure, Enrolment, Self-reported health
Research	Systematic reviews of CRTs, RCTs, CBAs, and observational studies	Systematic reviews of CRTs, RCTs, CBAs, and observational studies

Date of most recent search: August 2013 in PDQ Evidence, PubMed and the Cochrane Library.

Limitations: Few well designed studies to provide robust data on health outcomes at population level.

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collaborators:



The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.

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Conflicts of interest

None known.

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