REPUBLIC OF UGANDA

HEALTH FINANCING STRATEGY

2015/16 – 2024/25

(Draft)

May 2015

01 MAY 2015
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1 INTRODUCTION

1.1 Uganda's Development Plan

The theme of the Uganda's National Development Plan (NDP) is "Growth, Employment and Socio-Economic Transformation for Prosperity." The thrust is to accelerate socio-economic transformation to achieve the National Vision of a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years. This will be supported by the environment necessary for sustainable development, which will entail making continuous improvements to the political, social and economic conditions[1].

The NDP places emphasis on investing in the promotion of people's health and nutrition, which constitute fundamental human rights for all people. Constitutionally, the Government of Uganda (GoU) has an obligation to provide basic health services to its people and to promote proper nutrition and healthy lifestyles. The 1995 Constitution further provides for all people in Uganda to enjoy rights and opportunities and have access to education, health services and clean and safe water.

In line with its theme, the Plan seeks to significantly improve specific socio-economic development indicators associated with transformation. These include raising average per capita income levels, improving the labour force distribution in line with sectoral GDP shares, raising the country's human development indicators, and improving the country's competitiveness to levels comparable to middle income countries.

Social sectors consist of sectors and sub-sectors that provide services required for maintaining a healthy and quality population, and developing the required human resource for effective engagement in profitable economic activities. These sectors include: education, health, water and sanitation, social development and gender, and population.

To achieve the NDP theme, **increasing access to quality social services,**i.e.improvingliteracy levels, life expectancy at birth, infant mortality rate, maternal mortality rate, safe water coverage, sanitation levels and reducing the incidence of communicable diseases and HIV/AIDS is identified as being strategic.

To achieve all this, the NDP is pursuing a quasi-market approach, which includes a mix of government investments in strategic areas and private sector market driven actions. The private sector remains the engine of growth and development, while Government, in addition to undertaking the facilitating role through the provision of a conducive policy; regulatory and institutional framework is also actively promoting and encouraging public-private partnerships in a rational manner. Furthermore, the Government is continuing to pursue outward-oriented policies by encouraging foreign investments and exports with high value addition, as well as pursuing sound macroeconomic policy and management.

[1] National Development Plan 2010/11 – 2014/15)

1.2 The Health Sector Strategic and Investment Plan and The National Health Policy

1.2.1 National Health Policy 2010 (NHP II)

The National Development Plan, the 1995 Constitution of the Republic of Uganda and the new global dynamics, informs the second National Health Policy (NHP). The **Vision** of the NHP is "*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".* The **Mission** is *"To provide the highest possible level of health to all people in Uganda through delivery of promotive, preventive, curative and rehabilitative health services at all levels".*

The NHP puts the client and community in the forefront and adopts a 'clientcentredapproach and it looks at both the supply and demand side of health care. The following social values, as detailed in the Constitution of the Republic of Uganda and Uganda's Patients' Charter, guide the implementation of the policy.

(a) ***The right to highest attainable level of health:*** the Constitution guarantees rights of access for all people in Uganda to basic health care services.

(b) ***Solidarity:*** Government will give due consideration to pursuit of nationalsolidarity in its attempt to achieve health related MDGs, with special focus on social health protection for vulnerable groups.

(c) ***Equity:*** Government shall ensure equal access to the same health services for individuals with the same health conditions.

(d) ***Respect of cultures and traditions of the people of Uganda:*** All stakeholders shall respect the promotive health aspects of the cultures and traditions of the peoples of Uganda. At the same time, negative practices and behaviours shall be discouraged.

(e) ***Professionalism, integrity and ethics:*** All health workers in the sector shall perform their work with the highest level of professionalism, integrity and trust as detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.

(f) ***Patients' responsibilities:*** Individuals are ultimately responsible for the lifestyle decisions they adopt. Patients have the responsibility of seeking care and adhering to treatment as prescribed for their benefit.

(g) ***Accountability:*** At all times and at all levels, a high level of efficiency and accountabilityshall be maintained in the development and management of the national health system. The health service will be accountable for its performance, including its financial management performance, not only to the political and administrative system, but also, above all, to its client communities.

The national policy on health is guided by the following principles:

(a) ***Evidence-based and forward looking.*** The implementation of theNational Health Policy is evidence-based, forward looking and takes into account emerging trends.

(b) ***Pro-poor and sustainability.*** The policy is pro-poor and provides a framework to support sustainable development. In order to address the burden of disease in a cost effective way, GoU, Private for Profit Provider (PHPs) and Private-Not-For-Profit (PNFPs) provide services included in the UNMHCP with special attention to underserved parts of the country. Further, GoU continues to explore alternative, equitable and sustainable options for health financing and health service organisation targeting vulnerable groups.

(c) ***Partnerships.*** Government considers partnership with other institutions, ministries, CSOs and the private sector as a cornerstone of all its undertakings. With regard to service delivery, the private sector is seen as complimentary to the public sector in terms of increasing geographical access to health services and in terms of the scope and scale of services provided.

(d) ***Primary Health Care.*** PHC remains the major strategy for the delivery of health services in Uganda, based on the district health system, and recognising the role of hospitals as an essential part in a national health system. Greater attention and support is given to health promotion, education, enforcement and prevention interventions as defined in the UNMHCP and empowerment of individuals and communities for a more active role in health development. Communities are encouraged and supported to participate in decision making and planning for health services provision through VHTs and HUMCs.

(e) ***The Uganda National Minimum Health Care Package.*** In order to address the burden of disease in a cost-effective way, public and private providers offer services that are included in the UNMHCP.

(f) ***Integrated health care delivery.*** Curative, preventive and promotive services are provided in an integrated manner.

(g) ***Gender-sensitive and responsive health care.*** A gender-sensitive and responsive national health delivery system is achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.

(h) ***Mainstreaming of health in all policies.*** Health is mainstreamed in all relevant policies and MoH, with its stewardship role on health issues, provides advice to other government ministries and departments and the private sector.

(i) ***Uganda in the international context.*** In order to minimize health risks, the GoU plays a pro-active role in initiating cross border initiatives in health and health- related issues. Further, the NHP follows the principles of the Paris Declaration and the Accra Agenda for action through the IHP+ in the interaction and collaboration with national and international development partners.

(j) ***Decentralisation.*** Health services are delivered within the framework of decentralisation.

1.2.2 Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15

The Health Sector Strategic and Investment Plan (HSSIP 2010/11-2014/15) has been developed to guide the Health sector investments towards achieving medium term goals for health. The HSSIP provides the medium term strategic framework and focus that the Government intends to pursue in regard to

attaining the health goals for the country. It is anchored on the NHP II, the National Development Plan and the Public Investment Plan and is aimed at achieving the overall goals and deliverables of the country.

The six agreed on key areas for investment during the HSSIP include (a) human resources for health, (b) health infrastructure, (c) essential medicines, health supplies, and other health commodities, (d) health information systems, (e) preventive health/health promotion and education, and (f) management and coordination of sector activities.

1.3 Multi-sector approach

Different sectors including government ministries and departments have a role to play in managing health. Recognizing this, the MoH has taken a leading role in advising, mobilizing and collaborating with other government ministries and departments. The policy objective is to strengthen collaboration between the health sector and other government ministries and departments, and various public and private institutions (universities, professional councils, etc.) on health and related issues.

Some of the critical health determinants affecting the health of the population relate to the following[2];

- Sustainable population and high fertility,
- Safe hygiene and sanitation,
- Gender norms,
- Education, and
- Housing and Urbanization.

There are therefore a number of other key ministries relating to health and each of them is expected to play its role in order to address social and economic determinants of health.

The Ministry of Education and Sports is a key partner in addressing the high population growth rate. In addition, the fertility rates have consistently remained high, recorded at 6.9 in 1995, 6.5 in 2006 and 5.9 in 2012. If the current population growth rate of 3.2% continues unabated, it is expected that the population size will double by the year 2032. In the DHS surveys, the level of education attained constitutes one of the major correlates of health; e.g. infant feeding practices, prevalence of diarrhea, ARIs and fever among under-five children generally decrease the higher the educational level of the mother.

The Ministry of Water and Environment is another key partner in achieving acceptable safe hygiene and sanitation, which remains a challenge for Uganda with a significant proportion of the population (up to 32.5%) with no latrines. Addressing social determinants of health will help improve the health status of the people of Uganda.

For gender norms and relations, the key partner is the Ministry of Gender, Labour and Social Development. Decision making ability is an important determinant of health care seeking behaviour and in contexts where decisions

[2] Health Sector Strategic & Investment Plan 2010/11 – 2014/15

are made by men this may delay or deny seeking appropriate health care for women and children. For instance in most cases, married women may not be able to make decisions on their own regarding how resources in the home can be spent. Gender norms, roles and relations also have other effects on the incidence and ability to adequately respond to ill health. It is important that such dimensions (including the organization and delivery of health services) are considered and addressed in policies and programmes not only to enhance the effectiveness of policies and interventions, but also to ensure that unintended discrimination is avoided and the "right to health" of the various members of the population is realized.

Uganda is also experiencing rapid urbanization within the context of widespread poverty and the failure of local authorities to effectively provide social services. The UN Habitat estimates that currently 15% of Uganda's population lives in urban areas. The growth of urban areas for example Kampala exceeds the ability of the city administration to provide the needed infrastructure to combat pollution and reduce the incidence of diseases related to the environment.

Uganda has also experienced the negative health consequences of climate change. for example floods in Eastern Uganda in 2007 resulted in a humanitarian crisis. Higher temperatures and rainfall associated with El Nino may increase transmission of malaria leading to epidemics in the highland areas in Uganda. Prolonged drought may lead to food insecurity and malnutrition, further predisposing populations to illnesses. Better systems for weather forecasting, disease surveillance and public health planning offer some protection for the affected populations. Given the current situation, there is a need to emphasise mitigation of adverse effects of climate change.

Lastly, adequate nutrition has internationally been recognized as one of the key factors in human development and economic productivity.

1.4 Vision/Goal of the Health Financing Strategy and the guiding principles

1.4.1 Vision/goals

Over the last few years it has become increasingly accepted that the goal of achieving universal access to needed, good quality health services (prevention, promotion, treatment and rehabilitation) will not be achieved without well-functioning domestic health systems, including health financing systems. Health financing systems are not only critical for ensuring that financial barriers do not prevent people from using the services they need but are also a way to ensure that people do not suffer severe financial problems as a result of using them. The Government of Uganda with support from development partners shall provide adequate resources for the health sector over the next decade. Efforts for improving health financing in Uganda shall be guided by the concepts of Universal Coverage and Social Health Protection[3]. Specifically, the Government hopes to mobilize sufficient financial resources to fund the health sector programmes and enhance financial risk pooling whilst ensuring equity,

[3] National Health Policy 2010

efficiency, transparency and mutual accountability in resource allocation and utilisation.

Uganda is currently expanding the capacity of the health systems to effectively and efficiently handle the population's health and especially the health of women, children and the vulnerable. This requires additional resources and better information on financing of the health systems, a critical element of the health financing strategy. The health sector urgently needs:

- More money, greater equity in health services financing and accessibility,
- Efficient use of available health resources and;
- Expanded coverage of health services, especially those targeting the poor, women and children.

1.4.2 Guiding principles

In order to achieve thestrategic objective of ensuring that financial barriers do not prevent people from using the services they need and also ensuring that people do not suffer severe financial problems as a result of using them, Government shall, as highlighted in the National Health Policy;

(a) Develop comprehensive Health Financing Policy Guidelines based on the National Health Policy and addressing resource mobilisation, pooling efficiency (allocative, technical and administrative) and equity.

(b) Fulfil regional and international commitments on budgetary allocations to the health sector to which the Government of Uganda is a signatory.

(c) Ensure that public resources from GoU and Health Development Partners prioritise financing of the UNMHCP with preferential allocation to the priorities in the package and with a clear bias to protecting the poor and most vulnerable populations.

(d) Match all capital investment to resources available for recurrent costs; within recurrent expenditure, gradually increase the allocation to non-wage operational costs

(e) Improve equity in the allocation to districts by reviewing the district allocation formula.

(f) Promote alternative health financing mechanisms other than government budgetary provisions. These shall include national social health insurance and other community health financing mechanisms.

(g) Revise and expand contracting mechanisms with the private sector to improve resource use and efficiency in service delivery and general support services.

(h) Strengthen programming of external funding for health through improved harmonisation and alignment to sector priorities, mutual accountability and improved reporting.

(i) In addition to regulatory mechanisms, implement fiscal and financing mechanisms that promote private sector growth.

No country starts from scratch in the way it finances health care. All have some form of system in place, and must build on it according to their values, constraints and opportunities.

Therefore simply choosing from a menu of options, or importing what has worked in other settings, will not be sufficient for Uganda. The HFS needs to be homegrown, pushing towards universal coverage out of the existing terrain. It is imperative, therefore, that Uganda develops its capacity to analyse and understand the strengths and weaknesses of the current system in place so that it can adapt health financing policies accordingly, implement them, and monitor and modify them over time.

2 Current Health Financing System

Uganda, like many other developing countries, faces numerous challenges financing its health system. The unrelenting burden of disease and the ever increasing costs of medicines and the associated new technologies continue to overwhelm the system. To compound all this, Uganda has one of the fastest growing populations in the world, which puts pressure on the current system.

The analysis of Uganda's current health financing strategy will follow WHO's descriptive framework, which is grounded in the World Health Report 2000, which identified health, financing as one of the four functions of the health system[4]. The health financing strategy consists of specific sub functions and policies – revenue collection, pooling of funds, purchasing of services and policy on benefits entitlements and patient cost sharing obligations[5]. It is important to note that the health financing system does not act alone in affecting intermediate objectives and final goals; coordinated policy implementation across the health system functions is essential to achieving desired results.

2.1 Overview and description

The conceptual framework for understanding the organization of Uganda'sHFS is derived from Kutzin's descriptive framework[6] which considers the various health financing sub functions and policies, i.e. revenue collection, pooling, purchasing, and policy on benefits and patient cost-sharing.

2.1.1 Revenue collection/source of funds

The sources of funds financing Uganda's current health system are;

- General(un-earmarked) tax revenues/compulsory prepayment,
- Voluntary prepayment (voluntary private/community health insurance),
- Direct out-of-pocket payment at the time of service use, and
- Development partner contributions, which also include Global Health Initiatives (GHIs) and International NGOs.

The government budget is financed from three main sources; (a) **Taxes**: Tax revenues collected by Uganda Revenue Authority (URA) which include income tax, customs duties, consumption taxes; (b) **Non Tax revenue**: Fees (for example from Passport and Immigration fees) and Licenses; (c) **Loans and Grants**: Loans are Concessional credits provided by multilateral agencies; while Grants are mostly from bilateral development partners. Unlike in other countries, there is no specific tax earmarked for the healthcare sector.

[4] The other functions are stewardship, resource generation (investment in human and physical capital and inputs), and service delivery (personal health care and population-based health services).
[5] Health financing policy: a guide for decision-makers. Health Financing Policy Paper 2008/1.
[6] Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy, 2001, 56: 171-204.

The National Health Accounts for FY 2008/09 – 2009/10 provide a breakdown of health expenditure by financing source and show that during that period, public funds (compulsory prepayment) accounted for 16% of total health expenditure in the financial year 2008/09 but decreased its relative contribution to 15% in financial year 2009/10. Private funds (voluntary prepayment and direct out-of-pocket payments) contributed 50% and 49% of the resources to the health sector in financial year 2008/09 and financial year 2009/10 respectively. The rest of the world (Development partners, GHIs and International NGOs) contributed 34% in FY2008/09 and 36% in financial year 2009/10.

Table 1:Financing sources – General health for FYs 2008/09 and 2009/10

	FY 2008/09 Amount in Bn UGX	Percentage	FY 2009/10 Amount in Bn UGX	Percentage
Public funds	449.98	16%	472.35	15%
Private funds	1,392.08	50%	1,571.66	49%
ROW funds	966.42	34%	1,190.68	36%
Total	**2,808.49**		**3,234.68**	

Figure 1: Percent contribution by source of funds

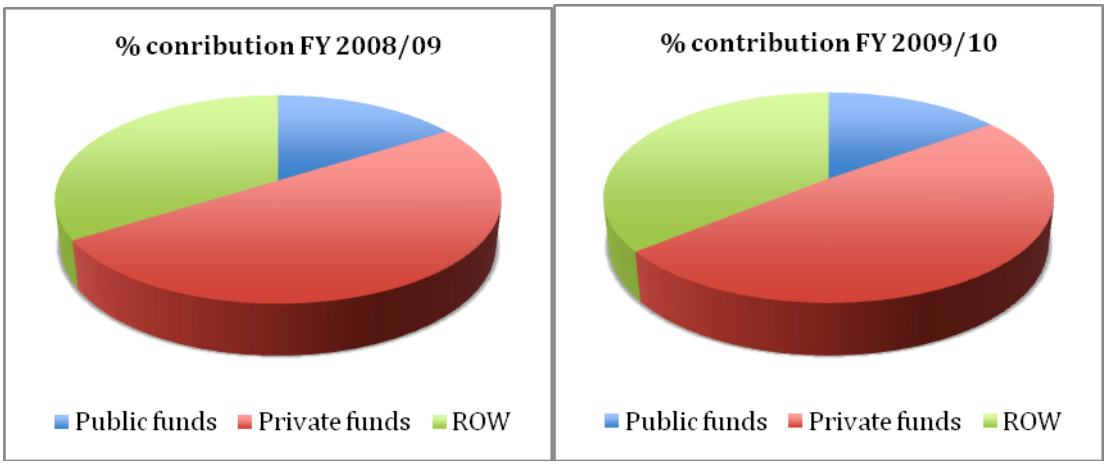


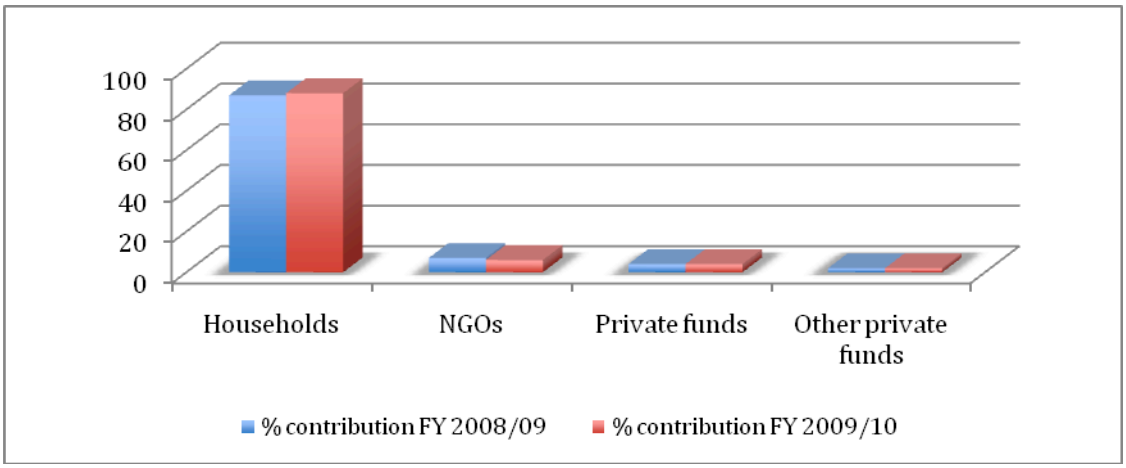
Table 2: Private sources of financing

	FY 2008/09 Amount in Bn UGX	Percentage	FY 2009/10 Amount in Bn UGX	Percentage
Households	1,214.06	87%	1,371.81	88%
NGOs	95.45	7%	100.86	6%
Private funds	52.42	4%	63.23	4%
Other private funds	30.15	2%	35.76	2%
Total	**1,392**		**1,571.66**	

As shown in table 2 above and the chart below, much of the private health financing (voluntary pre-payment and direct out-of-pocket payments) is contributed by households. Their contributions increased from UGX1.2 trillion in financial year 2008/09 to 1.37 trillion in financial year 2009/10 constituting 87% in 2008/9 and 88% in 2009/10 of total private funds.

The majority of the household expenditures on health constitute OOP expenditure. Household OOP expenditures have shown an increase over the years despite the government's 2001 effort to provide financial protection and increase utilization by eliminating cost sharing within government facilities[7]. This can be attributed to a shift from using government facilities where quality of services offered remains low to using more of private sector services by the better-off quintiles. In addition, the poor have also increased their expenditure on commodities, supplies and private clinics due to stock-outs in government health facilities[8].

Figure 2: Percentage contribution of different sources to private health funding



As for the Rest Of the World (ROW) the bulk of funding from external sources is from bilateral, multilateral donors and GHI as shown in the table below.

Table 3: Rest of the world sources of funds

	FY 2008/09 Amount in Bn UGX	Percentage	FY 2009/10 Amount in Bn UGX	Percentage
Donors and Global Health Initiatives	658.65	68%	851.67	72%
International NGOs	308.08	32%	339.01	28%
Total	**966.73**		**1,190.68**	

2.1.2 Pooling of funds

2.1.2.1 General tax (compulsory prepayment)

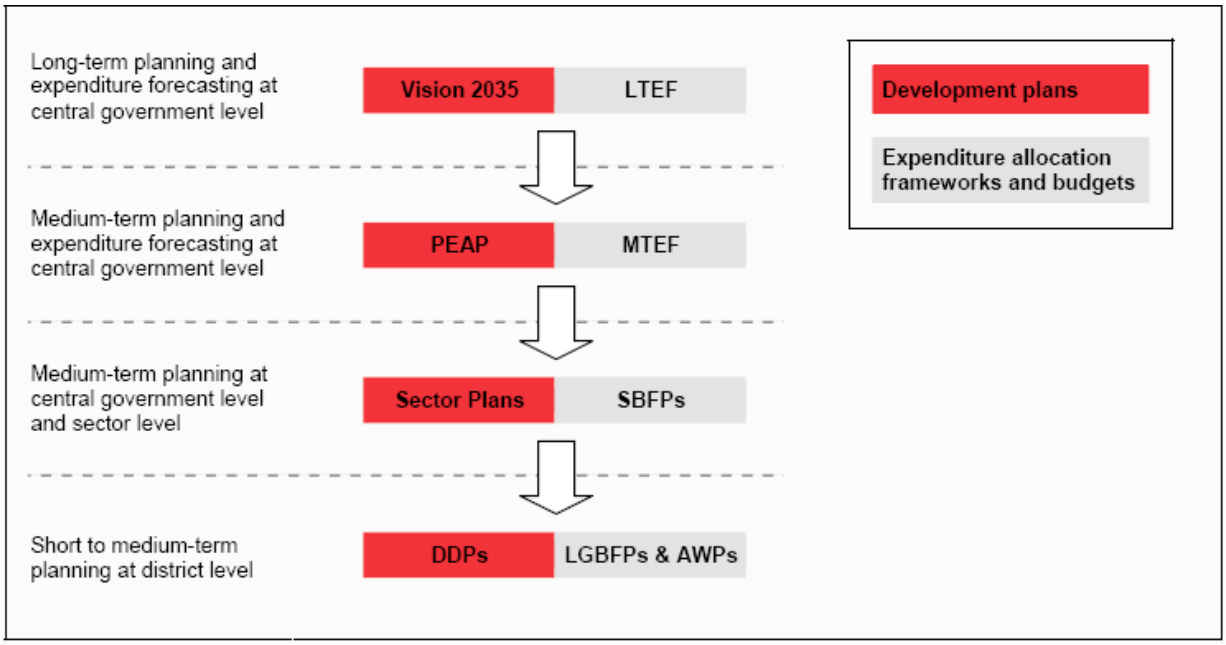
The Ministry of Finance, Planning and Economic Developmentis responsible for determining the resources envelop in consultation with other Government institutions such as URA and Bank of Uganda.The budget resource envelope for the medium term is largely derived from projected domestic revenues and external financing (grants and loans).

[7] Peter Okwero et. al. Fiscal space for health in Uganda. World Bank working paper no. 186. World Bank 2010.
[8] Nabyonga Orem et. al. Abolition of user fees. The Uganda paradox. 2011.

Once the resource envelop has been determined, the broad allocations of Government resources between sectors is then determined based on; (a) Priorities which have a direct bearing on poverty and growth; (b) The party manifesto, and; (c) Constraints faced during implementation.

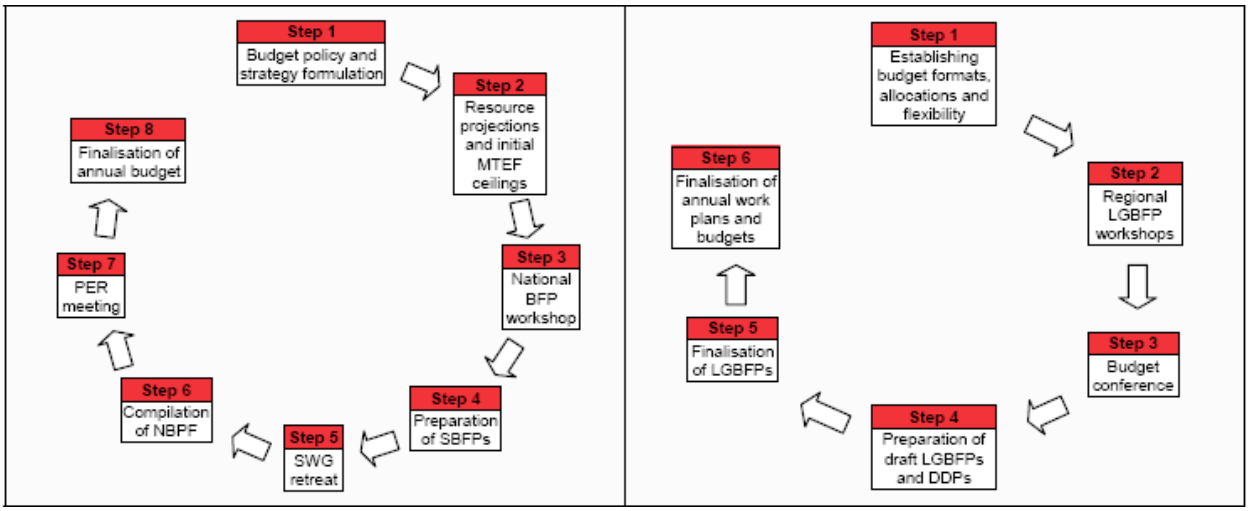
The Sector Ceilings for Government of Uganda (GoU) resources are set as follows; (a) the current financial year is used as a base; (b) all one-off expenditures undertaken in the previous year are deducted from the sector ceiling and made available for reallocation to identified priorities; (c) the projected additional resources over and above the current year's resource envelope are then allocated among the policy priorities with the higher priority areas and commitments receiving the first call on these resources.This then becomes the basis for the preparation of the indicative MTEF, which details the respective sector ceilings. These indicative ceilings are then given to the sectors under a Budget Call Circular. These are subsequently revised after the submission of Sector Budget Framework Paper (BFP), then after receiving comments from Parliament on the National BFP and finally just before reading the budget.

Figure 3: Overview of planning and budgeting tools in Uganda



The national budget plays a central role in the GoU's economic and political functions. It is used as an economic policy tool to allocate public financial resources in accordance with policy priorities and to use financial resources effectively to achieve government policy goals. The budget process is characterized by relative transparency and openness and broad participation. Important components of this process are the Budget Framework Papers, which are prepared at the national, sectoral and local government levels. They are three-year rolling frameworks used to streamline and guide the budget process, setting out planned outputs and their associated expenditures in the medium term.

Figure 4: Steps of the budget process at national and sub-national levels



The national budget is a compilation of BFPs prepared at the sectoral and sub-national levels. The national BFP is prepared by the Ministry of Finance and Planning for Economic Development (MFPED) and consists of the expenditures proposed by sectors and local governments. The process is guided by the GoU's annual budget strategy, sector strategies and inter-ministerial policy discussions on outstanding issues. The macro economic framework, an updated MTEF and its provisional ceilings impose spending restrictions and limitations.

The sector working groups (SWGs) are responsible for the sectoral budget process. The sectoral BFP is the official statement of sector expenditure priorities and outlines the sector's contribution to poverty reduction. In theory, a high-quality, well-formulated sectoral BFP accompanied by high sector performance leads to balanced and adequate allocations of sector ceilings in the MTEF. Ideally the sectoral BFPs are supposed reflect sector strategies and Sector Investment Plans (SIPs). Given that SWAps are increasingly important for the GoU's planning and budgeting process, for sectors to secure resource allocation within the MTEF and the national budget process it is essential that they develop sector strategies and associated investment plans. Resource constraints due to limited revenue generation and competition between sectors mean that only some of a sector's policies and strategies receive due attention. SIPs are planning instruments aimed in part at avoiding 'wish-lists' of actions and projects, moving instead towards prioritization within each sector in order to remain within budget limits. Although the SIP does not determine final and approved investments, it can help make a strong case for the sector as a poverty reduction tool.

One of the aims of decentralization is to enhance the efficiency of resource allocation for the achievement of development goals in line with local priorities. Increasing the discretionary powers of local governments to allocate resources and ensuring that local needs and priorities feed back into the national budget can do this. Local governments in Uganda enjoy 10% flexibility of non- salary conditional grant allocations to recurrent sector budgets and sector budget lines.

However local governments continue to suffer from a lack of adequate and appropriate technical capacity and it is therefore doubtful whether they are able to perform these prioritization, planning, budgeting and allocation responsibilities adequately.

There is also often a discrepancy between priorities at national and local levels indicating a divergence between the top-down decision-making process governed through sector ceilings in the MTEF and the bottom-up processes guided by local communities and governments. In order to reduce this discrepancy, it is important that local priorities identified through the local government budget process feed back into the budget process at national level through consultations, SWG meetings and HSSIP deliberations.

2.1.2.2 Development Partner contributions

Development assistance remains an important source of funding in Uganda with the health sector receiving the largest share. At the international level, the development agenda has evolved towards increased country ownership and improved aid delivery through harmonization and alignment of donor support, as reflected in the Monterrey Consensus, the Rome Declaration on Harmonization and the Paris Declaration on Aid Effectiveness. These new approaches to development assistance have led to a shift in aid modalities from support of stand-alone projects to project clustering and general budget support, with poverty reduction strategies (PRSs) and sector- wide approaches (SWAps) being used at the country level.

In Uganda a share of official development assistance is delivered through the national budget (budget support) and in effect through the government system of pooling funds for health, with the rest through project support and NGOs. The country-led approaches integrate the processes of strategy development, financing and Government-donor relations.

Vertical projects and NGOs receiving donor funds (development assistance) either receive funds through "requests for applications" (RFAs) for the funds or through targeted/earmarked programs for work fitting the specific interests of the funders. These interests of the funders may or may not be aligned to the national strategic investment plans: but ostensibly they are supposed to be serving the interests of the poor.

2.1.2.3 Voluntary prepayment

In addition to standard health insurance firms, there are some organisations that offer medical pre-payment schemes. Most of these organisations are health maintenance organisations, which, in addition to offering pre-payment schemes, also offer health services[9]. In Uganda, **health insurance organisations** are involved in collecting insurance premiums from either individuals or companies in return for a specified health benefit package for those who are covered by insurance. The insurers are not involved in actual health service provision. In contrast, **health maintenance organisations** have a dual role that involves the

[9] Charlotte M. Zikusooka et. al. Private medical pre-payment and insurance schemes in Uganda: What can the proposed SHI policy learn from them? Equinet discussion paper 53. January 2008.

collection of insurance premiums from individuals and/or companies on one hand, and the actual provision of health services to those who are medically insured on the other.

The share of private health insurance is negligible in Uganda – less than 1 % of the country's total health expenditure, and although Uganda has over 15 community-based health insurance (CBHI) schemes, households pay premiums, which are too low to make community-based health insurance schemes sustainable and viable[10]. The insurance organisations tend to cover clients around Kampala and a few other major towns in Uganda, offering mainly travel insurance (including health insurance) for clients travelling out of the country. In addition, they offer top-end health insurance cover for in- patient hospitalisation for senior executives and high net-worth individuals, including evacuation services. Premiums for this top- end health insurance are paid annually, and range from US$400-3,000 per person covered per year. The insured people usually obtain health services from providers outside Uganda, although they might sometimes require some initial care (for stabilisation) with providers in Uganda.

2.1.3 Purchasing of services

The delivery of health services in Uganda is by both public and private sectors with GoU being the owner of the majority of facilities. Over the past decade, Government has focused on expanding its health infrastructure through construction of health facilities in an effort to bring services closer to the people. The GoU owns about half of the health facilities in Uganda, followed by the PNFPs. The number of private facilities has dropped from 858 in 2004 to 277 in 2006 but increased to 998 in 2010. The private health delivery system consists of Private Not for Profit (PNFPs) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs). Hospital services are provided by the public, private health providers (PHPs) and private not for profit. Currently, there are 65 public hospitals: 2 National Referral Hospitals (NRHs), 11 Regional Referral Hospitals (RRHs) and 52 general hospitals. There are 56 PNFP and 9 PHP hospitals. With decentralisation, the local governments manage the public general hospitals. The RRHs have been granted self-accounting status and remain under MoH oversight. The NRHs, namely Mulago and Butabika, are semi-autonomous i.e. they are directly funded from the treasury. All PNFP hospitals are autonomous as granted by their respective legal proprietors[11].

2.1.3.1 Public system

Public health services in Uganda are delivered through health centres (VHTs, HC IIs, HC IIIs, HC IVs), and hospitals (general hospitals; RRHs and NRHs) and payment for these services is from general (un-earmarked) tax revenues. The range of health services delivered varies with the level of care. In all public health facilities curative, preventive, rehabilitative and promotive health services are free

[10] Cordaid 2007.
[11] Health Sector Strategic & Investment Plan (HSSIP) 2010/11 – 2014/15.

since user fees were abolished in 2001. However, user fees in public facilities remain in the private wings of public hospitals. Although 72% of the households in Uganda live within 5km from a health facility (public or PNFP), utilisation is limited due to poor infrastructure, lack of medicines and other health supplies, shortage of human resource in the public sector, low salaries, lack of accommodation at health facilities and other factors that further constrain access to quality service delivery. The MoH acknowledges that 75% of the disease burden in Uganda is preventable through improved hygiene and sanitation, vaccination against the child killer diseases, good nutrition and other preventive measures such as use of condoms and insecticide treated nets (ITNs) for malaria. Health Promotion and Education (HPE) and other health social marketing strategies promote disease prevention, uptake and utilization of services, care seeking and referral. Other players in service provision and promotion include the media, CSOs and community structures such as the village health team VHT.

The Constitution (1995) and the Local Government Act (1997) mandate the Local Governments (LGs) to plan, budget and implement health policies and health sector plans. The LGs have the responsibility for recruitment, deployment, development and management of human resource (HR) for district health services, development and passing of health related by-laws and monitoring of overall health sector performance. LGs manage public general hospitals and HCs and also supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility. The public private partnership at district level is however still weak.

According to the HSSIP, general Hospitalsprovide preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care programmes. In addition to the services provided by general hospitals, Regional Referral Hospitalsalso offer specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher-level surgical and medical services, and clinical support services (laboratory, medical imaging and pathology). They are also involved in teaching and research. National Referral Hospitalsprovide comprehensive specialist services and are involved in health research and teaching in addition to providing services offered by general hospitals and RRHs.

Under the Local Government system, the health sub-districts (HSDs) are mandated with planning, organization, budgeting and management of the health services at this and lower health centre levels. HSDs carry an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFPs and PFP service providers in the respective health sub district. The headquarters of an HSD are a HC IV or a selected general hospital. HC IIIs provide basic preventive, promotive and curative care, as well as providing support supervision of the community and HC IIs under their jurisdiction. They also provide laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care, community outreach services and linkages with the Village Health Teams (VHTs). A network of VHTs has been established in Uganda, which is facilitating health

promotion, service delivery, community participation and empowerment in access to and utilization of health services.

2.1.3.2 The private sector health care delivery system

The private sector plays an important role in the delivery of health services in Uganda covering about 50% of the reported health outputs. The private health system comprises the Private Not for Profit Organisations (PNFPs), Private Health Practitioners (PHPs) and the Traditional and Complementary Medicine Practitioners (TCMPs). the contribution of each sub-sector to the overall health output varies widely. The PNFP sector is more structured and prominently present in rural areas. The PHP is fast growing and most facilities are concentrated in urban areas. TCMPs are present in both rural and urban areas, even if the services provided are not consistent and vary from traditional practices in rural areas to imported alternative medicines, mostly in urban areas. The GoU recognizes the importance of the private sector by subsidizing the PNFP, a few private hospitals and PNFP training institutions[12].

The PNFP sub-sector is divided into two categories: Facility-Based (FB-PNFPs) and the Non-Facility Based (NFB-PNFPs). The FB-PNFPs provide both curative and preventive services while the NFB-PNFPs mainly provide preventive, palliative and rehabilitative services. The FB-PNFPs account for 41% of the hospitals and 22% of the lower level facilities complementing government facilities especially in rural areas. The PNFPs currently operate 70% of health training institutions. More than seventy five percent (75%) of the FB-PNFPs exist under 4 umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). Nearly 70% of the facilities are owned by the UCMB and UPMB. As noted previously, the government recognizes the importance of the FB-PNFPs and subsidises some of their services, specifically paying for some of their health workers as a subvention and also providing them with some medicines and health supplies. This only lowers the fees/charges that patients pay when accessing services to some extent; so in order to access FB-PNFP health facilities, patients have to pay either through voluntary prepayment or OOP payment at the time of service use but at lower subsidized rates.

The NFB-PNFP sub-sector is diverse and less structured comprising hundreds of NGOs and Community Based Organisations (CBOs) that mainly provide preventive health services such as health education, counseling, health promotion and support to community health workers. Although the diversity makes it challenging to achieve the desired goal of a coordinated voice from the community, the sub-sector remains critical in channeling concerns of communities where the CSOs are strategically positioned. NFP-PNFP services are often free of charge being paid for through NGOs or private funds; however where they are not free and are not subsidized by government, clients/patients have to pay either through voluntary prepayment or OOP payment at the time of service use.

According to the HSSIP, as of 2010 it is estimated that the PHPs constitute 22.5% of health care providers. Dual employment is common. While 54% of the doctors working in the private sector also work in the government sector, more than 90%

[12] HSSIP 2010/11 – 2014/15.

of the nurses, midwives and nursing assistants in the private sector work full time in this sector. A total of 9,500 health professionals were estimated to be working exclusively in the private sector, including more than 1,500 doctors. More than 80% of these doctors are employed within the central region and the major municipalities nation-wide. The PHPs have a large urban and peri-urban presence and provide a wide range of services, mainly in primary and secondary care. Few PHPs provide tertiary services. Curative services are widely offered; preventive services are more limited, with the exception of family planning offered by three-quarters of PHP facilities. While more than 90% of PHP facilities offer malaria and STD treatment, only 22% offer immunization services. About 40% of the PHPs provide maternity, post abortion care and adolescent reproductive health services. Difficulties in accessing capital and other incentives have limited the development of certain aspects of service delivery in the private sector. The PHP facilities cater for most of the out-of-pocket paying clients and also the voluntary prepayment clients; however as has been mentioned above, the majority of the PHPs are in urban areas therefore in effect locking out the majority of Ugandans.

Approximately 60% of Uganda's population seeks care from TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapists, spiritualists and traditional dentists) both before and after visiting the formal sector. TCMPs practice in both urban and rural areas with varying and inconsistent service provision. Many traditional healers remain unaffiliated and have no functional relationship with public and private health providers. This results into late referrals, poor management of various medical, surgical, obstetric conditions and high morbidities and mortalities. Non-indigenous traditional or complementary practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged in recent years. A regulatory bill and policy framework for TCMPs is awaiting cabinet approval, which is intended to establish functional relationship between the TCMP and the rest of the health sector. Payment for these services is almost always direct OOP payment at the time of service use.

2.1.4 Provision of services

Government collects tax revenue and allocates it to programs and facilities staff and other costs. Private resource application decisions are majorly out of government control—only 22% is controlled by government; 31% by NGOs and donors; and, 47% by the private sector. During the HSSIP period, 45-54% of the GoU budget for health is being directly disbursed to district health services of which 70% is supposed to be applied to primary health care (PHC) activities. The resource allocation formula takes into consideration the population size of each district, district surface area and relative infant mortality ratios while making allowance for a fixed administration cost.

For development grants, allocations depend on institutional submissions around the activities they intend to carry out based on needs assessment and also on central level priorities. This approach (not completely dependent on a numeric formula) is the conventional approach to allocating resources for development expenditure.

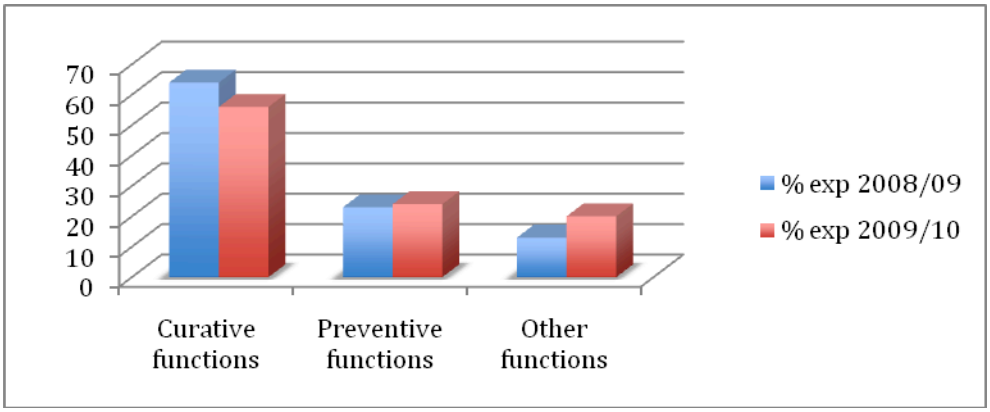
The second National Health Policy[13]ranking of health services provision—based on the disease burden profile—is: health promotion, disease prevention, treatment, rehabilitation and palliative care. In 2013, 21% of total health expenditure was applied to prevention services, and 73% on curative services—although the biggest burden of disease is preventable.

Curative services accounted for the highest percentage of health expenditure for the period 2008/9 –2009/10. Although the biggest burden of disease is preventable, prevention services only accounted for 23% and 24% of the total health expenditure during that period as is shown in table 4 and figure 6 below[14].

Table 4: Expenditure by type of services provided (functions)

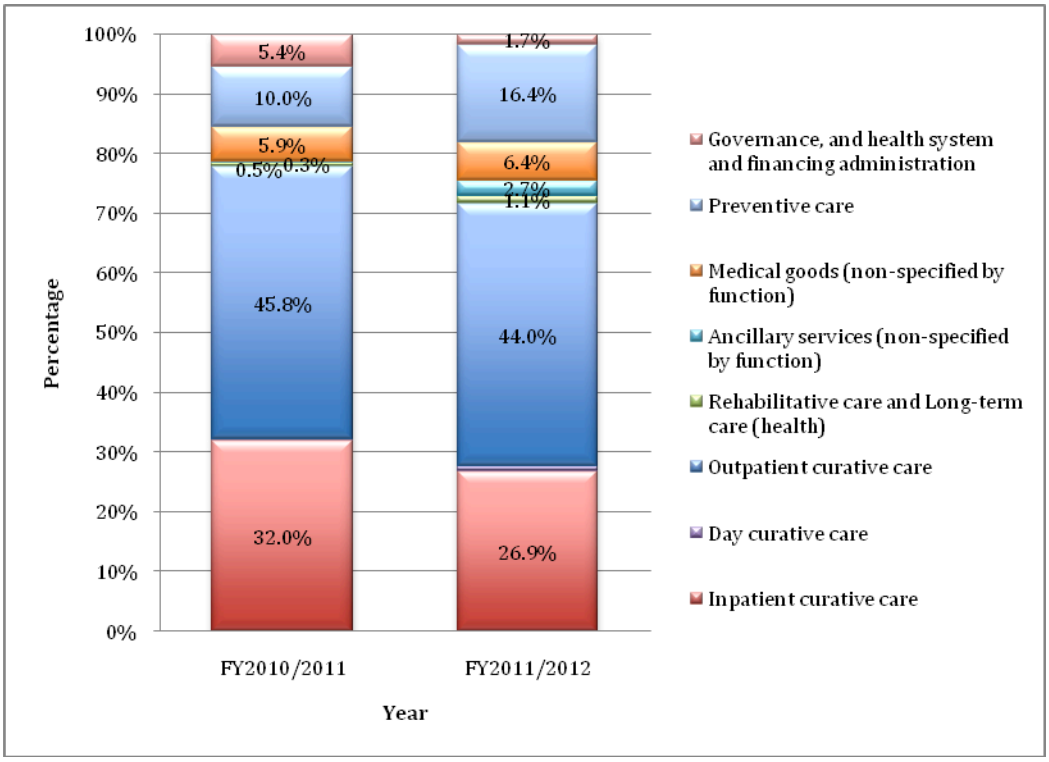
	FY 2008/09 Amount in Bn UGX	**Percentage**	**FY 2009/10 Amount in Bn UGX**	**Percentage**
Curative functions	1,805.99	64%	1,802.35	56%
Preventive functions	639.83	23%	774.77	24%
Other functions	362.98	13%	657.83	20%
Total	**2,808.80**		**3,234.95**	

Figure 5: Expenditure by type of service (%)



The same pattern was witnessed for the period 2010/11 – 2011/12 as is shown below

[13] National Health Policy 2010.
[14] NHA 2008/09 – 2009/10.



Source: NHA report 2013

2.1.5 Stewardship of financing

For public financing (compulsory prepayment) of health care, the process of collection of funds, pooling of the funds, purchasing and provision of services is jointly overseen by the Ministry of Finance, the Ministry of Health and the Local Governments with the Parliament (on behalf of the population) having a final say on the appropriation of funds to health.

Development partners support the efforts of government through general budget support, sector budget support and off-budget projects. In addition, Donors directly support project implementation and program support at district level and the oversight for this kind of support is largely with the respective individual donor organisation.

For private health care provision, decisions on collection of funds, pooling, purchasing and provision of services are largely out of control of government. Government only goes as far as setting up regulatory bodies to ensure best/ethical practice but the rest is left to market forces.

2.1.6 Overview of the entire system

The main challenges in the sector are increasing costs, which will – in the medium term – continue to be of concern. The main cost drivers include;(a) increased demand for maternal and child health and adolescents services as a consequence of a rapidly growing population due to high fertility; (b) increase in the non-communicable diseases burden—due to demographic and urban transition—when communicable diseases are still high on the agenda; (c) high public demand for access to high quality but affordable care as a result of the

marketing of new expensive technologies; and, (d) reduced likelihood of an increase in the resource envelope as a result of the global economic downturn and finally; (f) the high cost of improving health infrastructure in keeping with the need to move services closer to the community.

Formal health sector service delivery is by both public and private providers – with GoU owning more than 50% of facilities. The public sector accounts for less than 25% of the health service delivery. Private-Not-For-Profit (PNFP) facilities account for 20% of private service delivery and private facilities account for 45% and NGOs about 10% of the health service delivery. Government pays for services through direct provision of resources to its own facilities based on an incremental activity based financing—for staff salaries, supplies and operations. Government purchases health services from the PNFP health facilities through provision of grants for specified activities based on an agreed MOU. Budget transfers to local government fund preventive, promotional and curative care.

Ability to mobilize general public revenues (compulsory prepayment) depends on the level of economic development. The reality is that whereas Uganda's tax revenues as percent of GDP have risen from 6.5% in 1989/90 to 14.2% in 2012/13, the tax base is still small with 50% of the revenues generated by only a few large taxpayers. Development partner support will continue – in the foreseeable future – to play a significant role in financing health sector activities. Ease of implementability and political accountability are essential components of a financing strategy because the amount raised largely depends on government's commitment to forego some spending in other sectors in order to finance health. Good management systems and regulations are necessary to ensure accountability. Administrative capacity and human resources are essential for operating the system. The questions on fiscal space for health remain tagged to; (a) how to increase government contribution to health; (b) how to make the health system operations more efficient; (c) how to harness the contribution of the untapped, not easy to tax large sector comprised of small farmers and informal players; and, (d) how to increase private insurance contributions, in the quest to meeting government's goal of universal health coverage with a minimum package of basic services through introduction of social health insurance.

The major provider payment mechanism in the country is government input financing mechanism through granting quarterly funds to public and private not for profit health facilities, central Government level institutions and Local Governments. The out of pocket is used to purchase unknown quality of health care from the private sector through payment of user fees. The Minimum health care package is still not well defined and dealing with NCD is still a big challenge.

Lastly the high contribution of OOP expenditures to health care by Ugandans (almost 50%) is way above the WHO defined threshold (15%) for precluding a high incidence of catastrophic expenditures, whichis a very worrying development.

2.2 Attainment of health financing strategy objectives

2.2.1 Financial protection and equity in finance

In developing countries, systems that rely more on public funding tend to do better at attaining objectives such as financial protection, equity in finance and equity in utilization[15]. The more money that government has, the more it can spend on health. Uganda has not done well in this respect due to limited public resources generally and therefore a lot less available to spend on the health of the population.

As a consequence, households are contributing over 40% of total health expenditure funds, which is inevitably widening inequities in general health, access and utilization of health care services. This is also increasing the incidence of catastrophic expenditures thus increasing incidence of poverty (Maximum recommended OOP share as a % of THE is 15%).

Per capita government expenditure on health is around USD 11, which is far below the estimated USD 44 target of the innovative task force on health financing and the estimated requirement in the HSSIP of USD 41. Overall spending per capita is also below the recommended WHO level of USD 49 required to provide a minimum health care package. Further, the Abuja Declaration on total government health expenditure of a minimum of 15% has consistently not been met by the Government of Uganda with Uganda hovering around only 8% of total government expenditure on health.

2.2.2 Equity in the use of health services

Curative care[16] and administration – especially salaries – amount to the biggest government contribution to total health expenditure as compared to health promotion and other public health activities. Hospitals continue to be better resourced than Health Centers. To note is the subsidy to the PNFP medical facilities started in 1997 – with the objective of getting them to subsidize care to the poor – which has not resulted in expected outcomes i.e. access of the poor to health care has not greatly improved as originally expected.

2.2.3 Governance, Responsibilities, Transparency and Accountability of the financing system

Allocation to government facilities is dictated by a resource allocation formula, which takes into account financial risk protection of poor households, population coverage, human development index, equity and efficiency in allocation and use of resources. The process of resource allocation and use is fully consultational involving many stakeholders including government, civil society and the population through parliament.

However transparency and accountability of the voluntary prepayment mechanism are not yet satisfactory.

[15] Health financing policy: a guide for decision makers.

[16] Biased expenditure on curative services accounting for 55% of THE for the period 2008/09 – 2009/10.

2.2.4 Quality in service delivery

The 2008 study on user satisfaction and understanding of client experiences showed that in general clients were satisfied with physical access to health services, hours of service, availability and affordability of services including the providers' skills and competencies among other things. However, they were dissatisfied with a wide range of issues such as 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 it gives them an opportunity to participate in health services management[17]. Some of the recommendations from this study included improvement of service availability, improving staffing levels, sustaining a reliable drug supply and removal of unofficial fees, among other recommendations.

Nationally, almost 2% of all Ugandans surveyed in the 2012/3 UNHS reported not seeking medical care because the cost was too high, and an additional 1% because the health care facilities were too far (and thus too costly to reach). Compared to households in the top income quintile, however, households in the bottom quintile were much more likely to both not seek care (12.8% versus 9.6%) as well as to cite cost as a reason for not seeking treatment (22.7% versus 12.1%). Also, in the 2012/3 UNHS, households in the lowest quintiles reported travelling and waiting times at health treatment facilities that were twice as large as those experienced by better off households. In addition, poorer households were also almost three times as likely as better off households to cite distance and the lack of access to a nearby health facility as a reason for not seeking health care.

However of concern is that out-of-pocket care is purchasing unknown quality of health care from the private sector due to poor regulation and that there are large inequalities in access to quality health services.

2.2.5 Efficiency in the organization and delivery of services as well as in administration

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 least UGX.36.7 Bn annually due to waste through health worker absenteeism/presentism, expired drugs and poor payroll management.

Out migration of public health workers particularly specialist doctor's remains an issue and financing strategies critically needs to incorporate a comprehensive workforce compensation strategy to improve the health workforce skill mix and incentives.

Further, some of the factors in the resource allocation formula are not clearly defined and the weights not explicitly stated – necessitating a need to review the criteria and the resource allocation formula. The allocation process is incremental – by budget year – and does not have strong inbuilt incentives to promote efficiency. Similarly, although the district allocation formula captures some important indicators of need, the problems with this current formula are:

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

(a) It does not consider the demographic structure of the population in each district, and (b) It does not consider the relatively high cost of providing services in remote and isolated districts. The current overall allocation formula is an aggregation of 4 separate allocation formulae. Over the years, changes in demographic patterns and disease burden, including concerns around equity and effectiveness have necessitated the review of the current resource allocation formulae.

2.2.6 Perceptions and expectations of the population

The study by Jitta, J., et. al. mentioned previously showed the population's satisfaction with physical access to health services, hours of service, availability and affordability of services including the providers' skills and competencies among other things. However, they were dissatisfied with a wide range of issues such as long waiting times and unofficial fees in the public sector, quantity of information provided during care and other behavioural problems relating to health workers.

The population would expect improved services availability, improved staffing levels, a sustained reliable supply of drug and removal of unofficial fees.

2.3 Overall assessment of the existing system

The high level of OOP spending suggests that financing of health care is less equitable, with high likelihood of financial catastrophe on households. The multiplicity of health financing channels for Uganda points to the need to reorganize payment into the Health Financing system in order to pool risk and achieve efficiency and equity.

Total general health expenditure as a percentage of totalgovernment expenditure was 9% and 7% in 2008/09 and 2009/10 respectively, which still falls below the Abuja Target set is 15%. It is also noteworthy that prioritization of health in percentage terms is likely to remain low because of the renewed emphasis on infrastructure in the National Development plan.

The current financing system puts undue pressure on households with limitations in the ability of the Government of Uganda to allocate more public revenues to health. Hence there is a need to consider reforms in the way Uganda's health system is to be financed.

3 Health financing reform strategy

3.1 Strategic focus

Good Health is pivotal in the development of Uganda and health is a prominent component in the NDP. Financing is one of the six building blocks of the Health System.

The move towards Universal Coverage with health services requires an explicit strategy to raise continually increasing financial resources to serve an increasing population, whose demand for quality health and health services is growing. The total cost of implementing preventive and promotive Primary Health Care solutions is steadily rising due to the high population growth rate, estimated at 3.4% and the increasing/changing disease burden. Consumers of health increasingly expect high quality, technology intensive health services.

The overall purpose of this health financing reform strategy is to facilitate attainment of Universal Health Coverage through making available the required resources for delivery of the essential package of services in an efficient and equitable manner. The objective is to make funding available, ensure choice and purchase of effective and cost-effective interventions, give appropriate financial incentives to providers, and ensure that all individuals have access to effective health services.The national Development Plan, under the objective of strengthening the organization and management of the National Health System, commits to mobilize sufficient financial resources to fund health sector programmes whilst ensuring equity, efficiency, transparency and mutual accountability.

3.2 Specific objectives

The specific objectives of the health financing reform strategy are;

(a) To equitably and efficiently mobilise enough resources to finance the delivery of essential health services,
(b) To extend coverage for all people in Uganda in Social Health Protection mechanisms to enable risk pooling and financial protection against the cost of illness by 2024,
(c) To institute by 2020 strategic purchasing mechanisms for effective, equitable and efficient allocation of resources,
(d) To develop new and strengthen existing institutional arrangements in planning and management of resources by 2020,
(e) To strengthen mechanisms for harmonized and effective donor support for health,
(f) To produce timely information and evidence for policy making.

In effect this health financing reform strategy seeks to ensure that Ugandans should not become poor as a result of using health care, nor should they be

forced to choose between their physical (and mental) health and their economic well-being. Further, relative to their capacity to pay, the poor should not pay more than the rich. This idea of equity in funding is closely linked to the core value of solidarity. Also, health services and resources should be distributed according to need, not according to other factors such as people's ability to pay for services. This strategy will seek to ensure that financing arrangements reward good *quality*care and provide *incentives for efficiency*in the organization and delivery of health services.

3.3 Fiscal context and scenarios for levels of public funding

The amount that a government spends on health depends in part on its fiscal context and in part on decisions that it makes with regard to priorities. Fiscal context refers to the ability of the government to mobilize tax[18] and other public revenues, and the need for these to be balanced with total public spending. And, since systems that rely more on public funding tend to do better at attaining objectives such as financial protection, equity in finance, and equity in utilization, the fiscal context is critical, because the more money that government has, the more it can spend on health.

Uganda's economy has continued its steady recovery from the second round effects of the global financial crisis and stagnation in the Eurozone and it is expected to grow at a steady pace of 6 – 7 % over the short to medium term. These positive growth figures have been driven by strong export and public investment performance, bringing real GDP growth closer to Uganda's underlying growth potential of 7%. The economy's long-term growth is expected to be driven by private investment and improvements to labour productivity and competitiveness.

The suspension of budget support grants by a number of leading donors recently underscored the need to enhance tax mobilisation efforts and reduce reliance on external resources. Government has put in place a number of measures aimed at increasing the effectiveness of tax administration and widening the tax base. However a big part of Uganda's economy is informal and so difficult to tax.

Uganda's runaway population growth rate of 3.4% is a big burden to Uganda's economic growth; the 3.4% population growth rate effectively dampens the 6 – 7% economic growth rate resulting in an actual slow economic growth rate.

Further, in spite of this commendable economic performance, the country continues to face some challenges, which have undermined achieving much faster economic growth and socio-economic transformation. The country has not achieved significant productivity growth in agriculture[19] and has thus not witnessed sufficient release of excess labour from the agricultural sector[20]. There is also the daunting challenge of attaining a relatively higher per-capita income level in the face of a rapidly rising population. This requires a massive increase in

[18]this includes all forms of compulsory contributions, such as income and value added taxes that become part of general public revenues, and payroll taxes that are specifically earmarked as social security, including (compulsory) health insurance contributions.

[19] 80% of Uganda's labour force is in the agricultural sector.
[20] NDP 2010/11 – 2014/15

skilled labour and its redeployment to the production of value added export-oriented goods and services. Skilling and tooling the human resource also presents an opportunity for the achievement of development goals, such as, the reduction of poverty and improvements in health, education, housing, gainful employment, gender equality and conservation of the environment.

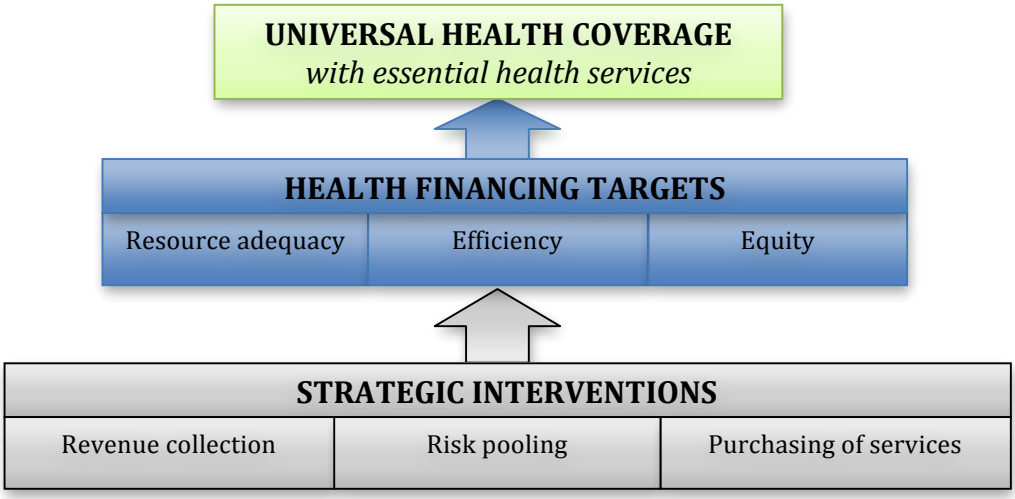
Going forward, Uganda's macroeconomic strategy as highlighted in the NDP is to avoid unsustainable public sector indebtedness and increased dependency on donor aid, while at the same time making more public investment. This will require increased mobilization of domestic resources and to achieve this, the Government will continue to depend on external resources in the short to medium term, but the plan is to maximize future revenues from the oil industry and utilize them for high return public investments in the longer term.

Further, in order to generate increased budget resources, in real terms, to allocate to priority social sectors and to public infrastructure investment, the government aims to continue strengthening domestic revenue mobilisation. This has been the hindrance to fiscal policy, with the revenue to GDP ratio being largely stagnant over the last decade. Government will aim to raise the revenue to GDP ratio from the current level of about 13 percent to 15 percent over the course of the NDP, through a combination of broadening the tax base and improving tax administration. The NDP development strategy mainly focuses on new spending on sectors that have the greatest potential to contribute to economic growth particularly agriculture, manufacturing, energy, oil and mineral development, tourism, infrastructure, education, health, water and sanitation; and curtailing the growth in spending in non priority sectors. All sector expenditures will increase in nominal numbers but the shares vary as they depend on the total resource envelope. The resource envelope is expected to increase every year.

3.4 The health financing strategy

The strategy focuses on definition of the required institutional arrangements that will collect resources from the different sources of funds, pool risks, and then purchase care in a manner that assures attainment of the goal.

Figure 6: Health Financing Strategic Framework



This health financing strategy is working towards facilitating the attainment of Universal Health Coverage with services as defined in the Health Sector Development Plan 2015/16 – 2019/20. This health financing strategy has clear outcome targets, defined in the three areas of resource adequacy, together with efficiency and equity in resource use.

Table 5: Health financing targets

Outcome	Indicator description	Indicator target
Resource adequacy	Per capita total health expenditure	
	Government health expenditure as % of total government expenditure	
Efficiency in resource use	Average district efficiency score	
Equity in resource use	Districts within 2 SDs for equity coefficient	
	% of THE from direct out of pocket sources	

The health sector needs to ensure it has adequate resources to finance the planned services as defined in the essential package. The country has committed to some health financing targets, which are providing guidance on the targets to be attained.

A related but distinct target relates to ensuring equitable funding. This aims to have funding for the health services provision be fairly allocated, with neither the better, or the worse off having to pay more than is a fair amount.

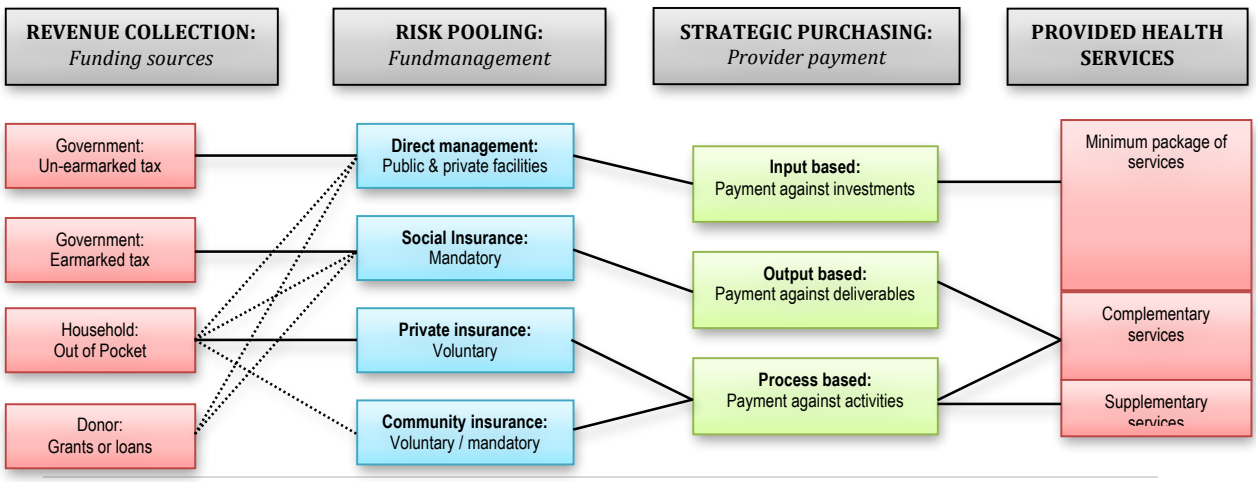
Finally, the efficient use of available resources is also a key target for the health financing system. This looks both at allocative, and technical efficiency in use of resources.

The attainment of these outcome targets is to be achieved, through a focus on three key strategic intervention areas – corresponding to the strategy objectives.

3.5 Strategic interventions

The three strategic interventions in this health financing strategy are in the areas of revenue collection, risk pooling and strategic purchasing of services. The intervention priorities to attain the financing strategy targets are interlinked, based on the framework below

Figure 7: Linkages of the strategic interventions



3.5.1 Strategic intervention 1: Increased revenue collection

The rationale for this strategic intervention is the fact that currently, the health sector is underfunded with the major sources of financing being out-of-pocket payments and external financing for health. With the interventions identified for resource mobilization, it is envisioned that increased funding will be availed to facilitate effective service availability. The objective is to equitably and efficiently mobilize enough resources to finance the delivery of essential health services. The logic would be to strengthen prepayment mechanisms so as to ensure that patients pay less at the time they use services with consequent implications for the objectives of financial protection, equity in finance, and equity in the use of services.

Further, recognition of both existing and likely future fiscal pressures facing Uganda implies that the health system should give increased attention to improving the efficiency of resource use. More needs to be got out of the public resources that are being spent.

Revenue is to be targeted from the following sources:

- Increased government revenue for health (government un-earmarked tax),
- Continued external financing for health (donor grants or loans),
- Heath Insurance Schemes (government earmarked tax and household out-of-pocket/voluntary prepayment),
- Efficiency gains/savings,
- Other financing instruments.

Table 6: Strategic priorities to increase revenue collection

Area of intervention	Priority interventions
Increased government revenue for health (government un-earmarked tax)	▪ Increased evidence-based advocacy for increased government revenue for health including sector-budget support. To enable this capacity shall be built to develop an investment case for health. ▪ Explore feasibility of innovative options of financing such as ear marked taxes for health e.g. sin taxes and/or others like dedicated telecom taxes.
Continued external financing for health (donor grants or loans)	▪ Increase evidence-based advocacy for external resources for health from existing partners ▪ Engage development partners to encourage on-budget support for health so as to reduce transaction costs and align funding to country priorities. ▪ Conduct resource mobilization based on national health strategic plans and priorities. These should in-turn be developed in a participatory manner to facilitate buy-in. Under this intervention, the Global Financing Facility (GFF) in support of Every Woman Every Child will be targeted.
Health insurance Schemes (national social health	▪ Actively engage and mobilise to get the NHIS approved and passed by Cabinet and Parliament. The intention is to have funds raised through actuarially determined payroll contributions from the formal sector -

Area of intervention	Priority interventions
insurance, community based health insurance and private health insurance)	8% of gross earnings (4% employer & 4% employee). Revenue collection shall be by NSSF in the interim as options appraisal to determine the most cost-effective option is done. NSHI will mainly target the formal sector employees. ▪ Government and HDPs subsidize the very poor in NHIS. ▪ NHIS to prioritize curative services in pre-defined benefit package. ▪ Scale up and support community-based health insurance schemes for the informal sector. General tax revenue and external funding can also be used to provide re-insurance. Revenue collection could be conducted by local leaders under the supervision of the District Health Team. ▪ Private Health Insurance to provide supplementary health care services.
Efficiency gains/savings	• Increased fiscal space for health to be realized through strategies enhancing allocative and technical efficiency including prioritizing primary health care, regulation and enforcement of standards, improved purchasing and others. • National and sub-national planning processes will be guided by the priorities of improving health outcomes and achieving universal coverage through appropriate balanced allocations between primary, secondary and tertiary care. • Costing and cost-effectiveness analyses, medium-term expenditure frameworks (MTEF), public health expenditure reviews (PER), results-based budgeting (RFB), and other appropriate tools will be used to increase efficiency from public spending. • Skills critical to achieving effective use of resources will be upgraded, including management of health workers and service delivery, financing and regulation of the health sector. • Unofficial fees and other leakages will be discouraged. Cost-effective initiatives, such as home-based care, will be promoted. • Measures shall be taken to reduce costs of pharmaceutical supply and distribution, by implementing policies on the rational use of essential drugs, rationalization of the supply chain to avoid duplication, creating incentives for good prescription practices, weakening monopolies where they raise costs, and improving social marketing to reduce irrational demand for drugs and diagnostics.
Other financing instruments	• Establish a special fund for HIV/AIDS, the AIDS Trust Fund (ATF). This Fund shall not form part of the Consolidated Fund; its monies shall consist of levies on beers, spirits, soft drinks and bottled water, and money received by way of voluntary contributions or donations from foreign governments and/or organisations. • Explore health bonds for service provision, • Explore sureties for service providers.

3.5.2 Strategic intervention 2: Risk pooling

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 general tax financing, with national standards but local solutions. Embedded in the model is support for the development of community-based and private health insurance as well as mechanisms to support the poor tackle the social determinants of health. 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 intention is to extend coverage for all people in Uganda in social protection mechanisms to enable risk pooling and financial protection against the cost of illness by 2024. The health financing strategy will focus on putting in place risk pooling mechanismsthat will operationalize the solidarity principle in the health sector, and so extend social health protection to all Ugandans. The risk pooling shall be effected for all sources of financing for health, with the following mechanisms strengthened:

- Direct management of service provision (public and private facilities),
- Social health insurance (mandatory),
- Voluntary private insurance (voluntary),
- Community based insurance (voluntary/mandatory).

Priority interventions the sector will strive to achieve are highlighted in the table below

Table 7: Strategic priorities for comprehensive risk pooling

Area of intervention	Priority interventions
Direct management	▪ Strengthen the Joint Action Fund (JAF) for pooling of government and partner funding. This will be a big pool for health financing in the short to medium term. ▪ Put in place mechanisms for financial transparency and accountability to encourage higher sector budget support mechanisms.
Social health insurance	▪ Establish a fund for the premiums collected from payroll contributions, premium for enrollees in informal sector and government subsidies for the poor. ▪ Include identification mechanism for the very poor to ensure that the very poor really benefit from the subsidy. The tool and/or mechanism used shall be informed by the experience in on-going experiments for social protection. ▪ Develop and implement a communication strategy to facilitate sensitization on the benefits of health insurance scheme, the types of schemes available and the benefits that enrollees will be entitled to. This will increase uptake and utilization of the insurance schemes and the benefit package.
Voluntary private health insurance	▪ Scale up private health insurance mechanisms for voluntary additional cover for additional supplementary services above those provided by the national social insurance scheme. ▪ Strengthen oversight bodies to be able to regulate and supervise the activities of private health insurance providers.
Community based health insurance	▪ Establish funds for community-based insurance at district level to increase cross-subsidization. Provide re-insurance for these funds by NHIS using general tax revenue and/or donor funding.

3.5.3 Strategic intervention 3: Strategic purchasing of services

The rationale for this strategic intervention is that current provider payment mechanisms do not encourage providers to provide good quality services. The

salary-based payment mechanism does not incentivize providers to perform. As such service delivery and quality is very poor. A new provider payment mechanism that stimulates optimal service delivery will increase effective availability of services that the sector prioritizes and allocative and technical efficiency. The intention is to institute strategic purchasing mechanisms for effective, equitable and efficient allocation of resources.

The sector proposes;

- To continue with the usual input-based provider payment (payment against investments),
- To complement the input-based mechanism with a pay-for-performance mechanism (payments against deliverables), and
- To streamline process based provider payment mechanisms (payments against activities).

The sector shall implement all these purchasing mechanisms to maximize effective, equitable and efficient use of resources.The specific priority interventions are highlighted below.

Table 8: Strategic priorities for strategic purchasing of health services

Area of intervention	Priority interventions
Input based provider payment	▪ Scale up clear provider incentive mechanisms to improve their performance for provision of the basic package of services ▪ Deepen autonomy of providers, to make them more accountable to the services provided
Output based provider payment	▪ Establish output based provider payment mechanisms to complement input based payments, that provide required incentives to improve their performance ▪ The agreed model will be implemented in both public and private health facilities. ▪ The output based mechanism will ensure that both demand and supply constraints to effective service availability are addressed.
Process based provider payment	▪ Establish institutionalized contracting mechanisms for reimbursement of activities best suited to this mode of payment (primarily focusing on non-clinical services).

The sector shall emphasise Results Based Financing (RBF)/Performance Based Financing (PBF) as a mode of output based provider payment. This will be rolled out systematically and progressively to cover the whole country by the end of this HFS.

3.6 Attainment of the investment priorities

The attainment of the priorities for health financing is determined by the sector ability to do what is needed for them to be attained. Key sector actions required are in the areas of:

- Organization of Services,
- Financing and financial management,
- Health information, and
- Governance and regulation

3.6.1 Organization of services

The aim is to provide an affordable, uniform and locally appropriate benefit package to ensure access to needed health services for common, emerging and priority health conditions. The rationale is the fact that Uganda is experiencing an epidemiological transition and increased life expectancy. As a result of this, the current health care system's emphasis is no longer entirely in accordance with the prevalent morbidity and mortality changes. Non-communicable diseases are on the increase and are not well prioritized. Many services, especially those related to rehabilitation and promotion are insufficiently developed within the public sector and are mainly delivered by NGOs. Population groups incurring the highest health care costs are currently not sufficiently catered for, including non-communicable chronic diseases.

The sector needs to rationalize its essential/minimum social and medical benefit package, identifying services that will be managed based on the different institutional arrangements available. a clear selection criteria shall be used, to determine where different essential services shall be managed and provided that will be based on burden of disease conditions, public good nature, likelihood to produce externalities, technical feasibility, costs and benefits amongst other considerations.

- The essential/minimum package of services shall primarily be provided by direct management arrangements
- A Complementary benefit package shall be defined primarily focused on services not covered by the essential/minimum benefit package but are associated with catastrophic expenditures for the majority of the population, whose funding will primarily be through the mandatory social insurance and community based insurance mechanisms
- A supplementary benefit package shall be defined primarily focused on services not covered by the essential/minimum and complementary benefit packages and are associated with a specific population group, whose funding will primarily be through private and / or community insurance mechanisms

These packages shall be reviewed every two years for relevance and usefulness with modifications made in line with disease burden, actuarial projections and

available resources. In addition to the identification of services, the sector shall also define and enforce standards to be adhered to in provision of these services.

3.6.2 Financing and financial management

The health financing strategic focus calls for some critical actions to improve the efficiency of the health system. It is anticipated that almost 36 billion shillings can be realized, purely from savings accrued through operationalization of the priority interventions in this strategy. The following represent the key investments that the sector shall embark on, to attain the efficiencies arising from better institutional management of funds.

- Improve the capacity for costing, budgeting, and financing for health at program, and district levels to strengthen the ability to negotiate, and advocate for more budgetary allocations
- Conduct comprehensive resource mapping processes, to identify all (public and donor) resources based on program, geographical focus, and system investment area. This allows for regular and updated database of health resources to guide allocations for new resources
- Develop and constantly update investment cases for health using the One Health Tool[21]. This should be used to constantly make the case for health investments to all sources of financing
- Update the resource allocation formula to ensure it takes cognizance of efficiency in resource use, in addition to equity considerations. More efficient resource use should be rewarded. It therefore shall include:
    - Socio-economic status depicted by the deprivation index as or other similar measures of need given the correlation between poverty and ill-health.
    - Burden of disease depicted by healthy life expectancy or other similar measures that reflect both morbidity and mortality.
    - Population size and demographic profile in the district or catchment area of the facility to reflect the magnitude of need.
    - Standard unit of output that reflects the output of different health units given the fact that some units of the same level have higher workload than other.
    - Efficiency in resource use depicted by the relative efficiency score of the health units, appropriately risk-adjusted as needed.

3.6.3 Evidence and information on health financing

The rationale for this is the fact that decisions for health financing have been taking place in an ad-hoc manner. This has been mainly due to the fact that the research agenda usually is not driven by the health sector. In addition, generation of evidence occurs out of sync with the decision-making cycle. There is need to institutionalize evidence generation specific for health financing so as to track progress on key indicators and also to inform decision-making.The aim is to produce timely information and evidence for policy making.

[21] The One Health Tool is a software tool primarily intended to inform sector wide national strategic health plans and policies in low- and middle-income countries. It provides planners with a single framework for costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components (http://www.who.int/choice/onehealthtool/en/).

The health sector shall work towards making available comprehensive health financing information, to improve the evidence base for decision making in health financing. Key evidence and information mechanisms to be focused on include the following:

- Design and conduct dynamic, micro costing of health services provision, to provide real time information on costs of service provision by different providers, and at different levels of care. This shall provide guidance on where attainment of cost efficiencies in the sector should be focused
- Deepen the implementation, and application of the annual public health expenditure reviews, to ensure all partners in health are aware of the findings and using these to guide their allocations
- Conduct regular actuarial analysis of the benefit packages within the essential package
- Conduct regular expenditure tracking surveys to identify bottlenecks in resource availability and use. These shall apply for all sources of funding, not only government resources
- Conduct cost effectiveness analyses on different conditions of value to society and the population, to improve on the priority setting process
- Conduct efficiency assessments comparing districts, hospitals, and other facility types to provide guidance on required efficiency improvements
- Develop an equity gauge to compare fairness in the distribution of health investments across districts
- Conduct benefit-incidence and other such analyses to ensure that the distribution of resources is efficiently targeted towards more vulnerable groups.
- Conduct annual health accounts, to provide comprehensive information on health expenditures

3.6.4 Governance and regulation

The sector intends to strengthen the overall health financing governance, to improve stewardship and regulatory capacity to the level needed to guide the implementation of this financing strategy. The private sector decisions and operations are largely out of the control of government and this must be addressed. The priority investments the sector will work towards include the following:

- Establish a high level coordinating mechanism for health financing, involving Ministries of Health, Gender, Labor and Social Development together with Ministry of Finance and the insurance regulatory authority to provide oversight and coordinate activities related to social health protection.
- Establish a national health insurance authority, to effectively steward the development and roll out of the social insurance mechanism.
- Establish the HIV/AIDS Trust Fund Board of Trustees to steward the development and rollout of the ATF.
- Establish a verification unit at the national level to verify claims made by autonomous service providers, and so curb the occurrence of fraudulent claims that create inefficiencies and cause cost escalation.

- Strengthen the MOH capacity for health financing oversight, focusing on capacity for:
    - Enforcement of service delivery and standards
    - Contracting of providers
    - Regulation of health professionals development & management
    - Enforcement of rational use of investments (medicines, infrastructure, health workforce)
- Formulate the required legislation to provide oversight needed for implementation of the strategy, such as the National Health Insurance Act

Table 9: Investment priorities for attaining the strategic interventions of the health financing strategy

Investment area	Investment priority
Service delivery systems	Rationalization of the essential package of services, across a minimum, complementary and supplementary packages of care
	Definition and enforcement of standards of care
Financial management systems	Improve the capacity for budgeting, and financing for health at program, and district levels
	Develop and constantly update investment cases for health
	Conduct comprehensive resource mapping of public and donor resources
	Update and apply an efficiency and equity driven resource allocation formula
Information systems	Design and conduct dynamic, micro costing of health services provision
	Deepen the implementation, and application of the annual public health expenditure reviews
	Conduct regular actuarial analysis of the benefit packages within the essential package
	Conduct regular expenditure tracking surveys
	Conduct cost effectiveness analyses on different conditions of value to the population
	Conduct efficiency assessments comparing districts, hospitals, and other facility types
	Develop an equity gauge to compare fairness in distribution of investments across districts
	Conduct benefit-incidence analyses to ensure efficient and pro-poor distribution of resources
	Conduct annual health accounts
Governance and regulatory systems	Establish a high level coordinating mechanism for health financing
	Establish a national health insurance authority
	Establish an HIV/AIDS Trust Fund Board of Trustees
	Establish a verification unit at the national level
	Strengthen the MOH capacity for health financing oversight
	Formulate required legislation, such as the National Health Insurance Act

4 Implementation arrangements for implementation of the health financing strategy

4.1 Human resources

The various financing mechanisms that are already operational have the core human resource requirements to run the schemes. They will however need to be sensitized on the new HFS for buy-in and cooperation. It is important to ensure that the various instruments of health financing are aligned with each other.

The SHI scheme is new and this will require new competences and expertise. A Board of Directors appointed by the Minister responsible for health will oversee the scheme. The BoD shall (a) determine the policies of the scheme, (b) ensure the effective implementation of the policies of the scheme, and (c) carryout any other functions that may be necessary for purposes of achieving the object of the scheme. The BoD shall appoint a Managing Director of the scheme and she/he shall have the necessary training and experience in health insurance, health financing, institutional management or the provision of health care services. The BoD shall also appoint such officers and employees as may be deemed necessary for the proper and efficient discharge of the functions of the scheme.

So too is the HIV/AIDS Trust Fund. It will require new competences and expertise. The Fund shall be administered by the Minister responsible for health in consultation with the Minister responsible for Finance. The Minster of Health shall appoint the Chairperson of the Board and some of its members. The functions of the Board are to (a) oversee the management of the Fund;(b) establish a criteria for assessing the eligibility of beneficiaries to receive financial support from the Fund;(c) approve applications for financial support from the Fund;(d) establish procedures for application for financial support from the Fund;(e) evaluate beneficiaries for eligibility for support from the Fund;(f)establish procedure for release and utilization of funds from the Fund; and(g) develop model documents for application and approval for support from the Fund.Except for general directions on matters of policy given to the Board from time to time by the Minister, the Board shall be independent in the performance of its duties and functions.

4.2 Institutions and competence building

The scheme will be run by an independent/autonomous body complete with a BoD to oversee the running of the scheme. The BoD shall be composed of a representative from the Ministry of Health; a representative from the Ministry responsible for Public Service; a representative from the Ministry responsible for Finance; a member of the public representing the members of the scheme; and a representative of the accredited private health service providers.

The funds of the scheme shall be held by the Board in trust for the contributors and the beneficiaries of the scheme and shall be administered and controlled by the BoD in accordance with the law. The Auditor General shall audit the scheme. An Appeals tribunal will also be set-up to review the decisions made by the BoD.

The established AIDS Trust Fund Board of Trustees which shall be the governing body of the Fund and the accounts of the Fund shall, in respect of each financial year, be audited bythe Auditor General.

4.3 Communication strategy

The timely and accurate communication of carefully chosen messages to specific individuals and groups, through appropriate and effective channels, is a key enabling factor for any change process. A communications plan for this HFS should be incorporated as an element in the implementation plan of the health sector strategic plan, and is subject to its planned monitoring and evaluation and review processes.

There is a need to not only create a greater connection between the national strategic level and the operational levels, but to also communicate the financing strategy and its implications to all stakeholders, including other government sectors. Its imperatives can only be achieved if there is common understanding and conceptualization of them by all. This strategy will aim to reach to a greater audience than traditionally sort and demonstrate relevance and key benefits to target audiences.

The communication strategy will focus on:

1. Ensuring that all stakeholders are fully informed and understand their roles and responsibilities in the implementation of the health financing strategy
2. Enhancing consultation with agencies in achieving set outcomes;
3. Ensuring that all stakeholders understand the strategy

A detailed communications plan with intended communications actions, their timing and responsibility should be completed on the basis of the stakeholder assessment. This will be guided by assessment of stakeholders' perceptions and needs and the environmental (internal and external) implementation of the strategy.

A communication audit will be used to establish the existing current channels of communication, who they reach, and how effective they are. The audit will also outline the key and secondary target audiences of the strategy and clearly spell out the communication goals and objectives for each stakeholder. The plan will among others identify:

- The key messages for communicating to the key stakeholders;
- The method by which the key messages are communicated to key stakeholders;
- The key messages to be communicated to the key stakeholders;
- The actions required for implementation of the strategy and the communication roles;

- Resources needed to undertake the communication tasks;
- Communication risks; and
- Methodology and time-frame for evaluating the effectiveness of communications.

4.4 Roles and responsibilities

This HFS proposes a raft of interventions, whose implementation is dependent on various stakeholders. These include:

- The government stakeholders, involving
  - Ministry of Health as the overall steward of the financing strategy
  - New / existing authorities or agencies whose mandate it is to facilitate attainment of the imperatives of the financing strategy
  - Other ministries, such as Finance, Gender, Labour and social protection
  - Local governments and districts
- The donors / external partners, involving
  - Technical partners providing technical guidance to operationalization of the different interventions in this strategy
  - Donors providing financing of the interventions, and / or the overall sector
- The implementing partners, involving
  - Private Not For Profit and for profit implementing partners providing complementary health services to populations
  - Civil society organizations amplifying the voice of the population
  - Non-governmental organizations supporting the implementation of the interventions

4.5 Other

Health financing decisions being made by the voluntary prepayment mechanism are largely out of the control of the government. This is partly contributed to by the poor regulatory framework. In order to have a useful and an all-encompassing HFS, this aspect has got to be addressed.

The fragmentation of Uganda's health financing arrangements is also a challenge. The objectives of financial protection and access to care are best served by risk pooling arrangements that maximize the potential for cross-subsidising from the healthy to the sick; the larger the pool, the greater the amount of risk protection (cross subsidy) that can be provided[22]. Attempts should therefore be made to reduce this fragmentation as it can also promote inefficiency in the organization of service delivery.

[22] Health financing policy: a guide for decision makers.

5 Monitoring and evaluation for the Health Financing Strategy

Monitoring and evaluation will enable tracking performance of the priority interventions and timely intervention when required. Monitoring will be an ongoing routine activity that will provide the sector managers and other stakeholder's regular information about the performance of the activities they implement. The aim is to determine the fulfillment of objectives, effectiveness, impact, and sustainability; and more specifically objectives relating to coverage and access.

5.1 Approach to monitoring and evaluating

The Health Finance Strategy will take due account of the strategies and interventions forwarded in the Policy and identify realistic goals for each of them that can be achieved within the given time period. Apart from monitoring and evaluating progress towards attainment of these strategies and interventions, due consideration should be given to concurrently assess whether the principles and functions of health financing are respected, especially issues such as financial risk protection, equity in funding and access, efficiencies and accountability. For all issues to be monitored and evaluated, objective indicators will have to be developed.

5.2 Participatory Monitoring

This involves the recognition of the importance of ensuring the participation of wide ranging stakeholders, including local people, development partners and policy makers in deciding how progress should be measured and what progress has been made. Health financing performance will be monitored through the Health Sector Performance Review to be carried out annually, led by the Ministry of Health, as part of the Joint Health Sector Review.These review meetings will be attended by both internal and external stakeholders in the sector, and will use the annual and periodic performance indicators. The joint sector review will take stock of progress made, identify areas of improvement, challenges and the reasons for them. The results obtained from the review would then be used to inform future strategies and plans.

5.3 Key performance indicators

The key indicators are derived from and are informed by the country's long-term vision and strategic direction (Vision 2040, Post 2015 Development Agenda, NDPII, Ruling Party Manifesto). These indicators are specified within the logical framework of the health financing strategy, which aim to measure progress on performance towards the attainment of the desired health financing objectives and outputs. The main sources of data for baseline, monitoring, review and evaluation of the sector are from the latest information available: NHA 2012, DHIS, UDHS 2011, HMIS, OBT, JAF, HIV/AIDS Annual Reviews, and AHSPR.

5.4 Evaluation

The sector will undertake a midterm evaluation of the HFS to allow stakeholders to reflects on successes and failures of the strategy and identify changes and refinements that need to be put in place to ensure results are met at all levels of the results chain. An external evaluation of the health financing strategy is planned in the mid term. A first external evaluation is planned for 2018 and second to be conducted in 2020. The health financing strategy will be adapted and aligned with the next NDPII, Vision 2040 and HSDP policy orientations.

5.5 Reporting on progress

Monitoring of the health financing strategy is integrated in the Sector Development Plan. 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.

6 Financing the Health Financing Strategy

6.1 Resource requirements for implementing the health financing strategy

The resource needs to implement this financing strategy are shown in the table below.

Table 10: HFS resource requirements

Investment area	Investment priority	Annual resource requirements (UGX)					TOTAL
		2015/16	2016/17	2017/18	2018/19	2019/20	
Service delivery systems	Rationalization of the essential package of services, across a minimum, complementary and supplementary packages of care						
	Definition and enforcement of standards of care						
Financial management systems	Improve the capacity for budgeting, and financing for health at program, and district levels						
	Develop and constantly update investment cases for health						
	Conduct comprehensive resource mapping of public and donor resources						
	Update and apply an efficiency and equity driven resource allocation formula						
Information systems	Design and conduct dynamic, micro costing of health services provision						
	Deepen the implementation, and application of the annual public health expenditure reviews						
	Conduct regular actuarial analysis of the benefit packages within the essential package						
	Conduct regular expenditure tracking surveys						
	Conduct cost effectiveness analyses on different conditions of value to the population						
	Conduct efficiency assessments comparing districts, hospitals, and other facility types						
	Develop an equity gauge to compare fairness in distribution of investments across districts						
	Conduct annual health accounts						
Governance and regulatory systems	Establish a high level coordinating mechanism for health financing						
	Establish a national health insurance authority						
	Establish a verification unit at the national level						
	Strengthen the MOH capacity for health financing oversight						
	Formulate required legislation, such as the National Health Insurance Act						

6.2 Available financing, and financial gap analysis

The available financing and financing gap for the HFS implementation is shown in the table below.

Table 11: HFS available financing and financing gaps

Investment area	Investment priority	Requirements (UGX)	Available financing		Financing gap
			Amount (UGX)	Source	
Service delivery systems	Rationalization of the essential package of services, across a minimum, complementary and supplementary packages of care				
	Definition and enforcement of standards of care				
Financial management systems	Improve the capacity for budgeting, and financing for health at program, and district levels				
	Develop and constantly update investment cases for health				
	Conduct comprehensive resource mapping of public and donor resources				
	Update and apply an efficiency and equity driven resource allocation formula				
Information systems	Design and conduct dynamic, micro costing of health services provision				
	Deepen the implementation, and application of the annual public health expenditure reviews				
	Conduct regular actuarial analysis of the benefit packages within the essential package				
	Conduct regular expenditure tracking surveys				
	Conduct cost effectiveness analyses on different conditions of value to the population				
	Conduct efficiency assessments comparing districts, hospitals, and other facility types				
	Develop an equity gauge to compare fairness in distribution of investments across districts				
	Conduct annual health accounts				
Governance and regulatory systems	Establish a high level coordinating mechanism for health financing				
	Establish a national health insurance authority				
	Establish a verification unit at the national level				
	Strengthen the MOH capacity for health financing oversight				
	Formulate required legislation, such as the National Health Insurance Act				