# STATEMENT FROM THE MINISTRY OF HEALTH

Technological advances, demographic transitions, the rapid changes of trends in morbidity and mortality, and the emergence of public health problems such HIV/AIDS, Hepatitis, Ebola and Marburg call for efficiency in the use of resources, and, in most cases, for additional resources. In Uganda, health care is provided through a complex and dynamic public and private sector (for-profit and not for profit) system. In this environment, policy-makers need reliable information on financing sources and use of funds dedicated to the health sector (preferably comparable information across all financing sources) to improve the national health system performance.

Because it describes the current use of resources within the health system, National Health Accounts (NHA) information is helpful to decision makers. When conducted on a regular basis, NHA is a systematic, consistent, and comprehensive methodology for monitoring financial flows within the health sector. Indeed, the NHA tool was developed specifically to inform the health policy process: policy dialogue, design, and implementation, as well as monitoring and evaluation of ensuing health interventions. NHA findings are evidence that help policymakers, non-governmental stakeholders, health development partners and health committees, boards and managers make better decisions in their efforts to improve health system performance.

With technical and financial support WHO and UNFPA, The Ministry undertook the tracking of resources and expenditures for health in order to help to align actions to priority activities and the sector moves towards midterm review of the health sector development plan (HSDP).

It is therefore important to encourage and bring all stakeholders, including donors, to support this resource tracking effort, proof of effective and evidence-based management of resources allocated to health.

It is my sincere hope that the health sector stakeholders will use the NHA findings to re-focus their resources to cost effective interventions that will accelerate our pace towards achieving the SDGs. All stakeholders should join hands in ensuring that the objectives of compiling the NHA for financial years 2014/15 and 2015/16 are fully realized.

Dr. Diana Atwine

**Permanent Secretary** 

#### **FOREWORD**

Health Financing is one of the top most health systems agenda. The main concern is not only on the total amounts or volumes of health expenditures but also equity, effectiveness and efficiency. More importantly, how these funds are allocated among different levels of health services, priority health interventions and identifications of socio economic groups benefiting from the financial resources allocated for health. In trying to respond to some of these questions the Ministry has conducted seventh round NHA (2016). The first round was conducted in 1998.

This report presents the National Health Accounts for Uganda covering the FY 2014/15 and 2015/16 The uniqueness of this NHA is that it also contains the analysis of household health expenditure based on the UDHS 2016 report. Uganda has committed herself to the achievement of SDGs and this has necessitated the in-depth analysis of all health related SDGs.

Among others, the benefit of the financing information presented is that, it provides inputs into the preparation of Sector Strategic plans, which the Ministry plans to review in the fiscal year 2018/19. It is evident that NHA is a useful tool in mapping the sources and uses of funds and thereby assisting in devising appropriate health financing policies and suggesting how to reallocate resources efficiently.

This report in its wholeness facilitates and shades light on the resource commitments, disbursements and actual expenditures and their relationship with the policy statements. The stakeholders in the health sector are encouraged to read and make use of this report.

Dr. Henry Mwebesa

**Ag.Director General of Health services** 

#### **ACKNOWLEDGEMENT**

The development of this seventh publication of Uganda National Health Accounts is based on the internationally recognized and revised 2011 version 3.34 of Systems of Health Accounts (SHA 2011). This was made possible through the collaboration and support of the World Health Organisation and UNFPA.

We express our sincere gratitude and recognise the support from the Uganda Bureau of Statistics for providing statistical data on households and national macro-economic statistics which were used to compile this report. They made significant contribution towards the compilation of this publication.

We also wish to thank the entire National Health Accounts (NHA) team members for their patience and support throughout the production and development of this publication. Special thanks to **Mr Ezrah Trevor Rwakinanga** – Technical Advisor, **Dr. Abel Nkolo** of WHO-Country office Uganda and **Dr. Hapsa Toure** – Technical Advisor (TA) from WHO Headquarters in Geneva for their invaluable effort in guiding the NHA technical team..

Data analysis was done using a combination of software especially Health Accounts Analysis Tool (HAAT) and MS-Excel. Interpretation of the results and the writing of the report were done by the NHA technical team. Finally, the efforts, contributions and the enormous support from the various programs and units of Ministry of Health are greatly acknowledged. The Ministry would like to appreciate WHO and UNFPA for co-financing the publication of this report.

Tom Aliti

**NHA Focal Person** 

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#### **KEY MESSAGES FROM THE NHA REPORT 2017**

The overall purpose of the NHA study initiative is to reduce health inequalities affecting the poorest populations in the region by focusing on supply and demand-side interventions, particularly changes in policy, new interventions, the expansion of proven and cost-effective healthcare packages, and the delivery of incentives for effective health services.

Critical areas of focus are the problems regarding the efficiency and equity of resource allocation as a consequence of inadequate distribution and to evaluate the efficiency and effectiveness of public spending and health care logistics, as well as their effects on the most disadvantaged population groups.

The methodology of the System of Health Accounts (SHA 2011) provide a systematic description of the financial flows related to the, production consumption and financing of health care goods and services.

Their intent is to describe a health system from an expenditure perspective and to provide a clear and transparent picture of the key transactions (flows) and the structure of the health financing system of countries.

There are two main users of NHA - for international audience, where the emphasis is on a selection of internationally comparable expenditure data, and for national use with more detailed analyses of health care spending and a greater emphasis on comparisons over time.

The most current methodology SHA 2011 was used to ensure that in future NHA exercises the same conceptual framework and would ensure the comparability of information. The implementation process for the study involved the following key stages:

Planning; data collection; data processing; validation of the final report which involved several meetings with Ministry of Health Officials together with a set validation meeting; and final report.

#### **Interpreting Data for Policy Purposes**

The report describes several critical components of the Uganda's Health Care System. The estimation of expenditures and financing flows by NHA provides a solid indicator of the "financial health" of a health system, and this can be used as a strategic planning tool.

The value of NHA is not the findings themselves but the "so what" questions that the findings can answer. For example, Government of Uganda spends 7.4 percent of its GDP on health care. This information in itself is not as meaningful as the answer to "so what if Uganda spends so much on health care?"

On comparing this level of expenditure with health outcomes in Uganda, or with other countries in its socio-economic category, the answer to the "so what" question becomes apparent – this level of expenditure may be so low for a country that is experiencing high rate of economic growth. The policy implication, then, is reform and reprioritization in the health system. In other words, NHA results must be analysed in terms of the broad policy context. The full value of NHA is in a three-step process – obtaining NHA results, interpreting the results, and implementing appropriate policy.

#### **KEY MESSAGES**

- National health accounts (NHA) track the flow of money through the health system to monitor, compare and evaluate health sector performance. In the report, country data have been under-reported and underutilized for policy analysis.
- Increased reporting and utilization of NHA data assist governments to pursue national goals, including health planning and public financial management, regulation of public and private services, aid harmonization and universal coverage.

Ш	provide an accessible, consistent and valuable tool for monitoring regional, donor and country health sector performance, and demonstrate the utility of building a genuine NHA network in the East African Community.
	The Country needs to address high levels of out of pocket expenditure in order to protect households from catastrophic spending by broadening pre-payment mechanisms such as Social Health Insurance. This is in line with World Health Assembly resolution of 2005 on Universal Health Coverage and sustainable health financing and as well as revisiting the Paris Declaration that calls for greater Investments in the Health Sector and Social Health Insurance and Financing
	Increase government investment in health towards meeting the Abuja Declaration target and reduce the dependence on external resources to finance health care. This is especially more critical now given the macro-economic challenges facing most industrialized countries.
	Strengthen government's stewardship role in coordinating donors and ensuring alignment to country strategies in line with the Paris Declaration principles for more effective aid. In this regard, the development of strategic partnerships which allow for predictability of funds over a longer period will ensure sustainability of funding.
	Explore alternative ways of mobilizing domestic resources to improve financial sustainability including the improvement of efficiency in resource use.

In summary, the report indicates low per capita spending at US\$51 per year and reduction from the previuos study findings and low public financing of health care services at US\$ 10 per capita per year to deliver health care services and about US\$ 1.09 per capita per year for capital development in the health sector. These figures compared to what is internationally acceptable are far below the expectations of African Union and UN bodies. The results further indicated LOW prepayment schemes at 1%, high spending by households on health care at US\$21 per capita, high donor dependency at US\$20 per capita per year especially for disease based programs, low spending on reproeductive health, inequity in distribution of resources and low spending for preventive health care services.

AHC	Ambulatory Health Care	NHA	National Health Accounts
AIDS	Acquired Immune Deficiency Syndrome	NHIS	National Health Insurance Scheme
ASMC	Ancillary Services to Medical Care	OECD	Organization of Economic Corporation Development
ATP	Alternative or Traditional Practitioners	OPP	Out-of-Pocket Expenditure
CSOs	Civil Society Organizations	PATHS 2	Partnership For Transforming Health Systems 2
CWIQS	Core Welfare Indicator Questionnaire Survey	PHC	Primary Health Care
DFID	Department for International Development	RH	Reproductive Health
ENSK	Expenditure Not Specified Kind	SHA	System of Health Accounts
MOH	Ministry of Health	MOH	Ministry of Health
GDP	Gross Domestic Product	TB	Tuberculosis
GGE	General Government Expenditure	THE	Total Health Expenditure
GGHE	General Government Health Expenditure	UNAIDS	United Nation Aids
GHS	General Household Survey	UNFPA	United Nation Fund for Population Activities
GHS	General Household Survey	UNFPA	United Nation Fund for Population Activities
HAAT	Health Accounts Analysis Tool	USAID	United States Agency for International Development
HIV	Human Immunodeficiency Virus	WHO	World Health Organisation
HMBs	Health Management Boards	CHE	Current health expenditure
HMN	Health Metrics Network	GoU	Government of Uganda
HMOs	Health Maintenance Organizations	MoLG	Ministry of Local Government
ICHA	International Classification for Health Accounts	PHP	Private Health Providers
IMNCH	Integrated, Maternal, Newborn and Child Health	PNFP	Private Not for Profit
IEC	Information, Education and Counselling	IGA	Income Generating Activities
LG	Local Government	UCMB	Uganda Catholic Medical Bureau
LGA	Local Government Act	UPMB	Uganda Protestant Medical Bureau
LGHE	Local Government Health Expenditure	UMMB	Uganda Muslim Medical Bureau
MDAs	Ministries, Departments and Agencies	GHI	Global Health Initiatives
MDGs	Millennium Development Goals	UGX	Uganda shillings
UAC	Uganda Aids Commission	OOP	Out of pocket contributions
NASA	National Aids Spending Assessment	WHS	Work Health and Safety Information
UBOS	Uganda Bureau of Statistics	US\$:	United states dollars
UDHS	Uganda Demographic and Health Survey	PER	Public Expenditure review
NGO	Non-Governmental Organisation	AHSPR	Annual Health Sector Performance Report
FB	Facility Based	UBOS	Uganda Bureau of Statistics
NFB	Non Facility Based	IFMS	Integrated Financial Management system
CHE	Current Health Expenditure	GF	Global Fund
FA	Financing Agents		Government Health Expenditure ( CHE plus capital
FP	Factors of Health Care provision	GHE	spending)
FS	Revenues of health financing schemes	HK	Capital Expenditure
DBC	Disease based costing	ICD	International Coding of Diseases
DHO	District Health Officer	IP	Inpatient
HDP	Health Development Partners	JICA	Japan International Cooperation Agency
HPAC	Health Policy Advisory Committee	NCD	Non Communicable diseases
GCF	Gross Capital Formation	OP	Out Patient
GDP	Gross Domestic product	PCHE	Private Current Health Expenditure
GFCF	Gross Fixed Capital Formation	DHIS2	District Health Information System
GGCHE	General Government CHE	TGE	Total Government Expenditure
НА	Health Accounts	THE	Total Health Expenditure
HC	Health Care Functions	UNAIDS	Joint United Nations Programme On HIV/AIDS

Financing Schemes	UNICEF	United Nations Children's Fund
Households	NPISH	Not for Profit Institutions Servicing Households
Health Care Providers	OTC	Over the Counter Drugs
Long Term Care	PHI	Private Health Insurance
Ministry of Finance	PPP	Purchasing power parity
Not Elsewhere Classified	PVHI	Private Voluntary Health Insurance
Not for Profit Institutions Servicing Households	SHA	Systems of Health Accounts
Over the Counter Drugs	TCAM	Traditional, Complementary and Alternative Medicine
Private Health Insurance	DFID	United Kingdom Fund for International Development
Purchasing power parity		
Private Voluntary Health Insurance		
Systems of Health Accounts		
	Households Health Care Providers Long Term Care Ministry of Finance Not Elsewhere Classified Not for Profit Institutions Servicing Households Over the Counter Drugs Private Health Insurance Purchasing power parity Private Voluntary Health Insurance	Households NPISH  Health Care Providers OTC  Long Term Care PHI  Ministry of Finance PPP  Not Elsewhere Classified PVHI  Not for Profit Institutions Servicing Households SHA  Over the Counter Drugs TCAM  Private Health Insurance DFID  Purchasing power parity  Private Voluntary Health Insurance

# **EXECUTIVE SUMMARY**

The Total Health Expenditure (THE) was 4,944 Billion UGX in financial year 2014/15 equivalent to US\$ 1.7 Billion and which represents 7.1% of Gross Domestic Product and for financial year 2015/16, the THE was 5,309 billion UGX equivalent to US\$ 1.8billion, The health expenditure per capita on average for the two years under study was US\$ 51 reducing from US\$ 56 in the previous NHA study mainly due to increase in population and devaluation and rebasing of the Uganda Shillings (UGX).

The THE for both years in a row is much lower than the Minimum \$84 per capita recommended by WHO(C-ME) if quality care is to be provided by any country in sub-Sahara African Countries. Over the same period, PPP(GDP) grew in nominal terms by 4.7% on average and in real terms from Ushs.76,727 Billion in 2014/15 to Ushs 86,549 Billion in 2015/16. Total health spending as a percentage of GDP was at 7.1% for 2014/15 and 7.4% for 2015/16.

Globally it has been noted that Universal Health coverage is difficult to achieve if public health financing is less than 5% of GDP. A high share of government spending in relation to the the Total Health Expenditure generally implies provision of essential and adequate public infrastructure and health service delivery at subsidized cost. Government spends a lot on social determinants of health which impact health outcomes and these expenditures are not captured in the National Health Accounts because the primary objectives are not for improving health.

The allocation between public, private and development partners for current health expenditure(CHE) from 2014/15 to 2015/16 is as follows: The contribution of public funds increased from 13.8% to 15.3%; private funds increased from 41.4% to 42.6%; Development partner funds decreased from 43.4% to 41.7% and the trend has been decreasing since financial year 2013/14 from 46.7% of the CHE.

The 2.7% increase in private sector contribution to current health expenditure in 2015/16 was attributed mainly to increase in household OOP expenditure from UShs. 1,925 billion in 2014/15 to Ushs 2,108 Billion in 2015/16 in absolute terms. The actual percentage of household out of pocket expenditure to the current health expenditure increased from 33% in 2014/15 to 37% in 2015/16 owing to the increase in population spending on health care outside the public health facilities. The household expenditure generally reduced as a percentage of CHE from 41 % in the previous NHA to 37% in this study. This may be attributed to the increased levels of poverty as indicated in the UDHS 2016 report.

The increase in investments into health over the past two years are collectively attributed to expenditure by Health Development partners, households and Government as indicated in table 0-1. Monitoring these trends over the next years will inform policy decisions like equal access to health care and the ability of a citizen to guarantee and contribute towards their own health. There is need to mobilize alternative financing for health care of the indigents as the country steadily moves towards middle income status.

Health care providers that accounted for most of the health expenditure in 2014/15 and 2015/16 were hospitals and lower level health centres averaging 47.5% during the two years. This was closely followed by providers of health systems administration and ancillary services. A big percentage of the expenditures were financed by health development partners and private sector as indicated in table 3-1.

In terms of how the health budget was used – Health Functions, the largest share of health spending went to curative services forming an average of 62% of the current health expenditure during the two years. 60% of the curative care budget was spent on inpatient and 40% on outpatient care. The other key expenditure was on medical goods (4%). The expenditure on curative is so large because households spend almost 95% of their OOP health expenditure on Curative care and government considers curative services as an emergency on the already sick person and tends to provide for it more than providing for those who are yet to fall sick or prevent anticipated sickness from occurring.

The share of PCHE by Functions clearly indicates that Health goods and medicines holds the highest share of private health expenditure at 59% of the PCHE. Ancillary Services expenditure represented 2.2% of the PCHE. The expenditure on preventive care increased from 1,442 billion UGX in 2014/15 to 1,992 billion UGX in 2015/16. This may be attributed to the private providers and households spending less on preventive care than curative probably because it is not considered as an emergency to the financing agent. But the trend indicates that preventive care are now being considered even by households because it is considered the root cause of the burden of diseases.

Health care expenditure in Uganda remains largely funded by health development partners representing on average 42% of the CHE channeled through government offices and the private sector. Hospitals and health centres have been the major recipient of the financing. Health administration remains a significant item of government spending on health over the period under review.

Table 0-1 National Health Accounts-summary of key indicators FY2014/15- 2015/16

INDICATORS		UNITS	FY2014/2015	FY2015/2016
General	Population	Millions	34,856,813	35,902,519
	Gross Domestic Product (GDP)-current prices	UGX Millions	76,727,255¹	86,549,765
	Total Government Expenditure (TGE)	UGX Billions	9,791.6	8,972.6
	Total Health Expenditure(THE) includes capital expenses on health infrastructure	UGX Millions	4,944,945	5,309,654
	Current Health Expenditure (CHE) excludes capital expenses	UGX Millions	4,866,846	5,174,058
	CHE plus Capital Spending	UGX Millions	4,994,945	5,309,654
	GDP Per capita	USD	670	715
	THE Per Capita -	UGX	143,299	147,869
	Exchange rate UGX (NCU per US\$)	UGX	2,808	2,875
	THE per Capita-	USD	51	51.4
	THE as % of nominal GDP	nominal	7.1%	7.4%
	Household Expenditure on Health	UGX Billions	1,925.96	2,107.53
	Household Expenditure on Health as a % of CHE	Percentage	33%	37%
	Household expenditure as % of private CHE	%	91%	96%
	Household OOP expenditure on health per capita UGX	UGX	54,264.51	57,644.69
	Household OOP expenditure on health per capita US\$	US\$	19.3	20.1
	Bilateral donors contribution to CHE	UGX Millions	1,456,110	1,593,304
Share of HDPs	Bilateral Donors contribution to CHE	%	69.6%	74.5%
unding	Multilateral donors contribution to CHE	UGX Millions	582,601	514,860
	Multilateral Donors contribution to CHE	%	27.8%	24.1%
	Rest of the World Contribution to CHE	UGX Millions	54,751	31,663
	Private Donors/Rest of the World Contribution to CHE	%	2.6%	1.5%
Revenues of	Government Current Health Expenditure (GCHE) <sup>2</sup>	UGX Millions	739,041	813,087
Schemes	General Government Health Expenditure (GGHE) including k formation	UGX Millions	771,233	843,555
	Private Health Expenditure(PCHE)	UGX Millions	2,015,058	2,203,547
	Development Partners' funding	UGX Millions	2,112,746	2,157,424
	GCHE as a % of CHE	%	13.8%	15.3%
	Private Health Expenditure as a % of CHE	%	41.4%	42.6%
	Development Partner funds as a % of CHE	%	43.4%	41.7%
	GCHE as a % of TGE	%	7.5%	9.1%
	GCHE as a % of GDP	%	0.94%	0.93%
	GCHE per capita	UGX	22,126	23,702
	GCHE per Capita	US\$	8	8.2
	Private Current Health Expenditure as a % of GDP	%	2.56%	2.51%
	Development Partners' funding as a % of GDP	%	2.68%	2.45%
Financing	Government Financing Schemes as a % of CHE	%	14.6%	15.1%
Schemes	Voluntary Health Insurance Schemes as a % of CHE	%	2.4%	2.3%
	Out of Pocket (OOP) expenditure as a % of CHE	%	39.6%	41%
	Development partners support as a % of CHE	%	43.4%	41.7%
Capital forma- tion	Expenditure on capital formation	UGX Millions	128,099	134,814
Capital Forma- tion	Capital expenditure as a % of CHE plus capital spending(GHE)	%	2.6%	3%
	Government Capital expenditure as a % of GHE	%	1.6%	1.6%

Table 0-2 Disease-based Cost for FY2014/15 to FY2015/16

	FY2014/2015 FY2015/2016												
	Public				Devt Parti	ners	Public		Private		Devt Partne	ers	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Millions)	Share (%)	
	Infectious and parasitic diseases	275,589.33		1,021,997.82		1,819,571.83		300,881.16		1,117,175.88		1,770,200.20	
DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	126,950.29	17.2%	140,566.46	7.0%	1,622,297.48	76.8%	150,103.99	18.5%	153,902.24	7.0%	1,518,852.40	70.4%
DIS.1.2	Tuberculosis (TB)	4,622.98	0.6%	0.00	0.0%	21,501.10	1.0%	5,126.45	0.6%	4.39	0.0%	10,505.37	0.5%
DIS.1.3	Malaria	102,900.33	13.9%	648,013.38	32.2%	134,782.30	6.4%	97,355.66	12.0%	709,526.51	32.2%	153,568.84	7.1%
DIS.1.4	Respiratory infections	7,561.37	1.0%	176,901.06	8.8%	7,556.39	0.4%	25,989.96	3.2%	193,013.99	8.8%	8,688.06	0.4%
DIS.1.5	Diarrheal diseases	23,902.32	3.2%	55,679.73	2.8%	12,651.42	0.6%	11,722.20	1.4%	60,060.32	2.7%	33,991.51	1.6%
DIS.1.6	Neglected tropical diseases	38.51	0.0%	0.00	0.0%	156.24	0.0%	42.67	0.0%	0.04	0.0%	0.00	0.0%
DIS.1.7	Vaccine preventable diseases	2,682.50	0.4%	837.19	0.0%	16,286.06	0.8%	2,837.45	0.3%	661.81	0.0%	36,506.30	1.7%
DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	6,931.02	0.9%	0.00	0.0%	4,340.85	0.2%	7,702.78	0.9%	6.59	0.0%	8,087.71	0.4%
	Reproductive health	111,393.15		416,927.27		204,546.10		164,930.69		455,302.84		153,287.18	
DIS.2.1	Maternal conditions	63,152.03	8.5%	243,626.15	12.1%	92,221.44	4.4%	94,141.02	11.6%	265,675.74	12.1%	63,325.28	2.9%
DIS.2.2	Perinatal conditions	25,522.78	3.5%	173,301.12	8.6%	51,706.35	2.4%	45,611.90	5.6%	189,605.50	8.6%	32,962.65	1.5%
DIS.2.3	Contraceptive management (family planning)	6,931.02	0.9%	0.00	0.0%	31,937.12	1.5%	7,681.82	0.9%	6.59	0.0%	34,206.41	1.6%
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	15,787.33	2.1%	0.00	0.0%	28,681.19	1.4%	17,495.94	2.2%	15.01	0.0%	22,792.84	1.1%
	Nutritional deficiencies	1,618.97	0.2%	125,161.92	6.2%	3,203.64	0.2%	14,322.89	1.8%	136,921.33	6.2%	49,760.59	2.3%
	Non-communicable diseases	204,350.26		324,182.00		12,000.38		240,565.08		355,196.64		25,097.78	
DIS.4.1	Neoplasms	35,350.28	4.8%	0.00	0.0%	0.00	0.0%	40,059.43	4.9%	32.52	0.0%	0.00	0.0%
DIS.4.2	Endocrine and metabolic disorders	2,310.34	0.3%	0.00	0.0%	0.00	0.0%	2,603.27	0.3%	2.45	0.0%	0.00	0.0%
DIS.4.3	Cardiovascular diseases	11,847.15	1.6%	0.00	0.0%	0.00	0.0%	13,661.11	1.7%	9.85	0.0%	0.00	0.0%
DIS.4.4	Mental & behavioural disorders, and Neuro- logical conditions	12,887.97	1.7%	19,253.15	1.0%	0.00	0.0%	23,591.76	2.9%	21,070.82	1.0%	0.00	0.0%
DIS.4.6	Diseases of the digestive		0.0%	0.00	0.0%	866.36	0.0%	3.18	0.0%	0.00	0.0%	18,556.70	0.9%
DIS.4.8	Sense organ disorders		0.0%	0.00	0.0%	6,549.81	0.3%		0.0%	0.00	0.0%	6,178.24	0.3%
DIS.4.9	Otherl diseases	138,620.43	18.8%	0.00	0.0%	4,584.21	0.2%	153,647.06	18.9%	131.77	0.0%	362.84	0.0%
DIS.4.nec	Other and unspecified noncommunicable diseases (n.e.c.)	3,334.09	0.5%	304,928.85	15.1%	0.00	0.0%	6,999.26	0.9%	333,949.23	15.2%	0.00	0.0%
	Injuries	69,396.83	9.4%	113,806.94	5.6%	3,218.26	0.2%	37,567.27	4.6%	123,639.92	5.6%	371.27	0.0%
	Non-disease specific	3,095.19	0.4%	763.25	0.0%	32,485.64	1.5%	3,523.35	0.4%	3.64	0.0%	75,298.79	3.5%
	Other and unspecified diseases/conditions (n.e.c.)	73,597.57	10.0%	12,219.10	0.6%	37,720.27	1.8%	51,296.80	6.3%	15,306.50	0.7%	83,407.97	3.9%
	TOTAL	739,041.31	100.0%	2,015,058.31	100.0%	2,112,746.12	100.0%	813,087.24	100.0%	2,203,546.75	100.0%	2,157,423.78	100.09

#### 1.0 BACKGROUND

#### 1.1. Introduction

The report on National Health Accounts (NHA) for a period from FY2014/15 to FY2015/16, a seventh round of NHA, records health expenditure in Uganda using the 2011 edition of System of Health Accounts (SHA). The changes to the SHA-2011 are a reflection on how the dynamics and environment surrounding health has transformed considerably on the global level since the release of the previous version of the SHA framework in the year 2000.

The increased complexities of the health sector that are strongly influenced by culture, environment, socio-economic and political factors further constrained by limited resources, challenges the Ministry of Health to provide greater in-depth information and analysis of health care expenditure over time to respond accordingly and plan for future health reforms.

The SHA 2011 framework was also intended to provide greater consistency and comparability in the measurement and reporting of health expenditures between developed and developing countries.

The reports makes an effort to track financial resources into the health system and provide evidence to guide development of health financing strategy, effective and efficient resource allocation and respond to health financing policy questions. Specifically, this report addresses the following healthcare financing policy issues:

- 1. Where resources can be mobilised
- 2. How resources should be managed management
- 3. How efficiency and effectiveness can be enhanced
- 4. How resources and services can be distributed equitably

The report builds on the previous NHA report. The major areas of concern were in the following areas:

	The re-demarcation of revenue sources and financing schemes
	Costing of inputs through the factors of production
	More alignment to the current Government of Uganda budget reporting system
	Disease Expenditure based on the International Classification of Diseases (ICD -10).
П	Treatment of capital investment separate from the total Current Health Expenditure.

# 1.2. Structure of the Health Sector and Flow of Funds

## 1.2.1. Structure of the Health Sector

The Ministry of Health implements both clinical and public health programs and activities through a decentralized health system that caters for integrated health care at primary, secondary and tertiary care level. This is not the same with the administration and management of medicines and supply, which are centralized.

On the direct healthcare service delivery, there are 2 national referral hospitals, 15 regional referral hospitals, 3 specialised institutions, 137 Local Governments, 67 PNFP hospitals, 46 General Hospitals and 4235 lower level health units both public and private. (Source: HMIS 2013)

#### 1.2.2. Flow of Funds in the health sector

A major change in tracking the flow of funds towards health in SHA 2011 is the identification of the actual source of how revenue was raised and collected by responsible agencies (Revenue Source) in addition to the institution that manages and distributes funds (Financing Schemes). SHA 2011 apart from demonstrating that majority of the public health sector funding in Uganda is financed by partners, also explores in detail how revenue is generated and collected.

Furthermore, SHA 2011 also describes the distribution of household or business/corporate taxes, Development Partner grants and transfers and government taxation through various modes of delivery schemes which could also be through central government schemes, insurance schemes or directly through household out-of-pocket expenses.

#### 1.3. NHA Data Sources

#### 1.3.1. Government Data Sources

The estimates of government expenditure presented in the 2014/15 - 2015/16 NHA report are based on statistics obtained from respondents including the Ministry of Finance, the government and private institutions and integrated Financial Management System (IFMS) Unit and is a reflection of the actual expenditure captured in its final accounts for both years. The provided National and macro-economic data such as population and official Gross Domestic Product figures for 2014/15 and 2015/16 were obtained from the Uganda Bureau of Statistics (UBOS) and Bank of Uganda . Health expenditures from Ministries, Departments and agencies that provide health and health related services were captured and analysed.

Since the Ministry of Health expenditure data in the IFMS system is based on input based accounting system whereas NHA reporting focuses on expenditure leading to the delivery of outputs, the NHA Technical team used the IFMS chart of accounts and mapped the IFMS expenditures directly to the new SHA 2011 classification.

In ensuring continuity of comparison of results from all the past NHA reports, a major activity earmarked for 2017 is the re mapping of the Health expenditure trends for the past NHAs for the years 2008/09 and 2009/10.

#### 1.3.2. Other Data Sources

Expenditure data from the private sector for 2014/15 and 2015/16 were obtained through the data collection tools. All survey questionnaires were vetted by the NHA Technical team to reflect the needs of SHA 2011 reporting. All data obtained from respondents were treated with the highest level of confidentiality.

#### 2.0. Current Health Expenditure (CHE)

Current health expenditure (CHE) measures the economic resources spent by a country on healthcare services and goods, including administration and insurance. Current Health Expenditure includes, for example expenditure on; utilities in health facilities, medicines and health supplies, salaries of health workers, expenditure on vaccination and immunisation programme and payments for health facility operational and administrative costs.

According to System of Health Accounts (SHA) 2011, the aggregate CHE combines, in a single figure, the monetary value of the final consumption of all health care goods and services. CHE, thus, equals final consumption expenditure on health care goods and services by residents of a given country during a given period. Note that CHE excludes capital expenditure on health care.

#### 2.1. Trends in Total Health Expenditure (THE)

The Total Health Expenditure (THE) plus capital spending in Uganda 2014/15 was 4,944 billion with a per capita spending of Shs. 143,299(\$51)¹ and Shs 5,174,058 trillion in 2015/16, with per capita spending of Shs. 147.869 (\$51.4). The reduction in per capita spending from financial year 2013/14 expenditure tracking report may be mainly attributed to increase in population of Ugandas , rebasing and devaluation of the Ugandan shillings during the year under review.

From financial year 2014/15 to 2015/16, Current Health Expenditure increased in nominal terms by 6.3% and by Shs 307,212 billion excluding capital purchases. Over the same period, GDP grew in nominal terms by 4.7% and in real terms by Shs 9,822 billion. Current health Expenditure as a percentage of GDP was at 7.1% for 2014/15 and 7.4% for 2015/16. Government health expenditure as a percentage of GDP was on average 2.09 % of the GDP. According to WHO Commission on Macro Economics, low income countries should spend at least 5% of their GDP on health if the country is to move steadily towards Universal Health Coverage.

Table 3-1 CHE, GDP, Annual Growth Rates and Share of Health on GDP, 2014/15 to 2015/16

	Current H	Health Expe	nditure (UGX	( Millions)	Share o ture (%)	f Current	Health Ex	rpendi-	Current Health Expenditure as a Share of GDP (%)			
YEAR	Public Private Dev't Partners TOTAL		Public	Private	Dev't Part- ners	TOTAL	Public	Private	Dev't Part- ners	TOTAL		
FY2014/ 2015	739,041	2,015,058	2,112,746	4,866,846	15.2%	41.4%	43.4%	100.0%	0.94%	2.56%	2.68%	6.2%
FY2015 /2016	813,087	2,203,547	2,157,424	5,174,058	15.7%	42.6%	41.7%	100.0%	0.93%	2.51%	2.45%	5.9%

**NB**: GDP figures were obtained from the UBOS annual statistical reports for the two financial years.

The gross domestic product (GDP) is one of the primary indicators used to gauge the health of a country's economy. It represents the total dollar value of all goods and services produced over a specific time period.

The ratio of UGANDA's CHE to its GDP (health to GDP ratio) provides an indication on the proportion of the health sector contribution to the overall economic activity. Between 2014/15 and 2015/16, health Expenditure from all sources as a ratio of GDP averaged 10.15% (Table 3-1).

Currency exchange rate is based on Bank of Uganda annual financial report for that financial year

#### 2.2. Current Health Expenditure contributions

The percentage contribution of public, private and development partners to the Current Health Expenditure is indicated in Figure 3-1 below. In FY 2015/16, Government funds contributed 15.7%, private funds 42.6% and development partner funds 41.7% to the Current Health Expenditure. Development partner funds increased from 43.4% in 2014/15 to 41.7% in 2015/16 while Government contribution increased from 15.2% of CHE in FY 2014/15 to 15.7% in 2015/16.

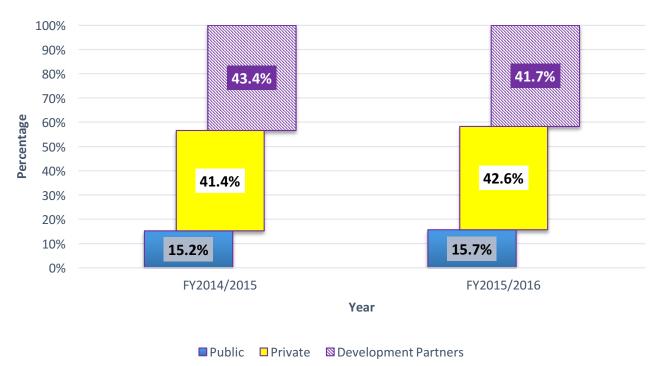


Figure 3-1 Contribution of current Health Expenditure by financing source

As the population grows, demand for improved healthcare also raises, health expenditure in most countries and most of the time increases correspondingly. It is useful to examine health expenditure on a per capita basis in order to remove the influence of changes in the overall size of the population. GDP per capita is often considered an indicator of a country's standard of living and the source of this healthcare funding is important.

As can be seen in Figure 3-1, the estimated CHE per capita per year by development partners decreased from 43% in 2014/15 to 41% in 2015/16.

In terms of US Dollar the per capita health expenditure per person per year decreased from US\$ 56 in 2013/14 to US\$ 51 in 2015/16. The per capita health expenditure is below the minimum recommended WHO per capita expenditure on health for low developing countries of US\$ 84 per capita for health care for a person per year.

The decrease in per capita expenditure in FY 2015/16 from FY 2014/15 may be explained by the increasing population with not commensurate increase in health spending by all financing sources. This picture portrayed is tainted by the fact that public share of this per-capita spending only averages 15% which implies that without the development partners whose contribution averages 43%, the lion's share of this burden would fall on the laps of private sector (especially households) who are already contributing an average of 42% (See Figure 3-1).

# 3.0. Financing of Current Health Expenditures

The revenues of health financing schemes (FS) describe;

- i) The contribution mechanisms the particular financing schemes use to raise their revenues, and
- ii) The institutional units of the economy from which the revenues are directly generated.

#### 3.1. Revenue of Financing Schemes

The major source of revenue in FY 2014/15 and 2015/16 for the health sector in Uganda comes from the Development partners and the Private Sector respectively (Table 3-1) and averages 42.% and 42.6% respectively of the Current Health Expenditure. Government contribution to health financing increased slightly from 15.2% in 2014/15 to 15.7% in 2015/16 of the CHE and also increased slightly from 0.94% in 2014/15 to 0.93% in 2015/16 as a share of GDP.

The share of private financing has fluctuated between 2014/15 and 2015/16; the trend for the private sector shows an increase from 41.4% in 2014/15 to 42.6% in 2015/16 of the Current Health Expenditure (CHE). The share of funding by development partners as a percentage of CHE has decreased from 43.4% in 2014/15 to 41.7% in 2015/16.

From the private sector, most of the funding comes from Households, which accounted for an average of 96% of the Private Current Health Expenditure (PCHE) over the period 2014/15 to 2015/16. The Private Current Health Expenditure (PCHE) changed as a share of GDP from 2.56% in 2014/15 to 2.45% in 2015/16 though this did not have any significant impact on financing health services.

The share of development partners, expenditure as compared to the CHE reduced from 43.4% in 2014/15 to 41.7% in 2015/16. The GDP share of CHE by development partners also decreased from 2.63% in 2014/15 to 2.45% in 2015/16. Over the period 2014/15 to 2015/16 development partner's contribution towards health expenditure has slightly increased from 2,112,746 trillion to 2,157,424 trillion by UGX 44,678 billion in real monetary Value.

#### 3.2. Financing Schemes

SHA 2011 explains health care financing schemes as the main types of financing arrangements through which people obtain health services or can get access to health care. A financing scheme defines who is obliged to participate in the scheme, what the basis for entitlement to health care is and what benefits the scheme offers as well as the rules on raising and pooling the contributions<sup>2</sup>.

Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health services and the rules on raising and then pooling the revenues of the given scheme.

Table 3-2 shows that household out-of-pocket financing scheme was the second largest financing scheme after NPISH accounting for 39.6% in 2014/15 and 40.7% in 2015/16 of the CHE. The health system is mostly financed by the private sector.

Table 3-2 Current Health Expenditure by Financing Schemes, 2014/15 to 2015/16

	FY2014/2	2015	FY2015/	2016
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Government schemes	708,795	14.6%	781,775	15.1%
Voluntary health care payment schemes				
- Employer-based insurance	114,888	2.4%	117,317	2.3%
- NPISH financing schemes (including development agencies)	2,111,887	43.4%	2,156,628	41.7%
- Enterprises (except health care providers) financing schemes	5,617	0.1%	11,743	0.2%
Household out-of-pocket payment	1,925,000	39.6%	2,106,000	40.7%
Rest of the world financing schemes (non-resident)	660	0.0%	594	0.0%
TOTAL	4,866,846	100.0%	5,174,058	100.0%

Household Out-of-pocket (OOP) is direct payments made by users of health at the point of demand. The OOP reflected in this table is presumed to be predominantly cash. Private firms (enterprises) account for on average 0.1% of the financing schemes and private insurance accounts for 2.35% on average of the financing schemes.

Partners and not for profit institutions serving households (NPISH) account for 43.4% of the financing schemes in 2014/15 and 41.7% in 2015/16. That was largely off budget financing some of which end up with government health providers. This excludes partner contributions under general budget support through loans and cash grants.

The Government provides funding for the healthcare system in Uganda through general tax- financing and general budget support. Overall there was a slight increase in government funding scheme in the two financial years under review. The Government scheme accounted for on average 14.85% of the financing scheme from 2014/15 to 2015/16 (Table 3-1). The Rest of the World financing scheme (non-resident units) those involved in health related activities and in both cases the provision is directed for final use to country residents. This scheme accounted for 0% of the financing schemes in both financial years.

The total government scheme as a percentage of the financing schemes was 14.6% (UGX 708.7 billion) in 2014/15-and 15.1% (UGX.781.7 billion) in 2015/16 and in both years on average accounted for 1.57% of the GDP. Table 3-1. GCHE as a percentage of the CHE was 15.2% (739 billion) in financial year 2014/15 and 15.7% (813 billion) in financial year 2015/16 of the CHE. Table 3-1. The total development partner contribution as a percentage of CHE was 43.4% (UGX.2.11 trillion) in 2014/15 and 41.7% (UGX 2.15 trillion) in 2015/16 and on average in both years accounted for 4.3% of the current GDP.

# 4.0. Current Health Expenditure by Providers

Health Care Providers encompass all organizations and actors that deliver health care goods and services as their primary activity, as well as those for which health care provision is only one among a number of activities (SHA 2011).

#### 4.1 Health care Providers

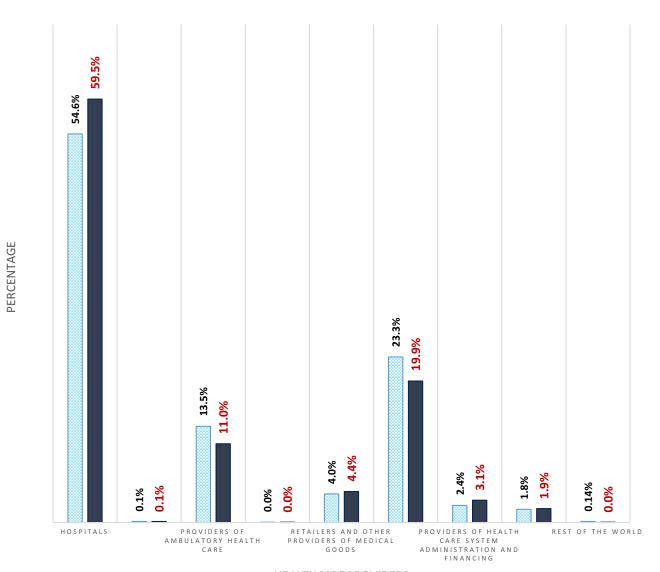
Hospitals, Health units, private clinics and other providers of health goods and providers of ambulatory health care remain the top providers in terms of accounting for health expenditures. This is apparent given the fact that the largest recipients of revenue and utilization of resources are mainly the health units, private clinics and hospitals.

A substantial decrease is noted in expenditure by providers towards procuring and delivering preventive care. There is a reduction by UGX 103 billion from UGX 1,133 billion (2014/15) to UGX 1,029 billion in financial year (2015/16). This may mainly be explained by household's mainly consuming curative care services more than preventive care also more falling sick is an emergency and the services provided mainly are curative in nature.

Table 4-1 Hospitals, Health units, private clinics and other providers of health goods

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Hospitals	2,658,045	54.6%	3,078,634	59.5%
Residential long-term care facilities	6,330	0.1%	6,456	0.1%
Providers of ambulatory health care	658,958	13.5%	571,589	11.0%
Providers of ancillary services	1,120	0.0%	103	0.0%
Retailers and other providers of medical goods	195,488	4.0%	225,346	4.4%
Providers of preventive care	1,133,335	23.3%	1,029,972	19.9%
Providers of health care system administration and financing	117,298	2.4%	161,260	3.1%
Rest of economy	89,439	1.8%	100,410	1.9%
Rest of the world	6,831	0.14%	288	0.0%
Other health care providers (n.e.c.)				
TOTAL	4,866,846	100.0%	5,174,058	100.0%

Figure 4-1 Share of Current Health Expenditures by Providers (%), 2014/15 to 2015/16

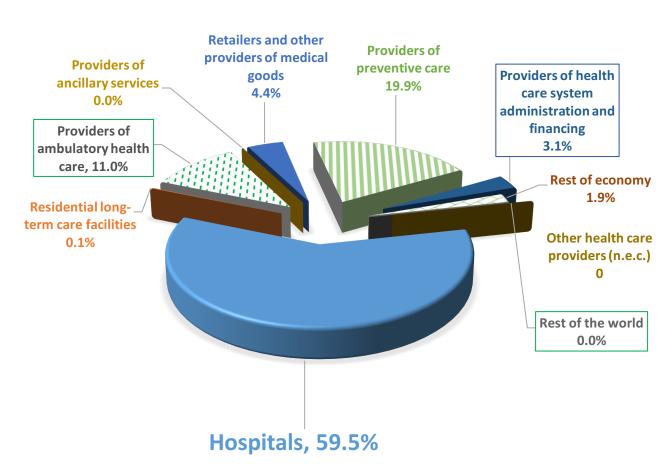


**HEALTHCARE PROVIDERS** 

■ FY2014/2015 Share (%)

In 2015/16, hospitals expended an additional 420.5 billion in their current expenditure relative to 2014/15. Hospital spending increased as a percentage share to CHE from 54.6% in 2014/15 to 59.5% in 2015/16 (refer Table 4-1). Expenses incurred by the retailers and other providers of medical goods recorded an increase in expenditure by 29.8 billion from Shs. 195.4 billion in 2014/15 to Shs. 225.3 billion in 2015/16. Ambulatory Health Care expenditure decreased from 658.9 billion 2014/15 to 571.5 billion in 2015/16 (refer Table4-1). Most health service delivery takes place at lower level facilities but still half of the health expenses take place at hospital level hence the inequity in resource allocation with potential for widening disparities for the rural poor in accessing health care services.

Figure 4-2 Share of Current Health Expenditures by Providers (%), 2015/16



# **FY2015/2016 SHARE (%)**

# 4.2 Hospital Expenditure

Hospital expenditure in Uganda is mainly funded by private sources. Figure 4-2 highlights that Hospitals are the major health care provider representing 59.5% of the health care provider's expenditure. This may be attributed to the increase in support to hospitals by health development partners and increase in utilisation of services in hospitals by households.

Table 4-2 Current Health Expenditure at Hospitals by financing source, 2014/15 and 2015/16

	Pub	lic	Priva	ate	Developi Partne	TOTAL	
YEAR	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Mil- lions)
FY2014/2015	573,213	21.6%	1,310,177	49.3%	774,655	29.1%	2,658,045
FY2015/2016	522,584	17.0%	1,471,047	47.8%	1,085,004	35.2%	3,078,634

Figure 4-3 Share of Current Health Expenditure at Hospital by financing source 2014/15 and 2015/16



The private health care providers account for about 49% of the providers in Uganda on average in the two years.

## 4.3 Non-Hospital Expenditure

Non-hospital expenditure refers to the expenditure of other health providers as categorized in the SHA 2011 health provider classification. Expenditure reduction were recorded by providers of preventive care from 23.3% in (2014/15) to 19.9% (2015/16), providers of ambulatory care registered decrease in expenditure from 13.5% (2014/15) to 11.0% in (2015/16) and retailers and other providers of medical goods increased slightly from 4.0% to 4.4% in (2015/16).

Retailers and other providers of medical goods are involved in providing pharmaceuticals and other durable health goods to outpatients and mainly households. The CHE for these providers reduced by Shs. 59.9 billion over the two years of 2014/15 and 2015/16.

Providers of preventive care consist of various public health programs coordinated by the private and public sector. Providers of Ambulatory Health Care (not necessarily preventive) recorded a decrease from Shs. 658.9 billion in 2014/15 to Shs 571.5 billion in 2015/16. On average, providers of healthcare system administration and financing recorded a slight increased expenditure of Shs. 44 billion in the two years.

5

Health expenditure by function simply means "the services and goods on which the health money has been spent". The international SHA methodology categorizes certain areas of use and functions, and codes them using the ICHA-HC classification (see also table 5-1). The analysis by function is important for any health system as it delivers information relevant for the policy level. For example, the balance between inpatient and outpatient care expenditure, or how much was spent on preventive care, curative care and on Health administration is vital for policy decision formulation. In this way, health expenditure by function provides a platform for policy makers to move from input based to output based health service delivery.

Table 5-1 Current Health Expenditure by Function, 2014/15 to 2015/16

		FY2014/2015	j		FY2015/201	6
		millions			Millions	
	Public	Private	TOTAL	Public	Private	TOTAL
Inpatient curative care	389,783	851,536	1,241,319	193,635	889,650	1,083,285
Day curative care	0	255,045	255,045	17,426	90,385	107,810
Outpatient curative care	194,033	667,185	861,218	151,851	704,572	856,423
Rehabilitative care and Long-term care (health)	1,767	13,965	15,732	10,973	10,730	21,703
Ancillary services (non-specified by function)	0	16,705	16,705	0	20,993	20,993
Medical goods (non-specified by function)	1,177	194,415	195,592	4,112	224,277	228,389
Preventive care	84,694	1,358,731	1,443,425	371,790	1,620,583	1,992,373
Governance, and health system and financing administra- tion	58,516	34,782	93,297	62,882	34,177	97,060
Other health care services not elsewhere classified (n.e.c.)	9,071	735,440	744,511	418	765,604	766,022
TOTAL	739,041	4,127,804	4,866,846	813,087	4,360,971	5,174,058

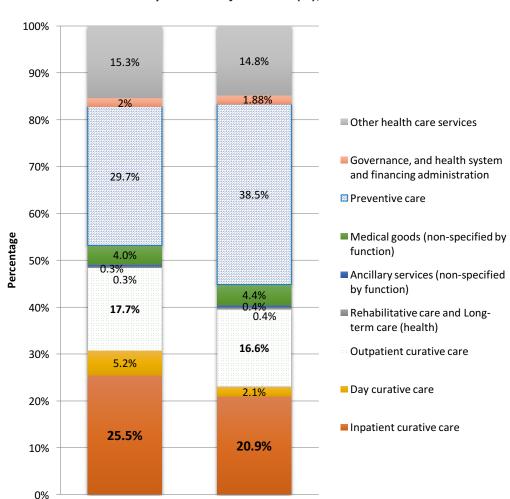
<sup>&</sup>lt;sup>1</sup>Ancillary services to health care include laboratory and imaging services

The National Health Accounts (NHA) systematically classifies the purposes or functional uses of health expenditures. Table 5-1 shows the distribution of CHE by function in 2014/15 and 2015/16. There was a slight increase in the proportion of expenditure for outpatient care, inpatient and preventive care by retailers and private clinics. Governance, health systems & financing administration expenditure increased marginally. Rehabilitative, and palliative care expenditures decreased as a percentage of CHE. Ancillary services increased in the two financial years under review.

In nominal terms, there was decrease in day curative care expenditure from Shs 225 billion to Shs. 90.3 billion. This may be explained by the increasing emphasis by Government and development partners on households to embrace preventive care.

There is need for a policy shift to emphasize preventive care services. However, in spite of the nominal decrease in preventive, it is also still far below what was spent on curative care (see figure 5-1). There was also a slight decline in the proportion of expenditure for outpatient care, health goods dispensed to outpatients expenditure increased, and governance, health systems and financing administration expenditure slightly declined.

Figure 5-1 shows CHE by functions for the years 2014/15 to 2015/16. The Figure shows that expenditure on inpatient curative care is more than outpatient curative care. The increase in outpatient care expenditure compared to was largely due to the increase in private health expenditure in 2014/15 and 2015/16 from households.



FY2015/2016

Year

Figure 5-1 Current Health Expenditure by function (%), FY2014/15 to 2015/16

FY2014/2015

There was increase in expenditure for health goods and a decrease in expenditure on rehabilitation and long term care, while governance, health systems & financing administration expenditure stagnated as a percentage of CHE for both years. Ancillary services had no change in expenditure for both years (1%).

Overall, Uganda spent 29.7% and 38.5% of CHE on preventive care in 2014/15 and 2015/16 respectively. The country spent more on governance, health systems & financing administration when compared to expenditure on rehabilitation in both years. This calls for reprioritisation of expenditures and policy shift in financing of rehabilitative health interventions.

# 5.1. Inpatient and Outpatient Care Services

The largest part of health spending by function is for curative care (inpatient and outpatient care services) as shown in Table 5-1.

Inpatient care is mainly financed by the private sector (includes funds from development partners, households, private firms and health insurance), which accounted for 25.5% in 2014/15 compared with 20.9 % in 2015/16 (Table 5-2). Outpatient care was also mainly financed by the private sector with private expenditure share of 17.7% in 2014/15 compared to 16.6% in 2015/16. Note that Households spend almost 95% of their OOP health expenditure on outpatients' care that probably explains the high percentage.

Table 5-2 Share of current health expenditure functions by financing source;

	Amount (UGX Millions)	FY2014/2015	Amount (UGX Millions)	FY2015/2016
Inpatient curative care	1,241,319	25.5%	1,083,285	20.9%
Day curative care	255,045	5.2%	107,810	2.1%
Outpatient curative care	861,218	17.7%	856,423	16.6%
Rehabilitative care and Long-term care (health)	15,732	0.3%	21,703	0.4%
Ancillary services (non-specified by function)	16,705	0.3%	20,993	0.4%
Medical goods (non-specified by function)	195,592	4.0%	228,389	4.4%
Preventive care	1,443,425	29.7%	1,992,373	38.5%
Governance, and health system and financing administration	93,297	2%	97,060	1.88%
Other health care services	744,511	15.3%	766,022	14.8%
TOTAL	4,866,846	100.0%	5,174,058	100.0%

Note: Private Expenditure also includes Development Partners and Households

#### 5.2. Medical Goods

The third major component of health spending by function is on medical goods. This category includes only pharmaceutical and therapeutic appliances and comprises sales of medicines and other health goods from private pharmacies and other clinics. This is because under the SHA guidelines, expenditure on pharmaceuticals, during an inpatient episode of care is categorized as inpatient expenditure. Drug consumption under government facilities are coded to inpatient and outpatient care and not included under this category. Thus it is important to note that the expenditure on medicines included in this category accounts mainly for clinic sales by private pharmacies and drug shops.

Uganda spent UGX 228 billion or 4.4%% of CHE in 2015/16 on medical goods (Table 5-1). This has increased in percentage terms since 2014/15 which was Shs 195 Billion (4%). The increase is either an increase in drug prices or increased quantity of purchased drugs. Nevertheless this is an important indicator to monitor since in the private sector this is largely financed by households out of pocket expenses.

Table 5-3 Medical goods expenditure by sub-classes

	FY2014/201	5	FY2015/2016			
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)		
Pharmaceuticals and other medical non-durable goods						
- Prescribed medicines	82,027	41.9%	94,237	41.3%		
- Other medical non-durable goods	109,918	56.2%	134,152	58.7%		
Unspecified medical goods (n.e.c.)	3,647	1.9%	0	0.0%		
TOTAL	195,592	100.0%	228,389	100.0%		

Table 5-3 shows expenditure on medical goods by subclasses in 2014/15 and 2015/16. It reflects that an average of 41.7% of the expenditure on health goods was spent on prescribed medicines while much (57.4%) on average was spent on other medical non-durable goods.

#### 5.3. Preventive Care

SHA 2011 explains Preventive care as any measure that aims to avoid the occurrence or the severity of injuries and diseases and their complications. Prevention is based on a health promotion strategy that involves a process to enable people to improve their health through the control over some of its immediate determinants. This includes a wide range of expected outcomes, which are covered through a diversity of interventions, organized as primary, secondary and tertiary prevention levels. The expenditure mostly includes primary and secondary prevention programmes.

Preventive care expenditures accounted for UGX1.443 trillion of CHE in 2014/15 and UGX 1.992 trillion in 2015/16 of the CHE. (Table 5-1). This increase was due to a decrease in funding by development partners for public health preventive programs.

Figure 5-2 shows that approximately the financing of these programs was through Government funding (58.4%), from development partners (40.4%) and from the private sector (1.2%) in 2015/16. For 2014/15, 64.3% of the financing of these programs was through Government funding, 35.5% from development partners and 0.3% from the private sector.

Figure 5-2 Share of Preventive care by Source (%), 2014/15 to 2015/16



Figure 5-3 Share of Preventive care by categories of service (%), 2014/15 to 2015/16

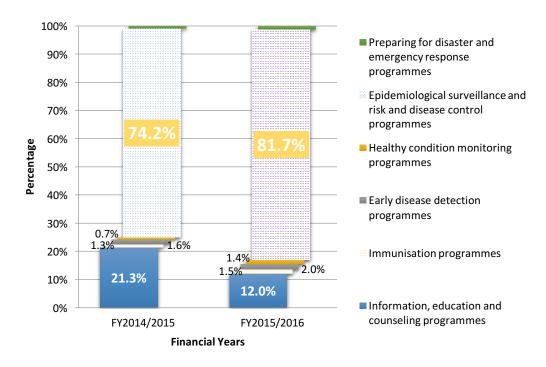


Figure 5-3 shows that information; education and counselling programmes accounted for on average 21.3% of total preventive care expenditure in 2014/15 and 12% in 2015/16. The other largest portion of preventive care was spent on risk, surveillance, behaviour change communication, advocacy and disease control programmes on average about 77.9%. There was an increase in expenditure for early disease detection programmes and immunisation and monitoring

Table 5-4 Preventive care by categories of service (Millions UGX), 2015/16

	FY2015/2016						
	Public	Private	Development Partners	TOTAL			
Information, education and counselling programmes	87,862	230	151,506	239,597			
Immunization programmes	1,047	-	28,892	29,939			
Early disease detection programmes	24,526	-	15,959	40,486			
Healthy condition monitoring programmes	18,709	-	9,846	28,556			
Epidemiological surveillance and risk and disease control programmes	226,187	428	1,401,522	1,628,137			
Preparing for disaster and emergency response programmes	13,458	-	12,201	25,659			
Total	371,790	658	1,619,925	1,992,373			

**Table 5-5 Reproductive Health Expenditure.** 

Reproductive Health expenditure accounted for 15% (UGX 111 Billion) of the CHE in 2014/15 and 20.2% (164 Billion) of the CHE in 2015/16 (Table 6.4). Much of the expenditure under reproductive health was for maternal conditions followed by perinatal conditions. Government finances about 15% of the reproductive health expenditure and the rest (85%)of the finances come from the private sector and rest of the world.

		FY2014/20	15	FY2015/2016		
	Reproductive health	Amount (UGX Millions)	% share	Amount (UGX Millions)	% share	
DIS.2.1	Maternal conditions	398,999.62	54%	423,142.05	55%	
DIS.2.2	Perinatal conditions	250,530.25	34%	268,180.06	35%	
DIS.2.3	Contraceptive management (family planning)	38,868.15	5%	41,894.81	5%	
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	44,468.51	6%	40,303.79	5%	
	TOTAL	732,866.52	100%	773,520.71	100%	

# Table 5-6 Current Health Expenditure by disease and conditions

Table 5-6, depicts the varied disease condition expenditures by the Government, Private sector and Development partners.

		FY2014/2015						FY2015/2016	;				
	Public		Private		Devt	Partners	P	ublic	Р	rivate	Devt	Partners	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Mil- lions)	Share (%)	
	Infectious and parasitic diseases	275,589.33		1,021,997.82		1,819,571.83		300,881.16		1,117,175.88		1,770,200.20	
DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	126,950.29	17.2%	140,566.46	7.0%	1,622,297.48	76.8%	150,103.99	18.5%	153,902.24	7.0%	1,518,852.40	70.4%
DIS.1.2	Tuberculosis (TB)	4,622.98	0.6%	0.00	0.0%	21,501.10	1.0%	5,126.45	0.6%	4.39	0.0%	10,505.37	0.5%
DIS.1.3	Malaria	102,900.33	13.9%	648,013.38	32.2%	134,782.30	6.4%	97,355.66	12.0%	709,526.51	32.2%	153,568.84	7.1%
DIS.1.4	Respiratory infections	7,561.37	1.0%	176,901.06	8.8%	7,556.39	0.4%	25,989.96	3.2%	193,013.99	8.8%	8,688.06	0.4%
DIS.1.5	Diarrheal diseases	23,902.32	3.2%	55,679.73	2.8%	12,651.42	0.6%	11,722.20	1.4%	60,060.32	2.7%	33,991.51	1.6%
DIS.1.6	Neglected tropical dis- eases	38.51	0.0%	0.00	0.0%	156.24	0.0%	42.67	0.0%	0.04	0.0%	0.00	0.0%
DIS.1.7	Vaccine preventable diseases	2,682.50	0.4%	837.19	0.0%	16,286.06	0.8%	2,837.45	0.3%	661.81	0.0%	36,506.30	1.7%
DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	6,931.02	0.9%	0.00	0.0%	4,340.85	0.2%	7,702.78	0.9%	6.59	0.0%	8,087.71	0.4%
	Reproductive health	111,393.15		416,927.27		204,546.10		164,930.69		455,302.84		153,287.18	
DIS.2.1	Maternal conditions	63,152.03	8.5%	243,626.15	12.1%	92,221.44	4.4%	94,141.02	11.6%	265,675.74	12.1%	63,325.28	2.9%
DIS.2.2	Perinatal conditions	25,522.78	3.5%	173,301.12	8.6%	51,706.35	2.4%	45,611.90	5.6%	189,605.50	8.6%	32,962.65	1.5%
DIS.2.3	Contraceptive management (family planning)	6,931.02	0.9%	0.00	0.0%	31,937.12	1.5%	7,681.82	0.9%	6.59	0.0%	34,206.41	1.6%
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	15,787.33	2.1%	0.00	0.0%	28,681.19	1.4%	17,495.94	2.2%	15.01	0.0%	22,792.84	1.1%
	Nutritional deficiencies	1,618.97	0.2%	125,161.92	6.2%	3,203.64	0.2%	14,322.89	1.8%	136,921.33	6.2%	49,760.59	2.3%
	Non-communicable diseases	204,350.26		324,182.00		12,000.38		240,565.08		355,196.64		25,097.78	
DIS.4.1	Neoplasms	35,350.28	4.8%	0.00	0.0%	0.00	0.0%	40,059.43	4.9%	32.52	0.0%	0.00	0.0%

DIS.4.2	Endocrine and metabolic disorders	2,310.34	0.3%	0.00	0.0%	0.00	0.0%	2,603.27	0.3%	2.45	0.0%	0.00	0.0%
DIS.4.3	Cardiovascular diseases	11,847.15	1.6%	0.00	0.0%	0.00	0.0%	13,661.11	1.7%	9.85	0.0%	0.00	0.0%
DIS.4.4	Mental & behavioural dis- orders, and Neurological conditions	12,887.97	1.7%	19,253.15	1.0%	0.00	0.0%	23,591.76	2.9%	21,070.82	1.0%	0.00	0.0%
DIS.4.6	Diseases of the digestive		0.0%	0.00	0.0%	866.36	0.0%	3.18	0.0%	0.00	0.0%	18,556.70	0.9%
DIS.4.8	Sense organ disorders		0.0%	0.00	0.0%	6,549.81	0.3%		0.0%	0.00	0.0%	6,178.24	0.3%
DIS.4.9	Otherl diseases	138,620.43	18.8%	0.00	0.0%	4,584.21	0.2%	153,647.06	18.9%	131.77	0.0%	362.84	0.0%
DIS.4.nec	Other and unspecified noncommunicable diseases (n.e.c.)	3,334.09	0.5%	304,928.85	15.1%	0.00	0.0%	6,999.26	0.9%	333,949.23	15.2%	0.00	0.0%
	Injuries	69,396.83	9.4%	113,806.94	5.6%	3,218.26	0.2%	37,567.27	4.6%	123,639.92	5.6%	371.27	0.0%
	Non-disease specific	3,095.19	0.4%	763.25	0.0%	32,485.64	1.5%	3,523.35	0.4%	3.64	0.0%	75,298.79	3.5%
	Other and unspecified diseases/conditions (n.e.c.)	73,597.57	10.0%	12,219.10	0.6%	37,720.27	1.8%	51,296.80	6.3%	15,306.50	0.7%	83,407.97	3.9%
		739,041.31	100.0%	2,015,058.31	100.0%	2,112,746.12	100.0%	813,087.24	100.0%	2,203,546.75	100.0%	2,157,423.78	100.0%

This chapter looks at Government Current Health Expenditure (GCHE) and provides details to show where and how the money was being spent.

#### 6.1. Government Expenditure on Health

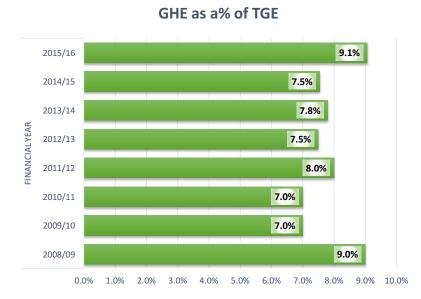
Analysis of Government spending as in Table 6-1 shows that over the four (4) year period, Government Health Expenditure (GHE) has increased in nominal value (current). In real terms this means that Government's expenditure on health in FY2015/16 increased from FY 2014/15.

Table 6-1 Government Health Expenditures (UGX), 2008/09 to 2015/16

		FINANCIAL YEAR										
	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16				
Nominal value (current) - Millions UGX	450.0	473.0	633.0	724.0	814.0	879.0	739.0	813.1				
Total Government Expenditure (TGE) - Millions UGX	4,949.0	6,318.0	8,972.0	9,273.0	8,149.0	8,788.0	9,791.6	8,972.6				
TGCHE Per Capita (\$)	12.4	11.2	9.1	9.0	9.3	9.7						
% of TGE	9.0%	7.0%	7.0%	8.0%	7.5%	7.8%	7.5%	9.1%				

GHE when reflected as a percentage of Total Government Expenditure (TGE) averaged to 7.8% and has remained relatively constant over the period from 2008/09 to 2015/16 (refer table 6-1). The trend indicates that the GHE per capita has been increasing in the 3 years of NHA study mainly due to additional financing from the Government national budget. The World Health Organization (WHO) in its study suggests that universal health coverage and equal access to health care maybe attained if Governments spend at least 15% of TGE on health (World Health Report 2010). The WHO Commission of Macro Economics on Health suggests that TGCHE per capita should be at least \$34 per capita for Sub-Sahara African countries to steadily move towards UHC and Health Sector Development Plan (HSDP2015/16-2019/20) suggests a minimum of \$17 per capita to attain high health status in Uganda.

Figure 6-1 GHE as a % of TGE from F2008/09 to 2015/16.



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The increase and decrease in percentage spending by government is largely driven by fluctuations in Government revenues (thus affecting the Government fiscal position) over those years. The financing was less aligned with the health status of the population and the increasing (financial) needs for people with chronic diseases.

As a percentage of GDP, GHE averaged 2.9% over the study period. The percentage has remained relatively constant without any significant increase over the last 4 years (refer Table 3-1).

# 6.2. Government Current Health Expenditure by Sources

Government had spent UGX 739,041 Billion in 2014/15 and UGX. 813,087 billion in 2015/16, an increase of UGX.74,043 billion in the GCHE in 2015/16 over 2014/15 (refer Table 6-2). This reflects a nominal increase in government expenditure of about 7.8% from FY2014/15 to FY2015/16.

Table 6-2 Sources of Government Current Health Expenditures (UGX), 2014/15 to 2015/16

	FY2014/2	2015	FY2015/2016		
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	
Transfers from government domestic revenue (allocated to health purposes)	739,041	79.9%	813,087	97.1%	
Transfers distributed by government from foreign origin	185,834	20.1%	23,873	2.9%	
TOTAL	924,875	100.0%	836,960	100.0%	

The GCHE also includes financing from external development partners through on budget cash grants which is channelled through the Government system (budget support) and reflected in the annual budget. Over the two year period, the GCHE averaged 85% funding directly from Government domestic revenues and 11.5% funding distributed by Government from foreign origin through project funding/ on budget support as shown in Table 6-2

# 6.3. Government Current Health Expenditure (GCHE) by Providers

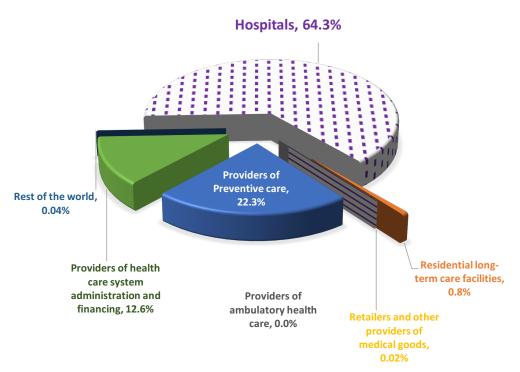
Government health providers exist at different levels within the healthcare system and they are described by the types of the health services they provide. As outlined in Table.6-3, we distinguish between hospitals, Long-term care facilities, Providers of Ambulatory health care, Providers of ancillary services, Providers of preventive care, Providers of health care system administration and financing, Rest of economy (which constitute other industries within the country as secondary providers of healthcare) and rest of the world (which constitute mostly expenditure by health development partners).

Table 6-3 Government Current Health Expenditures by Providers (UGX), 2014/15 & 2015/16

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Hospitals	573,213	77.6%	522,584	64.3%
Residential long-term care facilities	6,330	0.9%	6,456	0.8%
Providers of ambulatory health care	23,615	3.2%	0	0.0%
Retailers and other providers of medical goods	80	0.0%	168	0.0%
Providers of Preventive care	70,269	9.5%	181,377	22.3%
Providers of health care system administration and financing	65,534	8.9%	102,217	12.6%
Rest of the world	0	0.0%	286	0.0%
TOTAL	739,041	100.0%	813,087	100.0%

Figure 6-2 shows the distribution of Government current health expenditures among the health providers that constitute the major recipients of Government health funds in 2015/16.

Figure 6-2 Share of Government Current Health Expenditure by Provider, 2015/16



Hospitals which include regional referral hospitals, Health units, NGO hospitals, and General hospitals, mental and specialized hospitals/Institutions account for the largest share of Government spending(64.3%) in 2015/16. This was also the case as reported in the Uganda Health Account reports for the financial years 2010/11 and 2011/12 and thus, for the last 3 years hospitals remain the major recipient of government health spending.

Hospital expenditure accounted for 64.3% of GCHE in 2015/16 (refer Figure 6-2). Of this value 38% was spent on General Hospitals, 18% in private hospitals, 6.4% in national and regional hospitals and the rest was spent by lower level primary health care facilities

From the year 2014/15 there was an increase in funding to primary health care facilities perhaps as a result of additional human resource recruitment. In 2015/16 there was an increase in ambulatory care expenditures arising from reforms to strengthen primary health care by increasing the effectiveness of the services provided at health centres through investigations.

Providers of ambulatory care refer to expenditures at health centres. In 2014/15 this accounted for 3.2% of GCHE and equates to UGX 23 billion. (refer Table 6-3). The ambulatory care expenditure consisted of both health centres managed by government and PNFP facilities. This expenditure includes spending on ancillary services. Ancillary services refer to expenditures for laboratory services, imaging services and patient transportation. The bulk of ancillary expenditure pertain to the cost of consumables and reagents for both imaging and laboratory services.

Providers of preventive care expenditures were included under health systems administration. There was an increase in these expenses in 2015/16. The main reason may be due to decrease in expenditures in the on-going curative programs such communicable and Non-Communicable Diseases (NCDs).

Other Health care system administration and financing expenditure includes activities in overall administration of the health care sector, including administration of health financing such as formulation, supervision, coordination, administration and monitoring of overall health policies and budgets which accounted for UGX 102 billion or 12.6% of GCHE in 2015/16 (refer Table 6-3).

Rest of the World refers to industries or organizations that offer health care as a secondary activity. Rest of the World accounted for UGX 286 billion of GCHE in 2015/16 (refer Table 6-3).

The staff costing spent on salary and wages is distributed across all providers and is incorporated into expenditures of health providers.



Government spending (GCHE) on disease conditions is depicted as below, (Table 6.4)

		FY2014/2015 FY2		FY2015/2016	6
	Public		Pub	lic	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	
	Infectious and parasitic diseases	275,589.33		300,881.16	
DIS.1.1	HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	126,950.29	17.2%	150,103.99	18.5%
DIS.1.2	Tuberculosis (TB)	4,622.98	0.6%	5,126.45	0.6%
DIS.1.3	Malaria	102,900.33	13.9%	97,355.66	12.0%
DIS.1.4	Respiratory infections	7,561.37	1.0%	25,989.96	3.2%
DIS.1.5	Diarrheal diseases	23,902.32	3.2%	11,722.20	1.4%
DIS.1.6	Neglected tropical diseases	38.51	0.0%	42.67	0.0%
DIS.1.7	Vaccine preventable diseases	2,682.50	0.4%	2,837.45	0.3%
DIS.1.nec	Other and unspecified infectious and parasitic diseases (n.e.c.)	6,931.02	0.9%	7,702.78	0.9%
	Reproductive health	111,393.15		164,930.69	
DIS.2.1	Maternal conditions	63,152.03	8.5%	94,141.02	11.6%
DIS.2.2	Perinatal conditions	25,522.78	3.5%	45,611.90	5.6%
DIS.2.3	Contraceptive management (family planning)	6,931.02	0.9%	7,681.82	0.9%
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	15,787.33	2.1%	17,495.94	2.2%
	Nutritional deficiencies	1,618.97	0.2%	14,322.89	1.8%
	Non-communicable diseases	204,350.26		240,565.08	
DIS.4.1	Neoplasms	35,350.28	4.8%	40,059.43	4.9%
DIS.4.2	Endocrine and metabolic disorders	2,310.34	0.3%	2,603.27	0.3%
DIS.4.3	Cardiovascular diseases	11,847.15	1.6%	13,661.11	1.7%
DIS.4.4	Mental & behavioral disorders, and Neurological conditions	12,887.97	1.7%	23,591.76	2.9%
DIS.4.6	Diseases of the digestive		0.0%	3.18	0.0%
DIS.4.8	Sense organ disorders		0.0%		0.0%
DIS.4.9	Other diseases	138,620.43	18.8%	153,647.06	18.9%
DIS.4.nec	Other and unspecified non-communicable diseases (n.e.c.)	3,334.09	0.5%	6,999.26	0.9%
	Injuries	69,396.83	9.4%	37,567.27	4.6%
	Non-disease specific	3,095.19	0.4%	3,523.35	0.4%
	Other and unspecified diseases/conditions (n.e.c.)	73,597.57	10.0%	51,296.80	6.3%
		739,041.31	100.0%	813,087.24	100.0%

Analysis of the current health expenditure by disease and conditions indicate that HIV/AIDS takes the largest share of expenditure in both years at 17.2% and 18.5% in 2014/15 and 2015/16 respectively, followed by expenditure on Malaria 13.9% 2014/15 and 12% 2015/16, Reproductive health conditions account for 111 billion share of the CHE in 2014/15. Non-communicable disease expenditure accounts for 204 billion share of the CHE in 2014/15 and 240 billion in 2015/16, and injuries and nutrition take on average of 7% and 1% respectively during the period under review. This calls for the need to increase funding for nutrition and NCDs.

Other disease conditions not elsewhere classified (n.e.c) accounted for 10% (73 billion) of the expenditure in 2014/15-and 6.3% (51 billion) in 2015/16.

#### 6.5. Government Current Health Expenditure by Functions

This section focuses on Government current health expenditures (GCHE) by function and is reflected in Table 6.7.

Table 6-7 Government Current Health Expenditures by Functions, 2014/15 and 2015/16

	FY2014	/2015	FY2015/2016	
Public Funds' HC	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Inpatient curative care	389,783	52.7%	193,635	23.8%
Day curative care	0	0.0%	17,426	2.1%
Outpatient curative care	194,033	26.3%	151,851	18.7%
Rehabilitative care and Long-term care (health)	1,767	0.2%	10,973	1.3%
Ancillary services (non-specified by function)	0	0.0%	0	0.0%
Medical goods (non-specified by function)	1,177	0.2%	4,112	0.5%
Preventive care	84,694	11.5%	371,790	45.7%
Governance, and health system and financing administration	58,516	7.9%	62,882	7.7%
Other healthcare services	9,071	1.2%	418	0.1%
TOTAL	739,041	100.0%	813,087	100.0%

**Note:** GCHE on health goods are incorporated into the above categories mainly in curative care (in-patient and outpatient care)

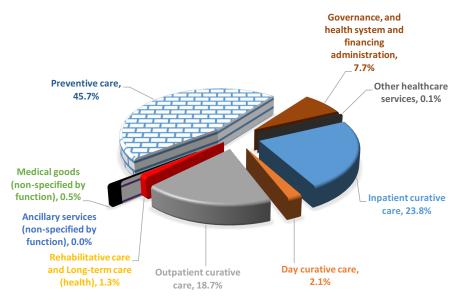
Inpatient expenditure incurred the largest expense, 52.7% in 2014/15 and reduced to 23.8% in 2015/16 (Table 6.7 of GCHE). Outpatient was 26.3% and in 2015/16 and reduced to 18.7% of GCHE. The decrease in outpatient expenditure in percentage terms may relate to the increase in the support to primary health care services and perhaps increased healthcare seeking among the private providers. This can be traced by the increased out of pocket expenditures of households (40.7%).

In-patient services are mostly provided at hospitals and inpatient expenditure has decreased in shillings value in 2015/16. The outpatient services which are provided at hospitals and ambulatory health centres and clinics have also decreased in Shillings value and percentage.

Preventive care services incurred 11.5% (2014/15) expense of the GCHE and 45.7% (2015/16). The increase in preventive care expenditure in 2015/16 is attributed to the decrease in expenditure for curative care services.

The increase in GCHE do not necessarily indicate improved efficiency nor does it measure the quality of health care delivered; this will require more in-depth studies and analysis which can assist in developing some monitoring and evaluation system to monitor these two critical services in terms of both costs and quality.

Figure 6-3 Government Current Health Expenditure by Functions, 2015/16
FY2015/2016



Governance, and health system and financing administration (Excluding employee wages and salaries) accounted for 7.7% of the functional expenditure from the GCHE in 2015/16. These are expenditures which involve administration of management of funds, formulation and administration of Government policies and monitoring and evaluation of such resources.

Preventive care has the largest share of health expenditure which accounted for 11.5% (UGX 84.694 billion) in 2014/15 and 45.7% (UGX 371.790 billion) in 2015/16. Preventive care programmes are further broken down into six (6) categories of services and the expenditures have been distributed accordingly by respective years as shown in Table 6.7 Health expenditures in both years have been mostly on Information, education and counselling (IEC)/BCC programmes.

Table 6-8 GHCE by Preventive care categories, FY 2014/15 and 2015/16

	FY2014/	FY2014/2015		FY2015/2016	
Preventive Care services	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	
Information, education and counselling programmes	51,449	60.7%	87,862	23.6%	
Immunization programmes	1,234	1.5%	1,047	0.3%	
Early disease detection programmes	13,356	15.770%	24,526	6.597%	
Healthy condition monitoring programmes	8,928	10.5%	18,709	5.0%	
Epidemiological surveillance and risk and disease control programmes	8,507	10.0%	226,187	60.8%	
Preparing for disaster and emergency response programmes	1,220	1.4%	13,458	3.6%	
TOTAL	84,694	100.0%	371,790	100.0%	

Rehabilitative care has the lowest expenditure and accounted for only 0.2% (UGX 1.767 billion) in 2014/15 and 01.3% (UGX 10.973 billion) in 2015/16 of Government Current Health Expenditure (GCHE). Rehabilitative services are treatments provided to improve or restore impaired body functions and structures (e.g. disease, disorder, orthopaedics and injury) to improve the quality of life.

The GCHE on health goods for both 2014/15 and 2015/16 are incorporated mostly into curative care (in-patient and outpatient care). Government spending on medical goods not specified by function (nsf) either to inpatient or outpatient is shown in figure 6-8 and that accounted for 0.35% of the GCHE on average for the two years.

Private Current Health Expenditure (PCHE) in this chapter represents all money spent on health either by households, private firms or private organizations and excludes development partners and the government *sector*. This chapter explains where the money for private healthcare is coming from, who manages these funds, the service providers and the type of services provided.

#### 7.1. Private Current Health Expenditure by Sources

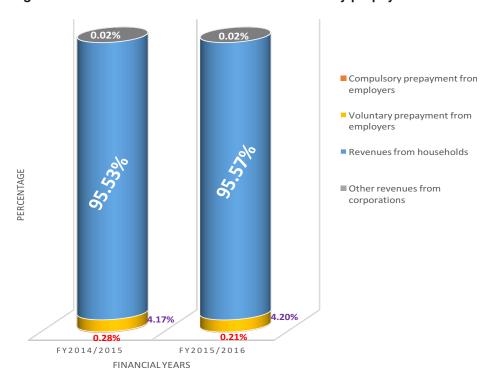
The Private sector contributes significantly to the health sector and an analysis of health expenditure indicates its contribution increasing slightly from 41.4% in 2014/15 to 42.6% in 2015/16. In 2014/15. PCHE was UGX 2.015 trillion in 2014/15 and by 2015/16, it increased to UGX 2.2 trillion (refer Table 7-1).

The source of expenditure for the private sector is mainly from other domestic revenues (households) and voluntary prepayments (individuals, employers and other). Household expenditure accounted for 95% on average and voluntary prepayments 4.2% on average of PCHE (refer Table 7-1.).

Table 7-1 Private Current Health Expenditure by Sources, 2014/15 to 2015/16

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Voluntary prepayment from individuals/households	5,610	0.28%	4,548	0.21%
Voluntary prepayment from employers	83,998	4.2%	92,633	4.2%
Other revenues from households n.e.c.	1,925,000	95.5%	2,106,000	95.6%
Other revenues from corporations n.e.c.	450	0.02%	366	0.02%
TOTAL	2,015,058	100.0%	2,203,547	100.0%

Figure 7-1 Domestic revenues account and voluntary prepayments of PCHE in 2015/16



Household Out-of-Pocket (OOP) revenues slightly increased in shillings value by UGX 181,000 billion from UGX 1.925 trillion in 2014/15 to UGX 2.106 trillion in 2015/16 (refer Table 7-1). However, it increased as a share of the CHE from 39.6% in 2014/15 to about 40.7% in 2015/16 due to overall increase in CHE. OOP is the largest revenue source for PCHE.

Table 7-2 Private Current Health Expenditure by Schemes, FY2014/15 to FY2015/16

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Employer-based insurance (Other than enterprises schemes)	79,349	3.94%	89,615	4.07%
Other primary coverage schemes	9,298	0.5%	6,036	0.3%
Community-based insurance	961	0.05%	1,530	0.07%
Unspecified voluntary health insurance schemes	0	0.0%	0	0.0%
Enterprise financing schemes	450	0.0%	366	0.02%
Other household out-of-pocket payment	1,925,000	95.5%	2,106,000	95.6%
TOTAL	2,015,058	100.0%	2,203,547	100.0%

#### 7.2. Private Current Expenditure by Financing Schemes

Table 7-2 shows the PCHE by schemes. Schemes relates to financing arrangements through which people pay for their health service. In Uganda the two most common options are voluntary insurance, or pay at the point of service from their primary income/savings (.i.e. out of pocket).

Households OOP is a direct payment made for services either from primary income or savings. The financing schemes for the private sector are mainly from OOP and voluntary health insurance. Voluntary health insurance schemes include employer based insurance, employee based voluntary insurance and other insurance coverage such as those from group or community based schemes.

Expenditures in these schemes has been at an upsurge in value except the scheme of other Sources which has declined by 3,262 billion in the period under review. Table 7-2 highlights household out-of-pocket expenditure scheme as the leading scheme with an average expenditure of 95%, followed by private health insurance (4%) and other sources accounted for 1% of the scheme financing.

Figure 7-2 Private Current Health Expenditure by Providers, 2014/15 to 2015/16

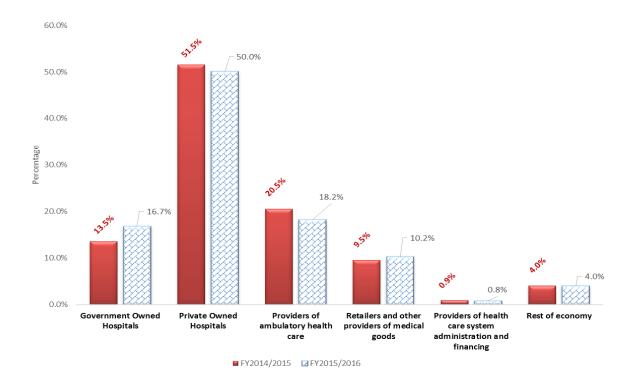


Table 7-3 shows the overall private health expenditure by all providers had increased by about 9% in 2015/16 from 2014/15. Some notable expenditure that contributed towards this increase was Government owned hospitals shares (Private wing) and Retailers and other providers of medical goods.

Table 7-3 Overall Private Health Expenditure by all providers

	FY2014/2015		FY2015/2016	
	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Millions)	Share (%)
Government Owned Hospitals	272,540	13.5%	368,934	16.7%
Private Owned Hospitals	1,037,637	51.5%	1,102,113	50.0%
Providers of ambulatory health care	413,335	20.5%	401,634	18.2%
Retailers and other providers of medical goods	191,760	9.5%	225,178	10.2%
Providers of health care system administration and financing	18,935	0.9%	17,234	0.8%
Rest of economy	80,850	4.0%	88,454	4.0%
TOTAL	2,015,058	100.0%	2,203,547	100.0%

#### 7.3. Private Current Health Expenditure by Functions

The PCHE by function shows that there were increases for all categories in Shillings value except for Governance, and health system and financing administration. There were as well slight increases in share variations with limited decreasing variations. Health goods having the highest expenditure for both years also showed an increase by 17.5% from 2014/15 to financial year 2015/16 by UGX 33 billion.

Table 7-4: Private Current Health Expenditure by Functions, 2014/15 to 2015/16

	FY2014/2015		FY2015/	<b>′</b> 2016
	Amount (UGX Mil- lions)	Share (%)	Amount (UGX Millions)	Share (%)
Inpatient curative care	559,511	27.8%	609,931	27.7%
Day curative care	80,850	4.0%	88,452	4.0%
Outpatient curative care	461,469	22.9%	515,852	23.4%
Medical goods (non-specified by function)	190,768	9.5%	224,277	10.2%
Preventive care	763	0.0%	0	0.0%
Governance, and health system and financing administration	8,535	0.4%	6,417	0.3%
Other healthcare services	713,164	35.4%	758,618	34.4%
TOTAL	2,015,058	100.0%	2,203,547	100.0%

In 2015/16, the largest PCHE spending was on Other healthcare services averaging 34.9% (735 Billion) during the two years. Expenditure on Medical goods (non-specified by function) was the third largest expenditure function by the private sector after Inpatient curative care.

As evidently shown curative care continues to show a noticeable increase. Note that some aspects of curative care may be for preventive care too and it was very difficult to disaggregate the kind of expenses from the data collection tools returned by respondents.

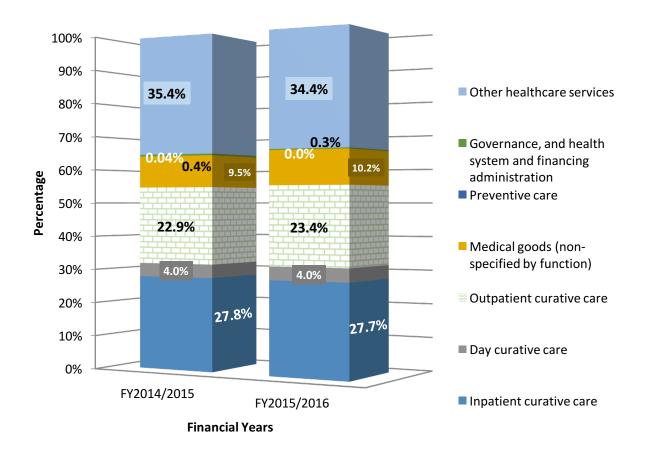
In the private sector there are not many facilities for inpatient or rehabilitative care hence, health expenditure in these areas are very small. Alternatively the private sector could be selectively damping expensive inpatient and rehabilitative services to the public facilities or the beneficiaries find it more affordable to access such services away from the private sector.

Outpatients and purchase of health drugs and consumables are common services provided by the private sector hence, the high expenditures in these areas. In the private sector, a large part of health services was directly funded by households through out-of-pocket expenditure. With increase in fees for service by clinics due to an unregulated market, households and individuals who can afford the services are purchasing health care services either through their employer or insurance purchases to avoid direct payments at the point of service.



The share of PCHE by Functions clearly indicates that medical goods, though it increased approximately by 0.7% in 2015/16, still holds the fourth highest share.

The healthcare expenditure on preventive care, as a share of PCHE, has remained low under the review period this could be attributed to increased curative care cases among households.



Development partners in this section refer to Rest of the World as classified in *the System of Health Accounts 2011* (SHA2011). It is noted, for clarity purposes, that the information presented hereunder only reflects development partners who responded to the NHA questionnaires distributed by the study team.

The Health sector in Uganda continues to get support from Health Development Partners (HDPs) and receives this support through direct in-kind contributions, financial contributions, technical expertise, medical and non-medical supplies and equipment. The Health sector's traditional bilateral partners include US-AID, BTC, DFID, SIDA, JICA, and DANIDA while the multilateral agencies include WHO, UNAIDs, UNFPA, UNICEF, GAVI, ADB, The World Bank, Global Fund and others who responded to the study.

Table 8-1 reflects general development partner investment to the Health sector, which has seen a steady increase from UGX 2.093 trillion in 2014/15 to UGX 2.139 trillion in 2015/16.

Table 8-1 Financing contributions by Development Partners, FY2014/15 to FY2015/16

	FY2014/2015	5	FY2015/2016		
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	
Bilateral donors	1,456,110	69.6%	1,593,304	74.5%	
Multilateral donors	582,601	27.8%	514,860	24.1%	
Private donors	54,751	2.6%	31,663	1.5%	
TOTAL	2,093,461	100.0%	2,139,826	100.0%	

Figure 8-1 illustrates shares of the total expenditure on health and health-related activities by development partners where Bilateral HDPs/donors still account for the largest share of 74.5% of all the expenditure by HDPs.

These were followed by Multilateral HDPs at 24.1% and last but not least, the Private donors (1.5%) who include international pharmaceutical companies and foundations like Bill & Melinda Gates Foundation.

Figure 8-1 Share of funding by Development Partners (%), 2015/16

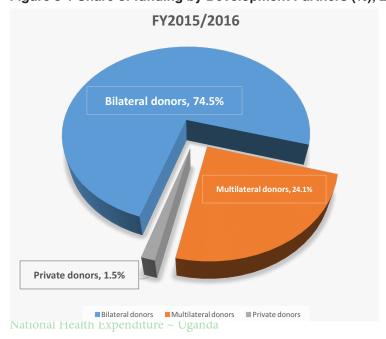


Table 8-2 Financing contributions of Development Partners as a share of CHE, 2014/15 and 2015/16

YEAR	CHE (UGX Millions)	Funding by External Partners (UGX Millions)	Ratio of External funding to CHE (%)
FY2014/2015	4,866,846	2,112,746	43.4%
FY2015/2016	5,174,058	2,157,424	41.7%

In 2014/15 the development partner health expenditure was UGX 2.112 trillion which represented 43.4% of CHE. The HDPs' expenditure increased both in nominal terms to UGX 2.157 trillion, which represented 41.7% of CHE in 2015/16. The previous NHA report³ asserts that in 2012/13, the development partner budget was UGX 1.884 trillion and represented 38.9% of CHE while UGX 2.042 trillion was spent in 2013/14 that represented 41.2% of CHE..

#### 8.1. Development Partners (Rest of the World) funding by Providers

In 2014/15 the provider receiving the largest share of the development partner funding was providers of preventive care (50.3%) followed by hospitals and lower level health facilities (36.7%). This trend changed in 2015/16 with providers of preventive care receiving 39.3% while hospitals' and lower level health units share increased to 50.3% of HDPs total funding (Table 8-3). This picture generally changes the previous allocation of HDPs largest funding going to providers of health care system administration and financing.

Table 8-3Allocation of Development Partners' funding by Providers, FY2014/15 to FY2015/16

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Hospitals	774,655	36.7%	1,085,004	50.3%
Residential long-term care facilities	0	0.0%	0	0.0%
Providers of ambulatory health care	222,007	10.5%	169,955	7.9%
Providers of ancillary services	1,120	0.1%	103	0.0%
Retailers and other providers of medical goods	3,647	0.2%	0	0.0%
Providers of preventive care	1,063,067	50.3%	848,595	39.3%
Providers of health care system administration and financing	32,829	1.6%	41,808	1.9%
Rest of economy	8,589	0.4%	11,958	0.6%
Rest of the world	6,831	0.3%	0	0.0%
TOTAL	2,112,746	100.0%	2,157,424	100.0%

Hospitals who are the largest recipients of development partner funding cover training institutions in hospitals and reflects developments and investment support to the Ministry of Health in training health professionals to respond to Uganda's population health needs, accommodation, expansion of services, construction of new health facilities.

### 8.2. Development Partners (Rest of the World) funding by Functions

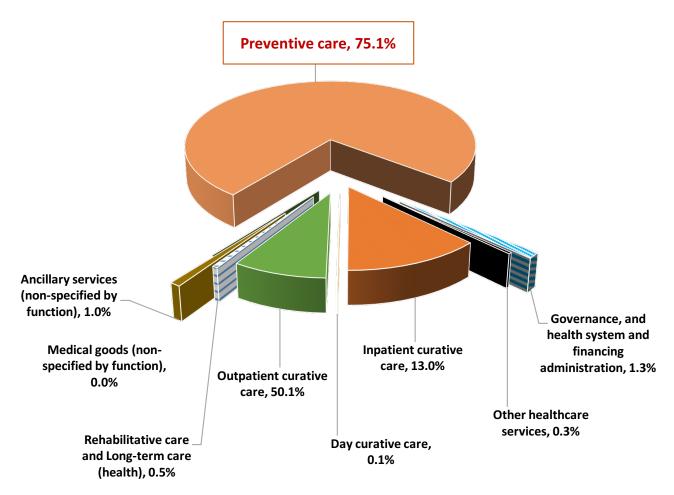
Table 8-4 shows that in 2014/15, Health development partner funds were allocated by functions mainly to preventive services (64.3%), 31.87% was assigned to curative and 4% for the rest of the services including health system, financing and administration. A similar allocation was reflected in 2015/16 where prevention accumulated 75.1%, curative got 21.8% and other services shared 3.1% which was quite different from the historical universal practices whereby curative services, civil and capital works are funded by Health development partners.

National Health Expenditure FY2014/15 and FY2015/16

Table 8-4 Allocation of Development Partners' funding by Functions, FY2014/15 to FY2015/16

	FY2014/2	2015	FY2015/2	2016
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Inpatient curative care	292,026	13.8%	279,719	13.0%
Day curative care	174,195	8.2%	1,933	0.1%
Outpatient curative care	205,716	9.7%	188,720	8.7%
Rehabilitative care and Long-term care (health)	13,965	0.7%	10,730	0.5%
Ancillary services (non-specified by function)	16,705	0.8%	20,993	1.0%
Medical goods (non-specified by function)	3,647	0.2%	0	0.0%
Preventive care	1,357,968	64.3%	1,620,583	75.1%
Governance, and health system and financing administration	26,247	1.2%	27,761	1.3%
Other healthcare services	22,277	1.1%	6,986	0.3%
TOTAL	2,112,746	100.0%	2,157,424	100.0%

Figure 8-2 Allocation of Development Partners' funding by Functions, FY2015/16



A breakdown of the 2015/16 allocation indicates the function receiving the largest provision of development partner funding was Epidemiological surveillance and risk and disease control programmes followed by Information, education and counselling programmes (Table 8-5).

Governance, and health system, financing and administration accounted for an average of 1.25% of the development partner budget.

Table 8-5 Preventive Care Funding by Development Partners, FY2014/15 to FY2015/16

	FY2014/2015		FY2015/2016	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)
Information, education and counseling programmes	256,453	18.9%	151,506	9.4%
Immunization programmes	17,057	1.3%	28,892	1.8%
Early disease detection programmes	9,345	0.7%	15,959	1.0%
Health condition monitoring programmes	1,856	0.1%	9,846	0.6%
Epidemiological surveillance and risk and disease control programmes	1,062,640	78.3%	1,401,522	86.5%
Preparing for disaster and emergency response programmes	10,618	0.8%	12,201	0.8%
TOTAL	1,357,968	100.0%	1,619,925	100.0%

(Table 8-6) indicates the financing sources for all disease expenditures; the data indicates health development partners contribute substantially to prevention of HIV/AIDs 76.8% (UGX 1.622 Trillion) while they spend 6.4% (UGX billions 134.782.3) on malaria control programs. Government expenditure on HIV/AIDS was UGX.126.950 billion (17.2%), and 150.103 billion (18.5%) in 2014/15 and 2015/16 respectively. These expenditure patterns on HIV/AIDS and Malaria did not show any structural change in the following year 2015/16 as shown in Table 5-6.

**Table 8-6 Reproductive Health Expenditure** 

	FY2014/2015					FY2015/2016			
	Public		Private		Pu	Public		Private	
	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	Amount (UGX Millions)	Share (%)	
DIS.2.1	Maternal conditions	63,152	56.7%	335,848	54.0%	94,141	57.1%	329,001	54.1%
DIS.2.2	Perinatal conditions	25,523	22.9%	225,007	36.2%	45,612	27.7%	222,568	36.6%
DIS.2.3	Contraceptive manage- ment (family planning)	6,931	6.2%	31,937	5.1%	7,682	4.7%	34,213	5.6%
DIS.2.nec	Unspecified reproductive health conditions (n.e.c.)	15,787	14.2%	28,681	4.6%	17,496	10.6%	22,808	3.7%
TOTAL		111,393	100.0%	621,473	100.0%	164,931	100.0%	608,590	100.0%

#### 9.0. Household Expenditure on Healthcare

The demand for and use of statistical information for evidence-based health policy and decision making in the health sector has, without doubt, transcended the margins of traditional administrative boundaries to cover household activities and behaviour regarding the household expenditure patterns on healthcare services. Monitoring changes at household level through household surveys has, therefore, become more important now than ever before and is currently being undertaken by the Uganda Bureau of Statistics (UBOS).

A Household in this section, like the UBOS standard definition, is defined as a person or group of people who normally cook, eat and live together (for at least 6 of the 12 months preceding the interview) irrespective of whether they are related or unrelated.

The health care boundary drawn in SHA 2011 includes personal home health services provided within households by family members, in cases where they correspond to social transfer payments granted for this purpose. Therefore, it should be noted that under this section, information hereunder comprises private households as providers of home health care and unpaid care by household members is not included in the core health accounts of SHA.

Problems of data comparability across countries and over time may arise when households have the choice between benefits in cash or benefits in-kind, in which case both kinds of care (by laypersons within the family and by specially trained nurses) are considered to be close substitutes, but are treated differently in common national accounting practice (as health care benefit in kind or social transfer in cash). However, in SHA, those parts of the cash transfers to private households for care givers of home care for the sick and disabled are treated as paid household production of health care.

#### 9.1. Total Household expenditure on health

The annual household expenditure on health (out of pocket expenditure on health) was estimated at UGX 1,925billion in financial year 2014/15 and 2,107 billion in 2015/16. The composite consumer price index (CPI) was used to scale the 2014/15 estimate to 2015/16.

#### 9.2. Per capita expenditure on health

Per capita expenditure on health is the total Health expenditure divided by the total population is estimated as shown below (Table 9-1).

Table 9-1 OOP per capita expenditure on health

Fin. Year	Population Estimate	Out of Pocket Expenditure (Billion)	Per Capita OOP Expenditure (UGX)	Per Capita OOP Expenditure (US\$)	Health-CPI	Exchange rate
Α	В	С	D=C/B	E=D/G	F	G
2008/09	29,592,600	1,214.06	41,025.80	21.3	114.75	1,930.0
2009/10	30,661,300	1,371.81	44,740.76	22.1	129.61	2,028.0
2010/11	31,755,550	1,533.50	48,290.77	18.9	151.04	2,557.0
2011/12	32,939,800	1,775.60	53,904.40	20.7	179.85	2,609.0
2012/13	34,131,400	2,059.62	60,343.85	23.1	199.20	2,609.3
2013/14	34,856,813	1,936.52	55,556.43	20.1	214.18	2,766.1
2014/15	35,492,100	1,925.96	54,264.51	16.4	154.33	3,301.8
2015/16	36,560,700	2,107.53	57,644.69	16.9	148.94	3,404.9

#### 9.3. Equity analysis

#### Per capita household out-of-pocket expenditure by quintiles

Looking at average expenditure by quintiles and in absolute amounts, Figure 8-9 shows that the richest quintile spent more than other quintile as the expected pattern. Table 8.9 further shows that all income groups registered increases in expenditure between the observed periods.

The drivers of the increase of household expenditure include; inflation, population growth, accessibility of private health services, sickness treated as an emergency in households, private wing establishments in government public facilities. Government may need to improve the quality of services in public facilities through increasing health financing to the health sector and mobilisation of alternative financing through national health insurance scheme if the country is to reduce Household OOP to a maximum of 15% of the CHE which is the maximum house hold health expenditure % acceptable according to WHO to mitigate catastrophic impoverishment by households.

The ongoing development of the health financing strategy for the country may enhance mobilisation of additional resources to enable the country embrace universal Health Coverage.

Table 9-2 Total OOP and per capita out of pocket expenditure by regions

	FY2015/16				
	Amount billions	US\$ Per capita			
Central	928.9	27.3			
Eastern	430.9	12.7			
Northern	268.5	7.9			
Western	479.4	14.1			
TOTAL	2,108	16.9			

#### 9.4. Provider analysis

Household out-of-pocket expenditure on health in private for profit facilities constitutes the largest Household provider total expenditures. Even with free services at public facilities, the share of Household expenditure spent in public health facilities was between 14.1% and 17.5% in the period under review, which was significantly at a low side. Evidence indicates that inadequate resources to deliver health services in public facilities to some extent indirectly impacts on the amount of household expenditure on health.

Table 9-3 Total household expenditure by service provider (billion shs.)

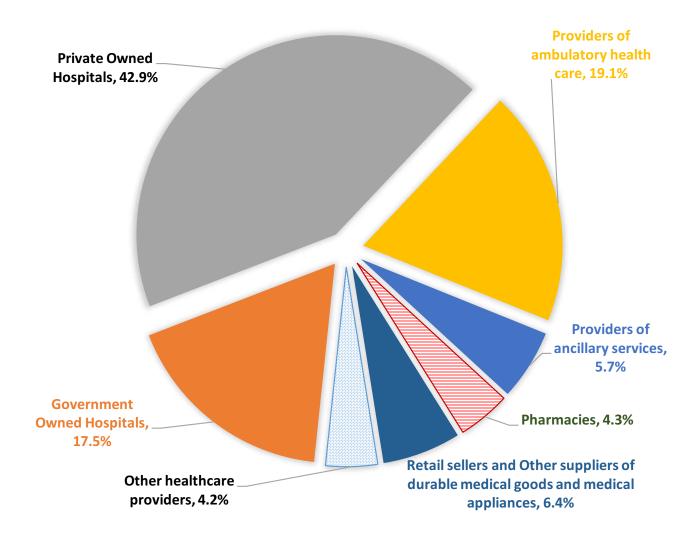
	FY2014	/15	FY2015	16
	Amount (UGX Millions)	Share (%)	Amount (UGX Mil- lions)	Share (%)
Government Owned Hospitals	271,821.80	14.1%	368,358.58	17.5%
Private Owned Hospitals	720,692.83	37.4%	904,100.29	42.9%
Providers of ambulatory health care	413,327.82	21.5%	401,631.01	19.1%
Providers of ancillary services	248,490.00	12.9%	120,890.00	5.7%
Pharmacies	80,861.44	4.2%	89,946.15	4.3%
Retail sellers and Other suppliers of durable medical goods and appliances	109,917.50	5.7%	134,152.20	6.4%
Other healthcare providers	80,850.00	4.2%	88,452.00	4.2%
TOTAL	1,925,961.38	100.0%	2,107,530.22	100.0%

Source: UBOS-Household survey 2014/15

Figure 9-1 Total household expenditure by service provider (billion shs.)

Financial years under 2015/16 -Service analysis

# FY2015/16



#### 10.0. Capital Expenditure (HK)

The System of Health Accounts 2011 (SHA 2011) describes Capital Expenditure (HK) as a very integral component in health expenditure and it's an important factor due to its contribution in production of health services. For example construction of new health facilities or expansion/upgrading of existing ones, training, investment into new health equipment or upgrading or enhancements in computer or information systems for instance DHIS2 and IFMS. The HK information helps in analyzing the health systems production capability, whether it's appropriate, deficient or excessive.

This chapter provides how much HK was spent on the production of services and which Government, Private and Development Partners have contributed towards the formation of this HK and what types of services have been provided. The information presented on private and development partners have been consolidated from the survey responses.

#### 10.1. Types of Assets in production of health services

Capital Expenditure (HK) is classified under two major categories namely;

- Gross capital formation which comprises of three sub- categories which are infrastructure, machinery and equipment and ICT related equipment and other machinery & equipment not specified elsewhere;
- 2) Non-produced non-financial assets which comprises of land and others.

Figure 9-1 provides the amount spent on various types of assets for the period between 2014/15 and 2015/16.

	FY2014/1	5	FY2015/1	16
	Amount (Millions UGX)	Share (%)	Amount (Millions UGX)	Share (%)
Infrastructure	64,946.21		88,208.34	
- Residential and non-residential buildings	64,173.79	50.1%	87,663.75	65.0%
- Other structures	772.42	0.6%	544.59	0.4%
Machinery and equipment	61,658.72		44,930.31	
- Medical equipment	15,129.92	11.8%	1,113.81	0.8%
- Transport equipment	44,675.12	34.9%	42,823.69	31.8%
- ICT equipment	444.37	0.3%	190.35	0.1%
- Machinery and equipment n.e.c.	1,409.30	1.1%	802.48	0.6%
Intellectual property products	0.00	0.0%	255.92	0.2%
Unspecified gross fixed capital formation (n.e.c.)	1,494.47	1.2%	1,418.96	1.1%
TOTAL	128,099.39	100.0%	134,813.53	100.0%

The total capital expenditure which contributed towards the production of health services in 2014/15 was UGX128 billion compared to UGX134.8 billion in 2015/16 which represents a 5% increase in capital investment. The major expenditure in 2014/15 was on Infrastructure which relates to civil works that is equal to UGX 64.9 billion (50.7%) compared to UGX 88.2 billion (65.4%) which was spent on the same category in 2015/16 as seen in Table 10-1.

Figure 10-1 shows that the second largest HK category in 2015/16 was on Machinery and Equipment which relates to Medical equipment, Transport, ICT, Machinery and Equipment n.e.c, and so on, that is equal to UGX 61.6 billion (49.3%) compared to UGX 44.8 billion (34.6%) which was spent on the same category in 2014/15.

64,946.21 64,946.21 FY2014/15 FY2015/16

Figure 10-1 Capital Expenditure by Type of asset, FY2014/15 to FY2015/16 (Millions UGX)

Other HK including Unspecified fixed capital formation accounted for UGX 1.4 billion (1.2%) in 2014/15 while in 2015/16 it stagnated at UGX 1.4 billion (1.1%) in expenditure on the same category (Table 10-1).

■ Machinery and equipment

■ Unspecified gross fixed capital formation (n.e.c.)

#### 10.2. Capital Expenditure by Sectors

■ Intellectual property products

■ Infrastructure

Health Development Partners (HDPs) were the largest (74.8%) contributor in HK followed by the GoU (25.1%) and lastly the Private sector at 0.1% of all expenditure on Capital expenditure on health in 2014/15.

The same picture, as seen in Table 10-2 is maintained with Health Development Partners (HDPs) were the largest (77%) contributor in HK followed by the GoU (22.6%) and lastly the Private sector at 0.4% of all expenditure on Capital expenditure on health in 2014/15.

Table 10-2 Capital Expenditure by Sectors, FY2014/15 to FY2015/16

	FY2014/1	5	FY2015/16		
	Amount (Millions UGX) Share (%)		Amount (Millions UGX)	Share (%)	
Government	32,192.12	25.1%	30,468.17	22.6%	
Private	79.72	0.1%	553.91	0.4%	
<b>Development Partners</b>	95,827.55	74.8%	103,791.44	77.0%	
TOTAL	128,099.39	100.0%	134,813.53	100.0%	

Both Government and private sector healthcare capital expenditure includes the construction or upgrading of infrastructures like hospitals, purchase of equipment like medical equipment, vessels, vehicles such as ambulances and ICT equipment & software in their respective sectors. The HK by development partners is mostly investments made in the form of new infrastructure, maintenance of existing health facilities and equipment purchase.

#### 10.3. Government Capital Expenditure

Government capital expenditure mostly includes the construction or maintenance/ upgrading of infrastructures and purchase of equipment. Table 10-3 shows that, overall, Government capital expenditure (HK) has reduced by 10% between 2014/15 (UGX 32.1 billion) to 2015/16 (UGX 30.4 billion).

Table 10-3 Capital Expenditure by Public Sector (Government), FY2014/15 to FY2015/16

	FY2014/15		FY2015/16	
PUBLIC	Amount (Millions UGX)	Share (%)	Amount (Millions UGX)	Share (%)
Infrastructure	29,011.77		28,008.73	
- Residential and non-residential buildings	28,404.30	88.2%	27,559.20	90.5%
- Other structures	607.47	1.9%	449.54	1.5%
Machinery and equipment	1,699.30		1,040.48	
- Medical equipment	120.00	0.4%	95.00	0.3%
- Transport equipment	80.00	0.2%	94.00	0.3%
- ICT equipment	90.00	0.3%	49.00	0.2%
- Machinery and equipment n.e.c.	1,409.30	4.4%	802.48	2.6%
Intellectual property products	0.00	0.0%	0.00	0.0%
Unspecified gross fixed capital formation (n.e.c.)	1,481.05	4.6%	1,418.96	4.7%
TOTAL	32,192.12	100.0%	30,468.17	100.0%

Much (90%) of the government capital expenditure in the health sector for the year 2014/15 was spent on infrastructure followed by expenditure on Unspecified gross fixed capital formation (4.6%) and Machinery & Equipment (5.4%) This pattern was also repeated in the following year 2015/16 with infrastructure (92%) followed by Unspecified gross fixed capital formation (4.7%) and Machinery & Equipment (33%) of all the GoU capital expenditure (Table 10-3).

#### 10.4. Private Capital Expenditure

Private capital expenditure mostly includes the machinery and equipment and not on construction or maintenance/ upgrading of infrastructures and purchase of equipment like government does. Table 10-4 shows that, overall, Private capital expenditure (HK) has increased by 35% between 2014/15 (UGX 1.8 billion) and 2015/16 (UGX 2.4 billion).

Table 10-4 Capital Expenditure by Private Sector, FY2014/15 to FY2015/16

DDIVATE	FY2014/15		FY2015/16		
PRIVATE	Amount (Millions UGX)	Share (%)	Amount (Millions UGX)	Share (%)	
Infrastructure	69.72		12.50		
- Residential and non-residential buildings	0.00	0.0%	0.00	0.0%	
- Other structures	69.72	87.5%	12.50	2.3%	
Machinery and equipment	10.00		285.50		
- Medical equipment	0.00	0.0%	21.25	3.8%	
- Transport equipment	0.00	0.0%	230.00	41.5%	
- ICT equipment	10.00	12.5%	34.25	6.2%	
- Machinery and equipment n.e.c.	0.00	0.0%	0.00	0.0%	
Intellectual property products	0.00	0.0%	255.92	46.2%	
Unspecified gross fixed capital formation (n.e.c.)	0.00	0.0%	0.00	0.0%	
TOTAL	79.72	100.0%	553.91	100.0%	

In (Table 10-4), much (69.7%) of the private capital expenditure in the health sector for the year 2014/15 was spent on Infrastructure followed by Unspecified gross capital formation (20.3%) and Machinery and equipment at(10%) and. In 2015/16 Machinery and equipment accounted for (51.5%) followed by Intellectual Property Products (46.2%) and infrastructure at (2.3%)

### 10.5. Rest of the World Capital Expenditure

HDPs capital expenditure usually includes a great mixture of the construction or maintenance/ upgrading of infrastructures as well as machinery equipment. Table 10-5 shows that, overall, HDPs capital expenditure increased by 8.3% between 2014/15 (UGX 95 billion) and 2015/16 (UGX 103 billion).

Table 10-5 Capital Expenditure by Development Partners, FY2014/15 to FY2015/16

	FY2014/15		FY2015/16	
DEVT PARTNERS	Amount (Millions UGX)	Share (%)	Amount (Millions UGX)	Share (%)
Infrastructure	35,864.72		60,187.10	
- Residential and non-residential buildings	35,769.48	37.3%	60,104.55	57.9%
- Other structures	95.24	0.1%	82.55	0.1%
Machinery and equipment	59,949.41		43,604.34	
- Medical equipment	15,009.92	15.7%	997.56	1.0%
- Transport equipment	44,595.12	46.5%	42,499.69	40.9%
- ICT equipment	344.37	0.4%	107.10	0.1%
- Machinery and equipment n.e.c.	0.00	0.0%	0.00	0.0%
Intellectual property products	0.00	0.0%	0.00	0.0%
Unspecified gross fixed capital formation (n.e.c.)	13.42	0.0%	0.00	0.0%
TOTAL	95,827.55	100.0%	103,791.44	100.0%

Much (59.4%) of the HDPs capital expenditure in the health sector for the year 2014/15 was spent on Machinery and equipment (62.6%) especially the medical equipment while expenditure on infrastructure at (37.4%).

This pattern however was altered in the following year 2015/16 with infrastructure (58%) and Machinery and equipment accounted for (42%) of all the HDPs sector capital expenditure in that year (Table 10-5).

More analysis may be required to reveal why the expenditure pattern of HDPs in regard to capital investments changed radically from 2014/15 to 2015/16.

#### Policy Implications and Conclusions.

The World Health Organization and UNFPA have made this seventh round of NHA exercise in Uganda possible. The findings of the study have shown that the CHE per capita has decreased and it still falls short of the minimum amount of US\$84 per capital per annum which is required to provide essential health services in developing countries. Furthermore, the share of out of pocket expenditures decreased from 41% of CHE in 2012/13 to 37% in 2015/16. Concerning external financing, the findings show that the donor component of health financing has decreased faster than the government component. This has implications for sustainability of the health care system, unless there is a reliable and predictable flow of donor funds and domestic resources into the health system

In line with regional initiatives and commitments, there is a need for the government to increase its allocation of resources to the health sector, and introduce prepaid health financing mechanisms such as social health insurance so as to increase its resource base and avoid possible financial burden for households. There is also a crucial need to strengthen measures that had started in enhancing allocative efficiency so as to purchase (produce) the right mix of inputs and outputs to address the health problems of the majority of the population.

The current analysis indicates that the health care system is biased in favor of hospital-based curative services. The disease based expenditure also demonstrate critical shortages of resources relative to the burden of morbidity and mortality. This is not surprising as these are a reflection of the overall health system resource constraints. It is thus necessary to solicit more funds and utilize these in an equitable and efficient manner in order to achieve the sustainable Development Goals and the National Development plan II goals.

In the final analysis, it is essential for the government and development partners to utilize the information generated by this NHA study for evidence-based decision making as it relates to all aspects of the health financing function. The MoH has to play its stewardship role, so that the recommendations are implemented as deemed appropriate. Health financing is one the core functions of a health system; it is therefore necessary to have NHA institutionalized and integrated with the routine health information system. To this end there is a need to build more capacity in health financing and NHA.

From the 1998 NHA report donor financing has doubled and the increase leans towards HIV and AIDS spending. Most external financing has been targeting specific programme with very little or no flexibility on expenditure patterns. In order to have quality health care delivery and positive health benefits government needs to solve health systems problems in a holistic manner.

Most donors tie their support to purchase drugs only or other supporting items and neglect other very important components of the health system like human resources and infrastructure. More flexibility is needed to recipients of support for better health results.

There is need to introduce health insurance and revise the key performance indicators to include health promotion and prevention so as to mobilise additional resources to finance interventions in the program area.

There is need to mobilise additional funds through medical credit schemes for the private sector to enhance financing for health care delivery and minimise out of pocket spending. Government may also have an affirmative action to deploy immunisation funding to the private sector to scale up prevention measures and reduce morbidity and mortality rates.

There is need to over haul the health system through restructuring and cause a revolution in the health sector. Given the above recommendations there is need to reform the health sector if the country is to steadily move towards middle income status and achieve universal health coverage.

### (Footnotes)

- 1 See relevant chapters for breakdown of the global figures in this column
- 2 Note that part of the Government Current and Capital Health Expenditure is financed by external partners through general budget support



# UGANDA'S NATIONAL HEALTH ACCOUNTS

#### Introduction.

Health Financing, globally, is one of the topmost health systems' agenda due to its vital contribution towards achieving Universal Health Coverage (UHC). In Uganda, among other countries, the main concern is not only on the total amounts or volumes of health expenditures but also equity, effectiveness and efficiency.

The National Health Accounts has taken a pivotal role in providing health sector managers with necessary information to make favourable resolutions aimed at UHC.

Introduction &

Interpreting Data for policy purpose

**Key Results** 

**Conclusions &** 

**Recommendation** 

# **MINISTRY OF HEALTH**

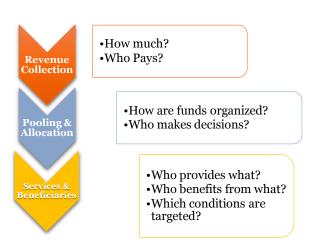
Plot 6, Lourdel Road Kampala - Uganda Tel: +256-414-340884 http://www.health.go.ug/ JULY 2018

# INTERPRETING DATA FOR POLICY PURPOSE

The purpose of the National Health Accounts (NHA) study initiative is to track health expenditure highlighting inequities and inefficiencies in health spending with a major aim of informing health financing policy.

In explaining the findings, NHA study paints a picture of critical components of healthcare system in the country which, then, can be used as a strategic planning tool for government and other health development partners.

Interpretation of findings is imperative because the meaning of figures not the figures themselves is what is counted as success indicator. Thus, obtaining financing & expenditure figures, interpreting the results, and designing of appropriate policy is the process which consummates the full usefulness of NHA.



In Uganda, based on health sector policy priorities and international conventions for reporting NHA, the findings point at different policy areas regarding revenue generation, pooling & allocation, purchasing &services offered, and beneficiaries.

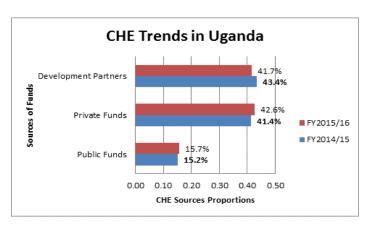
Findings of NHA study that covered FYs 2014/15 & 2015/16 show that healthcare financing and expenditure have increased from the previous years. While this might be linked to the general economic conditions in the country, there are key findings that should be highlighted for purposes of informing policy decision-making.

#### **KEY RESULTS**

☐ Current health expenditure (CHE) increased from UGX 4,944 Billion (☐US\$ 1.7 Billion) in FY2014/15 to UGX 5,309 Billion (☐US\$ 1.8 Billion) in FY2015/16.

CHE, in this context, measures the economic resources spent in Uganda on healthcare goods and services. This includes administration and insurance, salaries, the costs of vaccination programmes and payments for hospital cleaning services, among many others. CHE excludes capital expenditure on health care.

While the general health expenditure is important, unit expenditure per Ugandan sheds more light on how an ordinary household is catered for. World Health Organization endorses a minimum of US\$86 per capita for quality healthcare provision in sub-Saharan Africa as recommended by World Health Organisation.



- ☐ The health expenditure per capita on average for the two years under study was US\$ 51 reducing from US\$ 56 in the previous NHA study and this was attributed to an increase in population and devaluation of the Uganda Shillings (UGX).
- Universal Health Coverage (UHC), which has become a top-notch priority for many countries, is difficult to achieve if public health financing is less than 5% of GDP. It is construed that higher government spending generally provides public infrastructure and health service delivery at subsidized costs.

Over the period from 2014/15 to 2015/16, Uganda's GDP grew in nominal terms by 4.7% on average and in real terms from UGX 76,727 Billion in 2014/15 to UGX 86,549 Billion in 2015/16. Current health spending as a percentage of GDP was at 7.1% for 2014/15 and 7.4% for 2015/16. These figures are low on the expected

scale and portray how far Uganda is as far as public spending towards UHC is concerned.

From FY2014/15 to FY2015/16, different actors contributed to healthcare financing in Uganda who include government whose contribution increased from 13.8% to 15.3% of CHE. Development partner contribution decreased from 43.4% to 41.7% of CHE and the trend has been decreasing since financial year 2013/14 (46.7% of CHE).

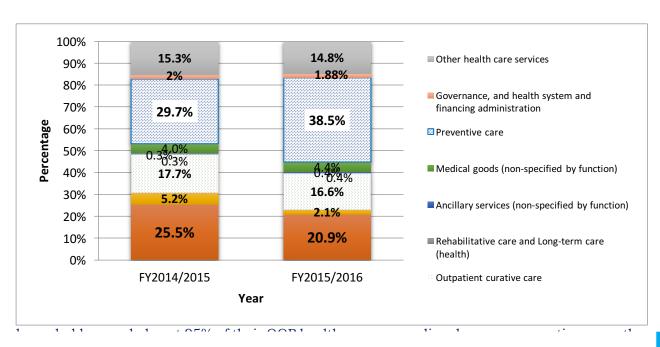
On the other hand, private funds increased from 41.4% to 42.6% of CHE for the years under study. The proportionate (2.7%) increase in private sector contribution to current health expenditure in 2015/16 was attributed, mainly, to increase in household OOP expenditure from UGX 1,925 billion [33% of CHE] in 2014/15 to UGX 2,108 Billion in 2015/16 [37% of CHE] in absolute terms.

- ☐ The healthcare providers that accounted for most of the health expenditure in 2014/15 and 2015/16 were hospitals and lower level health centres averaging 47.5% during the two years. This was closely followed by providers of health systems administration and ancillary services. A big percentage of the expenditures were financed by health development partners and private sector.
- ☐ To know what is provided, data on services was collected and findings show that curative care took an average lion's share (62% of CHE) for the two years under study.

It should also be noted that a huge proportion (61%) of the curative care budget was spent on inpatient and 38% on outpatient care. The other key expenditure was on medical goods. Pre-

ventive care increased from 29.7% in 2014/15 to 38.5% of CHE in 2015/16 which is a good development that should also be seen in prevention of preventable disease burden in households. The expenditure on curative was so large because households spend almost 95% of their OOP health expenditure on Curative care and government considers curative services as an emergency on the already sick person and tends to provide for it more than providing for those who are yet to fall sick or prevent anticipated sickness from occurring.

- Looking, meticulously, at the private sector contribution to CHE shows that health goods and medicines hold the highest share of private health expenditure at 59% of the PCHE. Ancillary Services expenditure represented 2.2% of the PCHE. This could be shading more light on what households (individuals) are looking for in private facilities which could be lacking within the public facilities considering the fact that only 15.5% of household OOP is spent in public/government facilities.
- The expenditure on preventive care increased from UGX 1,442 billion in 2014/15 to UGX 1,992 billion in 2015/16. This may be attributed to the private providers and households spending less on preventive care than curative probably because it is not considered as an emergency to the financing agent. But the trend indicates that preventive care are now being considered even by households because it is considered the root cause of the burden of diseases.
- The financing landscape for HIV.TB, Immunisation and Malaria was difficult to estimate due to lack of accurate, complete and timely data available



# SPENDING ON SOCIAL DETERMINANTS OF HEALTH.

Social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole.

Social determinants of health are the primary determinants of whether individuals stay healthy or become ill (a narrow definition of health). The categories of SDH include; Education, employment, food security, Housing, safe drinking water, Good sanitation, social safety nets, Income redistribution and Early childhood development.



# placed on the households when the public sector should be taking the lead role.

## **KEY MESSAGES**

# EXPENDITURE ON HEALTH CARE (TOTAL HEALTH EXPENDITURE)

- Government contributes 15% of the total health expenditure
- Households contribute 40% of the total health expenditure
- Development partners contribute 42% of the total health expenditure
- Other private players contribute 3% of the total health expenditure
- ☐ The healthcare expenditure in Uganda is, largely, funded by health development partners (average 42% of the CHE) channelled through government offices and the private sector especially NGOs. From this depiction, there is a clear calling for government to step up unto healthcare resource mobilization platform for availability and sustainability issues.

This will also help MOH to reduce on duplication of healthcare services in the country which has been, largely, attributed to a large chuck of resources that are spent off-budget.

- ☐ With CHE per capita below the endorsed US\$84 and reducing, government needs to come up with measures to improve the situation. This is because, a reduction in CHE per capita shows that, on average, a Ugandan has lost some money meant for healthcare which leads to reduced healthcare consumption both in quality and quantity.
- The high OOP is actually a sign of malignancy in the health sector because it means there is a huge health cost burden that has been

With households spending, on average, only 15.5% (2014/15 – 2015/16) of their high OOP in government facilities (which are located in across the country) is a sign that something is amiss in these facilities considering that services in these government facilities are free.

This, therefore, calls for government to intervene by improving services in public facilities in addition to having efforts into pooling resources through better mechanisms like health insurance for all Ugandans.

### WHAT IS THE DISEASE BURDEN?

The disease based expenditure demonstrates critical shortages of resources relative to the burden of morbidity and mortality. The report indicates that about 70% of disease based expenditure was spent on HIV/AIDs, followed by Malaria 8%, maternal conditions and Diarrheal.

Hospitals and health centres have been the major recipient of the financing compared to primary health care health centres. Health administration remains a significant item of government spending on health over the period under review.

### **CURATIVE VS PREVENTION.**

Primary health care should be boosted based on evidence of disease burden of the region if the increase in preventive care cost (29.7% to 38.5%) is to be seen in the picture of households' welfare. With malaria for instance still

consuming majority (above 50%) of OOP raises more questions than answers. In this context,			Low spending on RMNCAH- 9% of the THE
preve tion a	ention should be based on a health promo- and communications strategy that involves		High dependency of disease based programs on donor financing
	ocess to enable people to improve their through embracing social determinants alth		There is inequity in distribution of resources especially among regions
	Domestic contribution for public health financing is still very low at \$10 per capita.		There is Lack of evidence on spending on TCAM
	Government public financing as percentage of Total Health Expenditure is at 15%. Government contribution to health care is extremely low, and virtually below standards for child health, reproductive health, and HIV/ AIDS activities. Government expenditures go principally to salaries; there are little government		Domestic financing for HIV is at 16% and 6% for Malaria control and prevention. The country will experience huge financing gaps in funding unless domestic and global commitments increase in the long term  POLICY RECOMMENDATIONS.
	ernment resources available to support the functioning of the health system. Donors and		
	external partners are also reluctant to fund recurrent costs.		control Knobs should be altered by ic policy to change the performance of nealth sector to sustain change in the red direction.
	Health Expenditure was 40%. Where out of pocket is more than 15-20%, there is low or little financial risk protection. The high private		alterations should be in the following th systems:
	expenditure reflects the need felt by population, and the high OOP reflects the lack of prepayment and risk sharing approaches in the		Health Financing
	health system.		Payment mechanisms
	Donor financing as percentage of total health		Organisational arrangements
	expenditure was 42% and is declining over the years while household spending on health		Policy and Regulations
_	is increasing.		Behaviour Change
	Other sources of financing as a percentage of total health expenditure was 3%		hese will influence efficiency, quality nd access .
	Low prepayment schemes at 1% population coverage		Scale up domestic financing to the health sector from 15% of the THE to at least 35% of
	Low funding for medicines and health supplies at \$3 per capita		the THE and or increase capita spending from \$10 to \$17 per capita
	% of the population with large household expenditure on health as a share of total household expenditure:		Government is advised to Introduce Social Health Insurance to scale up prepayment mechanisms.
	Share greater than 10% of household expenditure is 13.3%		More needs to be done to improve the frequency and outputs of resource tracking
	Share greater than 25% of household expenditure is 2.3%		tools. Accurate and timely data is necessary to monitor and track health financing and its efficiency.
	Proportion of the population whose household expenditure on health exceeds 40% of capacity-to-pay is 5.8%		The Country needs to address high levels of out of pocket expenditure in order to protect households from catastrophic spending by
	More than 90% of the capital expenditure was spent on medical and non medical buildings and only 8.8% was spent on procurement of medical equipment's		broadening pre-payment mechanisms such as Social Health Insurance. This is in line with World Health Assembly resolution of 2005 on Universal Health Coverage and sustainable health financing and as well as revisiting the

Paris Declaration that calls for greater Investments in the Health Sector and Social Health Insurance and Financing

- To ensure the effectiveness and sustainability of child health services, the government should allocate adequate resources needed to implement key activities, such as immunization, micronutrient supplementation, nutritional support for malnourished children, and mosquito nets. Government should build a strict control and regulation system for pricing and prescribing of medical drugs to children under the age of five years.
- The non-public sector is a major player in provision of health services (60%), Government needs to develop appropriate policies that build appropriate public-private partnerships with a view to increasing access to affordable health services for the entire population and especially the 20% below the poverty line population

\* \* FND \* \*