FINANCING NCD MEDICINES IN PRIMARY HEALTH CARE

A Case Series of Colombia, Uganda, and Nepal

NCD Alliance

TIME TO ACT on NCDs LEAD
GLOBAL WEEK FOR ACTION ON NCDs

Acknowledgements

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INTRODUCTION

The global NCD burden and the demand for chronic care

Noncommunicable diseases (NCDs) are the leading cause of death and disability globally, accounting for over 43 million deaths in 2021. Of these, 18 million occurred before age 70, with 82% concentrated in low- and middle-income countries (LMICs) (WHO, 2024a). These mortality figures represent only a fraction of the broader burden: a growing population lives with NCDs, often without adequate diagnosis or treatment. More than 1.3 billion adults have hypertension, yet only one in five achieves control (WHO, 2023), and over 800 million adults live with diabetes, with more than half untreated (NCD Risk Factor Collaboration, 2024). The persistence of avoidable mortality reflects not a lack of effective interventions, but rather systemic barriers to sustained, affordable access to essential medicines and care. WHO estimates that improved hypertension control alone could avert 76 million deaths between 2023 and 2050 (WHO, 2023). Addressing this challenge requires a shift from episodic interventions to reliable, long-term supply systems that can meet the needs of chronic disease management.

Achham District, February 2018. ©Marty Logan

Medicines in PHC as a core test of UHC

Medicines represent a significant portion of out-of-pocket (OOP) health expenditure and often require point-of-service payments due to their frequent dispensing outside clinical encounters. Additionally, in many countries, public health budgets cover salaries and other fixed costs more reliably than medicines, resulting in frequent stockouts at public pharmacies. Consequently, patients often resort to private retail pharmacies and pay the full price out of pocket (Watkins *et al.*, 2025; WHO, 2026). This explains why medicines dominate household health spending in numerous health systems, as observed in all three cases in this series.

For individuals living with hypertension, diabetes, cardiovascular disease, chronic respiratory disease, severe mental health conditions, or palliative care needs, uninterrupted access to affordable medicines at the primary health care (PHC) level determines whether the disease is controlled or escalates to crisis. Consequently, access to essential NCD medicines in PHC serves as a concrete and measurable indicator of the effectiveness of universal health coverage (UHC): a country may declare universal entitlement, but if patients cannot obtain amlodipine, metformin, insulin, inhaled salbutamol, or morphine at their local facility without financial hardship, coverage remains nominal rather than substantive.

Medicine availability is influenced by factors beyond financing alone. Even when a medicine is included in a publicly financed benefits package and sufficient resources are allocated, access may still be disrupted by deficiencies in procurement, forecasting, distribution, prescribing, information systems, or facility-level implementation.

Accordingly, this case series employs access to NCD medicines as a tracer for the interaction between health financing and the broader health system. The **financing dimension** examines whether adequate, prepaid resources are mobilised, pooled, allocated, and utilised to establish an entitlement to essential medicines. The **implementation dimension** assesses whether purchasing, procurement, supply chains, service delivery, and accountability mechanisms convert that entitlement into continuous access at the point of care. Both dimensions are essential for achieving effective coverage.

From global financing commitments to country implementation

International policy attention has shifted from advocating for increased investment in NCDs and mental health to identifying the financing and health system reforms required to achieve effective coverage. This has been a central focus at key dialogues over the past several years. The WHO Global Dialogue on Partnerships for Sustainable Financing of NCD Prevention and Control convened in Copenhagen in 2018, identified sustainable financing as a central constraint on the NCD response. The second International Dialogue on Sustainable Financing for NCDs and Mental Health, convened by the WHO and the World Bank in Washington, DC in June 2024, advanced the agenda toward practical policy options. Discussions highlighted the need to increase and utilise public resources more efficiently, reduce the costs of essential medicines, strengthen excise taxes on tobacco and other health-harming products alongside other fiscal measures, link NCD services to broader UHC reforms, and establish multisectoral coalitions to support sustained implementation (WHO, 2019; WHO, 2024b; Watkins *et al.*, 2025).

These discussions informed the Fourth High-Level Meeting of the UN General Assembly on the Prevention and Control of NCDs and the Promotion of Mental Health in September 2025. The resulting political declaration called for adequate, predictable, and sustained financing, as well as for stronger publicly financed, primary health care-based services that enhance financial protection and equitable access to quality care and essential health technologies (United Nations General Assembly, 2025). **While the policy direction is increasingly well-defined, the primary challenge lies in how countries with diverse political, fiscal, institutional, and health system contexts can convert these commitments into actionable reforms.**

The Third International Dialogue on Sustainable Financing for NCDs and Mental Health in to be held in February 2027 addresses the challenge of implementation. A WHO practical guide developed in parallel with this process structures country action around interconnected financing and health system levers, such as revenue generation and fiscal space, pooling and entitlement, benefits package design, purchasing and provider payment, medicines and technologies, models of care and workforce, and data and accountability (WHO, 2026). The guide, which will be released in 2027 in coordination with the Dialogue, underscores the necessity of linking policy choices to the implementation conditions required for their success, including costed priorities, budget allocations, procurement and supply systems, provider-

payment arrangements, clinical guidance, workforce capacity, information systems, and mechanisms for learning and accountability. Its objective is to assist countries in identifying feasible next steps based on their specific contexts, rather than prescribing a uniform approach. This case series supplements the guide by analysing how these financing options are being implemented in practice across health systems with varying fiscal and institutional starting points, including contexts where implementation is incomplete or financing remains inadequate.

Methodology and analytical approach

This case series uses a desk review methodology, synthesising evidence from peer-reviewed literature, grey literature from Ministries of Health, WHO, and the World Bank, as well as official policy, financing, planning, and legal documents. Findings were validated with country partners and national stakeholders.

Three countries were purposively selected to reflect contrasting income levels, health financing arrangements, and implementation contexts:

- **Colombia**, an upper-middle-income country in the Americas with a mature social health insurance system;
- **Nepal**, a lower-middle-income country in South Asia implementing health financing reforms within a federalised system; and
- **Uganda**, a low-income country in sub-Saharan Africa with a tax-financed system.

The countries are not presented as three equivalent "success stories." Rather, they illustrate different points in the process of translating NCD financing commitments into effective coverage. The analysis is informed by the approach set out in WHO's forthcoming practical guide on sustainable financing for NCDs and mental health, which distinguishes between policy and system levers, the implementation conditions required for those levers to work, and the UHC objectives they are intended to improve (WHO, 2026). Particular attention is given to whether countries have made NCD financing needs visible; established publicly financed entitlements and priorities; linked those commitments to budgets, purchasing, medicines and service delivery arrangements; and begun to demonstrate effective coverage and financial protection.

Lessons learned: What the three cases illustrate

The three cases demonstrate that the options available to governments vary based on their financing architecture, fiscal capacity, institutional arrangements, and implementation context. Collectively, these cases illustrate distinct combinations of financing capacity, institutional development, and implementation constraints along the progression from public commitment to effective coverage and financial protection.

Colombia illustrates the most institutionalised financing pathway of the three cases. Public revenues are pooled nationally through ADRES and distributed mainly through a risk-adjusted capitation payment, the Unidad de Pago por Capitación (UPC), to finance a broad and legally enforceable benefits package. The same entitlement applies across the contributory and subsidised regimes, while additional financing mechanisms exist for non-UPC technologies. Price regulation, health technology assessment, risk adjustment, and pharmaceutical purchasing arrangements complement the financing architecture. Importantly, Colombia also shows improved financial protection: OOP expenditure as a share of current health expenditure has decreased substantially over the past three decades (Brun Vergara *et al.*, 2023). Remaining problems related to access, resource flows, medicine availability, and fiscal sustainability show that mature financing institutions still require ongoing adjustment and accountability.

Nepal illustrates the challenge of converting a strong legal entitlement into effective coverage within a relatively new federal health system. The Constitution and Basic Health Services package establish a publicly financed floor, while federal transfers finance implementation by provincial and local governments. The Package of Essential NCD Interventions (PEN) and PEN-Plus provide increasingly concrete models for converting the entitlement into NCD services, medicines, diagnostics, and referral pathways at primary and district levels. The National Health Insurance Program and targeted schemes add further layers of financial protection. However, high OOP expenditure, uneven medicine availability, weaknesses in decentralised procurement, and limited insurance coverage show that the links between entitlement, financing, purchasing, and implementation remain incomplete (Khatri *et al.*, 2025; Adhikari *et al.*, 2024).

Uganda illustrates the complexities of establishing institutional foundations for NCD financing amid significant fiscal constraints. The implementation of a costed multisectoral NCD plan, disease-specific National Health Accounts, an explicit essential health care package, the Essential Medicines and Health Supplies List, primary health care grants, and centralised procurement arrangements provides structured mechanisms to identify, cost, budget, procure, and monitor NCD priorities. Uganda has further demonstrated that existing HIV and chronic care infrastructure can be repurposed to support hypertension and diabetes care. However, these institutional foundations exist alongside a substantial financing deficit: the Ministry of Health has reported funding gaps exceeding 99% for NCD commodities in fiscal years 2023/24 and 2024/25 (MOH, 2023c; MOH, 2024b). Consequently, Uganda represents a case of preparedness for financing reform rather than adequate financing.

This approach does not represent a linear maturity ranking. Countries may exhibit advanced arrangements in one financing function while encountering significant constraints in another, and reforms may not follow a predetermined sequence. Instead, the cases identify the financing choices already undertaken, the institutional capacity generated by those choices, the persistent bottlenecks between policy and implementation, and the next feasible steps toward sustainable financing for NCD medicines.

Cross-cutting insights

Four cross-cutting insights emerge from the cases.

First, NCD priorities become more actionable when they are converted from general political commitments into costed services, medicines, and care pathways. Uganda's costed NCD plan and health accounts, Nepal's Basic Health Services package and PEN implementation, and Colombia's UPC-financed benefits package represent different mechanisms for making the resource implications of NCD care explicit.

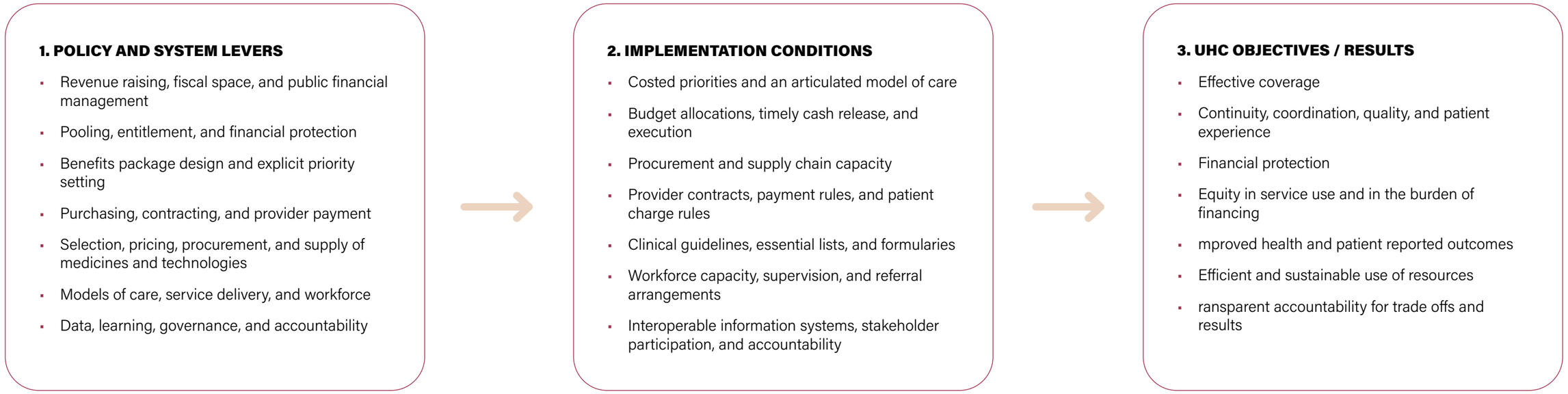
Second, inclusion in a benefits package is necessary but insufficient. A public entitlement must be linked to an actual financing mechanism and to the purchasing, provider-payment, procurement, supply chain, workforce, and information system arrangements required to deliver it. The gap between formal entitlement and effective access is particularly visible in Uganda and Nepal, but remains relevant in Colombia as well.

Third, feasible policy options depend on countries' institutional and fiscal starting points. A country with limited public revenue and purchasing capacity may first need to cost priorities, strengthen expenditure tracking, define an essential package, and use existing service platforms more efficiently. A country with established pooling and purchasing institutions can focus more directly on risk adjustment, strategic purchasing, price regulation, benefit package refinement, and accountability for effective coverage. Therefore, the relevant question is not whether all countries should adopt the same financing model, but which reform removes the most important constraint at the country's current stage of implementation.

Fourth, success should ultimately be assessed in terms of effective coverage and financial protection. The existence of a strategy, benefits package, procurement agency, insurance programme, or essential medicines list is evidence of institutional development, but not necessarily evidence that patients can obtain medicines continuously and without financial hardship. Medicine availability, stockouts, OOP expenditure, unmet need, continuity of treatment, and outcomes appropriate for each condition are therefore essential complements to measures of policy adoption and population entitlement.

Figure 1. From financing policy to effective coverage: an implementation lens for the three country cases

The analytical pathway links policy and system choices to the conditions needed for implementation and, ultimately, to universal health coverage objectives.



COUNTRY EXAMPLES	COLOMBIA	NEPAL	UGANDA
WHAT IS IN PLACE	National pooling through ADRES; risk-adjusted UPC capitation; broad and legally enforceable benefits package; additional financing for non-UPC technologies; HTA and price regulation; mechanisms for high cost conditions.	Constitutional entitlement to Basic Health Services; federal transfers; essential medicines list; PEN/PEN-Plus care pathways; NHIP and targeted protection for severe and high-cost chronic conditions.	Costed NCD plan; disease-disaggregated health accounts; essential health care package; EMHSLU; PHC grants; centralised procurement; integrated HIV/NCD chronic care platforms.
WHAT THE CASE SHOWS	A substantially institutionalised pathway linking pooling, entitlement, purchasing, and medicine policy, with comparatively strong evidence of financial protection.	How legal entitlement can progressively acquire financing and service delivery mechanisms within a federalized system.	Institutional foundations that make NCD priorities more visible, costable, budgetable, and implementable even under severe fiscal constraints.
REMAINING CONSTRAINT	Resource flow transparency, medicine dispensing and effective access, territorial variation, and long-term fiscal sustainability.	High OOP spending, uneven medicine availability, variable local procurement capacity, incomplete insurance coverage, and external financing dependence for some services.	A 99.6–99.8% NCD commodity financing gap, recurrent stockouts, high OOP spending, and limited pooled prepayment.

Interpretive note. The figure is an analytical lens, not a linear maturity framework or a ranking of countries. Countries may have well-developed arrangements in one domain and substantial gaps in another, and movement need not occur in a fixed sequence. The relevant policy question is which bottleneck most constrains progress from financing policy to effective coverage in the country's current context.

Medicines note. Medicine availability is used as a tracer of the interaction between financing and the wider health system. Adequate financing is necessary but cannot by itself overcome failures in forecasting, procurement, distribution, prescribing, information systems, workforce, or facility level implementation.

Source. Adapted from the conceptual framework in World Health Organization, Sustainable financing for noncommunicable diseases and mental health – a practical guide (editorial draft, July 2026), especially the framework linking policy and system levers, implementation conditions, and UHC objectives. Country annotations are synthesised from the Colombia, Nepal, and Uganda case studies.

CASE STUDY 1

COLOMBIA

Financing NCD and mental health medicines through pooled funding and a universal benefits package

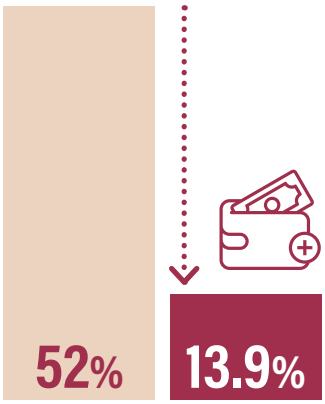
1. Context

Colombia demonstrates the significance of linking pooled public financing to a comprehensive and enforceable health entitlement for NCD medicine access. Following the reforms introduced by Law 100 of 1993, the country has systematically developed the General System of Social Security in Health (SGSSS). Currently, revenues from payroll contributions and general taxation are consolidated in the central fund ADRES, which allocates risk-adjusted per capita payments, known as the Capitation Payment Unit (UPC), to insurers for financing the Health Benefits Plan (PBS). This unified benefits package covers both contributory and subsidised populations and encompasses services and medicines for major NCDs and mental health conditions (Brun Vergara *et al.*, 2023; MSPS, 2025d).

The financing architecture is significant as it connects entitlement to a stable, recurrent source of pooled funding, thereby reducing reliance on disease-specific projects or annual discretionary allocations for NCD medicines. Medicines not routinely financed through the UPC, yet not explicitly excluded from coverage, are supported by a separate prospective financing channel via the presupuestos máximos mechanism. Additional mechanisms, such as health technology assessment, selective pharmaceutical price regulation, centralised information systems, and provisions for high-cost conditions, further support the management of the fiscal implications associated with a broad entitlement.

The Colombian case provides evidence that this financing architecture has resulted in substantial financial protection. Out-of-pocket (OOP) expenditure as a proportion of current health expenditure declined from 52% in 1993 to 13.9% in 2021, coinciding with near-universal population affiliation (Brun Vergara *et al.*, 2023). During this period, the benefits framework evolved into a broad and legally enforceable entitlement to health services and medicines, particularly after the enactment of Statutory Law 1751 of 2015 (Congreso de la República de Colombia, 2015; Brun Vergara *et al.*, 2023). However, these outcomes do not guarantee universal or uninterrupted access to NCD medicines, as challenges persist in resource flows, medicine dispensing, territorial access, and the sustainability of a broad benefits package. Despite these challenges, Colombia comes closest among the three cases to demonstrating a pathway from pooled financing and benefit entitlement to measurable financial protection.

OUT-OF-POCKET
expenditure as a proportion of current health expenditure
DECLINED FROM

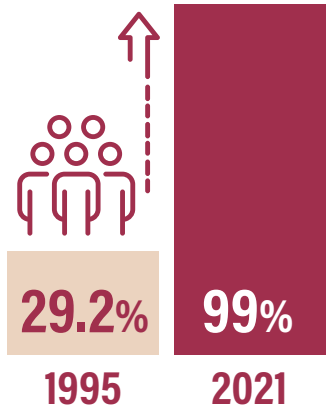


2. Health system and entitlement architecture

Colombia is classified as an upper-middle-income country with a population of approximately 52 million. Most residents are affiliated with either the contributory or subsidised regime. A smaller segment, including members of the armed forces, teachers, Ecopetrol employees, and certain public employees, participate in special and exception regimes characterised by distinct financing and institutional structures (Giedion & Villar Uribe, 2009; Escobar *et al.*, 2010). Population affiliation increased from 29.2% in 1995 to 99% in 2021; however, complete unification of insurance arrangements remains unachieved (Brun Vergara *et al.*, 2023).

Key institutions within the health system fulfill distinct financing and service delivery roles. The Ministry of Health and Social Protection (MSPS) establishes national policy; ADRES pools and allocates resources; insurers, known as Health Promotion Entities (EPS), manage risk and purchase care; and provider institutions (IPS) deliver health services (Giedion & Villar Uribe, 2009; Escobar *et al.*, 2010). Territorial health authorities at the departmental and municipal levels oversee

POPULATION AFFILIATION
INCREASED FROM



public health and regulatory functions. Two technical bodies are particularly significant for medicine financing: Institute for Health Technology Assessment (IETS), which supports health technology assessment and priority setting, and the National Commission for the Pricing of Medicines and Medical Devices (CNPMDM), which regulates pharmaceutical pricing (Congreso de la República de Colombia, 2011; CNPMDM, 2023).

Colombia's entitlement framework is grounded in a series of legal reforms. Law 100 of 1993 established the SGSSS and its initial benefits structure, while Law 1438 of 2011 enhanced the emphasis on primary health care (PHC) and system efficiency. Statutory Law 1751 of 2015 subsequently recognised health as a fundamental, autonomous, and enforceable right, stipulating that services and technologies are covered unless explicitly excluded according to the criteria in Article 15 (Congreso de la República de Colombia, 1993, 2011, 2015). The law further defines continuity, timeliness, accessibility, and progressivity as core elements of entitlement, and mandates the state to ensure sustainable financing and prompt resource allocation. These provisions are especially critical for chronic conditions, where treatment interruptions can compromise the effective realisation of the right to health. This statutory right also supports the tutela[1] mechanism, enabling individuals to seek rapid judicial enforcement of access to health services and medicines, with resolutions achieved within days (Lamprea & García, 2016).

Operationally, the PBS converts this broad entitlement into the services and technologies routinely financed via the UPC. Notably, entitlement and financing channels are not synonymous: services and technologies not financed through the UPC may still be included within the right to health if not explicitly excluded. Consequently, Colombia has established separate financing mechanisms for these technologies, as detailed in the subsequent section. This distinction enables the system to uphold a broad entitlement while employing differentiated mechanisms to finance and manage its fiscal implications (Congreso de la República de Colombia, 2015; MSPS, 2021; MSPS, 2025d).

National planning instruments establish a broader policy framework for NCDs and mental health. The Ten-Year Public Health Plan (PDSP 2022–2031) addresses healthy living, NCDs, and mental health (MSPS, 2022). Additionally, the 2022–2026 National Development Plan mandates the government to enhance mental health promotion, prevention, comprehensive care, rehabilitation, and social inclusion through territorial and community-based implementation (Congreso de la República de Colombia, 2023).

1 *Acción de tutela*: a fast-track constitutional injunction that any citizen can file to enforce fundamental rights, including the right to health. *Tutelas* are widely used to claim medicines and services, and courts resolve them within days.

3. Financing mechanisms for NCD and mental health medicines

To support its broad universal benefit package, Colombia utilises pooled, risk-adjusted capitation mechanisms designed to ensure predictable financing for NCD and mental health medicines, medical devices, and primary care services.

3.1 Public pooling and capitation

Routine financing of the PBS is structured through a national pool managed by ADRES, which collects payroll contributions, general taxation, and other public revenues. ADRES allocates the UPC to each EPS as a prospective per capita payment to fund services and technologies included in the benefits package. The UPC is mainly adjusted for age, sex, and geographical location. It does not directly account for morbidity, diagnosed conditions, or multimorbidity, which underscores the importance of complementary arrangements for high-cost risks in a system serving a population with significant chronic disease needs.

US$19.7 MILLION INVESTED in 21 MEDICINES for MENTAL HEALTH CONDITIONS

For 2026, the government established the UPC through Resolución 2764 of 2025, increasing its global value by 12.94%. The total UPC pool increased from approximately US$30 billion (COP 89.8 trillion) in 2025 to more than US$33 billion (COP 101.3 trillion) in 2026, with increases of 9.03% for the contributory regime and 16.49% for the subsidised regime (MSPS, 2025c; ADRES, 2026). Following a process of benefit package unification that began in 2012 and was completed by 2015, driven by the Constitutional Court, contributory and subsidised populations receive the same benefit package. This is an important equity feature of the financing arrangement: lower-income affiliates are formally entitled to the same NCD services and medicines as those contributing through formal employment. The continued size of the subsidised regime, in a labour market characterised by substantial informality and movement between regimes, also demonstrates the importance of general government revenues in sustaining equal entitlement (Giedion *et al.*, 2014; International Labour Organization, 2014).

3.2 Benefit package design and medicine inclusion

Resolución 2765 of 2025 specifies the services and technologies financed through the UPC for 2026 (MSPS, 2025d). By late 2025, the government reported that UPC-financed services and technologies accounted for more than 96% of authorised technologies (MSPS, 2025e). The technical annexes include tracer medicines required for major NCDs, including antihypertensives, oral hypoglycemics and insulins, statins and other cardiovascular medicines, inhaled therapies for asthma and COPD, and psychotropic medicines.

Mental health illustrates how the package can expand over time. The PBS covers psychiatric and psychological consultation, hospitalization, and psychotropic medicines. Resolución 2765 of 2025 also removed the previous administrative prohibition on financing psychoanalysis, leaving the choice of therapeutic modality to clinical judgment (MSPS, 2025d). An earlier expansion incorporated 21 medicines for conditions including panic disorder, phobias, and generalised anxiety, with an announced annual investment of approximately US$19.7 million (COP 60 billion) expected to benefit around 400,000 people (MSPS, 2018).

For services and technologies not financed through the UPC but not explicitly excluded, Colombia uses a separate prospective financing mechanism known as *presupuestos máximos* (maximum budgets). Introduced to replace much of the previous ex-post recobro model, the mechanism transfers a prospective allocation from ADRES to each EPS for eligible non-UPC technologies, with prescriptions recorded through MIPRES[2] (MSPS, 2021; Cárdenas *et al.*, 2025). Residual reimbursement remains for defined exceptional categories that fall outside both the UPC and maximum budget arrangements.

2 "Mi Prescripción": the national electronic platform through which clinicians prescribe, and the system traces, medicines outside routine UPC financing.

The result is a differentiated financing architecture in which a broad legal entitlement can be maintained while routine and non-routine technologies are financed through distinct mechanisms.

The PBS is maintained through a continuing review process drawing on UPC sufficiency databases, INVIMA marketing authorisation information, MIPRES prescribing data, SISMED price data, clinical guidance, and other technical evidence. The 2026 update materials also describe an "alternative technologies" pathway under which an unlisted technology may be financed with UPC resources where it substitutes an explicitly financed technology at equal or lower cost and meets applicable quality and authorisation requirements (MSPS, 2025e). This creates a mechanism for adapting routine financing to changes in clinical practice and technology while retaining explicit fiscal and regulatory controls.

3.3 Purchasing, prescribing, and dispensing

Within this financing architecture, EPS organise and purchase care from IPS and other contracted providers, while pharmacies and gestores farmacéuticos contracted by EPS dispense medicines. MIPRES serves as the prescribing and information platform for technologies financed outside the UPC and also provides data that can inform subsequent decisions about whether frequently prescribed technologies should migrate into routine UPC financing. In a significant 2025-2026 episode, the MSPS issued Circular Externa 044 of 26 December 2025, requiring that UPC-financed outpatient medicines also be prescribed and traced through MIPRES, with obligatory implementation from 1 June 2026, to improve traceability and detect supply failures under the Constitutional Court's monitoring (MSPS, 2025a). Following concerns that this could create administrative barriers, the Ministry reversed course: in June 2026, Circular 019 de 2026 repealed Circular 044 (MSPS, 2026a), moving the registration of UPC medicines to the Digital Care Summary (RDA), the interoperable electronic health record instrument adopted under Resolución 1888 of 2025 (MSPS, 2025b). As of July 2026, MIPRES continues to operate for non-UPC medicines while the RDA-based pathway for UPC medicines is being implemented progressively.

3.4 Managing costs and sustaining a broad entitlement

Colombia uses a multifaceted cost management approach. Pharmaceutical price regulation is applied selectively rather than universally. All marketed medicines are subject to monitored freedom, while selected products are placed under direct control and assigned maximum sale prices, including through external reference pricing. For new medicines, Circular 16 of 2023 links price setting to six therapeutic value categories assessed by IETS (MSPS, 2019; CNPMDM, 2023). MIPRES prescription or non-UPC financing does not, by itself, create a regulated maximum price. Although direct price control can significantly reduce unit prices, evidence indicates that lower prices may also increase utilisation and total public pharmaceutical expenditure. Therefore, price regulation should be considered alongside health technology assessment, benefit design, prescribing practices, procurement, and budget management, rather than as an isolated expenditure cap (Prada *et al.*, 2018). Colombia has also implemented pooled procurement, including for hepatitis C medicines through the PAHO Strategic Fund (Pérez *et al.*, 2019). Additionally, capped and income-graded copayments, along with explicit protections for high-cost and chronic conditions, help limit patients' financial burden (Brun Vergara *et al.*, 2023).

Monitoring and risk adjustment reinforce these tools. The High Cost Disease Fund, a technical body created by the Ministries of Health and Treasury, standardises and validates insurer data on designated high-cost NCDs and monitors indicators relating to risk management, disease progression, treatment, and outcomes (Fondo Colombiano de Enfermedades de Alto Costo, 2022). Its legal mechanism also provides for pooling and redistributing resources among insurers for designated high-cost conditions, complementing ex-ante capitation and helping reduce incentives for risk selection (Presidencia de la República de Colombia, 2007).

Colombia has also strengthened the fiscal and regulatory side of NCD prevention through tobacco controls and taxes on sugar-sweetened beverages and ultra-processed foods. These instruments can reduce exposure to risk factors and generate public revenue, although they are not a substitute for stable recurrent health financing (United Nations Development Programme *et al.*, 2019; World Bank, 2024). Early observational evidence comparing matched products between 2015 and 2024 found lower median sugar content in beverages and sodium content in foods, suggesting that the combined regulatory environment—including sodium limits, warning labels, and taxes—has encouraged reformulation; the study cannot isolate the effect of any single measure (Cadena *et al.*, 2025).

Colombia has strengthened the fiscal and REGULATORY SIDE OF NCD PREVENTION through TOBACCO CONTROLS AND TAXES ON SUGAR-SWEETENED BEVERAGES AND ULTRA-PROCESSED FOODS.

3.5 Translating financing and entitlement into PHC delivery

Colombia is advancing a PHC-oriented model that includes Basic Health Teams and the National Rural Health Plan. The training and deployment of these teams constitute a significant effort to expand territorial access. However, these activities should be interpreted as indicators of implementation progress rather than as direct evidence of improved access to NCD medicines or health outcomes. The policy significance of these initiatives lies in their capacity to connect households to provider networks, provided that referral pathways, information systems, and continuity of treatment are effectively integrated into implementation (García Ruiz *et al.*, 2025). The 2025 National Mental Health Policy, established through Decreto 729 of 2025, introduces a territorial, community-based, and networked approach to mental health care (Presidencia de la República de Colombia, 2025). Implementation includes 39 mental health reference centres supported by US$ 205 million (COP 626.685 billion) in announced investment (MSPS, 2026b).

4. Remaining challenges and next steps

Colombia faces the ongoing challenge of maintaining recent advances in coverage, entitlement, and financial protection while upholding a broad, primarily implicit benefit package. Key concerns include the technical adequacy and transparency of the UPC and maximum budgets, the lack of direct morbidity and multimorbidity adjustments within the UPC, the persistence of a large subsidised regime in a labour market marked by high informality, and diminished traceability of resources as they move from ADRES through EPS to providers, pharmacies, and suppliers (PROESA and Cámara de Dispositivos Médicos e Insumos en Salud–ANDI, 2020).

These challenges do not undermine the case study's central conclusion. Rather, they underscore the necessity for universal entitlement to be supported by transparent actuarial methodologies, enhanced ex-post risk adjustment, prompt payments to providers and pharmacies, comprehensive HTA and budget impact analysis, interoperable information systems, and systematic monitoring of both effective access and affiliation. Incorporating household-level evidence into monitoring remains essential, as low aggregate OOP expenditures may coexist with significant burdens related to medicines, transportation, and territorial access (Martínez Barrera & Soto Rojas, 2026). Household survey evidence illustrates this distinction: the proportion of households reporting expanded OOP spending, including expenditure on medicines and transport, declined from 74.6% in 1997 to 33.2% in 2025, representing substantial long-term improvement while showing that direct household expenditure remains relevant for a sizeable minority of the population (Martínez Barrera & Soto Rojas, 2026). Furthermore, as implementation progresses, Basic Health Teams and emerging mental health networks should be evaluated on continuity of care, medicine availability, referral completion, equity, and outcomes. The overarching policy objective is to enhance the sustainability, efficiency, and accountability of entitlement financing and delivery, rather than to restrict entitlement itself.

5. Key takeaways for advocates and policymakers

Colombia's experience offers three broader lessons for financing NCD medicines.

First, a broad entitlement becomes materially stronger when it is linked to a recurrent, pooled financing mechanism. The important feature is the connection between population entitlement and a predictable flow of prepaid resources capable of financing chronic care across different population groups, rather than the specific institutional form of ADRES, the UPC, or the EPS.

Second, broad entitlement requires institutions that actively manage its fiscal consequences. Colombia combines benefit package review, health technology assessment, differentiated financing channels, pharmaceutical price regulation, risk adjustment, procurement, and information systems. These mechanisms do not eliminate expenditure pressures, but they provide tools to manage access, innovation, and fiscal sustainability within a common financing architecture.

Third, population coverage and formal entitlement should be assessed alongside financial protection and effective access. Colombia's low aggregate OOP expenditure is an important performance indicator, but it does not establish that medicines are continuously available or that all population groups experience the system equally. Therefore, monitoring should extend to medicine availability, unmet need, timeliness, continuity of treatment, and territorial inequalities.

These lessons should not be interpreted as an argument for replicating Colombia's institutional model in other settings. Financing arrangements are shaped by fiscal capacity, labour market structure, administrative capability, provider markets, and political economy (Savedoff et al., 2012). The transferable principle is aligning pooling, entitlement, purchasing, medicine policy, and accountability around a recurrent public commitment to chronic care.

CASE STUDY 2

NEPAL

Connecting public entitlement to NCD financing under federalism

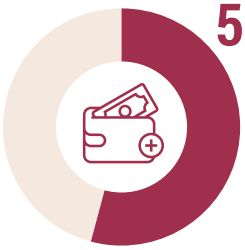
1. Context

Nepal illustrates the complexities involved in translating a robust public entitlement into consistently financed and delivered NCD care within a relatively new federal health system. Nepal's 2015 Constitution designates basic health care as a fundamental right, and subsequent legislation establishes a Basic Health Services (BHS) package provided free of charge through public facilities. Responsibility for implementing this commitment is distributed across federal, provincial, and local governments, with local governments playing a substantial role in planning, budgeting, frontline service delivery, and medicine procurement (Government of Nepal, 2015; Government of Nepal, 2018; Government of Nepal, 2017a).

The primary financing challenge is not a lack of public commitment, but rather ensuring that this commitment is consistently linked to resources, purchasing, medicines, and service delivery across all levels of government. OOP expenditure remains substantial, as highlighted by a 2025 review that estimated OOP at 54.2% of current health expenditure, with approximately 10% of households experiencing catastrophic health expenditure and households directly financing 62% of NCD-related expenses directly (Khatri *et al.*, 2025). While decentralisation has brought financing and procurement decisions closer to communities, disparities in administrative and procurement capacity have contributed to medicine shortages, delays, and variations in purchasing costs (Adhikari *et al.*, 2024).

The package of essential NCD interventions (PEN) and PEN-Plus provide some of Nepal's most effective mechanisms for progressively narrowing the gap between entitlement and implementation. PEN specifies the screening, diagnostic, medicine, follow-up, and referral requirements for common NCDs at the PHC level, while PEN-Plus expands chronic care delivery for more severe conditions to district hospitals. These initiatives matter because they translate broad public commitment into defined care pathways that can be costed, financed, procured, and monitored. Although implementation remains uneven and only partially financed, these initiatives serve as practical focal points for Nepal's evolving approach to publicly financed NCD care.

OUT-OF-POCKET payments remain substantial, accounting for over **HALF OF HEALTH EXPENDITURE**



OF HOUSEHOLDS PAY OOP FOR NCD EXPENSES

2. Health system and financing architecture

Nepal is a lower-middle-income country with a population of approximately 29 million. It underwent a major administrative transformation under the 2015 Constitution, which established a federal system comprising the federal government, seven provinces, and 753 local governments (Government of Nepal, 2015). The Ministry of Health and Population (MoHP) maintains national stewardship, overseeing policy, standards, and benefit design. Provincial governments are responsible for provincial and many secondary hospitals, while local governments manage health posts, primary health care (PHC) centres, and basic hospitals. Local governments have also assumed substantial responsibility for health planning, budgeting, and essential medicine procurement (Government of Nepal, 2017a; Adhikari *et al.*, 2024).

Within this federal structure, the **Basic Health Service (BHS)** package establishes a universal, tax-financed foundation for health coverage. The package includes prevention, diagnosis, initial management, and referral for major NCDs. National treatment protocols and the National List of Essential Medicines define the clinical and pharmaceutical inputs required at each level of care (Government of Nepal, 2018; MoHP, 2021; KC *et al.*, 2015). Mental health services are integrated through the National Mental Health Strategy and Action Plan 2020 and the community mental health care package, which delineate service, medicine, and referral responsibilities across the health system (MoHP, 2020; MoHP, 2022). Nepal's involvement in the WHO Special Initiative for Mental Health has further supported the strengthening of PHC-based mental health services (WHO, 2022).

Beyond the BHS foundation, Nepal implements contributory schemes to enhance financial protection. The **National Health Insurance Program (NHIP)**, established under the Health Insurance Act 2017, offers family-based coverage for services and medicines that extend beyond the basic package, with government premium subsidies available for designated groups. The **Social Security Fund** serves as a separate contributory mechanism for formal sector workers (Government of Nepal, 2017b; Government of Nepal, 2017c; Khatri *et al.*, 2025). These mechanisms introduce pooled financing for services that would otherwise require direct household expenditure. However, challenges persist regarding population coverage, renewal rates, provider reimbursement, and perceived value.

An additional layer comprises **non-contributory targeted schemes,** most notably the Bipanna Nagarik Kosh[3], or Impoverished Citizens' Treatment Fund, which finances treatment for eligible poor and marginalised individuals with specified high-cost conditions (Khatri *et al.*, 2025). Collectively, this financing architecture integrates a universal tax-financed foundation, contributory pooled coverage for supplementary services, and targeted protection against catastrophic health expenditures.

The National Health Financing Strategy 2023–2033 establishes the overarching framework to address persisting constraints. Its priorities include increased domestic resource mobilisation, enhanced pooling, more equitable allocation across government levels, and more strategic purchasing (MoHP, 2023). These reforms create the system-wide context needed to implement the NCD medicines entitlement progressively.

National Health Financing Strategy 2023–2033 PRIORITIES INCLUDE INCREASED DOMESTIC RESOURCE MOBILISATION, enhanced pooling, more **EQUITABLE ALLOCATION** across government levels, and more **STRATEGIC PURCHASING**

3 A non-contributory government fund that directly finances treatment of specified catastrophic and high-cost illnesses for poor and marginalised patients, on application through participating hospitals.

3. Emerging financing and implementation pathway

While fiscal constraints persist, Nepal's strategic health sector plans and decentralised funding channels establish a clear operational framework to transition essential health package commitments into local service delivery.

3.1 PEN and PEN-Plus as mechanisms for converting financing into service coverage

PEN plays a critical role in the financing framework by providing operational content to Nepal's broad legal entitlement. While a constitutional right or benefits package outlines the services individuals should receive, a standardised care pathway clarifies the specific government financing required to deliver these services. For conditions such as hypertension, diabetes, chronic respiratory disease, and other priority NCDs, this includes health worker time, diagnostics, medicines, follow-up systems, referral capacity, and supervision. Therefore, PEN serves as a link between benefit package design and the processes of annual planning, budgeting, procurement, and service delivery.

Nepal implemented the WHO PEN to incorporate cardiovascular risk assessment, hypertension and diabetes management, chronic respiratory care, and selected cancer services into primary care. Initially piloted in two districts in 2016 and later expanded through the PHC system, PEN operationalises the BHS entitlement by specifying screening protocols, required diagnostic tools, prescribed medicines, and referral criteria for health workers (Teufel *et al.*, 2026). The urgency of this initiative is underscored by the fact that fewer than one in five Nepali adults with hypertension or diabetes currently receive treatment (Teufel *et al.*, 2026).

A NATIONAL EVALUATION across all seven provinces found that blood pressure was **MEASURED IN 82%** of observed visits and medication was **ADJUSTED IN 85%**

Implementation evidence demonstrates improvements in service readiness as PEN has expanded. From 2015 to 2021, facility readiness scores increased by approximately 10 percentage points for cardiovascular services and 9 points for chronic respiratory disease services, with primary care facilities showing significant progress and expanded diabetes service availability (Thapa *et al.*, 2024). Direct observations further confirm the implementation of core clinical tasks: a national evaluation across all seven provinces found that blood pressure was measured in 82% of observed visits and medication was adjusted in 85% (Teufel *et al.*, 2026).

Patient experiences offer a mixed picture of where PEN implementation is working and where gaps remain. Interviews with recipients of PEN services across 14 districts identified free medicines, affordable services, geographic accessibility, reduced waiting times, and positive provider relationships as key facilitators of service utilisation. The same participants also described shortages of medicines and equipment and continuing affordability barriers as reasons for not using services (Mali *et al.*, 2025). While PEN provides a mechanism to operationalise the BHS entitlement at the point of care, effective coverage still relies on reliable financing and implementation inputs.

Since 2021, Nepal has expanded this approach to address severe NCDs through PEN-Plus, led by the MoHP and EDCD with the Kathmandu Institute of Child Health as an implementing partner. PEN-Plus establishes decentralised chronic care units in district hospitals for conditions that cannot be adequately managed through the primary care platform, including type 1 diabetes, sickle cell disease, thalassemia, rheumatic and congenital heart disease, severe asthma, epilepsy, and other severe NCDs. By May 2025, six hospitals were operating as PEN-Plus centres and had provided care to 3,278 patients, including 603 people under 19 years of age. Expansion from the initial sites has been supported by development partners alongside government policy commitments and provincial budget allocations (Karki *et al.*, 2026). The financing model also incorporates social protection measures where eligible patients can receive free diagnostics, medicines, and consultations; support is available for transport and accommodation for tertiary referral; and PEN-Plus covers NHIP premiums for patients unable to afford enrollment (Karki *et al.*, 2026).

Two main financing gaps remain. **First, adherence to PEN protocols is limited, as national evaluations report low scores for hypertension and diabetes management and for lifestyle counselling.** Essential clinical steps, such as blood glucose measurement and cardiovascular risk assessment, are often omitted, primarily due to unreliable supplies of diagnostics and medicines rather than gaps in protocols or training (Teufel *et al.*, 2026). **Second, PEN-Plus remains heavily dependent on development partner financing, which poses a sustainability challenge as the programme expands** (Karki *et al.*, 2026). In both instances, the central issue is that while defining services and training providers creates an obligation, only sustained domestic financing for diagnostics, medicines, follow-up, and referral guarantees actual coverage. Assessing whether financing reaches patients requires measures of fidelity and continuity, rather than simply tracking nominal service availability.

3.2 Federal transfers and frontline financing

General revenues support the financing of the BHS package, which includes providing free medicines through public facilities. Within the federal system, the federal government allocates resources to provinces and local governments via conditional grants and broader intergovernmental fiscal transfers. Local governments may also utilise locally sourced revenues and health equalisation grants. This structure creates a financing pathway from national policy to frontline service delivery: the central government defines minimum entitlements and standards, and subnational governments finance and organise service delivery based on local population needs (MoHP, 2023).

Decentralisation allows financing decisions to be more closely aligned with local service needs. Local governments can coordinate medicine procurement with staffing, outreach, screening, referral, and other operational requirements. However, realising these opportunities depends on sufficient administrative, financial management, procurement, and logistics capacity. The main policy challenge is to maintain national entitlements and standards while granting subnational governments adequate resources and flexibility to organise service delivery (MoHP, 2023).

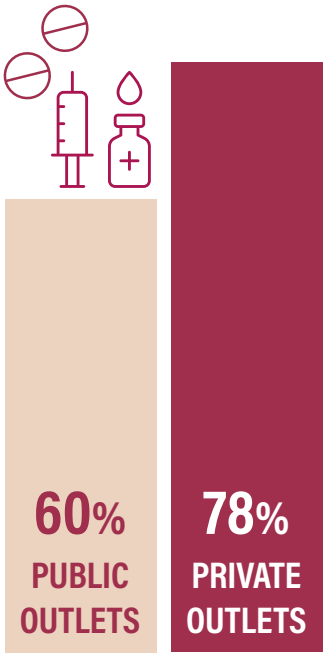
The success of this approach depends on administrative capacity and on the quality of procurement decisions. In Bagmati Province, procurement delays at the local level have been a major contributor to shortages of essential medicines, while unrealistic demand estimation, risks of duplicate orders, near-expiry supplies, and gaps in quality monitoring and inventory management created additional inefficiencies (Adhikari *et al.*, 2024). These problems can result in both shortages of needed products and unnecessary or wasteful purchasing. Nepal's experience demonstrates that fiscal decentralisation must be accompanied by needs-based quantification, clear procurement guidelines, transparent oversight, coordination across levels of government, skilled procurement personnel, and adequate logistics and information systems.

3.3 Essential medicines as the bridge between entitlement and purchasing

Nepal's essential medicines list turns clinical priorities into a defined public obligation. It informs procurement and inventory planning, supports standard prescribing, and determines which medicines should be provided free of charge at each facility level. The National List of Essential Medicines (sixth revision, 2021) is aligned with the WHO PEN package, ensuring that medicines for the prevention and management of major NCDs, including cardiovascular diseases, diabetes, chronic respiratory diseases and selected cancers, are specified for availability at appropriate levels of the health system (MoHP, 2021). In practice, the BHS package, essential medicines list, and treatment protocols function as interconnected instruments rather than as separate policy documents.

Data on medicine availability serve as indicators of the effectiveness of this policy link. A national survey using WHO/Health Action International methods found that selected NCD medicines were available in 60% of public outlets, compared to 78% in private outlets. Substantial variation existed at the product level: insulin was available in only 20% of public outlets, whereas metformin was found in 60% (Khanal *et al.*, 2019). Affordability in the survey was assessed using the WHO/Health Action International methodology, which expresses the cost of a standard treatment regimen in terms of the number of days' wages required by the lowest-paid unskilled government worker. For the NCD medicines assessed in this Nepal survey, affordability was calculated for one month of treatment. The selected treatments generally cost no more than one day's wage and were therefore considered affordable under this survey convention (Khanal *et al.*, 2019). This threshold should not be interpreted as a universal measure of affordability as it does not capture the burden on people earning below the reference wage or on households managing multiple chronic conditions. Nor do affordable private sector prices constitute a public entitlement if patients are compelled to purchase medicines privately because of stockouts in public facilities.

SELECTED NCD MEDICINES were available in 60% of public outlets, compared to 78% in private outlets



Nepal's experience indicates that listing a medicine creates a formal obligation, but entitlement is achieved only when medicines are consistently available at the point of care. Procurement delays, deficiencies in demand forecasting and inventory management, and inadequate quality monitoring can disrupt timely and reliable supply (Adhikari *et al.*, 2024). Effective provision depends on both sufficient financing and the procurement and supply chain capacity necessary to translate that financing into medicines available at the point of care. Monitoring should extend beyond including medicines on official lists to include indicators such as stockout frequency, prescription fulfilment rates, the proportion of public versus private purchases, household expenditure on medicines, and continuity of treatment.

3.4 Insurance as an additional layer, rather than a substitute for BHS

The NHIP can extend financial protection beyond the free basic package; however, its effectiveness remains limited. The 2025 health financing review reported population coverage of approximately 28%, renewal rate of 54%, and provider payments that exceeded collected revenues (Khatri *et al.*, 2025). Low renewal rates undermine the risk pool and coincide with broader concerns regarding service availability, financial sustainability, claims administration, and the perceived value of coverage. Additionally, fragmentation among the NHIP, BHS, and categorical funds restricts the coherence of financial protection arrangements.

An additional purchasing challenge involves the relationship between utilisation incentives and provider reimbursement. Recent mixed-methods research from Nepal identified ex-post moral hazard among certain insured users. Providers reported that some patients sought consultations, tests, or medications beyond clinically assessed need, while hospitals experienced delays and inconsistencies in reimbursement (Shrestha *et al.*, 2026). A separate qualitative assessment

conducted in 2026 across 22 health facilities also documented irregular reimbursement cycles, with some facilities waiting extended periods for payment and being required to provide services on credit (Karmacharya *et al.*, 2026). These findings indicate that expanding insurance coverage should be accompanied by effective utilisation management mechanisms, prompt claims processing and provider payment, and purchasing arrangements that discourage unnecessary care while ensuring access to clinically indicated services.

Recent evidence from the Nepal case cautions against the assumption that insurance enrolment alone improves medication adherence or chronic care outcomes. A 2025 hospital-based study of 402 patients with hypertension in Kailali found no significant association between NHIP enrolment and medication adherence. The study's authors emphasised that counselling, patient education, follow-up, and reliable medicine availability are necessary complements to insurance coverage (Dangaura *et al.*, 2025). Nepal has established an institutional purchaser, yet its experience demonstrates that financial coverage must be linked to service quality and pharmaceutical supply.

3.5 Household costs and the case for continuous public financing

The financial burden of NCDs persists across various disease groups. Among older individuals living with NCDs in Dharan, 14.6% experienced catastrophic health expenditure in a community-based study (Rai *et al.*, 2022). A costing study of individuals with type 2 diabetes in Kavrepalanchok and Nuwakot estimated mean six-month resource costs of US$ 22.87 per patient, with 61% attributed to direct medical expenditure. The remaining costs included transport and lost productivity, which represent significant opportunity costs for households reliant on daily wages or agricultural income (Dahal *et al.*, 2023). These expenses can be substantial for households with irregular incomes, especially when multiple family members require long-term treatment.

This financing principle also applies to mental health. A national investment case estimated the costs and the health and economic returns of scaling up priority mental health interventions in Nepal (MoHP, 2025). Trial-based evidence from Chitwan shows that delivering psychotherapy within integrated primary care depression services increased healthcare utilisation without significantly increasing costs to the health system or individuals (Aldridge *et al.*, 2022). However, qualitative evidence from Sudurpaschim Province identifies low budget allocation and implementation gaps as persistent policy-level barriers to accessing mental health care (Khanal *et al.*, 2025).

Each of Nepal's three financing layers addresses a distinct component of household financial burden. Free BHS medicines reduce routine OOP spending at the point of service. Insurance mechanisms pool higher outpatient and hospital costs, while targeted funds offer protection against catastrophic illnesses. **The primary policy challenge is to integrate these layers to ensure patients experience a coherent, continuous coverage pathway, rather than navigating fragmented schemes with differing eligibility criteria, provider networks, and administrative processes.**

4. Future financing and implementation priorities

Nepal faces the immediate challenge of strengthening the integration of existing financing instruments. The National Health Financing Strategy 2023–2033 outlines comprehensive reforms, including increased domestic resource mobilisation, stronger pooling, improved allocation across government levels, and more strategic purchasing (MoHP, 2023). For NCD medicines, it is essential that services defined in the BHS package and PEN are consistently incorporated into federal and subnational budgets, procurement plans, insurance arrangements, and recurrent financing for medicines, diagnostics, workforce, and follow-up.

Implementation capacity is equally critical. Local governments must possess adequate procurement, forecasting, logistics, information system, and financial management capabilities to utilise transferred resources effectively and ensure consistent medicine availability (Adhikari *et al.*, 2024). Simultaneously, the NHIP should deliver greater value and continuity for enrolled households by ensuring reliable medicine availability and timely provider reimbursement, thereby reinforcing rather than fragmenting the universal BHS floor (Khatri *et al.*, 2025).

Monitoring should therefore focus beyond formal entitlement, programme rollout, or insurance enrolment to whether financing reaches patients. Medicine stockouts, prescription fulfilment, continuity of treatment, OOP expenditure, referral completion, and condition-appropriate measures of effective coverage provide more meaningful indicators of whether Nepal's existing financing commitments are being implemented.

5. Key takeaways for advocates

Nepal's experience underscores the necessity of ensuring that financing commitments are implemented from national policy through to the point of service delivery. While legal entitlement provides a durable foundation for advocacy, effective coverage depends on translating this entitlement into funded services, medicines, diagnostics, and care pathways. In a decentralised governance context, it is also essential to consider the mechanisms for resource transfer, assignment of responsibilities, and the capacity of subnational governments to procure and deliver the promised services.

PEN and PEN-Plus illustrate the benefits of standardised care pathways in clarifying financing requirements. By specifying providers, levels of care, required medicines and diagnostics, and referral arrangements, these programmes establish a practical framework for estimating the recurrent resources necessary for NCD care. The primary advocacy challenge is to ensure that budgets, procurement processes, insurance arrangements, and implementation capacity are aligned with these requirements.

CASE STUDY 3

UGANDA

Building the institutional foundations for sustainable NCD medicine financing

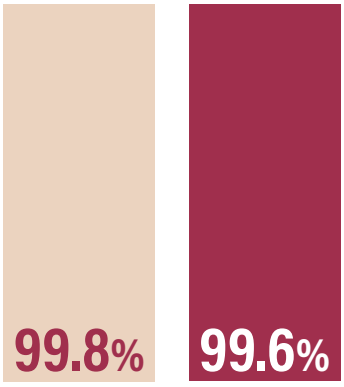
1. Context

Uganda's experience is defined by a substantial gap between the institutional architecture it has established for NCD financing and the resources currently available to implement it. The country has made NCDs increasingly visible in national planning. It has developed a costed multisectoral NCD plan, produced disease-disaggregated health accounts, incorporated NCDs into the Uganda National Essential Health Care Package, updated its Essential Medicines and Health Supplies List, established primary health care (PHC) financing mechanisms, and developed centralised public procurement and distribution arrangements. These are important prerequisites for translating NCD priorities into budgetary decisions.

Nevertheless, there remains a severe financing challenge. The Ministry of Health (MOH) quantification exercises estimated that NCD commodities faced a 99.8% funding gap in fiscal year 2023/24 and a 99.6% gap in 2024/25. In the latter year, estimated need was approximately US$139 million against available commitments of around US$0.5 million (MOH, 2023c; MOH, 2024b). Consequently, stockouts and high out-of-pocket (OOP) spending remain common, and an essential medicines list and free care policy have not yet converted into reliable access to NCD medicines (Armstrong-Hough et al., 2018; Armstrong-Hough et al., 2020; Tusubira et al., 2020).

Uganda exemplifies the process of establishing institutional foundations for sustainable financing, rather than representing a context where such financing has already been realised. The case is relevant to other low-income countries by demonstrating actionable steps under severe fiscal constraints: costing the response, increasing spending transparency, integrating NCDs into publicly financed benefits packages, developing operational financing and procurement channels, and optimising the use of existing chronic care infrastructure. These measures create a foundation for mobilising and utilising additional domestic financing, but they do not replace the need for such financing.

Uganda faces a **SEVERE FUNDING GAP** FOR NCD COMMODITIES



2. Health system and entitlement architecture

Uganda is a low-income country with a population of approximately 47 million. It has a tax-financed, decentralised public health system overseen by the MOH. Service delivery is organised through a tiered PHC structure comprising Health Center II, III, and IV facilities[4], district hospitals, and regional referral hospitals, complemented by a substantial private not-for-profit sector, largely faith-based, and private for-profit providers. Uganda does not currently have an operational national health insurance scheme; health financing instead relies mainly on government revenue, external funding, and OOP payments.

According to the UNICEF Uganda Health Budget Brief, the health sector's share of the government budget increased from 4.8% in 2017/18 to 7.7% in 2022/23 and remained at 7.7% in 2023/24, well below the Abuja Declaration target of 15% (Organisation of African Unity, 2001; UNICEF Uganda, 2023). Per capita public health spending was estimated at US$23, approximately one quarter of the benchmark of US$86 per person per year (UNICEF Uganda, 2023). OOP expenditure remains substantial, and medicine purchases when products are unavailable in public facilities are an important component of the household burden (Tusubira *et al.*, 2020).

OUT-OF-POCKET expenditure for NCDs remains substantial, and **MEDICINE PURCHASES** are an important component of **THE HOUSEHOLD BURDEN**

4 Uganda's PHC tiers: Health Center II (parish level, outpatient care), Health Center III (sub-county, adds maternity and laboratory services), and Health Center IV (county, adds inpatient care and surgery).

CASE STUDY 3: UGANDA

The institutional framework for NCD medicines in Uganda involves several key actors: the Ministry of Health, which sets policy, maintains the essential medicines list, and establishes service standards; the National Medical Stores, responsible for central procurement and distribution to public facilities; the Joint Medical Store, which supplies private not-for-profit facilities; district local governments, which receive primary health care grants; and the National Drug Authority, which regulates medicines (Lugada *et al.*, 2022).

The system faces particular challenges in ensuring access to NCD medicines. In Uganda, the burden of NCDs is concentrated among younger and poorer populations, with more than half of NCD disability-adjusted life years occurring before age 40, and higher mortality and financial hardship among disadvantaged groups (Uganda NCDI Commission, 2022). While the epidemiological transition is progressing rapidly, financing remains primarily directed toward communicable diseases and maternal health. As a result, continuous access to antihypertensives, insulin, and other chronic medicines is not assured.

Uganda abolished user fees in public facilities in 2001, establishing a policy of free care at the point of use, the foundational entitlement for medicine access, financed through general taxation and the PHC grant system. Public regional referral hospitals were, however, permitted to retain paying private wings, so the free care policy applies mostly to lower-level facilities and general wards (Odoch *et al.*, 2023). The benefits framework is the Uganda National Minimum Health Care Package (UNMHCP), later articulated as the National Essential Health Care Package, which includes NCD prevention and control as a component (MOH, 2024a). The medicines entitlement is operationalised through the Essential Medicines and Health Supplies List for Uganda (EMHSLU) — most recently the 2023 edition — which classifies medicines by level of care and by VEN (vital/essential/necessary) status, and which explicitly incorporates NCD medicines developed with input from the MOH Department of Noncommunicable Diseases Prevention and Control (MOH, 2023a).

Mental health is part of this entitlement architecture. The Mental Health Act 2018 replaced colonial era legislation and provides for mental health care to be delivered through general health services down to the district and PHC levels, rather than concentrated in the national referral hospital; it also protects the rights of people with mental illness (Government of Uganda, 2018). Uganda's policy of integrating mental health into primary care dates back further and assigns identification, prescribing, and refill responsibilities to lower-level facilities, although implementation has been constrained by workforce and funding gaps (Kigozi & Ssebunnya, 2009).

Institutional stewardship of NCDs has also been elevated: what began as a programme is now a dedicated Department of Noncommunicable Diseases Prevention and Control within the MOH, responsible for policy development, implementation, coordination, and monitoring. Uganda's NCD policy framework includes the national NCD policy, strategic plans, and the adoption of the WHO Package of Essential NCD Interventions (PEN) for primary care, which standardises screening, diagnosis, and treatment protocols and defines the medicines required at each level (MOH, 2023b; Rogers *et al.*, 2018). Governance is reinforced by partnerships beyond government. The Uganda NCD Alliance, the Parliamentary Forum on NCDs, the Uganda Initiative for Integrated Management of Noncommunicable Diseases (UINCD), academia, professional associations, and implementing partners such as the Clinton Health Access Initiative contribute to advocacy, capacity building in commodity quantification and forecasting, and service delivery innovation, including PEN-Plus (East Africa NCD Alliance, 2024).

A long planned National Health Insurance Scheme (NHIS) would add a pooled prepayment mechanism, but it is not yet operational. Parliament passed an earlier NHIS Bill in 2021, but the President did not assent to it and returned it for revision. In January 2025, the Ministry of Health reported that revised proposals were awaiting Cabinet approval before reintroduction to Parliament (Parliament of Uganda, 2025). In June 2026, passage and rollout of the NHIS Bill remained among the priorities identified in the outgoing health minister's handover recommendations (Ministry of Health Uganda, 2026).

3. Building the foundations: financing and implementation mechanisms

Despite chronic funding gaps and heavy reliance on external aid, Uganda utilises strategic budget prioritisation tools and integrated service delivery models to advance its primary health care and NCD coverage goals.

3.1 Using data to make NCD financing needs visible

Uganda has taken several steps to make NCD financing more visible within national planning and budget discussions. The National Multisectoral Strategic Plan for the Prevention and Control of NCDs identifies priority disease areas, links NCDs to treatment costs, productivity losses, and wider development objectives, and sets out implementation and monitoring arrangements. The plan is costed at approximately US$102.4 million (UGX 389.225 billion) over five years, with a substantial share of resources directed toward comprehensive and integrated NCD management (MOH, 2019). By attaching a defined resource requirement to national NCD priorities, the plan provides the Ministry of Health, Ministry of Finance, development partners, and civil society with a basis for budget dialogue and for identifying the financing mix required for NCD medicines and related PHC inputs.

NCDs account for a **NEARLY A QUARTER OF HEALTH SPENDING**, but **A LARGE PROPORTION OF THAT IS PAID OUT-OF-POCKET BY HOUSEHOLDS**

Priority setting work has reinforced this process. The Uganda NCDI Commission quantified the national burden of NCDs and injuries, highlighted its concentration among younger and poorer populations, and identified a package of high impact, cost-effective, and equitable interventions to inform investment and resource allocation decisions (Uganda NCDI Commission, 2022). Together, these exercises help shift NCD financing from a general policy aspiration toward a more explicit set of priorities and resource requirements.

Disease-disaggregated National Health Accounts provide a complementary view by showing how resources are currently being spent. These accounts estimated that NCDs represented 22.1%, 22.2%, and 23.9% of current health expenditure in fiscal years 2016/17, 2017/18, and 2018/19, respectively. Over the same period, OOP schemes accounted for 37.7%, 35.6%, and 38.6% of total health expenditure (MOH, 2021). These data highlight two issues at once – that NCDs already account for a substantial share of health spending, and that households continue to finance a considerable proportion of care directly.

Costing and expenditure tracking alone do not generate additional fiscal space or ensure medicine availability. Their primary value lies in defining the magnitude and structure of the financing challenge, identifying discrepancies between current spending and actual needs, and providing an evidence base for decisions regarding benefit design, budget allocation, procurement, and domestic resource mobilization.

3.2 Public financing, benefit design and PHC grants

Uganda's public financing base consists mainly of general taxation supplemented by external funding. Government resources are allocated to national institutions and decentralised local governments, including through conditional PHC grants. The country is also considering health promoting excise taxes, including on alcohol and sugar-sweetened beverages, as part of a broader domestic resource mobilisation and NCD prevention agenda (Ssegujja *et al.*, 2026). These measures can contribute to fiscal space and reduce harmful consumption, although additional revenue does not automatically translate into increased allocations for NCD services.

The 2024 Uganda National Essential Health Care Package (UNEHCP) gives NCDs an explicit place within the services the public system is expected to finance. Management and control of NCDs is one of seven service clusters and encompasses endocrine and metabolic diseases, cardiovascular diseases, disabilities and rehabilitation, mental health and substance use disorders, cancers, oral health, eye care, and palliative care. The package allocates 12% of projected resources to this cluster and is intended to guide resource allocation and investment across the health sector (MOH, 2024a). **This represents an important shift from recognising NCDs as a policy priority to specifying them within a costed package of publicly financed services.**

The PHC grant system provides an operational route for part of this commitment to reach frontline facilities. The PHC Non-Wage Recurrent Grant is allocated to health facilities to finance operating costs, with Ministry of Health guidance stipulating that at least 85% of the PHC non-wage recurrent allocation, excluding the hospital grant, should be directed to lower-level facilities (MOH, 2020). These operational resources matter for medicine access because chronic care depends on more than the commodity itself: functioning outpatient departments, patient registers, diagnostics, refrigeration where required, health worker time, follow-up systems, supervision, and referral all require recurrent financing.

The main limitation is the relative amount of resources available as compared to the commitments established through the benefits package. As previously mentioned, the Ministry of Health integrated quantification exercises estimated that NCD commodities faced a 99.8% funding gap in fiscal year 2023/24 and a 99.6% gap in 2024/25 (MOH, 2023c; MOH, 2024b). This gap is important because Uganda has been increasingly clear about what it intends the public system to finance, but the current level of funding for commodities is still much lower than what is needed to meet that commitment.

3.3 Medicines selection, procurement, and supply

The Essential Medicines and Health Supplies List for Uganda (EMHSLU) converts service priorities into specific medicines and supplies which the public health system should procure at each level of care. The 2023 list contains tracer medicines for NCDs such as antihypertensives, oral hypoglycaemics and insulin, cardiovascular medicines, and inhaled treatments for asthma and COPD. It is in line with the Uganda Clinical Guidelines and classifies products as Vital, Essential or Necessary, thus providing a basis for making prioritisation decisions when resources are limited (MOH, 2023a; MOH, 2023b). An economic analysis of possible changes to the diabetes medicines on the list also shows how budget impact and value for money can be used to guide decisions regarding the make-up of the publicly financed medicine package (Bonyani *et al.*, 2025).

Mental health medicines follow the same institutional process. Psychotropic medicines are covered by the EMHSLU and are intended to be procured and supplied according to facility level, consistent with Uganda's policy of integrating mental health into general and primary health care. Yet the implementation is still constrained by insufficient financing, a lack of workforce capacity, and the historical focus of mental health spending on hospitals (Kigozi & Ssebunnya, 2009; Ssebunnya *et al.*, 2018). Another example of how reforms in medicines policy and service delivery can lead to greater access to a previously overlooked essential treatment is Uganda's long-standing move to expand the availability of oral morphine for use in palliative care (Jagwe & Merriman, 2007).

The National Medical Store (NMS) is responsible for the central procurement and distribution of medicines to public facilities, with facilities ordering against defined credit lines. The Joint Medical Store carries out the same role for a large part of the private not-for-profit sector. Because procurement is centralised, it is possible to concentrate buying power, standardise the products, improve quality control, and offer a well-established distribution network, together with the credit-line system linking facility orders to a specific public budget (Lugada *et al.*, 2022). The National Drug Authority provides pharmaceutical regulatory oversight.

The institutional arrangements serve as means of ensuring efficiency and implementation, rather than as indicators of sufficient financing. Even with a developed procurement infrastructure, an insufficient commodity budget cannot be made up for. Persistent stockouts and inconsistent availability of antihypertensives, insulin, and other NCD medicines have been reported in public facilities, leading patients to rely on private pharmacies and OOP payments when public sector medicines are unavailable (Armstrong-Hough *et al.*, 2018; Armstrong-Hough *et al.*, 2020; Tusubira *et al.*, 2020). **Uganda therefore shows the distinction between having operational procurement mechanisms and providing them with sufficient resources to meet the needs of the population.**

3.4 Leveraging existing chronic care platforms

One of the most advanced examples of implementing PHC in Uganda is the integration of NCD care into existing HIV chronic care systems. HIV services have established the necessary infrastructure for long-term patient registration, clinical follow-up, laboratory monitoring, management of medicines, support for patient adherence, and differentiated service delivery. Research in Kampala, Wakiso, and other areas has examined how this infrastructure can be adapted to provide care for hypertension and diabetes in addition to HIV services (Birungi *et al.*, 2021; Bukenya *et al.*, 2022; Kivuyo *et al.*, 2023).

The INTE-AFRICA trial showed that integrated management of HIV, diabetes, and hypertension was feasible within standard health services and promoted patient retention and chronic disease management without the need for separate platforms specific to each disease (Kivuyo *et al.*, 2023). Further evidence from the INTE-COMM trial indicated that integrated community-based care achieved blood pressure and glucose control results that were similar to those obtained with integrated facility-based care (Kasujja *et al.*, 2026). Moreover, the Makerere University Joint AIDS Programme incorporated hypertension care into the Mulago HIV clinic, thus providing an example of how an existing chronic care system can be modified to offer treatment for NCDs (Muddu *et al.*, 2022).

Uganda is now applying this approach to a wider range of initiatives. The Ministry of Health's 2025 Roadmap for Health Services and Systems Integration aims at setting up integrated chronic care clinics to serve individuals with chronic conditions irrespective of whether or not they are HIV-positive (MOH, 2025). **This approach could be significant for countries that have made heavy investments in HIV-related infrastructure but are now dealing with an increasing burden of NCDs: by sharing staff, information systems, supply chains, refill procedures, and follow-up systems, efficiencies might be achieved compared with setting up separate NCD platforms.** The reform is still in its early stage. Although trial evidence shows the potential of integrated models when implemented under controlled conditions, routine evidence on outcomes for the wider group of non-HIV patients remains limited. Even if integration reduces duplication and improves efficiency, it does not remove the need to finance additional medicines, diagnostics, workforce, and other operational requirements for expanded NCD services.

4. Bridging the financing gap

The next challenge for Uganda is to convert its institutional foundations into sustained resource flows and effective coverage. The Health Financing Strategy and Uganda National Health Compact provide broader frameworks through which government health financing can become more predictable, pooled, and strategically allocated (MOH, 2016; Government of Uganda, 2025). It will still be important to increase domestic public financing, together with improved budget execution and closer alignment between quantified commodity needs, benefits package commitments, and procurement allocations. Health promoting fiscal measures may contribute to broader domestic resource mobilisation while also addressing NCD risk factors (Ssegujja *et al.*, 2026).

A national health insurance scheme could eventually add another prepaid pooling mechanism and decrease reliance on direct household payment. Insurance reform, however, would not by itself resolve the NCD medicine financing gap. Its contribution would depend on the services and medicines covered, the population entitled to them, the resources available to the scheme, provider-payment arrangements, and the capacity of procurement and supply systems to deliver covered products. It will therefore be necessary for greater pooling to supplement, not replace, adequate tax financing of PHC and the services offered to people who are unable to pay.

Efficiency improvements can accompany extra financing but cannot take its place. Integrated HIV and NCD care may allow Uganda to use existing chronic care infrastructure, staff, information systems, and refill mechanisms more efficiently, while centralised procurement can concentrate purchasing power and reduce duplication. However, both of these approaches will still need sufficient ongoing financing for medicines, diagnostics, staff, supervision, and for the running of the facilities. The same principle applies to mental health: integration of legal and policy aspects into PHC must be accompanied by financing for psychotropic medicines, community and outpatient services, referral, supervision, and appropriately trained personnel.

Uganda has established many of the prerequisites necessary to identify, justify, allocate, and utilise additional resources. The following step should be to secure financing commensurate with these commitments and to monitor whether the increased resources improve medicine availability, continuity of care, effective coverage, and reduced financial hardship.

5. Key takeaways for advocates

The example of Uganda shows that major financing reforms can begin even if fiscal constraints prevent adequate coverage of NCD medicines from being achieved immediately. Costed plans turn general commitments into specific requirements for resources; disease-disaggregated health accounts reveal current spending patterns and household burdens; benefits packages and essential medicines lists clarify the extent of public financing; and PHC grants and procurement systems create pathways for resources to reach service delivery points. Collectively, these measures strengthen the foundation for future budget negotiations and domestic resource mobilisation.

Uganda also demonstrates that policy inclusion does not equate to effective coverage. A costed plan does not create fiscal space, inclusion in a benefits package does not ensure a funded entitlement, an essential medicines list does not guarantee stock availability, and centralised procurement cannot offset insufficient budget for medicines. Advocates must therefore monitor financing commitments at all stages of the budget and implementation process, from priority setting and costing through to allocation, budget execution, procurement, facility financing, medicine availability, and household financial protection.

The integration of HIV and NCD services provides an additional example regarding efficiency. Countries with established chronic care platforms may adapt shared infrastructure, staff, information systems, and refill mechanisms instead of creating parallel delivery systems for NCDs. Although such integration can increase the impact of additional financing, it must be supported by explicit funding for the expanded services and products required.

In Uganda, sustainable financing has yet to be fully achieved. Although the institutional framework is increasingly established, the primary challenge remains securing sufficient funding to translate policy commitments into continuous access to medicines and effective, financially protected NCD and mental health care.

CONCLUSION

Different starting points, a common financing agenda

The three health system cases of Colombia, Nepal and Uganda demonstrate that sustainable financing for NCD medicines is established through a series of interconnected decisions, rather than a single reform. Governments are required to mobilise adequate public resources, determine resource pooling mechanisms, define publicly financed services and medicines, establish purchasing and procurement systems, organise chronic care, and monitor whether financing arrangements result in effective coverage and financial protection. Any weakness within this sequence can restrict access.

Each country begins this process from a distinct starting point:

- **Uganda has established many institutional prerequisites for enhanced NCD financing:** priorities are costed, expenditures are increasingly transparent, NCDs are included in the national essential health care package, and mechanisms exist for PHC financing and centralised medicine procurement. However, a significant gap remains between quantified needs and available NCD commodity financing. The immediate priority is to translate institutional readiness into substantially larger and more dependable resource flows.
- **Nepal presents a different combination of strengths and constraints, characterised by a relatively advanced connection between legal entitlement and a defined delivery model.** The constitutional commitment, Basic Health Services package, federal transfers, essential medicines list, and PEN/PEN-Plus platforms provide a pathway for delivering publicly financed NCD care across government levels. The primary constraints are the depth and consistency of financing, decentralised procurement and implementation capacity, and the persistent burden of OOP expenditure. The next steps should focus on reinforcing the links among existing policy instruments rather than developing an entirely new framework.
- **Colombia exemplifies the outcomes of a more institutionalised integration of financing functions.** National pooling, capitation, a comprehensive and enforceable benefits package, mechanisms for financing technologies beyond routine capitation, and pharmaceutical cost management policies have contributed to significant reductions in aggregate OOP spending. However, ongoing challenges related to effective access, resource flows, and sustainability indicate that no financing architecture achieves a final state where implementation and accountability are no longer necessary.

These differences are important for advocates and policymakers. A reform that is feasible and high priority in one setting may be premature or insufficient in another. Where NCD expenditure is poorly understood, costing and expenditure tracking may be critical first steps. Where services are already included in policy commitments, the priority may be to link benefit design to budgets and procurement. Where pooling and purchasing institutions are established, attention can shift toward strategic purchasing, price management, quality, effective coverage, and accountability.

The common principle is that policy commitments should progressively become financed and implementable entitlements. Costed plans, benefits packages, insurance laws, and essential medicines lists are important because they create the institutional basis for action, but they should ultimately be judged by whether people can obtain the medicines and services they need, continuously and without financial hardship. Therefore, the practical task for each country is to identify the most important bottleneck between its current financing arrangements and that objective, and to sequence reforms accordingly.

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