POLICY BRIEF

Strategic Health Purchasing in Uganda

A Summary of Progress, Challenges, and Opportunities

MAY 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

UGANDA AT A GLANCE

- Population (2019): **44.3 million**
- GDP per capita (2019): **US$794**
- Poverty headcount at $1.90/day (2016): **42%**
- Life expectancy (2018): **63 years**
- Current health expenditure (CHE) per capita (2018): **US$43**
- Domestic government expenditure as % of CHE (2018): **16%**
- Out-of-pocket expenditure as % of CHE (2018): **38%**
- External expenditure as % of CHE (2018): **43%**

Source: World Bank Databank

Health Financing Schemes in Uganda

Uganda is a low-income country committed to accelerating progress toward achieving universal health coverage (UHC) by 2030, as documented in the Uganda Health Sector Development Plan and Uganda's health financing strategy (2015–2024). This commitment to UHC aims to ensure that every individual will be able to access quality health services that they need without suffering any financial hardship.

Uganda has three main types of health financing schemes:

- **GOVERNMENT BUDGET FINANCING AT THE NATIONAL AND SUBNATIONAL LEVELS.** All Ugandans are guaranteed access to free basic health care at public facilities, as defined in the Uganda National Minimum Health Care Package (UNMHCP). The government also provides subsidies to private not-for-profit facilities, mainly to support provision of essential services such as immunization.
- **PERFORMANCE-BASED FINANCING (PBF).** After more than a decade of experimentation with donor-funded PBF pilot projects, the government launched the Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHIP) in 2017 to improve the provision of maternal, newborn, and child health services, with funding from the World Bank and the Global Financing Facility (GFF). As of 2020, URMCHIP covered more than 120 of Uganda's 135 districts, representing more than 95% of the population.
- **OTHER DONOR-FUNDED PROJECTS.** Uganda has dozens of health-sector projects funded by external donors, most of them United Nations agencies. Project focus areas include HIV/AIDS, malaria, tuberculosis (TB), maternal and newborn health, reproductive services, and community-level health care.

Uganda has aspirations to create a national health insurance scheme to advance the country's UHC goals. Parliament passed the legislation in April 2021, and it is currently awaiting presidential approval to become law. The country has private and community health insurance schemes, but they cover less than 1% of the population and contribute less than 2% of current health expenditure.

Table 1 compares the purchasing functions in the three main types of financing schemes in Uganda.

Table 1. **Purchasing Functions in Uganda's Health Financing Schemes**

	Government Budget Financing at the National and Subnational Levels	Performance-Based Financing (PBF)	Other Donor-Funded Projects
% of Total Health Expenditure (2015/16)*	15.1%	41.7%	
Main Purchaser(s)	Ministry of Finance, Planning and Economic Development (MoFPED)	Ministry of Health (MOH), funded by the World Bank and GFF	Individual donors
Governance	MoFPED allocates resources to MOH, national medical stores, and local governments (LGs). LGs provide health services using central government allocation, locally generated resources, and/or donor support. Public facilities have limited autonomy to allocate funds, according to MoFPED public financial management guidelines for the use of public funds.	MOH receives donor funds and transfers them to facilities based on achievement of targets. Facilities have some autonomy over how to use these funds. PBF guidelines prescribe rules for use of PBF funds.	Multiple donors based in specific regions provide in-kind support to facilities. Some transfer funds to providers, with rigid controls on how funds can be used and granting limited autonomy. Donors specify guidelines for the use of funds.
Financial Management	The annual budget is based on MoFPED's Budget Framework Paper, Medium Term Expenditure Framework, and historical expenditures and is approved by Parliament. Budget overruns are corrected by supplementary budgets approved by Parliament. Deficits are not carried over into the next year.	The annual budget is based on projected utilization of reproductive, maternal, newborn, child, and adolescent health services. Budget overruns are not allowed.	The annual budget is based on previous expenditure and on budget ceilings. Budget overruns are not allowed.
Benefits Specification	In the UNMHCP, a broad range of primary health care (PHC) and hospital care interventions provided free to all	Reproductive, maternal, newborn, child, and adolescent health services	Health services specific to the disease area or population (e.g., HIV, TB, malaria, etc.)
Contracting Arrangements	Loose arrangements with public providers; memorandums of understanding (MOUs) with private not-for-profit providers	Selective contracting with public and private not-for-profit providers that meet accreditation criteria	Contracting with local and global nongovernmental organizations and private providers
Provider Payment	Line-item budgeting, PHC grants with allocation formulas based on catchment population attributes and administrative roles	Fee-for-service and performance bonuses	Mix of results-based and input-based line-item budgets
Performance Monitoring	Monthly and quarterly facility activity reporting on DHIS2 and annual sectorwide performance reports; supervision by MOH and local governments	Monthly facility activity reporting; routine verification of quantity of services; annual independent external verification	Monthly facility activity reporting on DHIS2; donor-specific and disease-specific monitoring, mostly not aligned with national systems

** National Health Accounts 2015/16*

Progress and Challenges in Strategic Health Purchasing

Some progress toward strategic purchasing has been made across all purchasing functions in Uganda, with the most progress seen in the PBF schemes. Uganda has also made progress in transitioning national-level input-based budgeting to program-based budgeting, which links resources to outputs and achievement of national development goals. These budgeting processes have also been cascaded to local governments and linked to accountability measures.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. Institutional roles and responsibilities for purchasing are clear, although there are some overlaps. Autonomy of public facilities is limited by public financial management rules, but facilities have some autonomy over the use of PBF funds. Under the national policy on decentralization, local governments have a mandate to deliver health services under the policy direction of the MOH. The National PBF framework guides PBF implementation in the country. The MOH oversees PBF activities, and the PBF unit within the MOH is the purchaser.

FINANCIAL MANAGEMENT. A defined process is used to set the purchaser's budget and mechanisms for tracking budget execution and spending in all of the financing schemes, and it is enforced to some degree. But budget overruns do occur in the government budget–financed schemes. These overruns are managed through additional allocations in supplementary budgets. PBF and other donor-funded projects generally have fixed annual budgets, and overruns rarely occur.

BENEFITS SPECIFICATION. Benefit packages across schemes reflect Uganda's health priorities, but there are overlaps and duplication. The UNMHCP is a broad benefit package to be provided by public and private facilities to all Ugandans without copayments. However, informal payments have been reported. The MOH has developed service delivery guidelines for most services in the UNMHCP, but they are not effectively applied in contracting.

PBF benefits are focused on reproductive, maternal, newborn, child, and adolescent health services to reduce Uganda's child and maternal mortality rates. Other donor-funded projects subsidize benefits, which vary by project but generally address conditions that contribute most to the burden of diseases, such as HIV/AIDS, malaria, and TB. Assigning donors to specific regions has helped reduce duplication of efforts in some regions of the country.

CONTRACTING ARRANGEMENTS. Contracting arrangements are most formalized in the PBF scheme, and the MOH and local governments are using more formal mechanisms—including memorandums of understanding (MOUs)—with private providers. MOUs that local governments and the MOH sign with private not-for-profit facilities specify inputs to be provided by the government and expectations that providers will reduce user fees and report through the national health management information system (HMIS). PBF selectively contracts with both public and private not-for-profit facilities, and the contracts clearly define performance indicators and deliverables, as well as verification processes and expected payment for outputs.

PROVIDER PAYMENT. Resource allocation and provider payment in the government budget–financed schemes reflect population health needs, and PBF payment is linked to services delivered. Government budget resources generally flow from the central government to local governments in the form of both conditional and nonconditional grants. Local governments then allocate funds to public facilities, taking into account geographic location and remoteness. Under PBF, facilities are paid based on a formula that accounts for the quantity and quality of services provided. Payment rates are set annually, and funds are disbursed based on performance and achievement of indicators set out in the contract.

PERFORMANCE MONITORING. Facility-level performance monitoring is part of the government budget–financed and PBF schemes, but performance information is not used to inform broader purchasing policy. All public and private facilities are expected to report facility activity using MOH registers. However, the quality and accuracy of reporting varies widely. Local governments are financially accountable to the Ministry of Finance, Planning and Economic Development and report performance data to the MOH. District health management teams verify PBF service outputs using HMIS tools. In addition to the national facility activity reporting, donors usually require regular performance reports, which are often supplemented with site visits.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the three main types of schemes in Uganda. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Uganda**

Purchasing Function	Indicators of Strategic Purchasing	Government Budget–Financed Schemes	PBF	Other Donor-Funded Schemes
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	○	●●	○
	Providers have autonomy in managerial and financial decision-making and are held accountable.	●●	●●●	○
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	●●	●●●	●●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	○	●●	○
	The purchasing agency further defines service delivery standards when contracting with providers.	○	●●●	●●
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	○	●●●	●●
	Selective contracting specifies service quality standards.	○	●●●	●●
Provider Payment	Provider payment systems are linked to health system objectives.	○	●●	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	●●	○
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	●●	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	●●	○

The power of strategic purchasing is limited in Uganda because of the small share of total health spending that flows through strategic purchasing mechanisms. Public financing remains the most feasible option for expanding UHC, but low public spending on health (16% of current health expenditure, or CHE) contributes to high household expenditure on health (40% of CHE) and hinders strategic purchasing efforts. The high level of fragmentation and low proportion of funds that flow through the public schemes reduce leverage to improve purchasing functions and provide adequate incentives to providers. Fragmented project-based programs offer less comprehensive benefits than the UNMHCP and create overlaps in coverage in their target geographies or beneficiary types, leading to duplicative efforts and inefficiencies. Incentives to providers who are paid salaries as direct deposits from the national level are weak. Absenteeism and neglect of duty are not uncommon.

Opportunities to Improve Health Purchasing

Advancing progress on strategic health purchasing in Uganda requires reducing out-of-pocket payments through better pooling of funds and consolidating across all funders, including the government and donors, to create "basket funding" that can increase strategic purchasing power. The MOH can generate evidence and expand advocacy efforts to increase public resources for health and support health-sector reforms that will facilitate strategic purchasing.

Further, the government can take the lead in aligning government and donor-funded benefit packages to expand coverage of essential services and ensure more equitable access to services for all Ugandans. Uganda may consider giving local governments and facilities more flexibility in how they can spend funds, while strengthening transparency and accountability for purchasing at the district and national levels.

The MOH could improve strategic purchasing capacity by strengthening the HMIS to support verification of provider outputs and performance management activities systemwide, including to help the PBF scheme reduce verification costs. Strengthening performance management at the national and local levels and coupling that with appropriate incentives that promote high-quality and efficient service delivery will foster an organizational culture that promotes quality and efficient service delivery.

SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Uganda—Makerere University School of Public Health—will validate the SPARC findings with Ugandan stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Uganda.

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STRATEGIC PURCHASING AFRICA RESOURCE CENTER

RESULTS FOR DEVELOPMENT

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.