P4H Social Health Protection Network

Report of Visit to Uganda 1-4 July 2013

Introduction

The MoH Uganda, through the WR Uganda, requested the P4H network to support the finalisation of their health financing strategy (HFS) [see annex1]. The invitation was well recieved, in particular after a period of reduced interactions with the P4H network in 2012 mainly due to MoH staff changes and coordination issues of the HFS process. The request appeared to be a new opportunity to continue the dialogue and build on previous support to the HFS and NHIS draft bill.

CD Objectives of visit

To clarify the expectations towards P4H for the finalisation of the HFS; to ensure (P4H) DP involvement across levels and sectors and the development of a joint response / action plan; and to facilitate the link to current micro-insurance agenda in the finance sector and integration in the health reform process.

Preparing the mission

-- Understanding the request - taking stock: two work streams, two HFS drafts

The request originated from the MoH, Director of Planning (Dr. Isaac Ezaati). The MoH has been working on a HFS draft with support from WHO and the WB since 2012, though with different levels of intensity. At the same time, the Presidential Advisor on Health and Population has carried out a number of consultations with several communities and stakeholders, which led to the development of a separate HFS draft. Since both work streams have developed their own dynamics the task of the mission would be to bring the two processes together, to facilitate dialogue and build consensus on a synthesis of both drafts.

-- Engaging the (P4H) DPs

Since Feb 2009, P4H network support to Uganda was delivered through WHO, the WB and GIZ. Since USAID became a full member in May 2013, the CD also contacted the USAID health advisor in Uganda to participate in the joint response. Also UNICEF (currently DP chair in Uganda) was invited to participate in the HFS stakeholder workshop. Other members, in particular AfDB and ILO are copied in further email exchange.

-- Synthesis table and guiding questions; link to P4H HF training in Kenya, 17-21 June

Prior to the mission, WHO (head office) and the CD prepared i) a synopsis table of the two HFS drafts visualising a comparison of the main strategic pillars and related interventions of the documents (see annex 2); and ii) a set of guiding questions for the development of a synthesis of the two drafts (see annex 3). Both documents were shared with the MoH Team participating in a (P4H) knowledge sharing event on health financing and UHC in Kenya (17-21 June) supported by the WBI, WHO and GIZ. This workshop helped to prepare inputs for the upcoming development of an advanced HFS draft (synthesis), e.g. some slides from the workshop have been used to inform the working groups and plenary during the HFS Stakeholder Workshop in Kampala, 3-4 July 2013 (see below).

Milestones of the mission

-- Bringing the process - in particular two work streams - together.

A courtesy call of the CD to the Presidential Advisor helped to pave the way for a joint preparatory meeting of the MoH HFS Team and the team of the Presidential advisor, on 2 July 2013. The meeting of the two teams and the P4H members WHO, WB and GIZ served to

finalise the agenda, assign roles and responsibilities for the different sessions and to prepare the various inputs (from the minister's speech to the questions for group work).

-- HFS - national stakeholder workshop, 3-4 July 2013

The workshop brought together more than 100 stakeholders, though mainly from the health sector (MoH, public service providers, NGOs, etc); other sectors like MoF were invited but did not attend; good media attendance; participation of P4H members (WHO, WB, GIZ, USAID) as well as the P4H CD and UNICEF.

The objectives of the workshop were to provide an overview of the health sector, health financing situation and proposed key health financing reforms in Uganda; and guidance for the development of a health financing strategy (HFS).

The new Minister of Health (HE Dr. Ruhakana Rugunda) expressed his commitment to UHC, the need for effective, efficient and equitable use of resources for health, the importance of leadership and stewardship. He proposed to establish an inter-ministerial committee to debate on health financing reforms as he recognized the importance of multi-sectoral collaboration in moving the agenda forward.

The P4H members WHO, GIZ and the P4H CD assisted in facilitating the six working groups on resource mobilisation, pooling, purchasing, benefit package, community financing and governance. The minutes of the workshop can be found in annex 4.

-- P4H meeting to agree on the way forward

The MoH team, the Presidential Advisor and the P4H members met right after the stakeholder meeting to discuss the next steps. The following timeline has been proposed:

- Development of an advanced draft by end of July;
- Discussion of draft HSF with stakeholders and finalisation of HFS by August;
- Tabling of HFS in cabinet by September 2013.

It has also been agreed that the GIZ consultant will assist the Ugandan team (led by Dr. Runumi) in producing an advanced HFS draft based on the two earlier drafts, the discussions during the stakeholder workshop and further interactions between the writing team and the network members.

-- Developing an advanced HFS draft - still some issues to be solved

The mission concluded with a consolidated draft based on the agreed new format for the content and sequencing of the HFS. What is still missing is a coherent flow of the strategies based on the situational analysis. There was so far little discussion on how to compromise between HF reforms and the broader reforms that were indicated in the older HFS drafts. According to the MoH team, the advanced draft should include the MoH proposed HF model (based on Option X, see annex 5) while the debate on the proposed set up of creating several agencies would come at a later stage.

The next steps

- Agreement on main strategic thrusts of the HFS
- Initiate dialogue with other sectors: mainly finance and private sector (e.g. current discussion on health insurance regulation), and labour / social protection, local governments); establishment of a national inter-sectoral committee
- Soliciting commitment from the President and cabinet (through Presidential Advisor)

World Health Organization

Annex 1

OFFICE OF THE WHO REPRESENTATIVE FOR UGANDA

AFRO MEMORANDUM

FROM: Dr Wondimagegnehu Alemu
WR /UGANDA

TO: Dr Bokar Toure
HSS/AFRO

DATE: 07/05/2013

OUR REF:

YOUR REF:

ORIGINATOR:

ATTN: Dr Laurent Musango
HFS/AFRO

REQUEST FOR TECHNICAL ASSISTANCE FROM P4H FOR FINALIZATION OF THE HEALTH FINANCING STRATEGY IN UGANDA

Reference is made to the above subject.

The Ministry of Health Uganda has set up teams to develop and draft a Health Financing Strategy (HFS).

We have received a request from the Ministry of Health for Technical Support to consolidate and finalise the HFS.

Some work has been done and the Ministry of Health and would like to get support to consolidate and finalise the HFS before the financial year 2012/13 closes.

Best Regards

CC
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Uganda - Synopsis of proposed strategic objectives and interventiones of two HFS draft documents (5 June 2013)

HFS (swk)		**HFS (part 1 & 2)**	
1. Strengthen institutional arrangements for improved efficiency, accountability, transparency and effectiveness *[...reduce misappropriation and wastage of resources through better health sector organisation].*	6. Strengthening management capacity alongside greater autonomy	**5. Strengthen institutional arrangements in planning and management of resources**	Build capacity for planning, institutional reform, mentorship between centre/LG
	3. Quality assurance and accreditation mechanisms		
	2. Separate medical care from public/population health activities (through NMIA and NHSA, s. below)		
	4. Strengthening the referral system		
	10. Coordinated information management system		
	5. Purchaser/provider split; buying outputs - not supplying inputs; money follows patient	**4. Improve effectiveness and efficiency in allocation and use of raised resources**	*Results-based financing (RBF*); focus on UNMHCP (minimum benefits)
	7. Making more effective use of the private sector		Contracting out / outsourcing
	8. Consider establishing a ***Benefits & Tariffs Board***		
	1. Focus on mandates, e.g. MoH mainly stewardship (policy guidance, strategic planning, regulation, etc.)		Restructuring of central MoH (mandate)
	9. Better DP alignment		
			Public finance management (PFM)
2. To raise adequate funds to finance a minimum package of services *[...achieve national health goals and in a sustainable manner]*	1. Establish a ***Health Revenue Collection Agency***	**1. Mobilise adequate funds to finance health services**	Increase GoU alllocation to 15% of the national budget
	2. Continuous review of the case for earmarked taxes – especially in view of potential public health gains		Explore hypothecated taxes for health (alcohol, tobacco, marketing unhealthy foods; road toll, car insurance; ...)
	3. Consider health bond, promoting health savings		
	Expectation of full DP alignment		Alignment of DP contributions (--> on budget, IHP compact)
3. To develop a financing system which guarantees access to quality healthcare for all Ugandans, especially the poor and vulnerable groups *[Social Health Protection / effective risk pooling]*	1. Set up mechanisms to manage the National Health Services using pooled funds: ***- National Medical Insurance Agency (NMIA),*** ***- National Health Services Agency (NHSA)***	**2. Protect household from high OOP expenditure**	Establish ***National Health Insurance (NHI)*** to cover public sector, private and informal sector; contributions of the poor paid by GoU; regulate pvt. sector
	2. Community and other risk-pooling mechanisms		
	3. Harness informal sector financing potential		
	6. Protecting the poor and vulnerable groups	3. **Ensure equity in allocation of resources**	Introduce needs based *resource allocation formula (RAF);* awareness raising for use of services by the poor
	4. A broad benefits package		
	5. Strong provider incentives		

Uganda: Comparison of 2 HFS documents: observations and guiding questions *(June 2013)*

Reference documents: HF strategy input 1 (swk); HF strategy input 2 (section 1 & 2)

This document serves to stimulate discussions to clarify some issues in the two HFS drafts and initiate actions to merge them as one national document based on their common concerns and proposed interventions. **Guiding questions:** What do the two drafts have in common? what has been agreed upon? what still requires discussion? what are the gaps considering the goal of UHC.

HF Analysis - Is there agreement on the main issues and priorities to be addressed?

- *Low investment in health to deliver the HSSIP, UNMHCP. Gap: sector requires $48 per capita, but realises $25 per capita, of which only $ 9 is from public sources.*
- *Heavy reliance on out-of-pocket spending (a very inequitable financing mechanism)*
- *Misappropriation and wastage (efficiency)*
- *Attainment of efficiency and equity (in payment into the HF system) in health financing, its organization and implementation*
- *Limited cross-subsidization and high fragmentation of HF mechanisms*
- *Static / Decreasing domestic funding (in real terms), despite fast-growing population*
- *Insurance contributions are largely not pooled,*
- *Reliance on funding through development partners and global health initiatives.*
- *High population growth rate of 3.4%*
- *New and ever evolving service standards, norms and technologies,*
- *New disease patterns and patient preferences,*
- *Political pressures: Elimination of fees, proliferation of governance units, infrastructure intensive health plans, etc*

Strategy framework *(see attached table/synopsis of two HFS drafts)* **- Is there agreement on the main goal, objectives and interventions?**

If UHC is the main goal, it is important to assure that all these objectives contribute to UHC and guide the HF strategy and reforms.

Sequencing: (Re-)form follows function*:* what needs to be modified in terms of HF functions (resource generation, pooling, purchasing) to move closer to UHC?

Then in the following step: what needs to change in the administrative set-up (e.g. new agencies like HRCA, NMIA, ...)

Resource requirements and fiscal space - Is there sufficient information on what the country can and wants to afford?

Both drafts emphasize the importance of raising or mobilizing adequate funds, which is good. But clarity will be needed how much is needed along with the defined benefits, and how much the country can afford. For example, how much is needed

- to fund the minimum package nationwide;
- to cover the administrative and operational costs of establishing 3 new agencies (HRCA, NMIA and NHSA);
- to subsidize the poor and vulnerable which is about 25% of the population and how to identify these;
- to improve health service quality, efficiency, availability and equity especially for the 80% of the rural currently using only 40% of resources and whether the required amount of resources can be mobilized by the proposed means (introduction of HI and hypothecated taxes).

Benefit package - Is there agreement on the criteria for setting the priority health services that every person can access, use and afford when they need them?
What services are available now and physically accessible, who has access and uses them, how much people pay and what gaps in terms of the 3 UHC dimensions (population, service and cost coverage).

Service quality - Is there agreement about investments and incentives for quality as well as for support in the development of quality improvement and external assessment systems ?
Besides health service quality standard, norms and guidelines, it may require large investments and incentives to address the current issues. These include human resource shortage, training, salary levels, incentives, supply of medicine, medical equipment, maintenance, medical technology, and improvement of medical facilities in rural settings to ensure that appropriate and quality health services are available and accessible at every level of care which follows an established referral system.

Efficiency - Is there a common understanding about the existing causes of inefficiencies?
It seems that the organization and management of health service are quite decentralized at national and sub-national levels, revenues are allocated through fragmented structures e.g MoH and other line ministries, and disease specific programs. Irrational use of medicine and waste are also an issue. Pooling and purchasing functions are also fragmented. It is advisable that all types of health care providers operate in harmony to deliver quality health services that people need from the system.

Equity - what would be strategic interventions to reduce the equity in access gap? And the gap between health service need and utilization through the health financing reform?
This can be discussed in view of revenue mobilization from high, low income, the poor and vulnerable; resource allocation, distribution and use among the urban and rural population, different provinces, districts, and among different income and socioeconomic groups.

Governance and management capacity: This is a critical issue for success. Some questions like what regulatory mandates, managerial and administrative capacities will be needed to implement the strategy, how to build them, how to address some obstacles or build supporting environment, what good practices or experiences to rely on etc. How will the mandate in decision making about the distribution of health services and about provider payment systems and fee levels be divided over MOH and HI/purchasers. Will there be any national regulation of prices of drugs and supplies? Poorly organized and uncoordinated public and private practices, together with weak managerial capacity and law enforcement could be the major obstacle e,g to introduce compulsory health insurance.

Some additional issues for discussion: level of fragmentation due to proposed system changes (see pros and cons of Option X); voluntary vs. mandatory HI membership; capacity for implementation; etc.

Prepared by Dorjsuren Bayarsaikhan, Michael Adelhardt, Jan Bultman

HEALTH FINANCING REFORMS CONSULTATIVE MEETING
Imperial Royale Hotel
03-04 July 2013, 8:00AM-5:00PM
MEETING REPORT

Participants: Various health sector stakeholders, **126** participants on Day 1 and **101** on Day 2 – please see Attendance List

Agenda:

- *Overview of the health sector, health financing situation and key health financing reforms in Uganda*
- *Presentation on key health financing functions*
- *Workshop on current arrangement for health financing functions and recommendations – resource generation, pooling, purchasing, governance and community financing)*
- *Presentation of Workshop Outputs and discussion*

Highlights of the Meeting

1. Overview of Workshop Agenda by Mr. Tom Aliti
2. Introduction of Participants
3. Keynote Address delivered by Undersecretary of Health, Mr. Kyambadde on behalf of the Hon. Minister of Health

   He highlighted the importance of the meeting in line with the government's Vision 2040 where the focus will be "on building an efficient health delivery system". He recognized the leadership of Dr. Wandela Kazibwe and the MoH team in the development of health financing strategy and that this meeting seeks to build consensus on health financing and broader health sector reforms. He reaffirmed the government's commitment to improvement of health care delivery system and the move towards Universal Health Care Coverage. Likewise, he highlighted the government priorities to Promote Public–Private Partnerships in health, Improve health workforce welfare, Put in place a Health Insurance Scheme, Focus on Prevention by making vaccines available, and eradicate malaria, diagnosis at HCIII and Maternal & Child Health at HC II (Community Level).He called upon the participants to start thinking of a "triple action" approach of "Better Care, Better Outcome, and Better Value" and to design a system that will produce better health outcomes for the resources invested and ensure that each Ugandan has access to health care.

4. Overview of the Health Sector – Dr. Isaac Ezati , Director Health Services, Planning and Development, MOH

In his presentation, the Director emphasized the performance measures in the health sector as efficiency, quality and access while performance goals are health status of the population, degree of satisfaction and financial risk protection. With the MDG assessment of Uganda, there is clearly a need to focus in improving the health sector's performance in order for the population to gain. The main challenges that need to be faced are:

- Poor Health Indicators
- Inadequate financial resources
- Fragmented financing of the health system
- Incomprehensive implementation of public health interventions
- Human resources (distribution, migration, motivation, performance)
- Poorly coordinated infrastructure & technology interventions
- Health Information management still weak
- Demand factors perceived quality, perceived cost, cultural perceptions of health care
- Effective ME systems
- Limited progress in addressing health determinants

To address these challenges, the HSSP has identified the following priority interventions: Transformation of leadership and management practices, Promotion of community participation and ownership, Strategic human resource management, Modernizing health infrastructure, Improvement of the Quality, Safety, Cost and Value of Health Care, Establishment of a comprehensive knowledge management system, Strengthening public private partnerships and transformation of the health financing system. Specifically, the HSSIP recommends the development of a HF Strategy. The plan of MOH is to have a draft by end of July, revised version by end of August that will go to the Cabinet by Sept. In conclusion, the Director expressed his hope that everyone should strive for a health system that is responsive to the health needs of the population, where health gains are visible, people are financially protected and there is equity in health and finance. As a final inspiring thought, he quoted Barrack Obama, ***"Let's keep our heads toward the sun and our foot forward"***

5. Overview of Health Financing in Uganda – Dr. Francis Runumi, Commissioner, Health Services (Planning), MoH
   The presentation of Dr. Runumi included a background of health financing in Uganda and concepts on Universal Health Coverage and health financing trends. The latest result of the National Health Accounts was also discussed as shown below:

Indicators	2008/09	2009/10
Total population	***29,592,600***	***30,661,300***
Total government expenditure (UGX)	***4,949,000,000,000***	***6,318,000,000,000***
Total Government Expenditure on health (UGX)	***450,290,643,408***	***472,610,263,046***
Total Health Expenditure (THE) (UGX)	***2,808,798,380,887***	***3,234,946,082,266***
THE per capita (UGX)	***94,916***	***105,506***
Govt. health expenditure as a % of total govt. expenditure	***9%***	***7%***
Household expenditure on Health	***1,214,060,000,000***	***1,371,810,000,000***
Household expenditure on health as a % of THE(UGX)	***43.22%***	***42.41%***
Household out of pocket spending on health per capital(UGX)	***41,026***	***44,741***

The total funding for health care in Uganda is reasonable but there is still a funding gap. The households bear the largest proportion of the total health expenditure at 42.41% in 2010, very slight improvement from 2009 which was 43.2%. The government health expenditure relative to total government spending decreased from 9% to 7% in 2010 and short of the Abuja commitment of 15% while external funding accounts for 34 to 37% of the total spending. Private sector as financing agent accounts for 47-48% of the total health spending. In terms of function, medical care accounts for 46-47% of the THE compared to public health at 21-24% of THE. Clearly, there are issues in use of resources for health promotion, prevention, rehabilitation, community services and reproductive health which are all priority areas.

Universal coverage as a health sector goal ensures use of effective and needed **promotive**, **preventive**, **curative** and **rehabilitative** health services by all people without exposure to financial hardship. It aims to reduce the gap between need and utilization for everybody, something that is hard for poor countries. UHC is visualized more as a journey rather than a destination. Its objectives are:

- ***Equity*** in access to health services when needed
- ***Quality*** to ensure effectiveness and efficiency – improved health
- ***Financial risk protection*** – ensuring cost does not lead to impoverishment.

Several options/instruments that were identified to move towards UHC are the following:

- General Tax Revenue : National Health Service
- Social Health Insurance: Compulsory membership (contribution) for the whole population
- Mixed Health Financing System
- General Tax Revenues
- Specified groups covered on social health insurance principles
- Private insurance – regulated to provide specified package of care

The country needs to decide on the instruments it would use to cover its population and ultimately to achieve UHC. As a conclusion, the Commissioner emphasized that UHC is possible when health systems are:

- Better organized in Institutions, systems and structures which are well supported and functional
- Funding follows evidence on effectiveness and efficiency of an intervention
- Availability of the RIGHT Human Resource requirements
- Basic Infrastructure in place
- Good information management and flow: use of RESEARCH and evidence
- Community Involvement, organization and facilitation

6. Key Health Financing Reforms – Dr. Speciosa Wandira Kazibwe, Senior Presidential Advisor on Health and Population

Dr. Speciosa started her presentation by reminding the participants the definition of health and health system. She then thoroughly discussed the various key health system levers: Organization /Governance, Financing, Providers, Regulation and Behavior. The link between these levers with the health strategic plan and priorities was made before proceeding to the discussion of the health financing strategy, which she labeled as the trigger for change.

In Uganda, there are several challenges in the health sector that are related to health financing. These are inadequate financial resources, reliance on OOP spending, misappropriations & wastage, not equitable, ever evolving service standards, norms & technologies, fragmented system with no cross-subsidization, no pooling of contributions, significant funding through development partners & global initiatives, high population growth rate, new disease patterns, political pressure on fees, new units, infrastructure intensive health plans. Moreover, there is Inappropriate sector organization and management, absence of an integrated management and a holistic community information system, inadequate involvement of health sector stakeholders, resource availability, misapplication, wastage and financial hardship / impoverishment from direct under /over the counter payments for health.

In view of the above, there is a need for reforming the system which envisions " a *Health Financing Model that best fits Uganda's Health Sector Aspirations"* with a mission to *" to facilitate universal access to affordable quality health services by all Ugandans* " taking into account the following values: equity, solidarity, responsibility, transparency and accountability. In the long run, the health financing system shall have:

- Promoted the **effective use** of the health system, including participating in promotive activities & utilizing preventive services
- Protected Ugandans from health related **financial shock**
- Promoted **efficiency** in the provision of health services
- Improved the **effectiveness and efficiency** of revenue collection and risk-pooling
- Increased the **quality** of healthcare to all Ugandans
- Improved **governance and transparency** in order to optimize the use of resources
- Improved **aid effectiveness** in the health sector
- Ensured **sustainability** of the healthcare financing system in the country
- Promoted multi-sector and public private **partnerships approach** to health service delivery

Specifically, there are 3 health financing goals to achieve the reforms: (1) Effective organization & Governance, (2)Resource Mobilization and (3)Social Health Protection and Effective Risk Pooling. At the same time, there should be a paradigm shift that puts priority for public health care, focus on promotion and prevention, sustainable and equitable financing, strengthened governance and stewardship and client ownership.

As next steps, she proposed to agree on the transformative elements of the Health Financing reforms, establish and facilitate a **Health Reforms Secretariat** with a mandate to oversee the process of putting in place health reforms that will support the economic & social transformation of the country and mobilize the population to internalize the reforms

7. Discussion
   Questions from participants and responses from Dr. Especiosa Kazibwe and Dr. Francis Runumi
   - Inadequate funding as a challenge, maybe we have to look at alignment of all the elements in the HS (WHO) framework for a holistic approach
   - All the proposals look good on paper, how do we implement effectively? Why is there a need to go for treatment abroad, why not locally?
   - How soon is the reorganization going to happen and its implications
   - How are we engaging in the mid-term review process to ensure that HF is included in the mid-term review process?
   - Financing in the health sector- how do we improve the household role in health improvement?
   - Politics in the community is influencing the health in the community
   - 1% of all deliveries has congenital anomalies – what kind of mechanism should be available to assist the families in this situation?
   - How do we advocate for increased resources from the government?
   - We have been waiting for the structure of the MOH for the longest time…when is it going to be available?

Responses:

- There is a consensus , health reform secretariat will make the link to mid-term review
- Restructuring since 1995, people are protecting their positions
- Yes, there is a need to align the implementation of the segments for a holistic approach
- Why not stop travel abroad for treatment? RH will become Centers of Excellence to accommodate such cases
- In 1998 – MoH refused to be restructured
- There is a need to do the timelines, projections, investment envelope need to be known, cabinet workshop, meeting with all Permanent Secretaries
- Policy process will engage political structure and the cabinet
- Building capacity in the MoH to play its stewardship role. We need more resources to do capacity building

- MoH is working with local government and village health teams, not remunerated, attrition rate of 70%. There are 54 children born in parish/month on average, we need to work with local government
- Congenital diseases: broadening the BP to include health promotion, prevention, cure; given the means test result, the government should subsidize them in insurance to get treatment necessary

8. Presentation Input on Group Work, HF Functions –Dr. Robert Basaza, MOH
Dr. Basaza introduced the topics for group discussion by providing the definitions of the various health financing functions of resource generation, pooling and purchasing and benefit package. He also introduced 2 additional cross-cutting issue which are deemed important in health financing reforms: Governance and Community Financing.

The focus questions for each group were as follows: See Annex for Workshop Outputs

Group 1- Resource Generation facilitated by Roland Panea (GIZ) and Aliyi Klalimbwa (MOH)

- Based on NHA data what are the resource mobilizations implications?
- How should the National Minimum Health Care Package be financed?
- How do we ensure a fair and equitable way of mobilizing resources based on ability to pay?
- In your perspective, is mandatory premium contribution feasible for Uganda?

Group 2- Resource Pooling facilitated by Dr. Michael Adelhardt (WHO/P4H) and Tom Aliti (MOH)

- Why do we need pooling and pre-payment to achieve Universal Health Coverage?
- What is the current pooling arrangement in Uganda?
- What are the challenges and opportunities for improving pooling and pre-payment?
- What are possible new ways of shaping pooling in the health financing system for better outcomes?

Group 3- Purchasing facilitated by Dr. Olivia Nieveras (GIZ/P4H) and Eric Kakoole (MOH)

- How does the current system allocate resources for health and pay providers for services delivered?
- In your perspective, what are possible strategies to improve the efficiency of use of resources?

- What type of mechanisms/strategies/incentives should be implemented to improve quality of health care delivery?

Group 4- Benefit Package facilitated by Dr. Juliet Bataringaya (WHO) and Dr. Musila Timothy

- What benefits are currently included in the package delivered by the government? What do you think should be included in the package?
- Are you aware of the benefits you are entitled to? What can be done to improve transparency and awareness of population to improve utilization of benefits?
- In what ways can we improve individual and community responsibility towards improvement of their own health?

Group 5- Community Financing facilitated by Dr. Robert Basaza (MOH) and

- What are the existing community health financing practices; what should be the role of the community in financing of services?
- What are the community voices in provision and financing of health services;
- .what are the accountability mechanisms to the community with a target at Parish, sub-County and District levels?
- What are the current roles and envisaged roles of SACOS and other cooperative bodies in Health Financing Reforms?
- Any other issues of health financing reforms at the community level?

Group 6- Governance facilitated by - please insert questions here

9. Plenary Discussion

After the presentation of each group, participants were given the opportunity to comment and raise issues.

Resource Mobilization

- How about taxing of junk food? Tax unhealthy food, develop food policy
- Why implement a premium based on percentage of income? Why not a fixed amount for all civil servants, in that way it is more palatable for the people, as we are already paying a lot of taxes for for social sectors
- Why don’t we equate the premium contribution to something affordable, e.g. chicken

Response by Dr. Speciosa – consider concepts of taxation in relation to equity and solidarity in thinking about these things; also we need to discuss these with the Finance Ministry; we need to package it well, abolish user fee and use the term co-payment; marketing is an important aspect, contextualizing and social marketing is important in UHC

Tom – One of the ways to mobilize funds is to ensure business gains in utilization, reducing wastage and addressing inefficiencies; the issue of user fee need to be debated further due to its many implications, it actually has increased (under the table?)

Michael – concept of solidarity, flat vs. progressive fee based on income, the country needs to discuss this

Ministry of Public Service – we need to work within the meager salary of civil servants, currently 5% of salary

IRA – government recently imposed stamp duty from 5000 to 35000 for each third party insurance, not sure if additional amount to be collected will not put more pressure

Resource Pooling

- SACCOs have challenges but may be useful in understanding where we go
- The private sector role in provision of services needs to be regulated esp. the pricing of services even with insurance;
- What mechanism is there to improve the responsibility of people who are subsidized? Taxation already taxes the rich highly and how to ensure it goes for better health outcomes
- At which level is the pooling going to happen? Mandatory contribution is like tax…should the mandatory contribution be progressive? There is an Implementation issue regarding the very small salaried sector in Uganda; there is an evidence on burden of even small amount so mandatory contribution might be difficult
- Pooling of funds vs. management of pooling should be differentiated
- How is the government going to be involved in financing the poor – pool vs. pull (resistance)

Response from Dr. Speciosa – need to really look at the demography/ population and be the driving force for change; educate girls

Purchasing

- Quality of care is beyond purchasing, it is a broader discussion
- Need to include in recommendations the appreciation of policies, public procurement and disposal, etc
- Results-based financing can actually improve Q of care (Dfid), think about broader -implications- use the current experience
- How to purchase promotive/ preventive services did not come out clearly – what mechanisms?
- Clarification on performance based financing – what do you mean poor quality of services will not be paid
- RBF – need to consider geographic location, over-loading of the system, harmonization of provider payment systems
- Provider Moral Hazard lessen with pooling and with strategic purchasing

Response from Dr. Speciosa- we have to work on regulation and professional ethics as a priority, also capacity development

Benefit Package

- Promote competitions among villages with regard to health indicators
- Political – village politics; challenge is to assign clear responsibility and roles to elected village leaders in health
- Authority goes with resources
- Include ambulance costs in the benefit package – to be determined later
- Constitution provisions does not correspond with health as a priority- amendments
- BP should be affordable, evidence-based

Response from Dr. Speciosa- Local government is where the real implementation happens; LGUs/CBOs need to be tapped in improving transparency and awareness – highlighting the need to use these mechanisms in health promotion and prevention

Community Financing

- Network marketing can be considered for community financing
- regulation should be implemented and regulators should be empowered to do so.

Governance

- Uganda is still highly-dependent on external funding, this is a big concern
- No policy framework for aligning donors
- Lack of private sector regulation or traditional practitioners
- Lack of autonomy and feasibility of hospitals
- A regional RH has no control over the districts in its catchment area
- Lack of clarity on roles and responsibilities
- MOH plays a stewardship role, there is a need to bridge the gap between MoH and the communities
- Consider introducing an intermediate level to do monitoring and improved policy implementation
- PPP policy need to be in placed
- Uganda National Health Authority – role in governance? What is its function?
- How to deal with professionals? There is a gap in regulation and motivation of professionals
- Consider also issues of accreditation, empowering councils, empowering of boards and health management committees
- Concerns on complex design of the proposed National Health Insurance The model that you know is a product of long process of consultation since 2007, certificate of fund availability, establish a NHI scheme, launch and then implementation

Response from Dr. Speciosa:

- do what you do best, capacitating people to do their job well, many ways to do this, retooling you for what you are intended to do
- Under the constitution, districts can form a regional charter to strengthen their representation – look at what is on the ground and start based on what is in the law
- The role of the district is supervision; Implementation is at the sub-county level
- How do we bridge the gap in terms of monitoring and supervision? merge technical expertise and M&E, community mobilization and you are on your way…start with community
- Be informed with the data, surveys as basis for decision and policies

Dr. Runumi – politics matters and it is part of our work; political interference vs. intervention, need to prepare and share information to decision-makers, politicians for better decision-making, strategic allies with politicians, resources can be easily generated, but of course each case need to be contextualized…

10. Next Steps

- Finalize the Health Financing Strategy
  - Establish a technical secretariat (Key team members from MOH will be led by Dr Speciosa Kazibwe, with the help of P4H partners)
  - Synthetize the contributions/proposals in this consultative workshop and ensure that the proposed HFreforms are integrated into the HFS.
  - Suggestions on the content: Prioritize reforms and strategies which we can be immediately implemented (quickwins) and identify allies, the focus of the strategy should be the health financing functions within the context of health sector reforms, the strategy should be based on clear output indicators and targets and focused outcome; strategy needs to interface with other decentralised financing strategies and or other partners financing strategy; use research and evidence; consider a change management strategy
  - Timeline: next two weeks will be used by technical team to draft the document with the schedule below:
    - ✓ Week 9th-15th-July synthesize the reports
    - ✓ Retreat week 16th-21st July 2013.
    - ✓ Week 21st- 25th Team cleans the document
  - first draft completed by end of July 2013, final draft by August 2013
  - CHS(P) to coordinate the HFS finalisation processes; the P4H network(Dr. Olivia Nieveras) will provide technical guidance and put together key sections and issues of the HFS draft.
  - HFS secretariat to develop a budget for finalisation of the HFS
- Inter-sectoral and partner consultations on HF Strategy.Leadership, coordination and stewardship are key in pushing finalization of the HFS.
- Lobbying and presentation to the Cabinet
- Come up with draft Tor for the Health financing Reforms secretariat, multi-sectoral membership to be launched by MOH Minister

- Disseminate the HF Consultation Workshop Report to all participants, Minister, Cabinet

11. Remarks – Dr. Ezati, Director of Planning, MOH

He is totally in support of the reforms and wants to see the HF Strategy concluded as soon as possible, even before the HI bill is submitted to the Parliament. There are enough materials available to come up with a draft HF Strategy and there is a need to focus on HF reforms beyond the health sector reforms. He thanked all the participants, particularly the champion and advocate of HF reforms -Dr. Speciosa and the strong support of the MOH Minister, which are key strengths to move the agenda forward. He also thanked the MOH team, development partners and all the participants for the energy, work and efforts spent in the past 2 days.

12. Closing Remarks – Hon Minister of Health

The Minister thanked all the participants and apologized for his absence during the opening ceremonies. He appreciated the efforts of the participants to discuss in detail the financial reforms needed to take place in the health sector and the technical team who will synthesize the options for financing health care. He highlighted that Uganda has requisite resources but it is incumbent with the managers to use these resources in an equitable and effective way. As stewards of health sector, the need to be effective and efficient cannot be overemphasized. He is happy that as he started his tenure as a Minister of Health, such pertinent issues like health financing are being tabled and discussed with the view of reforming the health sector. He reiterated his full commitment to move the process forward and table the suggested reforms to the Cabinet. There is a need to move fast as people are yearning and it is our responsibility to respond to this call, fundamental changes are needed. He proposed to establish an inter-ministerial committee to debate on these reforms as he recognized the importance of multi-sectoral collaboration and to build the momentum to move forward. Finally, he reiterated that the sector cannot get ahead without resources so health financing is a foundation. Health sector reform is not a question but the issue is how to meaningfully implement them, how fast and how to effectively manage the forces that will oppose them. Powerful leadership and broad coalition are needed in confronting the road blocks. He urged everyone to continue working together and officially closed the meeting.

1. INTRODUCTION

A nation's health is its most precious asset. Uganda is at a critical stage of developing and reforming its health system. The government has made noticeable progress in the past decades but still facing the challenges of improving its health outcomes and achieving the Millennium Development Goals. Poverty rate has fallen down from 55% in 1993 to 24.5% in 2010 (Uganda National Household Survey 2009/10) and the average growth rate of GDP is 7%. Seventy two percent (72%)of the population resides within a 5 km radius of a health facility; universal primary education and secondary education has boosted adult literacy rates from 69% in 2006 to 71% in 2010; and support to tertiary institutional development and the promotion of skills training is giving Ugandans a foundation for participation in gainful employment and further monetization of the economy. Under a decentralized context, the necessary organic linkages between communities and their elected local governments for better planning, organizing, managing and monitoring resulted to improved service delivery.

My Health My Responsibility; Making Health Everyone's Business: Uganda's Health Financing Strategy

Globally, the 20th Century registered absolute increases in life expectancy for most groups around the world (Lee 2005). In Uganda, progress in overall human development indicators has been consistent but relatively low. The life expectancy has improved from **45 years in 2003** to **52** years in 2008. The key health impact indicators, particularly infant and under-5 mortality are improving. However, maternal and child health death remain high; accounting for 20.4% of the disease burden in Uganda. In 2006, estimates of Maternal Mortality Ratio (MMR) are at **435** deaths per 100,000 live births and Infant Mortality Rate (IMR) at **76** deaths per 1,000 live births.

Communicable diseases account for **54%** of the total burden of disease in Uganda with HIV/AIDS, tuberculosis (TB) and malaria, being the leading causes of ill health; Non-Communicable Diseases (NCDs) are an emerging problem with costly treatment implications. Couple with this is the high fertility rates—at 6.2 per woman, the second highest in the world (Source?). In addition, significant disparities exist in health status between regions and socio-economic strata with the rural areas bearing the highest burden of ill health and death.

The slowing down of progress in the sector may be attributed to an underperforming health system as well as barriers to access quality health care. The current system suffers from inefficiencies, urban-rural and geographic inequities, poor quality of health care and high out of pocket spending. Based on 2007 Household Survey, twenty eight percent of households in Uganda are experiencing catastrophic payments (defined as more than 10% of total household consumption). In addition, the recent global economic crisis and inefficiencies in use of resources has potentially impacted the government's ability to create the fiscal space to increase health expenditures.

The National Development Plan, under the objective of strengthening the organization and management of the national health system—commits government to mobilize sufficient financial resources to fund health sector programs, using a multi-sectoral approach involving pro-rata investments in and collaboration with sectors that have a significant bearing on the determinants of health, so as to ensure equity, efficiency, transparency and mutual accountability. Health

financing reforms will be a key area that will catalyze and trigger the transformation of the health system towards achieving universal health coverage (UHC)[1].

1.1 Rationale for a Health Financing Strategy

The transition to universal coverage is complex and may take decades. It requires extensive capacity and efforts to come up with a strategic approach and options that are tailored within the country context to facilitate the move towards UHC. Uganda has embarked in this exercise with an end view of developing a common vision for ensuring equitable access to quality health services and financial protection for all Ugandans. The Health Financing Strategy can serve as an instrument for resource mobilization at national level. Itwill help the country steer its health system investment in the right direction and contribute to health sector reforms to realize its overall sector goals. Moreover, the clarification of roles and responsibilities of various stakeholders in the strategy process will help to coordinate and harmonize the various contributions of stakeholders, while the strategy itself provides the basis for aligning resources and opportunities for efficiency gains. The development of this strategy is one of the identified priorities in the Health Sector Strategic and Investment Plan and is intended to assist in realizing the health sector policy objective of contributing to the overall growth and development agenda of the country.

1.2 Process of developing the Health Financing Strategy

This Health Financing Strategy (HFS) has been initiated by the GoU working closely with health development partners and civil society. It is developed through a participatory process that included a series of meetings, consultative workshops and discussions with key informants. The Health Financing Strategy Task Force chaired by the MoH Commissioner of Planning with the MOH Planning Department led the process of strategy development, in consultation with stakeholders and with the support of Providing for Health partners (GIZ, WHO, WB). The Senior Presidential Advisor for Population and Health and former Vice President of Uganda closely accompanied the process and guided the HFS Task Force. A core group was established to be responsible for the technical development of the document and prepare the drafts for consultation. It followed a process of analysis and the collection of evidence and best practice experiences, technical discussions, technical drafting, policy consultation and policy decision-making.

[1] Universal Health Coverage is defined by WHO as "ensuring that all people can use the promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."

2. BACKGROUND

2.1 Population and Demographics

Uganda has an area of 240,038 square kilometer and a population of 30.7million in 2009 with an annual growth rate estimated at 3.2%. It is estimated that 49% of the population is under the age of 15 and a high number of female under reproductive years, estimated at 7 million. A Total Fertility Rate of 6.7 births/woman and a contraceptive prevalence rate of 24% contribute significantly in the rapid increase in population. In 2009/10, an estimated 7.5 million Ugandans lived in poverty, with the poor in rural areas representing 27.2% of the population but only 9.1% in urban areas. The incidence of poverty is highest in Northern Uganda at 46.2% and least in the Central region at 10.7%. This shows the disparity and inequity in development between urban and rural areas. Although most of the country is physically accessible, there are geographical barriers to access in the mountainous areas and the islands on Lake Victoria.

2.2 Economic Context

Uganda's economy has been boosted by macroeconomic and political stability resulting from macroeconomic reforms. The country has substantial natural resources, including fertile soils, regular rainfall, sizable mineral deposits, and recently discovered oil. For almost a decade now, it has experienced robust economic growth rates averaging 7% in real terms. However at GDP of $430 per capita, it remains among the poorest countries in the world. Further economic growth has been constrained by inadequate infrastructure, limited capacity in the energy sector, high interest rates and extreme weather conditions. The National Development Plan (NDP) 2010-2015 provides the overall development framework for GoU to accelerate economic growth and reduce poverty. Over the period of NDP, GoU will increase availability and access to quality social services, including health service delivery. Specifically, the NDP prioritizes the implementation of the Uganda National Minimum Health Care Package (UNMHCP). A major policy objective of the health sector is to mobilize sufficient financial resources to fund the health sector programmes while ensuring equity, efficiency, transparency and mutual accountability

2.3 Policy Context

The Health Financing Strategy (HFS) is guided by key international, regional and national policies and goals:

2.2.1 Millennium Development Goals – related to health:
Goal 1: Eradicate extreme poverty and hunger (malnutrition)
Goal 4: Reduce child mortality
Goal 5: Improve maternal health
Goal 6: Combat AIDS, malaria and other diseases
The HFS is oriented towards speeding up the achievement of health-related MDGs in equitable, efficient and sustainable way. By putting an emphasis on the protection of household income against the impoverishing effects of illness and catastrophic illness related expenditure, the strategy will also strengthen the health sector's contribution to reaching MDG 1.

2.2.2 Abuja Declaration- Uganda has signed up to the Abuja Declaration committing 15% of government spending in the health sector.

2.2.3 Rome, Paris, Accra 2008, Busan Declaration - Donor commitment to the High Level Forum in Rome, Paris, Accra and Busan on harmonization and aid effectiveness are contribution to improved donor coordination: the HFS builds from these external frameworks and internal achievements to strengthen the effectiveness of external assistance in the health sector in the context of SWAp.

2.2.4 Health-for all Policy for the 21st Century in the African Region (Agenda 2020, Harare, WHO), WHO Health Financing Strategy for the African Region (2006) and the East, Central and Southern Africa guidelines for health systems development

2.2.5 International Health Partnerships and related initiatives which seek to achieve better health results and provide a framework for aid effectiveness

2.2.6 Kigali Ministerial Statement on Universal Coverage and Long Term Harmonization of Social Health Protection in the East African Community- A joint statement of the Ministers of Health and their representatives reaffirming the Tunis Declaration and recommending the establishment of a SHP Regional Committee to strategically guide, implement and collaborate among EAC member states to (1) promote best practices aimed at UHC across the region; (2) define a framework for long-term harmonization of SHP mechanisms; and (3) consolidate development partner's action plans to support the Kigali Statement in line with the prevailing environment in each member state

2.2.7 National Development Plan- overall development framework to accelerate growth to reduce poverty in Uganda. It places emphasis on investing in the promotion of people's health and nutrition which constitute a fundamental human right.

2.2.8 National Health Policy-emphasis is placed on attempts to achieve universal access to a minimum health care package as well as equitable and sustainable financing mechanisms

2.2.9 Health Sector Strategic and Investment Plan- provides the medium term strategic framework and focus that the government intends to pursue to attain the health goals of the country

2.2.10 Health Financing Policy Statement

The government with support from development partners shall provide adequate resources to the health sector. Efforts for improving health financing in Uganda shall be guided by the concepts of Universal Coverage and Social Health Protection. In order to achieve this policy objective, the Government shall:

1. Develop a comprehensive health financing strategy addressing resource mobilization, pooling of funds, efficiency (allocative, technical and administrative) and equity
2. Consider regional and international commitments to which the Government of Uganda is signatory in the process of budgetary allocations to and within the health sector

3. Ensure that resources are allocated in a manner that prioritises funding of the UNMHCP
4. Ensure that all financial resources to the health sector are administered according to the GoU financial regulations
5. Establish overall adjusted health financing mechanisms based on pre-payment and financial risk pooling aiming at universal coverage and social health protection. These shall include national health insurance and other community health financing mechanisms
6. Revise and expand contracting mechanisms with the private sector to improve resource use and efficiency in service delivery and general support services
7. Strengthen programming of external funding for health through improved harmonisation and alignment and sector priorities, mutual accountability and improved reporting
8. In addition to regulatory mechanisms, implement fiscal and financing mechanisms that promote private sector growth.

2.2.11 Public Financial Management legislations and standards

At the local level, public financial management in the health sector is supported by legislations and standards such as 1) The Constitution 1995; 2) The Budget Act 2001; 3) The Public finance and accountability Act 2003; 4) Local Government Finance Act 2007; 5) Public Finance and Accountability regulations 2005; 6) Treasury Accounting instructions 2003; 7) Local Government Act 2007; 8) Local Government financial and accounting regulations 2007; 9) Public Procurement and Disposal of Assets Act 2003; 9) The National Audit Act 2008; and, 10) and International Public Sector Accounting standards

2.2.12 Decentralization Policy

The GoU decentralized the delivery of services guided by the Constitution of Republic of Uganda (1995) and the Local Government Act (1997). The National Health Policy (NHP) supports the decentralization of services to districts and health sub-districts (HSDs). Each level has specific role and responsibilities but effective service delivery is constrained by limited district capacities, inadequate supervision and funding and weak logistics management

2.3 The Health Sector in Uganda

2.3.1 Vision, Mission and Values

In line with the Government of Uganda's National Development Plan (NDP) 2010/11-2014/15 which aims to accelerate the transformation of Ugandan society from a peasant to modern and prosperous country within 30 years, the health sector formulated the 2nd National Health Policy 2010/11-2019/20 and Health Sector Strategic and Investment Plan, 2010/11-2014/15.

Uganda's **vision** for the health sector is that of a healthy and productive population that contributes to economic growth and national development. The goal is to attain a good standard of health for all people in Uganda in order to promote a healthy and

productive life. Its **mission** is to provide the highest possible level of health to all people in Uganda through promotion, prevention, curative and rehabilitative/palliative health services at all levels—guided by the values of 1) the right to health; 2) solidarity; 3) equity; 4) respect for cultures and traditions of the people of Uganda; 5) professionalism, integrity and ethics; 6) stakeholder participation; and 6) accountability.

2.3.2 Social Determinants of Health

The major determinants of health in Uganda include levels of income, education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviors and access to quality health services. Based on study conducted by UBOS in 2007, diseases such as malaria, malnutrition and diarrhea are more prevalent among the poor than the rich households. The proportion of households with toilet facilities has increased to 88% in 2006 compared to 57% in 2005.Access to health services for women is limited by decision-making processes in families, where the husbands make decisions about their own health care.

2.3.3 Health Service Delivery

The delivery of health services is by both public and private sectors with GoU as the owner of about half of facilities. Public health services are delivered through Village Health Teams (VHTs), HCIIs, HCIIIs, HC IVs, general hospitals, regional referral hospitals and national referral hospitals. The private sector plays an important role in the delivery of health services, covering about 50% of reported outputs. The private providers are categorized into: Private Not For Profit (PNFPs) facility-based , Private Health Practitioners (PHP) and the Traditional and Complementary Medicine Practitioners (TCMPs). The government provides subsidy to PNFPs, which are mostly present in rural areas.

A key feature in health service utilization of the Ugandan population is the fact that approximately 60% of the population seeks care from TCMPs before and after visiting the formal sector (HSSIP). Many of these healers have varying and inconsistent service and no functional relationship to private or public providers, resulting to late referrals, poor management of cases and high morbidities. The government under the NHP will develop and establish collaboration mechanisms with TCMPs in the broad service delivery.

2.3.4 Challenges in the Sector related to Health Financing

There are several challenges in the health sector that are related to health financing: inadequate financial resources for health, reliance on OOP spending, misappropriations & wastage of resources, inequitable access, fragmented system with no cross-subsidization, no pooling of contributions, inadequate and de-motivated human resource, significant funding through development partners & global initiatives. Likewise, there is inappropriate sector organization and management, absence of an integrated management and a holistic community information system, inadequate involvement of health sector stakeholders, wastage and financial hardship from direct under/over the counter payments for health.

Moreover, the Ministry is challenged with cost drivers which will in the medium term continue to be of concern:

- A population growing at a rapid rate as a result of high fertility. This is responsible for increased demand for maternal and child health and adolescents services;
- Reduction in adult mortality leading to population ageing and increase in the non-communicable diseases burden when communicable diseases are still high on the health agenda;
- Marketing of new and more expensive technology with increased public demand for access to high quality but affordable care;
- The global economic downturn which worsens the financial resource situation with less likelihood for significant increase in development support

2.3.5 Responding to HF Challenges in the Sector

The first National Health Policy and associated strategic plans have guided developments in health during 1999-2009. One of its key features is diversification of health care financing in support of the national goals of improved health status and equity. Changes that occurred during this period are introduction of the Sector Wide Approach (SWAp), public-private partnership, abolition of user fees, introduction of the Uganda National Minimum Health Care Package (UNMHCP), autonomy for the National Medical Stores (NMS) and decentralization of the responsibility of delivering health services to local authorities..

Decentralization has modified the way health care services are organized and policies are formulated. Direct financing to Health Sub Districts (HSDs), the implementation units, was put in place, with their creation in 2000. This implied that HSDs received funds, against plans they developed for their operations, resulting to reduced transaction time.

Another significant reform initiated in 1997, was the provision of subsidies to the private not-for-profit (PNFP) health facilities. These facilities were expected to provide health care at an affordable price, particularly to the poor. However, this objective of keeping the price affordable was achieved by some PNFP facilities while some others failed to do so probably because the government subsidy was inadequate and operational costs gradually increased.

The removal of user fees at the point of use of services was effected in 2001. This made public health services free at the point of use, in all levels of care. A paying window was introduced for hospitals that allowed them to raise additional revenue from clients that sought higher quality services. Service utilization has sustainably increased as a result of this financing reform. The odds of not seeking care in 2005-06 were estimated to be 1.8 times higher than in 2002-03.

The sector has been utilizing Expenditure Tracking Surveys, and Expenditure Reviews as tools to monitor the efficiency of flow of funds, and funds utilization respectively. These have helped institutionalize a mechanism to monitor the financial management system on a regular basis since 2001. The establishment of strict

budgetary ceilings, and Sector Working Groups to manage available budgets has improved on budgetary discipline and, supposedly, allocative efficiency.

At the community level, newer forms of community-owned, pre-paid and pooled health financing mechanisms surfaced since mid-1990s. They are gradually evolving into a viable financing option for health. More than their resource-base, they also bring in some organizational advantages, particularly in identifying the poor and in monitoring the progress made by the public health programme. They could be potentially used in public health communication, needs assessment, resource tracking, organizing public camps, and health system management (HF Review, 2010). Under the National Health Policy, a key objective is ensuring that communities, households and individuals are empowered to play their role and take responsibility for their own health and well-being and to participate actively in the management of local health services. (NHP, 2010)

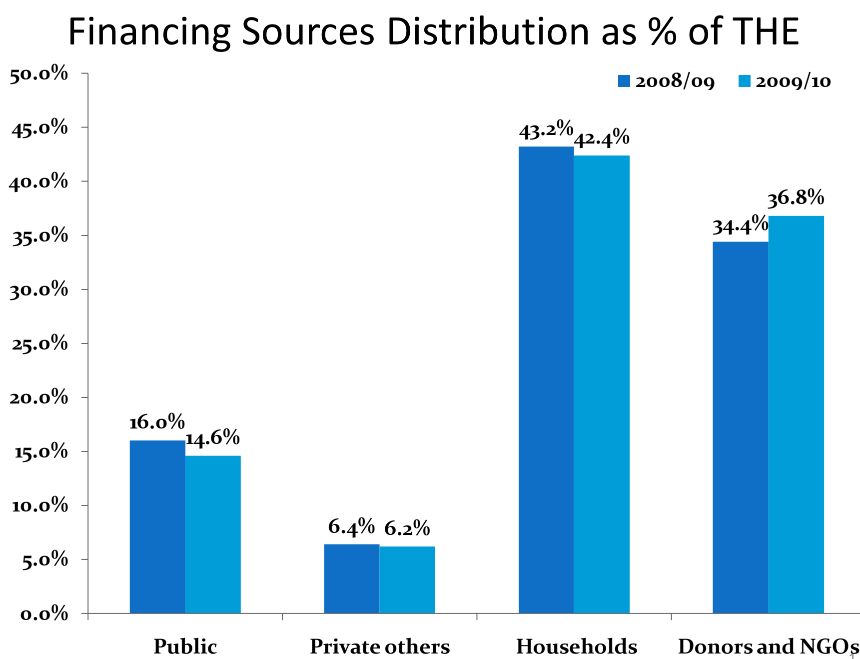
The national health policy recognizes the role played by different sectors in promoting health and will strengthen collaboration with government ministries and the private sector using a multi-stakeholder approach.

3. SITUATIONAL ANALYSIS

3.1 Key Issues in health financing

3.1.1 Revenue Collection

- Diversification of health financing and sources of funding: government, donors, NGOs, households, employers and philanthropists



- Low investment in health to deliver the HSSIP, UNMHCP. In 2012/13, the estimated total cost of benefit package under realistic scenario = 48$ per capita (did not take into account HH contributions), Government funding is $12, hence, a funding gap of $36
- Decreasing government funding for health at 9% (below Abuja target), despite fast-growing population
- High household spending at about 43% and out-of-pocket spending for health at $21 per capita in 2010
- Reliance on funding through development partners and global health initiatives amounting to about 35% of the THE
- Total health expenditure has increased from $49 to $52 per capita in 2008/09 and 2009/10 respectively. This is still below the WHO recommendation of $60 (NHA 2010)

3.1.2 Resource Pooling

- The biggest risk pooling facility is state-funded tax based financing and is the predominant mechanism for funding health infrastructure and health care
- Limited cross-subsidization and high fragmentation of HF mechanisms – government, NGO, community and for profit private schemes, as shown below

Institutional mechanisms through which health financing channels operate in Uganda

Financing channel	Financing sources used	Institutional mechanism	Key instrument
Government	Government budget	Direct purchasing	MoH budget
	External resources		Hospitals
	Household resources (payment ward)		Districts
			Demand side financing (cash transfers)
NGOs	Government budget (subsidies)	Direct purchasing	Hospitals
	External resources		
	Household resources (user fee)		
	Philanthropic resources		
	NGO resources		
Community-based	Household resources	Insurance	Community-based
	NGO resources (subsidy)		Provider-based
	Government budget (indirect through subsidies to NGOs)	Banking	Community-based credit
Private	Employer resources	Insurance	Provider-based insurance
			Formal insurance
	Household resources		Micro insurance
		Direct purchasing	Employer-run facilities
		Banking	Micro-credit

Source: Health Financing Review, 2009/10

- A small fraction of the population enjoys the pre-paid financing mechanisms cover (AHSPR 2010-2011, pg 31). Prepayment ratio has stagnated at 0.6 of THE from 2002 onwards. This indicates the absence of policy moves to limit financial barriers to access.
- Currentrisk pooling options in Uganda include:
  1) social health insurance—planned to meet medical expenses of government employees (NHI), in preparation
  2) community-based health insurance, about 15 schemes overseen by MOH and covers about 5-10% of the population in their catchment area;
  3) private/voluntary health insurance for urban-based formal sector employees with coverage of about 2%;
  4) Micro health insurance/cooperative medical services—for informal employees and;
  5) Medical deposits at health facilities—which includes student and child birth medical deposits.

- Development assistance continues to play a major role in financing but a bigger proportion is off-budget. In FY 2008/09, it was estimated that off-budget funding was US$440M while overall health budget stood at $628M. Programming of funds is not harmonized and may not be directed to health sector priorities.
- Draft NHI Law submitted to the Parliament for the implementation of a SHP model with multiple insurers to choose from, is currently in progress.

3.1.3 Purchasing of services and resource allocation

Provider Payment:

- Health service delivery is by both public and private sectors with GoU owning about 60% of facilities in 2010 (AHSPR 2009) composed of 64 hospitals and 2558 health centres at various levels. Government purchases services by (a) providing direct financial support to health facilities, including private non-for profit facilities amounting to about 20% of service delivery in the PNFP sector (b) payment of staff salaries (c) budget transfers to local government to fund preventive and curative care
- Development partners support the efforts of government through sector budget support and off-budget projects. In addition, they implement projects that are specifically targeted at health problems and also make funds available to only a few districts of the country as opposed to the whole country.
- Households may avail of services from public facilities, free of charge. But it is not uncommon that they will pay out-of-pocket for services through user fees at the point of use to private providers and PNFP. Forty three percent (43%) of patients visited private clinics as the 1st point of consultation (UNHS 2009/10)

Resource Allocation

- During the HSSP II period, 45 to 54% of the GoU budget for health was directly disbursed to district health services with the MOH headquarters getting 18 to 27%. At the district level, about 70% of the health budget goes to district primary health care. (HSSIP Annual Report? Validate this)
- Intra-sectoral resource allocation is based on the resource allocation formula, which considers financial risk protection of poor households, improving equity and efficiency in allocation and use of resources. There is however a need to review the formula as some of the factors are not clearly defined and the weights are not explicitly stated.
- NHA 2010 shows that non-public sector controls 78% of total health expenditures, 42% of which is managed by households followed by NGOs at 30%. Hospitals accounted for 27% of health expenditure while lower level facilities utilized 35% of THE to deliver health care services, mostly by private for profit clinic and drug shops.
- Curative services accounted for the highest percentage(56%) of health expenditure for 2009 and 2010 although the biggest burden of disease is preventable, prevention services only accounted for 24% of THE in 2010 (NHA 2010).
- The Fiscal Space for Health Study conducted by WB pointed out the need for Uganda to improve the efficiency of its health spending to maximize the health benefits for its population. Specifically, in the area of HR for health, strengthening procurement and logistics management for medicines and medical supplies and better programming of development assistance for health.

3.1.4 Stewardship and Governance

- Overall steward of the system is MOH which plays a role in budget formation, setting regulatory framework for the specifics of the health sector and provides tertiary level care health services.
- The decentralized health system delegates to districts the authority for running public health facilities to the level of district hospital in their territory and oversight of private providers
- Financial reporting is required for all institutions receiving public funds but there are challenges at the district level due to lack of capacity and commitment which lead to delayed fund releases
- An Integrated Financial Management System (IFMS)was introduced to promote efficient and secure data management as well as accountability to stakeholders but not yet rolled out to all facilities
- There are issues on procurement, financial management and audit follow-up.

3.2 Assessment of Health Financing Policy Objectives

3.2.1 Financial Protection and Equitable Distribution of Burden

- Based on 2007 Household Survey, there is significant inequality in access to health care. Twenty eight percent of households in Uganda are experiencing catastrophic payments (defined as more than 10% of total household consumption). The incidence of catastrophic health expenditure ranges from 24.8% in the richest quintile and 28.3% in the poorest quintile and between 23.4% in the eastern region and 38.1% in the western region.
- A quick look at current health care utilization in Uganda suggests that the poor use public facilities more than the richer quintiles. However, this analysis masks the income-related differences in utilization patterns: poor households predominantly use health centres and wealthy households use hospitals. This suggests that focusing on improving access to health centres and dispensaries is an important pro-poor strategy (HFS Review, 2010).
- GoU subsidizes PNFPs to enable reduction in user fees and facilitate poor access to their services.
- The HSSIP will aim at ensuring equity in delivering health care services. This is of particular importance given the human rights and gender concerns as mentioned in the NDP.

3.2.2 Efficiency

- Efficiency is currently not well addressed in the way resources are mobilized, allocated and used in the health sector. A 2010 study conducted by the World Bank, MoH and MoFPED estimated the health sector loses at UGX 36.7 Bn annually due to waste through health worker absenteeism, expired drugs and poor payroll management.
- The study further noted that significant fiscal space can be created by improving efficiency and effectiveness of health spending through; 1) improving management and performance of health workers; 2) linking funding to results and avoiding resource

wastage; 3) developing the health financing strategy; and, 4) better programming and management of development assistance for health.
- The Ministry of Health has committed during implementation of the HSSIP, to improve the efficiency of health service delivery through health sector reforms, donor coordination in the spirit of the Paris Declaration on aid effectiveness and the Accra Agenda for Action.

3.2.3 Quality of Health Care

- A study conducted in 2008 on user's satisfaction and understanding of client experiences showed that in general clients were satisfied with physical access to health services (66%), hours of service (71%), availability and affordability of services. However, they were dissatisfied with long waiting times and unofficial fees in the public sector, quantity of information provided during care and other behavioral problems relating to health workers. The clients were also more satisfied with community health initiatives because they provide free services and allow them to participate in health services management.[2]
- No available data on client satisfaction for the current year. However, there are indicators which point to improvement in quality of services – per capita OPD utilization has improved from 0.8 in 2008 to 1.2 in 2012 as well as remarkable improvement in medicine availability from 43% to 79% in the same period(Annual HS Performance Report 2011/12)
- There is also a Client Charter which was introduced to strengthen the demand side of accountability for service delivery. It spells out the roles, responsibilities and commitments of the MoH to their clients in order to achieve maximum sustainable health outcomes (Client Charter, MOH 2012). Likewise, there is a Patients' Charter to ensure that the Rights of Patients are protected in the course of seeking care (Patient's Charter, MOH 2009).
- Supervision and mentoring(S&M) aims at continuous quality improvement of health services and safety of health providers and clients through supervisory visits, coaching, periodic reviews and health management information system.

3.3 Summary of Key Health Financing Issues

3.3.1 Resource Generation:

- Low investment in health to deliver the HSSIP, UNMHCP. In 2012/13, the estimated total cost of benefit package under realistic scenario, = 48$ per capita (did not take into account HH contributions), Government funding is $12, hence, a funding gap of $36
- Decreasing domestic funding (in real terms), despite fast-growing population
- Reliance on funding through development partners and global health initiatives.

3.3.2 Pooling

- Heavy reliance on out-of-pocket spending which is a very inequitable financing mechanism

[2] Jitta,J.,J.Arube-Wani and H. Muyinda.(2008).Study of Client Satisfaction with Health Services in Uganda

- Limited cross-subsidization and high fragmentation of HF mechanisms
- Insurance contributions are largely not pooled

3.3.3 Purchasing

- Government is the purchaser and provider in the case of the public sector funds (no provider-purchaser split) which are allocated to health facilities based on a resource allocation formula

3.3.4 Stewardship and Governance

- Capacity challenges in public financial management (PFM), systematic data analysis, health economics, evidenced-based policy development and district health system management
- Weak coordination mechanisms on health financing and social health protection within the sector and inter-sectoral
- Need for an accurate, timely and functional health management information system and M&E system
- Engagement of private sector and communities in health financing is not currently optimized

3.3.5 Poor alignment of donor project funding with health sector priorities

4. THE HEALTH FINANCING STRATEGY

4.1 Vision, Mission, Goals and Objectives

4.1.1 Vision

In order to live up to the expectations of the NDP and as one of the key health sector interventions that will lead to ensuring a healthy and productive population, the **vision** for the health financing strategy is ‘***a Health Financing Model that best fits Uganda's Health Sector Aspirations'.*** This is in recognition of the moving target with respect to the people's expectations.

4.1.2 Mission

'To facilitate universal coverage and access to affordable quality health services by all Ugandans'

4.1.3 Goal

To develop an equitable, efficient and sustainable health financing system in which all Ugandans are able to access needed, good quality health services, without experiencing financial hardship.

4.1.4 General Objective

To foster the development of equitable, efficient and sustainable health financing to achieve national health goals by 2020.

4.1.5 Specific Objectives

1. To secure a adequate level of funding needed to achieve national health goals and objectives in a sustainable manner
2. Improve effectiveness and efficiency in allocation and use of raised resources
3. Strengthen institutional arrangements in planning and management of resources for improved transparency, accountability and sustainability

In pursuit of the above, the attitude and conduct of all stakeholders will at all times be guided by the following guiding principles and core values:

4.2 Guiding Principles and Values

4.2.1 Guiding Principles

1. **Country Ownership** must ensure that all health financing processes are led and owned by Uganda
2. **Efficiency** must ensure that maximum health benefits are derived from scarce available resources
3. **Risk-sharing and Solidarity** mechanisms must be expanded to increase the proportion of the health budget that is pooled and reduce their proportion of OOP. The better-off in society should support the cost of healthcare for the poor; the young to support the

ageing and old; and the healthy to contribute towards the cost of care for those who are sick.

4. **Evidence-based decision-making** should be practiced on a day to day basis, align with health financing reforms, rely on best practices and be economically viable
5. **Partnerships and multi-sectoral approach** should involve all health related sectors, various levels of government, the private sector, international development organizations, communities and civil society.
6. **Dynamism** should be a central principle in implementation of the HFS which involves being innovative and visionary**.**

4.2.2 Values

1. People First

The needs and satisfaction of communities, households and individuals will be a primary consideration in health service delivery.

2. Equity

All Ugandans should access health services according to their health needs and not according to their ability to pay (equity in finance). Discrimination based on age, gender, race, religion, political affiliation or any other socio-economic considerations should not be entertained (equity in access).

3. Responsibility

All Ugandans should 'own' their health and address their own health seeking behavior. All stakeholders should accept their duties and obligations and reciprocal responsibility in order to avoid misuse, fraud, etc., in order to ensure sustainability of the system.

4. Transparency and Mutual Accountability

Purchasers, providers and users should have access to information regarding the operation of the system and/or as required by any law or professional etiquette/practice; patients should receive sufficient information about their treatment, health and well-being. This HFS shall strive to attain the highest standard of technical, financial and political accountability in order to regain the trust and confidence of the public and development partners.

4.3 Strategic Pillars

More money does not automatically translate into better health.

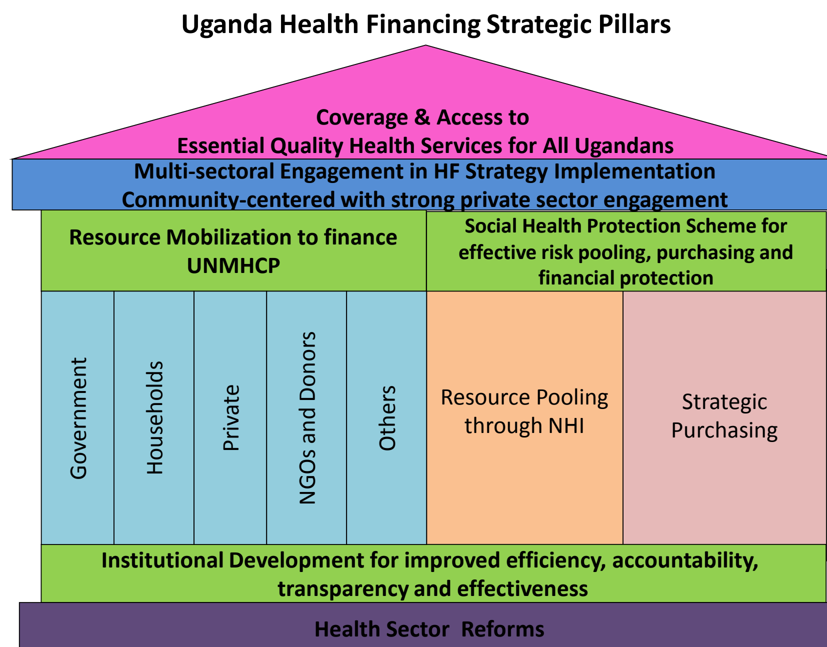
Focus on **efficient practices** in order to **deliver** universal coverage **without increasing spending**

Given the health conditions of the people, the current socio-economic context of Uganda, in-action is not an option if the government health policy objectives are to be met in the mid and long term. More money does not automatically translate into better health. Whatever the size of the envelope, the health sector is duty bound to deliver good results given the high expectations from the population. Priority must therefore be placed on smart policy choices and focus on efficient practices in order to deliver universal coverage without huge increase in spending.Based on the situational analysis, three main strategic pillars have been identified:

Pillar 1: Institutional Development for strengthened stewardship and governance of health financing towards improved transparency, accountability and sustainability

Pillar 2: Resource Mobilization to ensure an adequate level of funding to finance the Uganda National Minimum Health Care Package (UNMHCP)
Pillar 3: Social Health Protection – To develop an integrated health financing system that will efficiently pool resources and strategically purchase health services to improve equitable access and financial protection for all Ugandans

Uganda Health Financing Strategic Pillars



Need to discuss and agree on the strategies as basis for structuring the text. Once finalized, we can use the old HF draft and pick-out the relevant text for describing the strategies. We can structure it as follows:

1.1 Strategic Objective and Key Indicators:
1.2 Components:
1.3 Strategic Interventions:

This section is developed and proposed based on my understanding of Dr. Runumi's strategic direction and technical group's perspective of limiting the interventions to HF since another document will be developed for health sector reforms

4.3.1 Pillar 1: Institutional Development

Strategic Objective: To strengthen institutional arrangements for improved stewardship and governance of health financing resulting to improved transparency, accountability and sustainability

The health sector recognizes that in order to effectively deliver health services to all Ugandans, the financial, technical and organizational resource capabilities have to be redrawn and recast to fit into the current context. Under the new policy, the MoH will focus on its stewardship role, strategic planning, standard setting and monitoring and evaluation of the sector. Capacities will have to be built for it to effectively carry out these roles. The

Ministry is therefore divested of the responsibility of purchasing health services and focus on their mandates (Purchaser-Provider split). Stewardship and governance of health financing will be strengthened within the context of health sector reforms that will provide an enabling environment for the health financing strategies. Likewise, strategies to efficiently and effectively allocate resources will be implemented.

Key Indicators:

- Active participation of HF Unit in functioning working groups on health sector reforms and inter-sectoral SHP committee
- Number of PPP established
- National database for poverty targeting established
- Number of trainings conducted based on training needs analysis conducted
- NHA process institutionalized and supported
- Resource allocation formula revised and implemented
- Number of facilities operating under Results-Based Financing

4.3.1.1 Component 1: Create synergies and linkages between HF Strategy, health system reforms and other sectors

Strategic Intervention1:Closely collaborate with concerned departments and sectors for the effective implementation of health sector reforms in the area of organizational restructuring, functioning referral system, human resources for health, autonomy of health care providers, drugs and medicine availability, quality improvement and accreditation system

Strategic Intervention 2: Institutionalize linkages among key stakeholders across sectors through an inter-sectoral committee on HF/SHP

Strategic Intervention 3: Strengthen engagement with the private sector based on PPPH, including regulations for effective health service delivery

Strategic Intervention 4: Build on the strengths of communities and civil society to effectively participate in community financing of services and improving responsibility for their health

Strategic Intervention 5: Collaborate with concerned agencies on the implementation of a national database for poverty targeting

4.3.1.2 Component 2: Strengthen stewardship and governance on health financing

Strategic Intervention1: Establish a Health Financing Unit with good leadership capacity in the MOH

Strategic Intervention 2: Develop capacity of technical staff on health financing, health economics, public financial management, monitoring and evaluation, health policy research and evidence-based policy development

Strategic Intervention 3: Develop and implement an effective system of internal controls, including logistics, procurement and audits

Strategic Intervention 4: Implement an effective and harmonized health management information system that provides timely data for decision-making

Strategic Intervention 5: Institutionalize conduct of National Health Accounts

Strategic Intervention 6: Regularly disseminate information on health sector spending e.g. NMS, hospitals, PNFPs, etc.) and timely budget performance reports

4.3.1.3 Component 3: Efficient, effective and equitable resource allocation

Strategic Intervention1: Review current transparent resource allocation formula and implement a transparent and equitable allocation of resources in the health sector

Strategic Intervention 2: Improve management and performance of health workers through incentive schemes like results-based financing (RBF)

Strategic Intervention 3: Establish a mechanism for benefit development and pricing of services (Benefit and Tariff Board?)

Institutional Development Strategies

Most of the strategies described here are proposed to be part of health sector reforms document

4.3.2 Pillar 2: Resource Mobilization

Strategic Objective: Resource Mobilization to ensure an adequate level of funding to finance the Uganda National Minimum Health Care Package (UNMHCP)

To ensure efficiency and maximize benefits in the short run, general taxes and pay roll contributions will be the principle methods for collecting health revenue for social protection against ill health. The MOFPED will collect pay roll contributions from Public Sector and NSSF collect premiums from the private sector employees and transfer it to the NHIF. In the medium term, government may consider the creation of a National Health Revenue Agency to collect and distribute premiums and other revenue in order to ensure a public – private mix of insurers—once the private sector insurers become established. (More analysis, however, needs to be done to examine the most cost-effective modalities for collecting revenue, with a view to improving efficiency and maximizing the derived benefits). This will be discussed and debated

General revenue contribution to the overall pool of health financing is envisaged in the short and long run. Over time it may be required to finance national programs and insurance premiums for the poor. In the short run, there is a need for general revenue financing to supplement the insurance premiums for the non-poor, as well as ensure that everyone has access to the basic package of insured services—including screening for a package of diseases like cervical cancer, prostate cancer, HIV/AIDS etc.

Private insurance and other pre-paid schemes like community insurance and demand side financing will be promoted. Suitable incentives will be put in place by government to expand the pool of resources for health care, promote the culture of health insurance and increase efficiency in the way contributions are made towards health insurance. Private providers will be

will be paid by the insurance providers for the delivery of basic package of servicesto members.
.
Development partners will be urged to support the reforms and encouraged to continue to support the development of the health sector by contributing to the recommended implementation requirements especially in the improvement of the quality of care, equity in access and infrastructure development, as well as systems development. Pooling for social health protection will be done nationally. This will mitigate distortionary off budget projects, position accountability on the constitutionally mandated accounting officer and strengthen the framework under the agreed Long Term Institutional Arrangements (LTIA) for managing and coordinating health grants.

Cross-subsidization and consolidation within and between health financing mechanisms will be compulsory and have legal backing to ensure adequate pooled resources to sustain universal coverage. Initially, general tax sourced funds will be pooled within the Ministry of Health, and the private social insurance funds pooled within the NSSF. Funds specifically earmarked for public health activities and other national programs will be pooled under the Ministry of health.

Key Indicators:

- Per capita government expenditure on health
- Proportion of general government expenditure spent on health
- Government expenditure on health as proportion of GDP
- External funding for health as a % of total health expenditure
- Private funding as % of total health expenditure
- % of expected quarterly HDP donor project reports on disbursements and commitments that are received timely% of donor project funds budgeted that is on MTEF within the Health sector votes.

4.3.2.1 Component 1: To effectively mobilize internal resources for funding the health sector

Strategic Intervention1: Explore the possibility of using ear-marked taxes on tobacco, alcohol and other unhealthy products to fund preventive programs and provide subsidy to NHIF

Strategic Intervention 2: Advocate for increased government budget for health by improving the collaboration between MOH and MOFPED

Strategic Intervention 3: Identify and advocate for innovative ways of raising more resources for health – health bonds and promoting health savings, airline tax, foreign exchange tax

Strategic Intervention 4: Lobby for a portion of third party insurance collections to be transferred to NHIF i.e. Motor Vehicle Insurance, Workmen Compensation

Strategic Intervention 5: More effectively engage the private sector through corporate social responsibility, philantropic organizations/individuals to increase their contribution to the sector.

4.3.2.2 Component 2: To improve the effectiveness of external assistance in the health sector

Strategic Intervention1: Improve harmonization and alignment of development assistance in health following the principles in Paris Declaration and Accra Agenda for Action

Strategic Intervention 2: Strengthen long term institutional arrangements for management and coordination of Global Health Grants (LTIA) including a mechanism for pooled health funding

Strategic Intervention 3: Develop the fiduciary capacity of MoH to manage development assistance

Resource Mobilization Strategies

1 Establish a Health Revenue Collection Agency - to be debated

Efficient revenue collection is critical to ensuring that the maximum amount of funding is available to purchase medical services. Evidence points to the complexity of the purchasing function as well as its importance to the smooth functioning of the healthcare financing system. It is therefore necessary to separate revenue collection and purchasing functions with the former focusing on maximizing the amount of revenue, while the latter concentrates on deriving maximum value from the available revenue.

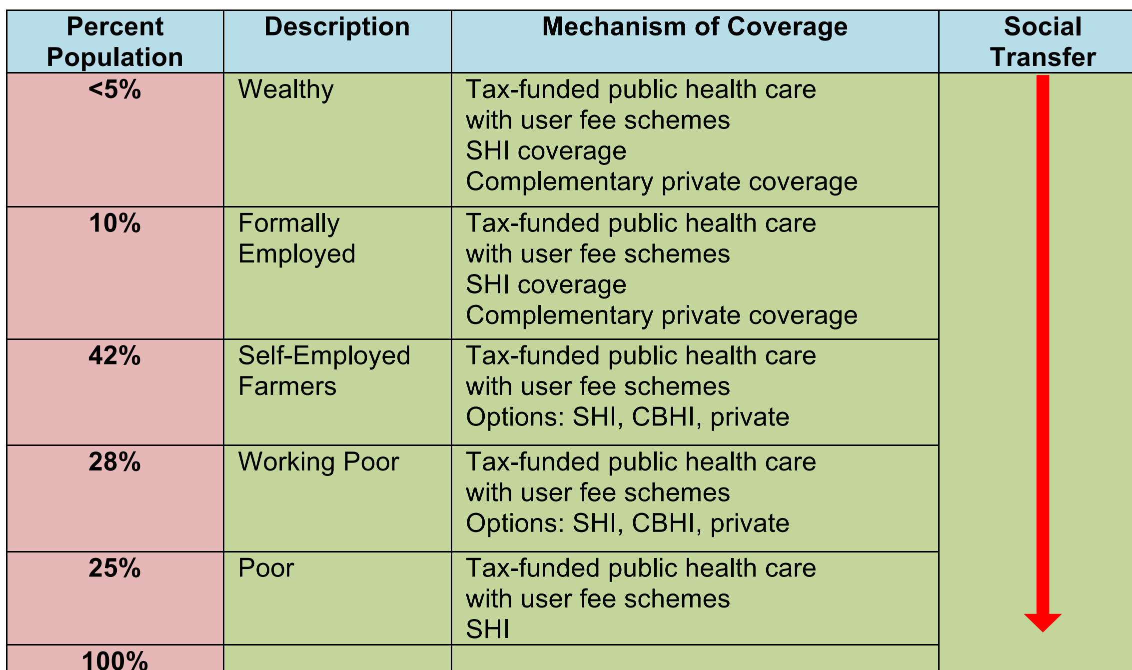
Merit in having the NSSF collect private sector health services revenue over the long term has to be explored. A National Medical Insurance Agency (NMIA) will be established to purchase medical care from all providers—public and private.

General revenue contribution to the overall pool of health financing is envisaged in the short and long run. Over time it may be required to finance national programs and insurance premiums for the poor. In the short run, there is a need for general revenue financing to supplement the insurance premiums for the non-poor, as well as ensure that everyone has access to the basic package of insured services—including screening for a package of diseases like cervical cancer, prostate cancer, HIV/AIDS etc. Funding from development partners to ensure equity and access will continue to play an important role in the overall healthcare financing system for the foreseeable future.

4.3.3 Pillar 3: Social Health Protection Scheme

Strategic Objective: **To develop an integrated health financing system that will efficiently pool resources and strategically purchase health services to improve equitable access and financial protection for all Ugandans**

Population Coverage Map, Uganda



Percent Population	Description	Mechanism of Coverage	Social Transfer
<5%	Wealthy	Tax-funded public health care with user fee schemes SHI coverage Complementary private coverage	
10%	Formally Employed	Tax-funded public health care with user fee schemes SHI coverage Complementary private coverage	
42%	Self-Employed Farmers	Tax-funded public health care with user fee schemes Options: SHI, CBHI, private	
28%	Working Poor	Tax-funded public health care with user fee schemes Options: SHI, CBHI, private	
25%	Poor	Tax-funded public health care with user fee schemes SHI	
100%			

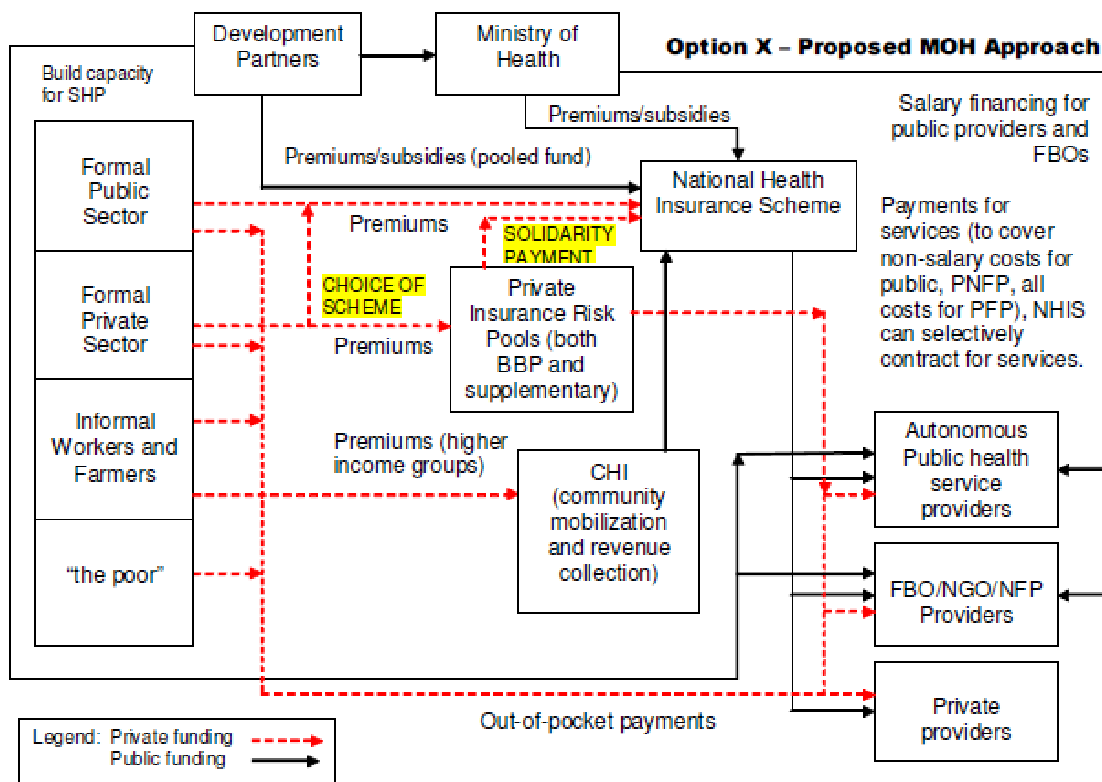
Source: Uganda National Household Survey 2009/2010, figures were extrapolated from given data (estimates only)

To extend social health protection to all Ugandans, the health financing system will be **country led** and **owned** and founded on complementary principles of social health insurance and tax financing. Embedded in the model is support for the development of private health insurance and community-based health insurance. To eliminate geographical, financial or cultural barriers in order to achieve universal coverage with a basic package of health services, mutually reinforcing policy initiatives and approaches will be put in place.

The social health insurance law will provide for coverage of the poor and accelerate coverage of the formal sector. Better regulation of the health insurance industry will be done in order to expand the diversity of social health insurance providers. This will make it possible for the population to access the basic health insurance benefits package from either public or private providers. Funding will follow the subscriber to the insurance provider of choice thus ensuring competition based on customer service. Collaboration with health related ministries, departments responsible for social protection and other stakeholders will ensure early attainment of social health protection goals and ensure sustainability of the system.

SHP Model - Multiple Insurers

Schematic flow of funds :



Key Features

Population Category/ Feature	Formal Public	Formal Private	Working Poor	Informal/ Farmers	Poor
1. Coverage by NHIS	Choice by subscriber	Choice by subscriber	Choice by subscriber	Choice by subscriber	Yes
2. Benefit Package	Basic Package	Basic Package	Basic Package	Basic Package	Basic Package
3. Premium Levels	Based on income	Based on income	Based on ability to pay	Based on ability to pay	Paid by GOU
4. Source of Funding	100% GOU	Employer-Employee	Employer-Employee + GOU subsidy	Self + GOU, if NHIS is chosen	100% GOU
5. OOP-Basic Benefit Package	Eliminate informal	Eliminate informal	Eliminate informal	Eliminate informal	Eliminate informal
6. Impact on private insurers	Increased business and numbers				
7. Impact on CHI	More members but reduced scope of activities (no claims processing)				
8. Impact on health financing mandate districts	Mandate restricted to supervision				

9. Capacity Requirements and impact on admin costs	Big capacity requirement and high admin costs
10. Advantages	-existing insurers keep current share and expand volume -choice of insurer for the citizens -equal access to care -elimination of informal OOP -solidarity payment of private insurance into NHIS
11. Disadvantages	-high admin cost for running multiple insurers -high admin cost for running and supervising the overall system – prevent cream skimming, risk rating/premium differentiation, risk equalization mechanism -continued payment of salary by MOH -will fragment the purchasing function and reduce options for NHIS

Key Indicators:

- NHI Law is approved and implemented
- Health insurance regulation available
- Population coverage of CBHI, SHI, Private insurance
- Percentage of indigent population covered under NHIS
- Number of health facilities on partnership contract with SHP schemes
- Proportion of OOP in relation to THE
- Percentage of population suffering from catastrophic expenditure
- Annual Client Satisfaction Survey conducted

4.3.3.1 Component 1: Establish the National Health Insurance Scheme(NHIS) for Uganda

Strategic Intervention1: Facilitate the approval of the NHI Bill

Strategic Intervention 2: Develop National Health Insurance Policy and Guidelines to implement the law

Strategic Intervention 3: Collaborate with Insurance Regulatory Agency of Uganda (IRAU) in establishing a regulatory mechanism for health insurance

Strategic Intervention 4: Ensure coverage of indigents and vulnerable groups under the NHIS through government subsidy for premiums (Solidarity Funds)

Strategic Intervention 5: Develop and implement a risk equalization mechanism among the insurers in the NHIS

Strategic Intervention 6: Expand the network of community health funds and micro health insurance schemes to effectively reach the informal sector

4.3.3.2 Component 2: Implement an appropriate and responsive benefit package

Strategic Intervention1: Define and cost a comprehensive benefit package for the NHIS and determine its feasibility for sustainable implementation

Strategic Intervention 2: Ensure availability and fair pricing of essential drugs and other services in health facility through Benefits and Tariffs Board (?)

4.3.3.3 Component 3: Strong Partnership with Health Care Providers

Strategic Intervention1: Study and implement a mixed system of provider payment mechanism that will provide the proper incentives for health care providers, including public health services

Strategic Intervention 2: Establish an accurate information management system to support the purchasing and minimize fraud

4.3.3.4 Component 4: Improving awareness on health insurance and ensuring client satisfaction

Strategic Intervention1: Conduct awareness campaign on health insurance, benefits and how to avail them, client's rights and responsibilities

Strategic Intervention 2: Conduct regular patient satisfaction surveys and provide mechanisms for appeal and feedback

SHP/Effective Risk Pooling Strategies – to be discussed

1 Set up mechanisms to manage the National Health Services using pooled funds

A National Medical Insurance Agency (NMIA) will be established to purchase health services from all providers. The body will also be responsible for ensuring service contracts for clinical care are sufficiently robust. It will as well be required to provide the right incentives for providers to fulfill their role in providing high quality services. NMIA will reinsure registered community health schemes. A National Health Services Agency (NHSA) will be set up to administer all funds destined for national public/population health programs in the country.

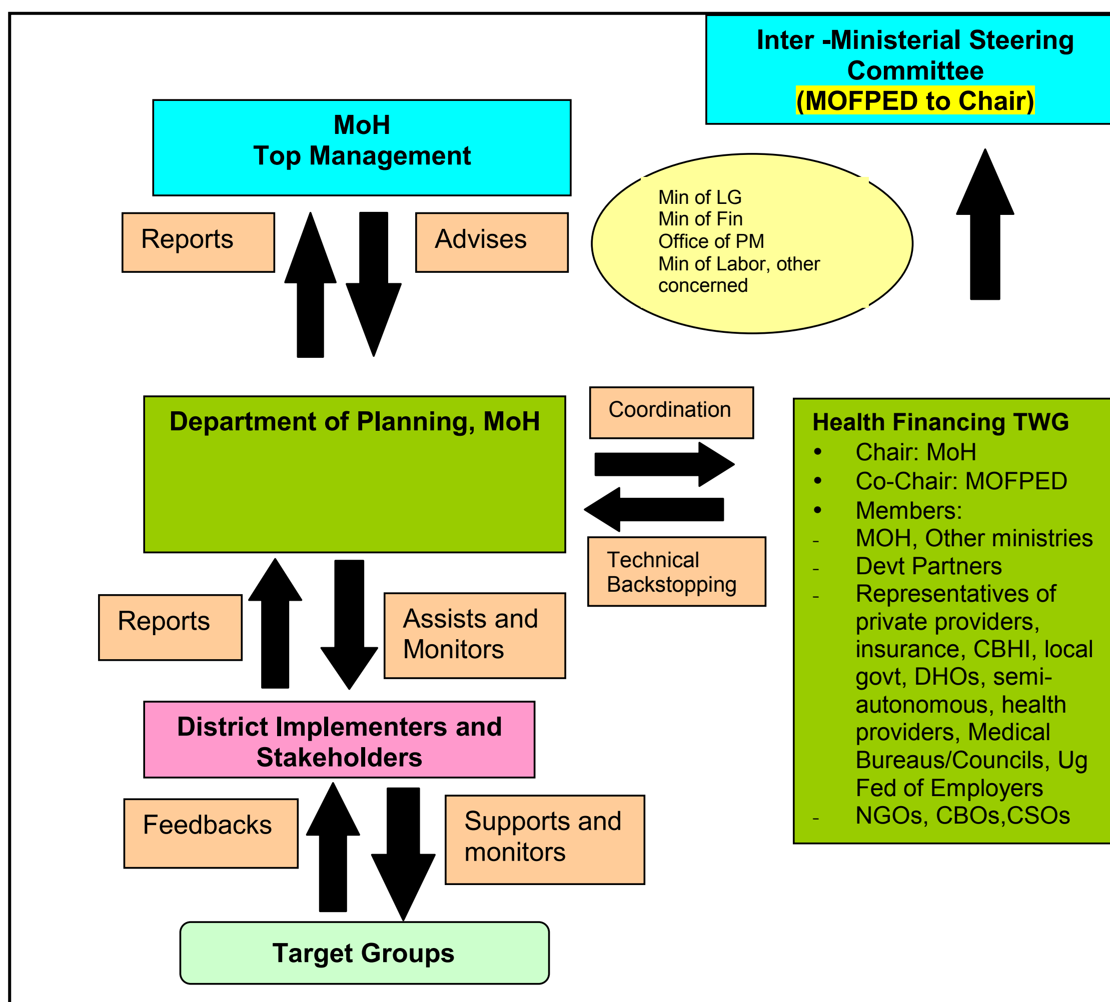
5. IMPLEMENTATION OF THE STRATEGY

5.1 Institutional Arrangement

The MOH through the Planning Department will take lead in coordinating and ensuring the implementation of the strategy. This will follow the national health system framework from national to local government level.

Other key players in the sector will include the Ministry of Finance, Planning and Economic Development, other government Ministries, departments and agencies. The private sector, development partners, civil society and the community shall play an important role in enabling successful implementation of the strategy.

Figure X: Proposed Implementation Arrangement for HF Strategic Plan



Dr. Basaza's Comment:
In this figure 2 we need to reflect SMC and HPAC.
I propose that the chair be Commissioner Health Services (Planning) and Co chair, be the Chair civil society organizations in the health sector as the peoples voice. HDP are most of the time

new and not familiar with the country health services . Secondly, the spirit of SWAP, the country should provide leadership.
We include autonomous insititutions.

5.2 Roles and Responsibilities

1. Office of the Prime Minister will provide the necessary oversight for the health financing Strategy implementation and monitor its progress. It will mobilize other sectors in support the strategy (multi-sectoral approach)

2. Ministry of Health-is the main responsible ministry to coordinate the implementation of the strategy. It is primarily responsible for ensuring delivery of quality health care services to the population based on the UNMHCP. It will spearhead the mobilization of resources for funding the implementation of the strategy, develop regulations, standards and guidelines, implement health sector reforms and oversee the implementation of the NHIS.

3. Ministry of Finance, Planning and Economic Development is responsible mobilizing, allocating and timely release of resources. It is also responsible for advocating for health sector resources, capacity building on financial management and closely collaborating with MOH for the strategy implementation.

4. Ministry of Gender Labour and Social Development will assist in community mobilization, gender mainstreaming and resource mobilization – poverty targeting?

5. Ministry of Local Government will ensure the support of local governments in the implementation of the strategy and implementation of the NHIS. It will assist to mobilize local resources, facilitate planning, strengthen accountability and infrastructure development.

6. Ministry of Information and Broadcasting will assist in advocacy, dissemination of information on policies and strategies and appeals for funding

7. Ministry of Information Technology –will support the sector in networking and enabling data capturing for monitoring progress in equity, access and financing data in the country

8. Ministry of Education will collaborate with MOH on funding aspects of service delivery in line with their mandate (funding health training, school health), manage pre-payment schemes for health for students

9. Ministry of Public Services shall ensure appropriate remuneration of health workers, implementation of incentive packages and establishment structures (appropriate categories and numbers)

10. Local Governments – will assist to mobilize resources (Local and international), mobilize the community for coverage under a pre-payment scheme and monitor effective coverage of its constituents.

11. Health Care Providers- ensure appropriate delivery of quality health services to population and participate in decision-making for health care related policies.

12. Development Partners involved in social health protection activities are responsible for providing technical and financial support to attain the objectives of the HF strategy, in an aligned and harmonized way.

13. Civil Society Organizations will assist in ensuring coverage of their target population within the context of government guidelines and sharing their experiences and lessons learned for more effective implementation.

14. Inter-ministerial Steering Committee – is the national coordinating body with representation of the various SHP/HF stakeholders. The committee will be chaired by the Office of the Prime Minister with members composed of high-ranking representatives from concerned ministries It shall mainly function for strategic, policy development and coordinated implementation of HF Strategy

15. HF Technical Working Group is an integral part of the Inter-ministerial Steering Committee. It shall be responsible for the technical work necessary for the implementation of the HF Strategy. It is responsible for coordinating the implementation of strategies and reporting of progress to the Inter-ministerial Committee

TEXT FROM TIMOTHY (for discussion and validation)

The HFS focuses on removing financial risks and barriers to access by all. The HFs is to be utilized as an instrument to effect health system reforms, including the necessary legal and legislative reforms. Focus will be putting the people and households first, as Health is made in the home, and ill health is managed in both homes and health facilities. Despite health financing coming from multiple sources, the consumers are the key financiers of health services in Uganda according to NHA reports, both as tax payers and financing care from out-of-pocket expenses. Because the households finance most health services, the focus should be in developing instruments and mechanisms for pooling financial resources from all sources with the community as drivers.

The principle role of the MOH in implementation will be to stewardship and coordination of stake-holders, regulation, standards setting and advocacy.

To promote efficiency, a purchaser-provider-regulator split framework will be utilized. Revenue collection will be organized by the MOFPED, and resources will be remitted to an independent purchasing agency, which will pay accredited providers for services delivered. The purchasing agency will develop guidelines outlining the mix of methods to be utilized in compensating

providers for services delivered, using a performance based financing model. The MOH would prescribe the essential package of services to be procured, monitor and supervise the implementation of the strategy, and set the research agenda for improvement and sustainability of the health financing arrangements. The MOH will work with the Ministry of Justice to ensure enactment of legislation that establishes the purchaser-provider-regulator split, and mandates all sector stakeholders to conform to the legal framework in place.

Institutional re-engineering will be a key requirement for implementing the strategy and reforms. Institutional governance reform is needed to support raising sufficient resources for health, including innovations moving forward, promoting efficiency and eliminating waste, addressing inequalities in coverage, structuring incentives for efficient consumption, facilitating and supporting change and separation of roles, developing robust accreditation and capacity for stewardship and regulation, transparency and accountability

The purchasing agency would be charged with establishment of linkages to the HDPs, National Social Security Fund and already existing community insurance initiatives, and making pooling attractive to informal sector.

The National Policy on Public-Private Partnership in Health provides the necessary framework for partnership and collaboration with the private sector in financing the health system, including mechanisms for community or beneficiary involvement in monitoring sector financing.

Development of a robust database for operationalizing the strategy is critical. The database will be developed and administered in partnership with the Ministry of Internal Affairs (national ID Project), Ministry of ICT, MOFPED, UBOS and the private sector. Outsourcing of database management could generate efficiency gains by reducing the administrative expenses for the strategy. The database design will incorporate capture of what is spent on social determinants of health by the responsible sectors-water, sanitation, food security, transport, etc

5.3 Capacity Development Plan (to be developed with text)

To include in the text:
-supporting evidence generation, supportive environment: health system strengthening; strengthen PFM capacities; enhance SWAp in health sector-DO NOT FORGET TCM providers; role of community; civil society; managerial capacity for health insurance, CBHI; MOH role/capacity as steward & resource mobilizer; functional capacities - social sciences; resource tracking; financial tools; research and evidence-based policy development; contracting, social health insurance management, health financing concepts and principles
- conduct Training Needs Assessment

5.4 Success Factors for HFS Implementation

Given the many challenges faced by the sector, maximizing the strengths of the proposed solutions while minimizing the weaknesses will facilitate faster resolution of the problems. Changing contexts dictate flexibility, developing institutional capacity and heeding lessons garnered from implementation. In theory it would be good to start from scratch. Reality dictates that the starting point is from where we stand. Efforts should be made to strengthen the existing systems and institutions.

For the country to move towards universal health coverage, several factors in the health system are critical:

- Better organized in Institutions, systems and structures which are well supported and functional
- Funding follows evidence on effectiveness and efficiency of an intervention
- Availability of the RIGHT Human Resource requirements
- Basic Infrastructure in place
- Good information management and flow: use of RESEARCH and evidence
- Community Involvement, organization and facilitation

Implementation of the Health Financing Strategy will require political support and public endorsement. There will, therefore, be need for constant dialogue and a continuous and effective communication strategy to set out the aims, expectations and results to be achieved in the course of implementing the strategy.

Whereas government is limited on the extent to which it can influence private spending on private providers, appropriate policy levers and enabling legislation must be in place—in the spirit of solidarity, equity and freedom—to ensure that services offered are safe, effective and of suitable quality. These provide the basis for monitoring of both public and private providers and thus the need for capacity building in this area.

A major factor to informed policy making is complete and accurate data. However, information will likely never be perfect and gaps in data always exist. Data gaps will be closed and effective monitoring systems put in place to assess progress. Regular reviews, feedback and taking prompt appropriate action will be done in order to keep the strategy on course.

Stronger health systems play an important role in promoting better health outcomes. However, health Systems **are rarely, if ever**, the most important factor. Progress in other sectors, such as education, as well as government-wide systems reforms in, for example, financial management and human resources also play key roles. It is important, therefore, to acknowledge the problems of attributing gains to better financing strategies, as well as the importance of complementary actions. The MoH has, to therefore, ensure it gives effective stewardship and organization of the health sector in order to harness resources and abilities from other sectors and institutions to achieve universal health coverage.

6. MONITORING AND EVALUATION FRAMEWORK

6.1 Monitoring and Evaluation Framework (to be developed by Team-Make proposals please)

The indicators were taken from the Uganda Health Financing Review and filled up with available data– need to be refined and linked with the HSSIP Core Performance Indicators –

Performance attributes and indicators for health financing assessment (HF Review)

Financing objective	Performance		Baseline data	Source/Remarks
	Attribute	Indicator		
Resource adequacy	Level of funding	Per Capita Total Health Expenditure (US$)	$52 (2009/10)	NHA FY 2009/10
		Government Health Expenditure as % of THE	22%	NHA FY 2009/10
		Government Expenditure on Health as % of Total Government Expenditure	7%	NHA FY 2009/10
		Per capita number of Human Resources available for Health		
		Number of hospital beds available per capita		
	Sustainability of financing	External funding as % THE	36.8%	NHA FY 2009/10
		% HH expenditure spent on health		
		Total health expenditure as % of HH expenditure	42%	NHA FY 2009/10
Equity in financing	Fairness in financing	Per capita OOP expenditure on health for the richest quintile	559.67Bn UGX total	NHA FY 2009/10
		Per capita OOP expenditure on health for the poorest quintile	73.05BN UGX total	NHA FY 2009/10
		% HH income spent on health for the richest quintile		
		% HH income spent on health for the poorest quintile		
		% population not receiving care due to lack of finance		
	Financial risk protection	% HH incurring catastrophic Health Expenditure	28%	HSSIP
		OOP as % of THE	$22pc=42% of THE	NHA FY 2009/10
		Pre-payment ratio		
	Level of solidarity	% population in a health financing pooling scheme		
		Number of pre-payment		

Financing objective	Performance		Baseline data	Source/Remarks
	Attribute	**Indicator**		
		schemes		
		Average target population for each scheme		
		% target population participating in a health financing pooling scheme		
	Geographic access	% population living within 5 km of a health care facility[3]	82.5%	HF review 2010
Resource use efficiency	Value for money	Wage to non wage expenditure ratio[4]	40-50% (FY 2008/09)	HF Review 2010
		OPD attendances vs. public expenditure[5]		
		DTP 3 vaccinations vs. public expenditure		
		Facility deliveries vs. public expenditure	40% (2011/12)	AHSPR 2010/11
	Service coverage (see HSSIP Core Indicators)	Per capita non wage expenditure		
		Per capita OPD	1.0 pc	AHSPR 2010/11
		ANC coverage		
		DTP-3 coverage		
		% births attended by skilled attendants		

6.2 Mechanisms for M&E

The key indicators defined in the table above are the most important indicators for measuring the health financing performance. Baseline data will serve as the basis for monitoring the progress relative to targets. These indicators will be included as part of the HSSIP monitoring framework. The main sources of data for monitoring, review and evaluation of the sector are: the HMIS, DHS, NHA and health sector performance reports.

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6.2.1 Annual Joint Sector Review

Health financing performance will be monitored through the Joint Health Sector Review, to be led by MOH. The meeting will be attended by both internal and external stakeholders in the sector, and will use the annual and periodic performance indicators. The main purpose of the joint sector review is to take stock of progress made in the sector, identify challenges and the

[3] ***Providing a minimum range of essential health care services***

[4] ***This indicator has to be handled carefully. Although proportion of non-wage expenditure in total expenditure is a key indicator of the quantum of health care services delivered, there is no blueprint on the optimal ratio. It depends on the level of facility and health care needs of a community.***

[5] **It needs to be interpreted with caution; not all OPD, deliveries and DPT3 are delivered using public expenditure.**

reasons for them. The results obtained from the review would then be used to inform future strategies and plans.

6.2.2 Evaluation

An external evaluation of the health financing strategy is planned every three years. The results of the external evaluation will feed into the planning process for national and sector strategy to align its objectives with policy orientations.

6.2.3 Reporting on progress

Monitoring of the health financing strategy is integrated in the monitoring of HSSIP. Each year after the Joint Annual Review a report will be produced with findings and recommendations, which will be widely distributed to all partners and stakeholders, on the national and district levels. Likewise any external reviews or evaluations will be disseminated. The Planning Department in the MOH will monitor the implementation of recommendations resulting from the annual reviews and external evaluations.

7. CONCLUSION AND IMPLICATIONS OF THE HFS

7.1 Implications of HFS with respect to UHC key objectives- see diagram, for validation

7.2 Contribution of HFS to broader Health Sector Reforms

In the recent HSSIP, six key areas for investment have been agreed as the main focus of HSSIP to address some of the priority issues in the sector:

- Human resources for health
- Health infrastructure
- Essential medicines , health supplies and other health commodities
- Health Information Systems
- Preventive health/health promotion and education
- Management and coordination of sector activities

The Health Financing Strategy as one of the key instruments in the implementation of the HSSIP is expected to contribute positively in the health sector reforms by having:

- Expanded the population access to health services
- Promoted the effective use of the health system, including utilizing preventive services where appropriate and seeking services at the appropriate level of care;
- Protected Ugandans from health related financial shocks;
- Increased the quality of healthcare to all Ugandans to an acceptable and sustainable level;
- Improved the effectiveness and efficiency of in health financing functions;
- Improved governance and transparency in order to optimize the use of resources;
- Strengthened aid effectiveness in the health sector;
- Ensured sustainability of the healthcare financing system in the country.
- Promoted multi-sectoral and public private partnerships approach to health service delivery
  (What about health facility fiscal autonomy and greater community participation and ownership of the health system?)

In the end, its achievement will be measured according to how much its strategies will have contributed to the ultimate goal of the health sector—healthy and productive Ugandans.

Implication of Strategic Pillars in Universal Health Coverage Objectives

HF Strategic Pillars	Key Objectives			Intermediate Objectives		
	Gap bet. Need and Use	Quality	Financial Protection	Efficiency	Equity	Transparency /Accountability
Pillar1: Institutional Development for strengthened stewardship and governance of health financing towards improved transparency, accountability and sustainability	★			★		
Pillar 2: Resource Mobilization to ensure an adequate level of funding to finance the Uganda National Minimum Health Care Package (UNMHCP)	★	★	★		★	
Pillar 3: Social Health Protection – To develop an integrated health financing system that will efficiently pool resources and strategically purchase health services to improve equitable access and financial protection for all Ugandans						
- Establish NHIS	★	★	★		★	
- Provide coverage and access to basic benefits	★	★	★		★	★
- Provider Payment Mechanism (Strategic Purchasing and provider incentives)		★		★		★

Framework from HFS for Universal Coverage: A reference guide for countries, WHO (2013)

LOGFRAME HFS UGANDA: PROGRAMMES WITH PRIORITIES, INTERVENTIONS, RESULTS AND INDICATORS

(FOR DISCUSSION , VALIDATION OF HF STRATEGIES AND DECISION ON INDICATORS) Revised based on the text

Compiled from draft HF strategies, HSSIP, consultative workshop output using the HF Policy Statement as basis

STRATEGIC PILLAR	COMPONENTS	STRATEGIES / INTERVENTIONS	INDICATORS	VALUES	
				Baseline	Target
1.**Institutional DevelopmentTo strengthen institutional arrangements for improved stewardship and governance of health financing resulting to improved transparency, accountability and sustainability**	Create synergies and linkages between HF Strategy, health system reforms and other sectors	Closely collaborate with concerned departments and sectors for the effective implementation of health sector reforms in the area of organizational restructuring, functioning referral system, human resources for health, autonomy of health care providers, drugs and medicine availability, quality improvement and accreditation system			
		Institutionalize linkages among key stakeholders across sectors through an inter-sectoral committee on HF/SHP			
		Strengthen engagement with the private sector based on PPPH, including regulations for effective health service delivery			
		Build on the strengths of communities and civil society to effectively participate in community financing of services and improving responsibility for their health			
		Collaborate with concerned agencies on the implementation of a national database for poverty targeting			
	Strengthen stewardship and governance on health financing	Establish a Health Financing Unit with good leadership capacity in the MOH			
		Develop capacity of technical staff on health financing, health economics, public financial management, monitoring and evaluation, health policy research and evidence-based policy development			

STRATEGIC PILLAR	COMPONENTS	STRATEGIES / INTERVENTIONS	INDICATORS	VALUES	
		Develop and implement an effective system of internal controls, including logistics, procurement and audits			
		Implement an effective and harmonized health management information system that provides timely data for decision-making			
		Institutionalize conduct of National Health Accounts			
		Regularly disseminate information on health sector spending e.g. NMS, hospitals, PNFPs, etc.) and timely budget performance reports			
	Efficient, effective and equitable resource allocation	Review current transparent resource allocation formula and implement a transparent and equitable allocation of resources in the health sector			
		Improve management and performance of health workers through incentive schemes like results-based financing (RBF)			
		Establish a mechanism for benefit development and pricing of services (Benefit and Tariff Board?)			
2. **Resource Mobilization to ensure an adequate level of funding to finance the Uganda National Minimum Health Care Package (UNMHCP)**	To effectively mobilize internal resources for funding the health sector	Explore the possibility of using ear-marked taxes on tobacco, alcohol and other unhealthy products to fund preventive programs and provide subsidy to NHIF			
		Advocate for increased government budget for health by improving the collaboration between MOH and MOFPED			
		Identify and advocate for innovative ways of raising more resources for health – health bonds and promoting health savings, airline tax, foreign exchange tax			

STRATEGIC PILLAR	COMPONENTS	STRATEGIES / INTERVENTIONS	INDICATORS	VALUES	
		Lobby for a portion of third party insurance collections to be transferred to NHIF i.e. Motor Vehicle Insurance, Workmen Compensation			
		More effectively engage the private sector through corporate social responsibility, philantrophic organizations/individuals to increase their contribution to the sector.			
	To improve the effectiveness of external assistance in the health sector	Improve harmonization and alignment of development assistance in health following the principles in Paris Declaration and Accra Agenda for Action			
		Strengthen long term institutional arrangements for management and coordination of Global Health Grants (LTIA) including a mechanism for pooled health funding			
		Develop the fiduciary capacity of MoH to manage development			
		Implement a mechanism for pooled health funding of medical and public health services			
Social Health Protection Scheme **To develop an integrated health financing system that will efficiently pool resources and strategically purchase health services to improve equitable access and financial**	**Establish the National Health Insurance Scheme(NHIS) for Uganda**	Facilitate the approval of the National Health Insurance Bill			
		Develop National Insurance Policy and Guidelines to implement the law			
		Collaborate with Insurance Regulatory Agency of Uganda (IRAU) in establishing a regulatory mechanism for health insurance			
		Ensure coverage of indigents and vulnerable groups under the NHIS through government subsidy for premiums (Solidarity Funds)			
		Develop and implement a risk equalization mechanism among the			

STRATEGIC PILLAR	COMPONENTS	STRATEGIES / INTERVENTIONS	INDICATORS	VALUES	
protection for all Ugandans		insurers in the NHIS			
		Expand the network of community health funds and micro health insurance schemes to effectively reach the informal sector			
	Implement an appropriate and responsive benefit package	Define and cost a comprehensive benefit package for the NHIS and determine its feasibility for sustainable implementation			
		Ensure availability and fair pricing of essential drugs and other services in health facility through Benefits and Tariffs Board (?)			
	Strong partnership with health care providers	Study and implement a mixed system of provider payment mechanism that will provide the proper incentives for health care providers, including public health services			
		Establish an accurate information management system to support the purchasing and minimize fraud			
	Improving awareness on health insurance and ensuring client satisfaction	Conduct awareness campaign on health insurance, benefits and how to avail them, client's rights and responsibilities			
		Conduct regular patient satisfaction surveys and provide mechanisms for appeal and feedback			

Need to develop a strategic approach – classify into immediate, short term, medium and long term interventions

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Annexes – Logframe, draft NHI Bill

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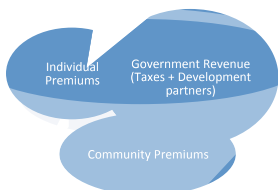
PROPOSAL - TO BE DISCUSSED AND DEBATED

The Social Health Protection System Model …1

Agency: Ministry of Health
Roles: *Policy, Strategic Planning, Budgeting, Resource Allocation, Stewardship & Sector Coordination, Research, Monitoring & Evaluation*

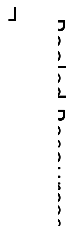


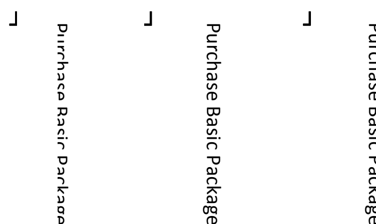
Agency: Health Services Commission (HSC)
Roles: 1) *Definition of Basic Package &. 2) Accreditation*

National Health Revenue Agency (NHRA): NSSF

Pooled

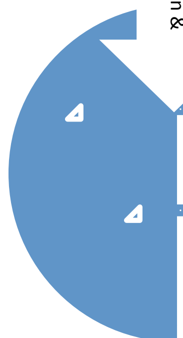
National Medical Insurance Agency: NEW





National Health Services Agency (NHSA) - Uganda AIDS Commission?

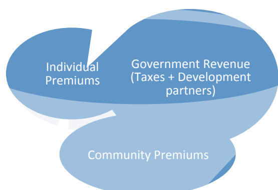
Accredited Provider:	Accredited Provider:	Accredited Provider:
Public Autonomous facility	Private Not for Profit Provider	Private Health Care Provider



Committee	Functions	Provider
District Health Committee	• Coordination • Supervision • Data cleaning / Validation	District Health Services Provider
Sub-County Health Committee	• Planning • Data Collection	Sub-county Health Services Provider
Parish Health Committee	• Mobilization • Implementation	Parish Health Services Providers –LCIs/VHTs

The Social Health Protection System Model …2

Agency: Ministry of Health
Roles: *Policy, Strategic Planning, Budgeting, Resource Allocation, Stewardship, Research, Monitoring & Evaluation*



Agency: Health Services Commission
Roles: 1) *Definition of Basic Package & 2) Accreditation of Providers*

National Health Revenue Agency (NHRA): NSSF

Public Resources

National Medical Insurance Agency: **Health Services Commission**

Public Resources

Purchase Basic Package

Purchase Basic Package

Purchase Basic Package

National Health Services Agency (NHSA) - Health Services Commission OR Uganda AIDS Commission?

Accredited Provider:

Public Autonomous facility

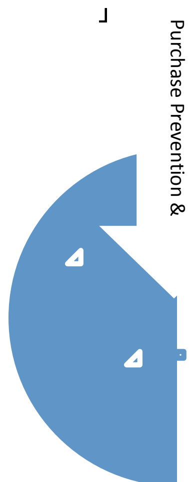
Accredited Provider:

Private Not for Profit Provider

Accredited Provider:

Private Health Care Provider

Purchase Prevention &



District Health Committee

- Coordination
- Supervision
- Data cleaning / Validation

District Technical Team

Sub-County Health Committee

- Planning
- Data Collection

Sub-County Technical Team

Parish Health Committee

- Mobilization
- Implementation

Parish Technical Teams