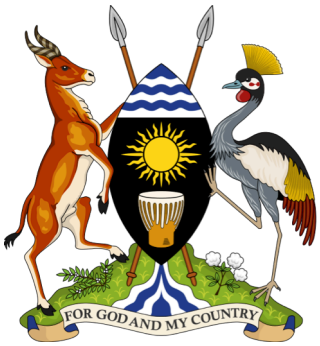

REPUBLIC OF UGANDA

A health financing system that responds to the dynamic aspirations of the health sector in Uganda

February 2016

HEALTH FINANCING STRATEGY

2015/16 – 2024/25

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ACRONYMS

AHSPRs	Annual Health Sector Performance Reports
ATF	AIDS Trust Fund
BFP	Budget Framework Paper
BoD	Board of Directors
CBHI	Community-Based Health Insurance
CSOs	Civil Society Organizations
DAH	Development Assistance for Health
DHIS	District Health Information System
GAVI	Global Vaccine Alliance
GDP	Gross Development Product
GFATM	Global Fund to Fight HIV/AID, Tuberculosis and Malaria
GNI	Gross National Income
GOU	Government Of Uganda
HDPs	Health Development Partners
HFS	Health Financing Strategy
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSDs	Health Sub Districts
HSDP	Health Sector Development Plan
HSSIP	Health Sector Strategic and Investment Plan
IHP+	International Health Partnership
IMF	International Monetary Fund
IRA	Insurance Regulatory Authority
JAF	Joint Action Fund
JMS	Joint Medical Stores
LGs	Local Governments
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOES	Ministry of Education and Support
MOFPED	Ministry of Finance Planning and Economic Development
MOGLSD	Ministry of Gender Labor and Social Development
MOH	Ministry Of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NDP	National Development Plan
NGO	Non-Government Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NHIS	National health Insurance Scheme

NHP	National Health Policy
NMS	National Medical Stores
OBT	Output Budgeting Tool
ODA	Official Development Assistance
OOP	Out-of-Pocket
PBF	Performance Based Financing
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PFP	Private for Profit
PHI	Private Health Insurance
PHPs	Private Health Providers
PNFP	Private-Not-For-Profit
PPP	Public Private Partnership
PPPH	Public Private Partnership for Health
RBF	Results Based Financing
SBWG	Sector Budget Working Group
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SWAps	Sector-Wide Approaches
TCMP	Traditional and Complementary Medicine Practitioners
THE	Total Health Expenditure
UDHS	Uganda Demographic Health Survey
UHC	Universal Health Coverage
UNHS	Uganda National Household Survey
VAT	Value-Added-Tax

Foreword

The health of the Ugandan population is central to the socio-economic transformation of the country. Along with increased literacy rates and vibrant economic growth, health outcomes are improving which translates to reduced mortality rates over the last 10 years. However, some of the millennium development goals are not on track due to numerous challenges in the health system.

Currently, the principal mechanism of funding health services in Uganda is through government general revenue tax financing, however, out of pocket payments and contributions by Health Development Partners contribute a substantial amount of financing for health care services. For various reasons, the out of pocket payments lead to financial hardships for many patients and their caretakers often leading to long term indebtedness or poverty. Poor and vulnerable population groups are to be protected from such hardships through introduction of social health insurance scheme and increasing government general revenue funding for health care.

The main objective of this Health Financing Strategy is to facilitate attainment of Universal Health Coverage through making available the required resources for delivery of the essential package of services for Uganda in an efficient and equitable manner. The instruments to achieve universal health coverage are sound health financing mechanisms. The strategic interventions herein are revenue collection, risk pooling and strategic purchasing. Thus in the medium term, no person should face risk of impoverishment when accessing health care nor should anybody forego medical services because of financial reasons.

When carefully implemented, these proposed financing reforms will jointly result in optimal health financing practices that support the health sector to achieve its goal of universal health coverage, where the population will access to health services in a timely manner and without financial hardship. Universal health coverage will be the overarching development goal for the next 10 years.

I therefore call upon all stakeholders to join hands to ensure the implementation of this Health Financing Strategy so that we can enable all citizens to have prosperity and jointly build a healthy and prosperous nation.

For God and my country.

Hon. Dr. Elioda Tumwesigye
Minister of Health

Preface

The mandate of a health system is to deliver individual and population health services, respond to legitimate concerns and expectations of the population, ensure fairness in financing and financial risk protection for households, and given the interdependence of all sectors of the society, contribute to socio-economic goals. Fairness in financing is about funds availability, reduction of out of pocket expenditure and ensuring equity, effectiveness and efficiency in allocation and use of raised resources. The Government of Uganda has chosen health financing as a catalyst for health systems reform to address the following challenges:

- Resource availability, efficiency, misapplication and wastage
- Financial hardship and impoverishment from direct under or over the counter payments for health care
- Inappropriate sector organization and management
- Ineffective engagement of key social determinants of health and other health sector stakeholders

Money is a necessary but not sufficient measure to achieve the desired health sector objectives. This Health Financing Strategy will serve as an instrument for resource mobilization at all levels, steer health systems investments in the correct direction, and provide the basis for aligning resources and creating opportunities for efficiency gains in the health sector.

Uganda has achieved remarkable success in health care service delivery though it has the lowest per capita health expenditure in the East African Community. However, it is now facing the challenge of increasing health care allocation due to the increasing population and health care costs. The country has unacceptably high out of pocket expenditure at the level of 50% of total health expenditure, government spending is around only 16%, and there are no mentionable social health insurance programs. These challenges call for focusing on deepening and broadening the resource base for health in Uganda. The country will require more than just increased financial resources for health; it will require improved ways of organizing resource mobilization, allocation and expenditure in order to obtain the maximum value for money to ensure equitable and sustainable financing and financial protection against health expenditures of the entire population.

The Health Financing Strategy provides an overview of the vision and goals followed by strategic objectives, each with their associated strategic interventions that respond to goals of health financing in Uganda. An action plan in the Health Sector Development Plan (HSDP) for possible implementation has been set out. Timely implementation of the HSDP following the strategy will strengthen the country's health system to succeed in improving the health of its citizens.

Dr. Asuman Lukwago
Permanent Secretary, Ministry of Health.

Acknowledgements

The Health Financing Strategy has been developed over a period of a year since the adoption of the Health Sector Strategic Plan (HSSIP 2010/11-2014/15). The development was through a participatory process, with inputs from a wide range of stakeholders.

The process has been led by the Planning and Development Directorate under the full support and proactive guidance of the Ministry of Health management structures. Since the beginning of the strategy development process, senior top management contributed to the drafting and carrying out of consultation processes.

The Ministry is thankful to Dr. Specioza Wandira Kazibwe the Special Senior Presidential Advisor on population Health, and The Planning and Development Directorate under the stewardship of Dr. Isaac Ezaati Alidria for drawing up the roadmap for the development of the strategy. The Health Financing Strategy Secretariat received technical support from the World Bank, World Health Organization, Local Governments, Civil Society Organizations and Health Development partners that facilitated the strategic development process. Much benefit has been derived from comments and advice of other line Ministries and especially Ministry of Finance, Planning and Economic Development. We acknowledge the critical guidance provided by international development partners who peer reviewed and provided comments on earlier drafts of this document, in particular Partners for Health (P4H).

Last, but not least, the participants in the different consultations deserve special mention for their contributions in making the strategy document focused to the real health care needs of the Ugandan Population. It is the product of the collaborative effort by many professionals inside and outside of the planning and development directorate. All Ministry of Health staff deserve thanks for their respective contributions.

Dr. Jane Ruth Aceng
Director General of Health Services, Ministry of Health

1 INTRODUCTION

1.1 Background

This is the second Health Financing Strategy for Uganda, and it comes at a time of global commitment towards Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC). It is anticipated that this strategy will serve as a critical element in Uganda's pathway to achieving the health-related SDGs and attaining UHC. UHC emphasizes access to good quality health care according to need, while at the same time limiting exposure to financial risk for those who seek care. Achieving UHC is a cornerstone of the new set of SDGs, which have been defined as the new global development goals. Uganda is transitioning from the Millennium Development Goals (MDGs) to the SDGs, in which UHC is the all-encompassing health goal. The attainment of the UHC goal in any country requires a well-functioning health financing system. In developing the HFS, the MOH recognizes that the implementation of the financing reforms in this strategy will rely on existing systems and structures, and progressively move towards building the required systems for UHC.

The development of the HFS is underpinned by the Constitution, Vision 2040 and the National Development Plan (NDP II). 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 Constitution further entitles all people in Uganda to enjoy rights and opportunities and to have access to education, health services and clean and safe water. Uganda's Vision 2040 envisions *"a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years*" and has been developed to shape Uganda's long-term development strategy. Vision 2040 acknowledges that good health is essential in ensuring socio-economic transformation and is critical if Uganda is to attain its long-term vision. The NDP II[1] also places great emphasis on investing in the promotion of people's health and nutrition, and the need to improve health and promote well-being. The MOH recognizes that strengthening human capital development is fundamental to accelerating the country's transformation. Indeed, human capital development is dependent on a healthy population, and it is needed to achieve Uganda's economic aspirations of becoming a middle income country. A strong and adequately financed health system is critical in maintaining a healthy population.

Further, the HFS has been developed in line with sectoral policies and development plans, including the National Health Policy (NHP II) and the Health Sector Development Plan (HSDP) 2015/16 - 2019/20. The NHP II has a vision of attaining "*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 NHP II puts emphasis on ensuring that financial barriers do not prevent people from using the health services they need and also ensuring that people do not suffer severe financial catastrophe as a result of using the services. The HSDP provides the

[1] National Development Plan 2015/16 - 2019/20

strategic direction for the implementation of the NHP and aims "*to accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life*". The HSDP also underscores the need to provide a quality package of essential health services, accessed by all, without suffering financial hardship.

1.2 Rationale for the Health Financing Strategy

Whereas health financing reforms can catalyze and trigger the transformation of the health system towards achieving its aspirations, they are not sufficient - on their own - to cause overall health system performance for the achievement of Government's health policy objectives. The rationale for developing Uganda's HFS is to provide a framework through which Uganda will finance its health sector to achieve its stated goals. The HFS is a document that will guide the country in equitably and sustainably mobilizing resources and efficiently utilizing them to implement sector plans. If well implemented, this HFS will serve as an instrument for resource mobilization; it will help Uganda in addressing the malfunctions of the current financing system; and, will provide the basis for aligning resources to the sector's priorities and creating opportunities for efficiency gains in the health sector. In developing the HFS, the MOH is cognizant of the fact that no single actor or factor is solely sufficient to bring about the attainment of the national health goals. Indeed, the attainment of such goals shall be approached in a multi-sectoral manner.

1.3 Health Financing Strategy Development Process

The process of developing this strategy started after a health financing review was conducted in 2010. The development of the HFS has been guided by evidence generated through an extensive review of relevant documents, including but not limited to: the National Health Accounts (NHA) studies and the Mid-Term Review of the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 - 2014/15, as well as a review of international evidence on best practices in health financing. The situation analysis (in chapter 2) and the proposed health financing reforms (in chapter 3) were guided by the framework of the core health financing functions namely; revenue collection, pooling, and strategic purchasing.

A Task Force for the HFS, chaired by the Director of the MOH Planning and Development unit, led the process of developing this strategy, under the guidance of the Sector Budget Working Group (SBWG). The strategy was developed through a consultative and participatory process that started in 2010 and included a series of wide-ranging consultative workshops with key stakeholders including Local Governments (LGs), Civil Society Organizations (CSOs), Health Development Partners (HDPs), and other international partners. A preliminary draft of the strategy was prepared in August 2014. The draft HFS was peer reviewed by several people (locally and internationally) The reviews done by local and international partners to ensure that the HFS document was in line with the country context, needs and aspirations, also in line with international and global frameworks, goals and best practices. The MOH is particularly grateful to the comments and guidance received from P4H Social Health Protection Network). P4H a global health partnership aiming at improving social health protection and strengthening health financing systems. In October 2015, a draft HFS was presented to the Health Policy

Advisory Committee (HPAC) and Top Management Committee. Comments from these structures were used to revise and finalize the strategy.

1.4 Organisation of the remaining part of the document

Chapter 2 summarizes a brief overview of Uganda's macroeconomic and fiscal context, and describes the key highlights of the situation analysis of Uganda's current health financing system. At the end of chapter 2, a summary of the challenges and gaps in the financing system that need to be addressed is presented, and these form the basis for the financing reforms described in Chapter 3. The reforms are discussed in detail under the different health financing functions of (a) revenue collection, (b) pooling of resources and risk, and (c) strategic purchasing. In Chapter 4, the best way of sequencing the implementation of different reforms is briefly described, and the implementation arrangements for these reforms are articulated. In Chapter 5, the monitoring and evaluation framework for the HFS is briefly described.

2 SITUATION ANALYSIS (OF CURRENT HEALTH FINANCING SYSTEM)

The purpose of this chapter is to provide the context relevant for understanding the rest of the information presented in the HFS. The macroeconomic and fiscal context sets the foundation for understanding the factors that have contributed to the current financing situation and the factors that will impact on the implementation of the financing reforms proposed. The situation analysis provides an evaluative assessment of the different aspects of Uganda's health financing system, with the view to identify strengths, weakness, gaps, and opportunities. The situation analysis is intended to set the stage for identifying appropriate financing reforms for Uganda.

2.1 Country context

2.1.1 Macro-economic and fiscal context

Uganda's economy remains rural and agrarian with a large proportion of the population still relying on low-paying jobs in the agriculture sector. Approximately three-quarters of Uganda's adult population are employed, mainly in subsistence/peasant farming. Poverty levels remain relatively high, with recent estimates showing that about 19.7 per cent of all Ugandans are living below the national poverty line ($1.25/day), and that even a larger share of the population (43.3 percent) remains highly vulnerable to external shocks and to falling back into poverty. Uganda is a low income country with estimated Gross National Income (GNI) per capita of US$ 660 (2014). Uganda's economic growth rate has averaged about 5.5% per annum over the years of implementation of the NDP 1 (2010/11-2014/15). This represents a deceleration from growth rate of 8% that was observed in the period 2006-2010. Uganda's economic growth rate, although commendable, is currently the least when compared to the other countries in the East African region. This state of affairs is attributed to domestic spending pressures and volatile external environment. Uganda's weak external position is due to low regional trade and weaker global demand resulting from the relapses in the global economy, following the global financial crisis and civil unrest within the regional markets especially in Southern Sudan.

In the short term, Uganda's economic outlook is characterized by a high level of uncertainty due to the current inflationary pressures. The mobilization of relatively low domestic revenue and the uncertainty regarding the date of commencement of oil production and subsequent flow of oil revenues, mean that Uganda's capacity to mobilize additional domestic resources will remain weak in the short to medium term. Uganda's tax revenues remain low compared to countries in the region. On average Uganda collects about 13.3 percent of GDP (2014) in taxes compared the average of 20% for SSA. The low tax collection has attributed to the low tax base and inefficiencies in tax collection. With regards to the latter, IMF estimates show that increasing tax compliance (focused on VAT) in Uganda to 40% in line with the regional average efficiency would increase VAT revenue by about 2.5% and would lead to an

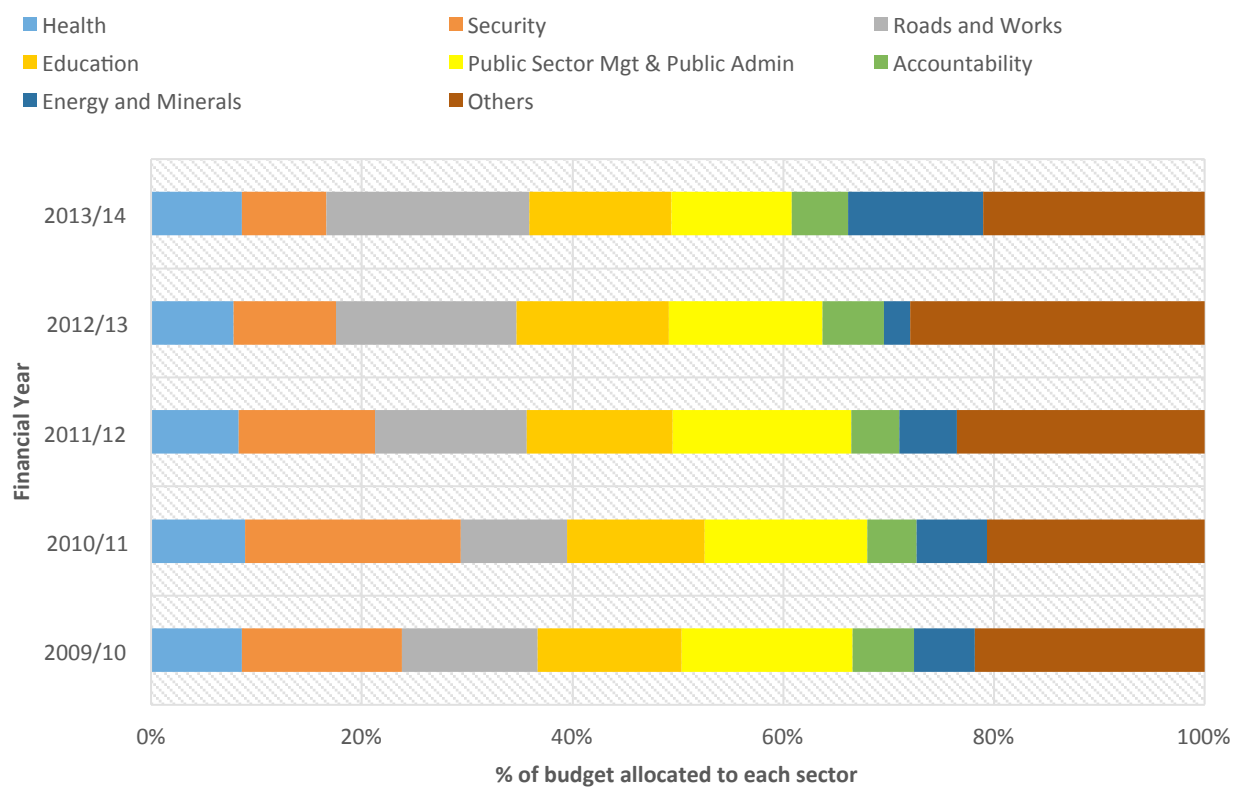
annual growth of tax revenue by about 0.5% as a percentage of GDP[2]. Increasing the productivity of the economy key in expanding the tax base. The 2015 Uganda Economic Update by World Bank identified the issue of increase productivity of the economy through addressing land issues especially the challenges of land tenure security and inefficient markets[3].

The country is operating in a deficit with expenditure estimated at about 21.7% (2014) of the GD (having been able to only mobilize 13.3 per cent in taxes). This deficit has been mainly driven by the recent heavy investments in infrastructure (mainly energy and road construction sectors) which have been the key investment priorities of Government in the recent years. Figure 1 summarizes the trends in government budget allocation to the different sectors between 2009/10 and 2013/14. While the proportion of the budget allocated to the health sector has stagnated at around 8% of the total budget, the proportion of the budget allocated to roads and works and energy and minerals increased from 18.7% to 23% of total budget within the same period. Although general government budget has been increasing over the years, allocations to the health sector have not matched with this increase. For instance, while the health budget has increased by 93 per cent over the 5 years (FY 2010/11-2015/16) from UGX 660 billion (FY 2010/11) to UGX1, 271 billion (2015/16), total government budget increased by 148 per cent from UGX 7,377 billion (FY 2010/11) to UGX 18,311 billion (FY 2015/16). It is important to note that the growth in the health budget has been mainly driven by increased external resources (e.g. the share of donor support to the health budget increased from 14 %(FY 2010/11) to 42 % (FY 2014/15). The health sector budget as a percentage of total government budget has been declining in the last five years (Table 1 and Figure 2).

[2] Hutton et al, Revenue Administration Gap Analysis Program—The Value-Added Tax Gap. 2014

[3] World Bank. Searching for the "Grail": Can Uganda's Land Support its Prosperity Drive?. 2015

Figure 1: Proportion of the total budget allocated by sector (Includes on budget ODA)



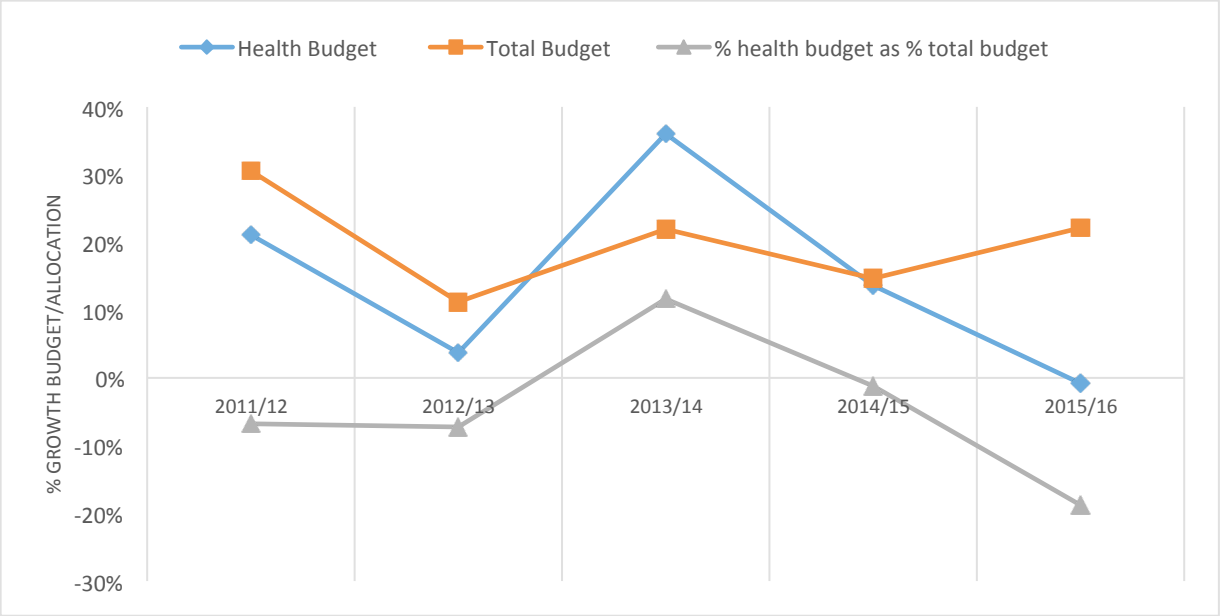
Source: MOFPED; Background to the Budget

Table 1: Total GOU Budget and Health Sector Budget (FY 2010/11-2015/16)

Year	Billions (UGX)				Health as % of total budget
	Health Budget	*growth*	Total Government Budget	*growth*	
2010/11	660		7,377		8.9
2011/12	799	*21%*	9,630	*31%*	8.3
2012/13	829	*4%*	10,711	*11%*	7.7
2013/14	1,128	*36%*	13,065	*22%*	8.6
2014/15	1,281	*14%*	14,986	*15%*	8.5
2015/16	1,271	*-1%*	18,311	*22%*	6.9

Source: MOFPED; Background to the Budget

Figure 2: Growth in Total GOU Budget and Health Budget

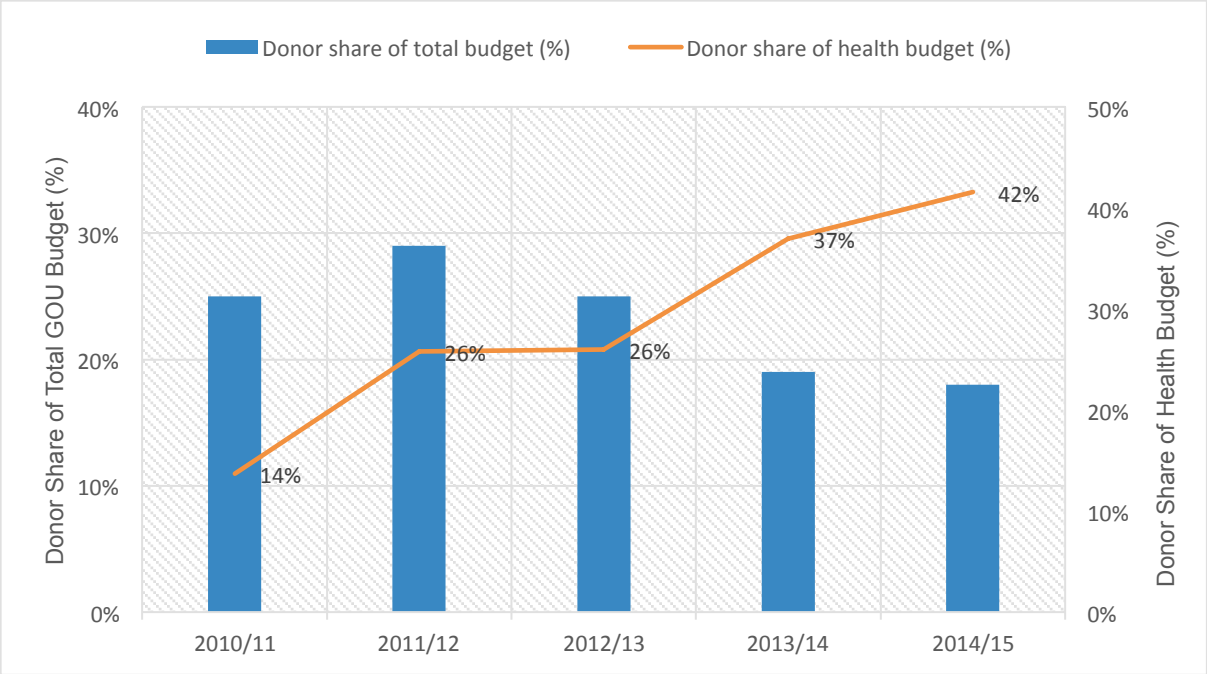


Source: MOFPED; Background to the Budget

In the short to medium term, external resources are expected to remain important for some sectors such as health (**Error! Reference source not found.**). These external resources include both grants and loans. With regards to the latter, Uganda debt is still at sustainable levels, as per the established benchmarks for debt sustainability. For instance, for FY 2013/14, Uganda's total public debt as a percentage of GDP was estimated at 24.6%, which is less than macroeconomic convergence criteria (i.e. less than 50 percent of GDP). Better management of resources from both grants and loans will improve their effectiveness in contributing to the achievement of country goals as expressed in the National Development Plan. This is particularly important for the health sector.

An interesting factor to note is the fact that while ODA as a proportion of the total Government budget has been decreasing, the reverse has been observed in terms of donor resources as a proportion of total health expenditure. Specifically, while the contribution of ODA to total government budget has declined from 25% in FY 2010/11 to 18% in FY 2014/15, the proportion donor resources contributing to total health budget increased from 14% to 42% within the same period (**Error! Reference source not found.** The increase in this period is attributed to increased contribution of Global Health Initiatives specifically, Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines Initiative (GAVI). The most recent National Health Accounts estimates show that external resources were the dominant source of health expenditure contributing 47% of total health expenditure (FY 2011/12).

Figure 3: Percentage contribution of ODA to total budget and to the health budget (2010/11-2014/15)



Source: MOFPED; Background to the Budget

In the medium term (by 2021), the country expects revenue from oil industry, which it hopes to utilize in high return public investments. However, in the initial stage, the mining industry requires heavy investment to set appropriate infrastructure and systems for oil mining. Allocating resources to the mining industry for these purposes has contributed to further tightening of the fiscal situation. Resources from foreign investors, which would have been helpful in boosting the preparatory phase of oil mining, are dependent on the global macro-economic outlook, which has also not been positive.

A very important issue to note with the expected oil revenue is that its expected contribution to GDP (estimated 10%-13%) is almost equivalent to what is currently being provided by external resources to support oil mining. This means that for sectors like health, where donors contribute a significant proportion, oil manufacturing will provide additional revenue only if it supplements and not substitutes the existing sources. Furthermore, oil mining (once it has commenced) is likely to result in a shift in classification for Uganda, from "low income" to "middle income". Such a shift in classification is likely to result in Uganda's disqualification for some donor funds (such as GAVI) is tagged to its status as a low income country. This means that such donor funding would no longer be available for Uganda, and yet it is noted earlier that the estimated level of resources anticipated from oil are not very significant.

Furthermore, as noted earlier, the elasticity of growth of health funding in Uganda is mostly dependent on growth in external funding and not increased domestic resources. While the elasticity of growth of health expenditure was estimated at 1.44 (implying that a 1% increase in GDP would lead to a 1.44% increase in health spending), this elasticity decreases to 0.95 when one excludes external resources. This implies that an increase in domestic resources alone does not guarantee significantly increased resource

availability for Uganda's health sector. According to the fiscal space analysis in 2010, the health budget quadruples every ten years, but because of the high population growth rate per capita spending on health only about doubles.

Uganda has potential to increase its fiscal space lies in promoting prudent fiscal management and governance so as reduce inefficiencies and wastage that has plagued the health system. Inefficiencies have been shown to consume up to 13% of total health expenditure[4]. Key areas of inefficiencies that have been identified are: human resources, pharmaceuticals and health supplies and procurement and management infrastructure and equipment. These are elaborated below:

a) Human resources for health: There are two main inefficiencies in human resource for health. First, the issue of health worker absenteeism has been widely documented in Uganda[5]. Absenteeism was estimated to result to a loss of about UGX 26 billion per year6. The second issue is that of "ghost workers". Ghost health workers are those who erroneously appear on the payroll despite having resigned, retired, absconded or even died. This is as a result of fraud or poor payroll management systems. Ghost workers also result into a loss of about UGX 1 billion. These inefficiencies were attributed to inadequate personnel management practices which demotivated health workers. This include: recruitment and incorporation of the payroll, confirmation and promotion, lack of appraisals and limited opportunities for additional training and refresher trainings.
b) Pharmaceuticals and health supplies: The inefficiencies in the pharmaceutical sector result from poor procurement and supply chain management practices and also through direct drug leakages. Although the centralization of procurement of medicines through establishment of Vote 116 and strengthening of quantification unit has addressed some procurement and supply chain related inefficiencies, key area of inefficiency is the "push" system at lower levels of care that results into expiries at facility level. There is also potential to reduce inefficiencies through encouraging rationale pricing, more appropriate prescription practices and use of medicines including encouraging use of generic drugs. With regards to direct drug leakages, there is still a challenge of loss of drugs at health facilities which has resulted into stock-outs at the health facilities.
c) Procurement of Equipment and Infrastructure: The Public Procurement and Disposal of Public Assets Authorities has documented considerable risk resulting into financial loss[7]. These losses was attributed to challenges in procurement planning, monitoring and contract performance. The area where these challenges has been most documented is in the area of procurement of equipment and construction of infrastructure. With regards to equipment, there has been a challenge of purchase of equipment to facilities which do not have personnel to use them

[4] Okwero et al. Fiscal Space for Health in Uganda. 2010
[5] J. Svensson and M. Bjorkman, Efficiency and Demand for Health Services: Survey Evidence on Public and Private Providers of Primary Health Care in Uganda. Washington, DC. The World Bank, 2009
[6] Chaudhury et al. Missing in Action: Teacher and Health Worker Absence in Developing Countries; Journal of Economic Perspectives, Volume 20 (2006), Pages 91–116.
[7] Okwero et al. Fiscal Space for Health in Uganda. 2010

resulting to wastage. Similarly, the practice of construction of health facilities based on administrative units as opposed to population is an indicator of waste. The process of planning for infrastructure development for health facilities needs also to put into consideration the availability of other key inputs.

In addition to the areas of inefficiency identified above, there is need to address issues of inadequate accountability, fraud and misappropriation of funds. Issues of corruption and embezzlement have been regularly identified in the media and in the Auditor General's annual reports. Addressing these challenges would also save the sector from financial loss and would enable the government to implement its fiscal space.

2.1.2 Organization of the health system in Uganda

The health care system of Uganda is organized under a decentralized arrangement. At the top is the Ministry of Health, which is responsible for policy and standards formulation, quality assurance, and resource mobilization. The districts and local governments are responsible for managing all health care providers under their jurisdiction. The districts are further divided into health sub districts (HSDs), which are administered at the health center IV level. The districts and HSDs are responsible for leadership in the planning and management of health services, supervision and quality assurance, procurement and supply of drugs, and provision of technical, logistic and capacity development support. One of the core aims of decentralization was to ensure that districts are able to direct resources to funding health services in line with local priorities.

The health care system is made up of public, private-not-for-profit, and private-for-profit providers as well as traditional and complementary practitioners. For the public facilities, the national and regional referral hospitals report to the central government; while general hospitals and health centers (types II—IV) report to the local governments. The private-not-for-profit providers are predominantly faith-based and are administratively coordinated nationally by the respective bureaus and locally by the diocesan boards. The private-for-profit providers predominantly comprise clinics, but also include drug shops and vendors operating informally. In terms of overall numbers of health facilities, excluding clinics, the public sector dominates: 55 percent of all hospitals, health centers II, III, and IV are government-managed, and the rest of the health facilities which are private and NGO-managed. Private-for-profit health facilities receive a subsidy from government using an input-based payment approach with no incentive for efficiency and equity. A summary of health facilities in Uganda by ownership and by level is shown in Table 2.

Table 2: Facility Ownership in Uganda (By Level of Care)

Level	Ownership				Percentage (Level)
	Public	*PNFP/ NGO*	*PFP*	*Total*	
Hospital	63	64	20	**147**	3%
Health Centre IV	170	15	8	**193**	4%
Health Centre III	916	264	70	**1,250**	24%
Health Centre II	1,695	520	1,395	**3,610**	69%

Total	2,844	863	1,493	**5,200**	100%
Percentage (Ownership)	55%	17%	29%	**100%**	

Source: Health Facility Inventory 2012

The recent proliferation in the number of districts has been a challenge on decentralized health service delivery. This has aggravated the challenges faced at district level which include: low levels of local revenue in the district, limited flexibility in planning as most of the central funds are earmarked, inadequate financial and human resource capacity. Furthermore, with regards to the Health Sub Districts, while notable progress has been made, the majority of the 214 HSDs have also encountered bottlenecks in meeting policy expectations because of inadequate funding and lack of human resources including managers at this level.

Lastly, it is worth noting that although the health infrastructure has expanded, a vast majority of health facilities are not fully functional, lack equipment, staff, and are poorly maintained. There is also inequity in the distribution of the functional health service providers with these located mainly in urban and peri-urban areas.

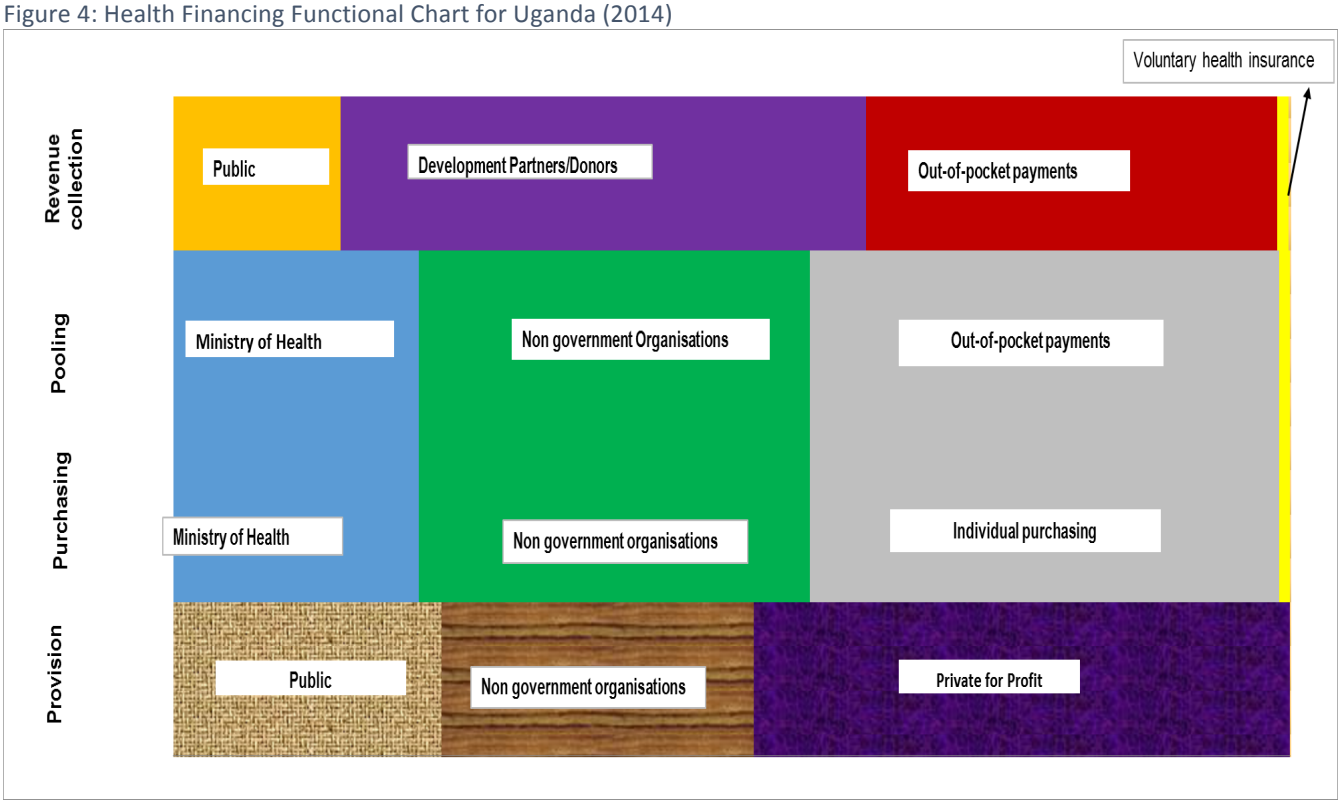
2.2 Situation analysis for Uganda's health financing

For this analysis, we have taken into consideration the framework by the World Health Organization.[8] To achieve financial protection and equitable access to health services, health revenues must be collected fairly, should be effectively pooled and managed, and should be used to purchase services strategically and efficiently. In the remaining sections of this chapter, a brief exposition of the performance of Uganda's health financing system is presented in terms of (a) revenue collection, (b) pooling of resources and (c) purchasing of services.

Figure 4 is a functional chart that summarizes the landscape of Uganda's health financing system. It shows the contribution of the various revenue sources, the entities responsible for pooling and purchasing (by proportion) and lastly the organization of health service provision. In sections 2.2.1 – 2.2.3, each of the functional areas is unpacked in detail.

[8] Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy, 2001, 56: 171-204.

Figure 4: Health Financing Functional Chart for Uganda (2014)



Source: Data from Uganda's National Health Accounts

2.2.1 Sources of Health Financing

Uganda's National Health Accounts show that *total health expenditure* (THE) was UGX 4.8 trillion in FY 2011/12. The sources of health financing are public, private funds (mainly household out-of-pocket expenditure), development partners (ODA) and voluntary health insurance. In 2011/12, public funds contributed 15.3%, private funds 38.4% and development partner funds 46.5%. The pattern of contribution to THE has been the same in the past years (Figure 5). The trends in the proportion contribution by each financing sources shows that there is a heavy reliance on direct out-of-pocket expenses and on external resources. These are explored in more detail below.

Figure 5: Trends in health financing for Uganda (billion-UGX) (2008/9 – 2011/12)

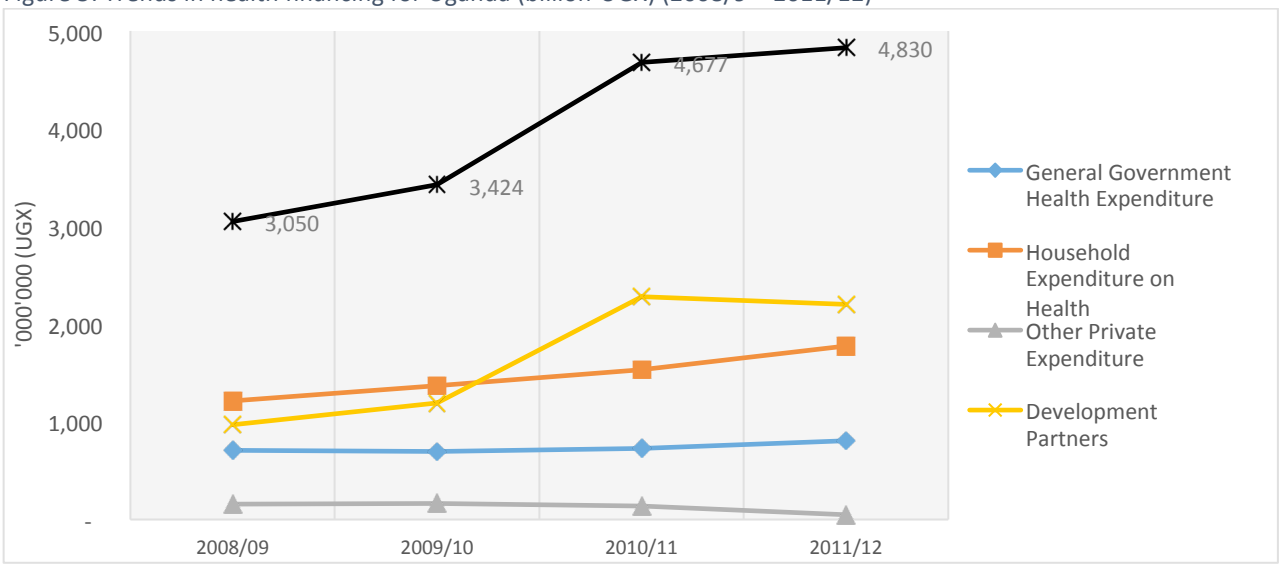
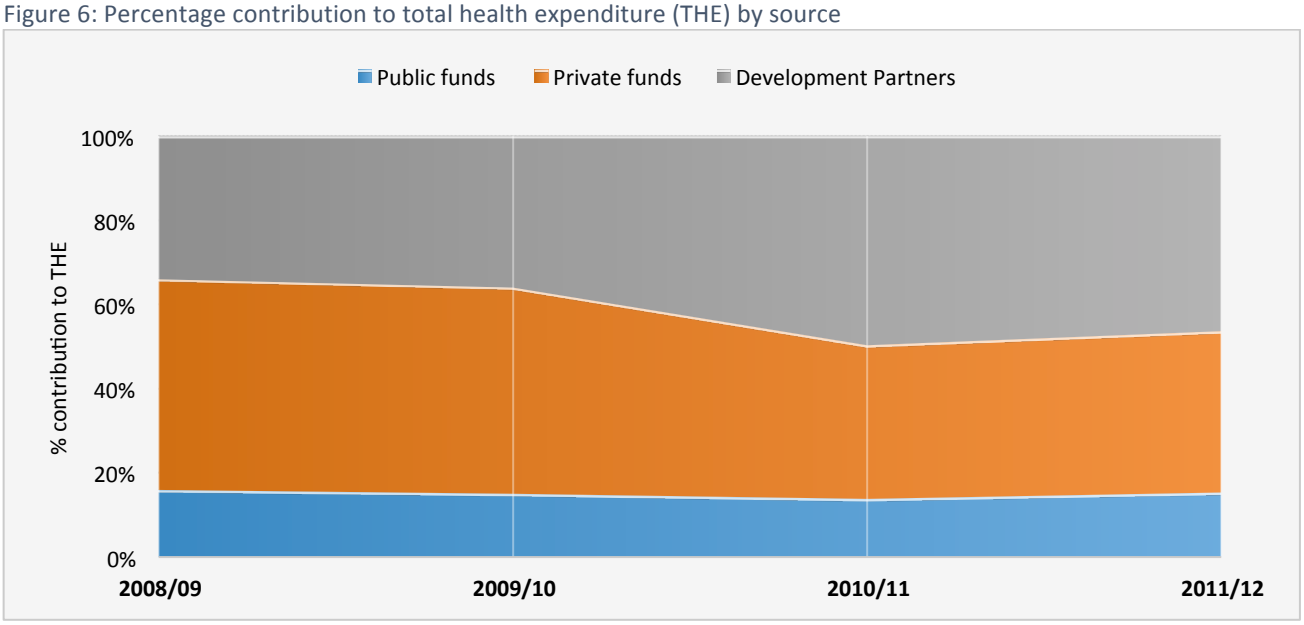


Figure 6: Percentage contribution to total health expenditure (THE) by source



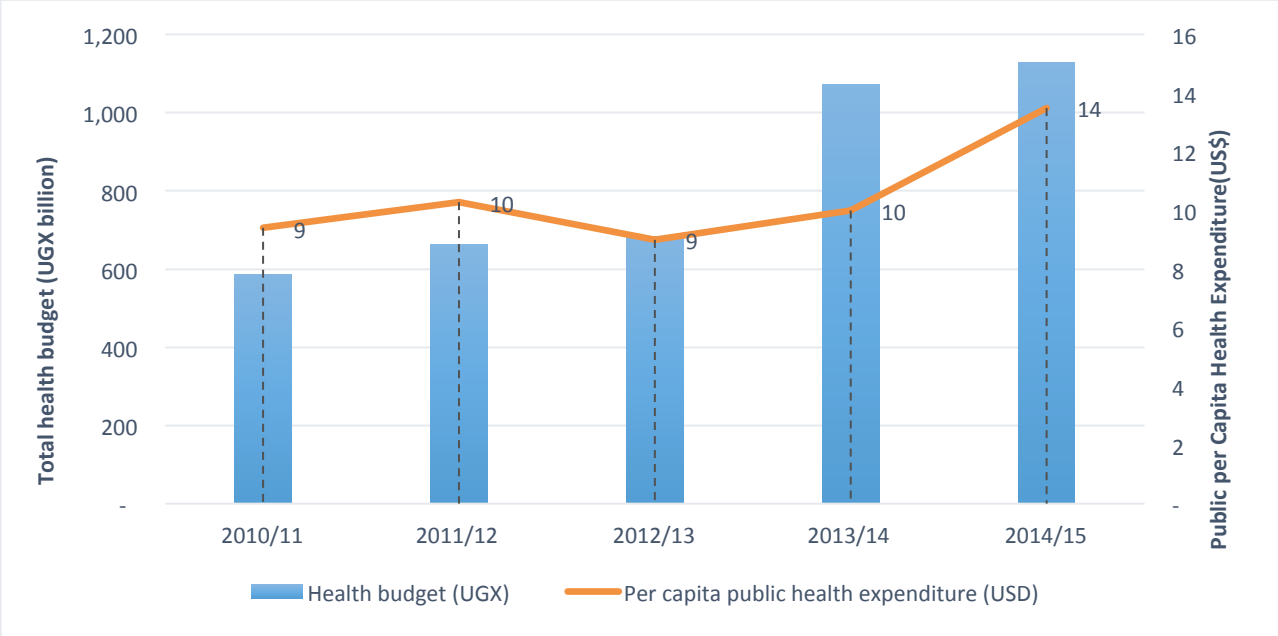
While the estimated *total per capita health expenditure* reported by the NHA (2011/12) was $50.1, the *per capita public expenditure* was only $9 (in 2012/13). Previous reviews of health financing in Uganda have shown that there are still challenges in aligning revenue from other sources towards providing the essential minimum health care package[9]. The low per capita public expenditure when compared to the health spending estimates levels of up to $86 per capita(2012), as recommended by High Level Task force on Innovative International Financing for Health[10], shows that resources for financing Uganda's

[9] MOH. Health Financing Review.2010.

10 McIntyre D and Meheus F. Fiscal Space for Health and Other Social Services. 2014

essential here care package are currently inadequate. Resource inadequacy for Uganda's health sector has been made worse by failure to organize all the available resources towards providing the essential health care package. Inefficient use of ODA resources in the past, which included big scandals of corruption, resulted in mistrust between the government and its development partners. This has largely fueled the current challenge of effective coordination and harmonization of ODA. OOP payments are still very dominant in Uganda, contributing a significant proportion to total health sector expenditure (Figure 6). Figure 7 presents the trend in *public per capita health expenditure* and the *government budget allocated to the health sector*.

Figure 7: Trend in per capita health expenditure and government budget allocation



According to current fiscal space projections, Uganda's health budget will continue to grow at a modest rate. The challenge facing the health sector is the shift in government spending priorities, with focus of government funding shifting towards the energy and infrastructure sectors in the recent years. The percentage of government budget (which includes on budget ODA) allocated to the health sector has stagnated at about 8.5% in the period 2010/11-2014/15 and it fell substantially to 6.9% in 2015/16.

According to the UNHS, OOP spending on health has continued to increase, with over 50 percent of total OOP health expenditure being spent on drugs[11]. OOP spending on health is associated with high financial risk. Specifically, over 20% of the population spend more than 10% of their total household consumption expenditure on health care. As such, this level of OOP health spending compromises households' consumption of other basic needs, and more than 4% of the population have been pushed

[11] Orem et al. 2013. Health care seeking patterns and determinants of out-of-pocket expenditure for Malaria for the children under-five in Uganda. Malaria Journal 2013, 12:175

below the poverty line ($1.25/day) due to these health care payments[12]. Studies have shown that households in Uganda cope with these OOP expenditures through depletion of savings and selling of assets, including some households being driven into debt[13]. OOP payments for health care also increase socio-economic inequality across the population.

With Uganda's health sector relying heavily on external resources, ensuring aid effectiveness remains a challenge for Uganda[14]. This is in addition to the other limitations associated with DAH such as the lack of predictability and making this financing source unsustainable in the long term[15]. As presented earlier, Government expects the coming of oil revenues, in the medium term, to most likely drive Uganda to "middle income" status. This will be associated with reduced external funding in general, and increased cost of borrowing and is likely to result in the following challenges:

a) The revenue expected from oil (10% of GDP) is nearly equivalent to external resources currently raised, implying that oil revenue may not translate to increase resource availability if a large proportion of external support is withdrawn as a result of the oil revenue;
b) Uganda's qualification to receive some of the external resources such as GAVI funding is dependent on income classification. If Uganda is classified as a low-to-middle income country, as a result of the oil mining and revenue, it will be disqualified from receiving GAVI support, and yet it may not be able to generate enough revenue to replace such external support (particularly for a very sensitive health service area of vaccines and immunization of children).

The insurance sector in Uganda is still under-developed and it contributes very little as a source of health financing. There is a generally very low insurance market penetration with insurance contributing less than 1% of Gross Domestic Product.[16] The health insurance market is faced with challenges of sustainability due to the very low membership numbers and high dropout rates[17,18,19]. This scenario is unlikely to change in the short term. While there are current efforts to establish a National Health Insurance Fund (NHIF), in the short term the focus will be on institutional capacity building before NHIF is implemented. While there are suggestions for earmarking taxes as an option to raise resources for the health sector, this option maybe challenging because it may be seen to interfere with the power and roles of other key stakeholders such as MOFPED and Parliament.

[12] Kwesiga B, Zikusooka CM, Ataguba JE. Assessing catastrophic and impoverishing effects of health care payments in Uganda. BMC Health Serv Res.

[13] Leive A, Xu K: Coping with out-of-pocket health payments: empirical evidence from 15 African countries. Bulletin of the World Health Organization 2008, 86(11):817-908

[14] Oliveira Cruz V, McPake B. 2011. Global Health Initiatives and aid effectiveness: insights from a Ugandan case study. Globalization and Health; 7(1): 20.

[15] ibid

[16] World Bank Estimates

[17] Cordaid 2007.

[18] Kyomugisha, E., Buregyeya, E., Ekirapa, E., Mugisha, F. & Bazeyo, W. 2008. Building strategies for sustainability and equity of pre-payment schemes in Uganda: Bridging gaps. . Harare.: Regional Network for Equity in Southern Africa

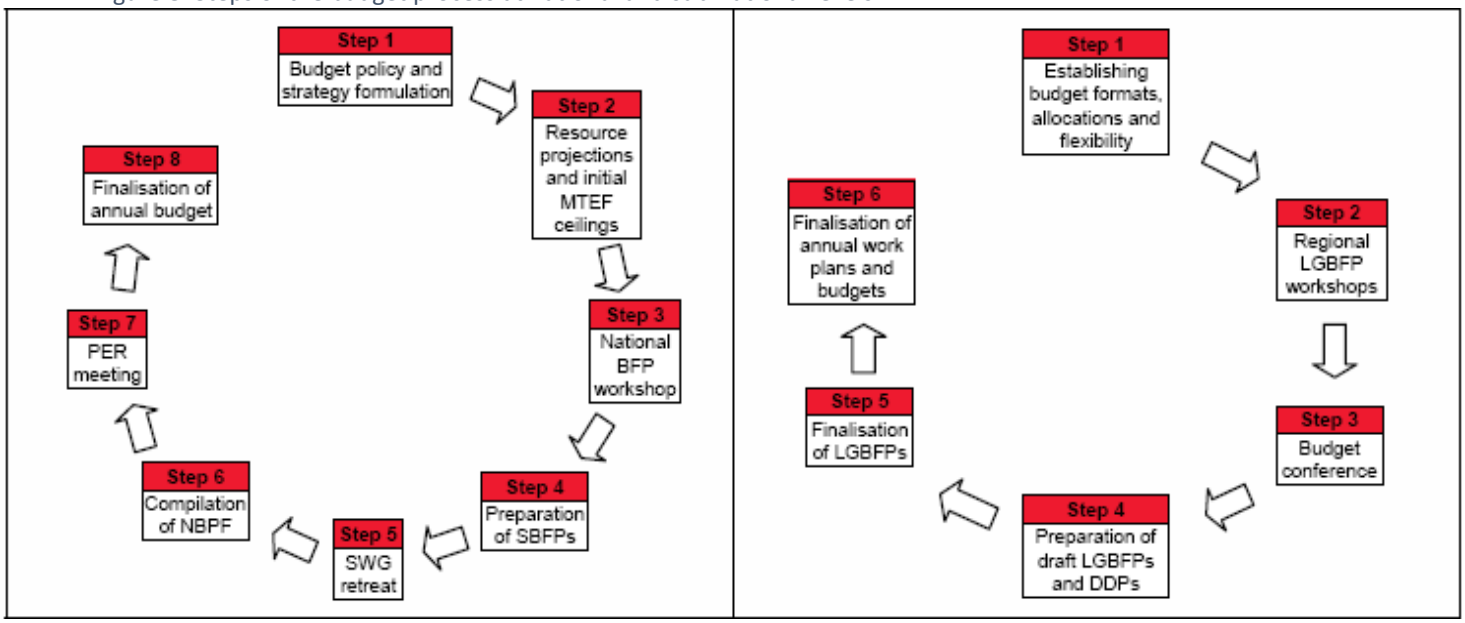
[19] Basaza, R., Pariyo, G. & Criel, B. 2009. What are the emerging features of community health insurance schemes in east Africa? Risk Management and Healthcare Policy. 2, 47-53.

In the face of low funding, Uganda is also under considerable pressure to increase spending for health. This is driven primarily by the rapidly growing population and the need to adopt for more effective—and expensive—health technologies and service standards to combat the high disease burden. Besides, continuing resource mobilization and reducing waste, Uganda needs to take proactive steps to mitigate growing pressure to increase health spending.

Budgeting Process

Figure 8 presents the steps in the budget process at national and sub-national levels. 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 ensure effective resource use to achieve government goals. The Ministry of Finance, Planning and Economic Development (MoFPED) leads the budget process, in consultation with legislature/parliament and Bank of Uganda (BOU).

Figure 8: Steps of the budget process at national and sub-national levels



National **Sub-national**

The resource envelope for the medium-term is derived from projected domestic revenues and anticipated external funds (grants and loans). Once the total resource envelope has been determined, broad allocations to sectors are determined based on: (a) priorities which have a direct bearing on poverty and growth; (b) the ruling party manifesto; and, (c) constraints faced during implementation.

Sector ceilings 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; and, (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 medium-term expenditure framework (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 Papers (BFPs), then again after receiving comments from Parliament on the National BFP, and finally just before reading the budget.

Uganda's budget process is characterized by relative transparency and openness and broad participation. Important components of this process are the Sector Budget Framework Papers which are prepared at the national, sectoral and local government levels. BFPs 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. The national budget is a compilation of BFPs prepared at the sectoral and sub-national levels. The national BFP is prepared by MOFPED and consists of the revenues required for 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 budget working groups (SBWGs) 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 to reflect sector strategies and Sector Investment Plans (SIPs).

Given that sector-wide approaches (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 not all 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 the decentralization policy in Uganda was 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 help accomplish this objective. 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. And issues arise with equalizing budget revenue across local government.

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 HSDP deliberations.

The budget performance of the health sector has been modest over the period of implementation of the HSSIP (2009/10-2014/15) averaging above 95% during this period. This performance varies between recurrent and development budgets. For instance, between 2009/10 and 2012/13 the execution of the recurrent budget averaged about 100%, while the execution of development budget averaged 87%. The lower performance for development budget is attributed to the lengthy bureaucratic procurement procedures involved in spending of development budgets. This is the key factor influencing budget performance at different levels and program area within the health sector. Within the HSSIP period (2010-2015), sector performance reports showed that the less-than-optimal budget performance in some years was due to challenges of recruitment where posts of new staff had been approved.

2.2.2 Pooling of resources

Pooling refers to the accumulation and pulling together of prepaid funds for health sector, with the view to finance sector priorities necessary to address the population health challenges. Another pooling function, which is more associated with health insurance, is the redistribution of funds between different pools with the view to promote income and risk subsidization in order to enhance equity. In the Ugandan context, with the exception of government funds, there are no clearly defined resource pools. The desired long term position is to have one health fund, but in the short to medium term pooling may not necessarily refer to having all sector resources in one bank account. Some kind of virtual pooling of resources is applicable to the Ugandan context. Virtual pooling refers to ensuring that funds from different sources are directed and planned for in a coordinated purchasing approach to ensure that they fund sector priorities identified within the sector development plans. A previous review of Uganda's health financing has shown that there are challenges in directing all the sector resources towards financing the health sector priorities[20]. This challenge that needs to be addressed.

Uganda's health sector is characterized by heavy fragmentation of "resource pools". OOP payments, which contribute significantly to the health sector resource envelope, represent the most extreme form of fragmentation. Even within government resources (which would be the appropriate pool), there is fragmentation in light of the rigid earmarks from the conditional grants and development partner projects. This earmarking leads to limited flexibility in allocation to sector priorities and results into budgetary distortions[21].

[20] MOH. Health Financing Review for Uganda. 2010
[21] Okwero et al. 2010. Fiscal Space for Health in Uganda. World Bank

Currently, there is no single pool for donor funds for health in Uganda. With regards to the channels for ODA, it is important to note that while some donor funds are channeled through the government system, the rest is through project support and non-state actors. There is also a "virtual pool" which represents the resources that are funding health sector priorities but are retained by their respective funders such as the UN agencies and some bilateral partners. The various channels through which financing from ODA is received makes it very challenging in terms of management and alignment of these funds[22,23]. While Uganda has strengthened its resource tracking system including institutionalizing the National Health Accounts, it is still challenging to fully estimate all the external resources. Comparison of donor contribution to the health budget and donor contribution to total health expenditure (as reported in the NHA) shows that a significant proportion of ODA is off-budget. While ODA contributed 50% (2010/11) and 47% (2011/12), the respective ODA contribution to the health budget was 14% (2010/11) and 26% (2011/12). Suffice it to say that in the past, there were better – but not ideal – attempts at coordination of ODA within the health sector. Through the SWAp arrangement, several HDPs pooled their funding into one basket and MOH was able to benefit from more effective collection and better allocation of these resources to sector priorities. However, inefficient use of resources that included big scandals of corruption resulted in mistrust between the government and its development partners leading them away from the preferred SWAps models (such as on budget/basket funding) to parallel donor funding channels (mainly focusing on projects). Establishing better pooling mechanisms for donor resources will have to learn from the challenges experienced with the previous SWAp models, with the aim of addressing these challenges in order to allow their effective and successful implementation in future.

Currently, voluntary health insurance provides a negligible proportion of sector resources in Uganda. Further, there are challenges in pooling of these insurance resources. There is no income and risk cross subsidization across the existing urban-based PHI and rural based CBHI schemes[24]. The existing CBHI schemes are often facility-based, located in the rural areas and their membership are often the rural poor. On the other hand, PHI schemes are mainly among the urban rich often provided to corporate employers for their employees and their dependents[25]. Suffice it to say that resources from PHI consist of several small 'pools' of resources (with each insurance scheme being a stand-alone pool) with no income and risk cross-subsidization between PHI schemes. Similarly, CBHI schemes are small stand-alone 'pools' for just a small number of members, and there is no cross-subsidization across the few CBHI schemes in the country. As the sector plans on moving towards mainly relying on prepayment for the health sector, including promoting health insurance, there is need to address the challenges in the current pooling arrangements for these insurance resources.

[22] Stierman E, Ssengooba F, Bennett S.2013. Aid alignment: a longer term lens on trends in development assistance for health in Uganda. Globalization and Health.
[23] Oliveira Cruz V, McPake B. 2011. Global Health Initiatives and aid effectiveness: insights from a Ugandan case study. Globalization and Health; 7(1): 20.
[24] Orem and Zikusooka et al. How Equitable is Proposed NHI. 2011
[25] ibid

In the period of implementation of the HFS, resources from households (organized as prepayments) and external resources will remain a major source of health financing for Uganda. It will therefore be critical for the sector to devise mechanisms to ensure that all health sector resources are used more effectively in funding government priorities. The feasibility of achieving the reforms aimed at improving resource pooling will strongly depend on addressing challenges faced previously with coordinating and managing external resources. Explicit actions for addressing the gaps in external resource will be critical key in encouraging donors to channel funds through government systems. Furthermore, reducing fragmentation will be even more successful if Government is able to direct resources previously paid as OOP through insurance prepaid schemes and to efficiently use these resources to finance core sector priorities.

2.2.3 Purchasing

There are multiple purchasers of health care services in Uganda, namely: public sector through the MOH and local governments (which represents 24% of total purchasing), NGOs which represent 28%, while individual purchasing by households through direct OOP payments which presents 42%, and health insurers purchasing contributing just about 1%[26].

In the public sector, purchasing of health services relies on mainly on the traditional input-based approach, where disbursement of funds is done quarterly to public and private-not-for-profit (PNFP) health facilities, central level government institutions, and LGs to support service provision. Government pays for health services through direct provision of resources for staff salaries, pharmaceuticals, supplies and operations. Government also purchases health services from PNFP health facilities through provision of grants for specified services based on an agreed Memorandum of Understanding (MOU). The input-based approaches used currently has different formulae for allocation of funds for allocation of PHC non-wage, PHC wage and PHC development funds. However, a significant proportion of the resources is earmarked and this results in challenges in attaining flexibility in resource use[27]. This problem is especially significant at lower levels where funds for purchasing the non-salary inputs have been almost constant over the years and yet needs at those levels continue to increase.

In the private sector, payment of services by households is mainly on a fee-for-service basis. The fee-for-service payment mechanism has contributed to the problem of cost escalation in Uganda, and may partly explain the increasing OOP payments in Uganda, especially considering that PNFPs and PFPs are left to individually determine the service fee rates. It is important to note that apart from the fiduciary management arrangements within the public sector, Uganda has not developed institutional capacity for purchasing and regulation of pricing of services in the private sector. Relatedly, the quality of health care services purchased from the private sector providers remains unmeasured and not documented.

Across the health sector, there is limited capacity for specialized procurements. The sector has streamlined the purchase of medicines for the public sector through National Medical Stores, and for

[26] Estimates based on National Health Accounts data
[27] Okwero et al. Fiscal Space for Health. 2010

PNFPs through Joint Medical Stores through centralization of procurement. However, even this area still faces some challenges. There is still no rational pricing of medicines with very high price mark ups by private sector actors. As noted earlier, the purchase of inputs such as equipment and infrastructure is not very well organized and remains ad-hoc and not very well coordinated. Although the role of recruiting and managing human resources has been decentralized, some districts, especially in the rural areas, have had challenges attracting staff resulting into inequalities in human resource distribution.

The nature of input-based purchasing described above is not fully reflective of the population's health needs. A review of health financing in Uganda has shown that resources for purchasing of non-salary inputs has been stagnant over the years[28]. It has also been noted that a significant proportion of the health sector budget is earmarked for fixed inputs such as pharmaceutical supplies. Furthermore, at lower levels, funds for purchase of inputs are not only inadequate but also resources at district level are earmarked mainly for wages, therefore flexibility in resource allocation necessary to attain optimal resource allocation is limited[29].

Furthermore, although the mandate of the MOH and districts provides for a purchaser-provider split, this has not been operationalized. MOH is mandated for overall governance, stewardship, oversight for the sector, and to develop policies, guidelines and standards that govern actual service provision. The mandate for service provision rests with local governments and health facilities. MOH is currently functioning as both the provider and purchaser of services in the public sector. This lack of a purchaser-provider split limits strategic purchasing and is associated with inefficiencies.

Uganda will need to move away from relying on mainly input-based purchasing towards more Results Based Financing (RBF). RBF refers to a mechanism where explicit performance-based subsidies are used to encourage delivery of services by paying providers based on specific outcomes (with clearly defined quality of services). The provision of performance incentives through PBF is meant to alter the incentive structure and set a chain of events across the health system that result to improved access to quality health care and equity necessary for attainment of UHC. Evidence from implementation of the mainly donor funded RBF pilot projects in Uganda is key in drawing lessons on the feasibility of national scale up of RBF across the country. Based on these, the government is currently developing a framework to institutionalize RBF with the objective of strengthening purchasing function in the health sector. Evidence from the assessment of implementation of pilot projects shows that while RBF has improved the delivery of quality health services to poor and vulnerable communities, there was need to strengthen capacity across the system for successful national scale up.

Having analyzed the Uganda's current health financing system, several gaps and weaknesses are noted. These are summarized in Table 3.

Table 3: Critical issues to be addressed within Uganda's health financing system

Revenue Collection

[28] MOH. Review of Health Financing in Uganda. 2010
[29] Okwero et al. Fiscal Space for Health. 2010

- Overall gross under-funding for the health sector, in the face of growing needs driven by increased population and new technologies, resulting into a failure to achieve sector objectives
- Low contribution of domestic revenue particularly general tax revenue. Capacity to generate additional domestic resources for the sector will remain weak in the short term
- Heavy dependence on external funds, in addition to their being unpredictable
- Challenges in effective coordination and harmonization of external resources
- Very high OOP payments which are associated with high catastrophic payments and impoverishment
- Very low levels of prepayment with voluntary prepayment schemes
- In the short to medium term prospects for increased resource mobilization from both domestic and external sources remains limited

Resource Pooling

- High level of fragmentation between and within resource pools. The concept of purchasing is new to the sector and needs to be developed.
- Lack of mechanisms for income and risk cross subsidization and risk equalization between the different sources of revenue
- Lack of alignment of donor funding to health sector priorities often leading to inefficiency and inequity
- weaknesses of donor funding predictability and managing projects by government

Purchasing

- Input based purchasing which does not have any incentives for high performance and quality
- In the public sector, government is the provider and at the same time the purchaser which is a disincentive for both efficiency and quality
- Payment for services based on a fee-for-service basis, in the absence of appropriate regulation of private sector, contributing to increased cost escalation in the private sector
- Challenges monitoring, regulation and in putting in place incentives for private sector providers to ensure both efficiency and quality
- Traditional input financing reinforces the inequities between the rural and urban areas and is not fully reflective of the population's health needs.

3 HEALTH FINANCING REFORM STRATEGIES

A good health financing system ensures that: contributions to financing are fair; there are no barriers to accessing services; and provides the incentives needed to obtain efficiency gains and for efficient health services provision. The reforms and strategies in this chapter are based on an understanding of the strengths, weakness, opportunities and threats, as highlighted in Chapter 2.

3.1 Strategic Agenda

Vision

A health financing system that responds to the dynamic aspirations of the health sector in Uganda.

Mission

A health financing system that promotes access to a universal and affordable package of essential health care services to people in Uganda, without suffering financial hardship.

Goal

To facilitate the attainment of Universal Health Coverage in Uganda through enabling the effective/efficient delivery of and access to the essential package of health services while reducing exposure to financial risk, by 2025.

Specific objectives

The specific objectives of the health financing strategy are to propose reforms:

(a) To enable equitable, efficient and sustainable mobilization of adequate resources to finance the delivery of essential health services in line with Health Sector Development Plans.
(b) To establish and roll out a Social Health Protection system and reach 30% of the people in Uganda by 2025.
(c) To increase effective pooling and strengthen strategic purchasing mechanisms that ensure the attainment of equitable and efficient resource allocation and delivery of quality health services by 2025.
(d) To develop new and strengthen existing institutional arrangements that will ensure effective accountability and transparency in resource management and use.
(e) To strengthen mechanisms for harmonized and effective partnerships in financing and delivery of health services, including external and private sector actors, by 2025.
(f) To strengthen systems for timely generation and production of health financing and expenditure information to guide policy and decision making.

Guiding Principles

The development and implementation of the reforms proposed in this Health Financing Strategy will be guided by the following core principles:

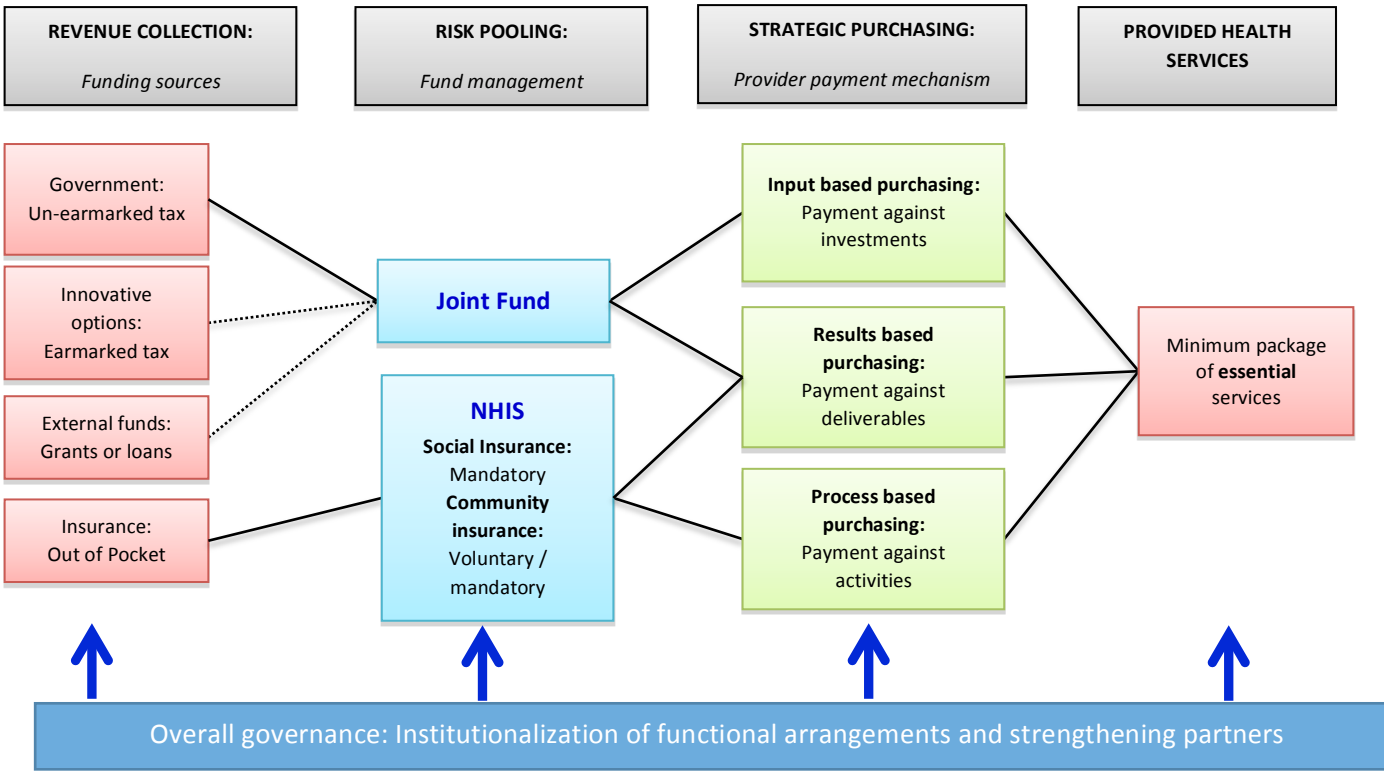
1) **Equity** in resource mobilization and allocation which refer to the notion of ensuring that resources are collected according to ability to pay and that services are distributed according to need.
2) **Solidarity** which is concerned with promoting health for all, with particular consideration for the poor and vulnerable, through realization of the income and risk cross subsidization.
3) **Efficiency** in resource mobilization, allocation and use to reduce wastage within the health sector.
4) **Transparency and accountability** in the management of health sector resources.
5) **Sustainability** through increased domestic resource mobilization.
6) **Effective partnerships** which include both public, private and external actors and recognizes the contribution of other sectors.
7) **Evidence based** decision-making which is a guiding principle for the NHP 2.

This is a strategic document that describes the key financing reforms, which once implemented, will together contribute to a health financing system considered desirable for Uganda. The level of detail presented in this document is only sufficient to provide overall guidance on the strategic direction desired by government. To operationalize the strategic agenda proposed in this document, there is need to develop detailed implementation guidelines and manuals as found appropriate and necessary for the different reforms articulated in this document. Put differently, the level of detail required to guide implementation of this strategy will be articulated in other documents that will provide guidance on how to implement each the different interventions proposed. Similarly, the resources and level of effort required to implement each of the proposed strategies are not articulated in this document. Considering the scope of estimating the resources needed to implement the HFS, it was agreed that such estimations are undertaken as a separate exercise that will generate a document that will be an annex to the HFS document.

3.2 Strategic Interventions

In the subsequent sections, the financing reforms necessary to address the problems in Uganda's current financing system are presented. The core strategic interventions in the HFS are in the areas of *revenue collection*, *pooling*, and *purchasing*. Figure 9 shows that these financing functions are interlinked. As such, in order to achieve the objectives of this strategy, MOH and its partners will need to intervene in each of the functions of a financing health system.

Figure 9: Linkages of the strategic interventions



3.2.1 Strategic Intervention 1: Revenue Collection

The rationale of the interventions under "revenue collection" is to address the current challenges of inadequate resources for the health sector, limited prepayments, catastrophe and impoverishment due to heavy reliance on OOP, and over dependence on external resources. A key principle guiding revenue collection is to ensure the promotion of prepayment mechanisms, with the view to reduce the burden of incurring direct OOP health care expenditures, i.e. households making contributions to insurance schemes before they fall sick, and hence paying nothing or minimal fees at the time when they use services.

Over the next 10 years, several interventions will be implemented with the aim of mobilizing significant additional resources for the sector. The mobilization, collection and management of these additional resources will be done in a manner that is equitable, efficient and sustainable. Further, recognition of both existing and likely future fiscal pressures facing Uganda implies that the health sector should give

increasing attention to improving the efficiency in resource use. Put differently, there should be commitment to ensure that resources are used more efficiently and that more is achieved with the current level of resources. The priority interventions for improving revenue collection are shown in Table 4 and are briefly described in turn.

Table 4: Strategic Priorities to Increase Revenue Collection

Area of intervention	Priority interventions	Timing	Milestone	Institution responsible
Institutional environment for sustainable health financing	Train relevant departments of MOH to create and strengthen the competencies required for successful implementation and monitoring of the HFS	Short term	• Relevant trainings • Recruitment of required cadres	MOH,
	Train relevant stakeholders who will be involved in the implementation of HFS interventions.	Short term	• Relevant trainings for stakeholders	MOH
	Improve health financing and expenditure information to guide policy and decision making.	Short term	• Establish a financial information data base (NHA, PER, PETs etc.)	MOH
Increase government resources for the health sector	Evidence based advocacy for increased government contribution to the health sector	Short term	• Conduct relevant studies (e.g. NHAs, investment cases, efficiency studies) • Increase the percentage of government budget allocated to health	MOH MOFPED Parliament Civil Society organizations academia
Efficiency gains from the existing resources	Strengthening mechanisms of governance and accountability	Short term	• Strengthen and empower relevant structures to ensure enforcement of standards	MOH MOLG Local Govts
	Rationalize use of medicines and pharmaceutical supplies (e.g. regulation of medicines pricing;)	Short-medium term	• Implement order based procurement (pull system) for all levels of care • Minimize direct drug leakages and theft • Minimize expiration of drugs at national stores • Improve prescribing practices	MOH NMS JMS
	Strengthen planning for and procurement of infrastructure development and equipment	Short-medium term	• Implement policies and plans for infrastructure development and equipment	MOH HDPs
	Introduce and scale-up PBF/RBF schemes/mechanisms in the public sector	Short-medium term	• Nation-wide scaled up implementation of PBF/RBF in public sector	MOH
	Emphasis on PHC and/or prevention of ill-health through early screening and improving health promotion (creating health at home advocacy)	short to medium term	• Advocacy for health promotion and disease prevention effectively implemented	MOH MOLG Local Govts
Improve the predictability	Develop a Memorandum of Understanding with HDPs on financing commitments over	Short-term	• Functional MOU in place, respected by all parties.	MOH HDPs

Area of intervention	Priority interventions	Timing	Milestone	Institution responsible
of external resources	the medium term			
Increase contribution of prepayment to the health sector	Engagement and mobilization for the approval of the NHIS bill by cabinet and government	Short term	• NHIS bill approved by cabinet and parliament	MOH Parliament Cabinet
	Strengthen and encourage growth of CBHI in Uganda which from the outset should be aligned to SHI to ensure full integration in the future	Medium term	• Increase in the percentage of the population covered by CBHI schemes	MOH IRA Insurers
	Sensitize, organise and support households to participation in CBHI			
	Put in place a system for effective implementation and monitoring of the SHI, including building relevant capacities required for its implementation	Medium – Long term	• MOH, district and health facility managers trained on health insurance	MOH MOFPED IRA Workers Unions Employers' Associations
	Establish an equity fund to subsidize the indigents and the CBHI schemes	Medium-Long term	• Subsidy fund established • The percentage of indigents benefiting from the equity fund	MOFPED MOH MOGLSD
Innovative health financing mechanisms	Operationalization of the AIDS Trust fund Set up mechanism for efficient and transparent collection and use of resources from Motor Third Party. Collect resources from a "Sin tax" targeting risky behaviors that affect health	Short-term Medium-term	• Amount of resources generated from the AIDS Trust Fund (UGX) • Amount of resources generated from the Motor Third Party (UGX) • Amount of resources generated from "Sin tax" (UGX)	MOH MOFPED IRA

1. **Develop and strengthen the institutional environment for sustainable health financing:** The implementation of all the financing reforms articulated in the HFS will require strong capacities in designing, implementing and managing the reforms descried in this document. The MOH needs to develop new capacities (in some areas) and to strengthen existing relevant capacities. The core competencies required include, among others: expertise in health financing, practical expertise in design and implementation of health insurance schemes, experts in results-based financing, experts in efficiency assessments and in designing corrective actions to ensure efficiency gains, and experts in coordination and management of development assistance for health.

2. **Advocate for increased government resources for the health sector**: The declining allocations of government resources to the health sector will be addressed in the short term. As a starting point, there will be sustained evidence-based advocacy towards ensuring the proportion of total

government budget allocated to health increases, even with the government resources that are currently available. The advocacy measures include improved engagement with MoFPED to explain and articulate some the existing myths about health sector funding (such as the health sector has a lot of external resources available). Further, the MOH will demonstrate practical steps of improving efficiencies in the health sector. In addition, advocacy with MOFPED will provide a detailed and explicit indication of the costs of providing health services with the view to improve the understanding on sector costs and how they increase with increases in population and the introduction of new technologies. As part of this generation of evidence for advocacy, joint sector expenditure reviews will be conducted by MOFPED and MOH.

In the medium-to-long term, government has the potential to generate additional revenues from taxes. Specifically, it is expected that more resources will be available for the country when oil mining starts (anticipated to start in 2021). As part of this strategy, the health sector will position itself in advance, through strategic advocacy, to benefit from increased government revenues generated through oil.

3. **Maximizing efficiency gains from the existing resources**: The health sector will leverage resources by addressing existing inefficiencies. As a first step, an in-depth assessment of efficiency bottlenecks in the health sector (and where they exist) will be undertaken. The outcome of this assessment will inform the specific actions required to achieve efficiency gains. To achieve this, efforts will be directed towards: strengthening mechanisms of governance and accountability across the whole system; building capacity in financial management for all actors, human resource management and rationalizing use of medicines and pharmaceutical supplies which are key cost driver within the health system. Some of the interventions that will help in achieving efficiency gains, such as the implementation of results or performance-based mechanisms for reimbursing health providers, are discussed elsewhere in this document. In addition, efficiencies will also be made through a shift in emphasis from curative services to disease prevention and health promotion services, through intense efforts to encouraging households to "create health at home". It is obviously cheaper to create health than to repair it once it has broken down. Furthermore, efficiency gains are anticipated from addressing the existing inefficient areas in the sector which include: absenteeism of staff at health facilities, expiry of drugs, rapid growth in infrastructure that is not matched to need and not matched to the availability of other key inputs, and the purchase of expensive equipment that are not aligned to need and/or suited to the country's context. Resources raised from efficiency gains will be channeled through appropriate financing mechanisms.

4. **Increase external resources and improve their predictability**: The sector will mobilize more external resources through evidence-based advocacy, use of investment cases, and demonstrating better stewardship and governance. The Memorandum of Understanding between MOH and Development Partners will require them to make firm financial commitments for at least three years, as part of addressing the challenge of unpredictability of DAH. Key attention will be paid to overall joint planning and budgeting of resources from major DPs and GHIs, for both on- and off-budget funds to ensure alignment to sector priorities. Inefficiencies in the allocation and use of DAH will be addressed, as part of the process of improving coordination and management of external resources.

5. **Build capacity for and establishment of prepayment schemes in the health sector:** In preparation for actual implementation of health insurance, MOH will put in place systems that aim to achieve effective and equitable collection of most of resources currently being paid as OOP. The immediate action needed is increasing the advocacy for passing of the National Health Insurance Bill. This will provide a legal framework for establishment of the National Health Insurance scheme for Uganda. The second action will involve the establishment of a Social Health Insurance scheme for all people who are formally employed. Furthermore, to ensure scale up of health insurance in Uganda, MOH will put in place a conducive environment to encourage and promoted growth of CBHIs to cover those who are not formally employed. In particular, effort will be focused on sensitizing and empowering households to participate in these SHI and CHBI prepayment mechanisms. Given the low income levels for people in rural/informal settings, contributions from CBHI schemes will require subsidies which will be initially jointly financed by government and Development Partners. Keeping in mind the objective of social health protection, these reforms will include establishing mechanisms that ensure that indigents are covered by solidarity/equity fund (supported jointly by government and Development Partners).

6. **Innovative health financing options**: In the spirit of mobilizing additional resources for the sector, MOH will continuously explore avenues for innovative financing. In the short term, three actions will be considered and carefully reviewed. First, MOH shall take immediate action on the collection of resources due to the health sector from Motor Third Party policy. At the moment, claims for these resources are not being actively followed and this is a missed opportunity. Second, considering that the legal framework for establishing the AIDS Trust Fund is already in place and the processes for its operationalization are ongoing, it is anticipated that additional resources for the health sector will be raised through this avenue. However, there are concerns that additional resources from this source may displace existing allocations by Government to the health sector. As such, efforts to mobilize resources through this avenue will require a more detailed consideration before this option is pursued. Third, MOH will consider the introduction of at least one "sin-tax" in the medium to long term, specifically one targeting risky behaviors that affect health such as tobacco/smoking and alcohol. MOH could lobby the MOFPED to ensure that the additional resources do not displace current allocations to the health sector. The establishment of the a new "sin tax" while at the same time having an AIDS Trust Fund will require careful evidence-based consideration, and if it is found to be more beneficial to have one rather than both, then the most desired option will be considered.

3.2.2 Strategic Intervention 2: Effective Pooling

This strategic intervention aims to reduce fragmentation in resource and risk pools. Effective pooling will be targeted at public resources, external resources and resources generated through the different health insurance schemes, with the view to provide the same essential health benefits package for all people covered. The emphasis for pooling is not just to create income pools, but also to ensure that these pools are integrated and coordinated in a manner that promotes the achievement of income and risk cross-subsidizations between the rich and the poor, and between the sick and the healthy. The

priority interventions for effective pooling are briefly described below and are summarized in Table 5 and illustrated in Figure 10.

1. **Pooling of development assistance for health:** The health sector will continue to relying on external resources in the short-to-medium term. As such, ensuring effective harmonization and alignment of these resources remains of paramount importance. DAH is currently not adequately coordinated and managed. In the short term, the Ministry of Health will explore mechanisms to reviving a basket fund for HDPs. Governance and the operations of the fund will be governed by the IHP+ principles. As part of the process of re-establishing this fund, care will be taken to address all bottlenecks that hindered its proper functioning in the past. Bottlenecks and factors that impede effective functioning of this fund will be identified through a consultative and participatory process (where all key stakeholders will be involved), with the view to put in place the required checks and balances that support its governance and management. The lessons learnt from the earlier implementation of the partnership fund will be critical in guiding this action. The key objective for these actions is to have a single pool for all external resources. This pool could even be a "virtual pool" in real life, as long as all planning and budgeting for external resources (in this pool) is coordinated to ensure effective use of resource and alignment of resource allocation to sector priorities.

2. **Pooling of government and donor resources:** Having established a basket fund for donor resources and strengthened mechanisms for prudent fiscal management and governance, the Ministry of Health will establish the Joint Action Fund (JAF), which will be a single resource pool for both government and external resources. This is in line with the HSDP interventions[30]. The purpose of the JAF will enhance better alignment of both public and external resources to sector priorities, promote equity, and will reduce inefficiencies that result from duplication of effort.

3. **Pooling of health insurance schemes:** In the long term, the MOH aims to establish the NHIS, as articulated in the HSDP. In the short to medium term, systems for the implementation of NHIS will be put in place and any additional implementation activities not feasible in this period will be implemented in subsequent periods. The NHIS will provide the legal framework for an overall pool that will bring together resources from the different insurance schemes, with the view to facilitate income and risk cross-subsidization and to permit effective strategic purchasing of the same essential benefit package for all. Having established different health insurance schemes, it will be necessary to reduce fragmentation of these pools.

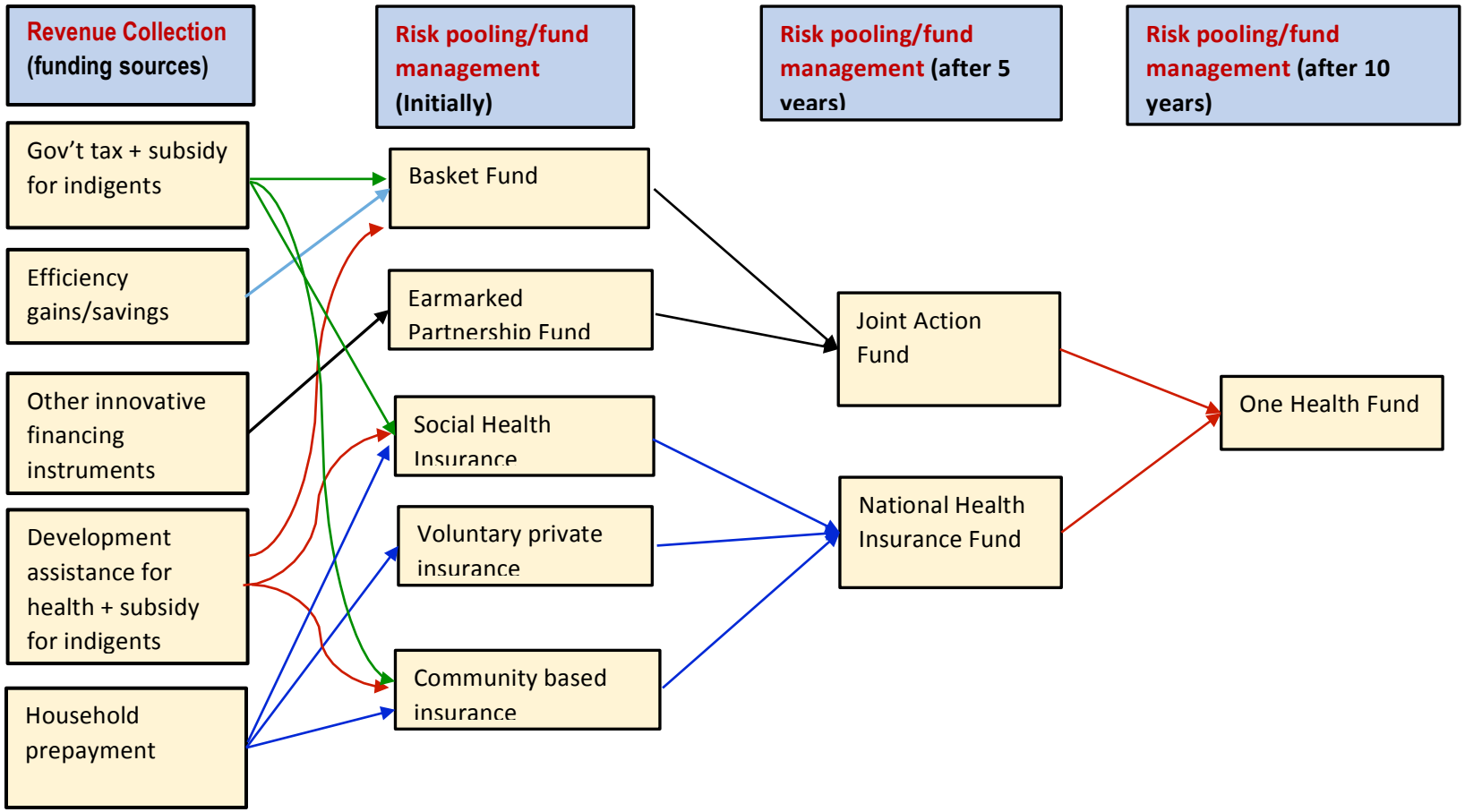
4. **Establishment of a health fund**: The key steps described above are part of a phased approach to reach a single pool for all health resources. With Joint Action Fund and NHIS in place, the longer term target is to establish a single Health Fund that pools together resources from these two pools. The feasibility of establishing this single fund is dependent on having the 2 funds established and functioning successfully, which may only be feasible in subsequent planning periods.

[30] MOH. 2015. Health Sector Development Plan 2015/16-2019/20. September 2015. Page 58.

Table 5: Priority interventions for effective pooling

Area of intervention	Priority interventions	Timing	Milestone	Institution responsible
Harmonizing and aligning DAH to sector priorities	Establish a single basket for DAH	Short-medium term	• Functioning basket fund for external resources	MOH HDPs MOFPED
Pooling DAH and government resources	Establishment of the Joint Action Fund (JAF)	Short-medium term	• A functioning JAF in place	MOH HDPs MOFPED
	Strengthen mechanisms for financial transparency and accountability to encourage trust among all partners			
Pooling resources from different insurance schemes	Establish the NHIS which integrates resources from all other insurance schemes (SHI, PHI and CBHI)	Medium –to - Long term	• A single pool for all health insurance schemes	MOH IRA Insurance schemes
Establish the Health Fund (for pooling JAF and NHIS)	Integrate the public pool and established health insurance schemes into a single pool	Long term	• Health fund established	MOH HDPs MOFPED
	Strengthen institutional capacities for relevant actors to ensure income cross subsidization and risk equalization across the different risk pools	Long term	• Legal framework for the different health insurance schemes to contribute to the national risk pooling mechanism	MOH HDPs MOFPED

Figure 10: Illustration of Pooling Arrangements



3.2.3 Strategic Intervention 3: Strategic Purchasing

Current purchasing arrangements in Uganda do not have the necessary incentives in place to encourage equity, efficiency, and provision of quality services. This is partly due to the fact that there is no effective provider-purchaser split. To achieve strategic purchasing, MOH will implement interventions aimed at addressing these challenges. These interventions are described briefly in this section and are summarized in Table 6.

1. **Build capacity for purchasing in the sector:** By law, the Ministry of Health should be the purchaser, while local governments are the service providers. This spilt of roles needs to be operationalized. Within the existing structures of MOH, a unit will be established which will be responsible for handling strategic purchasing for the health sector. As part of this action, relevant skills and capacities will be developed and/or strengthened (where they currently exist).

2. **Results-based financing:** The desired direction for the Government is to move towards results-based financing. In the medium term, providers of services will be remunerated on the basis of the quality and volume of services offered. Action will be taken to develop the institutional capacity of MOH and providers to implement results-based financing and contracting mechanisms. The process of setting up the structures and mechanisms required for RBF will draw lessons from previous RBF pilots in Uganda (including both supply side and demand side options). Details relating to the development of and establishment of RBF are articulated in a different document.

3. **Input based payment:** In the short to medium term, input-based payments will continue. Some critical investments are necessary to ensure proper functioning of health facilities. Inputs such as human resources, infrastructure, and pharmaceuticals will be allocated resources through input-based payments. The formulae currently used for resource allocation for human resources, infrastructure, and pharmaceuticals will be reviewed and revised accordingly. To ensure equity and relevance, resource allocation formulae will be regularly revised (every 5 years) to reflect of the needs of the population. Similarly, to encourage efficiency in resource use, emphasis will be placed on strengthening management competencies of facility managers, to ensure that they accountable and responsible for the quality of services provided. Appropriate provider incentive mechanisms, including the deepening of their autonomy, will be established so as to improve their performance in the provision of services.

4. **Process based provider payments:** This approach will be targeted at purchasing mainly the non-clinical services. Implementing process-based payment approaches will need establishing institutional and human resource capacity to implement this purchasing mechanism.

5. **Delivery of benefits package**: One of the objectives of this financing strategy is to facilitate the process of determining a package of essential health services that will be purchased. The objective of MOH is to have a uniform essential package across different pools from the outset. In the long term, as the sector achieves integration of resource pools, MOH shall move towards expanding the essential package to a uniform comprehensive package for all people, across all resource pools.

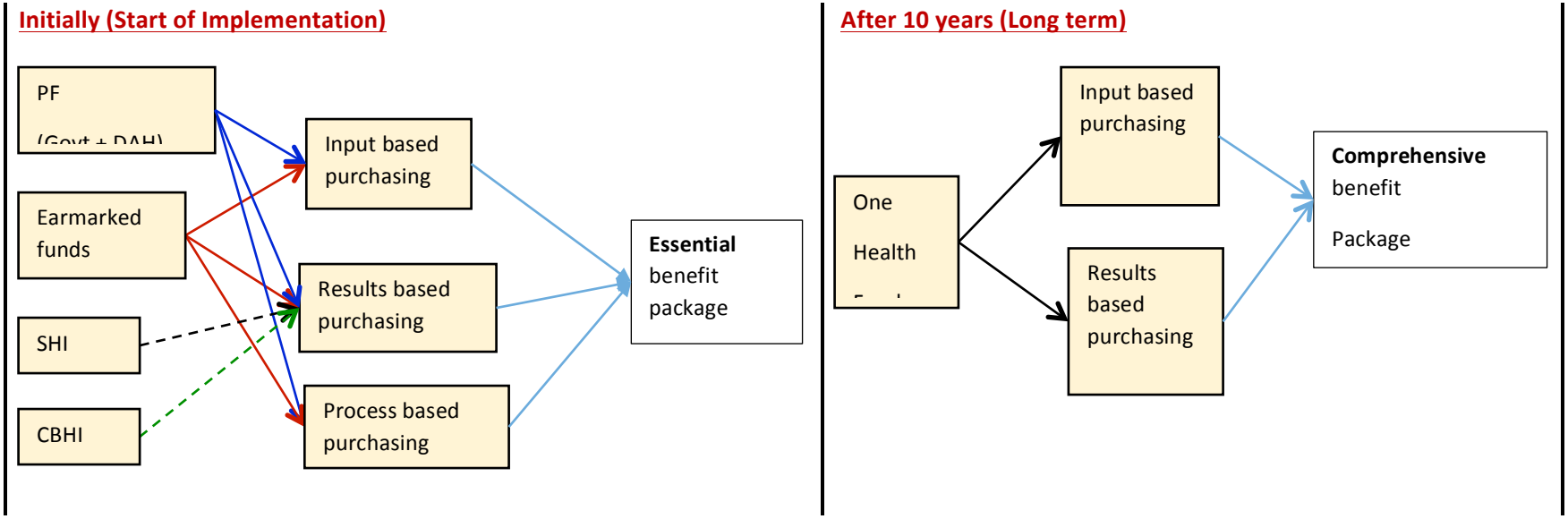
Table 6: Strategic priorities for strategic purchasing of health services

Area of intervention	Priority interventions	Timefra me	Milestone	Institution responsible

Build capacity for purchasing in the sector	Establish a unit to implement strategic purchasing	Short term	Functional unit in place	MOH
	Build capacity and strengthen existing capacity in the MOH to implement strategic purchasing	Short term	MOH staff trained to implement strategic purchasing Recruitment of needed Staff in the Unit.	MOH
Results-based financing	Develop institutional capacity of MOH and providers to implement performance based financing	Short term	Train staff at all levels on how to implement RBF	MOH MOFPED Service providers
	Establish results based payment mechanisms for the different providers	Medium term	RBF payment mechanism established for all providers	MOH MOFPED Service providers
Input based payment	Revise allocation formula to reflect need	Short term	Need based formula in place which incorporates workload of facilities based on the standard unit of output criteria	MOH MOFPED
	Build the management capacity of facility managers and to emphasize accountability for quality of services	Short term	Improvement in quality of services	MOLG MOH MOFPED
Process based provider payments	Establish institutionalized contracting mechanisms for reimbursement of activities best suited to this mode of payment	Short term	Mechanisms for contracting provision of non-clinical services instituted	MOH
Delivery of benefits package	Articulate the essential benefit package that will be accessed by the population	Medium term	Benefit package articulated and revised every 5 years	MOH IRA Insurers
	Build partnership arrangements between public and private sector to ensure availability of quality care for all	Medium term	Private providers given incentives to operate in underserved areas	MOH Private providers association
	Setting eligibility and qualification standards for accreditation of providers	Medium term	Providers accredited to provide the benefit package	MOH Private providers association Professional councils

It is important to note that there is a strong linkage between the pooling interventions (discussed earlier) and the purchasing interventions. The linkage between the implementation of the pooling and the purchasing is illustrated in Figure 11. It shows that, at the start, the various resource pools will implement a mix with of different purchasing mechanisms for the various resource pools. It is envisioned that in the medium term to long term when the country will finally pool all its resources in one health fund. From the outset, a uniform package of essential health services is proposed as the ideal approach, to promote equity among all people covered.

Figure 11: Illustration of Implementation Arrangements of Pooling and Purchasing



4 INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION OF THE HFS

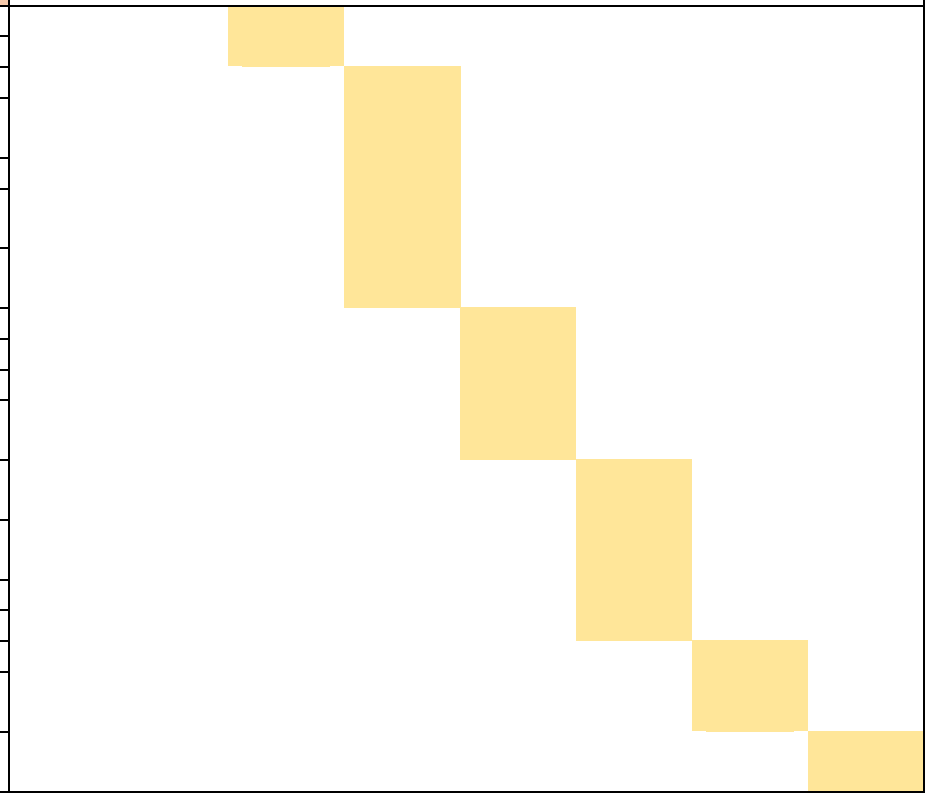
This section presents the implementation arrangements for the HFS, and includes: a brief description of the institutions required for its implementation, roles and responsibilities of the institutions, and the approaches to implementing the proposed reforms.

4.1 Sequencing of health financing reforms

The health financing reforms discussed in Chapter 3 are quite many and cannot all be implemented at the same time. While some of them can be achieved within a relatively short-term period (1-3 years), others are significantly big and complex, requiring a substantial amount of time and effort to be planned and implemented successfully. The implementation of all reforms will also require stakeholder buy-in, participation and ownership. Given this, the MOH plans to sequence the implementation of the reforms in a manner that allows their introduction to be feasible, as suggested in Table 7. As shown in Table 7, some interventions can be conducted simultaneously, while others are only feasible only after certain actions have been taken.

Table 7: Proposed sequencing of implementation of the financing reforms

Priority interventions	**Sequencing (this is not one year time period)**
Train relevant departments of MOH to create and strengthen the competencies required for successful implementation and monitoring of the HFS	
Train relevant stakeholders who will be involved in the implementation of HFS interventions.	
Improve health financing and expenditure information to guide policy and decision making.	
strengthening mechanisms of governance and accountability	
Rationalize use of medicines and pharmaceutical supplies (e.g. regulation of medicines pricing;)	
Evidence based advocacy for increased government prioritization of the health sector	
Operationalization of the AIDS Trust fund	
Set up mechanism for efficient and transparent collection and use of resources from Motor Third Party.	
Develop a Memorandum of Understanding with HDPs on financing commitments over the medium term	
Engagement and mobilization for the approval of the NHIS bill by cabinet and government	
Strengthen mechanisms for financial transparency and accountability to encourage trust among all partners	
Put in place a system for effective implementation and monitoring of the SHI (for the formal sector), including building relevant capacities required for its implementation	

Priority interventions	Sequencing (this is not one year time period)
Establish a single basket for all DAH	
Establish a unit to implement strategic purchasing	
Sensitize households to participation in the PHI and/or CBHI	
Strengthen and encourage growth for PHI and CBHI in Uganda (to cover the informal sector)	
Establishment of the Joint Action Fund (JAF)	
Build capacity and strengthen existing capacity in the MOH to implement strategic purchasing	
Develop institutional capacity of MOH and providers to implement performance based financing	
Establish an equity fund to subsidize the indigents	
Establish results based payment mechanisms for the different providers	
Revise allocation formula to reflect need	
Build the management capacity of facility managers and to emphasize accountability for quality of services	
Establish the NHIS which integrates resources from all other insurance schemes (SHI, PHI and CBHI)	
Establish institutionalized contracting mechanisms for reimbursement of activities best suited to this mode of payment	
Articulate the essential benefit package that will be accessed by the population	
Setting eligibility and qualification standards for accreditation of providers	
Integrate the public pool and established health insurance schemes into a single pool	
Build partnership arrangements between public and private sector to ensure availability of quality care for all	
Strengthen institutional capacities for relevant actors to ensure income cross subsidization and risk equalization across the different risk pools	

4.2 Institutions for Implementation of HFS

In order to implement the HFS, the MOH will work within existing structures and mechanisms, and only establish new ones where needed. In addition, MOH shall embark on strengthening the skills and competences of human resources in health financing and financial management, at different levels as required. A wide range of stakeholders will be involved in the implementation of this strategy, as briefly described below. The roles and responsibilities for the various stakeholders are illustrated in Tables 3, 4 and 5.

The **Ministry of Health**, in particular, all relevant structures in MOH, will be participate in different aspects of implementing HFS. This includes key directorates, technical working groups, policy advisory groups, senior management, and others. The Directorate of Planning will provide overall oversight and leadership for its implementation. Any new structures established to participate in the implementation of the strategy will be established within the Planning Department, to ensure clear leadership and guidance.

Health Development Partners: given their central role in financing the sector, HDPs will have a very critical role in the implementation of some the financing reforms, particularly those that relate to coordinating, harmonizing and aligning DAH.

Other line ministries: The multi-sectoral approach which has been emphasized in health policies and plans will guide the implementation of the HFS. In addition to MOH, other line ministries and institutions of government will be crucial in implementing the HFS. Some of the key institutions include: Parliament, Ministry of Finance, Planning and Economic Development (MoFPED), Ministry of Gender, Labour and Social Development (MoGLSD), Ministry of Education and Supports (MoES), Ministry of Local Government (MoLG) and Ministry of Public Service (MoPS).

Local Governments: The districts health services will work with the local government administration in ensuring successful implementation of the reforms. All other structures within the district will participate in the reforms implementation, where deemed necessary.

Private health insurances and CBHI: These entities will be directly affected by some of the reforms described earlier. They will be expected to participate in some the negotiations concerning the changes that they need to implement in order to fit within the reforms in this strategy. Their input as well as their participation are of paramount importance.

Private providers of services: these include both the private-for-profit (PFP) and private-not-for-profit (PNFP) and their governing bodies.

There are some institution that will be established and/or operationalized to enable successful implementation of the HFS. They include:

- **Results based financing (RBF) Unit:** This will be established within the Directorate of Planning in the MOH. It will be responsible for performing the purchasing role for the health sector. It will be

composed of a team of experts with relevant skills in results-based financing, health financing, actuarial science, etc. The unit will advise MOH on the package of services to be purchased. In addition, they work with other relevant structures to develop standards for service provision and be involved in accreditation of providers from whom services will be purchased.

- **National Health Insurance Board:** The structures for the NHI scheme are described in the National Health Insurance Bill. The scheme will be a corporate body with perpetual succession powers. This entity will be governed by Board of Directors who will be appointed by the Minister responsible for Health. The BoD shall (a) determine the policies of the scheme, (b) ensure the effective implementation of the policies of the scheme, and (c) carry out 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 officers and employees as may be deemed necessary for the proper and efficient discharge of the functions of the scheme.

- **Fund for resources from innovative financing:** If the MOH continues to operationalize the HIV/AIDS Trust fund, or if they choose to establish earmarked resources generated from a "sin tax" (as described earlier), the fund from such sources will be administered by the Minister of 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.

4.3 Partnerships for Implementation of HFS

The HFS will be implemented under the Sector-wide Approach (SWAp), in line with national and health sector policies and plans. The SWAp approach emphasizes: a) collaborative program of work; b) established structures and process of negotiating policy, strategic and management issues; and c) reviewing sectoral performance against agreed targets and milestones. The central and district levels will put strengthen existing mechanisms for multi-sectoral collaboration to ensure the implementation of the HFS.

Uganda is also a signatory of the Compact between the Government and International partners under the International Health Partnerships and Related initiatives (IHP+) which is built on the Paris Declaration and the Accra Agenda for Action. This provides a framework for partnership and coordination of activities within the sector including coordination with health development partners. The IHP+ compact seeks to ensure partners rally around: **one** results-focused country-led national health plan; **one** monitoring and evaluation framework and **one** review process focusing on results and mutual accountability.

Public Private Partnerships (PPP) are central for successful implementation of HFS. The private sector plays a significant role in Uganda's health sector. The PPP policy provides framework for the partnerships between the public and private sector. Within the health sector, the PPP for Health (PPPH) unit is the coordinating arm for any resolutions concerning the private sector (including umbrella organizations representing PNFP, PHP and TCMP). Implementation of the HFS will utilize these existing institution frameworks to enhance partnership.

Partnership with the public/community to make them part of the process of governance, accountability and monitoring performance is necessary in the implementation of HFS. There exists mechanisms for engagement of communities with the health system through community health workers, and health unit management committees and representation through the local government system.

4.4 Communication Plan

Appropriate and effective communication is an enabling factor to ensure successful implementation of the HFS. The communication strategy will be an integral element in implementing the HFS. The advocacy strategy will aim at creating linkages between the strategic and operational levels and seek to sensitize all stakeholders by:

1. Ensuring that all stakeholders are fully informed about and understand the HFS
2. Ensuring buy-in from stakeholders to encourage their effective participation in the implementation of the HFS
3. Enhancing strategic consultation with agencies in achieving set outcomes

A detailed communications plan with intended actions, their timing and responsibility will be developed and will be one of the key documents to facilitate HFS implementation. Its development will be preceded by a communication audit which 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 and clearly spell out the communication goals and objectives for each stakeholder. The communication plan will articulate the following:

- 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.

5 MONITORING AND EVALUATION OF THE HFS

Monitoring and evaluation (M&E) will enable tracking of the performance of the HFS implementation, and will generate evidence for timely and corrective action when required. Monitoring will be an ongoing routine activity that will provide information about the performance of the different financing reforms, clearly highlighting areas that need improvement in order to attain the goals of this strategy. This chapter briefly highlights the approach that should be considered for M&E and is not a detailed M&E plan for each financing reform. A more detailed M&E plan for the reforms will be developed as a separate document.

5.1 Approach to monitoring and evaluating

Monitoring HFS implementation will take into account the detailed implementation plan of each of the reforms described in this strategy. Special implementation plans for the big reforms (instituting RBF, introducing SHI, putting in place a Joint Action Fund, pooling all insurance resources into one NHI framework, etc.) will be developed, and will have their M&E plans spelled out to permit independent monitoring for each reform. As part of the M&E progress for HFS, the MOH shall continue to monitor the extent to which the key principles of the health financing reforms are being met. Specifically, principles such as financial risk protection, equity in funding and access, efficiencies, sustainability and accountability will be monitored and evaluated at designated times as during the course of implementation of the HFS.

Participatory monitoring: The measurement of progress in the implementation of the HFS will be an inclusive process encouraging active participation of the relevant stakeholders. Performance monitoring will be integrated in the joint Health Sector Performance Review processes, carried out annually, and will be led by the Ministry of Health.

Progress reporting: Reporting the progress of HFS implementation and its outcomes will become part of the Joint Annual Review process, and findings will be presented in the Annual Health Sector Performance Report (AHSPR). Some of the information for this reporting will come from special

assessments or studies conducted (as and when deemed necessary) for specific reforms in this strategy. Progress reporting will be a joint effort by MOH, civil society and HDPs.

Evaluations: An external and independent midterm evaluation of the overall HFS will be conducted in 2020. In addition to this, evaluations of individual reforms will be performed at appropriate times and findings from these evaluations will be used to determine corrective actions needed to steer implementation in the right direction. An end-term evaluation of the overall HFS will be carried out in 2025, but will be preceded by end-term evaluations of key reforms.

5.2 Key performance indicators

As noted earlier, this is not the detailed M&E plan for all the reforms suggested. This section presents a few indicators for monitoring the HFS in Table *8*. The indicators are focused on the UHC goal which is a main outcome of this strategy. The main sources of data for baseline, monitoring, review and evaluation of the HFS will be include: NHA, DHIS, UDHS, HMIS, OBT, JAF, HIV/AIDS Annual Reviews, and AHSPRs.

Table 8: Health Financing Key Indicators

Indicators	Baseline	Yr 1	Yr 2	Yr…	Yr …	Yr 10
Revenue Collection indicators						
Government expenditure on Health as a % of total government expenditure	x	x	x	x	x	x
Per capita public health expenditure (US $)	x	x	x	x	x	x
The percentage of indigents benefiting from the equity fund	NA			x	x	x
OOP health expenditure as % of THE	x		x		x	x
Incidence of catastrophic health expenditures at 10% threshold of household consumption expenditure	x			x	x	x
Per capita public health expenditure (US $)	x		x		x	x
Proportion of external assistance as a proportion of total health expenditure (%)	x	x	x	x	x	x
Amount of resources from Motor Third party insurance		x	x	x	x	x
Amount of resources from AIDS Action Fund		x	x	x	x	x
Amount of resources from other innovative sources		x	x	x	x	x
Amount of resources from efficiency gains			x	x	x	x
Introduction of SHI				x	x	x
Indicators for Effective Pooling						
Setting of basket fund for DAH	NA	x				
Proportion of DAH channeled through the basket			x	x	x	x
Proportion of DAH that is on-budget	x		x	x	x	x
Set up the Joint Action Fund			x			
Proportion of the population enrolled in health insurance schemes			x	x	x	x
Proportion of population covered by CBHI and PHI	x		x	x	x	x
Proportion of indigents covered by insurance	NA			x	x	x
Level of utilization of curative services among the poorest 40%			x		x	x
Implementation of NHI (pooling all insurance funds)					x	x
Indicators for Strategic Purchasing						
Set up of unit responsible for purchasing in MOH / RBF unit	NA		x			
Number of MOH staff whose capacity has been built in health financing, RBF, SHI and other relevant areas		x	x			
Development of a package of essential services			x			
% of sector resources for which RBF was mode of reimbursement			x			