

Why has Uganda not enacted its national health insurance law after 35 years? An evidence brief for policy action

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Abstract

BACKGROUND.

Despite sustained economic growth, Uganda still struggles to finance its basic social services including healthcare with a long-standing history of promising attempts to start a national health insurance scheme. Our study systematically maps the historical evolution of Uganda's quest for a national health insurance scheme, identifies the policy concerns that impede its enactment into law, and proposes contextual considerations for implementing a robust national health insurance scheme in Uganda.

APPROACH.

We conducted a multiple methods study consisting of three cross-sectional surveys using a mini-Delphi technique, nine key informant interviews, and six stakeholder dialogues. Also, we conducted a documentary analysis of 29 policy related documents regarding Uganda's national health insurance scheme, guided by a protocol we developed *a priori*, and worksheets of the Supporting Use of Research Evidence in African Health Systems (SURE), to conduct the policy dialogues. We collected data between 2016 and 2024. We analyzed the data quantitatively and qualitatively, separately, and then performed a triangulated synthesis.

FINDINGS.

The response rate was 100% for the first two rounds of the Delphi survey, that was face-to-face (30/30), whilst each of the stakeholder deliberation meetings had a sample size of between 25 and 45. These stakeholders were from government ministries, departments and agencies, parliament, the private sector, academia and non-governmental organizations. We identified five emerging themes about Uganda's national health insurance, that is, the "evolution and delay to start Uganda's national health insurance scheme"; that the insurance scheme would be "another collecting fund with a high risk of corruption"; that this would be an "elitist health insurance scheme exclusive of non-monetized citizens as well as the informal sector workers"; and finally, that the scheme was perceived as "a new tax with increased cost of production" by employers. Importantly, elites in the ruling National Resistance Movement political party, health insurance was perceived to alienate the voter base, given its 'free primary health care' policy.

CONCLUSIONS & NEXT STEPS.

Our study highlights that establishment of the Uganda National Health Insurance Scheme is long overdue, and still faced an uphill task, despite several efforts in the last three and a half decades. We identified perceived institutionalized corruption, an additional tax burden, and exclusion of rural and informal sector citizens outside the monetary economy, as the areas of most friction among stakeholders regarding the Uganda National Health Insurance Scheme. Policy actors, especially the national health insurance lobby, ought to re-mobilize, renegotiate and present a better case to circumvent these perceptions of friction among key stakeholders and enact a win-win law that is implementable.

INTRODUCTION

Innovative health financing is a game changer in transforming opportunities for the very poor in the world, more so in sub-Saharan Africa. The goal of a responsive health-financing plan is to enable universal access to quality health services and achieve the aspirations of 'Health for All' as enshrined in the Alma Ata Declaration of 1978 (Hone et al., 2018). In the past decade and a half, this has been echoed globally within the Universal Health Coverage (UHC) initiative for increased access to quality care with financial risk protection (Sachs, 2012).

Despite increased investment and policy reforms in the recent past, Uganda has not yet found a formula to solve the chronic shortage of funds to its health sector manifesting as 'unfunded priorities' in recurrent annual ministerial policy statements, (Essue & Kipiriri, 2018), including mass health professionals training, recruitment and retention. The economic environment in low-income states is typically that of high poverty, wide income disparities, and sub-optimal economic growth (World, 2025). Consequently, donor agencies and citizens finance the health systems as the state rebuilds its capacities (Obuku E.A, 2017), resulting in a vicious cycle of poverty from catastrophic health expenditure experienced by the common citizenry from high out-of-pocket costs (Eze et al., 2022). Indeed, the post-2015 agenda documented 'unfinished business' of the millennium development goals (MDGs) particularly in the low-income countries of sub-Saharan Africa (Requejo & Bhutta, 2015). For example, Uganda did not meet its crucial health-related goals to reduce the maternal mortality ratio by three quarters and reversing the spread of HIV/AIDS, mainly driven by poverty (Republic of Uganda, 2015). Consequently, the sustainable development goals (SDGs) addressed this problem aiming to reduce income inequality and the gender gap, in addition to the health-related goals on poverty, hunger and wellness (World Health Organisation, 2015), a basis for Uganda's third & fourth National Development Plans (NDP), specifically on human capital development (National Planning Authority, 2025).

A quick review of researched literature suggests paucity of empirical evidence exploring the reasons for Uganda's stall in health financing reforms, particularly in enacting a national health insurance scheme, unlike partner states in the East African Community. Previous work focused on continued enrollment in private insurance schemes with the advent of the national health insurance scheme (Zikusooka et al., 2009), health financing reforms (Orem & Zikusooka, 2010), willingness to pay (Basaza et al., 2019), the players & processes (Basaza et al., 2013) while more recent work covers integration of community health insurance (Namyalo et al., 2023) and the political economy of the national health insurance scheme (Basaza et al., 2023). Our study aimed to systematically map the historical evolution of Uganda's quest for a national health insurance scheme since its conception of the Professor Owori report of

1987. We also aimed to identify the policy concerns that impede its enactment into law, and propose contextual considerations for implementing a robust national health insurance scheme in Uganda.

METHODS

Design.

We conducted a multiple methods study consisting of cross-sectional surveys using a mini-Delphi technique (Pan et al., 1996), nine key informant interviews, and six stakeholder dialogues between 2013 and 2019, augmented by the documentary analysis until 2024. We developed a protocol *a priori*, and worksheets based on guidance from the Supporting Use of Research Evidence in African Health Systems (SURE) to conduct the policy dialogues (<http://global.evipnet.org/SURE-Guides/>).

Our first dialogue was an overall priority setting for health systems evidence using a mini delphi technique that identified health financing, governance and human capital as the most resilient priorities for health systems research in Uganda. Our second dialogue focused on the National Health Insurance Scheme Bill 2012. We presented a background document outlining Uganda's health systems financing context and clearly stated the purpose of the planned priority setting meeting, sent 21 days prior.

Thereafter, we provided sufficient time for participants to re-read the meeting papers (sent 21 days in advance) and then delivered a PowerPoint presentation on Uganda's health insurance portfolio. We followed Chatham House rules, where attendees share information freely without disclosing sources. We facilitated a brainstorming session, to identify policy concerns regarding Uganda's Health Insurance Scheme compared to those identified from the synthesis of existing literature. These inputs informed priority rankings by participants, as described under data collection. We then developed an evidence brief for policy over several months that informed deliberations on Uganda's health financing options and implementation considerations for policy action in our subsequent stakeholders meetings. The sixth dialogue was an advocacy engagement meeting with Uganda's Head of State in 2019 at State House, Entebbe. In between, we held the third and fourth dialogue with the Uganda Medical Association whilst the fifth was a multisectoral convergence.

Study setting in the context of Uganda health systems & policy.

Uganda's health financing model is mixed with a government free-for-service tax-funded public healthcare through the ministry of health, out of pocket purchasing of services by citizens, followed by a marginal population of community or private health insurance scheme users (Ministry of Health, 2022). Despite the quest to provide free-medical care (Moat 2009, Museveni, 2016), in reality, due to limited financing by the government, citizens pay to cover any shortage of medicines and laboratory tests in public hospitals (Ministry of Health, 2023b) with over 20% catastrophic expenditure.

Uganda's formal health sector includes public health facilities that provide the majority of the healthcare, private not-for-profit or non-governmental organizations and private-for-profit health facilities (Ministry of Health, 2023a). The informal sector consists of indigenous and complementary medicine practitioners, drug peddlers, and others such as spiritual healers. Uganda's public health care system constitutes health centers level 2, 3 and 4, and hospitals (district, regional and national referral). The Village Health Team is the thrust for primary health care in the community and the equivalent of health center level 1. The proposed national health insurance scheme would be implemented through these government structures, with participation of the private sector (Walimbwa, 2019).

Description of the policy intervention under study.

Briefly, health insurance is a mechanism intended to provide coverage against the financial consequences of health-related uncertainties, by spreading the anticipated costs resulting from the occurrence of these illnesses—also known as risks—among several persons (WHO, 2025; Xu et al., 2005, Smith & Twitter, 2004). For health insurance to function, there should be prior payment of premiums, that is, before the occurrence of the illness; sharing of risk, and the perception of guarantee also known as 'risk pooling'. The premiums paid by insured persons are pooled together and used to cover the expenses exclusively for those persons affected by the occurrence of a clearly defined illness, *a priori*. In exchange for the payment of premiums, insured persons obtain the insurer's guarantee to provide this financial protection from 'catastrophic health expenditure', also known as 'strategic purchasing'. Households experience catastrophic health expenditure when their out-of-pocket payments for healthcare exceed their financial capacity. That is, food, clothing, shelter, utilities, education and other basic needs are compromised due to health costs. Spending on health is said to be "impoverishing", if this expenditure is so large that it pushes households below the poverty line (World Health Organisation, 2015; James Lind, 2023).

Stakeholder participants, sampling and sample size.

We purposely identified and mapped stakeholders to maximize variability, representativeness, and engagement in the dialogues. Our map targeted the following stakeholders: insurance players and regulators, leaders of disease control programs and hospitals from government ministries, departments and agencies (MDAs) related to health insurance including regulation; the business community; private for-profit hospitals, private not-for-profit hospitals, civil society organizations representing health consumers; professional associations or unions for the workers' voice, and employer groups. The sample sizes in the first to fifth dialogues were 45, 22, 28, 35 and 32, respectively. The 6th dialogue at State House had about 40 stakeholders (*Personal communication with the Ministry of Health & State House*). Participants formally assessed the policy concerns in the second dialogue, whilst the other dialogues were open for free deliberations of the 2012 health insurance Bill (Ministry of Justice & Constitutional Affairs, 2012).

Data collection and management.

We collected data between 2013 and 2024. Our multipronged data collection for the second dialogue involved conducting a literature review in a systematic way on health insurance schemes in low-income countries, idea generation through brainstorming, evaluation of these ideas through discussion of their merits, and prioritization of the most promising options through judgment and ranking. We identified policy concerns about the National Health Insurance Scheme in Uganda.

To ensure successful brainstorming, we encouraged participants to make as many suggestions as possible, without immediately appraising the ideas generated. We then aligned all policy concerns into similar categories and requested the participants to make judgments and rank them using a 3–point Likert item, that is, no or low as 1, uncertain or medium as 2, and yes or high as 3. The specific questions were adopted from the SURE guides (Supporting Use of Research in African Health Systems). These were: Is the problem identified important? Are viable interventions available to solve the bottleneck? Is there an opportunity for change, including economic & political opportunity? Is there important uncertainty about the policy issue? Is relevant research available to support priority policy implementation options? Is there an interest in further deliberation? After each round of ranking, we displayed the results of the ranking after each round and permitted participants to review the updated list prior to the next round of ranking. We anticipated that the group would converge and consensus in three rounds. We thus conducted two rounds of face-to-face iterations of ranking, while we completed the third round as an online follow-up via email. Further, we reviewed the Hansard of the Parliamentary debate on the 2019 Bill on national health insurance, as well as newspapers of the leading dailies in Uganda until the pre-election season in 2024, including The Independent, Daily Monitor, and Uganda Radio Network.

Analysis and synthesis of the data.

We analyzed the data quantitatively and qualitatively separately, before performing a triangulated synthesis of data from the second to sixth dialogues (Hussein, 2009). We computed the sums and means of each item and thereafter ranked them in descending order, specifically the policy concerns regarding Uganda’s proposed National Health Insurance Scheme in the Bill of 2012. These ranked findings guided the synthesis of data in the systematic reviews and policy briefs that provided evidence on interventions and implementation considerations, which informed the content for subsequent dialogues. We applied content analysis techniques to synthesise proceedings of the subsequent deliberative policy dialogues including the Presidential dialogue at State House Uganda, as well as data from Parliamentary debate of the revised National Health Insurance Bill of 2019. We synthesized these into themes. Finally, we explored the contextual considerations for the national health insurance scheme using the agenda setting multiple streams framework by John Kingdon (Kingdon, 1995). This framework has problems, proposals and politics streams, which converge to unlock policy implementation opportunities, ‘windows’.

RESULTS

Description of participants in the policy dialogues.

The response rate was 100% for the first two rounds of the Delphi survey, that was face-to-face (30/30). We collected responses from 22 out of 30 respondents (73%) for the third round which was completed online by e-mail and telephone follow up. Details of the participants of the second stakeholders dialogue where we issued the mini-Delphi are in Table 1.

Table 1

Participating organizations and number of participants in the second priority setting exercise focusing on the Uganda National Health Insurance Scheme

CATEGORY, N = 7	DESCRIPTION OF ORGANIZATION, N = 27	N = 30
1. Government departments in Uganda	National Social Security Fund (NSSF), Kampala City Council Authority (KCCA), Uganda Nurses & Midwives Council (UNMC)	3
2. Civil Society/ Consumer Organizations	Uganda National Health Consumers Organization (UNHCO)	1
3. Employer Groups	Uganda Manufacturers Association (UMA), Federation of Uganda Employers (FUE)	2
4. Professional Associations & Workers Unions	Uganda Medical Association (UMA), Uganda Dental Association (UDA), Pharmaceutical Society of Uganda (PSU), Uganda Private Medical Practitioners Association (UPMPA), National Organization of Trade Unions (NOTU), Confederation of Free Trade Unions (COFTU)	6
5. Insurance Groups, & Associations	African Air Rescue (AAR), Uganda Community Based Health Financing Association (UCBHFA), Health Partners Uganda (HPU)	6
6. Health Management Organizations, Health Service Providers	AIDS Information Center (AIC), Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), Uganda Muslim Medical Bureau (UMMB), Uganda HealthCare Federation (UHCF), Bugolobi Medical Centre (BMC), St. Stephen's Nsambya Hospital Kampala, Kisubi Hospital Wakiso, Doctor's Clinic Seguku Wakiso	9
7. Research Institutions	International Health Sciences University (IHSU), Makerere University College of Health Sciences, (MakCHS) in the Department of Family Medicine & the Child Health Development Centre	3

Description of documents reviewed for policy analysis.

We reviewed 29 policy related documents about the establishment of Uganda’s national health insurance scheme. These included health insurance related laws (n = 5), health policies including selected ministerial policy statements (n = 3), annual health sector and insurance regulatory reports (n = 4), manifestos of the ruling political party (n = 6) and the opposition (n = 4), evidence briefs for policy and policy dialogue reports (n = 2), the Hansard of Parliamentary debate on the health insurance Bill of 2019 (n = 1) and newspaper reports (n = 4), Table 2.

Table 2
Data sources reviewed in the documentary analysis

CATEGORY	DESCRIPTION OF THE DOCUMENTS	N = 29
1. Laws (Acts & Bills)	Uganda Revenue Authority Act, 1991 National Social Security Fund Act, 1985 The Insurance Act, 1996 Uganda National Health Insurance Bill, 2012 Uganda National Health Insurance Bill, 2019	5
2. Policies	Ministerial Policy Statements 2015 & 2020, National Health Policy, 2005	3
3. Reports	Annual Health Sector Performance Reports 2013 & 2023 Annual Insurance Report 2013 & 2020	4
4. Political Party Election Manifestos	Manifestos of the National Resistance Movement (NRM) 2001, 2005, 2010, 2015 & 2020 Midterm review of the NRM Manifesto 2016–2021 Manifesto of the National Unity Platform (NUP) 2020 Manifesto of the Forum for Democratic Change 2020 Manifesto of the Uganda Peoples Congress 2020 Manifesto of the Democratic Party 2020	10
5. Evidence Briefs & Policy Dialogue Reports	Uganda National Health Insurance Scheme Bill 2012: Policy Concerns & Options. Proceedings of the Policy Dialogues on Uganda National Health Insurance Scheme.	2
6. Parliamentary Debate	Proceedings of the Parliamentary debate on the National Health Insurance Bill 2019	1
7. Newspaper articles	Public discourse on the national health insurance scheme	4

Emerging themes, policy concerns and policy proposals about Uganda's health insurance scheme Bills of 2012 and 2019.

There were five resilient themes about the proposed national health insurance scheme that inhibited its roll out. First was the “evolution and delay to start Uganda’s national health insurance scheme”; that the insurance scheme would be “another collecting fund with a high risk of corruption”; that this proposal would be an “elitist health insurance scheme exclusive of non–monetized citizens as well as the informal sector workers”; and that the scheme was perceived as “a new tax with increased cost of production” by employers including manufacturers. Importantly, elites in the ruling National Resistance Movement political party, health insurance was perceived to alienate the voter base, given its ‘free health care’ policy, Table 3. The shortlist of top 14 policy concerns identified by stakeholders is in table, and were narrowed down from 32 initial policy concerns specific to the Uganda National Health Insurance Bill of 2012.

Table 3
Delphi ranking of priority policy concerns about the Uganda National Health Insurance scheme

POLICY CONCERN	Rank & Iteration		
	1st	2nd	3rd
1 The governance & accountability (corruption)	6	4	1
2 Mode and rate of payment of health service providers	1	3	2
3 Costing of the health services in Uganda not done	9	13	3
4 Accreditation of healthcare providers (quality control)	3	5	4
5 Affordability at 8% premium given the existing tax regimes	12	7	5
6 Benefits: range of minimum health care package	2	1	6
7 Sensitization of stakeholders to appreciate the UNHIS	4	6	7
8 Limited access to health services in the hard to reach areas	15	14	8
9 Monopoly as the Bill is silent on private insurance schemes	10	10	9
10 Political will & commitment	8	11	10
11 Strategies to enhance/increase informal sector participation	13	12	11
12 Continuous research & development	11	8	12
13 Information management systems and portability in EAC	7	9	13
14 Phased implementation as a risk management strategy	14	15	14

Evolution and delay in starting the national health insurance scheme.

The quest for a national health insurance scheme started in 1987, documented in the so-called “Prof Owori report”, of the Health Policy Review Commission and revised in 1997 and 2001 (Owori, 1987). Subsequent proposals for a health insurance fund were highlighted in five-year electoral cycles, from 2001 to 2021, by both the ruling National Resistance Movement party and the opposition. At that time, there were three main health financing streams: government tax-based, donor aid, and cost-sharing user fees. In 1987, the national budget share for health was approximately 3% (Owori, 1987) and steadily increased to peak at 9% in 2016, still short of the ‘Abuja Declaration’ before declining to 6% (Ministry of Health, 2023b). In 2001, African Union countries met in Abuja, Nigeria and set a target of allocating at least 15% of their budget each year to the health sector, dubbed the Abuja Declaration (Govender et al., 2008).

The 2001 electoral cycle in Uganda was a turning point in the health financing landscape, since the ruling party abolished the cost-sharing policy of ‘user fees’ (Tashobya et al., 2006). This policy was initially mooted by the “Reform Agenda” (Refugee Review Tribunal, 2006), a breakaway political formation from the ruling party, that for the first time posed an internal challenge to the ‘movement political system’ (Khisa, 2016). The resultant increase in utilization of health services (Nabyonga-Orem et al., 2011), overwhelmed the ‘free primary health care’ general window, whilst the private wings of hospitals remained operational (Tashobya et al., 2006). This move created an opportunity to seriously reconsider a national insurance scheme and fill the health funding gap. Noteworthy, since 1997, private not-for-profit (PNFP) facilities received a subsidy (conditional grant) from Uganda’s Ministry of Health for primary health care (PHC), as a mechanism to subsidize costs for households that also provided an opportunity to mitigate the funding gap, (Tashobya et al., 2006).

While all member states of the East African Community (EAC) embraced pre-payment schemes for health, Uganda has delayed to do so. Yet the most recent comprehensive national health accounts study reported that up to a fifth (20%) of the households in Uganda experienced catastrophic expenditure between 1996 and 2019 (Ministry of Health, 2022). Although the Uganda government increased its public health sector funding from about 2.5% in FY 1987/1988, the sector is still grossly underfunded by over 50%, (Ministry of Health, 2023b). The same 2023 National Health Accounts study revealed that about 8 trillion shillings (USD 2 billion) were spent on health from all sources combined. Moreover, households were the main source of these finances (43%), followed by development partners (42%), and then the government through tax revenues (15%). Thus, despite the availability of substantial monetary resources in Uganda, pragmatic mechanisms to bridge the perennial health–financing gap are lacking.

A recurrent observation from newspaper analyses has been the prioritization of tax funds, extracted through supplementary budgeting mid-way the financial year (Bagaaya, 2024; Nakatudde, 2024; Uganda Radio Network, 2023; Wadero & Mukhaye, 2025). The most recent and third supplementary budget schedule for FY 2024/25 financial year, was in March 2025, just three months before the end of the FY. This allocation was Uganda shillings 4.255 trillion, approximately US\$ 1,159 billion, suggesting that funds can be made available to kick-start the Uganda National Health Insurance Scheme (Wadero & Mukhaye, 2025).

Another collecting fund with risk of corruption.

After the three iterations of the mini-Delphi process, corruption emerged as the most important policy concern, Table 3. Stakeholders expressed governance & accountability as crucial risks arising from the proposed pooling of funds for a national health insurance scheme in Uganda. These arguments were premised on Uganda’s previous record of managing public funds, including foreign aid (Tangri & Mwenda, 2008). The design of the 2012 and revised 2019 health insurance scheme bills, presupposed Uganda’s Ministry of Health as the fund supervisor, posing a perceived serious conflict of interest, in policy,

regulation, and implementing the national health insurance scheme. While this was the main argument of perceived corruption of the national insurance fund, stakeholders also pointed at health sector corruption in the form of ‘informal under the table payments’ by patients to medical workers, where health services would be free (Bouchard et al., 2012), and the necessary and dishonest use of health insurance just because it is available, known as a ‘moral hazard’(Ma & Riordan, 2002).

‘Ideological corruption’ was perceived as the tendency of officials of Uganda government ministries, departments, and agencies to use taxpayers’ resources to access private health insurance schemes. Our synthesis identified up to twelve government entities that benefited from these health financing arrangements (Table 4). Indeed, the spectrum of this paradox manifested as government officials shunning tax-funded public health facilities, being attended to in private medical facilities or private health insurance schemes, and at times opting for treatment outside Uganda, through ‘medical tourism’, all funded by the State (Habati, 2022; Walimbwa et al., 2025). In further cementing this notion of ‘ideological corruption’, a breakdown of the third schedule of supplementary budget allocation of approximately US\$ 1,159 billion in FY 2024/25 highlights a provision for “patriotism” of Uganda shillings 100 million for each Legislator, approximately US\$ 27,000 (Odongo, 2025). This amount is equal to that disbursed to each parish periodically under Uganda government’s financial inclusion flagship known as the Parish Development Model, with a population of at least 10,000 inhabitants (Kyambadde, 2021).

Table 4
Illustration of ‘ideological corruption’. Public entities with private or public (private wing) health prepayment schemes for employees using tax funding in Uganda

Government Parastatals/Enterprises		Government institutions	
1	Uganda Revenue Authority (URA)	7	The Executive/Cabinet of Ministers
2	Uganda Investment Authority (UIA)	8	The Parliament of Uganda
3	Uganda National Roads Authority (UNRA)	9	The Judiciary
4	National Social Security Fund (NSSF)	10	The Civil Service
5	Electricity Regulatory Authority (ERA)	11	Uganda’s People’s Defense Forces (UPDF)
6	National Water & Sewerage Coop. (NWSC)	12	Inspector General of Government (IGG)

Elitist health insurance scheme, exclusive of non–monetized citizens and informal sector workers, perceived as a new tax

A major bottleneck in advancing this 2012 Bill was the design that excluded the rural populations who hardly participated in the monetary economy (Uganda Bureau of Statistics, 2024) and the informal sector, Table 3. Further, the political establishment viewed the Bill as a Kampala affair ‘by’, ‘of’ and ‘for’ the elite. Subsequently, even the modified 2019 Bill became unpalatable during the electoral cycles, especially in 2021; and thus rejected by the Chairman of the ruling National Resistance Movement Party, (The Independent, 2023).

The 2012 Bill, by design, focused on those employed formally, with 4% deductions of their monthly salary at the port of entry,an area of friction with the Labour Unions, Table 3 (Ministry of Justice & Constitutional Affairs, 2012). The 8% premium (4% employee, 4% employer) was perceived as high, and unfairly overburdening the “already overtaxed employer and employee”, yet the informal sector workforce was seen to substantially contribute to Uganda’s Gross Domestic Product (Kwagala-Igaga, 2016). In the 2019 Bill, this was modified to a 1% contribution by the employer and a flat fee of 100,000 Uganda shillings (approximately \$30 dollars) by all those in the informal sector. Noteworthy, the 4% contribution by the employee was sustained generating friction from the labor unions (Walimbwa, 2019). Indeed, the business community, particularly the manufacturers’ lobby, argued that the Bill proposed a new tax that would increase the cost of production, reduce profit margins, and have a negative impact on employment.

DISCUSSION

Principal findings.

Our study mapped Uganda’s quest for a national health insurance scheme, and why this hasn’t been realised after over three decades of effort. We report that the resilient themes hindering the proposed national health insurance scheme were about the ‘evolution and delay to start’, ‘another collecting fund with high risk of corruption’, ‘elitist and exclusive of non–monetized citizens as well as the informal sector workers’ that is perceived as ‘a new tax with increased cost of production’ by employers. Importantly, the political elite in the ruling party perceived the insurance premiums as a disincentive to the voter’s base. In the next section of this article, we discuss the findings with the lens of John Kingdon’s multiple streams of framework of policy analysis (Kingdon, 1995).

Findings in relation to already existing evidence.

The politics of a delayed Uganda national health insurance scheme

To align Uganda with the ‘common protocol’ of other member states of the East African Community, a national health insurance scheme is inevitable (East African Community, 2002). This delay in enacting public health insurance was occasioned by lack of political consensus among decision makers in the ruling NRM party, that is the Legislature and the Executive. Although the 2019 Bill was passed by the Parliament (Nakatudde, 2019), Uganda’s President and the ruling NRM party Chairman declined to assent to it; and Cabinet recalled it (The Independent, 2023). Importantly, this was at the height of the general electoral cycle of 2021. Yet again the national health insurance scheme turned out to be a promise unkept!

Comparative political research in Thailand showed that investing more in universal health coverage was a vote winner (Selway, 2011). Political candidates relied on new national health policy reforms, from contributory health insurance established in 1975, to a single payer tax-based universal health coverage in the 2001 elections. In addition, political parties on both sides of the divide took health policy formulation seriously and independently. In turn, the government kept its promise to increase allocation of health resources, through the health security act of 2002, to finance Thailand's universal health care system, and health outcomes improved, (Erlangga & Shi, 2014). This case study of Thailand provides a clear intersection of competitive electoral politics and social service delivery that Uganda's Executive arm of government could learn from, as a vote winner and establish a transformative social contract with its citizens.

The problem of fighting health sector corruption

If Uganda is to succeed in enacting an effective national health insurance scheme, then it must deal with the negative perception of corruption by its informed public. Uganda ranked 148 out of 182 countries by the corruption perception index (CPI) globally in 2025 (Transparency International, 2026). The CPI scale ranges from highly corrupt (0 out of 100) to very clean (100 out of 100), and Uganda's latest score was 25% below the global average of 42% in the calendar year 2025.

We operationalised corruption as 'use, misuse or abuse' of financial resources for private gain, and may be actual or perceived (Widdus, 2006). Whilst ideological corruption refers to the manipulation or distortion of ideas, values, or principles for personal or political gain (Friedrich, 2002). Ideological corruption involves dogmatic thinking with unwavering adherence to an ideology, even when faced with contradictory evidence. In Uganda, the 'free primary healthcare mantra' by the ruling NRM party prevails when in fact, out-of-pocket costs for medical care are borne by Ugandan citizens at about 40% (Ministry of Health, 2023b) of total health expenditure (THE). This phenomenon occurs when those in power manipulate ideas, values, or principles for personal or political gain, often at the expense of the public interest (Friedrich, 2002). In this case, the ruling NRM party applies the idea of "free primary health care" as a campaign promise to win votes, while actually providing a service that is not free at all. This illustrates how the concept of free healthcare can be instrumentalized for political purposes, rather than being translated into actual service delivery. Furthermore, the fact that top government officials in Uganda used public taxes to access private health insurance schemes and treatment abroad, while the general population is left to bear the costs of healthcare, is a stark example of how ideological corruption can perpetuate inequality and injustice, so much so that Cabinet banned it (Daily Monitor, 2018). Today, government officials are tasked to exhaust all available options in Uganda before being paid for by tax consolidated fund for medical tourism.

While several evidence syntheses documented that health sector corruption leads to unfavourable health outcomes across population groups (Moya-Espinoza et al., 2022), hardly any work synthesized evidence of corruption in the context of health insurance schemes. A quick and clean search in PubMed yielded single studies with ambivalent findings. On the one hand, a discrete choice experiment in Sierra Leone on corruption diminished participation and the willingness-to-pay for a public health insurance scheme, (Jofre-Bonet et al., 2023). In a second study, the determinants of willingness-to-pay among Uganda's informal sector taxi drivers were perceived corruption, mistrust, and inadequate information about the community health insurance scheme (Basaza et al., 2019). On the other hand, several studies in China on 'red envelopes' identified bribery because of mass provision of a health insurance scheme, mostly in public compared to private ones (Liu et al., 2020). Specifically, having health insurance increased the probability of patients making informal payments to Chinese medical doctors (Zhu et al., 2018).

Beyond definitions and framing corruption, we sought evidence to inform interventions against health sector corruption and further contextualized this for public insurance schemes. A Cochrane systematic review of nine non-randomised studies on health sector corruption in five mainly high-income countries and few middle-income ones, showed that establishing an independent anti-corruption agency resulted in increased convictions and recovery of abused funds, with high certainty evidence (Gaitonde et al., 2016). In addition, information campaigns to change attitudes, mechanisms for improving detection of corruption and enforcement, as well as increasing transparency and accountability had positive benefits on reducing corruption. This evidence, although very uncertain, resulted in better attitudes against corruption, reduced overbilling, and savings in medical care expenditure. Overall, there was improved utilization of medical care and health outcomes due to fighting corruption in the health sector.

A Campbell systematic review of 29 randomised controlled trials in 20 countries about public sector corruption reported empirical evidence that was consistent with the Cochrane review above (Mugellini et al., 2021). Implementing more than one anti-corruption intervention resulted in more effective reduction in corruption than a single intervention alone, especially in the 9 included low- and middle- income countries compared to the high-income ones, (Mugellini et al., 2021). This review characterized corruption as administrative, with bribery or embezzlement acts involving civil servants during the implementation of public policies or service delivery. The specific interventions were grouped as either 'control and deterrence' through detection, incentives or sanctions; or 'organisational and cultural' through activities that aim to change the work ethic, values and attitudes of civil servants. Generally, the control and deterrence interventions were more effective than organizational and cultural reforms in reducing corruption in the public sector, especially misappropriation of public resources (embezzlement) than bribery.

Uganda has the Health Monitoring Unit (Uganda, 2025) specifically to fight corruption in the health sector, augmented by the Office of the Auditor General (Uganda, 2008) and the Anti-Corruption Court (Uganda, 2009), that together have registered remarkable success in convictions and recovery of abused funds (Kajubu, 2017; Musinguzi, 2017). These existing anti-corruption structures constitute 'control and deterrence' interventions, which could be entwined into the implementation considerations of the proposed Uganda National Health Insurance Scheme.

The problem of exclusions of sections of society from Uganda's health insurance scheme

The 'solidary' function of the proposed Uganda health insurance scheme posited that the health population subsidize the sick, the rich cater for the poor and the youthful adult uplift the retired elderly (Walimbwa, 2019). To improve diversity, equity and inclusion (DEI), stakeholders reviewing Uganda's 2012 health

insurance Bill, proposed a national health insurance scheme with multiple approaches that blends with existing private health insurance, community health insurance and Health Management Organizations (HMOs). Indeed, this revision was embodied in the 2019 Bill (Walimbwa, 2019).

One recent systematic review of 45 studies from sub-Saharan Africa conducted between 2009 and 2020 identified that, like Uganda's initial proposal in the 2012 Bill, the rural folk and informal sector workers including the self-employed were often excluded from public health insurance schemes (). The likely bias in this work is that over half ($n = 25$) of the studies were about the Ghanaian experience, with the rest coming from 10 other countries. Nonetheless, these studies further highlighted that men, those with a lower educational attainment and the poor were excluded too (xx). While this was a policy concern, from Uganda's recent 2024 national census, more vulnerable citizens are participating in the monetary economy at 63% up from 32% in the 2013 Census (Uganda Bureau of Statistics, 2024); hence are theoretically able to pay some premium for public health insurance.

Another systematic review of 19 studies from 10 low and middle-income countries conducted between 1992 and 2011, showed Social Health Insurance for informal sector workers increased utilization of health services and lowered out of pocket expenses (Acharya et al., 2013). The financial risk protection was diminished when insurance costs were considered. However, in this review of informal sector studies, there was no evidence of improved health status perhaps due to study design limitations.

The problem of a new health tax that increases cost of production

Despite this key policy concern of increased cost of production due to additional labour expenses by Ugandan manufacturers, researched evidence suggests livelihood benefits accruing from embracing public health insurance schemes. One systematic review of 68 studies on public health insurance schemes from 22 countries published between 2010 and 2016 identified some health benefits (9 of 12 studies), such as newborn health and nutrition status with no effect on mortality (Erlangga et al., 2019). This suggests that with health insurance in place, workers would be healthier and improve their productivity. This evidence base is augmented by a recent meta-analysis of 34 studies published in 2024, which showed health insurance had a positive impact on economic growth, reducing the medical economic burden, and improved the consumption level (Fan et al., 2024). In this review, public health insurance commercial schemes promoted economic performance. Still, these findings were moderated by different contexts of insurance scheme design and background economic activity in the different countries, with some studies pointing at robust benefits in high income countries and none or worse economic outcomes in developing countries.

A quick and clean review of health insurance schemes in countries similar to Uganda suggests enacting lower premiums for health insurance is feasible (Obuku et al., 2016). Premiums for public health insurance schemes in Ghana, the Philippines and Tanzania were 2.5%, 3% and < 6% respectively at the start (Community, 2014; Kozhimannil et al., 2009; Nguyen et al., 2011). The proposed 8% new deductions for Uganda's national health insurance would increase its labor-taxation regime for formal employees from a minimum of 45% to 53% of monthly salaries. This includes pay-as-you-earn of at least 30%, national social security of 15% and local service taxes. Of note, 10% of the social security is paid by the employer whilst 5% by the employee. Despite the revised 2019 Bill proposal to lower the insurance premiums for only the employer, and a one-off payment annually for informal sector workers, there was sustained resistance from the labor unions of formal workers (teachers, medics, plantations and factories) and the Uganda Manufacturers Association.

Proposals and implications for politics, policy action and health insurance practice.

Our team makes three key propositions. Uganda should immediately start its independent national health insurance fund enacted by an Act of Parliament, taking advantage of the low-hanging fruit targeting a 30% critical mass coverage over several 5-year planning cycles, rather than a full-blown scheme at once. For example, Uganda's national social security fund (NSSF), established in Law, has thrived for 40 years since 1985, with exponential growth in its portfolio that provides an exemplary model of governance of a huge fund valued at over US\$6 billion (<https://www.nssfug.org/about-us/mission/>). Noteworthy, NSSF managers who broke the law were prosecuted, and convicted, signifying the stringent enforcement of laws regarding this social protection fund (Daily Monitor, 2010; Uganda Radio Network, 2011). In addition, a design feature of the NSSF is the monetary collection mechanism from the formal sector employees, which the health insurance scheme of Uganda could embrace.

Second, political parties and other key actors on Uganda's national health insurance scheme, should rework the political process and rebuild a new bipartisan political consensus. This will entail further engagement of important, powerful groups, in particular, the Uganda National Organisation of Trade Unions, the Uganda Manufacturers Association and the Presidency. The key messages here should demonstrate real world examples of how the proposed national health insurance scheme will accrue immediate health benefits or financial risk protection to unionised workers, increase labour productivity to compensate for increased labour costs due to insurance expenses, and how the citizens newly absorbed in Uganda's monetary economy will be able to pay insurance premiums, yet not threaten the voter base of the ruling NRM party during subsequent general elections.

Third, the technical recommendations from previous evidence syntheses on what works, to arrest the other major policy concerns include alignment with the national electronic database, the National Identification Registration Authority (NIRA) (<http://www.nira.go.ug/>), to facilitate accurate planning and operations of the proposed national insurance scheme augmented by periodic actuarial studies. Establishment of a health insurance fraud unit under Uganda's Insurance Regulatory Authority (<https://ira.go.ug/>), complete with co-payments to curb the moral hazard (Koochi Rostamkalee et al., 2022). Enforcing accreditation for quality assurance in medical service standards in public and private health facilities across the country; and providing for multiple types of health insurance schemes that will cover the hard-to-reach population groups (Shewamene et al., 2021).

Implications for future research in health financing in Uganda.

Certainly, our work was not exhaustive of the approach to key policy issues to unlock the establishment of the Uganda National Health Insurance Scheme. A key policy research question under implementation considerations would explore opportunities to activate a national health insurance component under

Uganda's existing structures and laws. For example, the Uganda Cooperative Savings and Credit Union Limited (UCSU) was established in 1972 and regulated by the relevant cooperative societies Act of 1991 (as Amended). UCSU had a membership of 1,368 savings and credit cooperative societies (SACCO), over 1 million savers, in over 135 of Uganda's 146 districts, (<https://www.ucscu.coop/>). This entails engaging with the ministry of trade, industry and cooperatives, as a vital non-traditional partner to the ministry of health. A second area for future study would be exploring further ideological corruption; specifically, what would attract top government officials to utilize public health facilities that are free?

Strengths and limitations of this study.

The prominent strength of our study was triangulating multiple study methods, data sources and approaches to policy analysis done longitudinally over the last decade. In particular, systematic identification of Uganda's national health insurance stakeholder's concerns by the mini-Delphi technique & application of John Kingdon's multiple streams framework to explore the political contexts for agenda setting and decision making. Combining these two empirically unleashed the crucial bottlenecks for enacting Uganda's national health insurance scheme. Secondly, our study provides evidence-based recommendations from high quality systematic reviews, about interventions that have worked elsewhere to overcome these bottlenecks, to enact, operate and sustain Uganda's proposed public health insurance schemes.

The major limitation of our study was the dynamic evolution of the decision space for establishment of a national health insurance scheme for Uganda. This process is highly political with high stakes, for which further analyses would have been informative. Nonetheless, we employed Kingdon's agenda setting framework to synthesize study findings.

CONCLUSIONS

We conclude that political calculations driven by diminished consensus among key players, especially the organized labor movement, Ugandan manufacturers & business community, and uncertainty about how the voter base of the ruling party will perceive this insurance scheme, remains an important concern for the Presidency. Policy actors, especially the national health insurance lobby, ought to mobilize and present a better case to circumvent these perceptions and enact a win-win Bill.

Declarations

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Author contributions

Conception: EAO, HN, NKS | Data capture: EAO, NKS, HN, RA, AK, OM, FN & GN | Data synthesis: EAO, RA, AK, OM, GN, FN & NKS | Drafting initial manuscript: EAO | Reviewing & accepting final version of the manuscript: FN, NKS, RA, AK, HN, OM & GN

Human Ethics and Consent to Participate declarations

Our study received ethical and regulatory approval from the School of Medicine Research and Ethics Committee of Makerere University College of Health Sciences, the Uganda National Council for Science and Technology (SS3271) and Office of the President, Republic of Uganda (ADM/154/212/01).

Data Availability declaration

No. There is no research data outside the submitted manuscript file. All the data available is provided in the tables in this manuscript and in the references for the documentary analysis, for example the Uganda Ministry of Health Knowledge Management Portal: <http://library.health.go.ug/>, the Uganda Clearing House for Health Policy & Systems Research: <https://cordis.europa.eu/project/id/222881/reporting>, the Hansard of Parliament of Uganda <https://www.parliament.go.ug/hansards> and Political Party websites: <https://www.nrm.ug/>, <https://www.upcparty.net/>, <https://fdc.ug/>, and <https://nupuganda.org/>.

Competing Interest declaration

No. We declare that the authors have no competing interests as defined by this Journal, or other interests that might be perceived to influence the results and/or discussion reported in this paper. This manuscript arises from post-doctoral work of the lead author: E.A.O

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