REPORT

Achieving Sustainable Health Financing in Uganda: Prospects and Advocacy Opportunities for Domestic Resource Mobilization

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Palladium
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Contents

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Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CBHI	community-based health insurance
DFID	Department for International Development (U.K.)
FY	fiscal year
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	human immunodeficiency virus
IHME	Institute for Health Metrics and Evaluation
IMF	International Monetary Fund
MDR-TB	multi-drug resistant tuberculosis
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MOU	memorandum of understanding
MTEF	mid-term expenditure framework
NDPII	Second National Development Plan 2015/16 to 2019/20
NHA	National Health Accounts
NHIS	national health insurance scheme
NSSF	National Social Security Fund
OECD	Organisation for Economic Co-operation and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
TB	tuberculosis
UGX	Ugandan shilling
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
US$	U.S. dollar
WHO	World Health Organization

Executive Summary

Through its National Development Plan and Health Sector Development Plan, Uganda has set ambitious and likely unattainable financial targets for health. The Government of Uganda aims to increase government spending for health to 15% of general government expenditure in 2020, however, given projections, it is only expected reach 7%. While the overall government budget for health has generally increased slightly each year, spending per capita on health is declining and has not kept pace with the country's growing population. In addition, Uganda's health sector is heavily reliant on donors—based on the 2015 National Health Accounts, development partner spending on health is the highest source of financing at 42% while the public sector contributes only 16%. Out-of-pocket expenditure accounted for 41% of total health spending, putting a significant financial burden on households to pay for healthcare expenses, although the Health Sector Development Plan aims to decrease this amount. Given this financial landscape, it is critical for the Government of Uganda to mobilize domestic resources for health to reduce out-of-pocket spending and increase the sector's sustainability.

While there is strong political will to increase domestic resources for health, the likelihood of mobilizing significant additional resources through the government budget is low, given limited fiscal space and priorities in infrastructure, security, and education. Advocacy efforts should focus on building support for the development and implementation of ongoing health financing reforms and improved efficiency.

One of these reforms is national health insurance. Support for a 2014 national health insurance bill was solidified in 2017 when a Certificate of Financial Implications was issued by the Ministry of Finance, Planning and Economic Development. The bill was submitted to the cabinet in 2018 and is currently waiting for review. The bill, if passed and fully implemented, would provide health insurance to all people living in Uganda. However, there remain serious challenges and considerations to reaching many segments of the population, particularly the informal sector. Contributions are set for formal sector employers and employees but more analysis and discussion is needed to determine how it will reach the informal sector and indigents. While several organizations are involved in community-based health insurance, it only covers 0.4% of the population and private insurance covers around 2%. A national health insurance scheme could significantly increase financial protection and help reduce out-of-pocket spending on healthcare.

In addition to health insurance, the Government of Uganda is planning other strategies to increase domestic resources for health, including the development of earmarked taxes and trust funds for specific diseases such as HIV and malaria. However, the government should be wary of vertically funding diseases and focus on strengthening funding for all health areas and distributing the funds available based on need.

About half of Ugandans who seek health services choose to access care in the private sector. There is a large network of private not-for-profit clinics and hospitals affiliated with religious medical bureaus that are active around the country. There is a need to increase collaboration and coordination between the public and private sector to integrate private sector data into the government health management information system and ensure high-quality service provision.

The Government of Uganda has an opportunity to free-up resources through improving budget allocations and technical efficiency. While the health sector has a high budget execution rate for government financing, it struggles to execute available external financing. This suggests a need to improve coordination with development partners to ensure resources are available and allocated for common priorities. The Government

of Uganda should aim to work with the National Medical Stores to strengthen capacity and determine whether supplementary funding is needed to ensure adequate supply. Lastly, human resources for health are insufficient to meet existing demand, there are challenges retaining staff, and there are concerns about worker productivity. Strategies to improve performance and retention should be carefully considered.

Overall, Uganda has the opportunity to push reforms forward and improve efficiency to free-up additional resources for health. The government, development partners, and the private sector should work together to develop a coordinated and common vision and strategy for improving the sustainability of the health sector and helping Uganda move closer to universal health coverage.

Introduction

Like many sub-Saharan African countries, Uganda has ambitious goals for increasing funding for its health sector, in line with the United Nations' Sustainable Development Goals and in response to international pressure to move toward the achievement of universal health coverage. Uganda's health financing profile is reflective of sub-Saharan Africa's financing landscape. Official development assistance has remained relatively flat since 2015 and, while overall government contribution to health has increased, per capita government health expenditure has declined (OECD, 2018; Republic of Uganda, 2018). This trend suggests that the government's contribution to health, as a percent of total health expenditure, will be around 7% in fiscal year (FY) 2019/20—meaning that the country will fall short of reaching its goal of 15% by 2020.[1] While health is a priority in Uganda's Second National Development Plan 2015/16 to 2019/20, infrastructure, security, and education receive the highest proportions of the total government budget.

The disease burden remains significant in Uganda, with a 6% HIV prevalence rate and 191 malaria cases per 1,000 people in FY 2017/18 (MOH, 2018c). The case notification rate for tuberculosis (TB) has decreased slightly in the last two years, from 121 per 100,000 people in FY 2015/16 to 113 in FY 2017/18. All three of these disease areas—HIV, malaria, and TB—are heavily supported by external resources, which poses a threat to the sustainability of the programs as external funding declines.

Strong political will to increase domestic resources for health and increase financial protection for the 44 million people living in Uganda provides an opportunity to improve the sustainability of the health sector and move closer to achieving universal health coverage. However, several competing vertical programmatic initiatives for HIV, malaria, and immunization could hinder this progress. In addition, less than 1% of the population is covered by community-based health insurance schemes, social security does not currently offer health benefits, and discussions on how the proposed national health insurance scheme should be funded and implemented continue to be unresolved.

Uganda's economy is expected to see a 5% increase in gross domestic product (GDP) per year, however, with a population growth rate of 3%, the government has not been able to increase GDP per capita to reach its ambitious goals and government per capita health expenditure has actually decreased since 2013 (MOH, 2016a). With a rising debt ratio due to infrastructure investments and low tax capacity, Uganda is unlikely to be able to increase its fiscal space for health in the near future. Therefore, improving efficiency will be key to supporting the financial sustainability of the health sector. One area for improvement would be to increase the amount of on-budget external funds for the health sector that are released (currently only 30%) and executed (currently less than 80%) (MOFPED, 2018b). This inefficiency could be addressed through improved donor and government collaboration to better predict and allocate available resources. Health worker absenteeism, also a concern, was discussed at length at the most recent health sector performance annual review, during which stakeholders debated introducing performance-based contracts.

This report, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), provides findings from an assessment of the health financing landscape in Uganda. It serves as an evidence base for effective engagement and advocacy for increased domestic resource mobilization for health, specifically for HIV, TB, and malaria. The report explores how the health sector is financed, the status of various health financing mechanisms, the potential for increased resource mobilization, potential areas that could be targeted to increase efficiency, and the budget process as an entry point to advocacy. The assessment was conducted by Palladium and included a review of secondary data sources and 31 key informant interviews with organizations including Cipla Quality Chemicals, the Federation of Uganda Employers, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Ministry of Finance, Planning and Economic Development (MOFPED), the Ministry of Health (MOH), the National Social Security Fund, the Uganda Health Federation, Uganda Save for Health, the U.K. Department for International Development (DFID), the U.S. Government, and the World Bank.

1 Uganda's fiscal year spans July 1 to June 30.

Current Sources of Health Financing in Uganda

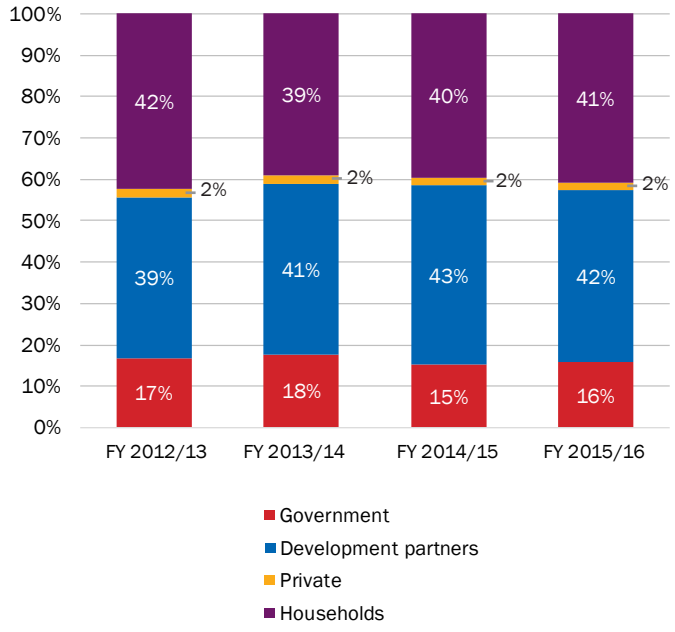
SOURCES OF HEALTH FINANCING

Uganda's health sector is mainly financed by households and development partners, with smaller contributions coming from the government and even smaller contributions from private enterprises, such as private health insurance schemes. Historically, the country has relied heavily on external financing to support the health sector, which represented 42% of health expenditure in FY 2015/16 (Figure 1). External financing comes from multilateral and bilateral donors, which provide funding to the government in the form of grants or loans, or executed by implementing partners, including nongovernmental, civil society, and other private organizations. Development partner financing includes mostly off-budget contributions and excludes general government support through loans and grants.

In FY 2015/16, out-of-pocket payments from households accounted for 41% of overall health expenditure, with over 96% of private health services financed directly by households. The government's share of health expenditure has remained relatively stagnant since 2012; in FY 2015/16 it provided only 16% of health expenditure. Government support primarily includes funding allocated to the health sector by the MOFPED.

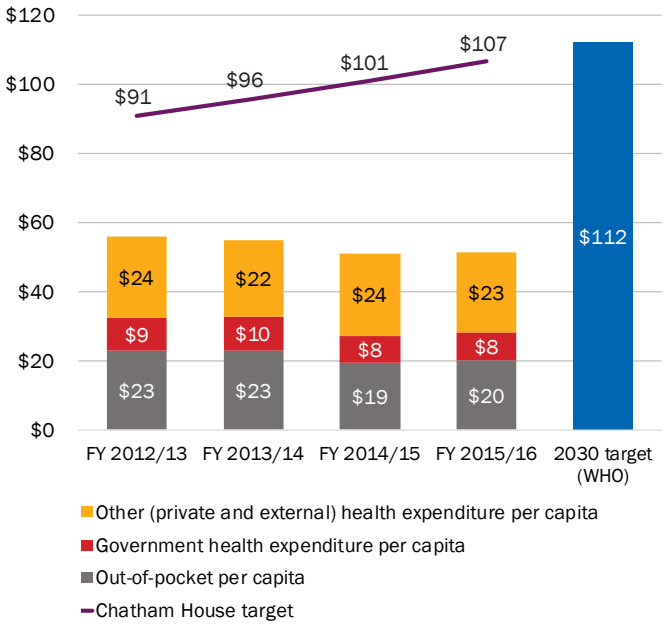
Government per capita spending has decreased slightly since 2012 (Figure 2). With an average population growth rate of 3% between 2010 and 2015 and a fertility rate of almost six children per woman, the government has not been able to increase its spending sufficiently to keep per capita spending constant (MOH, 2016a; United Nations, 2017). In addition, per capita spending has remained well below the amount recommended by Chatham House of US$86 (in 2012 terms) to provide "a minimum level of key health services in low-income countries" (McIntyre and Meheus, 2014, p. 25). The Chatham House target has been adjusted assuming an average annual inflation rate of 5.5%. This aligns with World Health Organization (WHO) estimates that the average level of per capita total health expenditure

Figure 1. Health Expenditure by Source



Sources: MOH, 2014 and 2016a

Figure 2. Per Capita Health Expenditure, Historical and Targets (US$)



Sources: McIntyre and Meheus, 2014; MOH, 2014 and 2016a

required to achieve health-related sustainable development goals in low-income countries by 2030 is US$112 per year (in 2017 terms) (Stenberg et al., 2017).

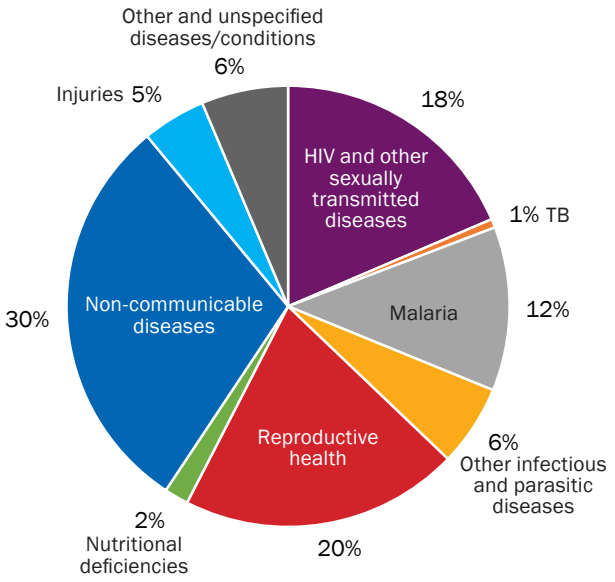
Key informants reported that a higher percentage of funding for specific disease areas is going to cover the cost of commodities—including HIV and TB treatments and insecticide-treated nets—compared to prevention services and outreach, monitoring and evaluation, supervision, or training. Key informants expressed a need for more health systems strengthening and community-level intervention support, particularly for prevention efforts. Based on National Health Accounts (NHA) data, overall health spending is fairly balanced between preventive and curative care, with 39% being spent on the former and 40% on the latter. However, the government spends 64% of its resources at the hospital level and only 22% at the preventive care provider level.

Financing Priority Disease Areas

The Government of Uganda spends 30% of its health expenditure on non-communicable diseases, 20% on reproductive health, 18% on HIV and other sexually transmitted diseases, and 12% on malaria (Figure 3). By contrast, 70% of development partner financing is spent on HIV and other sexually transmitted diseases, about 7% is spent on reproductive health, and a similar amount is spent on malaria. Overall, development partners fund 83% of HIV efforts and the government funds 8%, based on NHA data. At 67%, TB is also heavily reliant on development partner funding; however, based on NHA data, the government's contribution to TB efforts made up 33% in FY 2015/16. Out-of-pocket spending accounts for approximately 70% of anti-malaria efforts.

Based on the Uganda National Household Survey 2016/2017, only 6% of people reported having a non-communicable disease (e.g., diabetes, heart disease, or high blood pressure) (Uganda Bureau of Statistics, 2017). While non-communicable diseases represented 12% of total health expenditure in 2015/16, they often go undiagnosed and have a higher treatment cost than most communicable diseases. Neonatal

Figure 3. Government Health Expenditure by Disease, FY 2015/16



Source: MOH, 2016a

disorders, HIV, and malaria are the top three causes of death in Uganda, and treatment for malaria remains one of the primary reasons that people visit a health center (IHME, 2017).

Table 1 compares the total funding for HIV, malaria, and TB—including government, private, and external development partner funding—with disease burden. HIV and TB funding depends significantly on external resources, particularly from the U.S. Agency for International Development (USAID), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund. In contrast, malaria has a smaller gap to close, percentage-wise, to be fully supported by the government. HIV and malaria have stronger, more highly visible political support than TB, which could help advocates succeed in securing increased resource allocations from the government to fund these programs. However, it is unlikely that the government will be able to fully cover this gap in the near future.

Table 1. Burden of Disease Compared to Funding, FY 2015/16

	HIV	Malaria	TB
Prevalence and incidence	6% adult prevalence in FY 2016/17 (1.5 million people living with HIV)	408 cases per 1,000 people (about 16.4 million cases)	121 cases per 100,000 people (about 50,000 cases)
Disability-adjusted life years (percent of total)	12%	9%	4%
Total expenditure on disease area (US$)	$563 million	$297 million	$5 million
Percent of total health funding	35%	19%	0.3%
Percent of government funding for health	19%	12%	0.6%
External funding as share of disease area expenditure	83%	16%	67%
Estimated FY 2019/20 government budget allocation* (US$)	$59 million	$38 million	$2 million
Estimated resource need in FY 2019/20 (US$)	$919 million	$320 million	$36 million

Sources: Global Fund, 2018; IHME, 2019; MOH, 2016a and 2016b

* Based on FY 2019/20 government budget for the health sector, assuming 2015 percentage of government funding for health.

HIV

Most HIV commodities are procured by the Global Fund and the U.S. Government (through USAID, PEPFAR, and/or the U.S. Centers for Disease Control and Prevention). The Government of Uganda pays for a portion of HIV commodities (excluding condoms) and for government worker salaries and other general health system costs. The Global Fund provides funding for prevention programs; prevention of mother-to-child transmission; treatment, care, and support; HIV testing services; and TB/HIV co-infection programs. The Global Fund funding request for 2018–2020 was about US$210 million (Global Fund, 2018).

PEPFAR is the largest funder of HIV programming in Uganda, supporting the majority of antiretroviral therapy (ART) procurement, prevention and testing services, and voluntary medical male circumcision (PEPFAR, 2018). In 2016, PEPFAR provided US$284 million of support for HIV programming in Uganda, including US$32 million for ART. Table 2 provides a summary of HIV spending by source and category. Despite large investments in HIV, an expected funding gap of 44% remains for 2018–2020; the Government of Uganda needs to support strategies that will reduce this gap. One initiative aimed at closing this funding gap is the government's recent mainstreaming guidelines, which recommend that public and private institutions—including government ministries, departments and agencies, and local governments—provide 0.1% of their total budgets, including pensions and transfers, to HIV efforts (Uganda AIDS Commission, 2018). In addition, the government is supportive of an AIDS trust fund (discussed later in this report).

Table 2. HIV Financing by Source and Category, 2016

Program area	Total expenditure (US$)	% funded by PEPFAR	% funded by Global Fund	% funded by Government of Uganda	% funded by other development partners
Clinical care, treatment, and support	$201,703,982	61%	26%	14%	0%
Community-based care, treatment, and support	$15,859,385	94%	1%	0%	5%
Prevention of mother-to-child transmission	$27,487,899	93%	0%	0%	7%
HIV testing services	$22,180,167	70%	29%	0%	1%
Voluntary medical male circumcision	$23,689,473	97%	3%	0%	0%
Priority population prevention	$11,416,844	97%	0%	0%	3%
Adolescent girls and young women prevention	$961,792	0%	49%	0%	51%
Key population prevention	$9,977,547	55%	45%	0%	0%
Orphans and vulnerable children	$22,366,257	100%	0%	0%	0%
Laboratory	$26,574,090	76%	24%	0%	0%
Surveys and surveillance	$7,865,029	84%	0%	0%	16%
Health systems strengthening	$26,049,938	88%	2%	8%*	2%
TOTAL	**$396,132,402**	**73%**	**16%**	**7%**	**4%**

Source: PEPFAR, 2018 (does not include private expenditure on HIV)

* Planning, coordination, and management

Malaria

While NHA data indicates that Uganda's malaria program is not heavily reliant on external sources, a midterm review of the Malaria Reduction Strategic Plan indicated that the program was 95% donor-funded and only 5% government-funded, not including private expenditure (MOH, 2017a). The Global Fund provides insecticide-treated bed nets and social and behavior change communication interventions, including support for a malaria nets campaign. The Against Malaria Foundation contributed 13 million nets from March 2017 to 2018 (Against Malaria Foundation, 2019) and the U.S. President's Malaria Initiative and DFID support indoor-residual spraying. DFID also supports a 48 million-pound malaria grant focused on high-prevalence districts and national-level support for training and surveillance and the transition from malaria control to pre-elimination. The government's 5% contribution (not including human resources and systems support) contributes to procuring artemisinin-based combination therapy drugs and insecticide-treated

nets. Overall, funding per capita is decreasing, including from the Global Fund (current grant is US$185 million). DFID also plans to phase out its bilateral support for malaria over the next five years, which puts additional pressure on Uganda's National Malaria Control Program to develop and implement a strong resource mobilization strategy.

There is strong political support within the Government of Uganda for malaria control efforts. In 2018, with support of the president of Uganda, the National Malaria Control Program launched the Mass Action Against Malaria initiative, which envisions a malaria-free Uganda. The president of Uganda launched a parliamentarian forum on malaria and promised to establish a presidential malaria fund (to be funded by earmarked taxes). The president also signed a United Nations General Assembly resolution on October 26, 2018 committing to accelerate efforts to control and eliminate malaria by 2030. The National Malaria Control Program is currently developing a resource mobilization strategy that reflects needs, funding strategies, and legal frameworks required to effectively implement the strategy.

Tuberculosis

Tuberculosis received the least funding of the three disease areas and is similarly dependent on external resources. The Global Fund provides 35% of Uganda's TB care and treatment costs and 42% of its multi-drug resistant tuberculosis (MDR-TB) program costs. Uganda's 2018–2020 funding request to the Global Fund was about US$54 million. Other donors, mostly USAID and PEPFAR, support 44% of Uganda's TB care and treatment costs and 58% of the MDR-TB costs (Global Fund, 2018). Development partners also fund human resources—for example, the Global Fund supports a data officer, MDR-TB coordinator, laboratory officers, monitoring and evaluation personnel, and a program officer. The Government of Uganda supports infrastructure and health worker salaries at 1,600 health centers. The U.S. Centers for Disease Control and Prevention and PEPFAR support implementation at the district level, including operations, supervision, training, and monitoring and evaluation. WHO provides technical assistance support and strategic direction and UNICEF supports child TB-related programming. The National TB and Leprosy Program collaborates with academia and other government institutions to implement its programs. The perception from key informants is that, overall, 75–80% of TB funding is provided by the Global Fund, 10% is provided by the U.S. Government, and 2–3% is provided by other donors. However, according to the 2015/16 NHA, 33% of TB is publicly funded and 67% comes from development partners. The TB program is looking to conduct an investment case and determine the cost and financial gap of priority funding needs.

According to the first-ever national tuberculosis patient catastrophic costs survey—a survey of over 1,100 patients attending 67 facilities across the country—households also contribute a significant amount to tuberculosis costs. The majority of households of TB patients (53%) experienced catastrophic expenditure, defined as at least 20% of household income spent on TB care. The survey results show that drug-susceptible TB patients spent a median of US$230 on TB-related care per episode, while MDR-TB patients spent a median of US$3,214 per episode. In the pre-diagnosis period, major cost drivers for both types of TB were medical and travel costs. In the post-diagnosis period, the major cost drivers were non-medical, namely travel, food, and nutritional supplements (MOH, 2018b). This finding has not been represented in the recent NHA and therefore differs from the data in Table 2.

Role of Major Donors

As is the case with disease-specific financing, the health sector in general is heavily dependent on external financing. When considering how to mobilize resources and identify partners for new initiatives or funding gaps, it is helpful to understand who is already supporting the health sector and what type of support they are providing. According to the most recent NHA (FY 2015/16), 75% of development partner funding is used to support preventive care, and 86% of this preventive care funding is used for risk and disease control programs and epidemiological surveillance. However, based on Global Fund data, more external resources are spent on treatment than

prevention, which has a larger funding gap (Global Fund, 2018). The health sector is supported by a variety of donors, mainly the Global Fund and the U.S. Government as previously mentioned, and other donors, such as the African Development Bank, DFID, Japan International Cooperation Agency, Korea International Cooperation Agency, the United Nations, and the World Bank. UNAIDS supports the Government of Uganda at the policy level and through technical assistance, specifically on resource mobilization and efficiency, and also participates on the country coordinating mechanism and provides financial support for its operation.

The Chinese government has also been involved in supporting Uganda's healthcare system. They mostly support infrastructure needs—such as providing grants to refurbish hospitals—and are interested in providing antimalarial treatment drugs from China (although they are not WHO-qualified). According to key informants, Chinese government representatives have continued to pursue and advocate to the Government of Uganda for a space in the market. While they are not a large player in the health sector, they should not be ruled out for future potential collaborations.

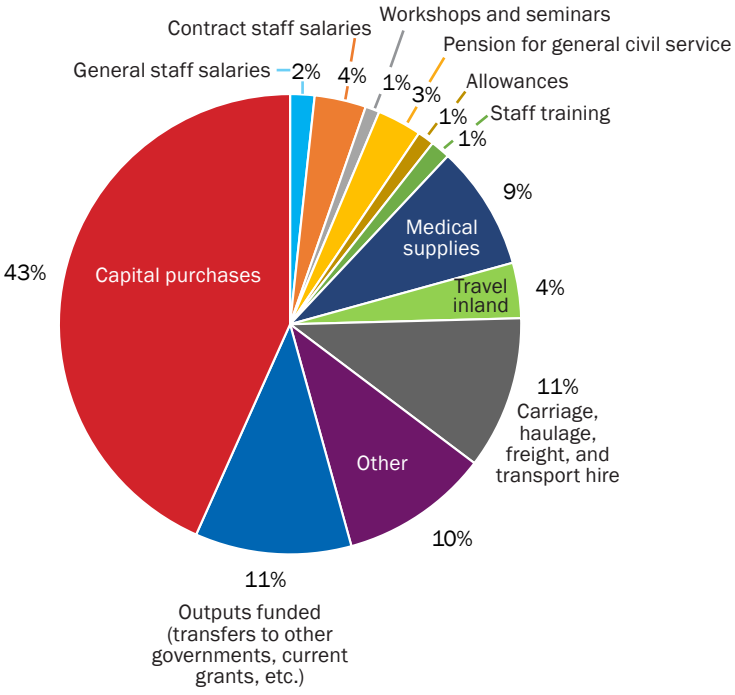
In other examples, the World Bank has provided a US$200 million grant (2017–2023) for health and education and Uganda's minister of health plans to use it to upgrade health centers (levels II to III) to employ more staff and offer laboratory and additional outpatient services.[2] This is in line with the government's emphasis on infrastructure development. Overall, most other donors are investing in infrastructure for the health sector and/or are providing technical assistance on particular data-generation activities or strategic planning.

DOMESTIC RESOURCES FOR HEALTH

In FY 2017/18, 30% of the central MOH's budget was funded by the government and 70% by development partners. Salaries accounted for 7% of the MOH's budget; 75% of health sector salaries are paid by local governments at the health center level and encompass about 85% of the local government health sector budget. Approximately 17% of health sector salaries overall are paid at the hospital level. Recurrent and operational costs made up 57% of the MOH's FY 2017/18 budget and development costs made up 36%—overall, MOH spending is highest for supply chain and capital improvement costs (MOFPED, 2018b). Figure 4 provides an overview of the MOH's FY 2017/18 spending, inclusive of funds provided to the MOH from external sources.

The FY 2015/16 NHA provides a more detailed breakdown of how the government allocates its resources to the entire health sector. When considering the level of the health system, the

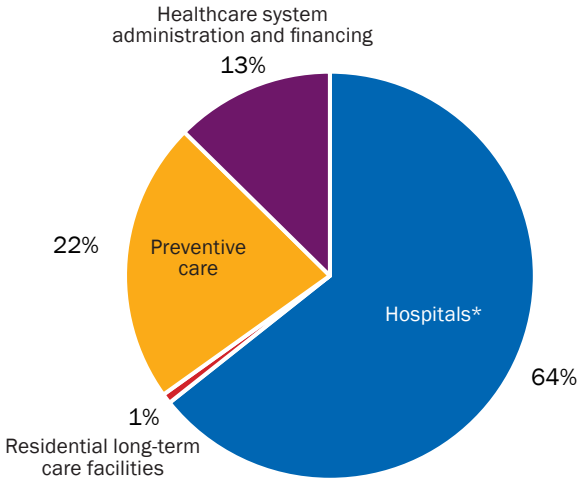
Figure 4. Breakdown of FY 2017/18 Ministry of Health Spending



Source: MOFPED, 2018b

2 A health center II is the lowest level of formal healthcare delivery in Uganda and is usually staffed by nurse aides and qualified nurses. A health center III offers basic laboratory services, maternity care, and inpatient care (often for onward referral). It is usually staffed by nurse aides, qualified nurses, and clinical officers (physician assistants).

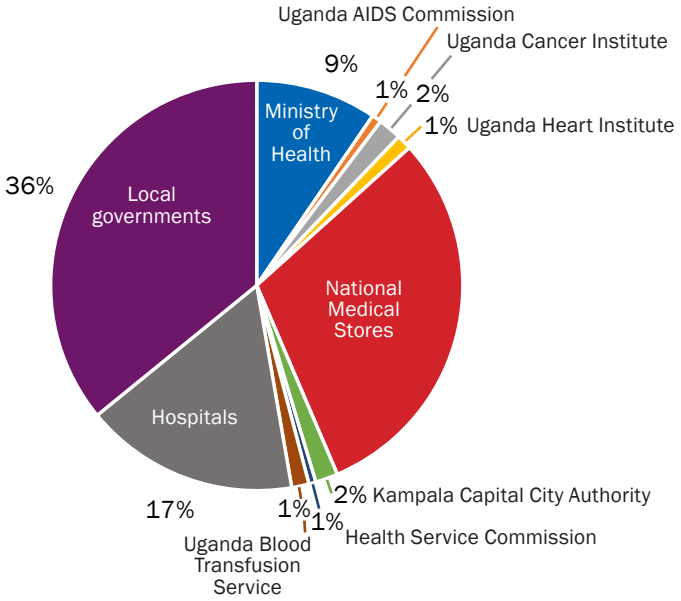
Figure 5. Government of Uganda Health Expenditure by Provider, FY 2015/16



* Hospitals include regional referral hospitals, health units, nongovernmental organization hospitals, general hospitals, and mental and specialized hospitals/institutions.

Source: MOH, 2016a

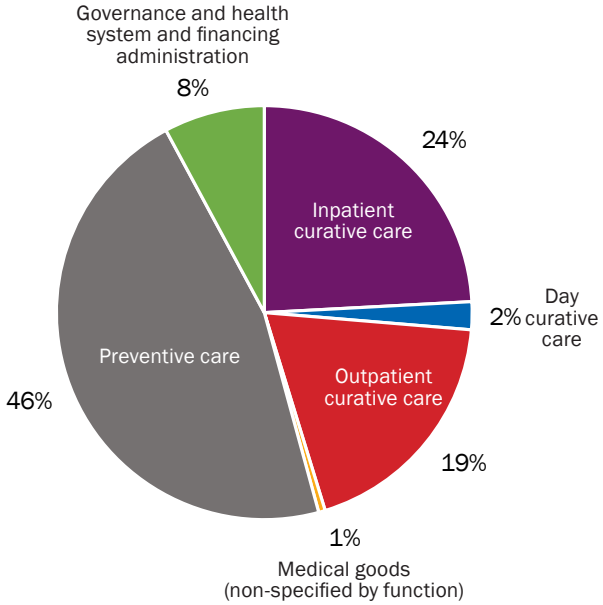
Figure 6. Government of Uganda Health Sector Spending by Entity, FY 2017/18



Source: MOFPED, 2018b

Government of Uganda spends most of its health sector-allocated financing (64%) at the hospital level, spends 22% on preventive care providers at the lower level of the healthcare system, and spends 13% on healthcare administration (Figure 5). The majority of public spending on health comes from local governments (36%), the National Medical Stores (30%), and hospitals (17%), with 9% coming from the MOH (Figure 6) (MOFPED, 2018b). By function, the government spends the majority of its funds on preventive care (46%), followed by inpatient curative care (24%), and outpatient curative care (19%) (Figure 7) (MOH, 2016a). According to the Uganda Bureau of Statistics' 2016/17 household survey, 26% of people who seek care did so at government health centers and clinics, while 8% sought care at government hospitals.

Figure 7. Government of Uganda Health Expenditure by Function, FY 2015/16



Source: MOH, 2016a

Insurance as a Mechanism for Domestic Resource Mobilization

National health insurance is not currently operational in Uganda. For the past 10 years, the government has discussed and debated the design of a national health insurance scheme (NHIS), which provides an opportunity to improve sustainable funding for healthcare (Box 1). In 2014, a national health insurance bill was drafted, and a Certificate of Financial Implications was obtained from the MOFPED in 2017, which indicates the MOFPED's approval of the financing stipulations in the bill. The draft bill was submitted to the cabinet in 2018 and is yet to be reviewed and approved, after which it will be sent to parliament for consideration.

The 2014 bill went through several drafts before receiving approval from the MOFPED. The first draft of the bill was rejected because it targeted the formal sector instead of the large informal sector and rural poor, who are seen as having the greatest need for insurance. The revised version of the bill delineates three different population subsets: government employees, employees of private firms, and community-based health insurance enrollees (for the informal sector). Indigents will be covered by the NHIS and the government will pay their contribution from funds appropriated by parliament to the scheme. The bill presents a draft list of health services covered in the benefits package, including treatment, prevention, dental, reproductive, minor and major surgical operations, and rehabilitation. The bill states that it will cover "diagnosis and treatment of common ailments." It's unlikely that HIV would be included in the benefits package as the majority of the costs—antiretroviral drugs—are currently provided by donors. The government still needs to determine affordable premiums and co-payments. There are also other data gaps that need to be addressed before the mechanism could become operational (Box 2).

According to key informants, the majority of people surveyed were willing to enroll and participate in an NHIS. There is a perception that adding health insurance premiums to an already heavily taxed formal sector, compared to the informal sector, which represents over 80% of the population, would be a high burden. According to government stakeholders, formal sector workers expressed concern about service quality and uncertainty that they would receive value for money. The Certificate of Financial Implications states that employers (including the government) and employees will both contribute 4% of the employee's salary.

BOX 1. SUSTAINABILITY OPPORTUNITY

The creation of a national health insurance scheme offers Uganda a strong opportunity to increase the quality of care and financial protection. Currently 1% of the country's population is covered by a pre-payment scheme and out-of-pocket spending makes up more than 40% of overall health expenditure. A national scheme has the possibility of reducing out-of-pocket spending while introducing performance-based financing mechanisms and facility accreditation requirements that could help increase the quality of care. Analyses are needed at the national and sub-national levels to determine the financial implications of a national health insurance scheme, the cost of the benefits package, and the capacity of each district/community to implement such a scheme.

BOX 2. DATA GAP

One of the main needs to implement national or community-based health insurance is accurate population and household income data. This is a challenge given that an estimated 49% of births of children under 5 years of age are unregistered (Republic of Uganda, 2016b). With support from the Global Financing Facility and the World Bank, Uganda will be developing and strengthening its civil registration and vital statistics systems, which will be able to provide important inputs to support health sector financing.

Overall, there have been several rounds of consultation between the MOH, the MOFPED, the National Social Security Fund (NSSF), the Uganda Revenue Authority, and development partners without an agreement on who will be responsible for paying premiums for indigents and how the informal sector scheme will function. Given this, there is a possibility that parliament will reject the bill and send it back to the MOH and MOFPED for further revision and refinement. The MOH is willing to invest in the supply side needed to support an NHIS (e.g., buy drugs, improve supply chain, renovate hospitals), but, to date, it is unclear how the government, as a whole, will allocate funds to support the demand side, particularly, supporting financing for indigent populations.

National Social Security Fund

According to key informants, some government officials feel that the NSSF should finance NHIS premiums for all Ugandans, including the poor, as there is a perception that the NSSF is overfunded and can afford to finance premiums within its current funding streams. However, the NSSF has insisted that it won't be possible to fund the entire NHIS with premium payments from less than 10% of the population.

The NSSF covers 1.8 million people plus their dependents with social security benefits mostly from the private sector. The monthly premium is 15% of salary (5% from employees and 10% from employers). There is about a 60% on-time premium payment compliance rate from companies and 75–80% comply within three months. The NSSF offers pension payments with the retirement age set at 55 and invalidity and survivor benefits in the case of death, but no direct health benefit. However, NSSF members have been requesting a health benefit for years and the NSSF is advocating to the government for a legal change that would allow the institution to provide such benefits.

If the NSSF were to offer a health benefit, it would have to create a new internal structure to serve as a risk pool for all members. Currently, each NSSF member has their own individual account as part of the NSSF and the funds are not pooled across individual accounts. Key informants indicated that while adding health benefits would require revising the legal framework for the NSSF, doing so could be advantageous as the NSSF already has experience managing and monitoring funds and processing claims. They do not, however, have the capacity to manage pooled funds, which would be required for an NHIS.

The NSSF hired a consultant in 2018 to analyze available options to amend the law and to finance a health benefit. The consultant is exploring several options:

1) Members voluntarily contribute an additional percentage of their salary to receive health benefits (around 2–3%)
2) Revenue from NSSF investments is used to fund a health benefit
3) Employers contribute an additional percentage for their employees to receive health benefits (around 2–3%)
4) A combination of the above

The NSSF also recently created a voluntary social security scheme that is currently only available to ex-members of the NSSF who have moved on from their previous employers. In this scheme, individuals continue to contribute to their funds through mobile money. This scheme has the potential to be scaled, but stakeholders indicated that it would need subsidized funding to be able to offer it to the entire informal sector. NSSF's experience could offer learning opportunities for the government in the development of an NHIS (Box 3).

BOX 3. LEARNING OPPORTUNITY

The government should take advantage of the National Social Security Fund's capacity and experiences in the formal and informal sectors to design and set-up a national health insurance scheme. The government should consider piloting the scheme among fund beneficiaries before scaling it up to a larger population.

Community-Based Health Insurance

In FY 2017/18, there were eight organizations promoting community-based health insurance (CBHI) schemes. These organizations supported 12 schemes, spread across 20 districts (out of a total of 127) in Western and Central Uganda, covering 152,260 people, or 0.4% of the population. The number of people enrolled in various schemes has been relatively stagnant over the last three years. Depending on the scheme, members pay a premium plus a co-payment at the point of service ranging from 1,000 to 30,000 Ugandan shillings (UGX) per illness episode. All schemes have a ceiling on the amount the scheme pays per episode, which ranges between UGX 80,000 to 500,000 (MOH, 2018c). Save for Health Uganda supports CBHI schemes across the country. In 2017, they worked in 10 districts and supported 113 schemes at the parish level, covering 5,660 families and 33,333 total beneficiaries (Save for Health Uganda, 2018).[3]

Key informants said that some people are wary of CBHI schemes and many cannot pay the premiums. There is an average 7% annual drop-out rate for families, and this is attributed to increments in premium payments, long distances to contracted facilities, and inability to afford health insurance given other family needs (Save for Health Uganda, 2018). For most plans, the premium is a flat rate, regardless of socio-economic status, and therefore premiums are regressive, being a higher burden on the poor. In principle, the services in public health centers in Uganda are free. In reality, people still pay for many services, so families can end up paying more for healthcare even when part of a CBHI scheme, by paying for services in addition to the premium payments. CBHI members generally come from middle-income quintiles. The schemes don't often attract the top quintile because the benefits package is limited and there is a perception that if the premium is not high then the benefits offered are not of high quality. The schemes mainly contract with private facilities and private wings of district hospitals. The benefits packages generally include all outpatient services and most inpatient services, excluding services for high-cost non-communicable diseases, such as heart disease and cancer. The coverage maxes out around UGX 200,000 per episode. Generally, 5–7% of the total bill is not covered by the scheme, according to Save for Health Uganda representatives. ART drugs are free of charge, being provided by development partners, and malaria and TB screening, diagnosis, and treatment are covered.

Save for Health Uganda reports that the cost of medical bills is fully financed by the members' premium payments to the schemes. In 2017, the schemes covered 100% of obligated healthcare bills. The premium payments cover part of administrative costs, but health insurance education and training for contractors, for example, are not covered by the scheme and are financed by donors.

CBHI schemes may only cover a small percentage of the population, but their experiences can help support the development of an NHIS (Box 4). The government should continue to include CBHI representatives in NHIS discussions, particularly in how to reach the informal sector, create demand, and design an attractive and affordable benefits package. CBHI is difficult to scale effectively but could be merged under a larger NHIS.

BOX 4. LEARNING OPPORTUNITY

Community-based health insurance schemes have developed mechanisms that use Meso technology to manage the enrollment of members and to pay facilities in a common system. These types of advancements could be adapted and applied to the national health insurance scheme, especially for the informal sector.

3 The 10 districts were Bushenyi, Kampala, Luwero, Masaka, Mitooma, Mityana, Mubende, Nakaseke, Nakasongola, and Sheema.

Private, Commercial Insurance

Private, commercial insurance in Uganda is limited and generally only available in urban areas. Approximately 850,000 Ugandans (about 2% of the population) have private, commercial health insurance. Private, employer-based insurance accounted for 2% of health expenditure by financing scheme, such as government schemes, voluntary pre-payment schemes, and out-of-pocket expenditure, in FY 2015/16 (Koseki et al., 2015; MOH, 2016a). The private, commercial health insurance contribution to health is approximately US$252 million.

Other Health Financing Mechanisms

The Government of Uganda has been discussing domestic resource mobilization for several years and, in 2016, developed a health financing strategy as a roadmap to a more sustainable health sector. However, the health financing strategy includes few specifics on how the government will mobilize domestic resources, indicating the need for further analysis to determine an appropriate strategy and the potential return on investments. As a result, the World Bank is supporting feasibility studies on various financing options, including a sin tax on tobacco; a 2% levy on beer, water, and soft drinks to fund the HIV and AIDS Trust Fund; and options through car insurance. In addition to these considerations, stakeholders are also discussing a national immunization fund (established in a 2016 Act) and a malaria-specific fund. These could be competing initiatives and there is no clear roadmap for how they will be implemented or how they will support each other and contribute to the overall health financing strategy. The MOFPED is not likely to support the creation of several vertical funds or earmarks as they limit budget allocations, increase administration costs, and lack data on their revenue-raising potential and impact. Therefore, additional consideration is needed to develop a harmonized approach to funding the health sector (Box 5).

Car Insurance

One of the studies that the World Bank is supporting will determine the potential of implementing Uganda's 1989 Motor Vehicle Insurance Act to support the health sector. The act requires car insurance plans to cover all passengers in road traffic accidents. In the case of an accident, the insurance is supposed to pay for hospital costs, among other expenses, if someone with insurance is injured. However, key informants reported that many people are unaware of this service and that the process for filing a reimbursement claim is lengthy. According to key informants, car insurance premiums cost, on average, US$30 per car per year and covers a person up to US$250. While this may be an avenue to support injury-related costs to the health sector, the impact would be limited.

BOX 5. KEY ENTRY POINT

The Ministry of Health is currently developing a multi-sectoral universal health coverage roadmap to harmonize approaches and address some of the issues around potentially competing health financing initiatives. The roadmap could be an entry point for partners and those working on specific disease programs to advocate for priorities. This roadmap and World Bank-supported feasibility studies will support engagement and decision making with the Ministry of Finance, Planning and Economic Development.

HIV and AIDS Trust Fund

The HIV and AIDS Trust Fund was established by law in 2014 as part of the HIV and AIDS Prevention and Control Act, however, specific regulations were only passed in 2018 and are not yet operational. The fund is estimated to bring in US$2.5 million per year when it is in place (Okiror, 2018b). While the trust fund will not be able to bridge the entire HIV funding gap, the fund could grow over time with a sustainable funding source. As explained in the HIV and AIDS Prevention and Control Act, the goal of the fund is to "secure a predictable and sustainable means of procuring goods and services for HIV and AIDS counselling, testing and treatment." The act states that the

fund will be managed by the MOH and can receive funding from domestic and international sources. Specifically, it states that funding will include, "two percent of the total tax revenue collected from levies on beers, spirits or waragi, soft drinks, and bottled water." While the MOFPED has issued its support via a Certificate of Financial Implications, it remains unclear how the 2% earmark will be implemented, particularly in the context of a larger health financing strategy.

Investments from Capital Projects to Support HIV and Gender-Based Violence Prevention

The Government of Uganda is also interested in examining options to generate funding for HIV and gender-based violence programming through taxing of capital projects, such as infrastructure development and oil extraction. The government plans to conduct a mapping of capital projects—particularly road construction and those in the oil and energy sector—to estimate the level of resources that could be generated from the projects and how they could be used to support HIV control and prevention.

PRIVATE SECTOR CONTRIBUTIONS TO HEALTH

The private sector contributes significantly to the Ugandan healthcare system. Based on the most recent household survey, 48% of people who seek care, including 45% of the rural population seeking care, does so at private hospitals or clinics (Uganda Bureau of Statistics, 2017). However, based on health management information system data, only 23% of patients who seek care do so in the private sector (MOH, 2018c), indicating a challenge with getting data from the private sector into the national system. The largest share of total household expenditure on health, 43%, is spent at private hospitals, compared to only 18% at government-owned hospitals (MOH, 2016a). A common perception among Ugandans is that private facilities offer higher-quality services, have more available and consistent staff, and drugs are more consistently available. Patients report that they are treated better in private facilities compared to public facilities (MOH, 2018c). Based on the MOH's most recent 2017/18 annual health sector performance review, the lowest ranked hospitals were mostly private hospitals due to irregular or no reporting into the national health information system. However, many private hospitals did improve their reporting from the previous year, showing improved performance related to admissions, deliveries, antenatal care visits, etc., compared to the previous year's incomplete data (Box 6).

BOX 6. DATA GAP

Collecting accurate and timely data from private health facilities remains a challenge in Uganda. Many private providers do not enter sufficient information into the government-managed health information system, making it difficult to determine disease burden, needs, and quality of care. Additional support and monitoring is needed to ensure private sector data is captured.

Stakeholders indicated that there was a need to strengthen the private sector, not only by improving their capacity to report into the health management information system, but also by providing them with microcredit to be able to successfully scale-up, keep costs down, and offer services with a low financial return. A loan, for example, could provide a private provider with the funds necessary to scale-up a high-return service, such as specialized care, and be able to offer a low-return service, such as family planning or immunization.

While TB diagnosis generally occurs in public facilities, the Uganda National Tuberculosis Prevalence Survey 2014–2015 reported that 37% of patients with symptoms sought care at a private facility. The national TB program only recently started engaging the private sector and is developing an operational plan to align with its strategic plan. The program is offering training to private sector providers and is working to get them accredited to be able to offer TB services. Private facilities currently receive TB drugs from public facilities, however, the national TB program is developing a framework that would allow private

facilities to access TB drugs directly from the Joint Medical Stores—the largest drug supplier to nongovernment providers.[4]

Regarding malaria, 44% of children with a fever attended a private facility, about the same proportion for overall health services. Artemisinin-based combination therapy drugs are often subsidized in the private sector; however, rapid diagnostic tests are not, which often leads to presumptive treatment of malaria in private facilities. There is a need to reduce the cost of rapid diagnostic tests at the manufacturer level to increase private sector access and institutionalize a treat only-after-test mentality.

When it comes to HIV, the 2012 National AIDS Spending Assessment revealed that 69% of HIV services were provided in the private sector (including civil society organizations, nongovernmental organizations, faith-based organizations, and private not-for-profit organizations). Among private providers, private not-for-profit organizations provided 79% of HIV services, mostly care and treatment. The majority of HIV tests (18% of women's last tests) occurred in the private sector. In 2011, in urbans areas, 24% of tests took place in a private (mostly a private not-for-profit organization) hospital, compared to 9% in rural areas (O'Hanlon et al., 2016).

The One Dollar Initiative

In 2017, the Federation of Uganda Employers assisted by the Uganda Manufacturers Association—with technical support from the Bill & Melinda Gates Foundation, the Global Fund, the International Labor Organization, the Uganda AIDS Commission, and UNAIDS—launched the One Dollar Initiative to engage the private sector and individuals to contribute the equivalent of 1 U.S. dollar per day, or per month, to support the private sector's response to HIV, particularly in the workforce. The goal is to mobilize domestic resources for HIV from private sector organizations to leverage government efforts and close the HIV funding gap. The initiative encourages all employees to contribute one dollar to the pooled fund and is focused on reaching students and adolescents, employees in vulnerable employment sectors, and business customers. The initiative has not yet secured significant funding, but is receiving in-kind contributions such as free meeting space. This initiative has limited potential to support sustainable financing for HIV.

Private Providers

There are many private providers across the country and many public hospitals have invested in private wings. The private not-for-profit sector includes four main bureaus that are affiliated with four religious institutions: Catholic, Protestant, Muslim, and Christian Orthodox. The Uganda Protestant Medical Bureau is the umbrella organization for a network of 292 health facilities including hospitals, district and community health centers, and health training institutions. Internally generated revenue (from user fees, tuition fees from health training, and CBHI) comprised 56% of its income in 2017/18, while the government contributed 12% and donors accounted for 32%. Over 11,000 people living with HIV, or 89% of individuals who tested positive for HIV at Uganda Protestant Medical Bureau health facilities, were linked to care, while 93% were newly started on ART. The Uganda Catholic Medical Bureau represents and supports 295 health facilities, including 32 hospitals and 15 health training institutions. Its facilities counseled, tested, and gave HIV results to 955,262 individuals, representing 11% of the total country in 2017. About 24,000 people living with HIV, or 88% of individuals who tested positive for HIV at Uganda Catholic Medical Bureau facilities, were linked to care (MOH, 2018c).

The Joint Medical Stores—founded and owned by the Uganda Protestant Medical Bureau and Uganda Catholic Medical Bureau—are the largest drug supplier to non-government providers, including for HIV drugs. Private not-for-profit providers have a memorandum of understanding (MOU) with the Joint Medical Stores for purchasing drugs and commodities. In addition, the MOH also contracts with private facilities to provide drugs and commodities and the medical bureau acts as a third signatory to the MOU.

4 The Joint Medical Stores are used by the private sector while the National Medical Stores serve public sector facilities.

Pharmaceutical Industry

Cipla Quality Chemical Ltd. is a local pharmaceutical manufacturer that produces the latest antiretroviral, antimalarial, and hepatitis medicines at their facility outside Kampala, with the majority of the raw materials and all of the active ingredients imported from abroad.[5] They have recently invested in new technology to increase production and efficiency and reduce the possibility of human error. Cipla sells to both the public and private sectors, supplying the Uganda National Medical Stores and first-line distributers in the private sector. Cipla's MOU with the Government of Uganda ensures that the National Medical Stores, which serve public sector facilities, procure available drugs only from Cipla, regardless of international pricing. Local drug prices are estimated to be 25–30% higher than on the international market, meaning the government is not getting the best value for its money. However, the government seems committed to building the domestic pharmaceutical industry. With a smaller demand than development partner procurement, the Government of Uganda cannot compete for lower prices for imported materials and believes that if external donors were to also use Cipla, pricing could be improved. Cipla is a WHO-certified facility, however, external donors—including PEPFAR—continue to procure from abroad. According to key informants, USAID is currently working with Cipla to obtain U.S. Food and Drug Administration approval so programs such as PEPFAR can purchase commodities directly from Cipla. At the same time, the government and partners should consider the difference over time in domestic versus international pricing to determine the sustainability and efficiency of procuring through a local manufacturer.

Cipla also recently signed an MOU with the Government of Zambia to increase its reach in the East African region. Cipla will need to expand its market in order to increase economies of scale and negotiate lower prices for raw materials and reduce the price of drugs. Having an MOU with governments makes it easier for the company to plan procurement and production and helps prevent shortages. The company could possibly expand if it were able to put in place other MOUs in the region. Cipla is already planning to add approximately 10 new products to their production line over the next year, including an antimalarial pill that is dissolvable in water designed for children.

KEY TAKEAWAYS: CURRENT SOURCES OF HEALTH FINANCING

- Health is mainly financed by out-of-pocket spending (41%) and external financing (42%).
- By disease, the government spends the largest proportions of its health funding on non-communicable diseases (30%), reproductive health (20%), and HIV (18%).
- Private, employer-based insurance covers about 2% of the population, while community-based health insurance covers less than 1% of the population. There is a need to focus on developing and scaling up the proposed national health insurance scheme.
- There are potentially competing vertical financing initiatives, such as a malaria fund and an HIV and AIDS Trust Fund, which could be streamlined and linked to the overall health financing strategy.
- Additional analyses are needed to inform a roadmap to sustainable health financing and universal health coverage, which is being developed by the MOH.
- Almost half of the population who seek healthcare, do so at private facilities. There is a need to strengthen collaboration and coordination between the government and private sector providers, particularly regarding data entry into the national health management information system.

5 Medicines manufactured include antiretrovirals Duovir-N, Duovir, Duomune, Efavirenz, Nevimune, and Trioday; the antimalarial Lumartem; and hepatitis B medicines Texavir and Zentair.

Finding the Money: Creating Additional Fiscal Space for Health

Uganda continues to face significant financing challenges to meeting its health sector goals. The MOH—in coordination with the MOFPED and other ministries and agencies at the national, regional, and local levels—must continue to emphasize the need for greater efficiency, increased budget allocations, and prioritization of health at all levels of government.

FISCAL SPACE AND MACROECONOMIC CONTEXT

From 1992 to 2010, national economic growth averaged 8% per year, tripling GDP per capita and halving the poverty rate to 35%. However, since 2010, the growth rate has declined, partly due to decreased agriculture and industry productivity (IMF, 2017). The government's efforts are focused on growth in agriculture, energy, tourism, and infrastructure development. The country's Second National Development Plan 2015/16 to 2019/20 (NDPII) aims to propel the country toward middle-income status by 2020, in line with the broader Uganda Vision 2040.

Over a 30-year period, the NDPII aims to increase GDP per capita from US$506 in 2010 to $1,039 in 2019/20 and $9,500 in 2040. With a 3% population growth rate per year, and about 5% GDP growth, GDP per capita is not increasing quickly enough to reach the country's goals. In 2015, GDP per capita was US$715 (MOH, 2016a), already behind by what's needed to reach US$9,500 in 2040. To have been on track, GDP per capita would have needed to increase about US$310 per year (reaching over US$1,000 in 2015), or by about 11% per year (reaching close to US$760 in 2015). While not growing fast enough to reach Uganda's ambitious economic vision, the economy is growing at a healthy rate. Nominal GDP is increasing each year and the International Monetary Fund projects a growth of more than 5% each year through 2021 (IMF, 2017). In addition, the MOFPED reported that agricultural sector GDP growth doubled to 3.2% in FY 2017/18, compared to 1.6% in FY 2016/17 (MOFPED, 2018b).

While GDP is expected to continue growing in the medium term, the tax capacity—nearly 14% of GDP—remains relatively low compared to other East African countries. This is in part due to the limited government capacity to collect taxes from the large rural and informal sectors. However, tax revenue increased 13% from FY 2016/17 to FY 2017/18 and the tax revenue-to-GDP ratio increased slightly from 13.6% to 13.8% (MOFPED, 2018b). Inflation has remained fairly stable, around the country's 5% target. The Bank of Uganda introduced inflation targeting in 2011, which has helped stabilize the inflation rate. Government debt is projected to continue to increase and peak at 42% of GDP in FY 2019/20 as infrastructure investment slows (IMF, 2017). The low tax revenue and high government debt limits the country's ability to increase domestic resources for health.

CURRENT TARGETS FOR DOMESTIC HEALTH SPENDING

The NDPII aims to increase health spending as a percentage of GDP and as a percentage of the total government budget (Table 3). The total health sector projected cost is UGX 25,468 billion (US$8 billion) over the 5-year period (47% for the public sector and 53% for the private sector), representing an average of 11% of the total NDPII projected cost over five years.[6] A major objective for the health sector outlined in the NDPII is to increase financial risk protection of households against impoverishment due to health expenditures. The plan lists diversifying funding sources, exploring innovative mechanisms, designing and implementing a national health insurance scheme and other pre-payment schemes, and efficiency gains as strategies to accomplish this goal.

6 In the NDPII, public sector financing includes external financing (budget support, concessional loans, semi-concessional borrowing, and non-concessional borrowing) and domestic financing. Private sector financing includes public-private partnerships, direct private sector investments (domestic and foreign), and civil society organization contributions.

Table 3. Summary of National Development Plan and Health Sector Development Plan Targets

	Baseline	Target
Second National Development Plan 2015/16–2019/20		
Health spending (% of GDP)	1.5%	3.1%
Government health budget as % of total government budget	7%	15%
Health Sector Development Plan 2015/16–2019/20		
Out-of-pocket as % of total health expenditure	37%	30%
Government health expenditure as % of total government expenditure	9%	15%

The Health Sector Development Plan—the strategic plan specific to the health sector—was developed for the same time period (2015/16 to 2019/20) and included the same financial protection objective. The plan aims to reduce out-of-pocket expenditure and to increase the general government allocation for health (Table 3). The plan references the MOH's annual health sector performance review from FY 2013/14 as the source for the baseline 9% government allocation to health, as a percentage of total government expenditure, while the FY 2013/14 NHA references a different baseline of 8%. The total projected cost of the Health Sector Development Plan over the 5-year period is US$16 billion, ranging from US$64 per capita to $97 per capita over the life of the plan. Given that current health expenditure per capita in 2015 was only US$51, according to the NHA, this leaves a 29% funding gap over the five years. Funding for HIV represents 17% of the total projected cost, malaria 5%, and TB less than 1%.

In 2016, Uganda developed a Health Financing Strategy for 2015/16 to 2024/25, which outlines a strategy for reaching universal health coverage by 2025. The strategy proposes several options to increase resource mobilization, including establishing an equity fund to subsidize indigent and CBHI schemes, operationalizing the HIV and AIDS Trust Fund, and collecting resources from sin taxes. With regard to pooling, Uganda aims to revive a basket fund for development partners and then establish a joint action fund to pool government and external resources for health to better align priorities and reduce inefficiencies. The Health Financing Strategy also aims to establish a national health insurance scheme. With regard to purchasing, Uganda's government plans to institutionalize results-based financing and revise the budget allocation formula to better reflect the health needs in each region according to burden of disease. The objectives for the strategy include rolling out a "social health protection system" and reaching 30% of people in Uganda by 2025. In general, the strategy aims to sustainably mobilize resources, allocate them equitably and effectively, and strengthen partnerships and policy.

PRIORITIZATION OF THE HEALTH SECTOR

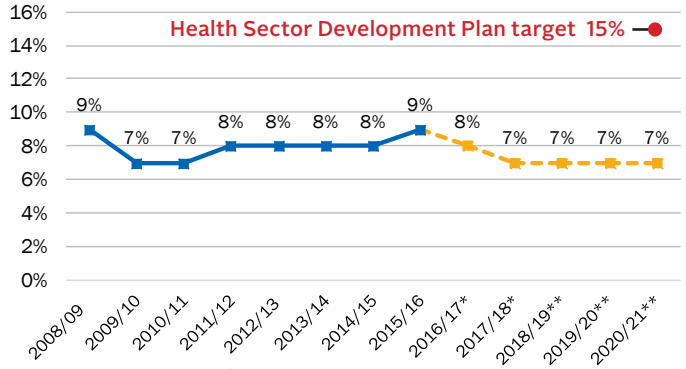
Significant government investment would be needed to reach Uganda's ambitious health sector goals. However, while Uganda's government expenditure on health has generally been increasing since 2010, it has been decreasing in terms of per capita spending. Overall, the NDPII is focused on agriculture, tourism, minerals, oil and gas development, infrastructure development, and human capital development. The health sector ranks fourth in terms of public NDPII projected costs or 11% (after works and transport, energy and mineral development, and education and sports). Based on the annual budget performance reports, the Government of Uganda spent 8% and 7% of its total expenditure on health in FYs 2016/17 and 2017/18, respectively, far behind its 15% goal (Figure 8). Similarly, needs per capita to fully fund the costed Health Sector Development Plan far exceed the trend in total health expenditure and government health expenditure

(Figure 9). While the government does not intend to fund the entire health sector, the gap between the need and what the government can support is wide (Figure 10). In 2017, the health sector ranked sixth (7%) in terms of total domestic government spending, behind works and transport (18%), education (16%), security (11%), justice, law, and order (9%), and public sector management (8%) (MOFPED, 2018b).[7] This is different from the NDPII cost projections for security (7%), justice, law, and order (5%), and public sector management (7%) in 2017. Based on the Midterm Expenditure Framework, health is expected to remain at about the same percentage of the government budget through 2020. Updated fiscal space projections suggest that the resource mobilization targets established in the NDPII and the Health Sector Development Plan are ambitious and likely unattainable.

KEY TAKEAWAYS: FISCAL SPACE FOR HEALTH

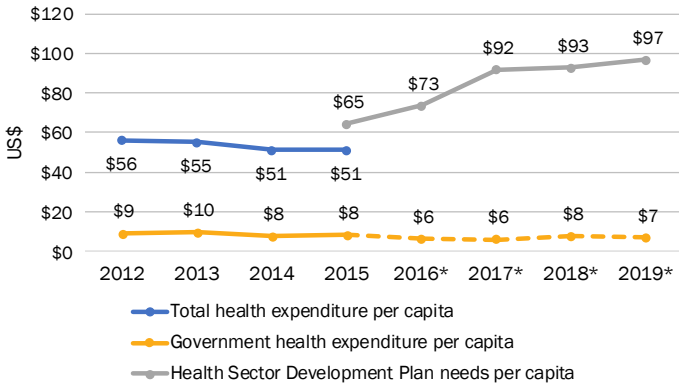
- The macro-fiscal environment is weakly conducive to mobilizing substantial domestic resources for health due to priorities in other sectors, high government debt, low tax capacity, and a growing population.
- While absolute resources allocated to the health sector by government are generally increasing, per capita government spending on health and health's share of the total government budget is decreasing.
- Based on projected government budgets for the health sector, health financing targets established in the NDPII and Health Sector Development Plan are ambitious and likely unattainable.

Figure 8. Domestic Government Health Expenditure as a Share of Total Domestic Government Expenditure



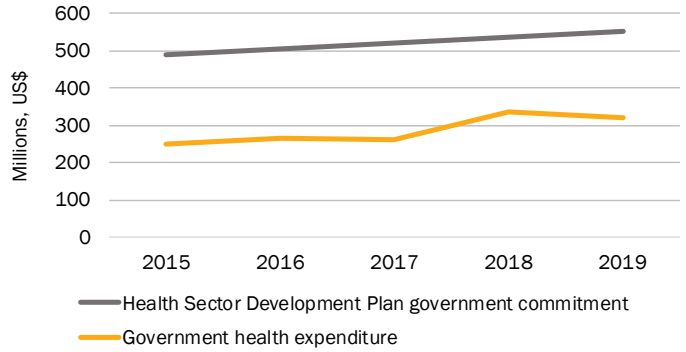
Sources: MOH, 2014 and 2016a
* Projections based on MOFPED, 2017 and 2018b
** Projections based on MOH, 2018a

Figure 9. Total Health Sector Development Plan per Capita Needs versus Actual per Capita



Sources: MOH, 2014 and 2016a
* Projections based on MOFPED, 2017, 2018a, and 2018b using World Bank exchange rates and United Nations World Population Prospects 2017

Figure 10. Government Commitment to Fund Health Sector Development Plan—Need versus Estimated Government Health Expenditure



Sources: MOFPED, 2017 and 2018b; MOH, 2016a; Republic of Uganda, 2015a

7 The government health sector includes the Health Service Commission, Kampala Capital City Authority, Ministry of Health, National Medical Stores, Uganda AIDS Commission, Uganda Blood Transfusion Service, Uganda Cancer Institute, Uganda Heart Institute, Uganda Virus Research Institute, 16 hospitals, and local governments' contribution to health (operations of lower-level health centers, etc.).

Getting More for the Money: Efficiency in Health Spending

Given the low prospects for increased government spending and unstable donor funding, it is even more important to improve efficiency in health spending. Table 4 provides data on key health spending indicators related to budget efficiency, allocative efficiency, and technical efficiency.

Table 4. Efficiency Indicators, FY 2017/18

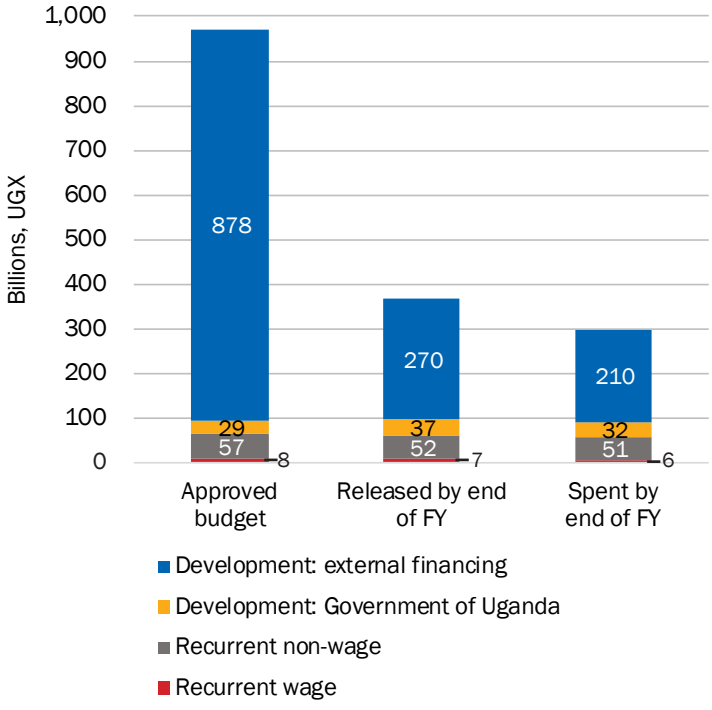
Indicator	Value
Budget Efficiency	
Health sector budget disbursement rate (Government of Uganda; external financing)	68% (106%; 30%)
Health sector budget execution rate (Government of Uganda; external financing)	93% (97%; 78%)
MOH budget disbursement rate (Government of Uganda; external financing)	38% (103%; 31%)
MOH budget execution rate (Government of Uganda; external financing)	82% (92%; 78%)
Uganda AIDS Commission budget disbursement rate	100%
Uganda AIDS Commission budget execution rate	98%
Allocative Efficiency	
Is burden of disease considered in MOH transfer formulas?	Yes
Is an epidemiological modeling tool used to make resource allocation decisions?	No
Health worker-to-population ratio	< 1/1,000 people
Percentage availability for a basket of 41 tracer medicines and supplies in the last three months (April–June 2017)	National Medical Stores: 54% Joint Medical Stores: 85%
Technical Efficiency	
Absenteeism rate	9%
Malaria test positivity rate	39%
TB treatment success rate	77%
TB case detection rate	56%
ART retention rate	76%
Accuracy of the health management information system report on stock-outs of tracer medicines	92%

Sources: MOFPED, 2018b; MOH, 2018c

BUDGET EFFICIENCY

Budget efficiency indicates the extent to which funds are allocated, released, and spent, on time and as planned. As shown in the FY 2017/18 budget performance report, the government has a 97% execution rate for the health sector—it is clearly able to release and spend public funds. However, only 30% of on-budget external financing to the health sector was released and only 78% of what was released was executed (Figure 11). This is consistent with previous year budgets as well. In addition, in 2017, only 31% of allocated on-budget external financing was released to the MOH and only 78% of those released funds were used, compared to 92% of public funds. This indicates a significant problem with the absorption of external funding and/or alignment of external funding with government priorities and needs. This could be due to external funding that arrived in quarter two of the fiscal year that did not fit within the MOH's cash limit for the quarter and was delayed in being spent.

Figure 11. Summary of MOH Allocation and Expenditure in FY 2017/18



Source: MOFPED, 2018b

ALLOCATIVE EFFICIENCY

Beyond how and if the budget is spent, allocative efficiency examines if funds are allocated appropriately based on priorities and needs. The MOH uses resource allocation formulas based on population and a standard unit of output (including antenatal care, family planning, child immunization, maternal mortality, and infant mortality). It also considers districts that are hard to reach and the contribution of other partners in the same area.

A lack of human resources for health in Uganda and delays in recruitment contribute to inefficiency. The health worker-to-population ratio is less than 1 health worker per 1,000 people, less than WHO's recommended 4.5 skilled health workers per 1,000 people needed to reach median universal health coverage of 80% (WHO, 2016). In addition, an average of only 57% of health facilities that reported had over 95% availability of a basket of 41 commodities (MOH, 2018c). Stock-outs remain a challenge, as was seen in FY 2017/18 for pediatric HIV treatment, TB drugs, and laboratory reagents and supplies. The National Medical Stores performed below the Joint Medical Stores, indicating a potential need to increase capacity of the National Medical Stores and strengthen the public sector supply chain. Key informants felt that while there are drug quantification challenges, the National Medical Stores' performance is also a result of a constrained resource envelope, which would indicate that the needs of the National Medical Stores should be re-examined.

As mentioned previously, coordination and alignment of external financing is a major concern for stakeholders. While there are evident challenges regarding government absorption of on-budget health financing, off-budget allocations are also challenging as they are difficult to predict, monitor, and align with government priorities and funding levels. This is an issue that needs to be addressed not only by the MOH, but also the MOFPED. Coordination mechanisms, such as development partner technical working groups, are in place for health and HIV. The latter met for the first time in March 2018 to align HIV, TB, and malaria funding. There is a need to institutionalize

coordination meetings and for development partners to be more engaged in the government budget development and review process. Key informants indicated that it would be helpful to develop and digitize a map of development partner resources to better track support across the country by source and intervention. The MOH spent UGX 210 billion from development partners (excluding off-budget contributions) in 2017, representing only 24% of the originally approved development partner budget and 70% of the total MOH budget. Given the sector's dependence on development partners to finance the health sector, it is imperative that the funding be aligned with government strategies and appropriately targeted to reach its goals.

In addition, Uganda is also in a unique situation as one of the largest hosts of refugees in Africa. The country hosts 1 million refugees, straining the health sector and diverting resources from development partners and the government (Okiror, 2018a). In FY 2017/18, vaccines were distributed to both Government of Uganda health facilities and to refugee communities, which resulted in shortages. Other general services are also affected, including at referral hospitals, such as Mubende, which receives referrals from Kyegegwa refugee camps. Uganda should integrate these challenges into their health financing strategy and universal health coverage roadmap to ensure sufficient allocation of resources.

TECHNICAL EFFICIENCY

Once resources are appropriately allocated, it is important that the resources are used effectively to avoid duplication or wastage and to maximize impact.

Drug Procurement

As mentioned previously, when possible, the government buys locally produced drugs, which are reported to be 35% more expensive than the prevailing international market price, while the U.S. Government uses their own, international suppliers. If development partners and the government used the same suppliers, the perception is that there would be additional buying power to negotiate better prices. However, the decision to invest in and purchase commodities from a domestic supplier should be carefully considered. The government should weigh the current procurement costs while considering sustainability and the financial implications if development partners decrease procurement demands over time, potentially causing a price increase due to lower volumes and more equipment than needed to meet demand.

There are also three different supply chains—the National Medical Stores, Joint Medical Stores, and U.S. Government—each of which comes with its own operating costs. There is an opportunity to strengthen the capacity of the National Medical Stores to be able to increase procurement and distribution, consolidate supply chains, and improve efficiency.

Malaria Testing

Uganda follows the test-treat-track policy, meaning health workers are supposed to test and diagnosis malaria for all patients (children and adults) before providing malaria-specific treatment, such as artemisinin-based combination therapies. In FY 2017/18, the test positivity rate decreased to 39% from 49% in FY 2016. The testing rate also decreased from 88% to only 57%. The treatment rate among people who received a negative malaria test increased; 40% of people who received a negative test were treated for malaria (up from 22% the previous year). Stakeholders indicate that this may be due to the fact that rapid diagnostic tests are expensive and not always available, and as a result, health workers are more likely to treat presumptively, resulting in over-treatment (MOH, 2018c).

Absenteeism of Healthcare Workers

Absenteeism and worker productivity were the most prominent health system concerns raised during a 2018 review of the MOH's last fiscal year's performance. A 2015 study revealed that 50% of health workers in the public sector did not show up for work or left early to collect dual pay at another facility (IntraHealth, 2017).

In 2016, as part of managing performance of health workers, the MOH, with support from the USAID-funded Strengthening Human Resources for Health activity, began to roll out a mechanism for attendance tracking and absenteeism management using automated attendance analysis, based on a human resources information system called iHRIS. By February 2018, the mechanism was rolled out to all districts. In March 2018, the absenteeism rate had dropped to 9%, however, stakeholders continue to be concerned as seen during the 2018 performance review (MOH, 2018c).

Attrition among health workers is also a challenge. One study estimated a 36% job vacancy rate in 2015 and, of facilities that reported they had lost a staff member in the last six months, 59% of those positions had not been refilled (HRH2030, 2018). The study also indicated that many health workers are poorly motivated, which may be a consequence of increased workloads due to staff shortages and ineffective staff recognition and reward systems. While iHRIS exists as a resource to help mitigate these challenges, given a lack of knowledge about this tool at the national level, additional roll-out, awareness, and capacity development are needed for long-term use and sustainability. The MOH is considering performance-based contracts to improve motivation for health workers to provide high-quality services, but this would require broad-scale reform of the legal framework behind government employee contracting because all employees are on permanent, pensionable contracts.

In addition, donors create a large wage differential when they hire healthcare workers at a higher salary than the government. This is demotivating for government workers and raises concerns about sustainability as donor-funded healthcare workers may choose to leave, reducing the institutional knowledge base, instead of transitioning to the government system at a lower wage. The Government of Uganda and development partners should coordinate to find a solution that motivates healthcare workers without creating a parallel pay structure.

KEY TAKEAWAYS: EFFICIENCY IN HEALTH SPENDING

- Improving efficiency is critical considering the limited fiscal space for new health resources.
- Budget disbursement of external funding is very low. Improved donor coordination with the government to better estimate available funding and align with government priorities should be a priority in order to use all available resources.
- Increasing the use of rapid diagnostic tests for malaria could prevent over-treatment of malaria and wastage of these essential medicines.
- Health worker absenteeism and performance is a concern; potential solutions, such as performance-based contracts, require careful consideration.

Mobilizing the Money: Understanding the Health Budget Process

Increasing domestic allocations to health at both the national and sub-national level will require sustained, effective, and targeted advocacy. A comprehensive understanding of the budget process is critical to be able to exploit key entry points and identify the appropriate audiences and timing of advocacy efforts. The following section describes the budget process and identifies key opportunities for advocacy.

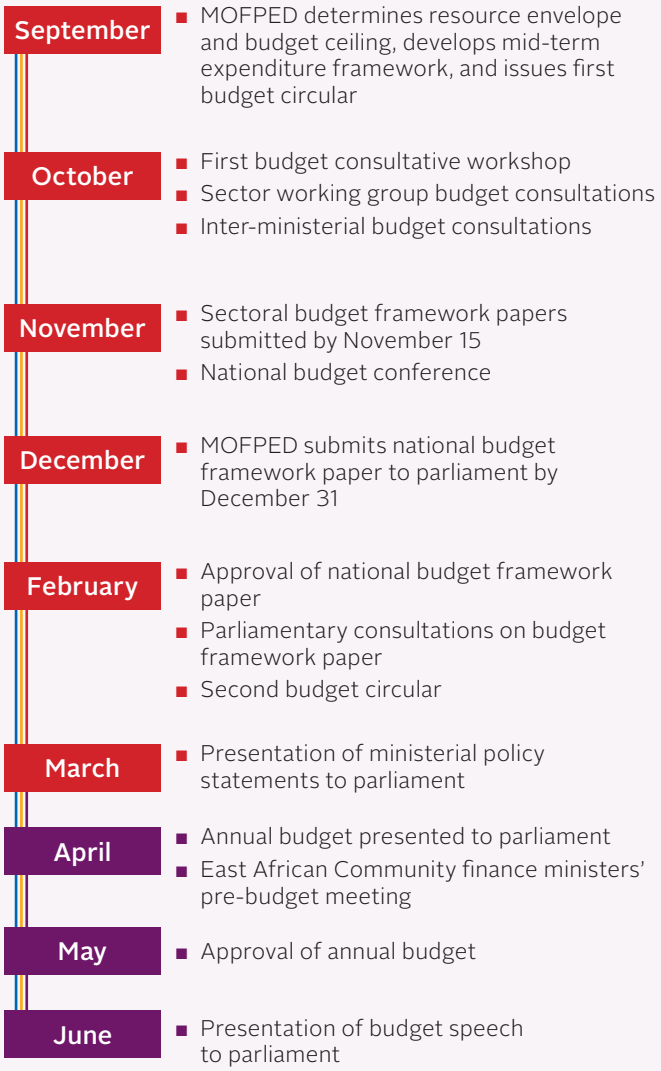
BUDGET PROCESS

The Ugandan budget process is conducted in a relatively open and transparent way. The budget process is undertaken by the MOFPED, sector working groups, line ministries and local governments, and the cabinet and parliament. The process, which starts in September and ends in June, consists of four main stages (Figures 12 and 13):

1. Budget preparation
   a. Determining the resource envelop
   b. Setting national priorities and sector ceilings
   c. Budget consultations (political and technical)
   d. Preparation of budget estimates
2. Presentation and approval of the budget
3. Budget execution
4. Budget monitoring and evaluation

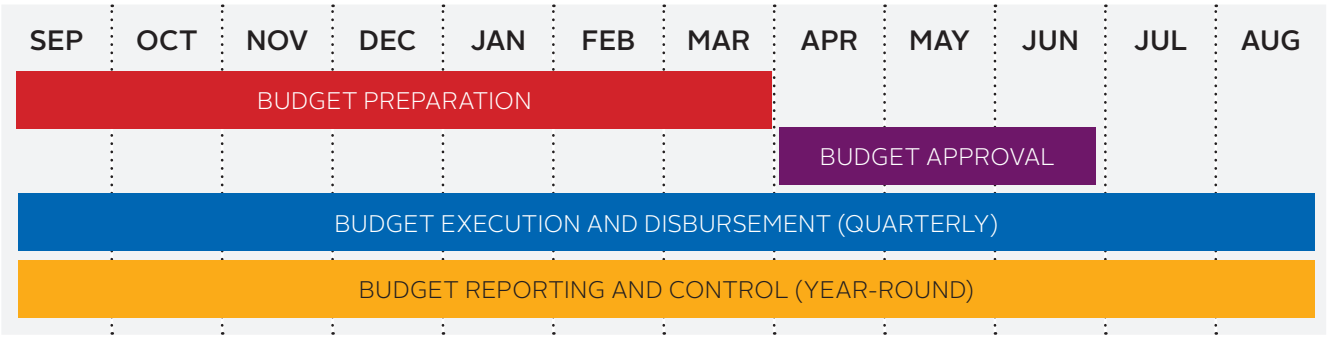
The following sections describe each stage of the budget process and are based primarily on the 2015 Public Financial Management Act and key informant interviews.

Figure 12. Budget Preparation and Approval Process



Sources: 2015 Public Financial Management Act; Civil Society Budget Advocacy Group, 2015

Figure 13. Overview of the Budget Process



Budget Preparation

In Uganda, the central and local budget development processes are integrated. The MOFPED at the central level leads the budget process by first determining the overall government resource envelop available for the year. The budget resource envelop is derived from projected domestic revenues, external financing, and non-bank savings, minus any debt the government has incurred. Based on the resource envelop, the MOFPED establishes the initial draft budget allocation for each sector using major expenditure drivers. The allocation is also based on political priorities that affect poverty and growth, the ruling party manifesto, and constraints faced during implementation (Republic of Uganda, 2016a). The sector budget ceilings are then set using the current financial year budget as a base, considering the latest budget execution rate, subtracting all one-off expenditures taken the previous year, and projecting additional resources available beyond the current year's resource envelop that can be allocated to priorities. The MOFPED then develops the mid-term expenditure framework (MTEF), which details the sector budget ceilings, and presents it to the cabinet in an annual retreat in September or October. The retreat guides the budget strategy and priorities for the next year, the indicative medium-term fiscal framework and MTEF, and discussion on budget implementation challenges.

When the cabinet approves the budget strategy and priorities, the agreed-upon MTEF is shared with the sectors in the first budget circular. The circular communicates the budget strategy, priorities, and sector ceiling to inform the sector's development of its budget framework papers. Budget framework papers are developed at the central and local level. At the local level, the local government holds a series of consultative workshops to disseminate central and local government priorities, share central-level budget figures, and identify and discuss policy issues that will affect operations. Each district and municipal local government then prepares a local government budget framework paper aligned with their consultations and local government development plans. The local government budget framework paper is submitted to the MOFPED by November 15 to inform the national budget framework paper.

BOX 7. EFFICIENCY OPPORTUNITY

The sector-wide approach to planning and budgeting provides the opportunity to align the budget with strategic plans and sector investment plans. In a constrained resource environment, sector coordination allows for prioritization and targeted investments to improve efficiency and increase value for money.

At the central level, cabinet ministers, members of parliament, technical officials from central agencies, local government officials, development partners, and civil society and private sector organizations participate in the first budget consultative workshop. As with the consultations at the local level, the purpose is to communicate and solicit feedback on the budget strategy and priorities, the MTEF, and the guidelines for budget development.

After the first budget consultative workshop at the central level, there are a series of additional consultations to eventually agree on a budget framework paper. The consultative process includes sector-wide working group consultations to encourage coordination in the planning process (Box 7). The sector working groups are comprised of representatives from ministries involved in the sector, the MOFPED, and representatives from civil society, the private sector, and development partners. Health is included in the social sector along with the Ministry of Water and Environment and Ministry of Education. Afterwards, consultations are held between the sector ministers and the MOFPED minister to prepare the sector budget framework paper. The MOFPED compiles and consolidates the sector budget framework paper and the local government budget framework papers into a national budget framework paper that highlights the government's macroeconomic policies, performance, and future plans, and the government's priorities on how

resources have been allocated to achieve national objectives. The MOFPED, with approval from the cabinet, submits the national budget framework paper to parliament by December 31. The MOFPED also issues a certificate, in consultation with the equal opportunities commission, certifying that the budget framework paper is equitable and provides equal opportunities for people of all genders, those with disabilities, and marginalized groups. Parliament must review and approve the budget framework paper by February 1.

After the national budget framework paper is approved, the MOFPED releases the second budget circular with the revised strategy and budget ceilings. Each ministry, agency, and local government then sets its priorities and determines the budget for each program. Ministry, agency, or local government department heads work with their teams to cost their activities for the next fiscal year, based on their strategic plans, and submits the budget to the central level to be consolidated into the annual budget.

Ministries also prepare ministerial policy statements that provide detailed information on how each ministry plans to spend its allocated funds and intended results. The document is used by parliament to review the budget and align priorities.

Budget Approval

The MOFPED submits a draft of the national budget framework paper to the cabinet for approval. After approval, the MOFPED submits it to parliament. According to the Public Financial Management Act, the proposed annual budget must be submitted to parliament by April 1, after which there is a series of consultations between the budget committee, sectoral parliamentary committees, and line ministries. There is a parliamentary committee for the social sector (which includes health) and a standalone committee on health. After the consultations, parliament approves the annual budget by May 31.

Once endorsed, the MOFPED presents the budget speech to parliament on June 15, a set date in which member countries of the East African Community agreed to present their budgets. The budget speech is publicized and made available in print media for the public. The budget is effective July 1 of each year.

Budget Execution and Disbursement

Once parliament approves the annual budget, line ministries, agencies, and local governments are entitled to spend their allocated budget. At this point, the MOFPED requests that the auditor general issue block grants from the consolidated fund to the MOFPED so it can distribute funds as needed. The government makes allocations based on expected revenue, however sometimes the projections are off, causing cash flow shortages, which may restrict the Government of Uganda's ability to release timely budget allocations. Given a shortage of funds, other sectors such as infrastructure and security may be prioritized over social sectors.

At both the national and local level, funds are released each quarter. The MOFPED issues quarterly expenditure limits based on quarterly and annual workplans and available resources. This means that each of the ministries is limited by what they can spend each quarter. Local government development grants, however, are released in full by quarter three to avoid unspent balances at the end of the fiscal year. Upon receipt of the quarterly limits, each ministry, agency, and local government's financial committee convenes, and the accounting officer submits a request to the MOFPED for the warranting of funds for the quarter.

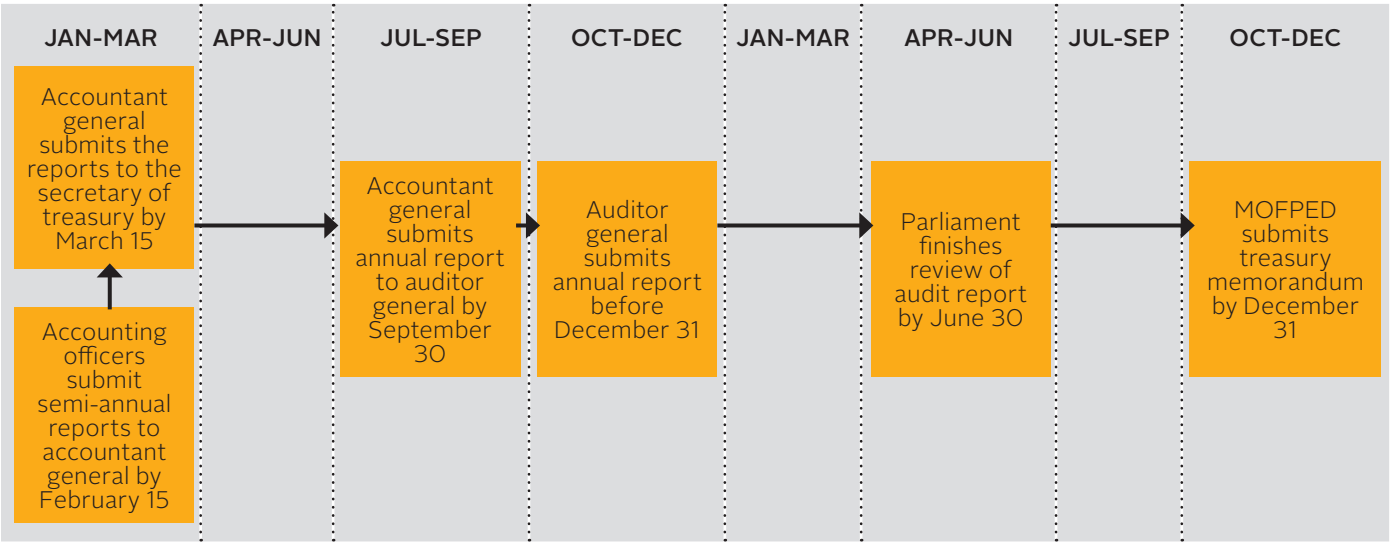
An accounting officer may reallocate funds within the same ministry/agency as long as it does not exceed 10% of the activity/line item. Parliament must authorize by resolution any reallocation of funds between ministries/agencies. Ministries, agencies, and local governments can reallocate funds within budget lines in the same expenditure category with the approval of the accounting officer. However, government entities cannot reallocate funds from different expenditure categories (e.g., recurrent and development/capital) without approval from the secretary of treasury. Reallocation of salaries requires approval from the Ministry of Public Service.

It is also possible for ministries, agencies, and local governments to receive supplementary budget allocations if there is a demonstrated need. Each year, a contingency fund is replenished with 3.5% of the approved government budget—85% is reserved for supplementary budget appropriations and 15% is reserved for natural disasters. The minister of health (or minister of any line ministry) may request financing from the contingency fund in writing from the MOFPED. The MOFPED minister can authorize release of supplementary funds for up to 3% of the approved budget. To request additional funding above 3%, the MOFPED may submit a supplementary appropriation bill to parliament when there is an explicit need. Finally, parliament may invalidate a withdrawal if there is belief that proper regulations were not followed.

Budget Monitoring and Evaluation

The Government of Uganda budget process is based on transparency and accountability and Uganda has put measures in place to ensure timely monitoring and reporting. Every ministry has an internal auditor, who develops a report on the financial management of the funds every three months. The report is submitted to the accounting officer, the audit committee, and the secretary of the treasury. At the end of the fiscal year, the secretary of the treasury consolidates the reports into an annual report for each ministry. In addition, every three months, an accounting officer in each ministry, local government, and agency prepares a report on the activities and budget execution and submits it to the secretary of the treasury. An accounting officer also develops a semi-annual financial report and submits it to the accountant general by February 15 each year. The accountant general then consolidates the reports and submits them to the secretary of the treasury by March 15. At the end of the fiscal year (June 30), the accounting officer compiles annual financial statements from all entities and submits them to the accountant general who then submits it to the auditor general by September 30. The auditor general reviews the reports and submits an audit report to parliament by December 31. Parliament reviews and discusses the auditor's comments and provides feedback and recommendations by June 30. Lastly, the MOFPED submits a treasury memorandum, which provides an update on actions taken based on recommendations from parliament by December 31 (Figure 14).

Figure 14. Summary of Budget Monitoring and Evaluation Process



KEY TAKEAWAYS: OPPORTUNITIES FOR ADVOCACY IN THE BUDGET PROCESS

The budget process allows several opportunities for the ministries, civil society, and partners to advocate to increase or better target resource allocations. The following are some of the main advocacy opportunities:

1. **Participate in national and local budget consultative workshops**: This is the main opportunity to influence the national and local budget framework papers by providing arguments to prioritize the health sector and/or specific sub-programs.
2. **Engage parliamentary committees**: Once the budget framework papers are prepared, they are reviewed and discussed by each of the relevant parliamentary committees. Stakeholders should engage with the health parliamentary committee (and relevant sub-committees, such as for HIV) to discuss the budget framework papers. In the health sector, the main committees are the committee on HIV/AIDS and related matters and the committee on health.
3. **Participate in inter-ministerial budget consultations**: This is an opportunity to engage other ministries on the health budget and to coordinate programming and support for the health sector through their allocated budgets.
4. **Engage ministry leadership and parliament on ministerial policy statements**: These statements provide the link between the ministry's strategic priorities and the budget. Engaging ministry leadership and parliament on these statements provides an opportunity to adjust budget allocations.
5. **Engage parliamentary budget and finance committees**: This is the last opportunity before final approval of the budget to influence decision-makers.

As previously mentioned, it is possible for ministries to receive supplemental budgets, but stakeholders must clearly demonstrate the need, cost-effectiveness, and impact of the intervention to the MOFPED for it to be considered. It is also important to show the intervention's alignment and impact on other government priorities such as economic growth. In addition, the MOFPED will consider the sector and program's ability to effectively execute its allocated budget. The health sector is unlikely to receive additional funding if it was unable to spend its previous year's allocation. Therefore, it's essential to identify and address budget execution and performance bottlenecks and/or clearly articulate the reasons behind lack of effective execution.

The National TB and Leprosy Program, for example, has been taking several steps to engage in the budget process. The program engages civil society to create an orientation package on TB, which is shared with parliament and the MOFPED. Tuberculosis stakeholders are participating in the national budget meeting for the health sector and district-level budget meetings, and provide input on the national and local budget framework papers. The malaria program is also active in sector-wide planning and coordinates with other sectors to add malaria-related interventions—such as malaria prevention education in schools—to other ministries' budgets.

The budget process offers entry points for influencing the budget, but advocacy for domestic resource mobilization and increased efficiency goes beyond the budget process. Uganda lacks an evidence base to inform high-level decision making on health financing efforts, such as earmarking funds for health or a particular disease area. A better evidence base would allow stakeholders, including the MOH and its vertical programs, civil society, and development partners, to effectively advocate throughout the year in line with the budget process and during strategic planning sessions for increased resource mobilization.

Conclusion

Uganda's economy is growing but there is limited fiscal space to mobilize significant resources for the health sector. The Government of Uganda has set ambitious targets for economic growth and health spending, which will be not be reached by 2020 based on government budget prospects. Government contribution per capita to the health sector is on the decline; with other competing political priorities, high debt, and low tax capacity, it is unlikely to increase significantly in coming years. While there is strong political will driving high-level discussions regarding domestic resource mobilization options, none are fully established or operational, and additional data and consultation is required before launching them. A national health insurance scheme is a long-term solution that has the potential to greatly change how Uganda finances healthcare, but it will take years to establish and scale-up. Less than 3% of the population is currently covered by any prepayment mechanism for health and almost half of the population that seeks care does so at a private health center or hospital, despite higher costs. This points to opportunities to strengthen the private sector to leverage government initiatives and increase access to care.

While mobilizing additional resources for health may be challenging for the Government of Uganda, there are opportunities to improve inefficiencies in the system as a way of expanding the resources available for health. The low density of skilled human resources for health, as well as continued issues with absenteeism and productivity, could be improved through systemic changes to examine and improve the distribution of health workers and the introduction of performance-based and other accountability mechanisms to incentivize workers. In addition, the government has struggled to coordinate with development partners, resulting in a low budget execution rate of external resources. Improved coordination and alignment of strategic plans and resources could improve the release of funds, allowing the government the opportunity to spend the entirety of its allocated resources.

As the MOH develops the universal health coverage roadmap and gathers evidence on the potential impact of various health financing approaches, such as the HIV and AIDS Trust Fund, the government (especially the MOFPED), development partners, and civil society should be engaged and agree on a multi-sectoral strategy to fund health, considering fiscal and political limitations. The roadmap should consider:

- Investing in the development and implementation of the national health insurance scheme, including analyses needed to inform inclusion of the informal sector and indigents
- Creating synergies between vertical funding initiatives such as the HIV and AIDS Trust Fund and malaria fund to support a holistic health financing strategy
- Increasing coordination with the private sector and leveraging private providers to advance common goals
- Increasing coordination with development partners to improve the low budget execution rate of externally sourced government financing and ensure allocation to common priorities
- Strengthening the National Medical Stores to ensure availability of tracer medicines and supplies
- Increasing qualified human resources for health and implementing performance-based strategies to improve performance and retention

Even with engagement from the MOFPED, implementation of the universal health coverage roadmap will require advocacy efforts toward the MOFPED, parliament, and other high-level

decision-makers. The Uganda budget process offers several entry points for advocacy during budget consultations. Health sector stakeholders should take full advantage of the opportunity to present the sector's needs and potential return on investment during the budget process. Advocacy should focus on three main areas:

- Sensitizing decision-makers to the status of health sector funding and reliance on external financing
- Using data and analytical projections to demonstrate the need for additional resources and reforms to ensure sustainability as well as show how additional resources will be used effectively
- Justifying these asks with evidence of health and economic impact, not only on morbidity and mortality, but on the demographic dividend, economic growth, and other sectors, particularly those prioritized in the government budget and national development plan (infrastructure, energy, tourism, security, and education)

The pathway to sustainable financing for health in Uganda will require a multi-pronged approach and multi-sectoral coordination and collaboration. With sustained political will, government leadership, and engagement of the private sector, civil society, and development partners, the country can make strides toward a transition from donor reliance to a sustainable future.

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