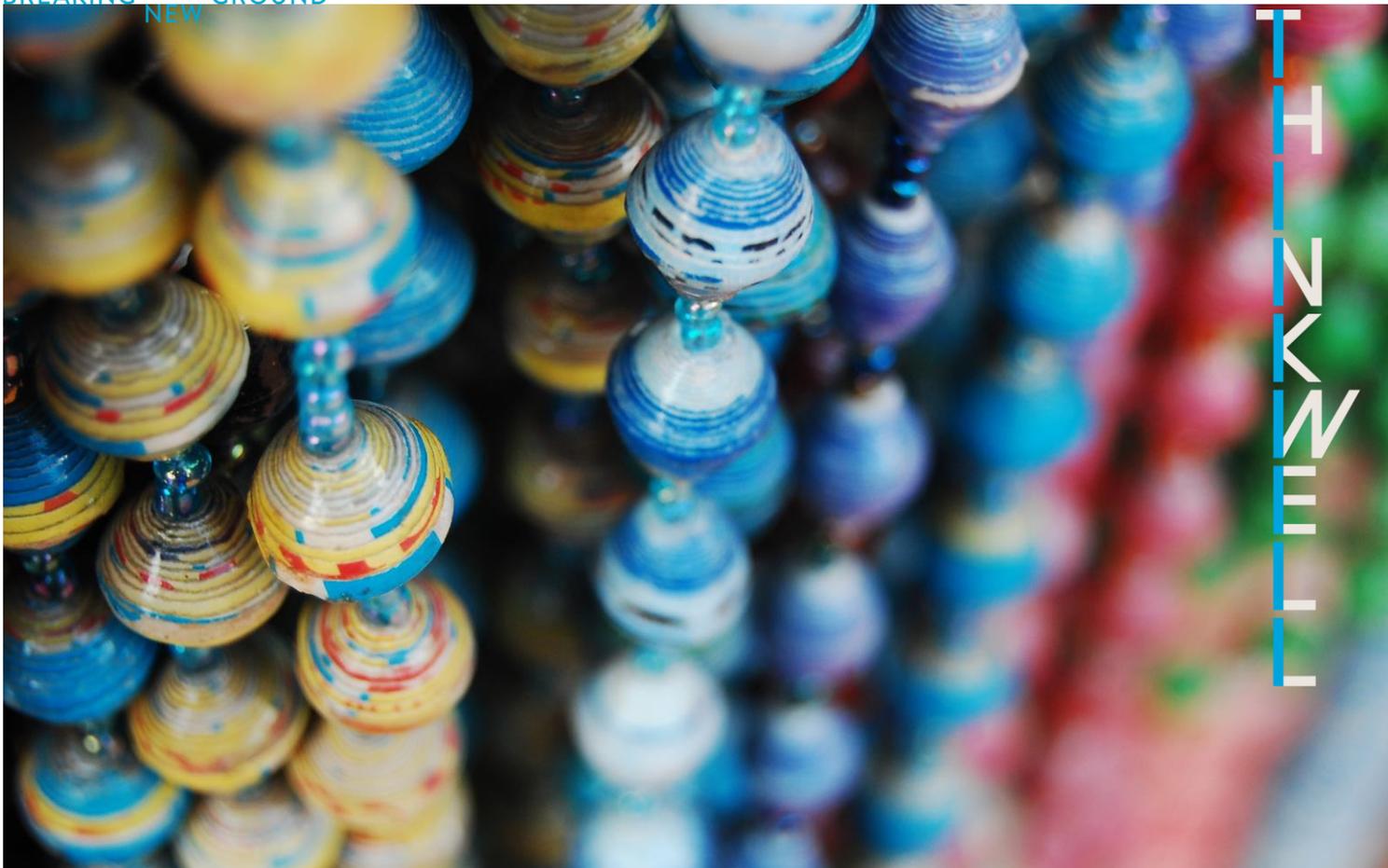


How Primary Health Care Services Are Financed in Uganda: A Review of the Purchasing Landscape

September 2020

BREAKING NEW GROUND



THINKWELL

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TABLE OF CONTENTS

Acknowledgments	2
Abbreviations	4
Executive Summary	6
Who purchases health services, and from whom?	6
What mechanisms are used to purchase services?	6
What services are purchased?	7
Conclusion	7
I. Introduction	9
II. Methodology	10
III. Analysis of health service purchasing	10
Who purchases health services, and from whom?	10
What mechanisms are used to purchase services?	14
What services are purchased?	20
IV. Conclusion	21
References	24
Annex A: Summary of key policies	26

ABBREVIATIONS

BMGF	Bill & Melinda Gates Foundation
BOU	Bank of Uganda
CAO	chief administrative officer
CBHI	community-based health insurance
CHE	current health expenditure
D/MHO	district/municipal health office
DPHSE	Directorate of Public Health Services and Environment (KCCA)
EMHS	essential medicines and health supplies
FP	family planning
GAVI	Global Vaccine Alliance
GoU	Government of Uganda
HC	health center
HDP	health development partner
HFS	health financing strategy
IPF	indicative planning figure
KCCA	Kampala Capital City Authority
MNCH	maternal, newborn, and child health
MOFPED	Ministry of Finance, Planning, and Economic Development
MOH	Ministry of Health
MOPS	Ministry of Public Service
NHA	national health accounts
NHIS	National Health Insurance Scheme
NMS	national medical stores
PBB	program-based budgeting
PBF	performance-based financing
PHC	primary health care
PHP	private health provider
PNFO	private not-for-profit

RAF	resource allocation formula
RBF	results-based financing
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
SP4PHC	Strategic Purchasing for Primary Health Care
UgIFT	Uganda Intergovernmental Fiscal Transfers Program
UHC	universal health coverage
UNICEF	United Nations Children’s Fund
UNMHCP	Uganda National Minimum Health Care Package
URMCHIP	Uganda Reproductive, Maternal, and Child Health Improvement Program
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Purchasing, in the context of health systems, refers to the allocation of pooled funds to providers of services on behalf of a population. *The World Health Report 2000* pushed forward the idea that countries should move beyond passive purchasing, where the purchaser follows a predetermined budget or simply pays bills. Instead, more strategic forms of purchasing are more appropriate, where the purchaser continuously searches for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom (World Health Assembly 53 2000).

As part of the Strategic Purchasing for Primary Health Care (SP4PHC) project, ThinkWell undertook a landscaping exercise to explore and document health purchasing policies and practices in Uganda. The team conducted a detailed desk review and interviewed key informants to answer the following questions: Who purchases health services, and from whom? What mechanisms are used to purchase services? What services are purchased? Insights from this review are informing the project's ongoing work to support strategic purchasing reforms in the country.

WHO PURCHASES HEALTH SERVICES, AND FROM WHOM?

The Ministry of Health (MOH) coordinates the purchase of publicly funded health services through central and decentralized government institutions that collectively oversee 15.7% of current health expenditures (CHE) in the country (Ministry of Health Uganda 2017). As a steward of the health sector, the MOH oversees many of the purchasing decisions at the central level through the annual work planning, resource allocation, and budgeting process. The design of Uganda's decentralized governance structure delegates health system management authority to local district and municipal governments, but they enjoy limited decision-making autonomy in practice. Many of the key purchasing and resource allocation decisions remain central government functions that, when combined with inadequate budgets, limit the ability at the local level to respond to local needs and priorities. A notable exception is Kampala, where the city's government has a greater autonomous purchasing role with public and select faith-based private not-for-profit (PNFP) facilities, which are very few among the city's vast numbers of private health provider (PHP) facilities.

Health development partners (HDPs) are a diverse group of nongovernment purchasers that play a substantial external financing role in Uganda, accounting for 41.7% of CHE (Ministry of Health Uganda 2017). Only an estimated 21% of HDP funds are coordinated on-budget with government purchasing mechanisms through the annual budgeting process (Ministry of Health Uganda and UNICEF 2020). The disproportionate purchasing power of HDPs often flows directly to district or municipal health offices (D/MHOs) and/or their facilities, which undermines the ability of the MOH to fulfill their stewardship role.

WHAT MECHANISMS ARE USED TO PURCHASE SERVICES?

Government of Uganda (GOU) mechanisms for the purchase of health services are input-based and driven by an annual planning process coordinated by the MOH. Largely driven through the allocation of PHC grants to decentralized local governments, the MOH coordinates planning of financing for human resources, essential medicines and health supplies (EMHS), and operational costs of service delivery in public and selected faith-based PNFP facilities that provide PHC services. The MOH uses resource allocation formulas (RAFs) for a portion of district and facility operations as well as development

funding¹ shifting from historical precedents toward a data-driven approach to improve horizontal equity across districts.

The GOU's purchasing mechanisms do not currently engage PHP facilities. In the mixed health system of Uganda an estimated 40.3% of facilities nationwide are PHP owned (Ministry of Health Uganda 2018a). In the urban areas of Kampala, PHPs are an estimated 96% of all service providers in the city. However, under current purchasing arrangements, neither the MOH nor local governments have mechanisms to purchase services using public funds from these providers to increase access to high-priority PHC services.

With support from HDPs, the MOH has tested alternative approaches to purchasing.

These approaches, both demand- and supply-side initiatives, fall into three categories: performance-based financing (PBF), vouchers for reproductive health services, and community-based health insurance (CBHI) initiatives. Particularly with national scale implementation of PBF and large-scale voucher programs that covered approximately half of the country, a wealth of relevant experience and evidence has been generated that can inform integration of these approaches with government systems and processes. Under the GOU and donor-supported Uganda Intergovernmental Fiscal Transfer (UgIFT) program, PHC grants are being increased and there are current efforts to reform the program to include PBF mechanisms.

Uganda has debated establishing a national health insurance scheme (NHIS) for nearly two decades, but the necessary legislative frameworks have yet to be passed. Cabinet approved a draft bill in June 2019 that then was before Parliament for debate. However in early 2020, the President directed MOH to withdraw the legislation and revisit key features of the scheme, including contribution rates and coverage for the poor.

WHAT SERVICES ARE PURCHASED?

The MOH established the Uganda National Minimum Health Care Package (UNMHCP) in 1999, which has served as a reference to services purchased by government. The UNMHCP is the basis of service delivery definitions and standards in the public sector, both in the purchase of services from PNFP facilities and in ongoing efforts to apply these standards to PHP facilities. However, underfunding of the health sector and health system inefficiencies have resulted in many service availability gaps in public facilities. This has spurred the growth of the private sector and, in turn, increased out-of-pocket spending, which accounts for 42.6% of CHE (Ministry of Health Uganda 2017). Out of need for prioritization and pursuit of their development assistance agendas, HDPs have supported narrowly defined portions of the UNMHCP in the three purchasing mechanisms mentioned above. These three mechanisms focus on Uganda's most pressing public health priorities, principally reproductive, maternal, neonatal, and child health services as well as substantial support for the procurement of EMHS, particularly for service provision under vertical programs such as HIV/AIDS, malaria, and tuberculosis.

CONCLUSION

While Uganda's health financing strategy for achieving universal health coverage (UHC) embraces the idea of strategic purchasing, a roadmap for how the country will harmonize a range of purchasing mechanisms into a more coherent purchasing ecosystem has yet to be articulated. Evidence, clarity, and consensus are needed across

¹ Internally referred to as "non-wage recurrent grants" and "development condition grants".

the technical and political levels within the sector to identify and prioritize the challenges and opportunities to make purchasing more strategic and align key stakeholders toward achieving UHC.

As the GOU, with support from HDPs, continues to pursue UHC through health reforms, ThinkWell recommends that the GOU prioritize the following to make purchasing more strategic:

- Increase the use and scope of RAFs to improve the efficiency and equity in the allocation of government resources used in the purchase of health services, particularly in the areas of EMHS and human resource allocations.
- Apply evidence from PBF programs, institutionalize performance-based payments to public sector facilities within government systems, and enhance autonomy at the local government and facility levels, which can collectively improve service delivery capacity and quality.
- Initiate government purchasing of PHC services from select PHPs to improve access, especially in Kampala and other urban areas.

The program of work that ThinkWell is pursuing in Uganda under the SP4PHC project is aligned with these recommendations.

I. INTRODUCTION

Purchasing refers to the allocation of pooled funds to providers of health services on behalf of a population. Examples of purchasing arrangements include supply-side financing of health providers through line-item budgets, or demand-side financing such as insurance schemes and vouchers. The *World Health Report 2000* pushed forward the idea that countries should move beyond passive purchasing, where the purchaser follows a predetermined budget or simply pays bills. Instead, more strategic forms of purchasing are appropriate, where the purchaser continuously searches for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom (World Health Assembly 53 2000).

The extent to which a purchasing mechanism can be made strategic is conditioned by a range of enabling factors in the health system that include political prioritization, the policy and regulatory environment, governance structures, and health information systems. Consequently, the first step in any strategic purchasing initiative starts with a clear understanding of the enabling environment. In this study, ThinkWell has explored the current purchasing landscape and identified examples and opportunities for strategic purchasing reforms that can be leveraged to maximize access, quality, and equity of primary health care (PHC) services.

The Strategic Purchasing for Primary Health Care (SP4PHC) project supports improvements in how governments spend funds for PHC services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project, supported by a grant from the Bill & Melinda Gates Foundation (BMGF) and implemented by ThinkWell, is working with government institutions on strategic purchasing reforms in five countries. In Uganda, the project is working closely with the Ugandan Ministry of Health (MOH) to develop and implement coherent approaches to purchasing through a two-pronged strategy that draws from the experience of ongoing results-based financing (RBF) experiences and leverages the full range of health facilities in Uganda. The two strategic approaches are:

- Support the MOH to harmonize and strengthen purchasing arrangements for PHC, with a focus on FP and MNCH.
- Support the development of an approach for the Government of Uganda (GOU) through the Kampala Capital City Authority (KCCA) to effectively purchase FP and MNCH services from private health provider (PHP) facilities.

Recognizing that a deep understanding of the Ugandan system is required to implement these three strategies, the SP4PHC team has undertaken analysis of the Ugandan purchasing environment and of financial flows within the health sector to better understand the policies and mechanisms that govern purchasing. This report focuses on the first part of the enabling environment—laws, policies, and strategies that shape current purchasing practices by the Ugandan government—and will be followed by the analysis of financial flows and other related studies designed to inform ThinkWell’s technical assistance and support to the Ugandan MOH.

This review of policies, laws, and strategies sets out to answer the following questions:

- Who purchases health services, and from whom?
- What mechanisms are used to purchase services?
- What services are purchased?

II. METHODOLOGY

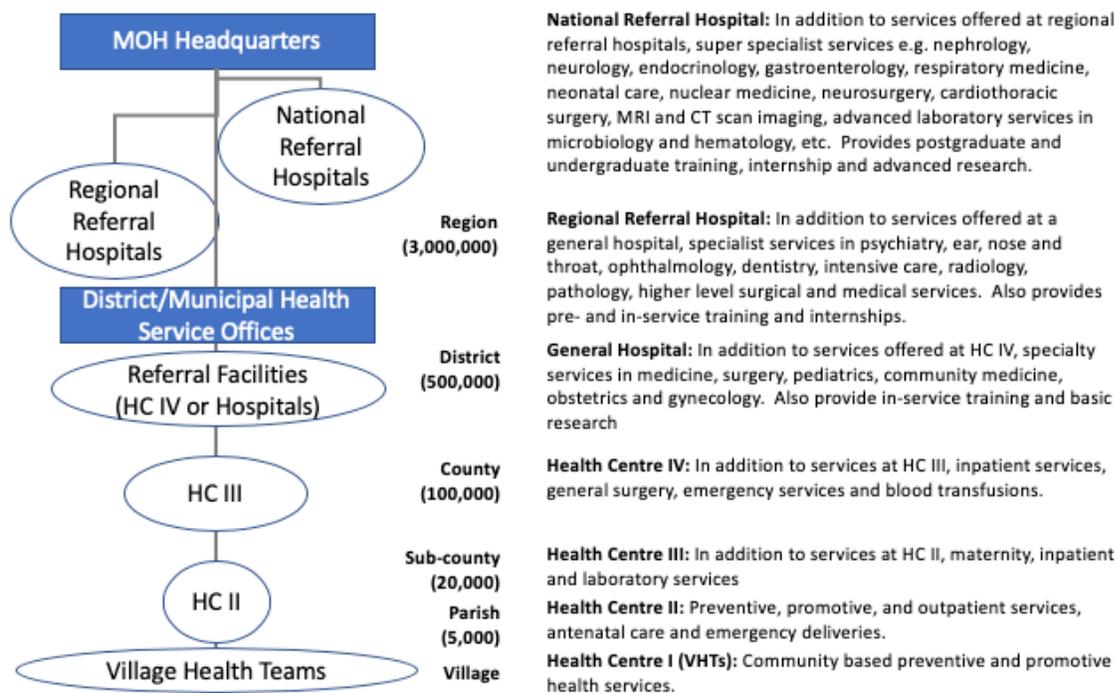
To answer these research questions, the ThinkWell team undertook a detailed desk review of relevant health policies and publications on purchasing approaches in Uganda over the last 15 years and conducted key informant interviews. The team reviewed over 25 policy documents to develop a shortlist of the key policies and regulations that govern the purchasing of health services in Uganda; a list of these are provided in a summary table at the end of this report in [Annex A](#). Key informants from the MOH Planning Department, the KCCA Directorate of Public Health Services and Environment (DPHSE), the national medical stores, and the MOH Procurement Unit were interviewed.

III. ANALYSIS OF HEALTH SERVICE PURCHASING

WHO PURCHASES HEALTH SERVICES, AND FROM WHOM?

The Ugandan health system includes multiple purchasers that can be divided into two main groups: public sector purchasers and externally funded health development partners (HDPs). The first group of public sector purchasers are within GOU structures and are largely coordinated by the MOH, which oversees the allocation of government resources (including tax revenues, loans, and grants) to service providers (refer to Figure 1). The second group of purchasers are HDPs that use pooled resources from donor countries or multilateral funders to support service providers, some of which is channeled through the GOU budget and a majority through separate project-based mechanisms. The presence of insurance-based purchasers using pooled funding from premium collection is minimal and estimated to be around 1% of current health expenditure (CHE).

Figure 1: Health Service Delivery Structures in Uganda



Source: Ministry of Health Uganda 2016, adapted by ThinkWell

Public Sector Purchasers

The MOH centrally coordinates the government purchase of health services. With statutory authority for stewardship of the health sector in Uganda, the MOH coordinates a multitude of national and subnational institutions that use pooled public funding to purchase health services primarily through public facilities and to a lesser extent from select faith-based private not-for-profit (PNFP) facilities. GOU spending accounts for 15.7% of current health expenditure as per the last national health accounts (NHA) that cover the fiscal year 2015/16 (Ministry of Health Uganda 2017). The annual work planning and budgeting process, as part of larger national budget development, serves as a key mechanism where these purchasing allocation decisions are determined.

Responsibility for the purchase of human resources at public health facilities is shared between the MOH, the Ministry of Public Service (MOPS), and an independent Health Service Commission (Government of Uganda 1995). The MOH, in coordination with the MOPS, determines staffing requirements by level of facility within the public health service delivery structure (diagrammed above in Figure 1). The MOH Human Resource Department coordinates identification of vacancies based on these norms at the national and regional referral hospital levels, and then seeks clearance from the MOPS to fill vacant positions (Matsiko and Kiwanuka 2003). If there is no objection, the MOH declares the vacant posts to the Health Service Commission that in turn conduct recruitment activities to identify candidates, who then are directly hired by the MOH. The Health Service Commission is an independent GOU body established under the 1995 Constitution, with members appointed by the President, who is responsible for recruitment, discipline, and removal of those in the public health service.

There is a process very similar to the national level used by local governments in the purchase of human resources for health facilities at the Health Center (HC) II to district hospital levels. At the local government level, the health system is managed by a district/municipal health office (D/MHO) that works with their respective district service commissions to fill vacant positions in coordination with the MOH and MOPS. The GOU also recruits, seconds, and finances human resources in some PNFP facilities based on expressed need (Matsiko and Kiwanuka 2003). Gaps in the purchasing systems for human resources for health (e.g., slow recruitment processes, low pay scales, limited applications) have led to significant numbers of vacancies and inequitable distribution of health workers that limit the public health system to delivering essential services (Namaganda et al. 2015).

The purchase of essential medicines and health supplies (EMHS) for the public health sector is coordinated through the national medical stores (NMS), a statutory corporation under the MOH.² The NMS holds responsibility for the procurement and distribution of EMHS to public health facilities; they also perform these functions for donor-funded procurements by the Global Fund, the U.S. Agency for International Development (USAID), and UNICEF. These are primarily for commodities required by vertical programs that support HIV/AIDS, malaria, and tuberculosis services.³ Government purchasing of services from select PNFP facilities includes earmarked funding for the purchase of EMHS from the

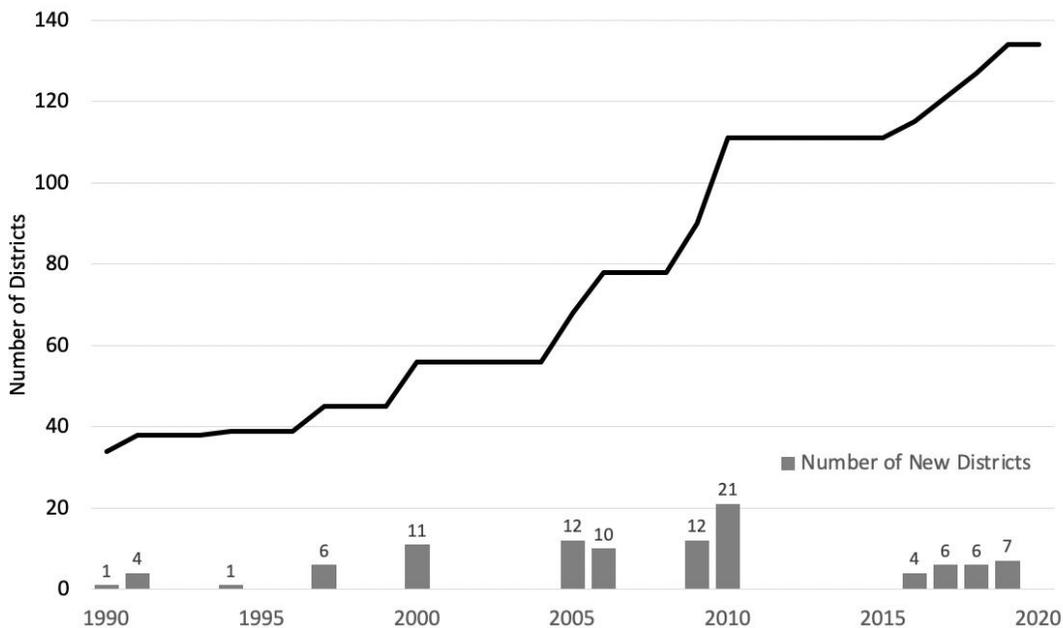
² National medical stores were established under the 1993 National Medical Stores Act.

³ In the 2018/19 fiscal year, government funding of NMS was only 31.9% of the total, with the remaining 68.1% coming from HDPs.

Joint Medical Stores,⁴ which similarly provide centralized procurement and distribution for nongovernmental facilities.

While decentralization reforms over the last few decades have delegated to district and municipal governments the authority to purchase health services, their autonomy is significantly limited in practice. The 1997 Local Government Act conveys responsibility to subnational authorities to manage publicly funded health services by planning, budgeting, and delivering a range of services (Government of Uganda 1997). Schedule 2 of the same act also outlines the function of subnational authorities to regulate, control, administer, promote, and license health services. However, given the specificity of MOH purchasing guidance in the budgeting and work planning process, these district and municipal health offices have little discretion on how or what to purchase. Furthermore, the ongoing creation of districts (34 in 1990 to 135 in 2020) (as depicted in Figure 2) has fragmented the health system, limiting the purchasing power of these subnational authorities in a context of rapid population growth and declining per capita national expenditures on health.⁵ (Wikipedia 2017)

Figure 2: Evolution of District Creation in Uganda, 1990-2020



Source: Vision Reporter 2010; The Independent 2009; Statoids 2016; Wikipedia 2017

The KCCA has greater legal standing as a high-profile municipal government but faces unique challenges to coordinate the purchasing of health services. The KCCA DPHSE is currently purchasing services from public facilities and select faith based PNFP facilities that account for 2% and 4% of total facilities in Kampala, respectively (Ministry of Health Uganda 2018a). Under the 2011 Kampala Capital City Authorities Act, KCCA has the mandate to “establish, acquire, erect, maintain, promote, assist or control clinics, dispensaries, health and inoculation centres” as well as the authority to promote health

⁴ The Joint Medical Store was established in 1979 as a joint venture of the Uganda Catholic Medical Bureau (UCMB) and the Uganda Protestant Medical Bureau (UPMB) to provide medical supplies to all mission-based PNFP and private hospitals, health centers, nongovernmental organizations, schools, pharmacies, and clinics.

⁵ Analysis of Uganda National Health Accounts 2008-2016.

schemes (Government of Uganda 2011). Under this act, it is the clear understanding of the KCCA DPHSE leadership that they have the remit to purchase services from PHP facilities (Okello 2019a). However, purchasing arrangements with the 94% of facilities in Kampala that are PHP have been mostly limited thus far to in-kind provision of equipment and vaccines.

While KCCA is pursuing options to expand its purchasing role within the city, its power to practically do so is limited due to a lack of resources and information. With an estimated 1.68 million permanent resident inhabitants, Kampala's allocation in the government health budget for fiscal year 2019-2020 is 40% lower than the national average on a per capita basis (Ministry of Finance Planning and Economic Development 2018b; Uganda Bureau of Statistics 2020). The government health budget per capita in Kampala is even smaller if the daily transient population, which swells the city from the immediately surrounding urban districts, is taken into consideration. In addition to a lack of resources, the current regulation of PHP facilities creates further challenges. PHP facilities are currently regulated by the government medical councils⁶ that register and then annually license both health workers and facilities, in addition to the KCCA trade licensing system. Each step of the process in registration and licensing requires payments of official fees by providers, which reduces compliance and limits the availability of current information; what is collected is not being fully shared between system stakeholders. While much of this system has been digitized, gaps in data sharing agreements have left the KCCA DPHSE without critical data that they would use to purchase services from PHP providers, such as geographic location, the services offered, the number of qualified health workers employed, and their quality of care.

As a potential purchaser, Uganda has made significant progress toward designing a national health insurance scheme (NHIS) as a social health insurance mechanism for all Ugandan residents, but legislative and stakeholder bottlenecks suggest that its enactment might be further delayed. The country has been developing plans for an NHIS for nearly two decades. The most recent iteration of the effort received Cabinet approval in June 2019 and proposes a national purchasing institution that provides financial protection to all Ugandans through a comprehensive set of health benefits financed through payroll deductions and premium collections. If enacted, it could begin a process to operationalize a purchaser-provider split and create a platform for transparent financing that could increase efficiencies and also catalyze greater revenue generation in the sector. However, there are significant concerns from the private sector business community over the prospect that NHIS would increase the tax burden on employers and employees, as well as concerns within the GOU that it would exponentially increase government spending. Based on these concerns, the President of Uganda requested that the bill be withdrawn from Parliament by the MOH in early 2020 for further consultations. While the Parliamentary Health Committee continues to review and debate the bill, related community and other stakeholder engagements have been delayed due to the outbreak of COVID-19 in March 2020.

External Purchasers

HDPs collectively provide a proportionally large share of health spending in Uganda.

Based on the most recent NHA, HDPs contribute 41.7% of CHE (Ministry of Health Uganda 2017). Most expenditures by HDPs are off budget, with only an estimated 21% reported

⁶ These include the Uganda Medical and Dental Practitioners' Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC), and the Allied Health Professionals' Council (AHPC).

on government budgets (Ministry of Health Uganda and UNICEF 2020). Given the likely presence of high overhead costs and lack of sufficiently detailed and available data, it is difficult to estimate the amounts that can be considered as true “purchasing” (i.e., allocation of pooled funds to providers of health services). Still, HDP spending as a whole is three times larger than that of the GOU in the health sector, making it very likely that they are larger purchasers of health services than the GOU.

Purchasing by HDPs is done through a wide array of multilateral, bilateral, international, and national nongovernmental organizations. In August and September of 2019, the government did a validation exercise of all 14,027 NGOs that had been registered to operate in Uganda to determine which were inactive, were unauthorized, or had unscrupulous and unclear operations. This resulted in 11,908 being struck from the list of those allowed to operate, leaving 2,119 active NGOs in the country (Okello 2019a). Out of these 191 operating within the health sector, 146 are domestic and 45 are international (Okello 2019b).

Significant experience has been generated by HDP support to MOH health-financing priorities that have tested and developed strategic purchasing approaches in Uganda. Three areas of relevant HDP support include 1) performance-based financing (PBF) approaches, 2) voucher mechanisms, and 3) CBHI schemes that have provided rich insights into many of the technical aspects of strategic purchasing and how they can function within the Ugandan health system. A key challenge inherent to external assistance efforts is the transition from project-based approaches to becoming government-owned institutionalized systems that can be counted as durable health system reforms.

WHAT MECHANISMS ARE USED TO PURCHASE SERVICES?

While government purchasers in the Ugandan system rely primarily on input-based financing mechanisms, there are significant initiatives to established payment mechanisms linked to outputs and performance. Purchasing by the MOH and associated GOU institutional mechanisms is largely determined during the annual work planning and budgeting processes. These are centrally controlled despite significant decentralization to district and municipal local governments. HDP-funded programs have introduced output-based approaches for purchasing, which offer important insights for strategic purchasing reforms within government systems and processes.

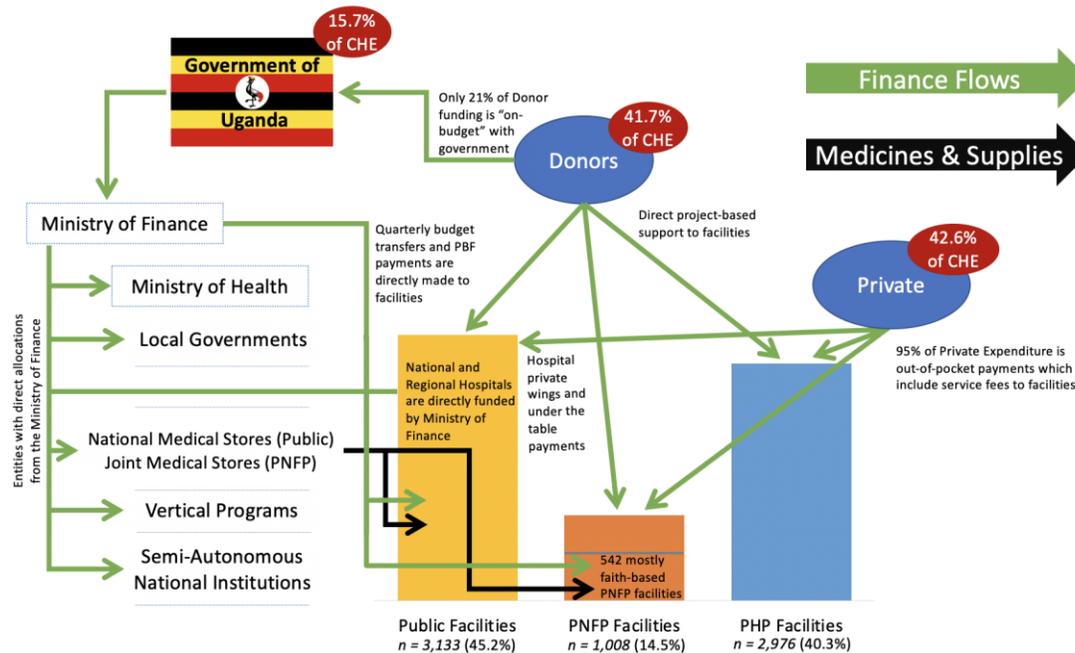
Public Sector Mechanisms

An overarching strategy of the GOU has been the introduction of a programme budgeting system (PBS). Starting in the year 2016-17, the GOU transitioned from an output-oriented budgeting approach to a PBS, which initiated a progressive process to incorporate performance measures into public financial management systems. The PBS approach seeks to systematically use performance information to influence budget and spending decisions within GOU programs to support the second National Development Plan and improve budget performance (Civil Society Budget Advocacy Group 2017). If fully implemented, PBS could make progress to improve government purchasing to be more strategic. Within the health sector, introduction of the PBS approach is a work in progress.

The MOH exercises significant purchasing authority within the health system through stewardship and coordination of the national and decentralized local government-level institutions. On an annual basis, the Ministry of Finance, Planning and Economic Development (MOFPED) initiates a work planning and budgeting process by issuing budget call circulars, which give indicative planning figures (IPFs) for government spending

across sectors, including health (seen in Figure 3).⁷ These planning figures are disaggregated by wages, operational costs, and sector development activities⁸ for the central MOH headquarters, decentralized local governments, national institutions (including NMS), regional and national hospitals, and the KCCA. Based on these IPFs, the MOH works with national-level institutions and local governments by issuing Sector Grant and Budget Guidelines to Local Governments to guide the development of annual workplans and budgets in line with current national policy (Ministry of Health Uganda 2018b). These guidelines include specific amounts to be allocated to each public and contracted PNFP facility as well as to individual D/MHOs at the local government level.

Figure 3: Uganda Health Sector Financing Flow Diagram



The annual workplans and budgets developed at the local government level result in funding allocations from the national budget to districts and municipalities through what are collectively known as primary health care or PHC grants. Table 1 details the various types of PHC grants for local governments, what they are for, who are the specific recipients, and the percentage breakdown of components within the grants in fiscal year 2019/20 (Ministry of Health Uganda 2018b). Donor contributions toward service delivery at the local government level, such as the PBF mechanism under the Uganda Reproductive, Maternal, and Child Health Improvement Program (URMCHIP) and Global Vaccine Initiative (GAVI) immunization support, are included within the PHC grant budgeting process as well.

⁷ As stipulated by the 2015 Public Finance Management Act, the process of annual work planning and budgeting begins in September of the preceding year, with preliminary ceilings of projected expenditures. These lead to the development of budget framework papers that are submitted to Parliament by the end of December, which are followed by relevant consultations that lead to its approval by May 31 in advance of the new fiscal year (which starts on July 1.)

⁸ Development budgets cover construction, expansion, or renovation of facilities or other large capital expenditures.

Table 1: Primary Health Care Grant Details

Type	Purpose	Allocation Basis	Disbursement Recipient	Percentage PHC grants in 2019/20
Wage Conditional Grants	Salaries for health care workers at the district/municipal level	Based on established salary scales	Individual health care workers	79.5%
Non-Wage Recurrent Grants	District Health Service Department operations	<u>District Level Resource Allocation Formulae</u> District health office: Maximum 20% of non-wage recurrent grant total, 80% minimum to facilities	District Health Service Departments	1.2%
	Health Center operations	PHC facilities: Population 60%; no. of HCIII & IVs 24%; infant mortality: 8%; fixed amount 4%; poverty 2%; pop. in hard-to- reach areas 2%	Public and PNFP health facilities	5.4%
	District hospital operations	Hospitals: Based on population adjusted for no. of hospitals 82%; infant mortality 10%; fixed amount 6%; poverty 2%		3.5%
Development Conditional Grants	Facility upgrades	Based on MOH guidance		7.0%
	Infrastructure maintenance	Squared LGPA scores; no. of HCIII-Hospitals 50%; population: 50%	District Health Service Department	1.9%
	Transition ad hoc	Based on MOH guidance to individual local governments		1.8%
	Sanitation	As per donor		0.5%
URMCHIP Performance-Based Financing	Funding to facilities for operations (60%) and additional staff incentives (40%)	Based on select RMNCAH outputs and quality assessment scores	Public and PNFP health facilities	
GAVI	127 Districts for HSS activities focused on immunizations	As per donor	n/a	

Source: Ministry of Health Uganda 2018

The Uganda Intergovernmental Fiscal Transfers Program (UgIFT) provides additional resources to local governments for service delivery in the health and education sectors.

Initiated in 2015 by the MOFPED with credit from the World Bank, the UgIFT Program aims to “improve the adequacy and equity of fiscal transfers to improve fiscal management of resources by Local Governments for health and education services” (World Bank 2017). Designed as a five-year program from FY 2017/18 to 2021/22, it is projected to increase both non-wage recurrent and development funds through the existing PHC grant mechanism by a total of UGX 209.29 billion (US\$57,329,826) (World Bank 2017).

The MOH employs needs-based resource allocation formulas (RAFs) to improve equity in the budgeting of resources.

Through multiple iterations over more than two decades, the MOH has used various indicators to determine allocation of resources to improve equity. These have included needs-based measures of population, poverty, mortality, and human development indexes to channel greater resources to areas within the country that have higher need. This use of RAFs is an important approach toward a more strategic purchasing of PHC services as it uses current data on needs to determine funding levels, replacing a previous system that largely functioned on historical precedents. There is significant opportunity for expanding the approach to resource allocation as it only applies

to an estimated 19% (based on the figures above) of total government financing to local governments in fiscal year 2019/20 (Ministry of Health Uganda 2018b).⁹

Based on approved budgets, disbursements are made by the Bank of Uganda (BOU) to different levels of the system based on user-generated warrants that are approved by MOFPED. For wage-conditional grants, the preparation and management of payrolls has been decentralized since 2014 to local governments. On a monthly basis, the Human Resources Unit within each local government prepares the monthly payroll in coordination with the MOPS. It is then approved by the chief administrative officer (CAO) and submitted to the MOFPED, which processes the cash releases that will be transferred by the BOU to each individual civil servant's bank account (Lwanga, Munyambonera, and Guloba 2018; Civil Society Budget Advocacy Group 2017). Similarly, on a quarterly basis, the non-wage recurrent grants (facility operating funds) and development conditional grants are prepared and signed by the CAO based on the approved plans and budgets. They are then submitted to the MOFPED for review, who then provide authorization to the BOU to make transfers to each facility account. Local tax revenue collected by districts and municipalities that is programmed for purchase of health services is minimal (Ministry of Finance Planning and Economic Development 2018a).

The NMS uses a modified pull system to distribute EMHS to both public and PNFP facilities. The pull system operates on two financing mechanisms. The first mechanism is earmarked credit line budgets allocated to individual facilities by NMS, which are backed by funds held centrally at the MOH. The second is the allocation of non-wage recurrent grants for operations, which individual facilities can use to purchase additional drugs from NMS. The MOH also has a Memorandum of Understanding with the Joint Medical Store that allocates 50% of non-wage recurrent funding provided by the MOH to PNFP facilities as a credit line for the procurement of EMHS (Ministry of Health Uganda 2018b; Atwine 2019). Both public and PNFP HC IV and higher facilities use these two sources of funding (as well as revenue from user fees) to purchase EMHS as needed. After adopting a pull-based system for EMHS in 2002, the system for facilities at the HC III level and below was modified to include facility-generated annual procurement plans. These are submitted to the NMS, which then supplies facilities on a quarterly basis based on their plans.

Higher-level hospital facilities are overseen by the MOH and receive funds directly from MOFPED through global budgets. As part of the annual work planning and budget process, national and regional referral hospitals, as well as specialized government service delivery agencies (such as the Uganda Cancer Institute), are provided with global budgets that they manage independently. The determination of funding levels for high-level hospital facilities is largely based on historical precedent and additional funding requests that require specific justification such as infrastructure improvements or expansions, large equipment purchases, and human resources.

Many high-level hospitals have established private wings, which charge user fees for access to faster services, specialists, and amenities such as "hotel" services (Ministry of Health Uganda 2010). Resources collected in private wings are non-tax revenues that are remitted to the GOU central consolidated fund. Facilities that generate this revenue are required to reprogram the money before receiving their revenues back from the

⁹ Analysis of initial planning figures provided in the Sector Grant and Budget Guidelines to Local Governments, FY 2019/20

consolidated fund. The Office of the Auditor General audits private wing incomes annually, and challenges remain in the non-disclosure of income by that generate income.

PHC facilities have little, if any, control over their inputs. With the GOU and local government processes in the recruitment and management of human resources, NMS management of EMHS, and minimal funding provided for operations guided by highly detailed line-item budgets, facilities have little autonomy to use resources they receive to best serve clients seeking care. The advent of PBF mechanisms such as those under the URMCHIP (described below in [External Mechanisms](#)) has initiated a purchasing mechanism that not only increases resources at PHC facilities but also gives more limited autonomy through guidelines for how they are used. With examples of PBF income and the revenue generated by private wings in public facilities, the potential benefits of autonomy for facilities needs to be explored.

The KCCA DPHSE purchases services via PHC grants from public and PNFP facilities.

Under their mandate to provide high-quality services to the population of Kampala to ensure healthy and productive citizens, the KCCA DPHSE provides PHC grants to a combination of 30 public and PNFP facilities (Kampala Capital City Authority 2019). Like other local governments, these grants coordinate a combination of financing streams for wages, operations, and development/ infrastructure. Given that the KCCA is not considered a local government and has its own vote in the national budget, the allocations to facilities are not included in the annual MOH Sector Grant and Budget Guidelines to Local Governments (Ministry of Health Uganda 2018b), yet the DPHSE follows their general guidance and the other relevant MOH policies. The facilities provided with PHC grants by the KCCA DPHSE are only a fraction of the estimated 1,497 facilities in the city, the vast majority (94%) of which are PHPs (Ministry of Health Uganda 2018a).

The advent of an NHIS could introduce a new purchasing mechanism that would be more strategic than existing financing mechanisms. Depending on the level of independence granted to an NHIS from the MOH, its alignment with existing health financing modalities, and the magnitude of its coverage and contribution toward CHE, it will likely function as a demand-side purchaser with the possibility of efficiently directing public health resources to service delivery. This could open the door to a wider range and use of multiple concurrent provider payment methods, such as case-based and capitation payments employed to improve efficiency, incentivize certain types of utilization and quality, and widen access to affordable health services.

[External Mechanisms](#)

The MOH, with support from HDPs, has been testing output-based purchasing mechanisms in Uganda for over two decades. Many of these efforts have been iterative, building up a base of knowledge and contextualized experience that aim to show the efficacy of these strategic purchasing mechanisms in Uganda. The ultimate goal is the incorporation of these mechanisms, in some fashion, into standard GOU and MOH systems. Below are overviews of the most notable purchasing mechanisms in the three categories of programs used.

Performance Based Financing: There are currently two PBF projects operating in Uganda. The first is a component of the URMCHIP, which supports national efforts to scale up FP and MNCH services. URMCHIP includes a PBF mechanism component of supply-side financing through direct transfers to PHC facilities, based on the volume of key outputs adjusted by quality scores and payments to district health offices to undertake claims verification. This PBF mechanism is financed through a loan from the World Bank (74.1%) and grants from the Global Financing Facility and the Swedish International Development

Agency (25.9%) (World Bank 2017). The MOH implements this mechanism through a project-funded RBF unit located in the Department of Health Services Planning, Financing, and Policy. This body coordinates the work of the district health service departments to support and monitor both the public and PNFP facilities in the project. The second ongoing PBF program is the USAID-funded Enhancing Health in Acholi project, which is being implemented by ENABEL¹⁰ from October 2019 through September 2024. With the anticipated end of URMCHIP in June 2021, there are currently discussions to integrate elements of the current PBF mechanisms into UgIFT. This would be a highly significant transition of the current project-based PBF approach toward integration into the institutionally established PHC grant mechanisms. MOH PBF pilots are also being used as a case study by the GOU, seeking to introduce PBF into other sectors.

Reproductive Health Voucher Programs: Voucher programs that aim to incentivize more use of reproductive and maternal health services have been implemented for decades in Uganda, with financing largely from HDPs. The two most recent voucher programs in Uganda have contracted directly with PHP and PNFP providers, as well as private wings of public facilities. Both programs established voucher management agencies as independent purchasers that were responsible for demand creation activities, provider accreditation, and quality improvement systems, as well as verification of claims and payment of providers. The two latest large voucher projects in Uganda are closing out. Phase II of the Uganda Reproductive Voucher Project funded by the World Bank and implemented by Marie Stopes Uganda ended in December 2019, and the USAID Voucher Plus activity, led by Abt Associates, is also set to end in September 2020. Precipitating the end of these voucher mechanisms were significant GOU concerns about the cost-effectiveness of these voucher schemes. This is because they had significant administrative outlays as a proportion of the total investment during their five-year implementation due to the high costs of establishing a demand-side purchasing mechanism.

Community Based Health Insurance: CBHI schemes have been operating in Uganda since 2002 and are currently estimated to have a membership of 165,000 across 32 districts. As project implementers under a variety of donors, the two organizations that primarily promote this model are Save for Health Uganda and HealthPartners, which have formed a consortium with other CBHI implementers. Despite relatively low coverage nationwide, the concept of CBHI features prominently in MOH strategies. Basic purchasing functions are managed through local cooperatives that each serve a community around single-service providers that are either PNFP or PHP facilities. Providers are paid through a quarterly capitation method and small co-payments from members for a package of services equivalent to those offered at the HC III level. CBHI schemes in Uganda are very small risk pools that operate on very thin margins and are hence not resilient to shocks or able to grow without significant support. This support comes from donors who serve as secondary purchasers to these schemes, providing them with significant levels of technical assistance and financial backing in cases where they are faced with a threat of insolvency.

¹⁰ Formerly the Belgian Technical Cooperation.

WHAT SERVICES ARE PURCHASED?

Public Sector Financed Services

The Uganda National Minimum Health Care Package (UNMHCP), introduced as part of the 1999 National Health Policy, defines government-prioritized health services. The

interventions included in the package are intended to address the major causes of the burden of disease and guide the allocation of public health funding to focus on cost-effective health services that address this burden. The package covers services at the community, primary, and hospital levels of care, and includes public health measures, such as the prevention of both communicable and noncommunicable diseases. The package is organized into four clusters of services:

1. Health Promotion, Disease Prevention, and Community Health Initiatives
2. Maternal and Child Health Services
3. Prevention and Control of Communicable Diseases
4. Prevention and Control of Noncommunicable Diseases

Main Causes of the Burden of Disease

- Malaria
- STIs/HIV/AIDS
- Tuberculosis
- Diarrheal diseases
- Acute lower respiratory tract infections
- Maternal conditions
- Vaccine preventable childhood illnesses
- Malnutrition

The UNMHCP sets standards that apply beyond the public sector to include PNFP and PHP facilities. The UNMHCP is the underlying policy to the 2016 Service Standards and Service Delivery Standards for the Health Sector, which provide definitions for each type of facility, the services delivered, and the relevant standards that should apply. These typologies and service delivery standards have been applied to public and PNFP facilities where the GOU is purchasing services with pooled public funding, via PHC grants and hospital budgets. The Uganda Healthcare Federation, an umbrella organization of private provider networks at the national level, is working closely with the MOH, medical councils, and professional associations in the health sector to standardize a clinic typology and service offerings for PHPs. This effort would bring the government standards of service delivery and the UNMHCP to apply to PHP facilities through a regulatory approach that includes quality assessments.

The UNMHCP provides useful overall prioritization, but the public health system is often unable to provide the full range of services. Overall, low levels of expenditures by the government, inefficient purchasing mechanisms, shortages of human resources, and EMHS, combined with centralized authority, have created challenges to local government management that often result in significant gaps in the ability of public facilities to deliver the full range of intended services, as defined by the UNMHCP.

External Financed Services

In response to these gaps, HDP-supported health financing programs, including PBF, voucher programs, and CBHI, have supported more narrowly defined sets of services within the UNMHCP that focus on specific needs of target populations and HDP objectives and agendas.

The current MOH PBF program, supported by URMCHIP, is designed to support the MOH RMNCAH Sharpened Plan by using performance indicators linked to additional supply-side financing for facilities to improve both the quality and quantity of these services. Likewise, voucher programs have provided narrow benefit packages of FP and MNCH services purchased from PHP providers for pregnant poor women. As a demand-side financing mechanism, vouchers have demonstrated what is necessary to purchase from PHP providers to ensure quality and financial accountability. CBHI schemes in Uganda have typically set up small risk pools from communities surrounding individual private or PNFP providers to purchase a basic package of PHC services using a capitation provider payment mechanism. While requiring significant levels of donor funding and technical assistance to sustain operations, CBHI schemes have demonstrated many of the challenges associated with insurance coverage of the informal sector and the dynamics of engaging private and PHP providers.

IV. CONCLUSION

There is a clear vision and plan for Uganda to transform government’s purchase of health services to be more strategic. As articulated in the health sector development plans in support of Uganda Vision 2040, there is a planned paradigm shift from curative to preventive, promotive, and rehabilitative services as a way to reduce costs and increase responsiveness (Government of Uganda 2013). In the interest of reducing the costs of the public health facilities, there is also a planned progressive investment in a mixed health system where public-private partnerships play an expanded role that allows the GOU to focus on highly specialized tertiary care. The Uganda Vision 2040 plan informs a cascade of policies, strategies, and development plans toward this vision.

At the MOH level, a set of health financing reforms have been identified and articulated in the 2016 national Health Financing Strategy (HFS)(Ministry of Health Uganda 2016a). Taking into consideration low government financing, lack of incentives for performance, high dependence on donor financing, and a large, poorly regulated private sector, the HFS identifies a set of key financing reforms in the areas of revenue collection, pooling, and purchasing. These include key purchasing arrangements such as establishment of a NHIS, improved RAFs, use of results-based financing, and creation of a purchaser-provider split resulting in greater provider autonomy.

Figure 4: Government Health Expenditures, 2015/16

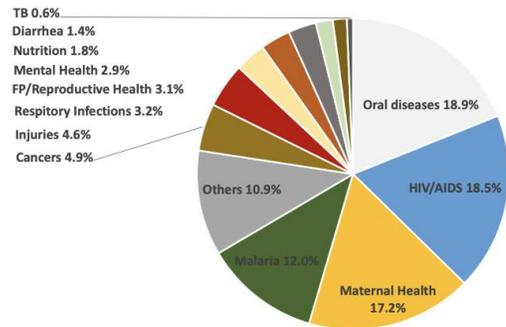


Figure 5: Private Expenditures on Health, 2015/16

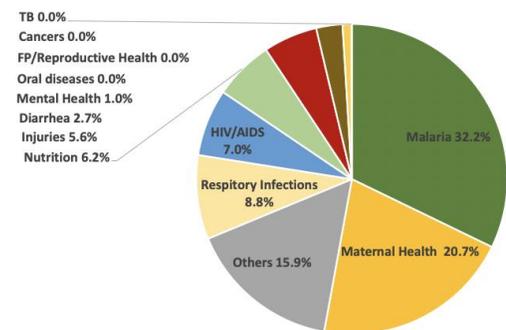
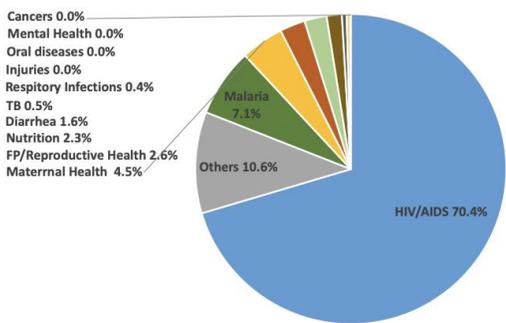


Figure 6: Health Development Partners Expenditures, 2015/16



Source: Ministry of Health Uganda 2017

Many of the proposed reforms in the HFS have yet to be fully realized, and input-based financing is the predominant approach in the public sector. After a two-decade process, efforts to establish NHIS as an output-based purchaser attained Cabinet approval but has since been stalled over concerns about how it would be financed and the level of protection it would offer to the poor. Additionally, the use of RAFs in the financing of service delivery are designed to improve equity and have been successfully established, but their use is only applied to a limited area of government purchasing.

Over the last 20 years, the GOU, with HDP support, has generated evidence and made progress on potential strategic purchasing reforms. The wide-scale implementation of results-based financing, both PBF and voucher programs, over multiple iterations has generated a wealth of experience and evidence about the potential of the mechanisms for both supply- and demand-side financing. Although often hampered by being project based, these efforts have had positive effects on both access and quality of PHC services. Likewise, the introduction of RAFs is an important positive development, with many potential applications beyond their current scope.

However, there are many challenges to the further use of strategic purchasing within the Ugandan health financing landscape. With government expenditures contributing only 15.7% of CHE, declines in the actual amounts spent per capita, and an official policy that services are free in public health facilities, the lack of resources and inefficiencies in current purchasing mechanisms have led to chronic shortages of health workers, medicines, and supplies, resulting in a system that is often described as “having free services that are not available” (ThinkWell 2020).

Filling the gap left by the public health system, the private sector has grown significantly. Particularly at the PHC levels of care, where 40% of facilities are PHP, the growth of the private sector directly contributes to the high OOP expenditures for health, which were most recently estimated to be 42.6% of CHE (Ministry of Health Uganda 2017). The current regulation system for PHP facilities (registration, licensure, quality assurance) is complex and poorly implemented, which results in an unpredictable market space that could inhibit investments to further improve private health care. The overall result is a sub-optimally executed MOH stewardship role and the creation of financial barriers for the poor and vulnerable, which threaten progress on key health indicators associated with the Sustainable Development Goals.

HDPs have also moved to fill in the gap with a myriad of project-based activities, some of which have generated valuable experience and evidence to inform strategic purchasing reforms, though this has created more fragmentation and weakening of the core health system. HDPs contribute 41.7% of CHE through largely project-based approaches, much of which is not included in MOH budgets, and is hence poorly coordinated toward national policy objectives (Ministry of Health Uganda 2017). This dependence on donor funding is a risk to the system and to many of the gains in health status achieved over the last two decades. There are notable exceptions of valuable HDP contributions, particularly in regard to strategic purchasing, where extensive, large-scale implementation of PBF and voucher programs have demonstrated the potential benefits of these approaches were they to be institutionalized within the national system.

Beyond the need for increased funding of the health sector by the GOU or the establishment of an NHIS to care for its young growing population and to realize the potential of a demographic dividend, ThinkWell recommends the following reforms to improve strategic purchasing in Uganda:

1. **Evaluate and iterate based on lessons learned from the use of RAFs.** Allocation of government resources to where they are needed most is a key element for achieving efficiency in service delivery through greater equity. The use of RAFs is a critical mechanism to this end, which needs further study to understand the positive effects they have generated to date in Uganda, understand their limitations, and inform policy options to expand their use.
2. **Institutionalize performance-based financing approaches within government systems.** The multiple iterations of PBF programs in Uganda have shown that increasing resources available to both decentralized local governments and individual public and PNFP facilities as well as linking those payments to performance metrics can have very positive effects on service delivery capacity and quality. Experience to date also offers important lessons about drivers of success, including timeliness of payments, simple but robust systems for measuring performance, functioning accountability mechanisms, and sufficient provider autonomy. Going forward, there is an urgent need to explore how the PBF mechanism can be integrated into government purchasing mechanisms.
3. **Develop, test, and scale government-initiated purchasing mechanisms for services provided by PHP facilities.** A key limitation on MOH stewardship of the sector is the lack of meaningful engagement with the estimated 40% of facilities nationwide that are PHP. Particularly at the PHC levels of care, PHPs are highly active, able to respond to changing patterns in demand, and increasingly relied upon for routine FP and MNCH services, which are key elements of national health policies and strategies. The reproductive voucher programs have demonstrated successful approaches and tools to inform purchasing from PHPs through an output-based purchasing mechanism that can leverage comparative advantages, increase transparency, and make efficient use of scarce government resources. Kampala would most benefit from initiation of purchasing mechanisms from the 94% of facilities in the city that are PHPs, and the unique position of the KCCA DPHSE as a potential purchaser provides an opportunity to demonstrate the advantages and challenges to this approach.

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ANNEX A: SUMMARY OF KEY POLICIES

Key Policies and Regulations Related to Health Purchasing

Policies and Regulations	Purpose
Uganda Vision 2040	Vision for the country to move to upper middle-income status. In health, emphasizes preventive care, nutrition, public-private partnerships, and a universal health insurance system.
National Health Policy (2000) Second National Health Policy (2010)	Sets national health policy and goals in line with the national development plans under Vision 2040.
Health Sector Development Plan 2015/16 – 2019/20	The second in a series of five-year plans to achieve Uganda Vision 2040 of a health population that contributes to economic growth.
Health Financing Strategy (2016)	Provides a framework through which Uganda will finance its health sector to achieve its stated goals. Guides the country in equitably and sustainably mobilizing resources and efficiently utilizing them to implement sector plans.
Public Financial Management Act (2015)	Authorizes funds to public sector bodies through the annual budgeting process and describes management of these public funds.
Local Government Act (1997)	Establishes the decentralization framework and authorizes local governments to purchase services.
Kampala Capital City Authorities Act (2011)	Establishes authority for the KCCA to govern and administer the capital city.
Sector Grant and Budget Guidelines for Local Governments (2019/20)	Sets framework to use PHC Grants released to district local government to fund health facilities and purchase health services from faith-based organizations. 2019/20 provides a refined allocation formula.
Uganda National Strategy for Public-Private Partnerships in Health, 2017/18 – 2021/22	Provides a vision that builds on key national health policies to define public private partnerships for health with a strategy and implementation plan to make them operational.
Results Based Framework and Implementation Guidelines (2017)	Provides a national level guidance on the principles, objectives, and model for RBF schemes in Uganda.
The Uganda National Minimum Health Care Package (2000)	An element of the 2000 National Health Policy and subsequent national policies.
Service Standards and Service Delivery Standards for the Health Sector (2016)	Provides a standardized typology of health facilities with service offerings and delivery standards.
Public Private Partnership Act (2015)	Establishes an institutional framework to implement public-private partnerships across all economic and social sectors.

Public Procurement and Disposal of Assets (PPDA) Act (2003) Regulates the policies and practices for public procurement and disposal activities.

The National Health Insurance Bill (2019) A bill to establish an NHIS and define its objectives and functions.
