



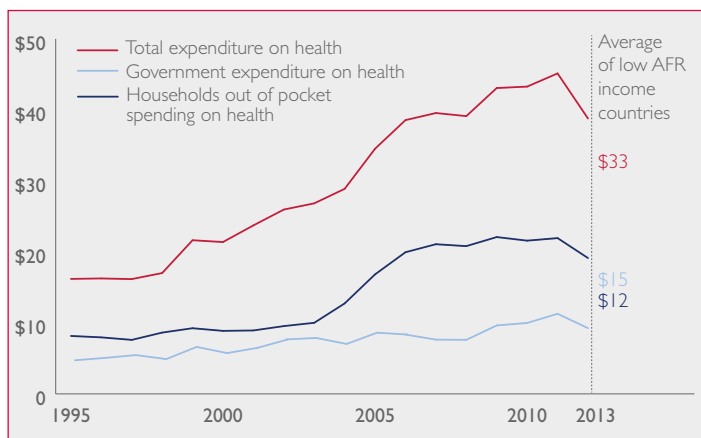
HEALTH FINANCING PROFILE: UGANDA

Key country indicators

Development indicators*	
Total population	37,579,000
Total fertility rate (births per woman)	5.9
Gross national income per capita (PPP)	\$1,370
Health care expenditure indicators**	
Expenditure ratio	
Total expenditure on health as % of GDP	8.0% ↑ avg. low-income countries (5%) ↓ global avg. (9.2%)
Level of expenditures	
General government expenditure on health as % of total government expenditure	10.2% ↓ targets set by Abuja Declaration (15%)
Selected per capita indicators	
Per capita total expenditure on health (PPP int.\$)	108
Per capita government expenditure on health at average exchange rate (US\$)	10 ↓ targets set in Health Sector Strategic Investment Plan (\$17)
Per capita government expenditure on health (PPP int.\$)	26
Sources of funds	
General government expenditure on health as % of total expenditure on health	23.9%
Private expenditure on health as % of total expenditure on health	76.1%
External resources for health as % of total expenditure on health	28.6%
Out-of-pocket expenditures as % of private expenditure on health	64.8%

Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents

Per capita expenditure in US\$ (constant 2013 US\$)**



*World Health Organization (WHO) Global Health Observatory, 2013

**WHO Global Health Expenditure Database, 2013

Contextual Factors

The health service delivery system in Uganda is decentralized, with districts and sub-districts playing a key role in the provision of health care. The private sector also plays a large role in the provision of services through private not-for-profit organizations and practitioners. Public health facilities account for more than half (55%) of all 5,200 facilities in Uganda, while private-not-for-profit and private-for-profit facilities account for 17% and 29% respectively.¹ While 85% of the population resides in rural areas and mostly utilizes public facilities, providers are inequitably concentrated in urban areas and health workers in rural areas.²

The approach of the Government of Uganda (GoU) to national planning for health has evolved over the last decade. Reforms to the country's public expenditure management have resulted in new institutional arrangements for planning and budgeting, including: sector-wide approaches (SWAs), the medium-term expenditure framework (MTEF), the Poverty Action Fund (PAF), the fiscal decentralization process, and the National Development Plan (NDP). The NDP provides a national medium-term planning framework.

The capacity of the GoU to finance desired programs in health, without detriment to its financial sustainability, can be increased through the prioritization of health over other sectors. Increasing this fiscal space for health depends on various pillars, including the following³:

- **Conducive macroeconomic conditions:** Uganda's economy has grown strongly over the last seven years. Projections show that after a lull through 2013-14, growth is expected to resume at 7% per year.⁴
- **Health sector-specific sources of revenue:** Out-of-pocket spending maintains a dominant share of private health spending despite the abolition of user fees at public health facilities in 2001. Accessing pooled sources of revenue, such as insurance, is critical.
- **Re-prioritizing health within the government budget:** Although funds allocated to the health sector steadily increased to UGX 735 billion in FY 2009/10, these were not enough to fund delivery of the Uganda National Minimum Health Care Package, estimated at over US\$47.9 per capita.⁵ Benchmarking for reprioritization and earmarking of funds is essential.
- **Development assistance for health:** With nearly 30% of financing for health from external resources, Uganda is vulnerable to fluctuations in donor financing patterns. A changing relationship with the donor community has indicated a decline in the importance of aid to the national economy. Diversifying external sources of financing is critical.
- **Increasing efficiency for health outlays:** Increased efficiency of health spending and reduced waste can be achieved through better geographic targeting of government health expenditures

and more effective purchasing and public financial management. Improvements to revenue forecasting and budget formulation systems can also improve the efficient use of resources for health.

Health Financing Functions

■ **Revenue contribution and collection:** Revenue collected through the public sector is limited. There is no specific tax earmarked for the health sector, and tax revenue includes direct and indirect taxes, both of which are minimal.

A large amount of external donor support is channeled through the national budget or through planned expenditures for the Ministry of Health (MoH). High amounts of donor funding are also allocated towards off-budget activities, which are over and above the Medium-term Expenditure Framework ceilings. In FY 2008/09, off-budget funding constituted US\$440 million, while the overall health budget stood at US\$628 million.⁶

A significant share of health financing is through private households, primarily in the form of out-of-pocket payments. The absence of adequate health insurance arrangements is an obstacle towards ensuring access to needed health care and leaves households at risk of catastrophic out-of-pocket payments in the event of illness.

Existing community health insurance schemes cover a very small proportion of the population (almost 1%) and suffer from sustainability issues due to high drop-out rates. Such schemes contribute a negligible share of health financing resources.

■ **Pooling:** To address equity and financial sustainability of health financing, the GoU is preparing to implement National Health Insurance in order to pool and redistribute funds to spread the financial risk of illness across populations. The scheme will require both the employee and the employer each to contribute 4% of the employee's salary and will not require any co-payments. Currently, however, there are a limited number of social protection schemes in Uganda.⁷

There are over 15 community-based health insurance schemes in Uganda coordinated by the Uganda Community Based Health Financing Association and overseen by the MoH. Private commercial health insurance arrangements exist but contribute less than 1% to the total health expenditure. Private health insurance coverage is limited (less than 1%) due to high premiums and is typically confined to health maintenance organizations (HMOs) targeting mainly formal sector workers and private individuals.⁸

■ **Purchasing:** Uganda's health system has multiple purchasers including the public sector (the MoH and local government authorities) and the private sector (households, non-governmental organizations and health insurers).

The MoH is both a provider and purchaser of health care services. Individual health care workers are paid for their services using fixed salaries, and health facilities are given funding through historical budgets estimated using a resource allocation formula

based on several factors such as the size of the population served. Funding for health facilities is not performance-based; payments are made on a fee-for-service basis, resulting in high out-of-pocket payments.

Meeting the Goals of Universal Health Coverage (UHC)

UHC can only be achieved when access to health services and financial risk protection are equitably addressed. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.

Financial protection

As many as 20% of Ugandan households incurred catastrophic health expenditures in 2009-10.¹ These were concentrated among the poor, for whom even small out-of-pocket payments are likely to cause impoverishment.

In 2010, 66% of the population in Uganda lived below the poverty line of US\$2.50.¹ When out-of-pocket expenditures on health care are taken into account, an additional 4% of the population was impoverished, translating into as many as 1.5 million Ugandans.

Equity in financing and utilization

An assessment of direct and indirect taxes in Uganda indicates that these mechanisms are progressive means of raising revenue, but there are certain regressive taxes.¹ Private financing, on the other hand, is dominated by out-of-pocket payments, and negatively influences the equitable financing.

A comparison of aggregate health care benefits with need across different socio-economic quintiles reveals that while the poorest quintile has the highest level of need (22.8%), it has the lowest level of benefit (17.9%).¹ The converse is true for the richest quintile. Such inequity in access to and use of health services may be addressed through a re-evaluation of the health financing functions in Uganda.

Endnotes

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8. Basaza, R, Pariyo, G. & Criel, B., [What are the emerging features of community health insurance schemes in East Africa?](#). Dove Medical Press Ltd, Volume 2, pp. 47-53. (2009)

Additional information can be obtained from:

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