REPUBLIC OF UGANDA
MINISTRY OF HEALTH

FEASIBILITY OF INCREASING FISCAL SPACE FOR HEALTH IN UGANDA

April 2025

WORLD BANK GROUP
Health, Nutrition & Population

GLOBAL FINANCING FACILITY

1818 H Street NW, Washington DC 20433
Telephone: 202-473-1000; Internet: www.worldbank.org

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Collins Chansa
Rogers Ayiko
Sven Engels
Charlotte Muheki
Sarah Byakika
Aliyi Walimbwa
Elizabeth Mabel Asege Ekochu
Julia Mensah
Brendan Michael Hayes
Grace Murindwa
Anne Musuva
Angellah Nakyanzi

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ACRONYMS

CHE	Current Health Expenditures
DAH	Development Assistance for Health
GAVI	Global Alliance for Vaccines and Immunizations
GOU	Government of Uganda
HIPC	Highly Indebted Poor Country
IHP+	International Health Partnership
KII	Key Informant Interview
MDG PF	Millennium Development Goals Performance Fund
MOH	Ministry of Health
PAF	Poverty Action Fund
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
RMET	Resource Mapping and Expenditure Tracking Tool
SDG PF	Sustainable Development Goals Performance Fund
SPIU	Single Project Implementation Unit
SWAp	Sector-Wide Approach
UgIFT	Uganda Intergovernmental Fiscal Transfer Program
UHC	Universal Health Coverage
UHFS	Uganda Health Financing Strategy
URMCHIP	Ugandan Reproductive, Maternal, and Child Health Improvement Project
WHO	World Health Organization

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Julia Mensah (Senior Health Specialist), Brendan Michael Hayes (Senior Health Specialist), Elizabeth Mabel Asege Ekochu (Health Specialist), Grace Murindwa (Consultant), and Edith Bateganya (Consultant) contributed to conceptualization of the study and reviewed the draft versions of the report. The final report was peer-reviewed by staff from the World Bank/GFF, namely: Nicolas Rosemberg (Senior Health Economist), Maud Juquois (Senior Health Economist), Mariam Ally (Senior Health Economist), Anurag Kumar (Health Economist), Peter Okwero (Senior Health Specialist), Sheila Dutta (Senior Health Specialist), and Silver Namunane (Economist). Damalie Evalyne Nyanja (Senior Program Assistant) provided logistical and administrative support; Alexandra Quiñones Nunura (consultant) edited the report; and Robert Waiharo (consultant) did the graphical layout and typesetting.

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EXECUTIVE SUMMARY

Although Uganda's health outcomes have improved over the past decade, the health sector still faces challenges in meeting the growing healthcare needs. Uganda faces a high burden of disease, sub optimal access to quality healthcare services, and underfunding of the health sector. To progress towards universal health coverage (UHC), it is crucial to explore opportunities for increasing fiscal space for health in Uganda. This study assessed the feasibility of expanding the fiscal space for health in Uganda across five areas: (a) Conducive macroeconomic conditions, (b) Re-prioritization for Health, (c) Health Sector–Specific Domestic Resources, (d) External Resources, and (e) Improved Efficiency.

The results show that Uganda could increase fiscal space for health through domestic resource mobilization. The potential to mobilize additional domestic resources is contingent upon Uganda having conducive macroeconomic conditions. The results show very conducive macroeconomic conditions that are favorable for the generation of additional revenues, part of which can be allocated to the health sector. It is projected that by the fiscal year 2029/30, Uganda could generate an additional US$1,626 million annually, equivalent to US$29.1 per capita per year (Table 1). This can be generated from two sources: reprioritization of health in the national government budget enabled by sustainment economic growth, and from health sector-specific domestic resources. The additional US$29.1 per capita would increase domestic general government health expenditure (GGHE-D) per capita from US$10 in fiscal year 2021/22 to US$39.1 per year by fiscal year 2029/30. Assuming Development Assistance for Health (DAH) remains the same, the additional funds could increase Uganda's total current health expenditure (CHE) per capita from US$44 in fiscal year 2021/22 to US$73.1 annually by fiscal year 2029/30. The estimated US$73.1 CHE per capita would be larger than the required US$58 per capita (moderate scenario) as stipulated in Uganda's National Essential Health Care Package but still lower than the target of US$106 per capita (optimistic scenario) for the fiscal years 2025/26-2029/30 (see Figure 1).

The above projections are very conservative given the low tax revenue as a proportion of the GDP in Uganda. Uganda's tax revenue as a proportion of the GDP is estimated at 12.5% which is lower than the average of 16% in Africa (OECD et al. 2024). The share of tax revenues to the GDP is also below the estimated tax potential of 19.9% of GDP for low-income countries (Benitez et al. 2023). This means that Uganda has room to improve efficiency in tax collection which could increase overall tax revenues. Secondly, Uganda's projected general government revenue (excluding grants) as a share of GDP at 15.2% in 2025 is lower than the average for the East African Community and Sub-Saharan Africa of 17.3% and 18%, respectively. Thus, there is room to generate more revenues in Uganda. Thirdly, on health taxes, this study proposes a 20% increase in the tax rates on unhealthy products, much lower than the recommended 50% by the high-level Task Force on Fiscal Policy for Health.

While it is important to raise additional revenues, it is equally important to improve efficiency in the allocation and use of resources. If efficiency is not improved, about US$11.8 per capita of the total available funds would be lost each year. Specifically, a substantial portion of the additional US$29.1 per capita from the expanded fiscal space for health would be lost each year if there are no improvements in efficiency.

Key findings by areas for expanding fiscal space for health

Conducive Macroeconomic Conditions

Uganda's macroeconomic outlook over the period 2025-2029 looks positive and can provide a stable foundation for financing the health sector. The International Monetary Fund (IMF) projects a real GDP growth rate of 7.6% on average per annum over the period 2025-2029. Through this growth, Uganda has potential to increase the annual tax to GDP ratio to 16% and overall general government revenue (excluding grants) as a share of GDP to 18%. Part of these revenues can be allocated to the heath sector. The health sector is likely to benefit from the projected increase in economic growth, as evidenced by the rising real GDP per capita, real general government expenditure (GGE) per capita, and real GGE as a proportion of GDP over the period 2025-2029. Furthermore, the decreasing general government gross debt relative to GDP suggests that there will be increased government spending in future, which could include increased government spending on health.

Reprioritization for Health

Adjusting the government national budget by prioritizing health presents the largest short-term potential for increasing fiscal space for health in Uganda. While health has been benefiting from additional resources through improved economic growth and revenue generation, the responsiveness of health spending to a percentage increase in GDP is only 0.76%. Therefore, there is need to prioritize health in the total government budget (TGB). This can be achieved by raising the government health budget (GHB) as a share of TGB from the current levels averaging 8% to 10%, 12%, or 15% annually (Table 1). The anticipated positive macroeconomic environment over the period 2025-2029 provides an opportunity for Uganda to reprioritization health in the TGB. If the GHB as a proportion of the TGB is raised to 15% per year, about US$1,468 million (US$26.3 per capita) could be raised annually by fiscal year 2029/30.

Health Sector–Specific Domestic Resources

Health Taxes

Uganda has potential to raise US$156.6 million (US$2.8 per capita) annually by fiscal year 2029/30 if the tax rates on cigarettes, beers, spirits, wines, and soft drinks are increased by 20%. While the primary objective of increasing the tax rate would be to reduce the consumption of harmful and unhealthy substances and foods, the government can also generate additional revenues. As observed by the high-level Task Force on Fiscal Policy for Health, *"if countries increased their excise taxes to raise prices on tobacco, alcohol, and sugary beverages by 50%, over 50 million premature deaths could be averted worldwide over the next 50 years while raising over US$20 trillion of additional revenues."* [iii] The proposed 20% increase in the tax rate in Uganda is expected to trigger a 5% reduction in beer consumption, and a 3% reduction in the quantity demanded for cigarettes and soft drinks. Meanwhile, the additional revenue could be earmarked to the health sector to strengthen the overall health system and support treatment and rehabilitation for addicts.

Motor Vehicle Accident Fund

Uganda has potential to raise US$1.3 million (US$0.02 per capita) annually by fiscal year 2029/30 if a levy of 5% on the gross third-party motor vehicle insurance premiums is introduced. Uganda has a road traffic mortality rate of 16 deaths per 100,000 population, one of the highest rates in the world. Road traffic accident victims account for approximately 45% of all hospital admissions in Uganda, resulting in significant costs for

treating injured individuals. Currently, road traffic accident victims in Uganda do not often receive compensation for their treatment from insurance companies, resulting in lifelong incapacitation or death. Therefore, the funds collected from the levy could be used to cover expenses associated with treating road accident victims in Uganda. A dedicated budget line or a Motor Vehicle Accident Fund could be established for this purpose.

National Health Insurance

Uganda's health financing strategy provides for the establishment of a national health insurance (NHI) scheme. This study did not calculate the potential revenue that could be generated from establishing a NHI scheme. NHI systems are complex and require feasibility assessments before implementation. Going forward, it is essential for Uganda to gather more evidence on the feasibility of establishing the NHI scheme. Evidence from several developing countries indicates that NHI schemes have been unable to generate sufficient resources and improve coverage for the poor and vulnerable populations. As such, the objective of the proposed NHI in Uganda could be to enhance strategic purchasing, as it is unlikely that the NHI scheme will generate sufficient revenues. Additionally, the NHI scheme would need funding from both contributory and non-contributory sources. Therefore, the suggested revenue sources in this paper (particularly from health taxes) could be directed to the NHI fund.

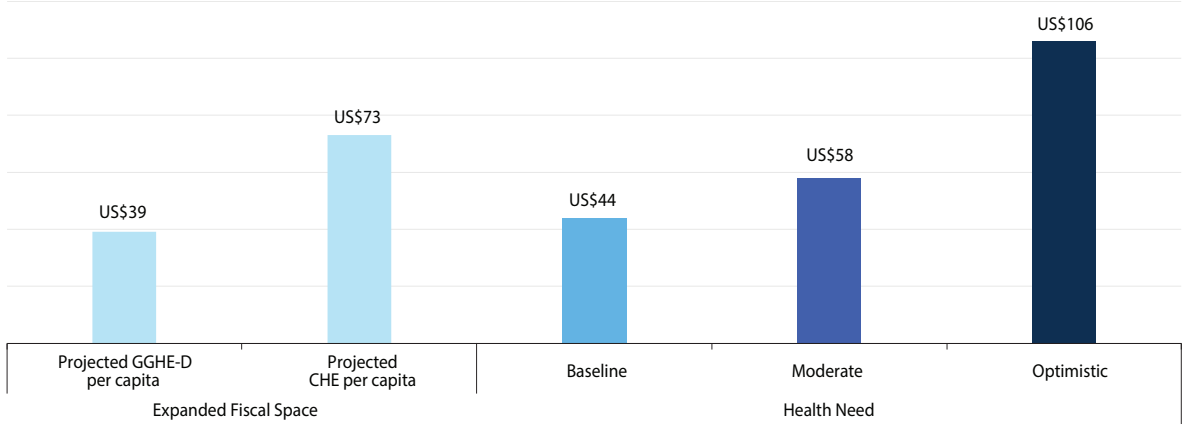
External Resources

It will be highly unlikely for Uganda to increase fiscal space for health through external resources. The results show that development assistance for health (DAH) as a share of the total CHE at 42% in fiscal year 2021/22 is already high. Furthermore, following the Israel-Palestine and Russia-Ukraine armed conflicts, along with the change in aid policy by the United States Government (USG) in January 2025, there have been substantial reductions in DAH globally. Uganda ranked 13th out of the 20 countries worldwide with the highest share of USG funding to health as a proportion of total DAH. This suggests that the change in USG policy is likely to have a significant adverse effect on existing and future USG funding, and the overall DAH to the health sector in Uganda. On the other hand, it is also worth noting that Uganda's rapidly growing economy and huge potential to reach lower middle-income status in a few years will naturally result in reduced DAH.

Improved Efficiency

There are some allocative and technical inefficiencies in the allocation and use of resources in the health sector in Uganda. These include low execution and absorption of funds especially of external financing; fragmentation and duplication of DAH; high absenteeism and low productivity among health workers; and corrupt procurement practices. Uganda is likely to lose US$660 million (US$11.8 per capita) annually by fiscal year 2029/30 due to absenteeism of health workers and corrupt procurement practices. If these vices are not addressed, most of the additional revenues generated would be lost.

Figure 1: Potential contribution of additional funds to Uganda's Health Need, 2025/26-2029/30



Source: Fiscal space estimated by the author. Health need from MoH (2024b)
Notes: GGHE-D=Domestic General Government Health Expenditure, and CHE=Current Health Expenditure

Table 1: Fiscal space scenarios, revenue potential, and recommended actions

Key areas	Fiscal space scenarios	Total additional amount by fiscal year 2029/30 (US$ millions)	Recommended Action
Conducive Macroeconomic Conditions*	Real GDP growth of 7.6% per year over the period 2025/26-2029/30		• Implement tax reforms to improve efficiency in tax revenue collection. • Maintain a stable economic environment and fiscal discipline for continued economic growth and revenue generation.
	Annual tax revenue as a proportion of the GDP at 16% over the period 2025/26-2029/30		
	General government revenue (excluding grants) as a share of GDP at 18% over the period 2025/26-2029/30		
	General government gross debt as a proportion of the GDP at 42.4% (annual average, 2025/26-2029/30)		
	Real GDP per capita of US$1,025.28 per year over the period 2025/26-2029/30		
	Real GGE per capita of US$199.99 per year over the period 2025/26-2029/30		
	Real GGE as a proportion of GDP at 19.2% (annual average, 2025/26-2029/30)		
Reprioritization for Health	GHB as a proportion of the TGB increases to 10% per year	326 (US$5.8 per capita)	• There is need to match economic growth with increased public spending on health. This can be achieved by raising the GHB as a share of the TGB from the current 8% to 10%, 12%, or 15% annually.
	GHB as a proportion of the TGB increases to 12% per year	783 (US$14 per capita)	
	GHB as a proportion of the TGB increases to 15% per year	1,468 (US$26.3 per capita)	

Table 1: Fiscal space scenarios, revenue potential, and recommended actions *(cont)*

Key areas	Fiscal space scenarios	Total additional amount by fiscal year 2029/30 (US$ millions)	Recommended Action
Health Sector–Specific Domestic Resources	Increase health taxes on cigarettes, beers, spirits, wines, and soft drinks by 20%	156.64 (US$2.8 per capita)	• Implement a 20% increase in health taxes on cigarettes, beers, spirits, wines, and soft drinks to avert premature deaths and raise additional revenues. In line with global norms, a 50% increase could be considered in the medium-term.
	Introduce a levy of 5% of the gross third-party motor vehicle insurance premiums	1.3 (US$0.02 per capita)	• Introduce a levy of 5% on the gross third-party motor vehicle insurance premiums. • Establish a dedicated budget line or a Motor Vehicle Accident Fund (like the ones in South Africa, Botswana, or Namibia) to be administering the funds to road accident victims.
	Establish a National Health Insurance	Not estimated	• Gather more evidence on the feasibility of establishing a NHI scheme. This includes undertaking an actuarial evaluation of the proposed NHI. • The NHI could focus on enhancing strategic purchasing and focus on specific types of health services.
External Resources	Declining funding from external development partners	Likelihood of a 40-50% reduction in DAH over the period 2025/26-2029/30	• Drawing lessons from the 2008 global financial crisis (Kirigia et al. 2011), implement measures to sustain funding to the health sector. • Fully implement recommendations of the Lusaka Agenda on coordinated action towards domestically financed health systems. • Develop and implement a comprehensive transition plan with timelines to shift from DAH to government domestic funding.
Improved Efficiency**	Allocative and technical inefficiencies in the allocation and use of resources in the health sector in Uganda	660 (US$11.8 per capita)	• Development partners should progressively increase the level of on-budget support. Strengthening resource mapping and expenditure tracking could help to facilitate this transition. • Establish a virtual pooling mechanism for DAH. • Reduce inefficiencies and corruption through muti-faceted and multi-level actions including strengthening PFM systems and governance structures; integrated planning, budgeting, and disbursement; strengthening performance management; improving procurement and supply chain management; scaling up digital health; and tracking of health interventions, resources, and results.
Total Potential Fiscal Space by fiscal year 2029/30 (assuming ambitious scenario for each area)		**1,626 (US$29.1 per capita)**	

Source: Prepared by the author.

*Notes: GHB=Government Health Budget, TGB=Total National Government Budget, GDP=Gross Domestic Product, GGE=General Government Expenditure, DAH=Development Assistance for Health, PFM=Public Financial Management. *Additional revenues from improved macro-economic conditions are realized through increases in the health budget i.e., prioritization of health. **Shows money lost due to inefficiency and corruption. Improving efficiency does not generate additional health funding but increases effectiveness and value-for-money hence the estimated overall physical space doesn't include efficiency savings.*

1. INTRODUCTION

Uganda's health sector continues to face significant challenges in meeting the growing healthcare needs of its population. Despite progress in recent years, the country still grapples with a high burden of disease, limited access to quality healthcare services, and inadequate health financing (UNICEF 2023). These challenges coupled with poor health outcomes constrain Uganda's progress in human capital accumulation and economic growth (World Bank 2023; 2024a). To address these challenges and achieve universal health coverage (UHC), it is crucial to explore opportunities for increasing fiscal space for health in Uganda. This study assesses the potential for increasing fiscal space for health in Uganda. Fiscal space refers to the capacity of a government to undertake additional spending without endangering the sustainability of its financial position or the stability of the economy. Assessing fiscal space for health involves examining how a government can increase health spending in the short- to medium-term while maintaining macroeconomic stability (Heller, 2005).

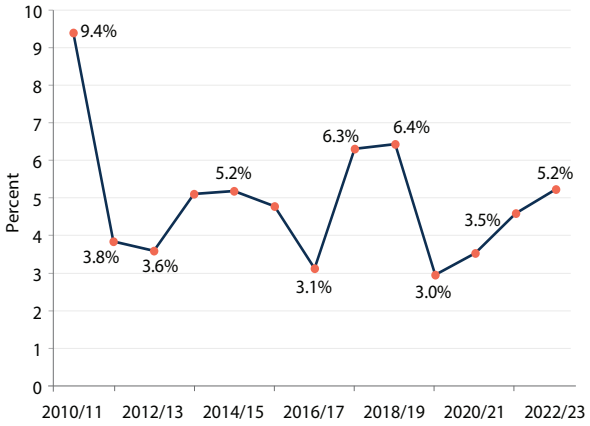
This study builds on the analysis on fiscal space for health in Uganda that was conducted by the World Bank in 2010. The previous study by Okwero et al. (2010) showed that there was low and inefficient health spending, limited scope for domestic revenue mobilization, high dependence on external financing, and that there was need for prioritization of health, and more concessional borrowing. It also provided some recommendations on enhancing efficiency of health spending, increasing DAH, and addressing corruption. The study also informed the development of Uganda's Health Financing Strategy 2015/16–2024/25 (MoH, 2016). In addition to the study by Okwero et al. (2010), this study builds on recent studies such as the Public Expenditure Review (2022-23), Raising Taxes for Improving Health in Uganda (2022), and a Cross Programmatic Efficiency Analysis (2022). These studies have also highlighted the financing constraints in the health sector in Uganda, and the need for more innovative and sustainable financing options.

This study uses the fiscal space for health analytical framework by Cashin and Tandon (2010) to explore the potential to expand fiscal space for health in Uganda. The framework has five areas, namely: conducive macroeconomic conditions, reprioritization of health in the government budget, health sector-specific domestic resources, external resources, and improved efficiency. It is also acknowledged that strategies to mobilize additional revenues must be implemented carefully to ensure the long-term sustainability of the country's macro-economic position. Therefore, the first section in this paper presents an overview of Uganda's socio-economic context and the health financing landscape. Thereafter, the five areas for increasing fiscal space for health are examined.

1.1 Socio-Economic Background

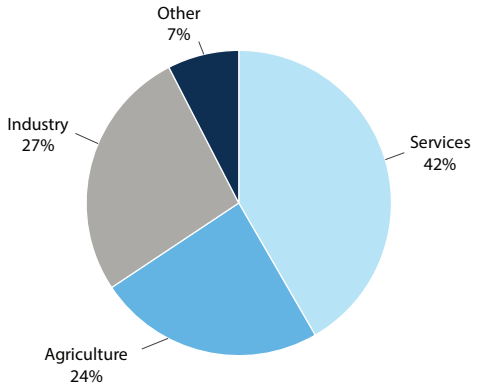
Uganda is a rapidly growing, low-income country with a population of approximately 46 million people. Uganda has experienced steady economic growth over the past decade, with an average annual growth rate of around 5% (Figure 2). The main economic sectors in Uganda are services (42%), agriculture (24%), and industry (27%) (Figure 3). Despite this growth, Uganda remains a low-income country, with

Figure 2: Real GDP growth (annual %)



Source: World Bank (2024b)

Figure 3: Uganda's GDP by sector, 2022



Source: World Bank (2024b)

a gross domestic product (GDP) per capita of US$1,093 in 2022/23 (UBoS, 2023). Uganda also faces some challenges in reducing poverty and addressing inequality. For example, in 2019, about 20% of the population were below the national poverty line while the Gini index was 0.42 (World Bank, 2024a).

Uganda has a decentralized system of government, with 135 districts, 11 cities, and 31 municipalities having some autonomy in local governance, although the central government still holds significant power and is increasingly recentralizing some of the functions. The Local Government Act of 1997 established a decentralized system of government to bring services closer to the people and improve local participation in decision-making (GoU, 1997). However, in the recent past, the Chief Administrative Officers (CAOs) functions have been recentralized,[iv] as has the collection of taxes at the local government level. This undermines the autonomy of CAOs and local governments to raise resources and allocate them towards specific sectors, such as health. In addition, discussions are ongoing around the recentralization of the recruitment of health workers.

Local governments (LGs) are responsible for providing a range of services, including health care, but face challenges due to limited resources and governance capacity. The decentralization process, which began in the early 1990s, has given LGs the responsibility for delivering key social services such as health care, education, water and sanitation, and agricultural extension services (Awortwi and Helmsing, 2014). However, the effectiveness of service delivery at the district level is often hampered by inadequate funding, limited human resources, and weak institutional capacity (OPM, 2020). LGs are funded through a combination of central government conditional grants (with no flexibility in their use), local revenue, and donor support, but they often face challenges in generating adequate resources to meet their mandates following the abolition of most local government taxes. In addition, the reliance on donor funding leads to sustainability challenges and limits the ability of LGs to set health priorities and coordinate local efforts.

Uganda faces a growing double burden of communicable and non-communicable diseases (NCDs) that could increase healthcare costs and demand in the future. The share of deaths attributed to NCDs increased from 25.3% in 2010 to 35.6% in 2019, while deaths from communicable diseases declined from 65.3% to 51.7% over the same period (World Bank, 2024b). Correspondingly, the prevalence of NCDs like diabetes is rising, from 2.8% in 2011 to 4.6% in 2021 among adults aged 20-79 years. With a population

projected to reach over 70 million by 2040 (NPC, 2021), this epidemiological transition coupled with population growth will exert pressure on Uganda's health system, necessitating increased capacity and funding to avert both communicable diseases and NCDs.

1.2 Trends in Health Financing

Uganda's Health Financing Strategy (2015/16–2024/25) aims to support the implementation of health financing reforms towards UHC. The main goal of the strategy is to safeguard individuals from financial hardship when seeking health care and to guarantee that no one abstains from or is denied medical services due to financial barriers (MoH, 2016). The strategy is in harmony with the Sustainable Development Goals, and it provides guidance for the provision of the necessary resources for the efficient and fair delivery of health services. As such, the strategy has recommendations on revenue collection, risk pooling, and strategic purchasing.

Uganda's health sector financing has been characterized by low government allocation, high out-of-pocket (OOP) spending, and a heavy reliance on external funding. Firstly, as shown in Table 2, government allocation to the health sector as a percentage of the total government national budget declined from 8.9% in 2010/11 to 7.7% in 2023/24. This is far below the spending norms in peer countries and regional benchmarks such as the Abuja target of 15%. Furthermore, in relation to the total CHE, OOP spending on health in Uganda has consistently been higher than domestic general government health expenditure (GGHE-D) over the period 2000-2022 (Figure 4). Over the past decade, OOP and DAH have been the primary sources of health sector funding in Uganda, while GGHE-D has remained low (Figure 5). This indicates low prioritization of health by the government which leads to a substantial reliance on DAH and high OOP spending on health. Additionally, the total CHE per capita declined from US$55 in 2012 to US$44 in 2022 while the total CHE as a percentage of GDP decreased from 6% in 2012 to 4% in 2022. This means that there is a need to mobilize additional resources to address the emerging financing gap in the health sector.

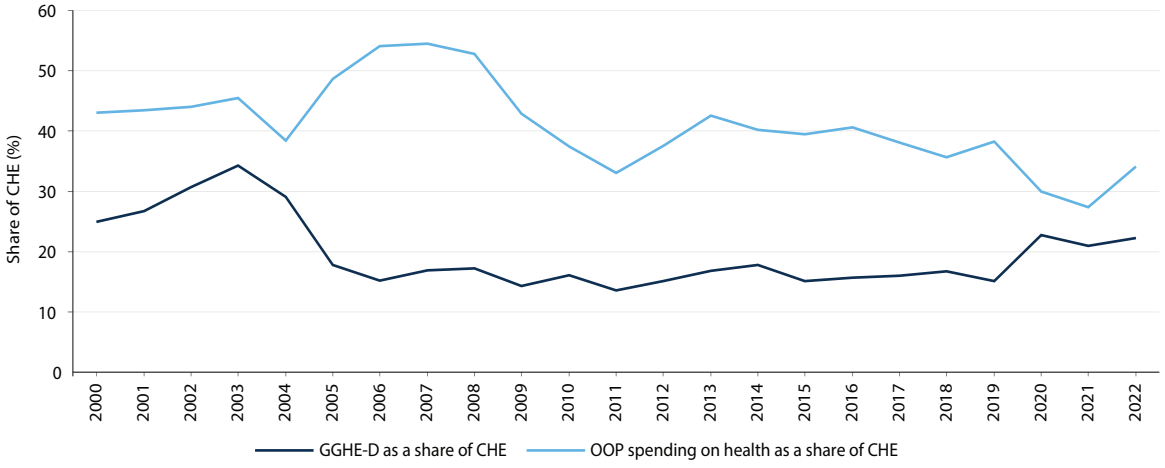
Table 2: Trends in government allocations to the health sector (nominal terms)

Year	Total National Government Budget (UGX Billion)	Government Health Budget (UGX Billion)	Government health budget as % of the Total National Government Budget
2010/11	7,377	660	8.9%
2011/12	9,630	799	8.3%
2012/13	10,711	829	7.7%
2013/14	13,065	1,128	8.6%
2014/15	14,986	1,281	8.5%
2015/16	18,311	1,271	6.9%
2016/17	20,431	1,827	8.9%
2017/18	29,000	1,950	6.7%
2018/19	32,700	2,373	7.3%
2019/20	36,113	2,589	7.2%
2020/21	45,493	2,788	6.1%
2021/22	44,779	3,331	7.4%
2022/23	48,130	3,685	7.7%
2023/24	52,740	4,052	7.7%

Source: Author's construction from MoH Annual Health Sector Performance Reports

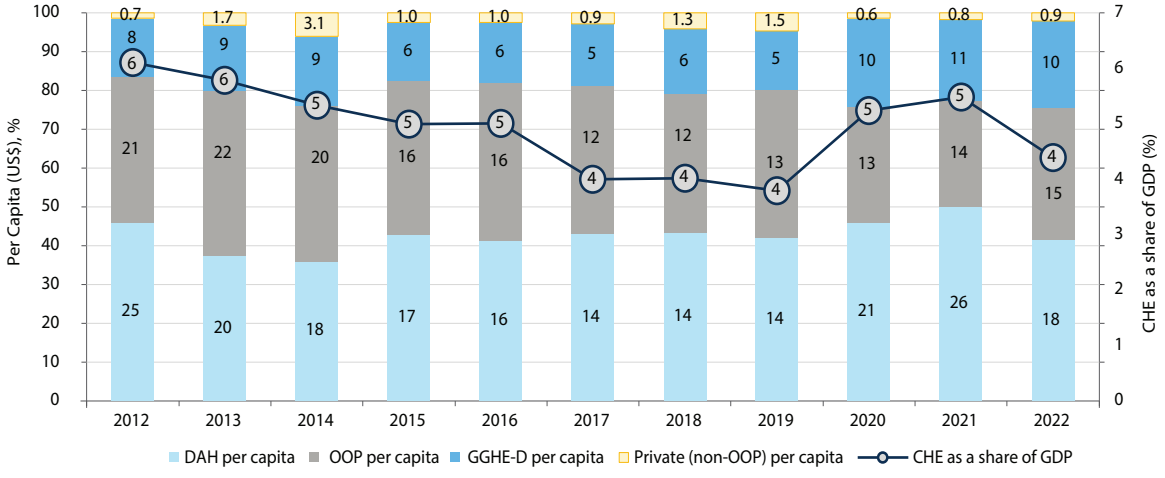
The overall level of spending on health in Uganda is inadequate and significantly below the level required to achieve UHC. Uganda's total CHE per capita at US$44 in 2022 is below the US$86 per capita (at 2012 prices) spending per year which is recommended for low-income countries to provide basic health services (McIntyre et al. 2017). Furthermore, at US$44 per capita, total CHE per capita in Uganda is also lower than the average spending of US$75.6 per capita in regional and peer countries (Ethiopia, Rwanda, Sudan, Chad, Kenya, Cameroon, Congo Rep) (World Bank, 2023). Furthermore, total CHE as a share of the GDP at 4% in 2022 in Uganda is below the 5% of GDP recommended by WHO, and average spending of 5.2% and 4.7% of GDP in structural and aspirational peer countries (World Bank, 2023). This underscores the need to mobilize additional funds for the health sector to finance existing and new priorities.

Figure 4: Government and out-of-pocket spending relative to CHE, 2000-2022



Source: Author's construction from WHO Global Health Expenditure Database
GGHE-D=Domestic General Government Health Expenditure, OOP=Out of Pocket

Figure 5: Per capita health expenditures by financing sources, 2012-2022

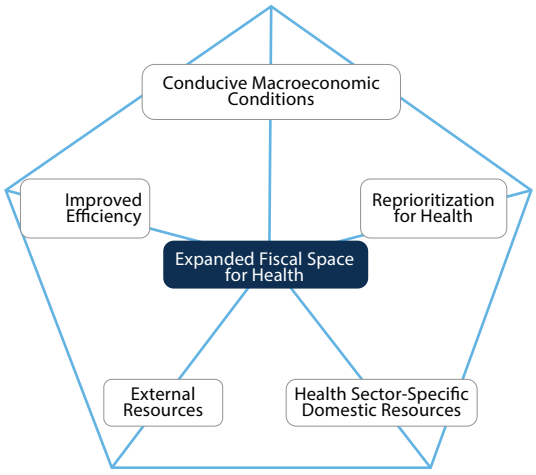


Source: Author's construction from WHO Global Health Expenditure Database

2. ASSESSING THE FEASIBILITY OF EXPANDING FISCAL SPACE FOR HEALTH

This section assesses five potential areas for increasing fiscal space for health in Uganda. The analysis is structured into five subsections, each focusing on the following: Conducive Macroeconomic Conditions, Reprioritization for Health, Health Sector–Specific Domestic Resources, External Resources, and Improved Efficiency. See Figure 6.

Figure 6: Framework for assessing fiscal space for health



Source: Adapted from Cashin and Tandon (2010)

2.1 Conducive Macroeconomic Conditions

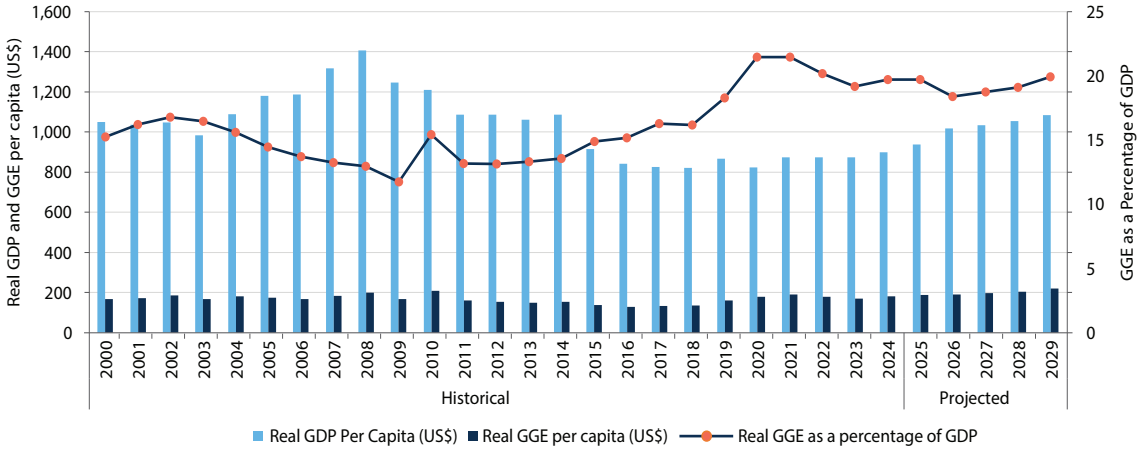
A favorable macroeconomic environment, including robust GDP growth, strong tax collection and administration, and well-managed debt and fiscal deficit, can greatly impact the fiscal space available for health. For example, a 5% annual growth in real GDP could lead to a corresponding rise in GGHE, assuming tax collection rates and the relative prioritization of the health sector remain unchanged. However, in practice, government's domestic resource mobilization, fiscal discipline, and prioritization of the health sector influence the degree to which economic growth results in more resources for health.

Uganda's economy has been consistently growing over the past decade, and this growth is expected to continue. Real GDP grew by 4.6% in fiscal year 2021/22, 5.2% in fiscal year 2022/23, and 6% in fiscal year 2023/24. This was driven by strong performance in the agricultural, service, and industrial sectors. For the medium-term, the International Monetary Fund (IMF) forecasts a GDP growth of 7.6% on average per year over the period 2025-2030. Anticipated growth in oil production could increase growth prospects. The positive outlook could increase business confidence, efficient and productive government spending, and private sector activity (IMF, 2024). Looking ahead, the government has set an ambitious target of achieving a ten-fold increase in GDP by 2040, with a strong focus on domestic resource mobilization (MoFPED, 2024). If successful, this could generate more funds for health if some of the extra revenues are directed to the health sector.

For Uganda to benefit from improved GDP growth, there will be need to improve efficiency in tax revenue collection. Uganda's tax revenue as a proportion of the GDP is estimated at 12.5% which is lower than the average of 16% in Africa (OECD et al. 2024). The share of tax revenues to the GDP is also below the estimated tax potential of 19.9% of GDP for low-income countries (Benitez et al. 2023). Secondly, Uganda's projected general government revenue (excluding grants) as a share of GDP at 15.2% in 2025 is lower than the average for the East African Community and Sub-Saharan Africa of 17.3% and 18%, respectively. Therefore, Uganda has potential to improve efficiency in tax and non-tax revenue collection. In line with the historical precedence in other Africa countries, Uganda should strive to increase the annual tax to GDP ratio to 16% and overall general government revenue (excluding grants) as a share of GDP to 18%.

To gauge whether the past and futuristic macro-fiscal environment have been favorable for increasing fiscal space for health, we examined trends in the real GDP per capita, real GGE per capita, real GGE as a percentage of GDP, and general government gross debt as a percentage of GDP. Real GDP per capita and real GGE per capita were used to account for changes in both prices and population. Over the years, real GDP per capita has been fluctuating, peaking in 2008, declining post-2014, and reaching the lowest point in 2018. From 2023, there was a consistent increase in real GDP per capita and this trend is expected to continue through 2029 (Figure 7). The projections (2025-2029) suggest an increase in government spending per capita which may include increased spending on healthcare. GGE as a percentage of GDP fluctuated over the period 2000-2024, with sharp declines over the period 2003-2009, a steady rise between 2012 and 2020, followed by a decline over the period 2021-2023. From 2027 to 2029, GGE as a percentage of GDP is expected to increase continually and remain high compared to earlier periods (Figure 7). This implies that spending on healthcare could be increased.

Figure 7: Real GDP per capita, GGE per capita, and GGE as a percentage of GDP

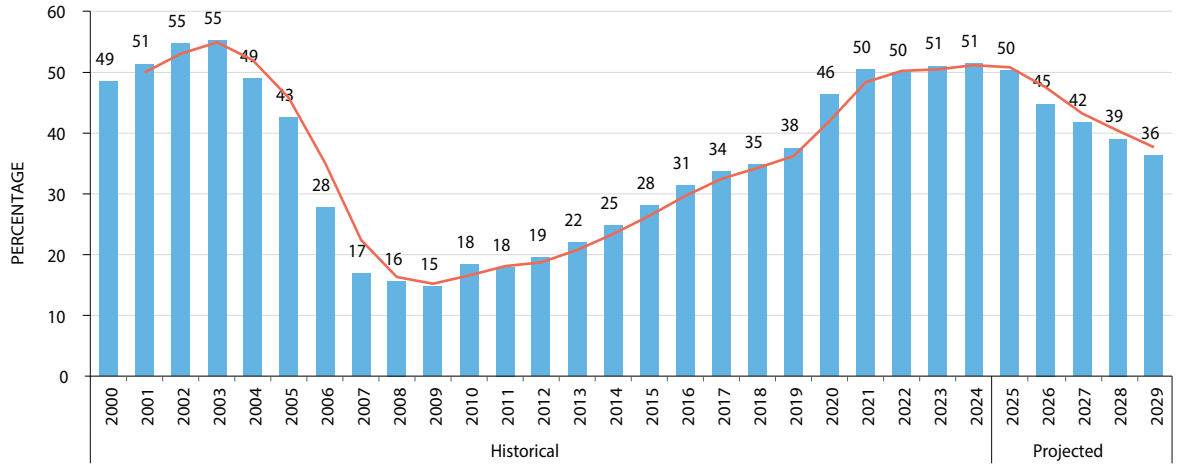


Source: Author's construction from IMF and World Economic Outlook Database, October 2024

Figure 8 shows the historical trend and projected trajectory of government debt as a percentage of GDP. It provides insight into the fiscal position of the government and its ability to fund essential services, including healthcare. From 2000 to 2003, government debt rose to 55% of GDP and then declined steadily to 15% by 2009. A gradual increase from 2010 pushed debt levels back to around 50%

of GDP by 2021. The steep rise from 38% in 2019 to 50% in 2021 aligns with the COVID-19 pandemic, when the Government of Uganda (GoU) increased borrowing to mitigate the negative impact of the pandemic on economic growth and domestic resource mobilization. The declining Debt-to-GDP Ratio (2025-2029) suggests reduced government borrowing, better revenue collection, or economic growth outpacing debt accumulation. As debt levels decline, the government may have more fiscal flexibility and could increase spending on healthcare. However, if debt reduction is achieved by implementing austerity measures such as reduced GGE per capita, spending on healthcare could decrease.

Figure 8: General government gross debt as a percentage of GDP



Source: Author's construction from IMF World Economic Outlook Database, October 2024

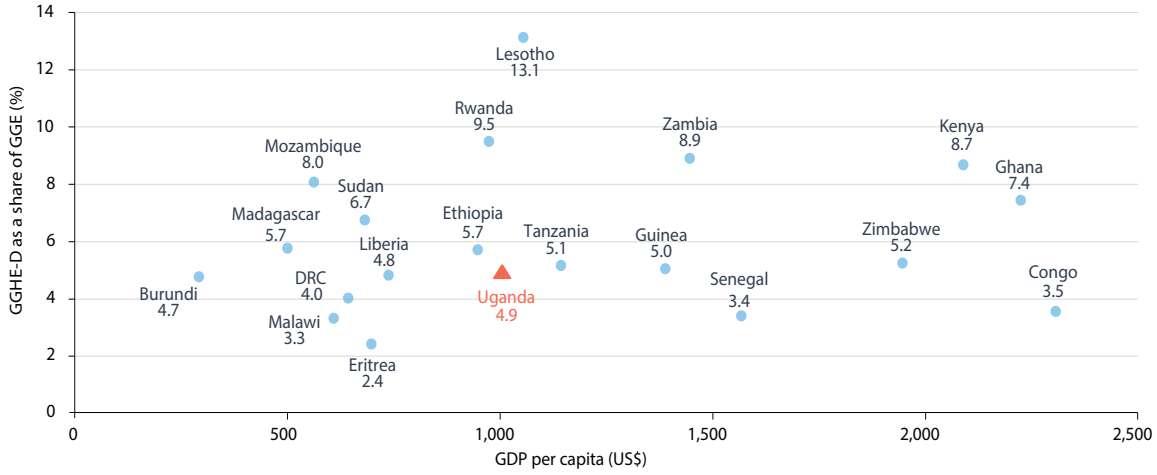
2.2 Reprioritization for Health

Like many low-and-middle income countries, Uganda finds it challenging to secure adequate funding for its health sector. The urgency for expanding fiscal space for health is underscored by the country's high dual disease burden and the pivotal role of population health in fostering human capital development and economic growth. The enhancement of fiscal space for health through budget re-prioritization can ensure that health is given greater priority in the budget, thereby leading to an increase in funding for the sector. Re-prioritization can foster equity in health expenditure, ensuring that resources are allocated based on need. In this section we present evidence and recommendations for budget reprioritization.

Budget re-prioritization is a strategic fiscal policy tool that involves reallocating resources within the government's budget to align with changing priorities and needs. In Uganda, this process is crucial for ensuring that the budget reflects the government's current policy and development objectives, including for health. Budget re-prioritization is also a critical tool for Uganda to navigate the challenges in the macro-fiscal landscape. Re-prioritizing the national budget towards health can lead to improvements in health outcomes if the resources are used effectively. For instance, budget re-prioritization towards health, particularly towards preventive care and primary health care, can improve health outcomes and facilitate economic development. Budget re-prioritization requires a comprehensive understanding of the health needs of the population, effective policy-making, and high-level political and technical commitment (UNICEF 2023).

As compared to countries with the same economic capacity, health budget prioritization in Uganda is relatively lower. To assess this, we used 2022 data to compare the level of health prioritization (GGHE-D as a share of GGE) to the GDP per capita across several low and lower-middle income countries in Africa. The results show that though Madagascar, Mozambique, and Sudan have a lower GDP per capita than Uganda, GGHE-D as a share of GGE is higher (Figure 9). Additionally, countries with similar GDP per capita as Uganda (i.e., Ethiopia, Rwanda, and Lesotho) allocate more government domestic budget to health than Uganda. In summary, these results show that Uganda's health budget prioritization is modest and suggests that there is room for increasing government funding to the health sector. These results are corroborated by findings by the World Bank (2023) which showed a decline of 2.6 percentage points in the GGHE-D as a share of the GGE between the fiscal year 2014/15 and fiscal year 2020/21.

Figure 9: Health prioritization and GDP, 2022



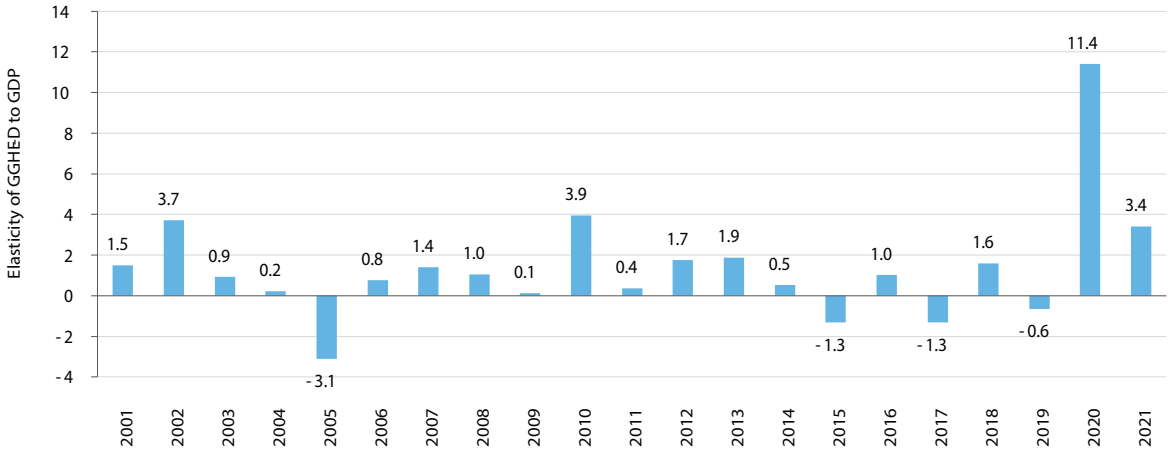
Source: Author's construction from WHO Global Health Expenditure Database except for Uganda (World Bank, 2023)

To understand whether health is prioritized when there are new or declining revenues, we examined the responsiveness of GGHE-D to changes in GDP. This analysis is important because favorable macro-fiscal conditions alone do not automatically translate into increased public spending on health. This is true for a low-income country like Uganda where there are huge demands for public funds. For instance, community development is important, infrastructure must be developed and maintained, education is crucial for long-term economic development, and investments in agriculture and rural development can help to increase food security and reduce poverty. In technical terms, the elasticity (or responsiveness) of government health spending with respect to GDP provides an indication of the historical relationship between economic growth and government spending on health.

Focusing on GGHE-D with respect to GDP from 2001 to 2019, we find an elasticity of 0.76, slightly below the 0.95 found in the 2010 fiscal space study. This implies that a 1% increase in GDP leads to an increase in GGHE-D by only 0.76%. The low elasticity suggests that the health sector has not been highly prioritized even during times of economic growth.[vi] This concern was also frequently mentioned in discussions with stakeholders. Figure 10 shows the elasticity of GGHE-D with respect to GDP in Uganda over the period 2001-2021. The years 2020 and 2021 represent significant outliers, with elasticity values exceeding the preceding decade, likely driven by the government's response to the COVID-19 pandemic.

Thus, focusing on the period 2001-2019, we found an elasticity of 0.76 on average. This is below the average elasticity of 1.0 for low-income countries (WHO, 2022).

Figure 10: Elasticity of GGHE-D with respect to GDP, Uganda (2001–2021)



Source: Author's construction from WHO Global Health Expenditure Database and World Bank (2024b). Note: Data in nominal UGX terms.

2.2.1 Recommendations on reprioritization for health

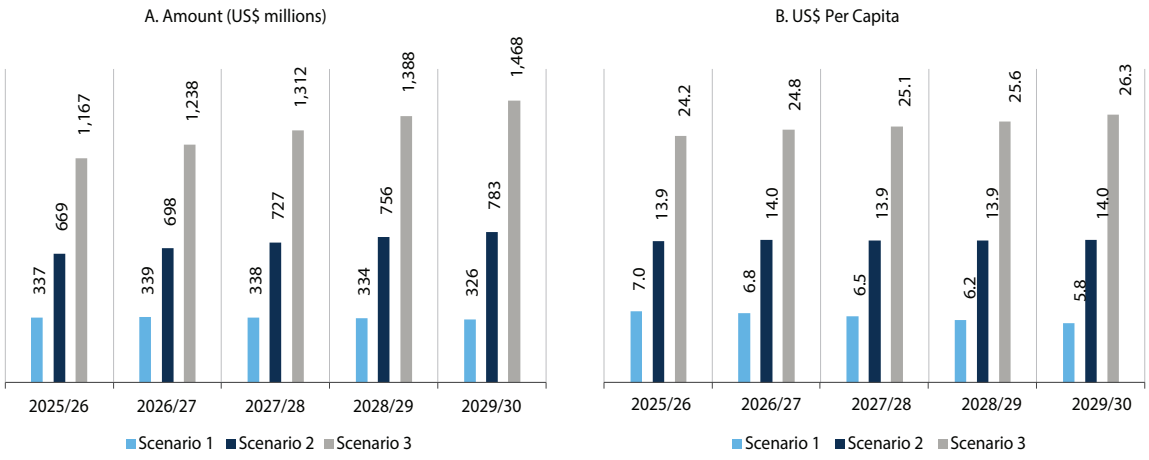
Policymakers need to focus on strengthening the relationship between economic growth and public health spending, which requires targeted deliberate policy measures and sustained commitment to health sector prioritization. Potential strategies include establishing health spending targets based on comprehensive assessments of population health needs, regularly reviewing and adjusting health budgets to reflect changing priorities, and ring-fencing the government's health budget, even during periods of economic downturn. Through these strategies, Uganda can work towards ensuring that health funding is both sufficient and resilient, regardless of economic fluctuations.

Strong advocacy efforts will play a crucial role in translating economic growth into increased health spending. The health sector must clearly demonstrate its contribution to human capital development and economic growth through evidence-based advocacy. This includes showcasing health's role in workforce productivity, highlighting successful health interventions, and quantifying the economic returns of health investments. The senior management at the Ministry of Health (MoH) should take advantage of the growing evidence to engage with and make the case for increased health allocations from economic growth dividends to the Ministry of Finance, Planning and Economic Development (MoFPED), Parliament, and Cabinet. Increasing government spending on health could potentially improve the responsiveness of GGHE-D to fluctuations in GDP, from the current 0.76 to at least 1.0, a common situation for low-income nations.

Proposed options. Uganda has developed a National Essential Health Care Package with the goal of achieving a health expenditure target of US$106 per capita to attain UHC (MoH, 2024b). To attain this target, GGHE as a proportion of GGE must be 31%, which means that increasing the GGHE to this level would be impossible to attain in the short- to medium-term. Thus, the main goal for the GoU would be to gradually increase government funding to the health sector every year to progress towards

meeting the health spending target of US$106 per year. Over the 2022/23 and 2023/24 fiscal years, the government health budget as a proportion of the total national government budget was about 8% on average. Therefore, over the fiscal years 2025/26-2029/30, we assume three scenarios: increasing the government health budget as a proportion of the total national government budget to 10% per fiscal year (conservative target – scenario 1); 12% per fiscal year (moderate target – scenario 2); or to 15% per fiscal year (optimistic target – scenario 3). For scenario 3, the results show that increasing the government health budget as a proportion of the total national government budget to 15% per fiscal year would generate an extra US$1,468 million by the fiscal year 2029/30, which amounts to US$26.3 per capita (Figures 11a and 11b). This would substantially contribute to closing the financing gap to achieving UHC as outlined in the National Essential Health Care Package.

Figure 11: Additional funding from increased government health budget, 2025/26 – 2029/30



Source: Author's construction

2.2.2 Insights from stakeholder

The stakeholders who were interviewed expressed strong considerations for government budget re-prioritization towards the health sector. While this strategy has the potential to secure significant additional resources, it is essential to also consider other governmental priorities. Consequently, officials from the Uganda MoH must provide evidence of a tangible need and establish a clear correlation between increased funding and enhanced health outcomes.

2.3 Health Sector–Specific Domestic Resources

Health Sector–Specific Domestic Resources refer to funds generated within a country that are explicitly allocated to health services. These include government budget allocations from general tax revenue, health taxes (e.g., excise taxes on tobacco, alcohol, or sugary drinks), user fees at health facilities, innovative health financing sources (airline ticket levies, financial transaction taxes, public-private partnerships, diaspora bonds, etc.), social health insurance contributions, and community-based health financing schemes. Unlike donor funds, these resources are mobilized and controlled domestically, offering more sustainability and autonomy in financing national health priorities. In this study, we analyzed the potential of generating additional funds from health taxes and third-party motor vehicle insurance premiums. The anticipation is that revenues generated from these two sources could be allocated to the health sector.

Earmarking resources for health is defined as "targeting new or existing streams of revenue for health systems, programs, priorities, and/or populations" (Cashin et al. 2017). As such, if existing or new revenues are earmarked to the health sector, the level of health spending can increase. However, the effectiveness of earmarking is context specific and is influenced by a country's political priorities and the broad resource allocation strategy. In Uganda, a road fund was established in 2010 by earmarking road-related taxes and charges to finance routine and periodic maintenance of public roads in the country. For the health sector, the Ugandan Parliament established a HIV/AIDS trust fund in 2014 and a national immunization trust fund in 2016, but neither has been operationalized due to lack of revenue. Through its health financing strategy (MoH, 2016), Uganda seeks to operationalize these trust funds by using earmarked revenues from taxes on harmful products.

2.3.1 Health taxes

A health tax (previously referred to as a sin tax) is a special tax on goods and services considered detrimental to public health and society (Miracolo et al. 2021). International experience has shown that raising taxes on unhealthy products such as tobacco, alcohol, sugary beverages, and trans-fat products can effectively reduce their consumption, leading to improved health outcomes and reduced demand for health services. For instance, a study by the WHO found that a 10% increase in the price of tobacco products can reduce tobacco consumption by about 4% in high-income countries and by up to 8% in low- and middle-income countries (WHO, 2021). Similarly, a meta-analysis of studies on alcohol taxation found that a 10% increase in alcohol prices through taxation, can reduce alcohol consumption by 5% in the short term and up to 8% in the long term (Gallet, 2007).

While the primary objective of implementing health taxes is to reduce the consumption of harmful and unhealthy substances and foods, these taxes can also generate additional revenue.[vii] This revenue could be earmarked for health-related expenses, thereby increasing the fiscal space for health while also reducing the consumption of unhealthy products. In Turkey, the government achieved significant success by increasing tobacco taxes from 64.8 percent in 2002 to 83 percent in 2017. This policy resulted in a 18% reduction in per capita cigarette consumption and a 476 percent increase in revenue (Cetinkaya and Marquez, 2017). Similarly, the 2012 Philippines tax reform on tobacco and alcohol facilitated better health, increased revenues, and good governance. After one year of implementation, tax revenues from tobacco and alcohol products rose by more than 86%, and the higher retail prices for cigarettes led consumers to reduce or cease smoking. The revenues from tobacco and alcohol nearly doubled the government health budget and were used to subsidize health insurance for the poorest 40% of the population, which included approximately 15.3 million poor and near-poor families by the end of 2015 (Kaiser et al. 2016).

Notwithstanding the above, it is essential to consider the potential impacts of health taxes on consumption patterns, revenue generation, and health outcomes before implementing them (Miracolo et al. 2021). Furthermore, political commitment to earmark the revenues generated to a specific program or sector is also important (Ozer and Sparkes, 2022). In Uganda, though laws for the creation of a HIV/AIDS trust fund and a national immunization trust fund were passed in 2014 and 2016, respectively, these two trust funds have not yet been operationalized. Subsequently, the Act that

established the immunization trust fund was repealed in March 2023 and replaced by the Public Health (Amendment) Act No. 4 of 2023.[viii] This may be because earmarking funds for health can disrupt the resource allocation process of the MoFPED. It also suggests low government interest in earmarking resources for the health sector.

2.3.2 Motor vehicle insurance

The other option for increasing fiscal space for health is by mobilizing revenues from motor vehicle insurance premiums and allocating the funds to the health sector. In 2021, there were 1.19 million road traffic deaths worldwide, or 15 deaths per 100,000 people (WHO, 2023). Africa accounted for 19% of these deaths (225,482) and had the highest fatality rate at 19 deaths per 100,000 people. In Africa, the impact of road traffic injuries and deaths is predominantly experienced by vulnerable road users (pedestrians) (ibid). In Uganda, the road traffic mortality rate was 16 deaths per 100,000 population in 2021 which is slightly above the global average of 15 deaths per 100,000 population but lower than the African regional average of 19.4 deaths per 100,000 population.[ix] The majority of the road traffic accidents in Uganda involve vehicles and motorcycles, and contribute about 45% of all admissions to hospitals in Uganda (MoH, 2019).

The estimated cost of treating one severely injured motorcycle accident victim is US$2,800 per year (Sebaggala, 2014) which translates to US$9.9 million per annum (World Bank, 2022). Therefore, allocating a portion of the revenue from motor vehicle insurance premiums to cover health-related expenses from road traffic accidents would be very beneficial. Uganda has already envisioned this financing option in its health financing strategy (MoH, 2016).

2.3.3 National Health Insurance

Proponents of social health insurance (SHI) contend that it allows governments to mobilize additional revenue from different sources (including payroll taxes, employer contributions, and government subsidies) to improve healthcare access for the entire population, including the poor (Jamal et al. 2022). For example, a study found that health insurance coverage improved at least two of four measures of maternal health care utilization in Ghana, Indonesia, and Rwanda (Wang et al. 2017). It is further argued that SHI can enable consistent financing for essential health services by protecting funds for health from annual budget fluctuations. In other words, SHI has the potential to increase transparency and provide certainty about funding levels for health in the medium term. Additionally, a well-designed SHI system can enhance transparency, improve cost containment, and create efficiencies in healthcare delivery by enhancing strategic purchasing mechanisms (Jamal et al. 2022). For instance, Afriyie et al. (2023) observe that Zambia's SHI scheme is likely to progress towards strategic purchasing for quality healthcare. More importantly, SHI can help reduce out-of-pocket healthcare payments by providing financial protection, particularly for vulnerable populations (Jamal et al. 2022). A study on a SHI scheme in Karnataka, India by Sood and Wagner (2018) showed that the scheme was successful in improving healthcare for the poor and reducing their financial burden in accessing tertiary level healthcare.

Through its health financing strategy (MoH, 2016), Uganda has envisioned the establishment of a national health insurance (NHI) scheme. Consequently, the Uganda NHI Bill of 2019 was approved by the Parliament of Uganda in March 2021 with the objective of providing health insurance for the entire population. The NHI Bill outlines the general structure for the establishment of a NHI scheme in Uganda, the benefits package, and potential sources of financing (P4H Network, 2021). The Bill stipulates that health benefits would be aligned with Uganda's National Minimum Health Care Package (Otieno and Namyalo, 2024). With regards to contributions, individuals in the informal sector were expected to pay US$28.6 annually while formal sector employees were expected to contribute 4% of their salaries while the employers were required to contribute one percent of the employees' salaries. Pensioners were expected to contribute one percent of their monthly pension payments. Dependents under the age of 18 would be covered at no cost, and the government was expected to subsidize contributions for the poor. It was also anticipated that private health insurance schemes would continue to operate alongside the NHI scheme by offering health benefit packages not included in the NHI scheme (Otieno and Namyalo, 2024). However, the NHI Bill was not signed into law by the President of Uganda due to disagreements among some stakeholders (HEJNU, 2023), and it was withdrawn later in 2021 by the MoH to enable further stakeholder engagement and re-drafting. As such, the Bill is currently at re-submission stage (Natukunda, 2022).

Even before it was approved by parliament in 2021, several weaknesses had been identified in the Uganda NHI Bill of 2019. For example, the Initiative for Social and Economic Rights (ISER) made a submission to the Parliamentary Health on Committee on November 20, 2019, where it contended that the Bill did not guarantee immediate coverage for all the poor people, there was no criteria to identify the poor, and absence of strong regulations on private healthcare providers (ISER, 2019). A Member of Parliament also revealed that an actuarial study on the viability of the NHI scheme was required while the Insurance Regulatory Authority of Uganda called for an in-depth review of the technical design, affordability, and sustainability (IRA, 2021). To date, Uganda has not yet established the NHI scheme even though the government is still determined to implement it. Several stakeholders have urged the government to implement the NHI scheme while some civil society organizations have engaged on several occasions to discuss bottlenecks impeding the implementation of the NHI scheme. This includes a meeting that was held on February 22, 2022, where civil society organizations concluded that the bottlenecks delaying the establishment of the NHI scheme were: divergent interests among stakeholders, affordability and challenges related to willingness and ability to pay, lack of innovations in resource mobilization, and low levels of awareness on the potential benefits of the NHI scheme (Natukunda, 2022).

Despite the widespread motivation to introduce a NHI scheme in Uganda, it is highly complex, especially in a country with a large informal sector. Many low- and middle-income countries have struggled with health insurance schemes, facing challenges in enrolment, revenue collection, and financial sustainability (Yazbeck et al. 2023). Implementation would also require extensive administrative capacity, robust legal frameworks, strong political commitment, and substantial upfront investments. Therefore, a thorough analysis of the potential benefits of a NHI scheme in Uganda is critical. Thus, compared to other health financing options, establishing the NHI scheme could be a long-term objective. This is because it is not as immediately implementable as the other health financing options. Additionally,

a national health insurance scheme requires both contributory and non-contributory revenue sources, such as earmarked funds from health taxes. Following the example set by Zambia (Afriyie et al. 2023), the proposed NHI scheme in Uganda could concentrate on improving strategic purchasing and safeguarding individuals from catastrophic health expenditures (World Bank, 2023). Evidence on the feasibility of establishing the NHI scheme, including an actuarial evaluation will be required.

2.3.4 Recommendations on health sector-specific domestic revenue sources

2.3.4.1 Health taxes

To discourage the consumption of harmful products such as cigarettes, alcohol, and sugary beverages, it is necessary to increase taxes on these products. This approach is predicated on the principle that higher tax rates or modifications to the tax base can significantly influence both the price and demand for these products. While increases in tax rates can reduce the quantities consumed, sold, and produced for each of these products, the magnitude of the changes is determined by the elasticity of demand and supply for each product. On the demand side, the size of the reduction is contingent upon the consumers' price elasticity of demand. To assess potential future revenues from health taxes on tobacco, alcohol, and sugary beverages, we re-evaluated raw data from a study by the World Bank (World Bank, 2022).[xi] Our focus was on whether an increase in tax rates could reduce the consumption of harmful products (cigarettes, beers, spirits, wines, and soft drinks) while simultaneously generating additional revenue. The formula below was used:

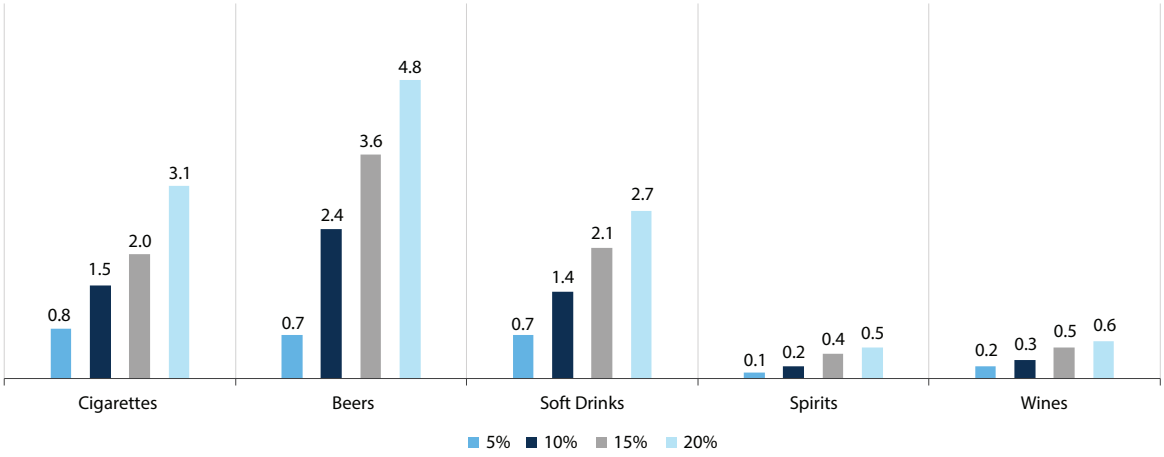
$$Estimated\ Revenue = Revenue_{Base\_year} * Tax\ Bouyancy\ Rate * GDP\ Growth\ Rate$$

Where the revenue (base year) is the revenue of the respective products in the base year; tax buoyancy rate is the responsiveness of tax revenue to changes in GDP, and GDP growth rate is annual expected growth rate of GDP.

The base year for the revenue data was the fiscal year 2018/2019. Based on historical precedence, the tax buoyancy rates for harmful products were assumed to be 0.18 for cigarettes, 0.69 for beers, 0.69 for wines, 0.21 for spirits, and 0.64 for soft drinks. These rates align with the overall excise tax buoyancy rate for Uganda, which was estimated at 0.66 over the period 1996-2003 (Ayoki et al. 2008), and the tax buoyancy of sales and excise tax, recorded at 1.11 over the period 1996-2005 by Mwakalobo (2015). According to IMF projections for the period 2025-2029, Uganda's real GDP growth rate is expected to average 7.6% per year. However, based on historical real GDP growth figures for Uganda over the past five years, a constant rate of 4% per year was applied for the entire estimation period. To come up with an appropriate increase in tax rates on the unhealthy products, we reviewed past trends in consumer responsiveness to tax increases in Uganda to project percentage changes in the quantity demanded. As shown in Figure 12, a five percent tax increase would have a minimal impact on quantity demand across all products. However, as the tax rate continues to rise, the rate of decline in the quantity demand would increase but not significantly.

Among the products analyzed, beer, cigarettes, and soft drinks exhibit higher sensitivity in quantities demanded in response to increases in tax than spirits and wines. At a 20 percent tax increase, beer consumption is expected to decline by approximately 5 percent, while the quantity demanded for cigarettes and soft drinks would decrease by 3 percent (Figure 12). Based on this analysis, we propose a 20% increase in the taxes for cigarettes, beers, spirits, wines, and soft drinks. The proposed rate of 20% is lower than the recommended 50% by the high-level Task Force on Fiscal Policy for Health.[xiii]

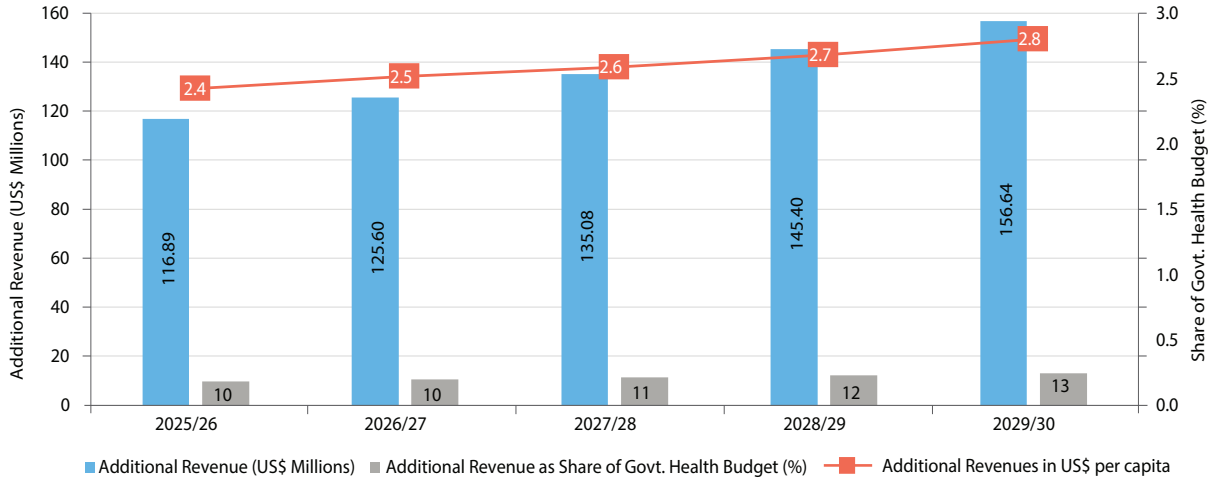
Figure 12: Projected reductions in quantities demanded with increasing tax rates (%)



Source: Author's construction from World Bank (2022)

An additional US$116.9 million could be mobilized in the fiscal year 2025/26 rising to US$156.6 million in the fiscal year 2029/30 if the tax rates on cigarettes, beers, spirits, wines, and soft drinks are increased by 20% (Figure 13). The additional revenue can be earmarked to the health sector to strength the health system and improve health service delivery. Using the fiscal year 2024/25 government health budget as a comparator, the additional revenue could increase the government health budget by 13% over the 2025/2026 to 2029/2030 fiscal years if all the additional revenues are allocated to the health sector (Figure 13). In per capita terms, the additional revenues would be US$2.4 per capita in fiscal year 2025/26 rising to US$2.8 per capita in fiscal year 2029/30. This suggests that a 20% tax increase on cigarettes, beer, spirits, wine, and soft drinks in Uganda has the potential to boost government revenues. If these additional funds are allocated to the health sector, the existing health financing gap can be reduced.

Figure 13: Size of additional tax revenues - 20% tax increase, 2025/26 – 2029/30



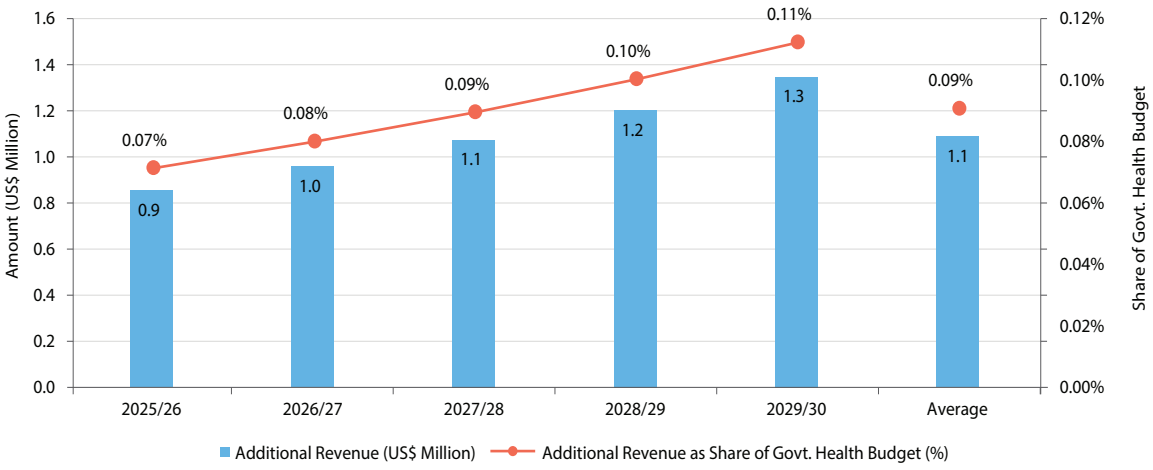
Source: Author's construction from World Bank (2022)

2.3.4.2 Motor Vehicle Accident Fund

As earlier stated, Uganda has a high annual road traffic fatality rate, but motor vehicle insurance coverage is low, with only 33% of vehicles insured despite motor vehicle insurance being mandatory (World Bank, 2022). Additionally, injuries from road traffic accident victims are significant in both the number admitted to hospitals and the cost of treatment (MoH, 2019). Road traffic accident victims often do not receive compensation, resulting in lifelong disability or death. Establishing a Motor Vehicle Accident Fund in Uganda could reduce the public and household costs of treating individuals injured in road traffic accidents and potentially decrease fatalities and disabilities. In Africa, Botswana, Namibia, and South Africa have been running very successful Road Accident Funds for several decades. For example, the Road Accident Fund of South Africa started operations in 1997 and is responsible for "providing appropriate cover to all road users within the borders of South Africa; rehabilitating and compensating persons injured as a result of motor vehicles in a timely and caring manner; and actively promoting the safe use of all South African roads."[xiv] Botswana's Motor Vehicle Accident Fund started operations in 1987[xv] while the Motor Vehicle Accident Fund of Namibia started operations in 1991.[xvi]

Using data from World Bank (2022), we estimated the potential revenue from third party motor vehicle insurance premiums. We assumed that 5% of the gross third-party motor vehicle insurance premiums could be used to finance the proposed Motor Vehicle Accident Fund. It is estimated that, from fiscal year 2025/26 to fiscal year 2029/30, an additional annual revenue of US$1.1 million on average, could be generated if a 5% percent deduction is applied to the gross third-party motor vehicle insurance premiums in Uganda (Figure 14). In per capita terms, the fiscal year 2029/30 revenues would be US$0.02. The estimated average additional revenues that could be generated each fiscal year over the 2025/2026 to 2029/2030 fiscal years are projected to be around 0.1% of the government health budget for 2024/2025 (Figure 14). If this money is dedicated to the provision of surgery services including rehabilitative health, physiotherapy, and blood transfusion; it could make a significant impact on reducing mortalities, disabilities, and treatment costs for road accident victims in Uganda.

Figure 14: Potential revenue for the proposed motor vehicle accident fund



Source: Author's construction from World Bank (2022)

2.3.5 Stakeholder insights

The stakeholders in Uganda who were interviewed considered earmarking resources to health as both feasible and desirable. Stakeholders viewed it favorably due to ease of implementation, potential to improve health outcomes, and generation of additional funds for health. Specifically, some stakeholders advocated for this option due to the potential cost savings linked to a decrease in diseases (such as NCDs) resulting from the reduced consumption of harmful products. Further, there is a favorable political economy landscape regarding the collection of additional resources from the health taxes, given the already existing platforms. However, a less favorable political economy landscape surrounds the designation of these resources for the health sector. Officials from the MoFPED expressed concerns that designating funds for health could establish a precedent, leading to similar requests from other sectors (World Bank, 2022). This fiscal space option is viewed as favorable and sustainable. As observed by the high-level Task Force on Fiscal Policy for Health, "if countries increased their excise taxes to raise prices on tobacco, alcohol, and sugary beverages by 50%, over 50 million premature deaths could be averted worldwide over the next 50 years while raising over US$20 trillion of additional revenues." [xvii]

2.3.6 Afterthought: Health sector-specific domestic revenue sources

While raising revenues through health taxes is a crucial first step, earmarking these funds for health can be challenging. Uganda could face obstacles when attempting to earmark tax revenues to the health sector, such as political opposition, competing budget priorities, or weak governance mechanisms. In 2014, Tonga introduced a tax on tobacco, alcohol, and soft drinks, but the revenue was not earmarked to health but it was channeled to the government's general budget (World Bank, 2019). This was also the case for revenues from a sugar tax in South Africa (South African Treasury, 2021). Studies also suggest that individuals are more likely to support health taxes when they believe that the revenues generated will be allocated towards specific social programs (Bird 2015; Vardavas et al. 2012).

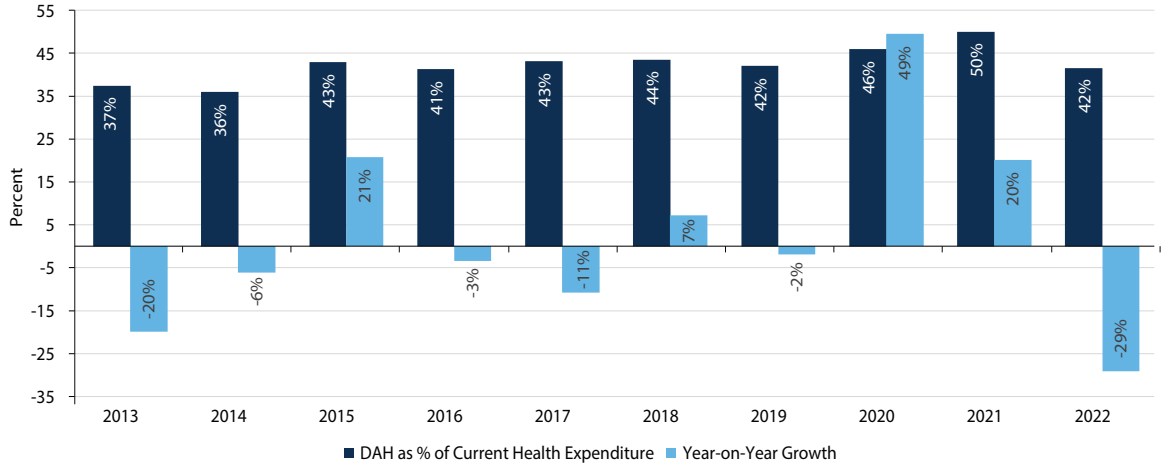
To ensure the effective use of earmarked revenues for health, it is crucial that earmarking processes are aligned with standard budgeting procedures, while maintaining flexibility in allocation within the health sector. In Thailand, a significant part of the tax revenues from alcohol and tobacco are allocated

to the Thai Health Promotion Fund, an autonomous government agency which supports various health promotion activities through grants. The Thai Health Promotion Fund reports to the Thai National Cabinet and Parliament (Pongutta et al. 2019). In the Philippines, the majority of the revenues from health taxes are channeled to the national health insurance scheme with the explicit goal of achieving UHC (Kimwell et al. 2022).

2.4 External Resources

This option is centered on the possibility of increasing funding for the health sector from external development partners. The results suggest that Uganda's health sector is already heavily reliant on external funding from development partners, and the likelihood of mobilizing additional external funding for health is very low. As illustrated in Figure 15, over the past decade, contributions from external development partners have been substantial, accounting for approximately 36% to 50% of the total current health expenditure between 2013 and 2022. Compared to other countries in the Eastern and Southern African region, external health expenditure per capita (current US$) in Uganda was US$14.5 and US$17.8 over the period 2000-2022 and 2013-2022, respectively (Figure 16). Uganda also ranked second after Rwanda in terms of reliance on external health funding (Figure 16). However, the year-on-year growth in health expenditures from external development partners has been fluctuating over the past decade, with no consistent pattern (Figure 15). This highlights the unpredictability of external financing.

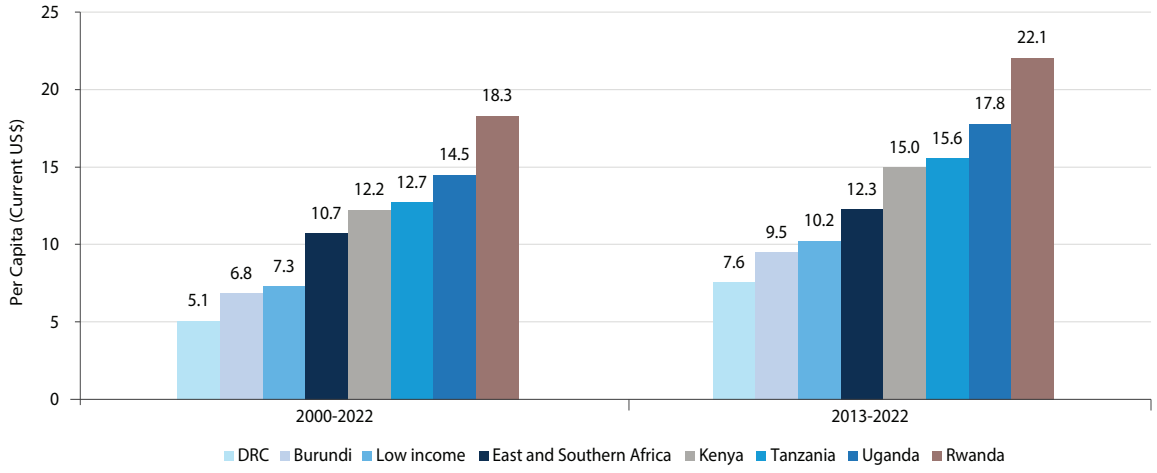
Figure 15: Contribution and growth in real external health expenditure, Uganda



Source: Author's construction from WHO Global Health Expenditure Database

Considering the significant decline in the growth of DAH in 2022 (Figure 15), the likelihood of obtaining additional funding from external development partners is very low. The significant increase in DAH by 49% in 2020, followed by reduced growth of 20% in 2021 (Figure 15), corresponds to the period of the COVID-19 pandemic which led to an increase in external support. Thus, this period can be regarded as an outlier. More recently, in most of the developing countries, the Israel-Palestine and Russia-Ukraine armed conflicts (TRT Afrika, 2023) and change in aid policy by the US Government (USG) (Executive Order No. 14169 of January 20, 2025)[xviii] have led to significant cuts in external funding for health.

Figure 16: External health expenditure per capita (current US$), Uganda vs Peers

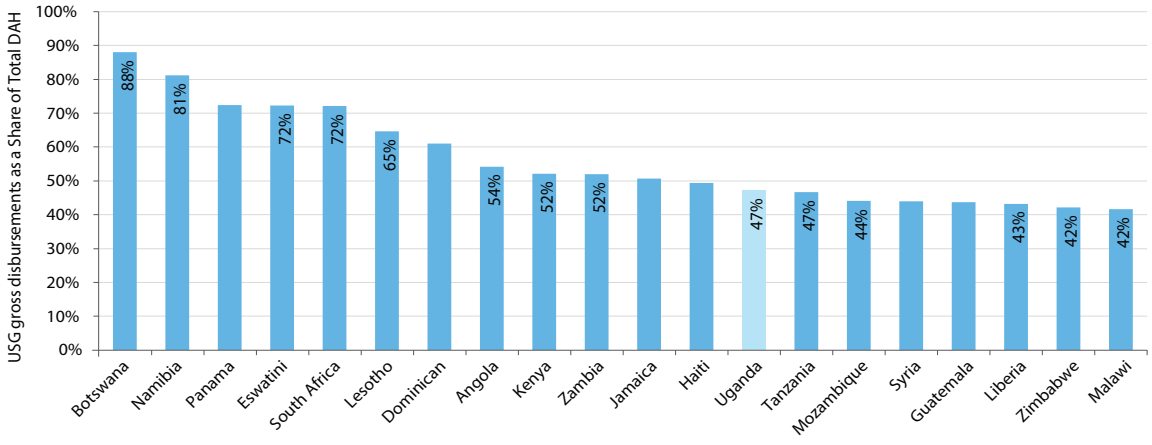


Source: Author's construction from WHO Global Health Expenditure Database

Based on data from the Institute of Health Metrics and Evaluation,[xix] about 62% of the total DAH to Uganda was from the US Government (USG) in 2022.[xx] This was the fifth highest share globally. We used 2022 and 2023 data from the OECD CRS website[xxi] to conduct an in-depth review of the significance of USG funding to Uganda's health sector. Uganda ranked among the top 20 countries worldwide in terms of USG funding to health as a proportion of total DAH. Specifically, Uganda ranked 13th out of the 20 countries (Figure 17). This suggests that the change in USG policy is likely to have a significant adverse effect on existing USG commitments and future funding for the health sector in Uganda. Moreover, given the substantial reliance on DAH in Uganda (Figure 15), the shift in USG policy is predicted to have a profound impact on the overall health system in Uganda.

To address the emerging funding gap, the GoU could seek assistance from other bilateral and multilateral agencies. However, considering that funding from the USG already includes contributions through multilateral organizations such as Gavi, Global Fund, WHO, UNFPA, and NGOs, this effort is likely to be unsuccessful. Notwithstanding the cut in funding from the USG, given that Uganda's economy has been growing rapidly over the past few years, external DAH was always expected to decline. Uganda is projected to transition to a lower middle-income country within a few years, a milestone that will naturally result in reduced development assistance for health.

Figure 17: USG health funding as a share of total DAH - Top 20 countries worldwide



Source: Author's construction from OECD CRS data

2.4.1 Recommendation on External Resources

It is very critical for the GoU to work with development partners to gradually and sustainably transition Uganda from DAH. As observed by the OECD (2021), external development partners need to provide funding in a manner that can easily facilitate transitioning to domestic financing. Therefore, to sustain programs currently funded by external development partners in Uganda, there is need to develop a viable transitioning plan with definite timelines. This can help Uganda to prepare for eventual graduation from external support. To facilitate this, a transition plan developed jointly by the GoU and development partners should be implemented. The transition plan needs to have definite timelines, similar to the transition frameworks by Gavi[xxii] and the Global Fund.[xxiii] Full implementation of the Lusaka Agenda[xxiv] on coordinated action towards domestically financed health systems would also be instrumental. Drawing lessons from the 2008 global financial crisis (Kirigia et al. 2011), the GoU should also strive to implement measures to sustain funding to the health sector.

2.5 Improved Efficiency

Unlike the other four sources of fiscal space, enhancing efficiency does not result in additional funds for health. Rather, it emphasizes the prudent use of existing resources to achieve maximum value and optimal health outcomes. Improving PFM is pivotal to achieving greater efficiency and effective delivery of services in the public sector. As such, the GoU has implemented a range of PFM reforms over the past three decades. The PFM reforms have been guided by various strategies, including the PFM Reform Strategy (2014-2018) (ICPAU, 2020), and the PFM Reform Strategy 2018-2023 (MoFPED, 2018) and the PFM Act 2015. The main objective of this strategy was to promote transparency, accountability, equity, fiscal discipline, and efficiency in the management and use of public resources for improved service delivery and economic development (MoFPED, 2018). These principles are crucial for improving service delivery in the health sector. For instance, improved PFM can enhance transparency and accountability in health spending and ensure that funds for health are used efficiently and effectively. In turn, this would lead to increased trust in the health system and subsequently, improved health outcomes. Similarly, promoting equity in health spending can ensure that resources are allocated according to need, thereby improving access to health services for vulnerable populations.

Uganda has made notable progress in improving PFM arrangements in the health sector. For example, Uganda has undertaken major budgetary reforms to optimize planning and budgeting, transparency, and accountability (Abaho, 2024). Some of the key reforms which have been undertaken include direct health facility financing; the shift to program budgeting; scaling-up and mainstreaming of results-based financing (RBF) at LG level; revision of the resource allocation formula for the allocation of primary health care non-wage recurrent government grants to LGs; and establishment of a credit line for essential medicines and health supplies under the National Medical Stores. The latter was aimed at ring-fencing the budget for medicines and health supplies from fluctuations in funding. While Uganda's PFM reforms have focused on all sectors of the economy, the health sector has benefitted immensely, and this signals a promising path towards improved fiscal management and better health outcomes. One notable example is the integration of the RBF mechanism at LG level at all the health facilities countrywide. This initiative was informed by the successful implementation of RBF in the health sector through a World Bank-financed project.[xxv] An analysis of performance indicators during the RBF implementation period

revealed improvements in financial and managerial autonomy, efficiency in resource allocation and use, and accountability. These contributed to the increased quantity and quality of health services (Mayora et al. 2024).

In the context of the health sector, efficiency can be examined from two dimensions: *allocative efficiency*, which involves selecting the highest impact interventions and optimal mix of inputs to produce outputs that most effectively address the country's primary health challenges; and *technical efficiency*, which looks at the degree to which maximum output is obtained for a given level of inputs. To assess the level of efficiency in Uganda's health sector, we examined various studies that have been conducted on this topic in Uganda. The results show that Uganda's health system is relatively more efficient than some peer countries. This can be attributed to the low cost of key inputs such as salaries and wages for health workers which are lower than most of the peer countries in the region. For example, Uganda's health workforce wage bill as a share of the total public expenditure on health estimated at 37% in 2020/21 is much lower than the recommended range of 45%-60% for low-income countries in Africa (World Bank, 2023). Consequently, a study by the World Bank shows that Uganda is more efficient than its aspirational peers and some countries in East Africa (Rwanda and Kenya) at using its limited resources to produce quality health services (World Bank, 2023).

Although the PFM reforms have contributed to several achievements, challenges persist. The challenges include a weak linkage between resource allocation and results, weak interoperability of information systems, low human resource capacity, and weak enforcement of accountability and transparency in service delivery (Abewe et al. 2023). Prioritization of projects and ensuring predictability of funding for service delivery is also a challenge (MoFPED, 2018). In the health sector, there are discrepancies between budget allocation, release, and actual expenditure. In 2022/23, only 92% of the government health budget was released, with 85% of the released amount being utilized. On-budget donor faced similar challenges, with only 86% of the funds that were committed being released and 68% utilized (MoH, 2024a). Lengthy procurement processes were the main reasons that was cited for the low budget execution and absorption of donor funds. The low budget execution and absorption rates compound the health sector's financing challenges, which are already significant due to the country's high disease burden and growing population. Improving budget execution and absorption in the health sector is crucial, as advocating for additional resources becomes redundant if budgeted funds are not disbursed and utilized.

The allocation, management, and disbursement of DAH in the health sector in Uganda is a huge challenge. Existing evidence shows that most of the DAH in Uganda is off-budget. For example, about 84% of the total DAH in the health sector in Uganda over the fiscal years 2014/15–2020/21 was off-budget (World Bank, 2023). Off-budget DAH is managed and channeled outside the government financial management systems. Rather than channeling the DAH through the government budget or PFM system, development partners disburse it through implementing agencies or through systems managed by themselves. This approach allows external development partners greater control over the utilization of DAH, but this can lead to duplication of funds and fragmentation of the health system. Off-budget support typically focuses on specific diseases or health programs, reflecting donor priorities rather than comprehensive health system needs (Mayora, 2021). As a result, off-budget funding limits the

government's flexibility in resource allocation and its ability to re-prioritize funding for emerging needs. It also negatively affects the PFM system in Uganda. The large proportion of off-budget DAH will make it extremely difficult for the GoU to sustain the financing and implementation of donor-funded programs in future (World Bank, 2023). Therefore, it is crucial to address these issues to ensure the efficient and effective use of DAH in Uganda's health sector.

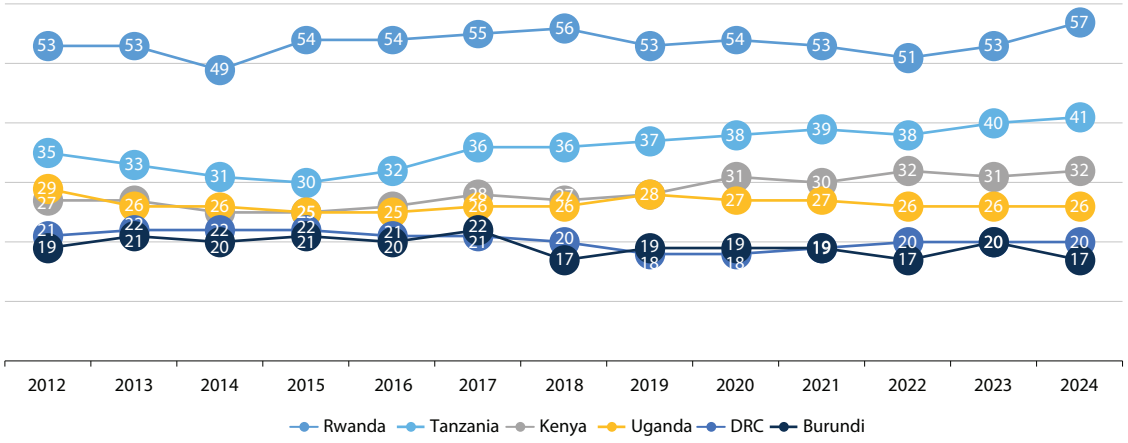
Uganda's health system has substantial room for improving technical efficiencies across multiple domains. An analysis of the performance of 78 general hospitals in Uganda over the fiscal years 2012/13-2016/17 showed that the hospitals were capable of delivering services by using 31% fewer resources (Ayiko et al. 2020). Similarly, a study by Ayesigwa (2019) found that Level III & IV Health Centers could have delivered their current level of services with 18% fewer resources. These findings align with an earlier study which suggested that several health facilities in Uganda can handle higher patient volumes at their current levels of staffing and infrastructure (IHME, 2014). The cross-programmatic efficiency study (MoH and WHO, 2022) also identified several inefficiencies in the health sector in the areas of health financing, service delivery, human resources for health, information systems, supply chain management, and governance. Details of the inefficiencies are presented in Annex I. Various factors contribute to observed inefficiencies in Uganda's health sector. These include multiple purchasing and procurement systems, fragmented implementation systems operating in parallel and vertical silos, overprescription and expiry of drugs, pilferage of drugs, suboptimal use of facilities, and weak governance (MoH, 2023). Consequently, Uganda is less efficient than Congo Republic, Sudan, and Ethiopia at producing quality health services (World Bank, 2023).

Stakeholders who were interviewed as part of this study highlighted concerns about the presence of ghost health workers and drug thefts in the public health system. These inefficiencies not only waste resources but also undermine the quality and accessibility to health services which then leads to poor health outcomes including mortalities. A case study by the World Bank in three districts (Ntungamo, Mukono, and Nwoya) revealed deficiencies in the management of the payroll for health workers. The study uncovered instances where some health workers were being paid through non-health facility cost centers and non-existent health centers. Although the health workers were serving at other health centers, the reasons for their pay points being at non-existent health centers was unclear (World Bank, 2023).

Uganda faces a significant shortage of skilled health workers, with an uneven distribution across its sub-regions. Although certain sub-regions have a higher number of skilled health workers, their efficiency and productivity in delivering quality maternal services is low (World Bank, 2023). A study by the World Bank (2023) showed that Karamoja and Kigezi sub-regions have more skilled health workers, but they have lower institutional deliveries than other sub-regions in the country. Consequently, maternal deaths at public facilities are higher in sub-regions which have higher numbers of skilled health workers. This suggests that there are some gaps in implementation efficiency which leads to poor quality of maternal healthcare services (World Bank, 2023).

High levels of corruption and absenteeism in the health sector in Uganda increases the cost of service delivery and perpetuates poor health outcomes. A study by the Inspectorate of Government revealed significant monetary losses in the public health sector due to: (a) absenteeism of health workers, UGX495 billion (US$133 million); (b) corrupt procurement practices, UGX3.5 billion (US$1 million); and (c) bribes or gifts to healthcare providers for better services, UGX140 billion (US$38 million) (IGG, 2021). These findings align to the four main sources of inefficiencies in health sectors globally, namely: health care workers, hospital services, health system leakages, and health care services (Chisholm and Evans, 2010). Moreover, Uganda has a high level of corruption, and was ranked 140th out of 180 countries on the 2024 Corruption Perceptions Index.[xxvi] While some countries made significant progress in reducing corruption between 2012 and 2024, Uganda is among countries where corruption levels have remained unchanged.[xxvii] Across countries in the East African community, Uganda ranks below Rwanda, Tanzania, and Kenya (Figure 18).

Figure 18: Trends in the corruption perceptions index, 2012-2024, East African Community



Source: Author's construction from Transparency International data

2.5.1 Recommendations on improving efficiency

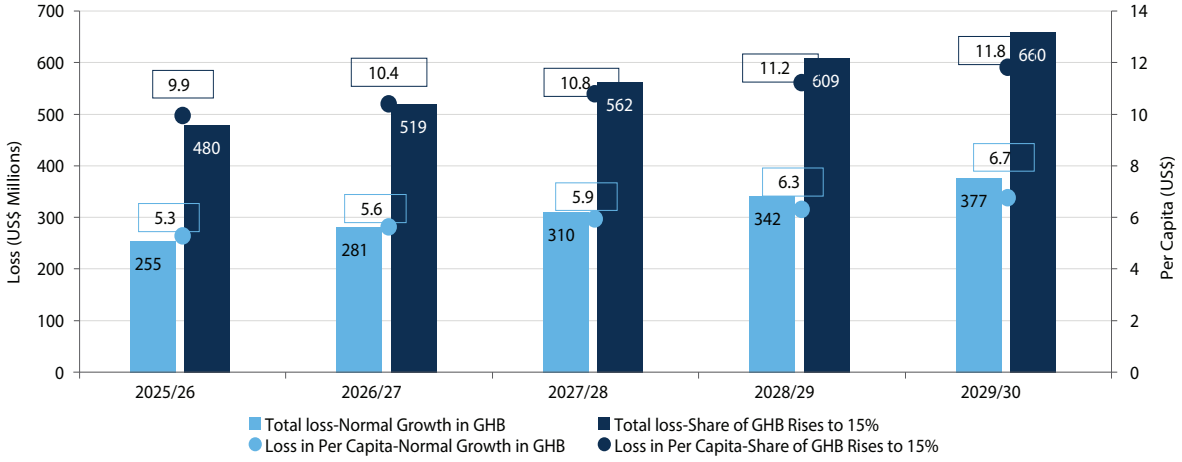
Uganda's health sector is grappling with a myriad of challenges, including allocative and technical inefficiencies. Firstly, as discussed in section 2.4, the health sector in Uganda has relied on DAH for several decades. However, the level of DAH has been decreasing over the years, with a significant reduction in January 2025. Therefore, Uganda's chances of generating additional DAH in the short-to-long term are extremely low. The GoU and external development partners should collaborate to eliminate duplication and fragmentation of DAH by moving towards the use of government PFM, procurement, and reporting systems. Pooling of DAH either physically or virtually should be among the various options that should be explored. This could help to minimize off-budget support which is associated with duplication and fragmentation of DAH. Based on discussion with development partners, MoH officials, and other key stakeholders, "virtual pooling" was consistently identified as the most feasible mechanism for better coordinating DAH. Stakeholders particularly emphasized how this approach allows development partners to maintain control of their funds while improving coordination and alignment with national priorities. While direct budget support would be the most effective approach for the management and disbursement of DAH, interviews with both government officials and development partners highlighted some mistrusts in the current PFM system in Uganda that make it less feasible in the short term.

The GoU needs to work with development partners to fully implement the Lusaka Agenda.[xxviii] Specifically, the Lusaka Agenda calls for countries and development partners to: (a) Make a stronger contribution to primary health care by effectively strengthening systems for health, (b) Move towards sustainable, domestically-financed health services, (c) Strengthen joint approaches for achieving equity in health outcomes, (d) Achieve strategic and operational coherence, and (e) Coordinate approaches to products, research and development, and regional manufacturing to address market and policy failures in global health.[xxix] In line with the Lusaka Agenda, the GoU could collaborate with development partners through joint planning and implementation of strategies aimed at increasing domestic resources for health, improving efficiency in the use of available resources, and ensuring sustainability of health financing. Such a partnership would not only strengthen Uganda's health system but also promote ownership and accountability, thereby fostering sustainable development.

To quantify the monetary loses from technical inefficiencies, results from the 2019/20 study by the Inspectorate of Government were used to estimate future monetary losses due to absenteeism and corrupt procurement practices in the public health sector in Uganda. Based on information from Transparency International,[xxx] corruption levels in Uganda have remained unchanged between 2012 and 2024. Therefore, to project the losses for the fiscal years 2025/26-2029/30, we assumed that corruption levels will be at the same level. The aim was to estimate continued monetary loss of government health funds if corruption was not controlled. For government health spending over the fiscal years 2025/26-2029/30, we assumed: (i) a natural nominal growth in the government health budget based on historical trends, and (ii) the government health budget as a share of the total national government budget increasing to 15% as previously estimated in section 2.2. The results are presented in Figure 19.

Uganda is likely to lose US$255 million to US$377 million annually in government health funds over the fiscal years 2025/26 to 2029/30 due to health worker absenteeism and corrupt procurement practices (Figure 19). If the government health budget rises to 15% of the total national government budget, the loss in government health funds due to health worker absenteeism and corrupt procurement practices would rise to between US$480 million and US$660 million annually, over the same period. This means that increasing funding for health without addressing corruption and other

Figure 19: Projected loss of government health funds, 2025/26-2029/30



Source: Author's construction

inefficiencies would be ineffective. In per capita terms, annual losses would range from US$5.3 to US$6.7 under natural growth in the government health budget and from US$9.9 to US$11.8 if the government health budget share is at 15% (Figure 19). If these losses are prevented, it would enable Uganda to deliver more services as outlined in the National Essential Health Care Package and to advance towards the achievement of UHC.

Governance and anti-corruption mechanisms are essential to ensure value for money in the health sector. To effectively tackle corruption in the health system and the broader economy, we recommend the development and implementation of a comprehensive national strategy on good governance and anti-corruption. While this was a high priority for stakeholders and is widely supported by the Ugandan public, it will require strong political will to succeed. Additionally, the GoU should strengthen PFM systems, as well as the broader governance and coordination structures. Particular attention should be given to reviewing and improving the processes for quantification, procurement, storage, and distribution of medicines, to curb the theft of essential medical supplies. Investing in systems that link patient data to medicine consumption would enhance transparency and accountability. Furthermore, performance indicators should be established for all health workers at all levels of the public health system. This includes developing mechanisms and systems for real-time tracking of the performance of health workers. This would drive improvements in service delivery.

2.5.2 Stakeholder insights and recommendations

Most of the stakeholders who were interviewed expressed the view that enhancing efficiency in resource allocation and use was a desirable approach for increasing value for money. They underscored several critical issues within the country's health system that require attention. These include high absenteeism rates and low productivity among health workers, inefficient procurement and distribution of medicines and supplies, and the duplication of donor-funded programs. To improve efficiency, the stakeholders called for the streamlining of programs to reduce administrative costs, combat corruption; and improve governance.

3. KEY FINDINGS AND RECOMMENDATIONS

3.1 Key Findings

Despite commendable progress in health outcomes over the past decade, Uganda's health sector still faces significant challenges in meeting the growing healthcare needs of its population. Among others, this can be attributed to inadequate government funding to the health sector. To increase funding to the health sector while also improving efficiency in resource allocation and use, this study assessed the feasibility of increasing fiscal space for health in Uganda, by looking at five areas. These are: (a) conducive macroeconomic conditions, (b) Reprioritization for Health, (c) Health Sector–Specific Domestic Resources, (d) External Resources, and (e) Improved Efficiency.

The results show that there is room for increasing fiscal space for health through domestic resource mobilization. The potential to mobilize additional domestic resources is contingent upon having a conducive macroeconomic environment. The results show very conducive macroeconomic conditions favorable for the generation of additional revenues which can be allocated to the health sector. Overall, the results show that by the fiscal year 2029/30, Uganda has the potential to generate an additional US$1,626 million annually, equivalent to US$29.1 per capita per year. This can be generated from two sources: reprioritization for health and health sector-specific domestic resources. The additional US$29.1 per capita would increase the domestic general government health expenditure (GGHE-D) per capita from US$10 in fiscal year 2021/22 to US$39.1 per fiscal year by 2029/30. The additional funds can increase Uganda's CHE per capita from US$44 in 2021/22 to US$73.1 annually by the fiscal year 2029/30. Compared to Uganda's annual health need, the estimated US$73.1 CHE per capita would be more than the target of US$58 per capita (moderate scenario), but less than the target of US$106 per capita (optimistic scenario) for the fiscal years 2025/26-2029/30.

The projections for increasing fiscal space in this paper are very conservative. Foremost, given the low tax revenue as a proportion of the GDP in Uganda (estimated at 12.5% in 2022), there is ample room for Uganda to increase the tax to GDP ratio to 16% in line with the precedence in other Africa countries. Secondly, the proposal in this paper is to increase tax rates on unhealthy products by 20%, which is much lower than the recommended 50% by the high-level Task Force on Fiscal Policy for Health. This means that additional revenues can be mobilized if the tax rates for unhealthy products are increased by 50%.

While it is important to raise additional revenues, it is equally important to improve efficiency. If efficiency is not improved, about US$11.8 per capita of the total available funds would be lost each year. In other words, a substantial portion of the additional US$29.1 per capita from the expanded fiscal space for health would be lost each year if there are no improvements in efficiency.

3.2 Recommendations

a) Implement tax reforms to improve efficiency in tax revenue collection.

b) Maintain a stable economic environment and fiscal discipline for continued economic growth and revenue generation.

c) Implement the strategies to increase fiscal space as provided, through government budget reprioritization and health sector-specific domestic resources. These strategies include:

   i. Raising the GHB as a share of the TGB from the current 8% to 10%, 12%, or 15% annually.

   ii. Implement a 20% increase in health taxes on cigarettes, beers, spirits, wines, and soft drinks in the short-run rising to 50% in the medium-term.

   iii. Introduce a levy of 5% on the gross third-party motor vehicle insurance premiums.

   iv. Establish a dedicated budget line or a Motor Vehicle Accident Fund.

   v. Generate more evidence on the feasibility of establishing a NHI scheme. This includes undertaking an actuarial evaluation of the proposed NHI.

   vi. Fully implement recommendations of the Lusaka Agenda on coordinated action towards domestically financed health systems.

   vii Develop and implement a comprehensive transition plan with timelines to shift from DAH to government domestic funding.

   viii Reach an agreement with development partners for them to progressively increase the level of on-budget support.

   ix. Establish mechanisms to pool development assistance for health virtually.

   x. Reduce inefficiencies and corruption through muti-faceted and multi-level actions including strengthening PFM systems and governance structures; integrated planning, budgeting, and disbursement; strengthening performance management; improving procurement and supply chain management; scaling up digital health; and monitoring of health interventions and results.

Notes

[i] According to Uganda's National Essential Health Care Package (MoH, 2024b), the health need is estimated at US$58 per capita and US$106 per capita for the moderate and optimistic funding scenarios, respectively, over the period 2025/26-2029/30.

[ii] Task Force on Fiscal Policy for Health, 2024. Accessed 30, March 2025. https://assets.bbhub.io/dotorg/sites/64/2024/09/Health-Taxes-A-Compelling-Policy-for-the-Crises-of-Today.pdf

[iii] Ibid

[iv] CAOs are responsible for finance and administration functions in their area of jurisdiction. They play a crucial role in managing the local government's resources and ensuring the smooth operation of administrative tasks. This includes overseeing the implementation of policies, managing staff, and coordinating with other government agencies.

[v] GGHE-D excludes on-budget donor assistance for health.

[vi] For more details on the calculation of these elasticity estimates and values for different time periods, please see Annex I.

[vii] Smart health taxes: A win for public health and the economy , World Bank Blog in Investing in Health, July 10, 2024. Accessed 30, March 2025. https://www.worldbank.org/en/topic/nutrition/brief/health-taxes

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[xii] Tax buoyancy rate measures how responsive tax revenue is to changes in GDP. It indicates whether tax revenue grows proportionally, faster, or slower than the economy.

[xiii] Objectives of the Task Force on Fiscal Policy for Health of the Bloomberg Organization, 2024. Accessed 30, March 2025. https://www.bloomberg.org/public-health/building-public-health-coalitions/task-force-on-fiscal-policy-for-health/

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[xx] This analysis included the contribution of the USG through multilateral agencies.

[xxi] Accessed, 30 March 2025. https://stats.oecd.org/Index.aspx?DataSetCode=crs1

[xxii] Gavi Co-financing Policy. Published January 2023. Accessed, 30 March 2025 https://www.gavi.org/sites/default/files/programmes-impact/Gavi-Co-financing-Policy.pdf

[xxiii] Global Fund Sustainability Transition Co-financing Policy. November 2024. Accessed, 30 March 2025. https://www.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdf

[xxix] Published December 2023. Accessed, 30 March 2025. https://futureofghis.org/final-outputs/lusaka-agenda/

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[xxvi] Consulted, 30 March 2025. https://www.transparency.org/en/cpi/2024

[xxvii] Ibid.

[xxviii] Published December 2023. Accessed, 30 March 2025. https://futureofghis.org/final-outputs/lusaka-agenda/

[xxix] Ibid.

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ANNEX I: DETAILS OF CROSS-PROGRAMMATIC INEFFICIENCIES IN THE HEALTH SECTOR

Extracted from a study by the Ministry of Health Uganda and World Health Organization (2022).

1. Health financing
    - Multiple and fragmented funding sources
    - Heavy reliance on donor aid, which is unreliable, unpredictable, and channeled off-budget
    - Allocation and use of some resources is not results/performance-based.

2. Service delivery
    - Limited horizontal and vertical integration of service delivery resulting in fragmented patient care pathways, missed opportunities and inefficient resource use
    - Weak and ineffective referral system with almost no gatekeeping – arising from the nonavailability of service packages. This leads to increased costs of care for both the user and the health system and overload at secondary and tertiary levels
    - Heavy focus on curative services and care drawing away resources and efficiencies associated with preventive care. The government is committed to health promotion and prevention, but budget allocations do not reflect that commitment.

3. Human resources for health
    - Verticalized recruitment, use, and remuneration of human resources at health facilities. Programs separately recruit staff for distinct programs with varying incentive arrangements.
    - Uncoordinated capacity building arrangements that can be disruptive to service delivery facilities
    - Poor performance management of health workers resulting into poor health worker attitude, absenteeism, and presenteeism.

4. Information systems
    - Suboptimal use of data at all levels
    - Different data capture tools at facility level by various programs
    - Limited data sharing across programs.

5. Supply chain and procurement
    - Multiple and fragmented procurement systems lead to increased costs.
    - Procurement should be guided by robust quantification of projected need. Poor quantification has resulted in unnecessary wastages through expiries (over supply) and stockouts (under supply).

6. Governance
    - Inadequate stewardship capacity in the health sector
    - Government/donor/stakeholder coordination arrangements exist at national level, but these structures are almost non-existent at subnational level
    - Misappropriation of resources and leakages in the system.

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