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ABBREVIATIONS USED

ACT	Artemisinin-Based Combination Therapy
AFDB	African Development Bank
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral
CBO	Community Based Organization
CHI	Community Health Insurance
CMR	
CORDAID	
DANIDA	Danish International Development Agency
DFID	Department For International Development
DAH	Development Assistance for Health
DTP	Diptheria, Tetanus and Pertusis
EC	European Commission
EED	
FB-PNFP	Facility-Based Private Not For Profit
GAVI	Global Alliance for Vaccines and Immunization
GDC	German Development Cooperation
GDP	Gross Domestic Product
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
GHWA	Global Health Workforce Alliance
GoU	Government of Uganda
HC	Health Centre
HIPC	Highly Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome
HSC	Health Service Commission
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IMR	Infant Mortality Rate
IRS	Indoor Residual Spraying
ITN	Insecticide Treated bedNets
JICA	Japan International Cooperation Agency
Km	Kilometre
LTFQ	Less Than Fully Qualified practitioners
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Disease
NDA	National Drug Authority
NGO	Non Governmental Organization
NHA	National Health Accounts
NHIS	National Health Insurance Scheme

NHP	National Health Policy
NMS	National Medical Stores
NRH	National Referral Hospital
NRM	National Resistance Movement
ODA	Overseas Development Assistance
OOPs	Household Out-Of-Pocket spending
OPD	Out Patient Department
ORET	
P4H	Providing for Health
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PFP	Private For-Profit
PNFP	Private Not-For-Profit
SACCOS	Savings And Credit Cooperatives
STI	Sexually Transmitted Infections
SUO	Standard Unit of Output
SWAp	Sector Wide Approach
TCMP	Traditional and Complementary Medicine Practitioner
TA	Technical Assistance
TB	Tuberculosis
THE	Total Health Expenditure
UAC	The Uganda AIDS Commission
UCBHFA	Uganda Community Based Health Financing Association
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHRO	Uganda National Health Research Organization
UNMHCP	The Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
UShs	Uganda Shillings
US$	United States Dollar
USG	United States Government
VHT	Village Health Team
WB MAP	
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

A Health Financing Review is an essential step in the process of shaping national health financing systems and strategies towards achieving universal coverage and social health protection. It contributes to guiding resource mobilization, pooling, allocation and utilization efforts so as to ensure that best and equitable outputs are achieved for the population receiving the health services. In Uganda, the HSSP-3, commencing in July 2010, presents an opportunity to take a new look at the country's health financing strategy.

Purpose of the review

The primary purpose of this review is to assist in the process of developing the national health financing strategy in Uganda. It provides an in-depth and comprehensive analysis of the national health financing system with a futuristic view so that the review results could be used in the development of the next health financing strategy and the Bill on National Health Insurance Scheme. The emphasis is on a comprehensive (quantitative and qualitative) analysis covering all potential sources of financing, including the health financing systems at Corporate level, at and below the district level and community-based mechanisms. A notable feature of the review is an assessment of institutional mechanisms associated with each health financing source.

The framework and methodology

The framework applied here is built on the overall premise that universal coverage, with particular emphasis on social health protection, remains the overall goal of health and health related activities in Uganda. That is, required health services will be delivered without any financial hardship to an increasing proportion of the Ugandan population, till the universal coverage is attained. The review is structured in a way to cover all health financing sources including, but not exclusively, the government funding. The report is organized under three major sections capturing the context within which the Health Financing System works; functioning of the existing national health financing system; and the future potential of various health financing sources.

Required quantitative and qualitative data were collected in three phases. The first phase comprising of document review and stakeholder consultation was carried out in August 2009 as part of a broader 'Providing for Health (P4H)' mission. The second phase (September-December 2009) reviewed the institutional capacity concerning the health financing system at the national level. The third phase (January-April 2010) collected additional quantitative data at the national level and conducted a detailed analysis of the decentralized and community-based health financing mechanisms. A total of 109 stakeholders were met during the first and third phases of the review.

Key observations

One of the key features of the first National Health Policy (1999) in Uganda is diversification of health financing in support of the national goals of improved health status and equity. At present, pluralism does exist in health financing, but not well coordinated to achieve the national health and health system goals. The review identified three distinguishable institutional mechanisms viz., direct purchasing, insurance and banking that are in operation in Uganda to channel financial resources from six primary sources of health financing viz., government, donors, employers, households/communities, philanthropists, and NGOs. Each health financing channel has its strengths (and weaknesses) and target population. Part of the challenge lies in the identification and better use of unorganized resources and their health financing mechanisms. More specifically, household, NGO and philanthropic resources and their channels of flow are not well documented or planned. This is also true, to a limited extent, to employer/corporate and donor resources.

The Government financing has maintained its portion of the General Government Expenditure within a narrow band (ranged between 7.5% in 2001-01 and 9.7% in 2004-05; 8.3% in 2008-09). However, there is still significant scope for an increase, with the increasing of GDP. Discussions between Ministries of Health and Finance could also fix a statutory minimum budgetary share for health (say, 10%) in order to avoid any fluctuation in resource allocation for health. In the longer term, it could be increased 15% in line with Abuja commitment. Significant improvement in value for money from Government resources is possible and service coverage improvements in the past were driven significantly by external resources. As an input into development of the Health Financing Strategy, the impacts of decentralization of resource management needs to be analysed, so that appropriate allocatively efficient targets for resource allocation and spending at different implementation levels can be identified.

External financing in health has been a significant portion of the overall finances available. A joint program of work, with investment priorities would act as a framework, to guide, and monitor investments towards allocative efficiency. The strategies to improve on the external resources therefore can be discerned, based on current trends, and sector priorities.

Philanthropic resources are currently not a recognized source of financing. As the country moves towards its new financing strategy, this potential needs to be looked into, so as to provide guidance with regards to the kind of strategies that needs to be employed to maximize this potential source of financing for health. These resources would represent a new source of financing for health in the country. They could free up existing resources for use in other priority areas, and also allow for implementation of some interventions that the sector was not implementing due to lack of financing.

Resources from the households are the dominant source of health financing in Uganda. At present, it is not clear how household resources are mobilized and what is being purchased out of them. Therefore, there is a need to develop a health financing strategy to streamline the mobilization and spending of such resources. This review provides an overview of some prevailing alternative institutional mechanisms to streamline OOPs.

Employers are a main source of financing for formal sector employees. However, some employees pay additional premium to avail additional services and/or pay premium for their family members who are not covered by the employer sponsored private insurance. They also don't receive any tangible health benefits from their social security contributions. In addition, employees also pay local service taxes. Some corporate agencies provide philanthropic resources to help the poor and other disadvantaged people.

Private not-for-profit facilities play a significant role in health care provision to the disadvantaged populations and have in the past not only reduced user fees but also flattened them selectively as a result of budget support from government. Government subsidies and contribution from external resources to the PNFP facilities actually benefit the marginal poor and the middle class by reducing their financial burden of accessing health care. It cannot be said to be benefiting the poorest because these facilities charge user fee, even if it is subsidized. The increasing dependence on user fees is likely to affect accessibility if the trend is not reversed. Although the government subsidizes PNFP health facilities, the level of subsidies has stagnated at about 20% of the total PNFP expenditures in the past few years.

Towards an integrated health financing system

Health financing challenges seem to co-exist with some promising options to overcome them to some extent. While challenges lie in the efforts to raise enough resources to appropriately finance health care, promises lie in the strength of the communities. As in many low-income countries, Uganda has certain community strengths, particularly organizational more than financial, which can be productively employed to address the challenges to some extent. In the past, there has been a strong emphasis on resource mobilization, with less emphasis on resource organization, pooling, purchasing, sustainability, equity and efficiency.

An approach that integrates various health financing sources, pooling mechanisms and purchasing types may be ideal for Uganda to create a win-win situation for all stakeholders. The approach needs to take into account the following:

- *Government is a dominant player with strong potential for provision and financing of health care, pooling of risks and resources, regulation and leadership.*

- *Government health care provision and financing are decentralized to some extent*
- *Decentralized planning process has its roots firmly set up, but is still evolving*
- *Households are a major player in health financing, particularly in resource generation*
- *Private sector (both for-profit and not-for-profit) has significant presence in health care provision, pooling (insurance) and financing (employer-based)*
- *Different variants of community-based financing mechanisms exist, but are based on local solidarity and risk pooling*
- *Philanthropic resources exist in different forms, but are not well coordinated.*

The government is in a better position to lead the proposed integrated system with adequate private participation in health care provision, pooling and resource mobilization; communities could bring in social and financial capital. This report provides a framework for such an integrated health financing system; it includes four major actors and six health financing functions. All the health financing functions are to be carried out under one umbrella to be steered by the government. Attainment of universal coverage requires an optimal and coordinated combination of all these actors and their mechanisms. Since four different actors with four different characteristics are involved, the institutional arrangement needs to be carefully worked out through a consultative process.

One area that requires immediate attention is the mapping of actors, their functions, strengths and weaknesses vis-à-vis community health care needs. The district health officers may be a in a position to map them in their own districts and could be consolidated at the national level for planning appropriate health financing strategies for the rural areas. A clear plan for the involvement of each actor as indentified in this report for each of the six functional areas concerning different sub-groups of population needs to be drawn in order to fix appropriate responsibility. Depending on the ability to perform the management role, a region or district could be used as a basic planning unit. This unit, under the leadership of an appropriate government body, could be represented by members from all the four key actors depending on their presence and strength in the respective areas. Activities of these units, facilitated as a sub-pool at the appropriate geographic level, should be integrated and pooled at the national level. Such an integrated system could pool budgetary (available for districts), community, NGO,

employer and philanthropic resources. Actors could also be involved in appropriate planning and budgeting activities of the entire pooled funds as well as monitoring and evaluation of the agreed on activities/strategies to spend the resources.

According to the integrated framework, each Ugandan resident will be clearly enrolled with one of the four actors, viz. government sector, private for-profit sector, private not-for-profit sector and the community-based mechanisms. While people could be given an option to enrol with any one of them, they should have the option to seek care from any health care provider, who is contracted by the integrated system. While the financial contributions and use of pooled funds under each actor could be jointly determined by a local committee, the fund holding role could be performed by individual actors or by a board as appropriate to the local context. Overall, conditions for fund raising, health care provision/purchasing, health care seeking, fund holding and use of funds could be locally determined, but nationally linked.

SECTION 1: CONTEXTUALIZING THE REVIEW

1 BACKGROUND

This chapter contextualises the health financing review. It describes health financing review and its utility, the economic context and past health financing reforms in Uganda.

1.1 Why a Health Financing Review

A Health Financing Review is an essential step in the process of shaping national health financing systems and strategies towards achieving universal coverage and social health protection. It is a critical instrument that helps a country to analyse the adequacy, organization, distribution and impact of its health investments in realizing the overall health goals. The review contributes to guiding resource mobilization, pooling, allocation and utilization efforts so as to ensure that best and equitable outputs are achieved for the population receiving the health services.

In Uganda, following the National Health Policy (1999), a 5-year Health Sector Strategic Plan (HSSP) guides the health system development in Uganda. Following HSSP-I and HSSP-II, the HSSP-III, commencing in July 2010, presents an opportunity to take a new look at the country's health financing strategy.[1]

1.2 Economic context

Uganda has had a stable political environment since 1986, when the National Resistance Movement (NRM) Government came into power. This has allowed the country to follow a consistent and predictable economic path. The economy has, as a result, been growing consistently, with an average GDP growth of over 6% during the years (1999-2009) of the First National Health Policy (Figure-1).[2] The 2008 GNI per capita of 1,140 (current international dollars) is higher than the African average GNI per capita of Int.$ 1,082.[3] The GDP growth rate has been accelerating in the immediate past, with the most recent (2007/08) GDP growth rate estimated at 9.8%. It continues to be solid, despite the vulnerability in the price of coffee, Uganda's principal export, and a consistent upturn in Uganda's export markets.

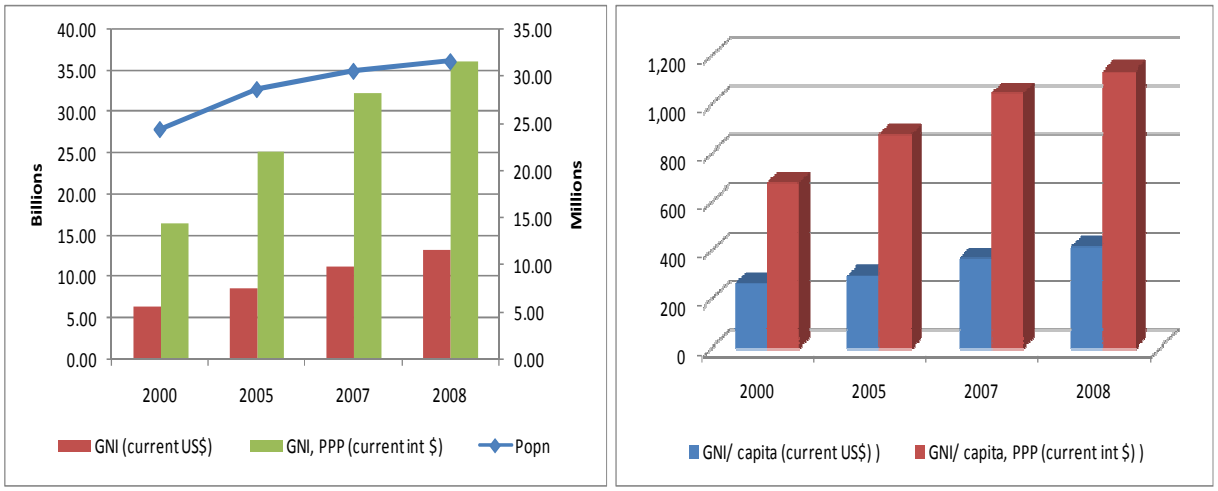
In 2000, Uganda qualified for enhanced Highly Indebted Poor Countries (HIPC) debt relief worth US$ 1.3 billion and Paris Club debt relief worth US$ 145 million. These amounts combined with the original HIPC debt relief added up to about US$ 2 billion.

The country has substantial natural resources, including fertile soils, regular rainfall, mineral deposits, and recently discovered oil. Agriculture, mainly the subsistence one, remains the main sector of the economy that employs over 80% of the work force. This explains why its contribution to the overall GDP is still small and consistently falling (Figure-2). It shows further that a smaller proportion of the population engaged in non-agricultural sectors is contributing to the country's economic growth. Nevertheless, significant progress has been made in

reducing the proportion of people living below the poverty line from 52% in 1992 to 31% in 2005.[1]

Figure-1

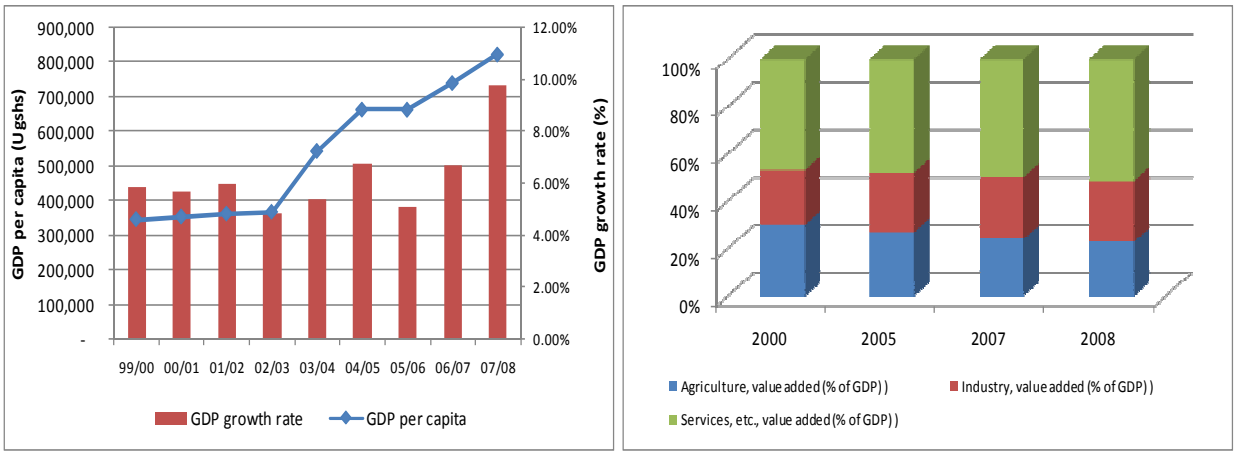
Uganda economic trends, 2000 – 2008



Source: World Bank: World Development Indicators database, September 2009

Figure-2

Trends in overall GDP, and sector contribution, 2000 - 2008



[1] *Uganda Bureau of statistics, National Household surveys, 1992, 2005*

1.3 Past health financing reforms

The National Health Policy of 1999 was largely guided by the Poverty Eradication Action Plan (PEAP), which detailed priority interventions of the Government of Uganda. It was also formulated within the context of the provisions of the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997) which decentralized governance and service delivery. The first National Health Policy and associated strategic plans have guided developments in health during 1999-2009. One of its key features is diversification of health care financing in support of the national goals of improved health status and equity. The National Health Policy 2010 is guided by the National Development Plan.

A number of changes have occurred during the period covered by the first National Health Policy. They are introduction of the Sector Wide Approach (SWAp), public-private partnership, abolition of user fees, introduction of the Uganda National Minimum Health Care Package (UNMHCP), autonomy for the National Medical Stores (NMS) and decentralization of the responsibility of delivering health services to local authorities. Some experiments with prepayment and community-based schemes too occurred during this period. In addition, there were other changes such as end of conflict in northern Uganda and the focus on recovery and development in the region, the huge increase in the number of districts, emergence of non-communicable diseases (NCDs), negative health consequences of changing climates, liberalization and privatization, constitutional reforms, civil service reforms, and broader decentralization efforts. The HSSP-1 too has introduced some key reforms affecting health financing.[4]

An earlier reform of relevance to the present-day health system is the decentralization of governance to districts with devolution of powers to allocate resources and deliver services (including health care). Initiated in the early 1990s, its key objective was to improve service organization and decision making that are more responsive to local needs, minimize duplication, increase accountability and encourage self reliance.[5] This reform modified the way health care services are organized and policies are formulated. Direct financing to Health Sub Districts (HSDs), the implementation units, was put in place, with their creation in 2000. The key innovation was in providing the funds direct from the centre to the HSD, not to the district, which was just another management unit. This implied they received funds, against plans they developed, for their operations. This reduced on the transaction time.

Another significant reform, initiated in 1997, was the provision of subsidies to the private not-for-profit (PNFP) health facilities.[6] These facilities receive government subsidies and are expected to provide health care at an affordable price, particularly to the poor. However, this objective of keeping the price affordable was achieved by some PNFP facilities while some others failed to do so probably because the government subsidy was inadequate and operational costs gradually increased.[7]

The removal of user fees at the point of use of services was effected in 2001. This made public health services free at the point of use, in all levels of care. A paying window was introduced for

hospitals that allowed them to raise additional revenue from clients that sought higher quality services. Service utilization has sustainably increased as a result of this financing reform.[8]

The sector has been utilizing Expenditure Tracking Surveys, and Expenditure Reviews as tools to monitor the efficiency of flow of funds, and funds utilization respectively. These have helped institutionalize a mechanism to monitor the financial management system on a regular basis since 2001.

The establishment of strict budgetary ceilings, and Sector Working Groups to manage available budgets has improved on budgetary discipline and, supposedly, allocative efficiency. At the community level, newer forms of community-owned, pre-paid and pooled health financing mechanisms surfaced since mid-1990s. They are gradually evolving into a viable financing option for health.

These strategies coupled with improvements in management and availability of inputs appeared to have resulted in an improved confidence in health care services and higher uptake of preventive, promotive and rehabilitative services. As a result, Ugandan health system has witnessed some positive developments in health care utilization. The odds of not seeking care in 2005-06 was estimated to be 1.8 times higher than in 2002-03.[6] At the same time, some sections of the population, particularly the poorest quintile and those in rural areas, continue to suffer and lack appropriate health care due to increasing cost of care and long distance to reach health care facilities.[2]

1.4 Report structure

This report is structured in a manner to allow for an in-depth and comprehensive analysis of the country's health financing system, in the context of supporting the sector achieve its overall goals. **Section-1** provides the review in context and introductory issues. It captures all the issues that are needed to understand the context within which the Health Financing System exists in the country. It has this introductory chapter, plus a chapter describing the Health Sector, and the review objectives and framework respectively. **Section-2** presents the heart of the analysis. It starts with a chapter on the overall analysis of the Health Financing situation and trends, followed by a chapter analysing the status, contribution, and institutional arrangements of each of the different health financing sources. **Section-3** then looks at the future of health financing in the country. It is based on the information from the first two sections. It looks at the potential future of the different sources of financing, and the institutional arrangements.

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[2] *Fiscal space for health in Uganda, 2009, World Bank, MoFPED and MoH*

2 HEALTH SECTOR IN BRIEF

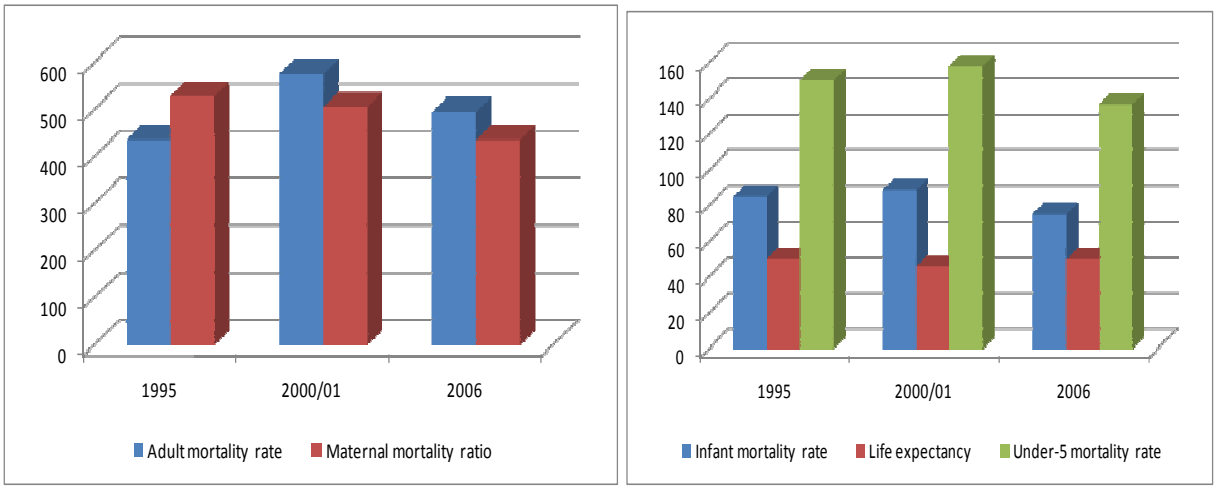
The country has made some small, but consistent improvements in overall human development and health in the recent past. There have been improvements in overall life expectancy, and in key health impact indicators. This provides relevant details (in brief) concerning the health sector in Uganda. Topics covered in this chapter are level and distribution of health status, health services organization and structure, and health service coverage trends.

2.1 Level and distribution of health status

Life expectancy has increased during the NHP period, following its reductions during the 1990s largely resulting from the HIV epidemic deaths. Life expectancy increased from 45 years in 2003 to 52 years in 2008; by 2006, it was as high as it was in 1990, negating finally the impacts of the HIV epidemic. This improvement is also reflected in the improvements seen in the key health impact indicators – particularly infant and under 5 mortality. Adult mortality had improved, from a high of 576 per 1,000 population in 2000, to 495 per 1,000 in 2006 (Figure-3). These indicators are still poor, but are showing movement in the correct direction. There, however, exist significant disparities in the health status, by urban and rural areas, and by the different regions of the country. The rural areas, and the northern region of the country bear the highest burden of ill health and death.

Figure-3

Trends in key health and health impact indicators



Source: Respective Demographic and Health Surveys, HSSP III

2.2 Health Services Organization and Structure

The focus of the health sector in Uganda is on the delivery of a defined minimum package of care, the Uganda National Minimum Health Care package (UNMHCP). It is a package based on

delivery of four clusters of packages: (i) Health Promotion, Disease Prevention and Community Health Initiatives; (ii) Maternal and Child Health; (iii) Prevention and Control of Communicable Diseases; and (iv) Prevention and Control of Non-Communicable Diseases (NCDs). While the first cluster includes health promotion and disease prevention through community health initiatives, the other three focus on programmes and strategies to handle the most common illnesses and conditions (Table-1).

Table-1

Uganda Minimum Health Care Package

<table>
<tr><th colspan="3">Cluster 1</th></tr>
<tr><th colspan="3">Health Promotion, Disease Prevention and Community Health Initiatives</th></tr>
<tr><td colspan="3">▪ Health Promotion and Education
▪ Environmental health
▪ Control of Diarrhoeal Diseases
▪ School Health
▪ Epidemic Disaster prevention, preparedness and response and
▪ Occupational Health</td></tr>
<tr><th>Cluster 2</th><th>Cluster 3</th><th>Cluster 4</th></tr>
<tr><th>Maternal and Child health</th><th>Prevention and Control of Communicable diseases</th><th>Prevention and Control of Non-communicable diseases</th></tr>
<tr><td>▪ Sexual Reproductive Health and Rights
▪ Newborn Health and Survival
▪ Management of common Childhood Illness,
▪ Expanded Programme on Immunization and Nutrition</td><td>▪ STI/HIV/AIDS
▪ Tuberculosis
▪ Malaria
▪ Diseases targeted for eradication and/or elimination (Leprosy, Guinea Worm, Sleeping Sickness, Onchocerciasis, Trachoma, Schistosomiasis, Lymphatic Filariasis)</td><td>▪ Non-communicable diseases
▪ Injuries
▪ Disabilities and rehabilitative health
▪ Gender based Violence
▪ Mental health & control of substance abuse
▪ Integrated Essential Clinical Care
▪ Oral health and
▪ Palliative care</td></tr>
</table>

Source: *Annual Health Sector Performance Report, 2009*[9]

The health system is decentralized up to the level of a health sub-district (HSD) under the overall leadership of the Ministry of Health (MoH). The National Health Policy devolved operational responsibility for delivery of the minimum package to the HSD. Each HSD management team is expected to provide overall day-to-day management of the health units and community level health activities under its jurisdiction. Its specific functions include:

- Leadership in the planning and management of health services within the HSD, including supervision and quality assurance
- Provision of technical, logistic and capacity development support to the lower health units and communities including procurement and supply of drugs.

Each Health Sub District is headed by a hospital, or Health Centre-IV, with a network of Health Centres-III and Health Centres-II providing the basic services, in line with their mandate, and capacities. The MoH has defined the functions and responsibilities of each level of health care and set the minimum service standards and staffing levels for each level.

Although significant progress has been made, many of the 214 HSDs have encountered difficulty in meeting the policy expectations. Constraints cited are related to

- Inadequate funding
- Recruitment, deployment and housing of personnel
- High rates of turnover of recruited staff
- Heavy workload resulting from combining clinical and health management functions of senior HSD personnel
- Low rates of completion and operationalisation of infrastructure

All these constraints have contributed to the lower-than-expected performance of the HSDs observed during the first Health Sector Strategic Plan (HSSP-1, 2000/01-2004/05).

The District Health System consists of various tiers under the overall direction of the District Health Officer. The District Health System comprises of a well-defined population living within a clearly delineated administrative and geographic boundary and includes all actors in the recognized spheres of health within the district. It is expected that the activities of the diverse partners in health are reflected in the District Health Sector Strategic Plan, which in turn is an integral part of the rolling District Development Plan.

Hospital services are provided by public, private not-for-profit and private health institutions (PFP). According to the 2010 Health Facility inventory, the number of Health Facilities owned by the public, private not-for-profit, and the private for-profit sectors are highlighted in Table-2.[1] Public sector owns 59.6% of the country's facilities, with the not-for-profit sector owning 17.6%.

The public hospitals are divided into three groups according to the level of services available and their responsibilities: general hospitals, regional referral hospitals and national referral

hospitals. The private hospitals are designated as general hospitals but the services they provide vary, with some providing specialist services usually found only in referral hospitals. Of the 102 hospitals in the country, 56 are public hospitals, 42 are private not-for-profit hospitals and 4 are private health practitioner hospitals. Lack of adequate resources is limiting hospitals in their effort to provide the services expected from them. In many instances basic emergency infrastructure, supplies and equipment for support services are inadequate. A National Hospital Policy has been formulated to streamline the role and functions of hospitals within the National Health System. The operationalisation of the new hospital policy is an integral part of the second Health Sector Strategic Plan (HSSP-2, 2005/06-2009/10).

Table-2

Ownership of facility, by type - 2010

FACILITY TYPE	VARIABLE	PUBLIC SECTOR	PRIVATE SECTOR		TOTAL
			For-profit	Not-for-profit	
Health Centre-II	*Total number*	1,562	964	480	3006
	Number per 100,000 population	*5.09*	*3.14*	*1.56*	*9.79*[3]
Health Centre-III	*Total number*	832	24	226	1,082
	Number per 100,000 population	*2.71*	*0.08*	*0.74*	*3.52*
Health Centre-IV	*Total number*	164	1	12	177
	Number per 100,000 population	*0.53*	*0.003*	*0.04*	*0.58*
Hospitals	*Total number*	64	9	56	129
	Number per 100,000 population	*0.21*	*0.03*	*0.18*	*0.42*
Total Facilities	*Total number*	2,622	998	774	4,394
	Number per 100,000 population	*8.54*	*3.25*	*2.52*	*14.31*

Source: Health Facility inventory, 2010

The National Referral Hospitals (NRH's) exist, either as general referrals (Mulago hospital), or specialized referral (such as Butabika hospital for psychiatry). These are currently operating with a high degree of autonomy, with separate votes and self accounting to the Ministry of Finance, Planning and Economic Development. These shall legally become fully autonomous if the Tertiary Institutions Bill is passed by the Parliament. In addition to the NRH's, other autonomous institutions exist, relating to specialized clinical services (Uganda Cancer Institute, Uganda Heart institute), specialized clinical support services (Uganda Blood Transfusion Services, National Medical Stores and National Public Health Laboratories), regulatory authorities such as the professional councils and the National Drug Authority (NDA) and research institutions; Uganda National Health Research Organization (UNHRO), Uganda Virus Research Institute, the Uganda National Chemotherapeutic Research Laboratory, Health Service Commission (HSC) and the Uganda AIDS Commission (UAC).

[3] *As per the estimated 2009 population of 30.7 million (as reported in the HSSP-III)*[1]

There is no administrative regional level supervision and mentoring support. The 'Area Teams' from the national level are designed around a pseudo region to provide some level of supervision. Regional Referral Hospitals (RRH's), however, exist. These operate as semi autonomous units and are self accounting, though to the Ministry of Health.

A Village Health Team (VHT) or Health Centre-1 facilitates the process of community mobilization and empowerment for health action. Each village would have a VHT comprised of 9-10 people to be selected by the community at the village level. The VHT is responsible for:

- Identifying the community's health needs and taking appropriate measures;
- Mobilization of additional resources and monitoring of utilization of all resources for their health programs including the performance of health centres;
- Mobilization of communities using gender specific strategies for health programs such as immunization, malaria control, sanitation and construction, and promoting health seeking behaviour and lifestyle
- Selection of Community Health Workers while maintaining a gender balance;
- Overseeing the activities of Community Health Workers;
- Maintaining a register of members of households and their health status and
- Serving as the first link between the community and the formal health providers.

The Health Centre-II represents the first level of interface between the formal health sector and the communities. It provides only ambulatory services, except in strategic locations where maternity services are being provided. An Enrolled Comprehensive Nurse is key to the provision of comprehensive services and linkages with the VHT.

2.2.1 Human resources

Health work force in the country is inadequate and is attracted towards greener opportunities provided by the private for-profit sector in and outside the country. The available human resources for health translate to only 8 Health Workers per facility (Table-3); 20% of them are at the National and Regional levels, with the largest number (35%) at the District/sub district level. Only 51% of the approved positions in government facilities at the national level were filled;[10] vacancies in Regional Referral Hospitals alone ranged between 13% for nurses and 54% for medical doctors.[9] The regional distribution remains highly inequitable disfavouring the areas that are poorly resourced in terms of social infrastructure and amenities.[11] Also, highly skilled professionals are better represented in urban areas.

Table-3

Overall Health Worker variables

LEVEL	VARIABLES	PUBLIC SECTOR
National referrals	*Total number*	2,323
	No. per 10,000 population	0.78
	No. per facility	1,162
Regional referrals	*Total number*	2,513
	No. per 10,000 population	0.85
	No. per facility	228
District / sub district hospitals	*Total number*	9,116
	No. per 10,000 population	3.08
	No. per facility	47
HC-3	*Total number*	6821
	No. per 10,000 population	2.30
	No. per facility	8.95
HC-2	*Total number*	4,051
	No. per 10,000 population	1.37
	No. per facility	3
Other (municipal, TC, etc)	*Total number*	90
	No. per 10,000 population	0.03
	No. per facility	
Total	*Total number*	26,371
	No. per 10,000 population	8.91
	No. per facility	11

Source: HRH Audit report, 2009. NB: No data readily available on NGO and private

The HSSP-II recognizes the critical role of the human resources and the Ministry of Health has directed its efforts towards increasing the staffing levels, improved training both in terms of Quality and Quantity as well as the provision of tools and an enabling environment for improved work performance and service delivery. The above efforts were further enhanced by the GHWA Kampala Declaration (March 2008) which emphasized the need for collective and sustainable Political, Structural, Systematic and Economic Interventions to check the global health workforce crisis. During the same period (2007-08), the Ministry developed a Master Plan for improved Health Service delivery which further underscored the significance of Human Resource for Health, among others.

2.2.2 Essential medicines

A major challenge to the health sector is the shortage of essential medicines. Over 74% of government health units reported monthly stock outs of any of the six tracer medicines in 2008-09; this indicates a significant increase from 65% in 2005-06.[11] The shortage gets

translated into lower use of outpatient care services; districts that spent all their essential medicines budgets had higher use of OPD services probably due to lower stock-out of medicines. However, there is no district specific information available on medicines stock-outs. Many research studies too have linked use of health care services by the population to availability of medicines.

2.3 Health Service coverage trends

Seventy two percent of the Ugandan households live within 5 km from public health care facilities.[8] An additional 10.5% have access to other health facilities indicating that 82.5% of the Ugandan households have access to any health care facility within 5 km radius. Many existing government facilities, however, lacked basic infrastructure and other essential inputs. Less than 25% of facilities have all essential equipment and supplies for basic antenatal care (blood pressure machine, foetoscope, iron and folic acid tablets, and tetanus toxoid vaccine) while basic equipment and supplies for conducting normal deliveries (such as scissors or blades, cord clamps or ties, and a disinfectant) are available in only 33% of facilities offering delivery services.

The expansion of private health providers has largely been unregulated; the pharmaceutical sub-sector is, however, better regulated. Most medicines are imported and distributed by the private sector; about 90% of all medicines are imported and close to 95% of them are generic products. The cost of medicines is 3-5 times higher in private sector. Even though the private sector provides 40% of health care services, it is not integrated with the public sector to fully take advantage of each other. However, the government has established a public-private partnership in health whose functioning needs to be expedited.

Approximately 60% of Uganda's population seek care from traditional and complementary medicine practitioners or TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydrotherapists and traditional dentists) before visiting the formal sector.[10] While 94% of women aged 15-49 years, who had a live birth during 2001-06, made at least one antenatal care visit, only 42% made a return visit and 40% of the live births took place in a health facility.

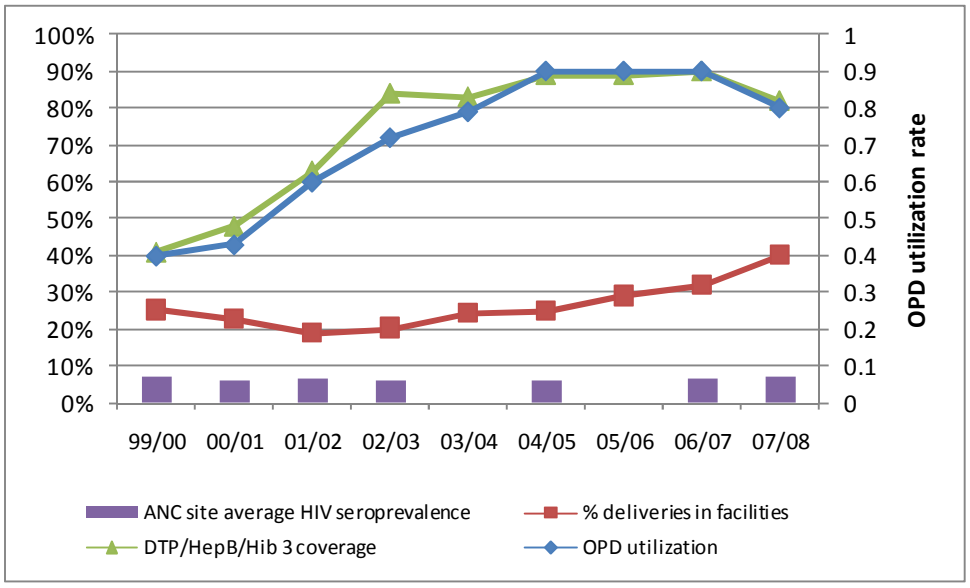
Health service delivery has been scaled up since 2000, with many new commodities and interventions introduced into the Health Service Delivery System. These include interventions to deliver the new vaccine antigens (Hepatitis B, Hib), ARV therapy, ACT's, IRS, and ITN's in malaria control, among others. As a result, the number of interventions and services available to the population in Uganda has tremendously increased. The HSSP-1 and HSSP-2 reviews illustrate the trends in the service coverage indicators during the past few years. Some selected trends in indicators, corresponding with the PEAP indicators, are illustrated in Figure-4.

There are three distinct sets of trends that are discernable. **The first set** relates to those services, for which significant improvements have been made in the coverage with services, and are currently peaking off in terms of coverage improvements. These are illustrated in

Figure-4 by trends of DTP-3, and OPD utilization indicators. This may reflect a failure of available strategies to improve uptake and use of available services, calling for a re-think of the strategic approach needed to jump start the required improvements. As an example, the OPD utilization rate of 0.8, while an improvement from 0.4 at the beginning of the policy, is still very low. **The second set** relates to those services for whom there are slow, but steady improvements in service coverage's. Facility deliveries indicator best captures this set of services. For these, the sector will need to re-think its approach to improving the coverage's in a more accelerated manner. **The third set** relates to those services for which progress has stagnated, or even may have reversed during the past years. The ANC site average HIV sero prevalence indicator best illustrates these set of services. Strategies to halt the decline, and reverse the declining trends are needed by the sector to address these trends.

Figure-4

Trends in selected indicators, 1999 – 2008



The HSSP-III (to commence in July 2010) presents the opportunity to address the specific requirements of these three sets of trends in service coverage that different interventions in the sector are facing.

3 OBJECTIVES, METHODOLOGY AND FRAMEWORK OF THE REVIEW

The current review takes stock of the health financing scenario in the country with a futuristic view so that the review results could be used in the development of the next health financing strategy and the Bill on National Health Insurance Scheme. This chapter details the objectives of the review, framework used, methodology and data sources.

3.1 Aim, and objectives

The main objective of the review is to assist in the process of developing the national health financing strategy in Uganda. The emphasis is on a comprehensive (quantitative and qualitative) analysis covering all potential sources of financing, including the health financing systems at and below the district level and community-based mechanisms. The key aspect of the review is an assessment of institutional mechanisms associated with each health financing source.

3.2 Framework for the review

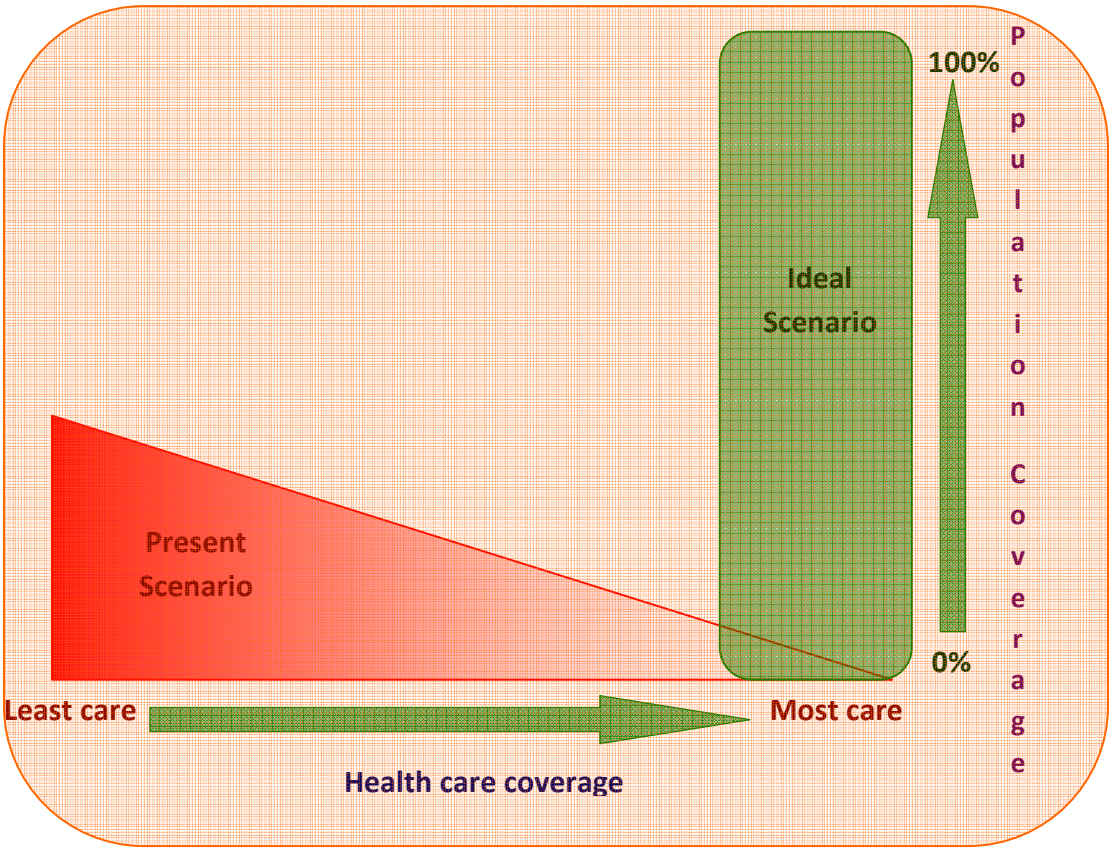
The review builds on the overall premise that universal coverage, with particular attention on social health protection, remains the overall goal of all health and health related activities in the country. That is, required health services will be delivered without any financial hardship to an increasing proportion of the Ugandan population, till the universal coverage is attained. There are critical gaps in the coverage of population, health care service and financing in Uganda.

- Only a very small proportion of Ugandan population probably receives adequate, appropriate and affordable health care; only 33% of deliveries occurred in government or private not-for-profit facilities in 2007-08.[9]
- Many others receive partial health care from qualified or less-than-fully-qualified practitioners (LTFQs) and incur household out-of-pocket spending.
- Share of prepaid resources in private health spending declined from 0.3% in 1998 to 0.2% in 2007.[12]
- Out of pocket payment for health care is still significant because of the extensive use of the private sector. PNFP and the Private sector continue to charge fees.
- Many people use more than one health provider for a given illness episode. As a result, they incur costs while accessing non-government health care providers, even though the public services are free.
- There are varying levels of quality of care available with the free public services, with many public providers not able to provide the expected scope of services.

These service gaps can be illustrated using the Figure-5. In the figure, the horizontal axis reflects the level of health care service provision or access while the vertical axis indicates the proportion of population receiving appropriate health care. The Ugandan scenario can be explained by the triangle (mostly covering the horizontal axis) which indicates that a section of population does not receive any or least care with only a very small proportion receiving the most appropriate care. The ideal scenario is explained by the rectangle (mostly covering the vertical axis) where the entire population receives the most appropriate care for their illnesses.

Figure-5

Universal coverage - a long hard way to go



So, the immediate task in Uganda is to extend the coverage beyond the current levels of population, health care service and financial provision coverage. From the health financing point of view, achievement of Universal Coverage should be done in a manner that ensures social protection, so as to ensure households are not prevented from seeking care owing to financial constraints or impoverished as a result of accessing, and/or using health services. This move towards universal coverage entails improving the health care financing strategic approach towards ensuring an increased

- Proportion of population is covered

- Number of services in the defined benefit package is made available
- Financial risk protection through prepayment

At the other extreme are people not receiving any care; in essence, the health care triangle (Figure-5) needs to be reworked. In the past, an increased government spending on health seems to have resulted in an increased health care coverage in Uganda.[13]

This health financing review is designed to cover all financing sources including, but not exclusively, the government funding. According to the framework (Figure-6), the final goal is to achieve universal coverage by achieving the key objectives of resource adequacy, equity and efficiency through the health financing functions of resource generation, risk/resource pooling and purchasing. Three institutional mechanisms viz., direct purchasing, insurance and banking are considered to channel the funding from six distinguishable sources of financing viz., government, donors, employers, households/communities, philanthropists, and NGOs. Eight attributes are used to assess the performance of the health financing system in achieving the desired objectives and goal.

3.2.1 Sufficient and sustainable resource generation (resource adequacy)

This objective is concerned with the health sector's ability to raise sufficient resources that are predictable in a manner to deliver health services (preventive/promotive, curative and rehabilitative) it has defined it needs to deliver (the UNMHCP). Two performance attributes are relevant for follow up:

- Level of funding
- Sustainability of funding

In other words, resource generation has two dimensions viz., adequacy and sustainability. It is necessary to generate enough resources in a sustainable manner. Domestic resources through taxes and other prepaid mechanisms are a preferred option to make health financing sustainable.

3.2.2 Equitable financial access

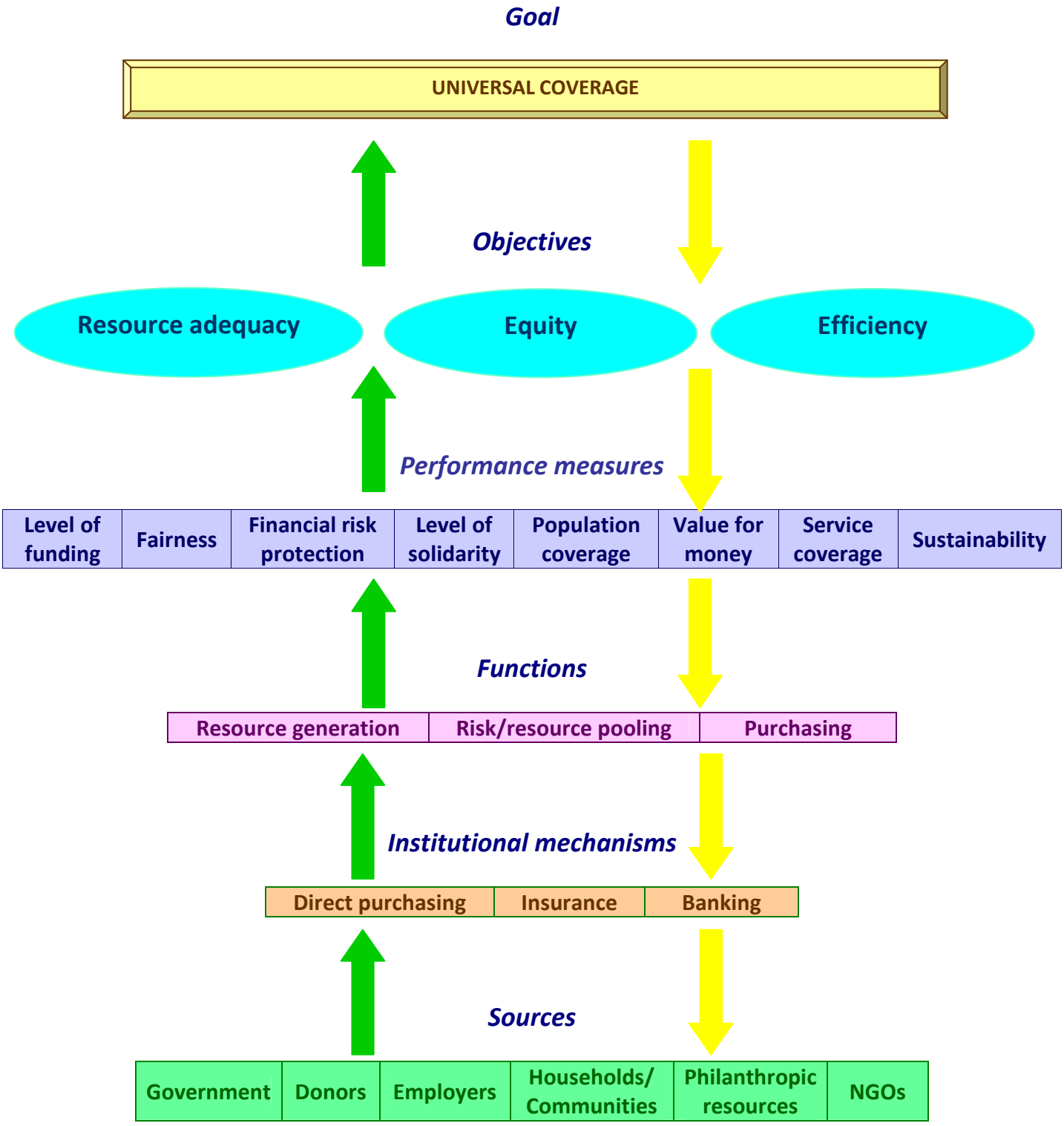
This objective deals with the level of financial access. It aims to separate the use, and financing of services, and is based on the premise that access and use are determined by need and payment by financial ability. Four performance attributes could be used for follow up:

- Extent of population coverage
- Level of solidarity
- Financial risk protection
- Fairness in financing

As a first step, it is necessary to bring the entire population under a prepaid, predictable and sustainable health financing mechanism. At the same time, the healthy and the rich need to cross- subsidize the sick, the poor and other disadvantaged populations; the level of such cross-

Figure-6

Framework for the Health Financing Review



subsidization indicates the level of solidarity. Moreover, ideally, those who need health care should not be prevented from seeking care due to financial constraints; those who succeed in seeking care when needed must receive optimal and not partial care. They also must not get impoverished or spend high disproportionate to their come. Fairness in financing requires that resources are spent without discrimination or differences in how people are treated.

3.2.3 Optimal use of resources (efficiency)

This objective is about the value for money. It is based on the premise that existing resources should be used in a manner that ensures the highest possible benefit to the users. Two performance attributes could be used for follow up:

- Value for money
- Service coverage

Value for money is achieved when services are provided in a cost-effective manner. On the other hand, service coverage means provision of maximum range, quantum and choice of services using the existing resources.

3.2.4 Sources of financing and their institutional mechanisms

An analysis of health financing sources and their institutional mechanisms is important in order to plan for an optimal utilization of the existing resources. In Uganda, there six distinguishable sources of financing; they are

- Government revenue (tax and non-tax)
- Donor funding (bilateral and multilateral agencies)
- Household resources (own and borrowed)
- Resources mobilized by the NGOs
- Employer or corporate resources
- Philanthropic resources (domestic and international)

Each one follows a different institutional mechanism to mobilize pool and spend the resources. All the institutional mechanisms used by these six sources of health financing can functionally be grouped under three broad heads:

- Direct purchasing (government provision and out-of-pocket spending)
- Insurance (national, private and community-based)
- Banking (formal and community-based)

Direct purchasing method is used by all the sources whereas insurance is employed by the employers, NGOs, and households. Banking as an institutional mechanism is predominantly used by households, particularly microfinance clients.

The health financing review not only looks at the amounts of resources available from the different sources of financing, but also the institutional arrangements that are used. This should provide information, not just quantitative information on resources, but also more qualitative information on the scope of different institutional mechanisms most suited for future health financing.

3.2.5 Performance attributes

Broadly, six performance attributes are identified taking into account the objectives and the availability of data. For each performance attribute, selected indicators could be used to probe into the progress made by each health financing performance attribute. Health financing objectives, performance attributes and the associated indicators are given in Table-4. Information for each indicator is sought, not just for the most current values, but also on past trends so as to provide a picture on whether the sector is making progress or not. Additionally, where feasible, information from peer countries is compared with the Ugandan achievement.

3.3 Methodology and data sources

The methodology uses a mix of qualitative and quantitative techniques to collect the required data and information on various sources of financing, their institutional mechanisms and their potential capacity and/or limitations to serve the ultimate goal of the universal coverage. Various government documents including the sector reviews, policy statements and the budgets were collected and analysed. Besides, the review team also carried out field visits to understand the community organization of health financing (and the resultant access to and utilization of health care services), health care provision and district level decision making under the decentralized health care service provision. Stakeholder interviews were conducted with community members, health care providers (government, PNFP and private) insurers (private, provider-based and community-based), employers, NGO facilitators, policy makers and academic experts. Besides, there were focus group discussions with some stakeholders.

Data collection was carried in three phases. The first phase of the data collection coincided with the 'Providing for Health (P4H)' mission in August 2009. Key documents were collected and referred to in addition to meeting various stakeholders in person and in groups. The second phase occurred during September-December 2009 when an institutional review was carried out by the MoH staff to collect information of the institutional capacity at the national level. The third phase was carried out by a team of MoH and WHO staff during January 2010. This phase focused on additional quantitative details as well as decentralized and community-based health financing options. Details of 109 stakeholders met during the 1st and 3rd phases are given in Table-5.

Table-4

Performance attributes and indicators for health financing assessment

FINANCING OBJECTIVE	PERFORMANCE	
	Attribute	**Indicator**
Resource adequacy	Level of funding	Per Capita Total Health Expenditure (US$)
		Government Health Expenditure as % of THE
		Government Expenditure on Health as % of Total Government Expenditure
		Per capita number of Human Resources available for Health
		Number of hospital beds available per capita
	Sustainability of financing	External funding as % THE
		% HH expenditure spent on health
		Total health expenditure as % of HH expenditure
Equity in financing	Fairness in financing	Per capita OOP expenditure on health for the richest quintile
		Per capita OOP expenditure on health for the poorest quintile
		% HH income spent on health for the richest quintile
		% HH income spent on health for the poorest quintile
		% population not receiving care due to lack of finance
	Financial risk protection	% HH incurring catastrophic Health Expenditure
		OOP as % of THE
		Pre-payment ratio
	Level of solidarity	% population in a health financing pooling scheme
		Number of pre-payment schemes
		Average target population for each scheme
		% target population participating in a health financing pooling scheme
	Geographic access	% population living within 5 km of a health care facility[IV]
Resource use efficiency	Value for money	Wage to non wage expenditure ratio[V]
		OPD attendances vs. public expenditure[VI]
		DTP 3 vaccinations vs. public expenditure
		Facility deliveries vs. public expenditure
	Service coverage	Per capita non wage expenditure
		Per capita OPD
		ANC coverage
		DTP-3 coverage
		% births attended by skilled attendants

[IV] *Providing a minimum range of essential health care services*

[V] *This indicator has to be handled carefully. Although proportion of non-wage expenditure in total expenditure is a key indicator of the quantum of health care services delivered, there is no blueprint on the optimal ratio. It depends on the level of facility and health care needs of a community.*

[VI] *It needs to be interpreted with caution; not all OPD, deliveries and DPT3 are delivered using public expenditure.*

Table-5

Details of stakeholders interviewed

STAKEHOLDER	NUMBER OF PERSONS MET
Policy makers or bureaucrats	31
Community members	18
Associations	13
NGOs	12
Insurance providers	12
Health care providers	10
Academicians	9
Development partners	2
District health officials	2
Total	**109**

Field Offices visited

1. Association of Microfinance Institutions of Uganda, Kampala
2. District Health Office, Luwero
3. Kakabala Parish credit-based Community Health Financing Scheme, Luwero district
4. Kamuli Credit-cum-insurance scheme, Luwero district
5. Kira Health Centre-III, Wakiso District
6. Kitovu Community Health Insurance Scheme, Masaka District
7. Kivoko Hospital, Nakaseke District
8. Makerere University, Faculty of Economics and Management, Department of Development Economics
9. Save for Health Uganda, Luwero
10. Uganda Martyrs University, Nkozi
11. Uganda Community Based Health Financing Association Office, Kampala

SECTION II: ANALYSIS OF THE HEALTH FINANCING SYSTEM

4 HEALTH FINANCING OVERVIEW

The national health policy calls for diversification of health care financing in support of the national goals of improved health status and equity. Uganda also faces the challenge of an increasing demand for health care and a growing private health sector. This chapter provides an overview of the health financing scenario in Uganda. It covers adequacy, equity and efficiency of financing as well its overall performance.

4.1 Level and sustainability of funding for health

The health financing system at present is designed around the need to finance the Uganda National Minimum Health care Package (UNMHCP). This package represents the set of interventions that the Health System is striving to provide to the Ugandan population. Financing for this is primarily from the Government, Donors, and households/communities. However, the extent of government influence on the donor and household/community resources to achieve this goal is unclear.

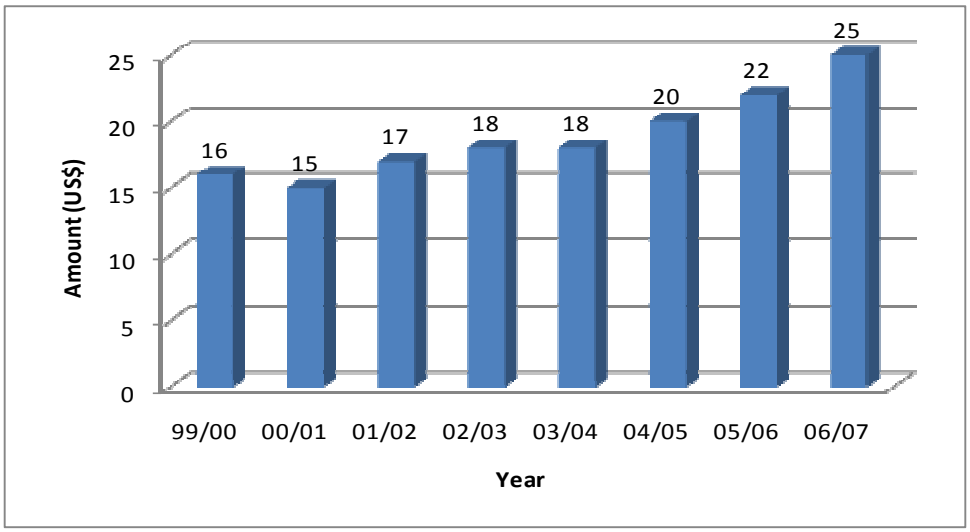
The estimated per capita annual health expenditure in Uganda in 2007 was US$ 27;[12] the government and donors accounted for half of this and another half was from private out-of-pocket spending. During the period of the current National Health Policy, it has consistently been increasing each year, as shown in Figure-7. Per capita government health expenditure ranged between US$ 4 and US$ 7, which is below the estimated cost (US$ 28) of delivering the minimum package (excluding the cost of expensive interventions like ACTs, ARVs, ITNs and Pentavalent vaccine) in Uganda,[14] and the estimated $34 target of the Commission for Macroeconomics for Health.[15]

Money available for the purchase of non-salary inputs particularly remained constant from 2003-04 to 2007-08.[10] Current per capita expenditure on essential medicines is only US$ 0.87 against an estimated requirement of US$ 2.4 per capita (excluding ARV's, ACT's ITNs and the pentavalent vaccine). Due to this, only 35% of the health facilities have six tracer medicines and supplies.[VII] When medicines are not available in public facilities, patients must buy from private facilities or pharmacies and, as a result, out-of-pocket expenditure on health remains high. Global Initiatives provide the bulk of resources needed for malaria, HIV/AIDS, tuberculosis, vaccines and reproductive health commodities. The sector is under-funded partly due to an increased cost of service delivery owing to the pressures of global human resources for health market that has driven up salaries, more costly service delivery standards, and adoption of new technologies and less-than-optimal efficiency levels.

[VII] *The tracer medicines and supplies are: (Coartem; Fansidar, Depo Provera (injectable contraceptive), ORS, measles vaccine, co-trimoxazole).*

Figure-7

Uganda Per capita Total Health Expenditure (US$)



Source: WHO Statistics estimates for Uganda, and National Health Accounts

Two key observations are made from this pattern, which is critical to the overall Health Financing goals.

Firstly, we see the significant increase in the expenditure, from an expenditure of 16 US$ per person in 1999-2000, the current total expenditure on health at over US$ 27 per person per year (69% increase in total health expenditure). This is less than the current estimates for provision of an appropriate basic package of services at US$ 34 per person per year in low income settings, as was defined by the WHO Commission on Macro economics and Health

Secondly, the pattern of increase shows a consistent increase as opposed to sudden, one – off increases. This pattern is desirable for a system that is consistently working towards increasing on its coverage of critical interventions, and suggests increases in financing which are most probably being matched to specific service coverage targets. This is consistent with the patterns seen in the implementation of the basic package of services, with an increasing coverage for a number of interventions, plus an increase in number of new interventions during this period.

Other analysis of the Health Expenditure patterns requires that we understand the components of this overall health financing picture.

4.2 Health financing sources and accessibility

Prior to the policy, the National Health Accounts carried out in 1997/98 showed that the contribution from the donors represented the main source of expenditure, at 43% of the Total Health Expenditure. Private sources (households, and to a smaller extent, employers) were the

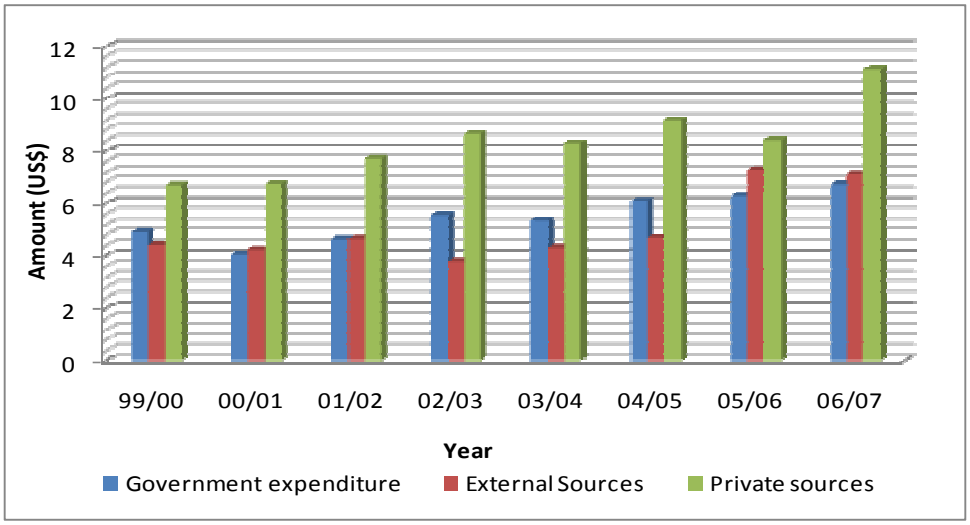
source of 36% of this expenditure, and with public sources contributing only 21%. This represented an inadequate health financing situation as:

- Non sustainable sources represented a significant portion of the total health expenditure.
- The high out-of-pocket expenditures represented a significant financial risk, particularly to the poor who are more easily pushed into catastrophic health expenditure without any means of social protection.

During the period of the policy, up to 2006-07, when the last realistic estimates are available, the trends in the different contributions, from WHO estimates, are highlighted in the Figure-8.

Figure-8

Contributions to Total Health Expenditure by key sources



Source: NHA, WHO Statistics

These trends suggest that

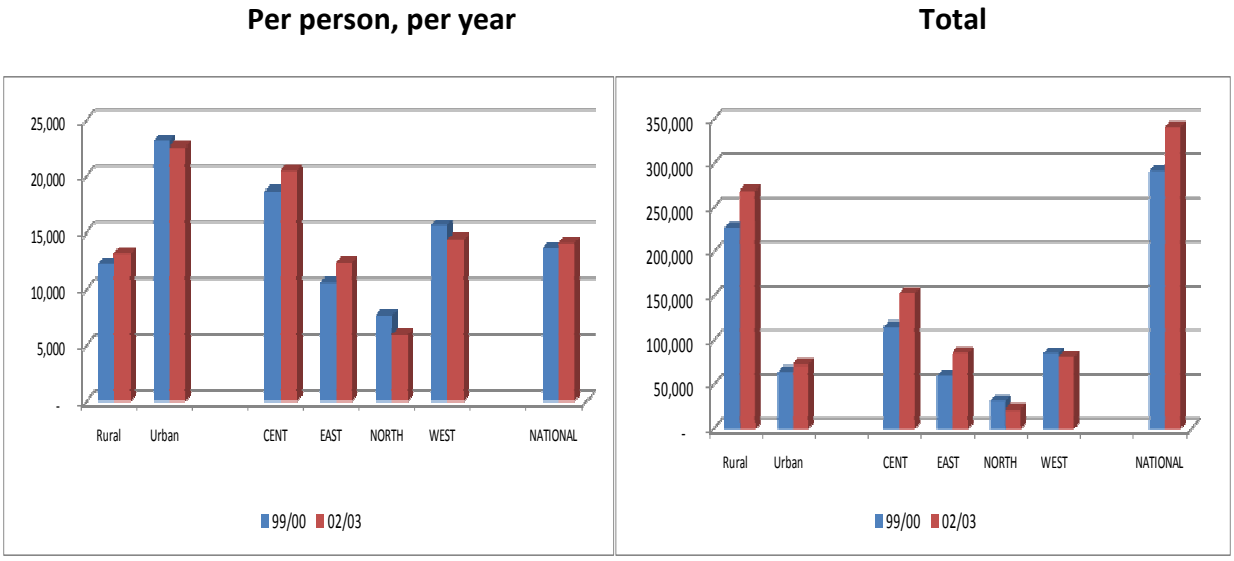
- Domestic resources constitute about 70% of the total health expenditure in Uganda.
- Contribution from the external sources fluctuated, with a significant increase in 2005-06. A portion of the external funds remains off-budget.
- Private or household sources continue to contribute the largest portion of the total health expenditure, with their contributions increasing. In 2006-07, per capita private health spending is about 70% higher than the per capita government spending on health.

The overall pattern, therefore, of unsystematic flow of financing for health has not changed, though overall health expenditure has increased. Unsustainable and non-solidarity forms of health financing are still predominant in the health financing landscape in the country.

A further look at the household health expenditure by location shows that there exist significant disparities in expenditure, based on where people reside (Figure-9). Persons living in urban areas are spending significantly more on health, than persons living in rural areas. A regional analysis shows persons living in the north, and east of the country are spending significantly less than persons living in the west, and central parts of the country. This pattern is similar to income trends which indicate lower capacity to pay.

Figure-9

Household health expenditure by location



Source: Household Surveys

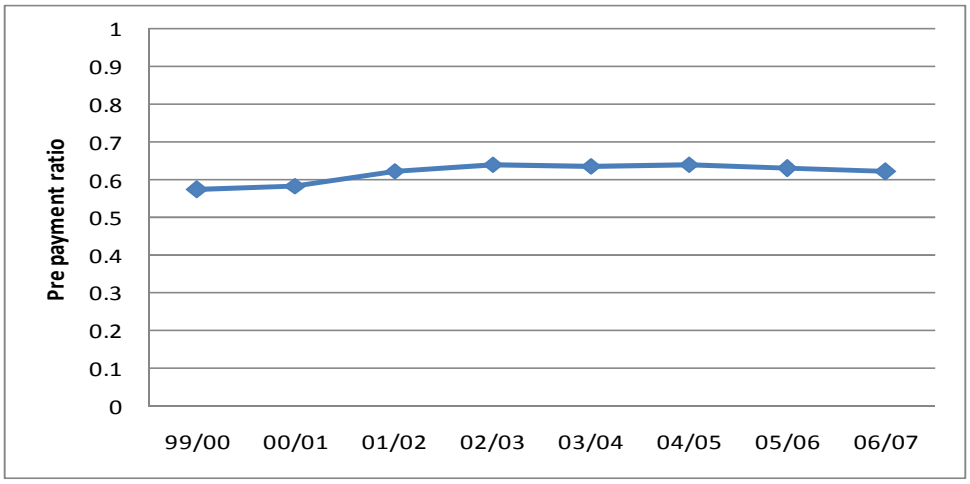
There is little evidence of solidarity in managing health expenditures at present. Prepayment schemes were only 12 at the start of the policy, with one closing during the period of the policy. Coverage of the target population for different schemes is mixed, though some have significantly higher population and service coverage. Prepayment through government and donor resources has largely been stagnant, with a slight improvement in 2001-02, corresponding with the period when user fees were removed in all public facilities (Figure-10).

This suggests that, apart from the removal of user fees, there have not been other policy moves that have impacted on limiting of financial barriers to accessing care when needed, with the prepayment ratios having stagnated since then. However, the Government of Uganda provides subsidy to the not-for-profit private sector to enable them reduce fees charged such that even

the poor are able to access services from these facilities. The level of subsidy is about 20%. Subsidies have been extended to a few private hospitals too.

Figure-10

Prepayment through government and donor resources



Source: WHO internal calculations, based on proportional contribution to THE

4.3 Optimal use of resources

Whether the population is getting adequate value for money is difficult to objectively ascertain, particularly when a large portion of the resource flow into health is unorganised. However, there are a number of pointers towards this, from the available information. It should be emphasized these are just pointers, and are best interpreted together, as opposed to drawing inferences on value for money from one variable of analysis. We look at the following areas for pointers:

- Comparison of impact of interventions in Uganda, with countries of similar health expenditures
- Comparison of trends in expenditures, against the coverage of key services (pentavalent 3, OPD and facility deliveries)
- Look at general coverage trends for key indicators

Looking on the other hand at the trends in investments in health, the respective annual reports of the Ministry of Health have shown the significant limitation in funding available for the Ministry to actualize its plans. In spite of this, the period of the health policy has been characterized by increases in the number, and coverage's of key health service interventions. Improvements in coverage attained have been highlighted in Chapter-2 of this report.

Additional interventions introduced, among others, as shown from the HSSP II review, include the following:

- Newer, more efficacious malaria treatment outputs (ACT's)
- Introduction of Insecticide Treated Materials for protection against malaria, particularly for children and pregnant women
- ART therapy, and other more comprehensive care approaches for persons living with HIV/AIDS
- Hepatitis B, and *Haemophilus influenza* type B vaccine for children
- Home Based management of fever approach
- Direct Observed Therapy, Short Course, for TB control
- Etc.

Additionally, key organizational changes were introduced, that were aimed at improving management of services. These include the creation of Health sub Districts for decentralized service delivery, introduction of the community approach, through Village Health Teams, among others. These interventions were directly targeted at the assumed major causes of ill health and death. Their interest to a Health Financing Review is in looking at what the Health Services were providing with their available resources during the course of the past years. It is clear that more services are being purchased, with the increasing health expenditure. Whether such purchases are allocatively more efficient, and so maintaining higher value for money would require a more detailed expenditure analysis that is beyond the scope of this review. However, we can probe into this, by comparing outputs being attained with peer countries.

The current estimates of Total Health Expenditure and health impact indicators (IMR and CMR used) compares with other similar countries as highlighted in Table-6. These are, however, crude comparisons because health investments don't get translated into health outcomes immediately. Among the African countries, Uganda appears to provide relatively good value for money, when CMR is compared with THE. It is better than the SSA average, though some countries (such as Tanzania) are able to do better. However, when compared with other countries beyond Africa, then the performance is not good. This suggests there may be some intrinsic factors within African countries including Uganda that are hindering adequate value for money from the health investments. However, the available data does not allow for a sector wide analysis of management, vs. service delivery data. This we shall therefore analyse for the respective sources of financing.

4.3.1 The Uganda Health SWAp[VIII]

Through facilitation from WHO, and with strong political leadership from the Ministry of Health, development partners and government agreed on a health SWAp arrangement in 1999. The improved cooperation between government and development partners was also instrumental

[VIII] *Largely based on Örtendahl 2007.*[15]

in the translation of the NHP into an operational plan – the Health Sector Strategic Plan I 2000-2005 (HSSP I) – which was launched in 2000, and followed by the HSSP II (2005-2010) in 2005. At the start of the sector-wide approach in Uganda in 2000, key issues faced by the health sector were:

- Poor health indicators.
- Serious shortage of funding to the sector.
- Weak health care organization and management, with especially low capacity at district level.
- Inadequate public-private partnerships.
- Inefficient allocation of resources at district level
- Disproportionately high national spending on tertiary care
- Disparities between different population groups and regions

The National Health Policy (NHP) was developed in the late 1990s as a result of the Poverty Eradication Action Plan (PEAP) planning process, and benefited from improved cooperation between government and development partners.

Table-6

Benchmarking Uganda's Health Expenditures and Under-5 mortality trends, 2006

COUNTRY	THE PER CAPITA (US $)	UNDER 5 MORTALITY
Ghana	35	120
Kenya	29	121
Senegal	40	116
Tanzania	18	118
Uganda	25	134
Sub-Saharan Africa average	**28**	**156**
India	39	76
Cambodia	30	82
Lao DPR	22	75
Vietnam	46	17
Low-income countries average	**30**	**98**

A range of stakeholders and expert observers tend to agree that the first three years of the Uganda health SWAp were very successful. The resource flow to the health sector improved considerably; more staff was hired and new infrastructure (predominantly in the primary health care domain) was developed. Progress in achieving the targets outlined in the HSSP I was visible a few years after the launch of the SWAp. New outpatient attendance rose from 0.4 visits per capita a year in 2000 to 0.9 in 2004-05, and child immunization showed similar sharp improvements. However, this was also the time of user fee abolition and we do not know how much of this improvement was due to the SWAp and/or abolition of fees.

However, currently both government and donors face numerous challenges, which may be explained by a number of factors. The increase in real term government spending for health slowed, creating an increasing dependence on ad hoc, often project based, development assistance for health. These projects have tended to reflect specific areas of interest among development partners, and only partially reflect the balance needed between different sub-sectors in the health strategic plan.

The problems experienced by the Uganda health SWAp have not gone unnoticed. They have opened new discussions between government and development partners on reforming SWAp processes and structures, based on the Paris Declaration on Aid Effectiveness. A number of initiatives in this respect have recently emerged. Following the poor management, GFATM, local development partners and government have held discussions on improving Global Fund integration into SWAp processes. The Ministry of Health and development partners have also agreed, in principle, on improved integration of Technical Assistance (TA) into routine Ministry processes and structures.[IX]

The structures for cooperation between Ministry of Health and development partners have involved a very intricate and complex net of working groups and similar processes. Efforts have also been made to considerably reduce the number of groups and to sharpen their roles to avoid duplication.[X]

4.4 Overall performance of the health financing system

From this information, therefore, we can draw some inferences relating to the overall performance of the Health financing system in Uganda:

- **Firstly,** we look at the performance in relation to ability to raise adequate, sustainable funds. The system has been able to raise additional financing, on a consistent basis in the near past. However, significant portion of these funds comes from unsustainable sources of financing, and out of direct management by the sector stewards.
- **Secondly,** looking at the financial accessibility, only the removal of user fees remains the key policy that has shown an impact on the financial accessibility in the country. Prepayment ways of financing services have not improved in terms of their contribution to the overall financing of health. Nationally, the northern region is the most disadvantaged in terms of financial fairness, a function of the instability it has faced for a while.
- **Finally,** there are pointers to fair value for money from the investments being made, though there is significant room for improvement. A more detailed analysis may be required to establish this point further.

[IX] *MoH; 2006; Reviewing and Harmonizing Technical Assistance in the Ministry of Health*

[X] *MoH, 2006, Review and Rationalization of Structures and Working Groups for Effective Implementation of the Second Health Sector Strategic Plan (HSSP II), 2006 – 2011*

5 GOVERNMENT RESOURCES

There is significant pressure to increase spending on health, particularly by the government. A number of factors are responsible for this pressure, including high fertility and population growth rates; the HIV/AIDS epidemic; adoption of more costly service delivery standards and new health technologies; and unregulated expansion of health infrastructure, which leads to escalating unit costs of health service delivery.

Despite fairly steady growth in the past, the overall level of funding for health remains inadequate in Uganda to meet its sectoral and national targets. Current evidence suggests that limited opportunities exist to mobilize new substantial financing. It is unlikely that Uganda can dramatically increase its share of health spending beyond the present level. Alternatively, social health insurance is under consideration. Its success will depend on the credibility of the scheme and the extent to which informal sub-sector employees and the unemployed or the disadvantaged can be brought on board as well as how concerns about the size of the premiums and perceived quality of health care are tackled.

In the short-term, increases in government health spending will mainly come from endogenous budgetary increases and DAH. This assumes that government health spending will respond in the same way to economic growth as it did in 2000-06. Nominal total government health expenditure and government per capita health expenditure are expected to triple and double, respectively, increasing the percentage of GDP spent on health from 3.13% to 4.08% over the period of 2007-15.[2] The impact of Uganda's high population growth rate mitigates the projected effect in per capita terms.

5.1 Level and sustainability of government financing

The total budgetary allocation to health in 2008-09 was Ushs 628.46 billion (Table-7); between 2004-05 and 2008-09, the GoU funding increased annually by 17.6% while donor project funding remained more or less the same. Health ranks third in receiving government budgetary allocation after works and transport and education sectors.[9] Government financing for health has been on an increasing trend during the period of the policy, as shown in Figure-11. Though the Government financing has been increasing, in real terms, we see that it has maintained a fairly constant share of key comparators of trends in financing. For some, such as financing as a share of Total Government expenditure, and as a share of GDP, a slight downward trend may be discerned. This suggests health financing by Government has remained at fairly the same manner of prioritization over the past years.

5.2 Financial accessibility

Government financing has been utilized for financing critical system inputs, particularly as relate to Human Resources for Health, essential traditional commodities, and infrastructure/maintenance. The resource allocation formula incorporates a number of elements that allow for equitable resource allocation, and so maintaining a fair level of equity

in financial access. This is done, taking into consideration information from known donor sources of financing, to ensure equal financing is available for equal need. Yet, the Northern districts receive far less than other districts even though health care needs are higher there.

Table-7

Budgetary allocation to health during HSSP II

Financial year	Allocation in billion UShs			Share of donors	Per capita allocation		GGHE as % of GGE
	GoU funding	Donor project funding	Total		UShs	US $	
2004-05	219.56	254.85	474.41	53.7	17,437	10.0	9.7
2005-06	229.86	268.38	498.24	53.9	18,213	10.0	8.9
2006-07	242.63	139.23	381.86	36.5	13,518	7.8	9.6
2007-08	277.36	141.12	418.48	33.7	13,949	8.2	9.6
2008-09	375.38	253.08	628.46	40.3	20,948	10.4	8.3

Source: *Annual Health Sector Performance Report, 2009*[9]

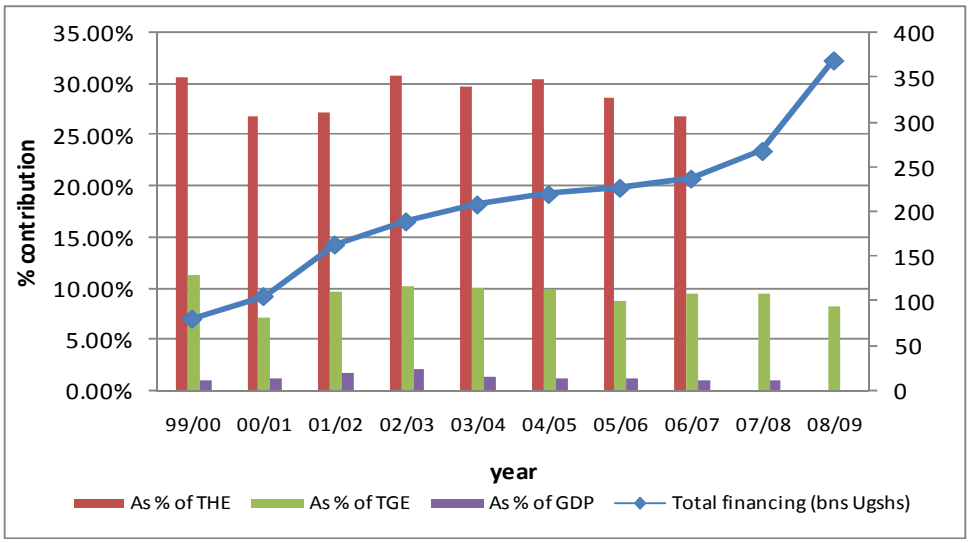
The absence of reductions in financing over the years suggests this is a fairly secure and sustainable source of financing. Estimates of future amounts, based on the current prioritization patterns of Government, can therefore be discerned from future estimates of total government expenditure, and GDP improving the predictability of this source of financing, for future health service provision.

From the 2006 survey, the poorer populations appear to have better access, shown by their lower average distances to a health facility when compared to the better off persons (Table-8). The persons in the northern region, which is also the poorest region in the country, also have to travel the least distances to access health services. Of course, there is a difference in quality of care received by different population groups in the country. This is amply reflected by the pattern of resource use on medicines across districts (Figure-12).

Government health care delivery institutions charged varied levels of user fee across districts between 1993 and 2001.[17-19] While few institutions did not charge any user fee, some others charged every service offered or a flat annual fee or for only medicines.[20] Outpatients were given a choice between 'free' and 'pay' options. Similarly, they had the option of paid private beds and free beds for inpatient care. Evidence suggests that there were noticeable improvements in the quality of services and supply of medicines in some districts. However, resource generation through user fee was only less than 5% of total health expenditure.[21]

Figure-11

Trends in Government financing for Health

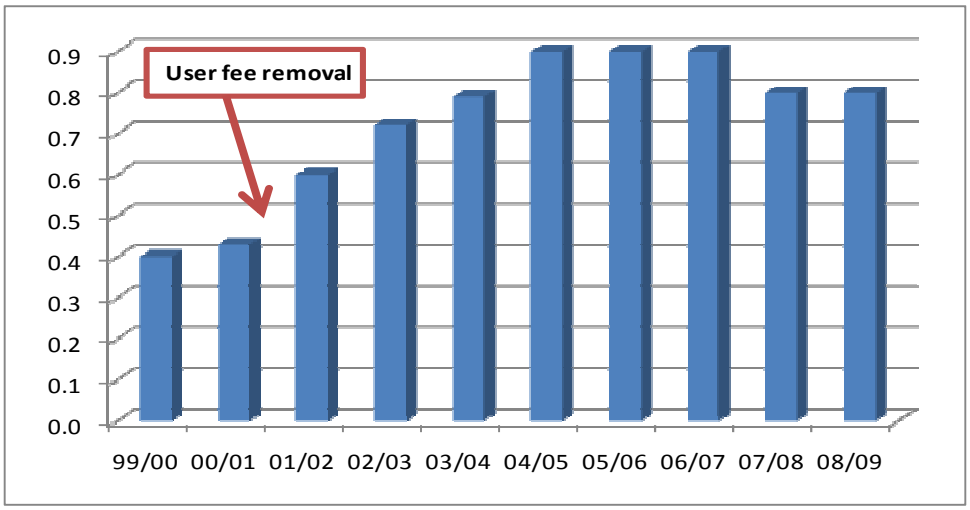


Source: MTEF returns, WHO calculations

In 2001, user charges were removed in all Public health facilities, in a move to further improve financial access to services. Simultaneously, government also increased its funding for district health services to compensate for any loss of revenue due to the abolition of user fee. This policy change, in March 2001, led to a sustained improvement in utilization of health services across the country, as seen in Figure-12.

Figure-12

Uganda Trends in OPD per capita utilization



According to a review of the impact of this change, this increase is mostly a result of increased utilization in the public facilities, as opposed to other service providers. The abolition seems to have encouraged more poor people to seek care at public facilities when they were ill. At the same time, medicine stock outs became a regular feature in public health care institutions.[22] These and other shortcomings limit the ability of Government resources to support good financial access. The incidence of catastrophic payments also increased among the poor, who used private services more.[8]

While the removal of user fee opened the doors of the government health care facilities for the poor, not all resources meant for health enter into the government resource allocation process. For instance, some donor resources remain off-budget and are not factored into the process, due to difficulty in getting this information. Also, some NGOs generate their domestic resources through the user fee and other such means. Domestic and foreign philanthropic resources, meant to serve the health goals, are not accounted for by the government in its resource planning. In addition, there is a large chunk of household resources about which the government has limited information.

Table-8[XI]

Average distance to health facility by wealth quintile, and region

CLASSIFICATION	AVERAGE DISTANCE TO HEALTH FACILITY (KM)	% REPORTING LIVING WITHIN 5 KM OF HEALTH FACILITY
Wealth quintile		
Lowest	3.1	85.9
Second	3.5	84.2
Middle	4.0	83.5
Fourth	4.7	78.0
Highest	5.0	81.6
Region		
Central	4.2	82.0
Eastern	3.8	84.4
Northern	3.5	84.7
Western	4.8	79.4
National average	**4.1**	**82.5**

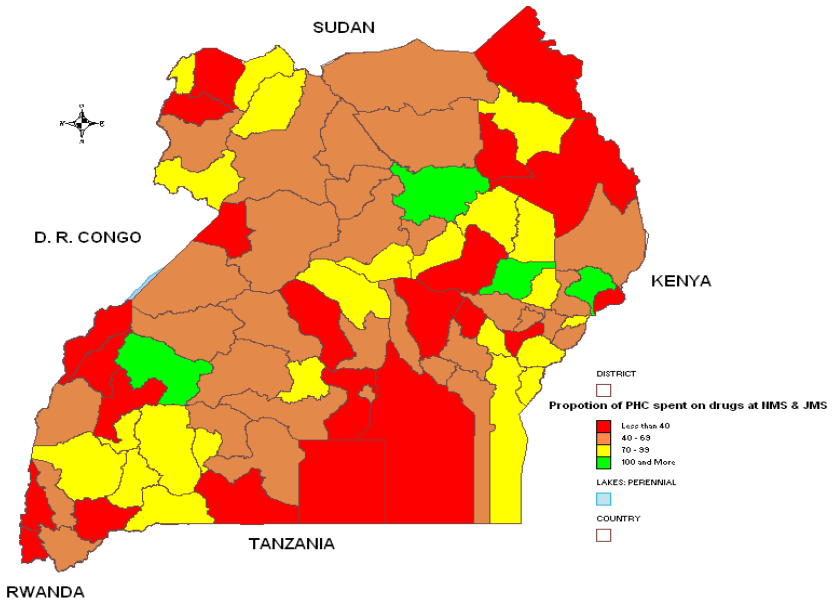
Source: PER, 2008

[XI] *Access in this table refers to access to any facility, public, PNFP, public provide, that is what the NHS collects.*

The sector has not been able to implement significant other interventions that would improve financial access, following user fees removal. User fees are not the only source of health expenditure, and the policy only applied to public facilities. Households usually utilize two or three sources of care for each illness episode, maintaining a high level of out-of-pocket expenditure. Support to prepayment mechanisms would help, but the Government financing has not targeted this. Furthermore, improving financial access calls for more than abolition of user fees; system wide improvements are equally important to improve geographical access and quality of care.

Figure-13

Spending on medicines across districts



Source: *Annual Health Sector Performance Report, 2009*

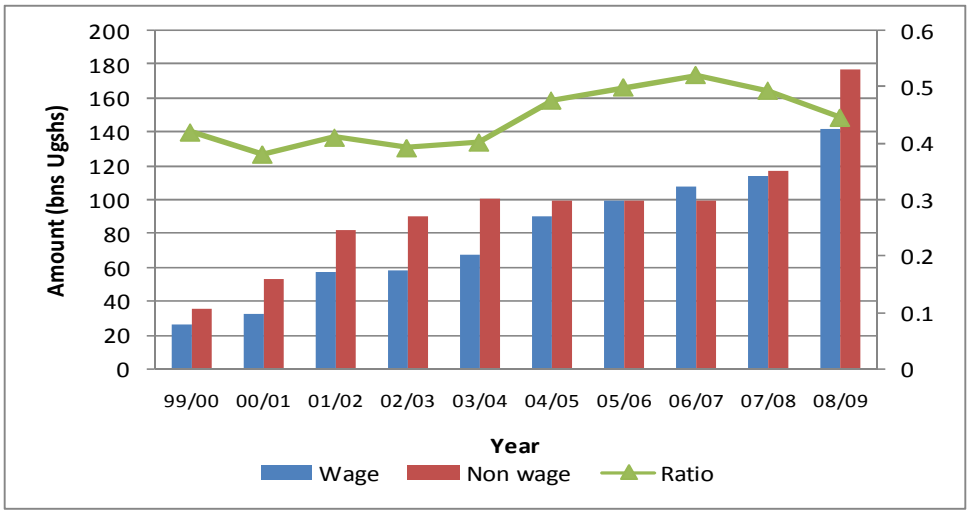
5.3 Value for Money

Delivery of government health care provision in Uganda is based on the Uganda Minimum Health Care Package (UMHCP), detailed in Section-2. Government finances are primarily utilized for investments in tangible inputs (human resources, infrastructure maintenance, medicines, and commodities/supplies). Of these, medicines, commodities and supplies represent the most direct investment in service provision, with human resources representing the most significant input into management. A look at the portion of Government resources spent on human resources as compared to total available resources shows the wage component has stagnated between 40–50% of the available expenditure (Figure-14). The overall expenditures have been increasing, in nominal terms. Of these, the wage component increased as a percent of total MTEF expenditures in 2004-05, but has been reducing since 2007-08. This trend suggests that

there are increasing funds available for direct services overall, in terms of available resources, and the prioritization of service delivery since 2007-08.

Figure-14

Wage-to-non-wage MTEF expenditure trends, 1999/00 – 2008/09 FY's



Source: Ministry of Finance expenditure returns

A further look at variables relating to value for money is seen in the portion of resources managed at the different levels of care. The trends in the national, vs. regional and district level share in management of Government resources, plus hospital vs. lower level facility investments are shown in Figure-15.

There is a marginal reduction in the portion of the total Government expenditure managed at the national level, which corresponds to a similar increase in the portion managed at the district level up to 2006-07. This trend appears to be reversing currently. Looking at the same variables for implementation units, we see the pattern as shown in Figure-16.

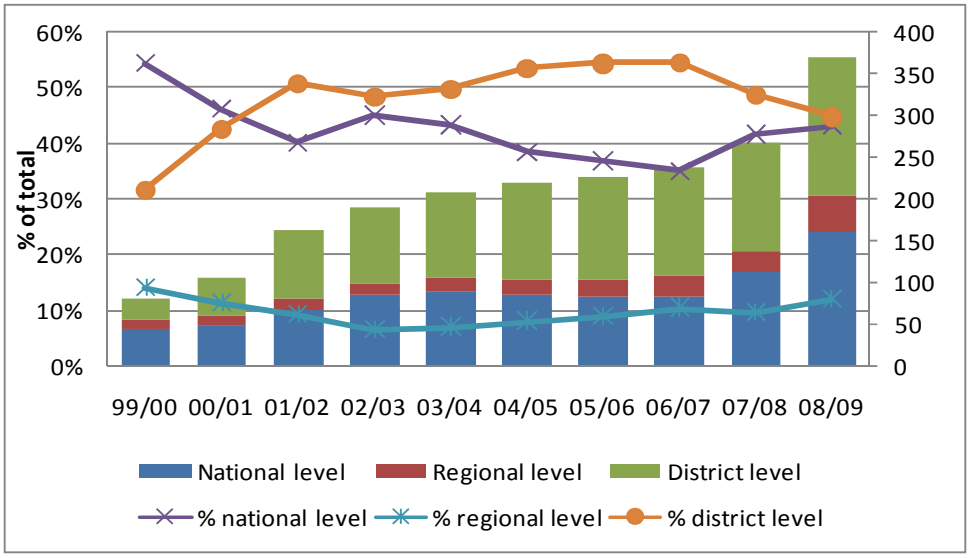
There was a significant change from hospital to lower level units as a portion of total resources up to 2002. This trend has stagnated since then, though, with approximately 50% of the sector resources going to lower level units. The portion spent by implementation units represented at the national level also showed reductions, up to 2006 that appear to be currently reversing.

Government and private not-for-profit hospitals are fairly efficient although there is scope for further improvement. Bed occupancy rate in Regional Hospitals (including PNFP hospitals) in 2008-09 was 84% while it was 66% in General Hospitals (Table-9). Bed turnover rate was adequately high in both General and Regional Hospitals, with a big jump in 2008-09 in General hospitals. This is in sharp contrast to a decline in bed occupancy rate in these hospitals. So, it is difficult to explain this jump in bed turnover rate. The only possibility is the reduction in the

length of stay due to a drastic improvement in technology or decline in complex cases. The decline in bed occupancy rate in General Hospitals indicates a shift away from them in favour of Regional/PNFP Hospitals.

Figure-15

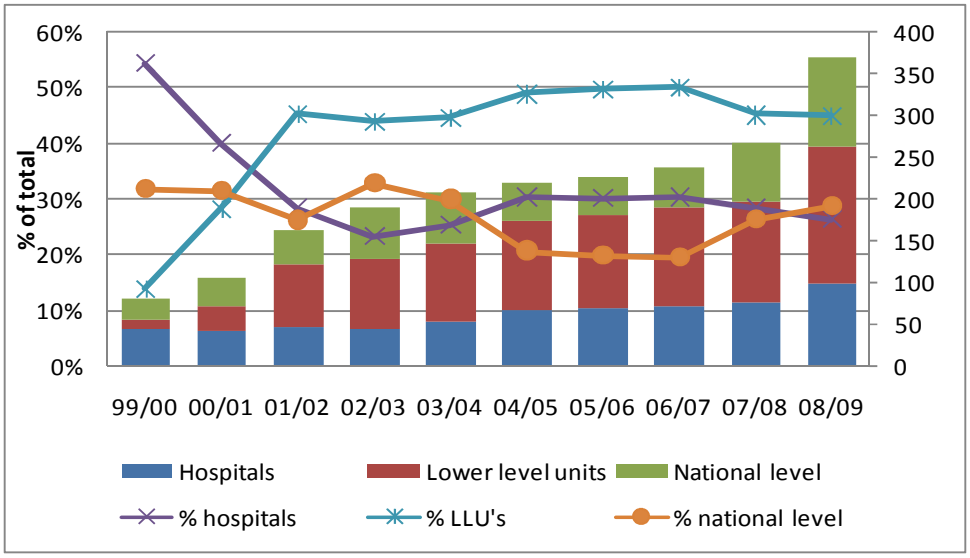
Trends in share of resources, management by different levels of care



Source: MTEF expenditure returns

Figure-16

Trends in share of resources, management by implementation unit



Source: MTEF returns

Number of outpatients treated in hospitals is generally low probably indicating two patterns. First, cost-effective of course, is the possibility of treating outpatients in lower level facilities. If this is true, then it is a healthy and optimal utilization of hospitals and other facilities. Second possibility is that people postpone their treatment till it becomes severe. This, if true, is not desirable. Similarly, antenatal care and immunization probably receive attention in lower level facilities.

Table-9

Hospital efficiency indicators

EFFICIENCY ATTRIBUTE	GENERAL HOSPITALS (8,236 BEDS)		REGIONAL HOSPITALS (3,879 BEDS)[XII]	
	2007-08	2008-09	2007-08	2008-09
Bed occupancy rate (%)	73.0	66.0	73.0	84.0
Annual bed turn-over rate[XIII]	24.6	59.1	55.2	63.0
Outpatient per bed day	0.70	0.72	1.11	0.93

5.4 Institutional mechanism and strength

The resource allocation principles are in line with sector objectives and the PEAP. Poverty indicators are taken as allocation parameters because the poor households typically rely more on publicly provided services such as health and Education. Allocation of public resources is largely formula based and rarely covers more than one sector. In order to increase the discretionary powers of Local Governments in the allocation of resources, it is important that all LG needs and priorities identified during the budget process feed back into the budget process at the national level. The administrative framework for allocation of public resources includes the following actors in Uganda:

- Ministry of finance (Technical advise on allocations)
- Spending agencies (Committees and councils having powers to allocate resources)
- Cabinet (Certification)
- Legislature (Approval)
- Auditor general (Verification)

[XII] *Including PNFP General Hospitals*

[XIII] *Bed turnover rate = Total number of admissions/number of beds. That is, the number of times a bed is used in a year.*

As mentioned before, government budget does not capture health financing in its entirety. It misses a portion of NGO resources, philanthropic resources and household resources. While it is understandable that the government cannot control all the resources meant for health, it could map and plan for those resources so that such resources are spent appropriately to maximize health gains.

The strength of the current budget allocation mechanism is that a portion of it is decentralized and districts are making their work plans and budgets. Districts are able to receive over 90% of what they are promised. While it is good, it could also mean that districts are scaling their demands down. With the prevalence of a wide range of unmet needs, particularly at the district level, meeting 90% of what was promised is not good. Districts are also not generating their own resources to the extent of having an impact on the local populations. At present, what is locally generated is barely covering the administrative cost of the district level structures; in some cases, it just covers the cost of electricity. Hence, the bigger challenge is inadequate funding at the district level. Also, much of the central allocation is tied in a sense giving little autonomy to the districts to decide on its use.

5.4.1 Planning, negotiation and absorptive capacity

Planning, negotiation and absorptive capacities are crucial for the government to allocate adequate budgetary resources and spend the allocated resources fully and efficiently. As in other countries, the major institutional mechanism for resource allocation in government is 'negotiation and political compromise'. This is particularly applicable to the allocation of capital development funds. This process is to some extent guided by perceived health care needs of the population. However, with the health care infrastructure and services often inequitably distributed, this approach could result in additional inequities in the allocation of resources and in access to health care services. An incremental approach serves only to perpetuate health and health care inequities.

Gaps in such skill and capacity make it difficult to effectively channel and utilize government resources. While fiscal space for health is already limited, such constraints further limit the fiscal space and its full use. The need for additional health sector resources is indisputable, but without improving the negotiation and absorptive capacity of the health sector, additional resources may not be adequately channelled or utilized efficiently. Providing additional resources beyond the absorptive capacity of a sector can have negative consequences if using such resources is not planned properly.

Without addressing the labour shortage and increasing the efficiency of existing staff, additional resources for health may lead to further inflationary pressures (e.g., increased wages for health workers) or displacement of some activities (e.g., maternal care) by others (e.g., HIV/AIDS counselling and treatment), which may not completely align with overall government priorities. Key priorities include addressing the human resource shortage in the short-term by reducing absenteeism, increasing numbers and in the long-term by increasing training of health workers and the availability of drugs, medical supplies, and basic equipment,

without which medical staff can achieve little. Moreover, the incremental nature of the budgeting process means that budgets cannot easily shift in response to changes in service delivery.

Better use of the decentralized government is another area for improvement. The negotiation and absorptive capacity, therefore, needs to be developed at the district level so that full potential of the decentralized government structures could be used. District level planning should include such resources left out of the centralized budgetary process.

5.4.2 Formula funding

Allocation of non-salary resources to districts for health care service delivery, particularly concerning the primary health care, is based on an allocation formula based on the following attributes:

- Population (85% weight after deducting mandatory and basic allocations)
- Number of deaths between birth and first birth anniversary
- Infant mortality rate
- Crude birth rate
- Number of live births
- Basic amount allocated to all districts for health care service delivery
- A special and fixed allocation for hard-to-reach areas (top-up)

On the other hand, PHC Development grant is allocated based on needs assessment taking into account other funding sources and the level of healthcare infrastructure facilities.

5.4.3 Technical appraisal

Technical appraisals based on cost-benefit analyses are carried out, especially for big capital infrastructure projects in the country.

5.5 Overall performance assessment

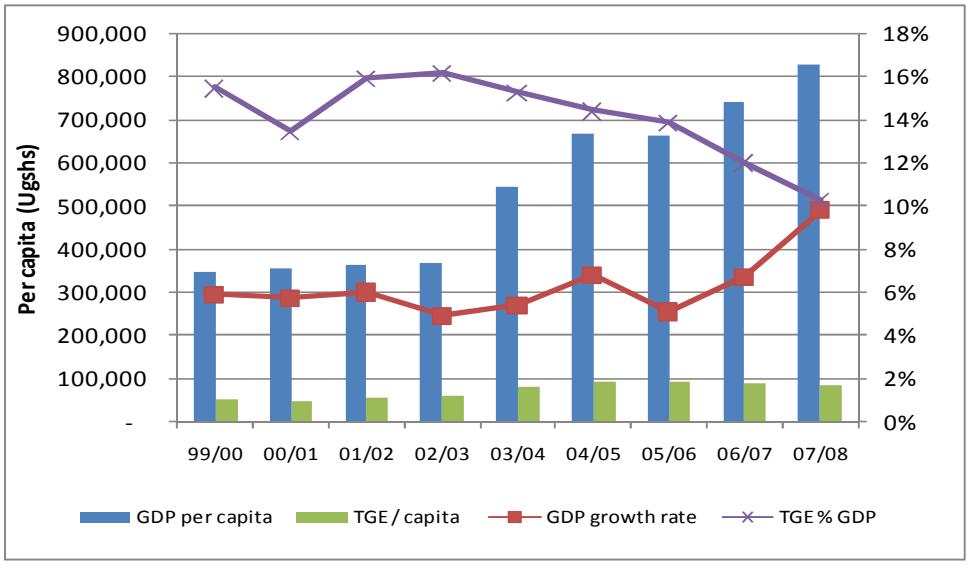
The Government financing has maintained its portion of the General Government Expenditure, as a portion of GDP within a narrow band. Furthermore, the percentage allocation to health as a percentage of total government budget has also remained fairly constant. This suggests that, unless the prioritization of health by the Government is to change, predicting the future resources available through Government is fairly feasible. Increases in GDP, and Government expenditure would have similar increases in health expenditure by Government. The economic growth has been consistently high in the recent past, as seen in Figure-17.

There is significant scope for increases in Government expenditure in health. This appears to be on a reducing trend, as a portion of GDP. The increasing GDP suggests more resources should potentially be available. The Government revenue collection ability will, however, always lag

behind as the GDP growth rate is too high for the capacity improvements in revenue collection to be at the same pace. Over time, however, the revenue collection should improve, as a portion of GDP as the revenue collection capacity improves, implying more resources for Government in the medium term.

Figure-17

Trends in key Government expenditure variables impacting on Government Health expenditure



Source: Government MTEF returns, WHO calculations

Maintaining the portion of health as a percentage of the Total Government budget constant, therefore, should be able to assure significant increases in real terms of the health sector budget. This should be made a key target for the sector to sustain, regarding expected Government expenditure on health.

Discussions between Ministries of Health and Finance could focus on providing a minimum budgetary share of approximately 10% for health, instead of the current reducing trend. This would ensure significant increases in Government health expenditures that are naturally driven by increases in Government revenue raising capacity, and GDP. In the longer term, then, the discussions could focus on increasing this portion further, in line with Government Abuja commitments to 15%. There is also a growing concern that the present grants formulae are not adequately targeting equity.

Development of need-based allocation formula based on certain proxies as mentioned earlier adequately reflect the extent of variation in health care needs across the country. However,

such a formula alone cannot guarantee equitable health care access. Other factors such as differing costs, topology of the area and other funding sources should be taken into account. There is little point in starting down the road of allocation formula if there are no effective mechanisms to regulate financial flows. Although policy analysis based on a formula is still prominent in Uganda, the use of appraisal techniques such as cost–benefit analyses is now largely restricted to the appraisal of large-scale infrastructure projects. Other resource allocation decisions are fundamentally based on political considerations and not only based on technical considerations.

Additional strategies to improve on financial accessibility of the population need to be explored. Investments of Government resources need to be made in pre-payment mechanisms of health financing that will reduce, in absolute terms, the amounts of financing that is currently coming from out of pocket. Government financing for insurance mechanisms, either at the community level or national level, should be explored, as should other mechanisms of ensuring sustainable, but equitable sources of financing.

Finally, there do not seem to be significant improvements in value for money from Government resources. The important service coverage improvements that were seen in the preceding chapter are driven significantly by external resources, as will be seen in the proceeding chapter. Additionally, as an input into development of the Health Financing Strategy, the impacts of decentralization of resource management needs to be analysed, so that appropriate allocatively efficiency targets for resources at different implementation levels can be identified.

6 DONOR RESOURCES

External resources still play a significant role in this country. We attempt to understand the trends, and form of external financing for Health in this chapter. The external financing in this context is taken as the Official Development Assistance to the country.

6.1 Level and sustainability of funding

The current value of this assistance has been on an increasing trend in the recent past. However, looking at the trend, the amounts have tended to fluctuate annually, particularly when viewed as a proportion of the total health expenditure – from a low of 22% to a high of 33%. It has however remained fairly constant as a share of total ODA (11%) and as a share of GDP (1.5-2%). The external financing was reducing, as a proportion of public health financing, up to 2002/03, when it started to increase again. This could be attributed to the increased funding from the Global Fund, and the US Government particularly targeted at HIV/AIDS, Malaria and TB. This ODA includes assistance managed as independent projects.

The key sources of external financing are varied, and their key characteristics in relation to focus and form of support are highlighted in Table-10. The bulk of the external fund sources rely more on program support. This support may be channelled through the Government MTEF process as earmarked or non-earmarked for particular programs, or managed separately by the source of funds. For this to be most effective, the sector needs to have, in addition to the HSSP, a comprehensive, detailed medium term program of work, which clearly outlines its programs of priority, with their investments needs based on the four input areas of Human Resources, infrastructure (including maintenance transport and ICT), commodities/supplies, and operations. This forms the investment plan that then guides both Government, and the external financing sources in terms of where to prioritize their funding. It is currently done in a patchy manner, with priority programs not clearly defined in this manner. This implies there is a high potential for allocative inefficiencies in use of the available external resources, with possibilities of funding spent in non–priority programs or outputs within programs. The apparent over-financing of HIV/AIDS program in relation to other priority program areas is a case in point.

There is a dramatic increase in HIV/AIDS funding seen, especially since PEPFAR came in from 2003/04 (Figure-18). This increase is in terms of absolute amounts, and as a % of Public (Government and Donor) Health Expenditures. In addition to PEPFAR, the Global fund, and the World Bank MAP projects were also contributing significant resources. The level of Government resource commitments remains the same across the years, and reduces as a proportion of total expenditure due to increases in the other sources.

The HIV/AIDS funding represents the risks associated with donor financing. In the 4 years shown in Figure-18, a key source that was project based closed (WB MAP), and the Global Fund expenditures remained unpredictable due to various institutional issues being sorted out. As a result, the expenditure sources tend to differ significantly on a year by year basis, and are

unpredictable. Additionally, the HIV/AIDS program is increasingly being funded by fewer sources, with no Government increases. This implies there is higher potential for the direction to be externally driven.

Table-10

The key characteristics of the external resources in Uganda

SOURCE OF FUNDING	FORM OF SUPPORT		
	Budget	Program	Project
AFDB	✓		
CLINTON			✓
DANIDA	✓	✓	
DFID	✓	✓	
EC	✓		
FRANCE	✓		
GAVI		✓	
GLOBAL FUND		✓	
GDC		✓	✓
ITALY		✓	
JICA			✓
UNAIDS		✓	
UNFPA		✓	
UNICEF		✓	✓
USG			✓
WFP		✓	
WHO		✓	
WORLD BANK	✓		

Donors also provide some resources directly to the private not-for-profit facilities. The trend in donor funding to these facilities between 1998-99 and 2003-04 is given in Table-11. As it can be seen, the size of donor funding directly given to the PNFP facilities increased almost three-fold during this period.

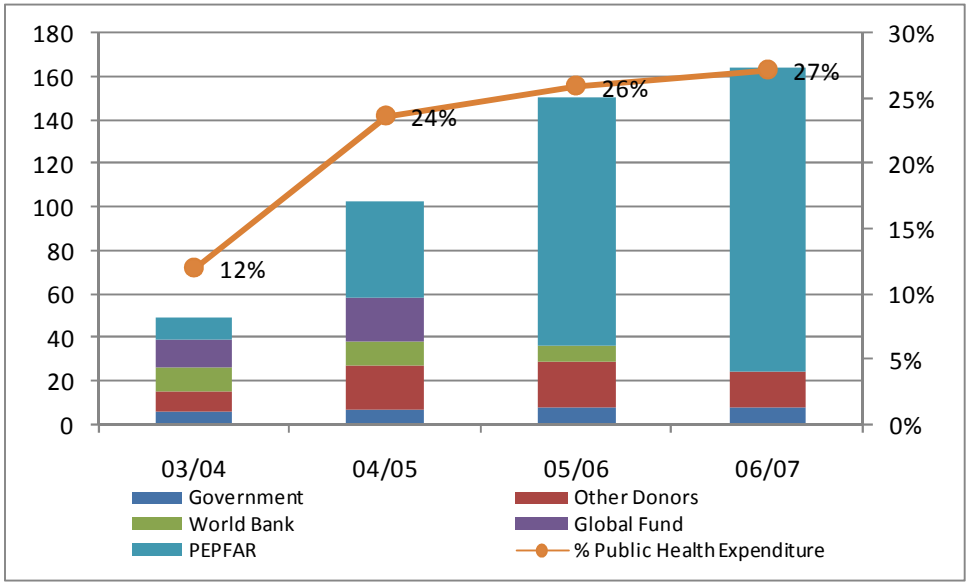
Table-11

Donor funding through Facility Based PNFPs in billion UShs

YEAR	1998-99	1999/00	2000/01	2001/02	2002/03	2003/04
Amount in billion UShs	5.875	8.179	10.548	7.251	9.405	15.423

Figure-18

Trends in HIV expenditures for selected years (billions of Ugshs)



Source: Ministry of Health Annual Reports, HIV SNA's of the NHA

6.2 Financial accessibility

External financing, being managed primarily through the Sector Working Group mechanism[XIV], is working towards and achieving the same outputs as described in section 5.2 in relation to financial accessibility. However, some of the external funds have been used to facilitate functioning of the community insurance, and other locally based solutions to strengthening prepayment of health services. This is what has managed to keep them functional, in the absence of Government support. This funding has largely been for supporting the management and operations of these insurance mechanisms, and not for co-payment of premiums.

6.3 Value for money

External finances are utilized in most of the investments in tangible inputs (human resources, infrastructure maintenance, medicines, commodities/supplies, or operations). However, these external resources represent a significant portion of the total expenditures in medicines, commodities/supplies and operations.

In relation to medicines, the external resources have been critical in the introduction of new commodities in the country. The ART drugs, pentavalent vaccines, ITN's, ARV's, and other new

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[XIV] *With the participation of various stakeholders including the civil societies and international (bilateral and multilateral) agencies*

commodities in the country have all been largely financed using external resources, while the Government resources have been primarily financing the traditional commodities. In this context, the external resources are giving good value for money if related to the improved health outcomes associated with the use of these commodities. There is, however, little evidence relating to how efficient these investments are. The new commodities are, by nature, high cost. This implies they are either attracting new resources that would not be available to the sector in their absence (a positive outcome), or they are depleting resources from other interventions (a negative outcome). As the sector works towards the overall financing strategy, it would be important to analyse further which of these effects predominates in the sector, to better inform the strategy towards improving efficiency of use of external resources.

Looking at the operations, a significant portion of resources spent on operations are provided through external sources, particularly at the national level. Some of the program areas depend on these for almost all of their operations. The inherent threats relating to the external resources are transferred to the functioning of these programs, as a result. In addition, the priorities in their operations tend to be influenced by the priorities of the funding source. Absence of clear guidance on what would be appropriate costs of operations is leading to a situation where they may be taking resources away from the other inputs relative to their needs. A clear guidance on costs of operations needs to be agreed by the sector.

The other inputs – Human resources, and Infrastructure, are primarily Government funded, though there are some significant external resources spent here too. For example, the World Bank District Health Services Project in the late 1990's and early 2000 years, and the ORET project with the support of the Netherlands Government and JICA have all significantly supported infrastructure investments in the sector.

6.4 Institutional capacity assessment

External resources are channelled through three institutional mechanisms. The most visible form of the external funding is through the government budget (earmarked and non-earmarked). The second institutional mechanism through the external resources flow into the health sector is the NGOs (could be facility based which are largely religious affiliated or non facility based) providing health care directly to the people. The third mechanism is donor implementing donor projects through setting up of implementation units.

6.5 Overall performance assessment

Overall, external financing in health has been a significant portion of the overall finances available. There have been significant fluctuations in the amounts available year by year, due to the fact that most of the external resources are managed as projects, or programs. The relative constancy in the relative share of external resources as a % of THE can act as a good guide as to the expected amounts of external resources the sector should work towards mobilizing in its financing strategy.

The fact that the external resources are largely supportive of program or project approaches should be looked into with more detail. There are real issues that exist within the sector, and country institutional arrangements that are leading to this situation. These may, or may not be out of control of the sector management processes. The sector needs to also focus on improving the management, and use of these resources, as opposed to only focusing on who manages them. A joint program of work, with investment priorities would act as a framework to guide, and monitor investments towards allocative efficiency.

The strategies to improve on the external resources therefore can be discerned, based on current trends, and priorities of focus. The Aid Effectiveness principles see external resources shifting over time from project to program to budget support mechanisms, as country institutions strengthen.

7 PHILANTHROPIC RESOURCES

Well-designed philanthropic resources could support targeted interventions to improve financial accessibility. There are a number of local individuals or institutions that could potentially provide resources for health related services. The increasing role of corporate social responsibility among major firms places a higher potential of this source of financing. Banks, airlines, supermarkets, and many other large corporations have in a number of countries ended up providing a significant amount of resources for given services. Some sector actors, such as UNICEF, have exhibited the capacity internationally to effectively tap into this source of resources. Such capacity can be put to use at the national level. Support to improving financial access for a defined population group, for example, can be a good use of philanthropic resources in the country.

7.1 Level and sustainability of funding

In Uganda, philanthropic resources are not a currently recognized source of financing and therefore, it is not easy to have an assessment of its size, spread and impact. Corporations donate resources to health care facilities and they are not captured or regulated; there is even a hospital ward run out of philanthropic resources. Rotary international has, in the past, financed polio related activities. More recently, in a particular district visited by the health financing review team, philanthropic resources in the tune of UShs 100 million (US$ 50,000) were generated in one year.

These resources usually target selected interventions, as opposed to generic support to health. This has the potential to free up resources for other sector activities. But, as these financing is usually time–limited, it is not a strong and sustainable source of financing. However, presence of a clear strategic approach and implementation process to guide generation, use and monitoring of resources raised in this manner can bring in some level of sustainability in this source of financing.

As the country moves towards its new financing strategy, this potential needs to be looked into, so as to provide guidance with regards to the strategies that need to be employed to maximize this potential source of financing for health.

7.2 Financial accessibility

Philanthropic resources are well–designed to support targeted interventions to improve financial accessibility. Support to improving financial access for a defined population group, for example, can be a good use of philanthropic resources in the country. These resources could be combined with resources meant for demand side financing. Presence of a clear strategic approach and implementation process to guide generation, use and monitoring of resources raised in this manner can bring in some level of sustainability in this source of financing.

7.3 Value for money

These resources would represent a new source of financing for health in the country. They could free up existing resources for use in other priority areas, and also allow for implementation of some interventions that the sector was not implementing due to lack of financing. In this manner, they are a positive influence on the sector.

The institutional and administrative costs of the management of these resources, however, need to be considered, for a proper analysis of value for money. Past experience with streamlining philanthropic resources (in an Indian state) indicates that these resources add very little (say, 1% of the government budget in any year) in quantitative terms, but help to activate idle government assets to the extent of about 10 times.[23] Moreover, they bring some qualitative improvements in health care services and help the health care infrastructure to serve more clients.

7.4 Institutional capacity and its strength

There does not exist any separate institutional mechanism to channel philanthropic resources in Uganda. At present, they use the existing institutional mechanisms to finance health. Some known ways of their operation are:

- Donations to health care facilities
- Direct funding to operate an inpatient care ward
- Direct financial support to patients to seek treatment
- Funding to create new facilities
- Contribution of funds to a district health office

These are some of the observed pathways used by philanthropists. Other pathways could be understood if proper national level assessment is undertaken.

7.5 Overall performance assessment

Currently, this is not a recognized source of financing and so, it is not possible to have an assessment of the performance in its regard. An inadequate performance can only be judged from the fact that it has not been explored by the sector in terms of its potential to support the financing of the country. As the country moves towards its new financing strategy, this potential needs to be looked into, so as to provide guidance with regards to the kind of strategies that needs to be employed to maximize this potential source of financing for health.

8 HOUSEHOLD/COMMUNITY FINANCING

Resources from the household are the dominant source of health financing in Uganda. This is the most unorganised form of health spending, as it occurs at the time of delivery of service. Such resources are usually termed as household out-of-pocket resources or OOPs. The predominant mechanism used by households to channel their resources into health is direct purchasing of health care services from a wide variety of providers, including the less than fully qualified practitioners (LTFQs). The impact of this form of health spending on the household economy is generally felt longer since households pursue some hard options such as high-interest borrowing and selling of assets, if any, so as to finance the out-of-pocket spending.

At present, it is not clear how resources meant for OOPs are mobilized and what is being purchased through OOPs. More often, households tend to mobilize resources through high-cost loans and selling of assets only to spend on unnecessary and inappropriate care. An assessment of household health care seeking behaviour shows that patients utilize multiple service providers to treat a single illness episode. Therefore, there is a need to develop a health financing strategy to streamline the mobilization and spending of such resources. Some institutional mechanisms do exist in Uganda. They could be mainstreamed and integrated into the national health financing system so as to minimize the ill-effects of OOPs besides reducing the dependence on it and breaking the financial barriers for those who are not able to exercise the option of OOPs. This review provides an overview of some prevailing alternative institutional mechanisms to streamline OOPs.

8.1 Level and sustainability of funding

In Uganda, the estimated share of OOPs in total health expenditure came down from 78.9% in 1995 to 35% in 2007.[12] This is mainly due to an increase in the share of external resources from 14% in 1995 to 31.2% in 2006 because the share of government funding remained more or less the same at about 25-30%. While OOPs signifies the level of (un)organization of health care finance and the level of social health protection, it masks the level and spread of inaccessibility to health care. The trend in OOPs in the past years is shown in Figure-19. Though OOPs has been increasing, in real terms, we see that it has been reducing as a proportion of the Total Health Expenditure. The ratio of OOPs to Public Health Expenditure (Government and external sources) is on a continuous downward trend.[xv] This is largely a result of the more larked increase in the latter seen during the period. This correlates well with the earlier findings that the direct payment mechanisms are reducing as a portion of the total health expenditure over the years, in favour of prepayment mechanisms.

The overall OOP expenditure as a portion of GDP shows significant fluctuations during the period under review, but with a general reducing trend which is discernable. In other words, the GDP has been increasing faster than the OOP health expenditures.

[xv] *Of course, this is not true for 2005/06 and 2006/07 when the ratio increased slightly.*

Figure-19

Trends in Out-Of-Pocket spending (OOPs) on health (billion UShs)

Source WHO statistics, NHA, WHO calculations

Further analysis of the household expenditures, using the information from the National Household Surveys, shows that they were, in 1999/2000, accounting for 7.8% for the richest quintile and 5% for the poorest quintile. This trend has been increasing over time, with the better off spending a larger portion of their income on health related expenditures (Figure-20).

8.2 Financial accessibility

There has not been any systematic review of resource organization and utilization concerning the OOPs. People may simply purchase duplicate or unnecessary care or pay for mark-ups, or inefficiency.

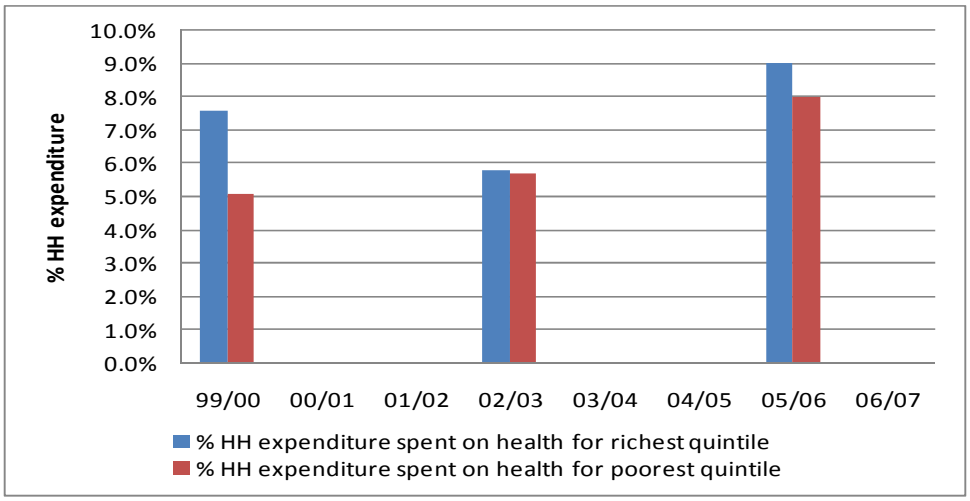
A quick look at current health care utilization in Uganda suggests that the poor use public facilities more than the richer quintiles. However, this analysis masks the income-related differences in quality of care and utilization patterns: poor households predominantly use health centres and wealthy households use hospitals. This suggests that focusing on improving quality of and access to health centres and dispensaries is an important pro-poor strategy. Over one-fourth of households report incurring health expenditures that can be deemed catastrophic, and a majority come from households in the lowest income quintile. Evidence suggests that OOPs incurred for medicines and hospital/clinic charges have increased, which implies that the abolition of user fees had only a marginal impact on OOPs.

The OOP expenditure still remains high in the country, limiting the level of financial access to health services. The latest National Household Survey data suggests that an estimated 28% of

households face catastrophic health expenditures (over 10% of disposable income). These values differ by income level, and by region as shown in Table-12.

Figure-20

Trends in Health portion of total expenditure, for the richest and poorest wealth quintiles



Source: *UNHS (various years)*

There is an increasing trend in Health expenditure as a share of household expenditure from the lowest to the highest wealth quintile, suggesting the better off are spending a higher proportion of their income on health. Looking at the regional disparities, household health spending is a significantly higher portion of the total household expenditure in northern region, where more households are having catastrophic expenditure.

8.3 Value for money

The expenditures on health by households and their organization vary significantly across population groups. An assessment following the abolition of user fees showed households utilize, on average, 3 different service providers for a single illness episode. They will use a mix of local clinics, Government facilities, drug shops, traditional service providers, NGO's, and other providers to resolve each illness episode. This is because each of the providers, on their own, is not able to take care of the totality of the health needs of the persons.

The OOP resources are primarily used for purchasing medicines and supplies, and consultation fees. Within the medicines/supplies expenditure, anecdotal evidence suggests resource use is primarily based on expectations, as opposed to actual need. This is both on the side of the clients (such as expecting injections for most illness management), and the providers (expecting clients to pay for medicines that are in stock, as opposed to what is actually needed). All these

suggest that there is a high wastage and low value for money from out-of-pocket expenditures in health.

Table-12

Health expenditure and catastrophic spending by wealth quintile in Uganda, 2006

CLASSIFICATION	HEALTH EXPENDITURE AS SHARE OF CONSUMPTION EXPENDITURE (%)	INCIDENCE OF CATASTROPHIC HEALTH EXPENDITURE (%)
Wealth quintile		
Lowest	7.8	28.3
Second	8.1	28.1
Middle	8.8	29.0
Forth	9.4	29.7
Highest	8.9	24.8
Region		
Central	7.6	23.6
Eastern	7.4	23.4
Northern	8.2	28.4
Western	11.4	38.1
National average	**8.6**	**28.0**

Source: *World Bank PER, 2007*

However, value for money is linked with the institutional mechanism used by the households to channel their resources. A small proportion of resources (say, about 5% of total health spending in Uganda) is channelled through some pre or post paid mechanisms such as insurance and credit. Although the amount of resources channelled through these mechanisms is small, the population coverage may be slightly higher (say, 10%) because they cover low-income populations. Value for money is also linked with their source of care. Most of the organized OOPs is spent on private not-for-profit institutions. To this extent, they receive value for their money spent because these institutions are reliable in terms of appropriateness of care and they are subsidized through donations and government subsidies.

Currently there are an estimated 16 community-based schemes operating in Uganda, covering about 100,000 clients (estimated target population of about 5 million). Some of these are community owned, while others are owned by providers of health care who are mainly PNFP hospitals and/or NGO's. All packages cover in-patient care, while some also cover out-patient care. Chronic conditions are usually excluded. All packages have a co-payment (equivalent to about 20% of the cost of the service), as well as an expenditure ceiling. The choice of providers is also dependent upon whether the scheme is being promoted by an individual facility or a community, although no schemes currently offer coverage beyond the immediate Geographic area. Public facilities are currently excluded as eligible providers. Coverage is typically 10-30%

of the target population, this is an estimate complicated by the lack of clearly defined catchment areas. Coverage is limited by both the lack of regular incomes and by chronically low incomes. There are regional variations, however, so these problems are evident in all areas where such schemes currently exist. These schemes in Uganda are only limited to Southern, Central and Western Uganda and none in the rest of the country. The plausible explanation could be relatively higher income in these areas compared to the rest of the country.

The umbrella group for the CHI's (the Uganda Community Based Health Financing Association or UCBHFA) would like to improve the regulatory framework for the schemes and pursue minimum standards. It is also very interested in working with the MoH and NHIS to promote CHI schemes in advance of the extension of SHI to the informal sector. However, it feels that the current timeline for this inclusion is much too long. UCBHFA also feels that it could play a useful role in vetting schemes to be included in the NHIS using accepted standards. It is not clear how the potential conflicts of interest (the Association is owned by its members) could be addressed if this was pursued. In order to play this promoting and vetting role, it would need some financial and perhaps material support. More recently (in the stage of finalization of this report), the Task Force on the formation of the National Health Insurance scheme with support of P4H has proposed a new design where the informal sector shall be taken on board at the launch of the scheme rather than a phased approach. Also UCBHFA could be represented on the Board. A new regulatory mechanism is being proposed as well.

Unorganized portion of the OOPs is spent on less than fully qualified practitioners, formal private for-profit providers and on under the table payments. A financing strategy, therefore, needs to work not only towards reducing the household expenditures due to its negative effect on equity, but also instituting strategies to improve on the value clients get from the expenditures they incur such as through better regulation of service providers.

8.4 Institutional mechanisms

Households use a complex set of institutional mechanisms to organize and spend their resources. The most predominant source of OOPs is the loan from informal money lenders with very high interest rate (up to even 3,000% per annum) followed by borrowing from friends and relatives (with or without interest), past income (to the extent of about 20% of the OOPs), selling of assets (if they have some) and borrowing from formal banking institutions including micro-credit with reasonable interest rate (very small proportion of the OOPs).[XVI] Some societies like SACCOS (Savings and Credit Cooperatives) offer loans with reasonable interest rate (17-30% per annum). There are also some prepayment mechanisms such as community-based, micro and private insurance. Biggest beneficiaries of the private insurance are the formal sector employees. However, one could say that only less than 20% of the household resources are organized through some form of formal mechanisms (insurance or banking).

[XVI] *This is based on observations made by academicians and community members during the stakeholder consultation and field visits.*

Besides the known institutional mechanisms such as the private insurance, four other alternative mechanisms prevalent in Uganda are presented here. They are

- Insurance-based, community-owned mechanisms
- Insurance-based, provider-owned mechanisms
- Banking-based, community-owned mechanisms
- Banking-based, corporate-owned mechanisms

Two are insurance-based and the other two are banking-based mechanisms. Each one is distinctly different in the way resources are mobilized, organized, pooled and spent. They are not strictly comparable although each one has certain comparative advantages.

8.4.1 Insurance-based, community-owned mechanisms

This is probably the most prevalent mechanism in Uganda to streamline OOPs, particularly in rural areas. At present, its targeted clients are the middle class and the marginal poor population groups. This institutional mechanism uses insurance and risk pooling as instruments to organize finance for health. Some schemes have risk pools limited to individual groups, while others pool risks from different groups. Premiums range from UShs 3,000 to 20,000 per person per year, and the rates depend upon the groups targeted and the specific fund manager. Some schemes have premium subsidies (of about UShs 2,500 per person per year) too for the poor. The dropout rate averages to about 10% per year, although the rate in some schemes is much higher. There are also several NGO's (primarily CORDAID and EED), who are supporting the CHI movement.

An overview of some of the existing schemes in Uganda reveals certain features of the community-based insurance schemes. Figure-21 describes the organization and pooling of resources under community-based insurance schemes. In the figure, there are three sizes of cylinders; the biggest one refers to the biggest pool covering a target population of about 200,000 - 1 million or people encompassing few sub-pools (only two sub-pools are shown in the figure) each comprising of smaller groups of few households. Therefore, essentially, there are three levels of risk/resource pools, well integrated and well coordinated. The lowest organizational unit for the community-based insurance schemes is a group of about 20-30 households or 100-200 enrolees.[XVII] They are termed as community groups forming the lowest level of risk pooling. These are mostly groups already existing for different purposes. A scheme or the sub-pool is the next level of organization covering 10-25 such community groups and could cover a target population of, say, 10,000-30,000. Depending upon the coverage rate, number of enrolees in a scheme may vary between 2,000 and 10,000 within this target population. Each scheme has an executive committee and a representative to make decisions about the membership, premium, and price. This committee also acts as a local fund holder. The next level is an umbrella organization of about 20-30 schemes or the target population

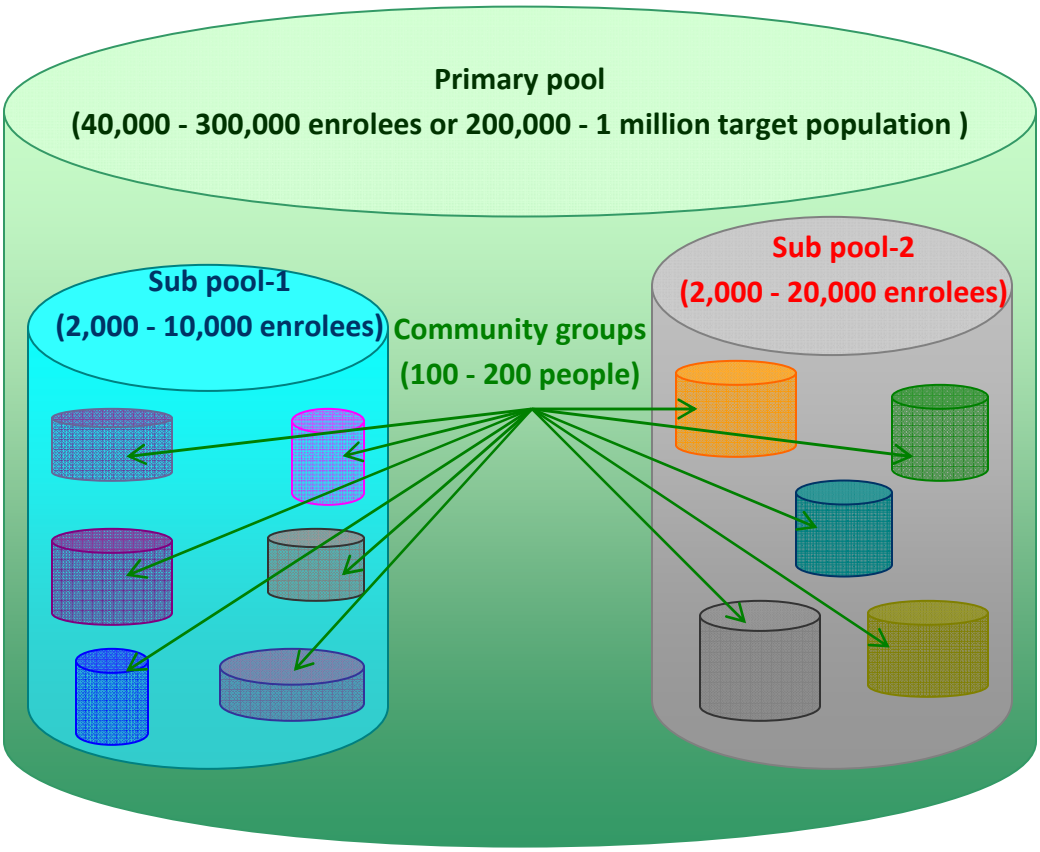
[XVII] *However, the optimal size of this grouping is still evolving.*

about 200,000 - 1 million. As a result, they are pooled thrice first at the community level (about 100 - 200 enrolees), next at the inter-community level (2,000 - 10,000 enrolees) and last at the inter-district level (40,000 - 300,000 enrolees).

The committee to supervise and to make decisions is chaired by a manager and includes scheme representatives. This committee acts as a fund holder for the entire pool, an integration of 20-30 sub-pools. Hence, membership, premium and prices are determined at the local level, but resources are pooled at a higher level. The key aspect of this mechanism is the differential premium (socioeconomically determined) and pricing (based on local conditions and inputs prices) for the same level of benefits. There is an element of subsidy as well; as a result, the scheme could stretch out a bit to include people from the lowest possible income level.

Figure-21

Risk and resource pooling under community-based health insurance



The benefit package is more or less similar although the quality of care is different depending on the provider because each scheme negotiates with providers at the local level. An NGO facilitates the entire process although the operations (including fund holding) are conducted by individual schemes and their umbrella organization. Currently, in a particular scheme with the

coverage of 20,000 members, the annual premium varies between UShs 3,000 and UShs 10,000 per person per annum with an additional (uniform) subsidy of UShs 2,500 per person per annum. These schemes seek to provide all essential care including basic hospitalization, some times with the benefit ceiling of UShs 100,000. This can be revised from time to time on agreement in a meeting when yearly budgets are drawn and costs of administration and premiums determined in the same meeting.

Some advantages of the community-based and community-owned health insurance, as practiced in Uganda, are:

- Community ownership and control;
- Purchaser-provider split;
- Well-coordinated
- Subsidized, if supported by government or NGOs
- Not-for-profit approach;
- Targets basic essential care
- Similar benefit package
- Pre-existing illnesses are covered;
- Insurance is cashless;[XVIII]
- Pregnant women are included;
- Differential premium (socioeconomically determined)
- Differential pricing (based on local conditions and inputs prices)
- Premium paid in instalments;
- Limited co-payments.

It also suffers from some known drawbacks. Some of its drawbacks are:

- Exclusion of real catastrophic expenses (e.g., major surgeries) because they are not provided by the designated provider;
- Exclusion of chronic diseases or charging of additional premium to cover them;
- Smaller risk pools, not capable of bearing the real 'shocks';
- Benefits are hospital service oriented;
- No transport allowance. In Uganda, at times, the cost of travel to facilities may be more than the treatment cost unless the facility is closely located.
- No limitation on household size to be enrolled as long as all members can pay up their premium.
- No reinsurance between schemes
- No choice of provider

[XVIII] *Cashless insurance allows people to receive care when needed without having to make any payment to the provider at the time of seeking care. On the other hand, if the insurance is not cashless, it requires patients to pay first to the provider at the time of seeking care and request for a reimbursement from the insurer by submitting receipts once the treatment is completed.*

Due to its advantages and due to the drawbacks of the provider-owned health insurance, many people seem to prefer the community-owned (and NGO facilitated) insurance and there is a perceived shift away from provider-based insurance towards community-based insurance.

8.4.2 Insurance-based, provider-owned mechanisms

This is another form of health insurance operating in somewhat similar fashion. The major difference lies in the ownership and enrolment. Unlike the community-owned insurance, the fund holder is the provider and therefore, there is no provider-purchaser split. Also, there is no larger risk pooling and pooling is restricted to the local pool covering a population up to 100,000. In this case also, membership is defined in a group manner and known groups are encouraged to enrol as a group to avoid adverse selection. No group newly formed for the purpose of the health insurance scheme is allowed to enrol. The size of each community group varies between 25 and 80 households (150 - 500 individuals). Community groups are known as 'self-help groups'.

Community groups, once formed, approach the provider for enrolment into the health insurance scheme. Enrolled members enjoy a price advantage (of about 80% for outpatient care and 100% for inpatient care) over the non-enrolees. However, there are no earmarked beds or preference for insured patients in hospital admissions. Population coverage rate is less (about 5% of the target population) compared to the community-based insurance (7-30%).

Premium is defined differently according to the number of family members and ranges between Ushs 7,000 and Ushs 10,000 per person per year. Persons suffering from chronic diseases such as diabetes and hypertension are required to pay a co-payment UShs 5,000 per person per outpatient care visit in addition to the premium. There is a subsidy involved (about 8% of the cost of care), but not known to the clients because it is absorbed as a hospital cost.

Known advantages of this mechanism are:

- Not-for-profit approach;
- Known facility;
- Price advantage over non-enrolees;
- No management burden or financial risk to the community; these two are borne by the provider.
- Subsidy;
- Communities don't have to bear any financial risk or administrative cost.

However, provider-based health insurance suffers from some disadvantages as well. Some of them are:

- Pregnant women are not allowed to enrol;
- Chronic disease patients have to pay co-payments;
- Services are only subsidized, not free;

- No purchaser-provider split;
- Insurance is not cashless.
- Benefits are hospital service oriented;
- No transport allowance. In Uganda, as stated earlier, the cost of travel to facilities may be more than the treatment cost unless the facility is closely located.

One of the limitations of low population coverage under community or provider based insurance is that insurance as a concept is not well understood by the people. Pre-existing conditions and pooling are difficult concepts for people to understand. Moreover, some people expect the return of premium when 'not used'. Another reason for its limited coverage is the lack of capacity to run the scheme effectively. Scaling up of these schemes may require additional training (institutional and people-to-people). Fear of adverse selection is also holding the coverage back a bit. Some people also drop out of the schemes because they are not able to pay the premium and probably don't see the benefits as well. The long distances travelled to the only provider in the district/community acts as a drawback on enrolments as members resort to use of near by clinics and LTFQs.

8.4.3 Banking-based, community-owned mechanisms

In Uganda, there are few banking-based (mainly credit) approaches exclusively for health initiated by some communities. Such credit schemes operate through a lump-sum initial payment, followed by regular maintenance payments. If a subscriber has a major medical expense, he/she can draw on the available credit. The loan is interest-free and is supposed to be repaid in 1-3 months, but enforcement of the timeframe has proven to be quite difficult. Repayments of 8 months and even a year are not uncommon. It is estimated that about 7% of the loans are not collectible but there currently isn't a process for writing off such loans. Some communities absorb it in their annual running cost.

The operating mechanism of this model is shown in Figure-22. The lowest organizational unit here is a *parish*[XIX] (population of about 3,000). Schemes were designed in participatory way, with reasonable contributions from people. People who live in the same parish come together and form a group, which does not exclude anyone including the elderly. They elect leaders and agree on internal operations of the scheme. They agree on the benefit package and the provider(s) whom they wish to contract. They collect money and sign a memorandum of understanding with the service provider(s).

There is an initial payment of about Ushs 3,600 (US$ 1.75[XX]) to become a member of a group. In addition, there is an annual payment of about UShs 3,000 - 5,000 to cover the running cost of the scheme. The running cost depends on the pool size and the loan default rate. In some

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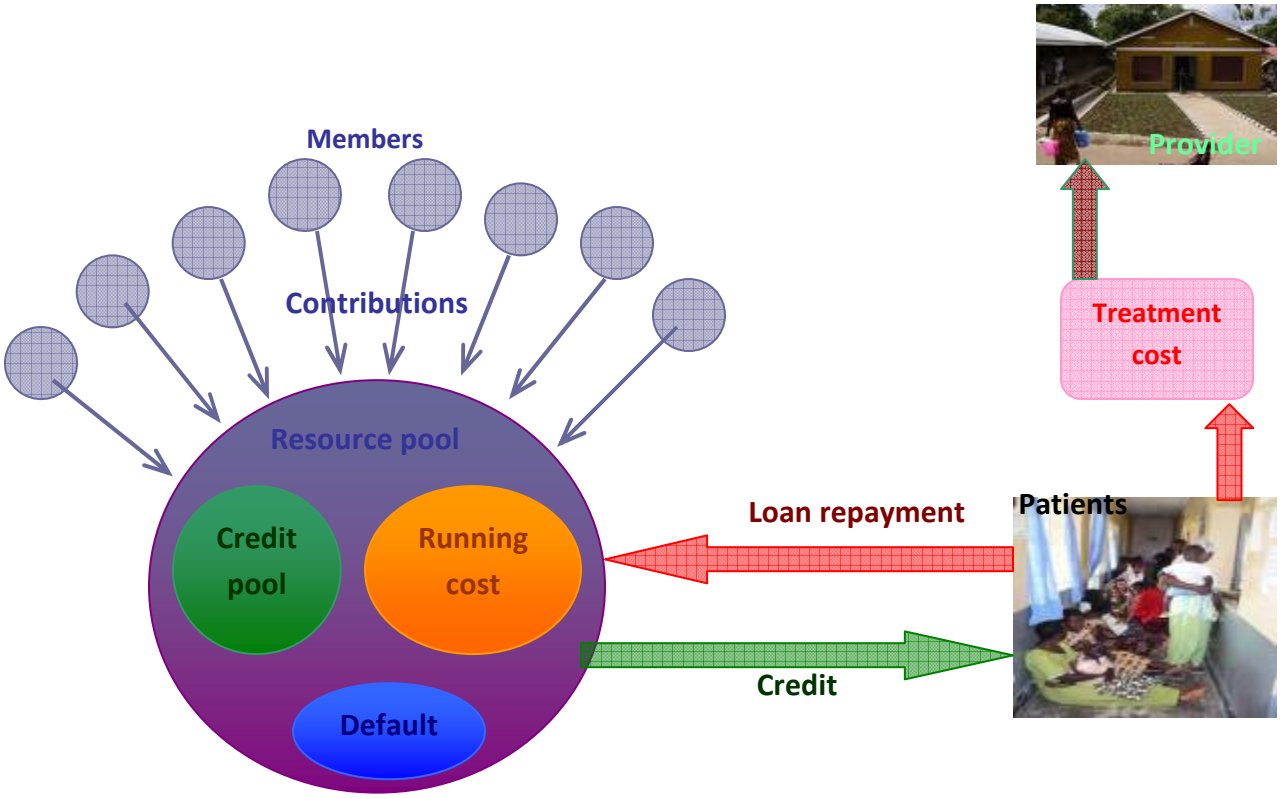
[XIX] *A parish is an administrative unit covering seven to ten villages*
[XX] *I US$ = Ushs 2,046 (as on 4th March 2010)*

parishes, payment towards the running cost is determined per family, not per member; however, the size of a family in practice could even get extended up to 30 members.

Figure-22

Community-owned pooled credit model



In a particular scheme, existing in *Luwero, Nakaseke* and *Nakasongola* districts, the size of the parish level pool varies between 350 and 1,000 members.[24] About 15 of such groups, spreading across 3-4 districts, form a union of about 10,000 members. Each group pays UShs 50,000 (US$ 24.50) to become a union member. The union has an elected chairperson to manage the schemes and to act as their fund holder. However, each group of the union is a separate operational entity deciding about the membership, annual payment, benefits, and loan disbursement. When a member becomes sick, he/she goes to the designated provider and receives the required health care. The bill is charged to the group, which in turn, settles it with the provider every month. The amount is kept as a loan against the member, who replay it in instalments within 3 months. The loan amount could be up to Ushs 100,000 (US$ 49) and does not carry any interest. If a member has a 'live' loan, he/she is not allowed to draw another loan before repaying the earlier loan. Therefore, the number of loans per member is kept at one. Experience during the last 10 years has shown that members are benefitting from the credit scheme. However, the credit was not able to cover the entire cost in some cases and the affected members had to seek additional loan from SACCOS.

Table-13 provides the trend in the enrolment concerning the scheme in *Luwero, Nakaseke* and *Nakasongola* districts. With 8,231 individual members, it covers a total target population of about 50,000 spread in three districts yielding a coverage or penetration rate of 16.5%. As it can be seen from Table-10, membership per household increased from 3.9 members in 2000-01 to 5.1 members in 2009-10 indicating that members are satisfied with the scheme, thus adding new members to it. The number of participating households too is showing an increasing trend.

Table-13

Enrolment trend in a credit-based community financing scheme

MEMBERSHIP CATEGORY	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Households	96	241	181	352	477	667	910	1,075	1,406	1,607
Individuals	373	812	824	1,593	2,156	3,013	4,077	5,183	6,930	8,231
Membership/ household	3.9	3.4	4.6	4.5	4.5	4.5	4.5	4.8	4.9	5.1

Number and size of loans disbursed under the credit scheme are given in Table-14. Over 10 years, the average size of a health loan varied between UShs 13,000 (US$ 6.35) and UShs 26,500 (US$ 12.96). The loan intensity (% of members availing loans) and the average loan size remained more or less the same during the 9-year period although the intensity was low between 2002-03 and 2004-05. The low intensity was apparently due to heavy amounts taken by few members, as indicated by the average loan size. Total amount disbursed in 9 years was about UShs 41 million (US$ 20,100). The scheme mobilized UShs 12 million (US$ 5,842) in 2008-09 alone. In all, a sum of UShs 4,500 (US$ 2.20) per capita was generated out of this credit scheme in 2008-09 including the payments towards the running cost. The running cost in this scheme also includes payments to cover the defaults (about 10% of the loans).

Many members of the scheme found it quite convenient because they don't have to make any contribution (except the running cost) unless they fall sick and they don't have to mobilize resources at the time of sickness. The following are its other advantages:

- Community ownership and control
- Purchaser-provider split
- Not-for-profit approach;
- No exclusion
- Interest-free loan
- Community solidarity in case of default
- Cashless at the time of seeking care

The drop out rate is also low (around 10%), as it can be seen from the scheme's growth in three districts over the 9-year period. In fact, a group of clients mentioned that it was the spirit of 'community pleasure', not community pressure, to help each other that makes the scheme

successful. The community also does not want to use legal provisions against defaulters as it feels that it would shatter the very foundation of the scheme based on mutual trust. The health care provider too plays a major role in promoting the scheme. There are certain drawbacks too as observed below:

- The scheme benefits people who can afford to take a loan and repay it.
- The fact is that people take loan, if it is interest-free, to meet the treatment cost. It has to be repaid at a time when the loan recipient is recovering from sickness. Hence, it suffers from drawbacks similar to OOPs financing because the loan repayment may require selling of assets.

Table-14

Health financing trend under the credit scheme

YEAR	NUMBER OF LOANS	LOAN INTENSITY (% OF MEMBERS AVAILING LOANS)	TOTAL AMOUNT DISBURSED (USHS)	AVERAGE AMOUNT PER LOAN (USHS)
2000-01	45	12.1	595,200	13,227
2001-02	92	11.3	1,925,850	20,933
2002-03	23	2.8	1,007,700	43,813
2003-04	89	5.6	2,359,550	26,512
2004-05	118	5.5	2,059,850	17,456
2005-06	336	11.2	5,395,950	16,059
2006-07	415	10.2	6,767,100	16,306
2007-08	581	11.2	9,039,900	15,559
2008-09	762	11.0	11,952,950	15,886

- The scheme does not cover the treatment cost fully. For instance, a member spent Ushs 170,000, but received the loan for only Ushs 100,000 and had to cover the rest from other sources; he sold his bicycle to meet the rest.
- There were other peculiarities with respect to the scheme. For instance, a female member of the scheme delivered a baby and her delivery cost was paid from the scheme. However, the baby fell sick and did not receive the benefit because the child was 'not a member'.
- The rule of 'one loan per member' also affects the enrolees because some times there were repeat illnesses for which loan was not available.
- Distance to health care provision is a major hindrance in some areas where people are not able to avail health care despite being in a financing scheme. This is applicable to insurance schemes as well.

However, credit-based approach may be useful in contexts where people don't want to pay before they are sick, the basic requirement for an insurance approach; some people don't want to pay unless they are sick. Moreover, credit-based approach limits moral hazard and avoids adverse selection. Now, they are trying to add insurance to the credit scheme to make it credit + insurance scheme so that minor costs (up to UShs 30,000) can be covered by the credit while the rest can be covered by the insurance if the bill exceeds UShs 30,000. In this case, this credit amount acts as a deductible for the insurance scheme. The major drawback of this approach is that the small community with limited resource base acts as an insurer and therefore, the scheme may not be sustainable due to high running costs.

8.4.4 Banking-based, corporate-owned mechanisms

Microfinance mechanisms using the banking approach also exist to finance health in Uganda. Unlike the community-based approaches, which operate on a not-for-profit basis, microfinance approach seeks profit. Started in 1996, over 90 financial institutions now offer microfinance in the country; some of them have a membership base of about 130,000 members. The promoters of microfinance tend to target organized groups and school-based schemes (covering both students and teachers) are becoming quite popular. While big institutions offer a wide variety of microfinance products, only few of them offer micro loans or insurance exclusively for health. However, the number and size of micro loans availed for the purpose of health are not known. As mentioned earlier, even members of community-based health financing schemes avail micro loans from SACCOS when the amount provided by their community scheme is not enough to cover the treatment cost.

Unlike community-based schemes, which predominantly exist in rural areas, microfinance benefits urban people. So, microfinance can be termed as an urban variant of community-based financing schemes. The main difference, however, is the profit seeking by microfinance schemes. In any case, microfinance has come to stay in Uganda. As noticed in other countries such as Bangladesh and India, where microfinance mechanisms have been existing since the 1980s, microfinance may mature into a full-fledged source of financing mobilizing savings, and offering credit and insurance in about 10 years' time from now. At present, in Uganda, only micro-credit is being widely used with only two institutions offering micro insurance. Microfinance institutors, unless they are formal banks, by law are not allowed to mobilize savings in Uganda. It is necessary to take the potential growth of microfinance into account and plan for its appropriate use in health.

8.5 Overall performance assessment

Household out-of-pocket is probably the worst form of health financing and it cannot be accepted as a major source of financing in Uganda. Therefore, there is a need to find alternative ways of channelling household resources. This review has provided four possible options to mainstream household out-of-pocket spending. At the same time, these options themselves are not mainstreamed into the national health financing system. Efforts are required to take stock of their potential and plan for their appropriate place in health financing. Additionally, there is

also a need to enhance access to those who are prevented from using health care due to financial barriers. Moreover, better planning and regulation of service providers is needed so as to ensure that they are providing the defined package of services, and in a manner that minimizes the financial burden on households.

9 EMPLOYER/CORPORATE FINANCING

Employers are a main source of financing for formal sector employees. In addition, some corporate agencies provide philanthropic resources to help the poor and other disadvantaged people.

9.1 Level and sustainability of funding

Finance from employers covers less than 1% of the Ugandan population. It share in total health spending could be up to 5% although there does not exist proper estimate on this. Poor state of the government hospitals acts as a major disincentive for the employees. However, some employees pay additional premium to avail additional services and/or pay premium for their family members who are not covered by the employer sponsored private insurance. Half of the currently insured are likely to continue with their private insurance despite the government proposed NHIS.[12] In future, employees not covered currently are more likely to join the NHIS compared to those who are currently covered.

8.6 Financial accessibility

A survey (only in Kampala) among the formal sector employers and employees revealed that 56% of the employees were covered by any form of health benefits;[14] 38% were currently insured and another 18% had some form (e.g., on-site clinic) of health care coverage. Employers and employees also contribute to social security. However, they don't receive any tangible health benefits from their social security contributions. In addition, employees also pay local service taxes.

8.7 Value for money

Employers avail two options - provide and purchase - to fulfil health care needs of their employees. Both forms have their own advantages and disadvantages. It is not feasible for all the employers to run their facilities in order to take care of their employees. Even those directly providing care are not able to provide all the necessary care and they supplement it with private insurance.

8.8 Institutional capacity assessment

Employer/corporate resources flow through three channels viz., direct provision, private insurance and philanthropy. At present, it is not possible to say about their relative size because there does not exist any estimate on this. A vast majority of the employers, however, use private insurance with a small group indulging in direct provision. Private insurance in Uganda relies heavily on employer finance. The size of philanthropic resources from the corporate sector is not known.

8.9 Overall performance assessment

All the three mechanisms through which the corporate sector operates in Uganda hold promises for future depending on the way the future health financing strategy will guide them. Private insurance has its operating structure predominantly in urban areas. However, there is no exclusive private insurer for health as it is not seen as a profitable venture. Hence, health insurance exists as a by-product of the insurance companies. Direct provision by some employers has some scope to extend its coverage to non-employees. Philanthropic resources, of course, are not streamlined. With better streamlining, such resources could be strategically used to achieve national health goals.

9 NGO FINANCING

Private Not For Profit (PNFP are in two categories, the facility based which are mainly religious affiliated. These own and operate health facilities and there is a close collaboration with MoH. They produce 40% of health sector outputs[11] and own 30% of health facilities in the country.[XXI] The second category is the Non facility based NGOs, these are diverse ranging from community based organizations operating at a very small scale, local and international NGOs which may operate in a number of districts providing a wide range of services even beyond health. Their area of work has been mainly advocacy and sensitization on health issues. The collaboration framework between non-facility-based NGOs and the MoH is yet to be put in place.

Facility-Based Private not-for-profit (FB-PNFP) facilities play a significant role in health care provision to the disadvantaged populations and have in the past not only reduced user fees but also flattened them selectively as a result of budget support from government. The FB-PNFPs provide both curative and preventive services. The faith-based NGOs account for 41% of the hospitals and 22% of the lower level facilities complementing government facilities especially in rural areas.[1] In 2007-08, PNFP hospitals handled over 1.5 million outpatients, 360,000 admissions and 70,000 deliveries. On the other hand, the non-Faith-Based PNFP sub-sector comprises of hundreds of NGOs and Community Based Organizations (CBOs) that mainly provide preventive health services which include health education, counselling, palliative services, rehabilitative services, health promotion and support to community health workers. This sub-sector is a very useful channel for communicating concerns of communities to the government.

9.1 Level and sustainability of funding

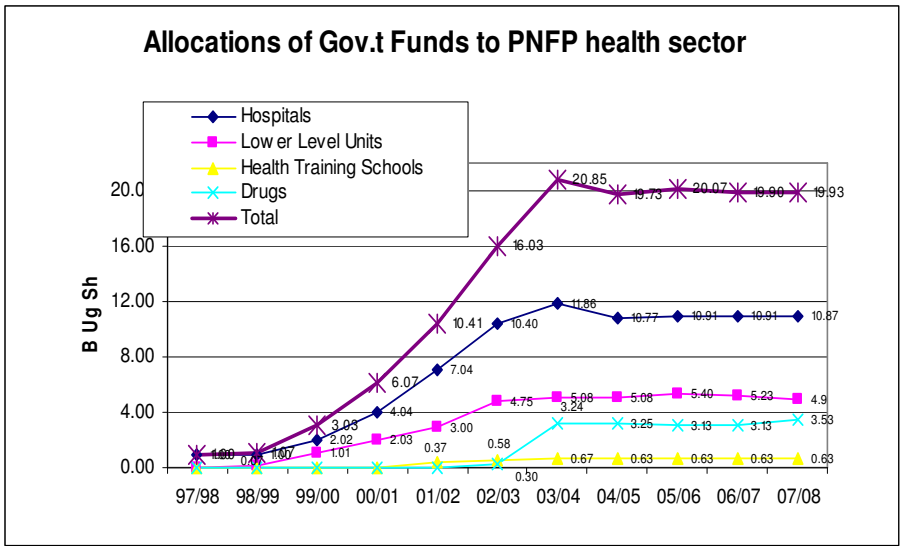
Although the government subsidizes FB-PNFP health facilities, the level of subsidies has stagnated at about 20% of the total expenditures in the past few years (Figure-23) and it was reduced in real terms. In 2007-08, total subsidy was UShs 19 billion financing 22% of the PNFP expenditures.[9] In 2008-09, it has declined to 20% as total cost increased because of increased volume of work but also because of increased unit cost of services. Data from a sample of 27 PNFP hospitals indicates that they actually received 89% of the allocated subsidy.

Additional sources of revenue for the sub-sector are donors (mostly foreign, but also local) and user fees from clients. In recent years, external resources from donors have increased, although the greater proportion of the external donor funds are earmarked for HIV/AIDS. The resources mobilized by the faith-based PNFP sub-sector amounted to UShs 113 billion in 2008-09.[11] This corresponds with the increased volume of service delivered by the sub-sector. Government contribution continued to finance less and less of what is needed for the PNFP facilities to provide services.

[XXI] *MoH, Infrastructure inventory, 2007*

Figure-23

The trend in government allocation to the NGO sector



Source: *Draft Health Sector Strategic Plan III, 2010*

9.2 Financial accessibility

Government subsidies and contribution from external resources to the PNFP facilities actually benefit the marginal poor and the middle class by reducing their financial burden of accessing health care. It cannot be said to be benefiting the poorest because these facilities charge user fee, even if it is subsidized. Due to rising unit costs of services along with the now reduced budget support from government to individual facilities, these facilities try to raise more money through user fees. Inflows from users have consequently increased both in absolute and relative terms financing up to 49% of the overall recurrent cost incurred by units to deliver services. The level of recurrent costs recovered from user fees is higher in Lower Level Health Centers (67%) than in Hospitals (44%). The volume of funds from external donations both in kind and in cash also reduced from 31% in 2007-08 to 25% in 2008-09.[11] This reduction is more significant in the Lower Level Health Centres (-9%) than in the Hospitals (-2%).

9.3 Value for money

Observations from a sample representing 65% of faith-based PNFP hospitals have shown positive trends with regards to the most important health indicators in 2008-09. Between 2007/08 and 2008/09, outpatient care service provision has increased by 5.4% while hospital admissions have increased by 0.1%; number of deliveries has remained more or less the same. But, the number of immunizations has registered the maximum increase (19.6%). Data on

service outputs of PNFP hospitals suggest that utilization (Standard Unit of Output – SUO) increased by 3% in 2008-09.[11] The increase in lower level facilities was higher.

9.4 Institutional capacity assessment

Aid in the form of cash or in kind from outside the country (donation of goods, equipment and drugs as well as project money) represent the larger source of financing (44%) with a slight decrease of 1% in 2008-09 compared to 2007-08.[11] However, over 70% of aid money is only for the Global Health Initiatives related programs (HIV, TB and Malaria). Income from user fees represents the second largest source of financing (41%, a rise of 2% as compared with 2007-08). Government subsidies represent now a proportion of only 14% of total hospital income (a decrease of 2% from 16% recorded in 2007-08).

For hospitals, the largest source of financing is user fees that have registered an increase of 9% while donors' input and Government subsidies decreased in their relative contribution by (-2%) and (-7%) respectively.

9.5 Overall performance assessment

Overall, NGO facilities are significantly contributing to increase access to rural populations, particularly the middle class and the marginal poor. But the increasing dependence on user fees is likely to affect accessibility if the trend is not reversed. Rural facilities, placed among the poor will be most affected. This underlines the need for an increased government support to reduce the increasing share from patients and improve service utilization.

SECTION III: SCOPE FOR FUTURE HEALTH FINANCING

10 CRITICAL CHALLENGES AHEAD

In Uganda, health financing challenges seem to co-exist with some promising options to overcome them to some extent. While challenges lie in the efforts to raise enough resources to appropriately finance health care, promises lie in the strength of the communities. In the past, there has been a strong emphasis on resource mobilization, with less emphasis on resource organization, pooling, purchasing, sustainability, equity and efficiency. This chapter discusses the health financing challenges mainly concerning its three objectives of resource adequacy, efficient use of resources and equitable financing.

10.1 Resource adequacy

The system has been able to raise additional financing, on a consistent basis in the near past. The pattern of increase shows a consistent increase as opposed to sudden, one – off increases. This pattern is desirable for a system that is consistently working towards increasing on its coverage of critical interventions, and suggests that increases in financing are most probably being matched to specific service coverage targets.

Though the Government financing has been increasing, in real terms, we see that it has maintained a fairly constant share of key comparators of trends in financing. There is significant scope for increases in Government expenditure. The increasing GDP suggests more resources should be made available. The Government revenue collection ability will, however, always lag behind as the GDP growth rate is too high for the capacity improvements in revenue collection to be at the same pace. Over time, however, the revenue collection should improve, as a portion of GDP as the revenue collection capacity improves, implying more resources for Government in the medium term.

Discussions between Ministries of Health and Finance, Planning and Economic Development that focus on, as a minimum, maintaining the health portion of the total budget at approximately 10%, instead of the current fluctuating trend would be feasible, and would ensure significant increases in Government health expenditures. In the longer term, then, the discussions would focus on increasing this portion further, in line with Government Abuja commitments to 15%.

Although full potential of the government resource base for health needs to be carefully utilized, there will still be some gap in health financing to be covered by other sources. Even if government resources are in a position to cover about 40-50% of the resource needs to adequately finance health care, the remaining 50-60% still needs to be filled by other sources. This review points out that careful planning of household, NGO, corporate and philanthropic resources could fill the other half.[XXII] After all this, there will still be some gap between the need and the resource base in the country, given the possible economic and health care context in

[XXII] *Donor projects and GHI are included in "government"*

Uganda in the near future. Therefore, optimal use of the existing resources is the key in addition to looking for additional resources.

10.2 Resource use efficiency

Allocative efficiency, particularly across key inputs, needs to be prioritized. The important service coverage improvements are driven significantly by external resources. Additionally, as an input into development of the Health Financing Strategy, the impact of decentralization of resource management needs to be analysed.

The fact that the external resources are largely supportive of program or project approaches should be looked into with more detail. There are real issues that exist within the sector, and country institutional arrangements that are leading to this situation. These may, or may not be out of control of the sector management processes. The sector needs to also focus on improving the management, and use of these resources, as opposed to only focusing on who manages them. A joint program of work, with investment priorities would act as a framework to guide and monitor investments towards allocative efficiency.

The bulk of the external sources fund mainly programs, which may be channelled through the Government MTEF process as earmarked for particular programs, or managed separately by the source of funds. For this to be most effective, the sector needs to have, in addition to the HSSP, a comprehensive, detailed program of work clearly outlining priorities, with their investments needs based on the four input areas of Human Resources, infrastructure (including maintenance transport and ICT), commodities/supplies, and operations. This could feed into a national investment plan that then guides both Government, and the external financing sources in terms of where to prioritize their funding. It is currently done in a patchy manner, with priority programs not clearly defined in this manner. The apparent over-financing of HIV/AIDS program in relation to other priority program areas is a case in point.

A quick look at current health care utilization in Uganda suggests that the poor use public facilities more than the richer quintiles. However, this analysis masks the income-related differences in utilization patterns: poor households predominantly use health centres and wealthy households use hospitals. This suggests that focusing on improving access to health centres and dispensaries is an important pro-poor strategy.

A financing strategy needs to work towards reducing or eliminating the out-of-pocket expenditures due to its negative effect on equity, but also institute strategies to improve its organization and management so as to maximize the value clients get from these expenditures. Alternative resource channelling mechanisms, in addition to the government, such as the community-based and NGO financing mechanisms (both insurance and non-insurance) could be used to better organize household resources in a prepaid manner. Regulatory measures are also required to streamline and improve the appropriateness of the health care provision by the private for-profit sector.

10.3 Equity in resource allocation and utilization

One of the challenges in Uganda is the inequitable distribution of existing resources. Present resource allocation is such that maximum resources (both government and private) are spent in areas where health care needs are moderate with the comparative neglect of areas where health care needs are high. In advantageous areas, both government and private facilities are functioning well while in disadvantaged areas, these are weak. Therefore, additional strategies to improve on financial accessibility of the population need to be explored. There is a need to do a resource mapping and move government resources away from advantaged to disadvantaged areas. Spending resources in areas where health care needs are high is both equitable and efficient.

Government needs to promote, facilitate and invest in alternative prepayment mechanisms including, but not necessarily limited to, insurance that will reduce, in absolute terms, the amount of financing currently coming from out-of-pocket. Government financing for insurance mechanisms, either at the community level or national level, should be explored, as should other mechanisms of ensuring sustainable, but equitable sources of financing. As mentioned earlier, philanthropic resources are currently not a recognized source of financing. Similarly, the size and potential of community-based mechanisms and private mechanisms including the microfinance are not known. All these resources need to be strengthened and coordinated at the district level so as to utilize them effectively. They could be integrated at the national level through the proposed NHIS.

11 ANTICIPATING THE FUTURE ROLE OF FINANCING OPTIONS

Uganda has a plural health financing system with an array of different financing options. Government and external resources together form a bigger chunk with other mechanisms completing the pie. As in many low-income countries, Uganda has certain community strengths, particularly organizational more than financial, which can be productively employed to address the challenges to some extent. Of course, their resource base is small, but significant as it can be seen from the amount of OOPs spent on health. Communities can play a useful role in resource organization, pooling and utilization. Community-based mechanisms are significant in places where they operate with their coverage or penetration as high as 30% of the target population. On the other hand, there are alternative options such as the NGOs, philanthropists and corporations to raise financial resources for health. NGO resources are widely prevalent. In fact, there is a strong link between NGO and community-based resources in many places although purely community-based mechanisms do exist as well. Philanthropic resources are available, particularly from big corporations. There may be other smaller contributions at the community level.

Part of the challenge, therefore, lies in the identification and better use of unorganized resources and their health financing mechanisms. More specifically, household, NGO and philanthropic resources and their channels of flow are not well documented or planned. This is also true, to a limited extent, to employer/corporate and donor resources. At present, four broad channels of resource organization are in use in Uganda using three institutional mechanisms viz., direct purchasing, insurance and banking. The channels and some crude estimates[XXIII] (based on observations and discussions with various stakeholders) of their potential for population, health care and financial protection coverage are provided in Table-15. Future organization of the health financing system could be designed keeping this potential in mind.

11.1 Government financing

Rough estimates, as given in Table-15, would suggest that government funding probably has the potential to channel up to 40% of the total health financing resources in the country, assuming that the external resources will gradually come down, at least as a budgetary source, while local philanthropic resources may gain entry into the budget, if planned that way. Government, on its own, is capable of covering up to 50% of the population, predominantly the urban and rural poor and 55% of their health care needs. Hence, the government financing is

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[XXIII] *Not based on any systematic estimation (in fact, such an estimate does not exist). An attempt is made here to quantify the potential purely based on observations, discussions and field visits.*

the dominant future mechanism to finance health. Its role is crucial to attain universal coverage in all three dimensions viz., population coverage, health care service coverage, and financial protection. It enjoys many advantages over the alternative financing mechanisms, such as

- Vast infrastructure
- Non-profit motive
- Neutrality
- Trained human resources
- Greater accountability
- Wide range of tools to intervene

However, in order to get maximum benefits, the decentralized government structures at the district level are required to play an active role in tracking health care needs, identifying the poor and other disadvantaged people, working with other sectors, regulating the private sector, working with community groups, providing efficient health care services, and planning and mobilizing philanthropic resources.

Table-15

Health financing channels and rough estimates of their potential in Uganda

FINANCING CHANNEL	TARGET BENEFICIARY GROUP	AREA OF OPERATION	POTENTIAL FOR COVERAGE (%)		
			Population	Health care	Financial protection
Government[XXIV]	Marginal & extreme poor	Urban, semi urban & rural	40 - 50	45 - 55	30 - 40
NGO[XXV]	Lower middle class and marginal & extreme poor	Semi urban & rural	20 - 25	20 - 25	20 - 25
Community-based[XXVI]	Lower middle class & marginal poor	Rural	25 - 30	25 - 30	25 - 30
Private[XXVII]	Rich & upper middle class	Urban, semi-urban	15 - 20	10 - 15	25 - 30

[XXIV] *Includes external and philanthropic resources*
[XXV] *Includes a portion of household, philanthropic and external resources*
[XXVI] *Includes a portion of philanthropic resources*
[XXVII] *Includes insurance and microfinance*

11.2 NGO financing

FB-PNFPs hold certain advantages as well. They are located much closer to the people and are well-versed with their needs. They actively seek financing from alternative sources other than the patient charges. More often, they provide appropriate quality of care at an affordable price, sometimes providing subsidies as well. At present, their strength lies in serving people from the lower middle class and the marginal poor. Their ability to reach the extreme poor, however, is limited although they do serve a section of this group as well wherever they are able to subsidize their care. They have the potential to serve up to 25% of the health care provision in the country. It is easier to mainstream this channel, given its close working relationship with the government.

On the other hand, the non-FB-PNFPs are varied in institutional set up, scope of operation and capacity. Although some may be located at the grass root, the capacity to manage and account for resources and provide services has been noted to be sub optimal. Lack of an effective regulatory framework, capacity of the MoH to monitor their operations and their weak engagement in policy development processes limits the extent to which they an meaningfully contribute to health sector objectives. However, they hold significant amounts of resources.

11.3 Community financing

Community-based mechanisms provide an additional strength to the national health financing system. More than their resource-base, they also bring in some organizational advantages, particularly in identifying the poor and in monitoring the progress made by the public health programme. They could be potentially used in public health communication, needs assessment, resource tracking, organizing public camps, and health system management. Such mechanisms could also be used to streamline the OOPs; but, their mainstreaming needs could be carefully planned. Community-based mechanisms, with appropriate regulation and guidance, carry the potential to channel up to 30% of resources (once again rough estimates). They could also cover up to 30% of the population and purchase up to 30% of health care. Like the NGOs, their ability to cover the extreme poor is limited. Their present strength lies in reaching out to the lower middle class and the marginal poor.[XXVIII] At present, community-based mechanisms are scattered every where with very little integration and therefore, there is a lot of resource wastage. Moreover, community insurance pools are not sustainable unless they have a larger mechanism to insure them. In fact, the government could act as a super-insurer or reinsurer for them with a nominal payment of a premium.

11.4 Private financing

Private financing channel operates in three ways - direction provision of services, private insurance and microfinance. Direction provision of service channel is being used by some

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[XXVIII] *Could include people newly impoverished, for example as a result of health care cost.*

employers to provide basic health care to their employees. But, the most prominent private mechanism for firms is the private insurance. Employers purchase health insurance for their employees from private insurance companies. Microfinance is another emerging new area of private finance. Its role in health is unknown, with not many health related products being offered. But, there appear to be indirect benefits, which are yet to be quantified. All these private mechanisms, however, are located in urban and semi-urban areas. Private channels, including the insurance and microfinance, could handle up to 30% of resources. Since they cover the relatively better-off, they deal with more resources. The population coverage could be up to 20% and could cover health care services up to 15%.

11.5 Summing up

Each health financing channel has its strengths (and weaknesses) and target population. The institutional mechanism(s) through which they carry out their tasks are also fairly clear. Given this, the Government of Uganda could plan for their optimal role in the national health financing system. What is clear is that there is a need to mainstream non-government and community-based health financing mechanisms in order to get full value out of the resources controlled by them as well as to streamline household out-of-pocket spending. At present, OOPs is mobilized through high-interest loans,[xxix] and selling of assets (like land, goats, bicycles, etc.); some people choose to forgo treatment or seek care from low-cost sources. Moreover, because it is unorganized, what is being purchased out of OOPs is not clear, with indications that it is spent on unnecessary or ineffective care. For these reasons, it is necessary to reduce or eliminate OOPs by channeling household resources through one of the organized resource flow channels viz., the government budget, NGOs, community-based and private mechanisms.

[xxix] *Some times bearing a very high interest rate of up to 3,000% per annum*

12 REQUIRED INSTITITIONAL ARRANGEMENTS

One of the key features of the first National Health Policy in Uganda was diversification of health financing in support of the national goals of improved health status and equity. At present, pluralism does exist in health financing characterized by six distinguishable sources of health financing viz., government, donors, NGOs, households, employers, and philanthropists, four channels to organize/pool them viz., government, NGO, community and for-profit private and three institutional mechanisms to purchase health care viz., direct purchasing, insurance and banking. However, all the financing sources, pooling and purchasing mechanisms are not well coordinated to achieve the national health and health system goals. The major focus of the next health financing strategy could be to effectively link them to achieve equitable and efficient health and health system outcomes. There is scope for improvement in every aspect of health financing - resource mobilization, resource/risk pooling and purchasing; the guiding principles could be resource adequacy, equity, efficiency and sustainability. This chapter presents a framework to enhance the linkage between sources, pooling and purchasing in an attempt to draw a road map to achieve universal coverage.

12.1 Existing health financing system

The predominant institutional mechanism almost used by all the major health financing sources is direct purchasing. Table-16 provides details of different health financing channels and their institutional mechanisms. Of course, OOPs also uses direct purchasing method to finance health care. It is not included here because it is not the organized form of financing. Of the three, banking is a newly emerging institutional mechanism mainly used by community-based finance and microfinance. Household out-of-pocket spending could be organized through any of the four channels using the insurance or banking method. Direct purchase of health care by households using OOPs is not an efficient, equitable and sustainable way of health financing.

12.2 Towards an integrated health financing system

Given the existing health financing dynamics and the likely future potential of various options in the country, an approach that integrates various health financing sources, pooling mechanisms and purchasing types may be ideal for Uganda to create a win-win situation for all stakeholders. The approach needs to take into account the following:

- Government is a dominant player with strong potential for provision and financing of health care, pooling of risks and resources, regulation, and leadership.
- Government health care provision and financing are decentralized to some extent
- Decentralized planning process has its roots firmly set up, but is still evolving
- Households are a major player in health financing, particularly in resource generation

Table-16

Institutional mechanisms through which health financing channels operate in Uganda

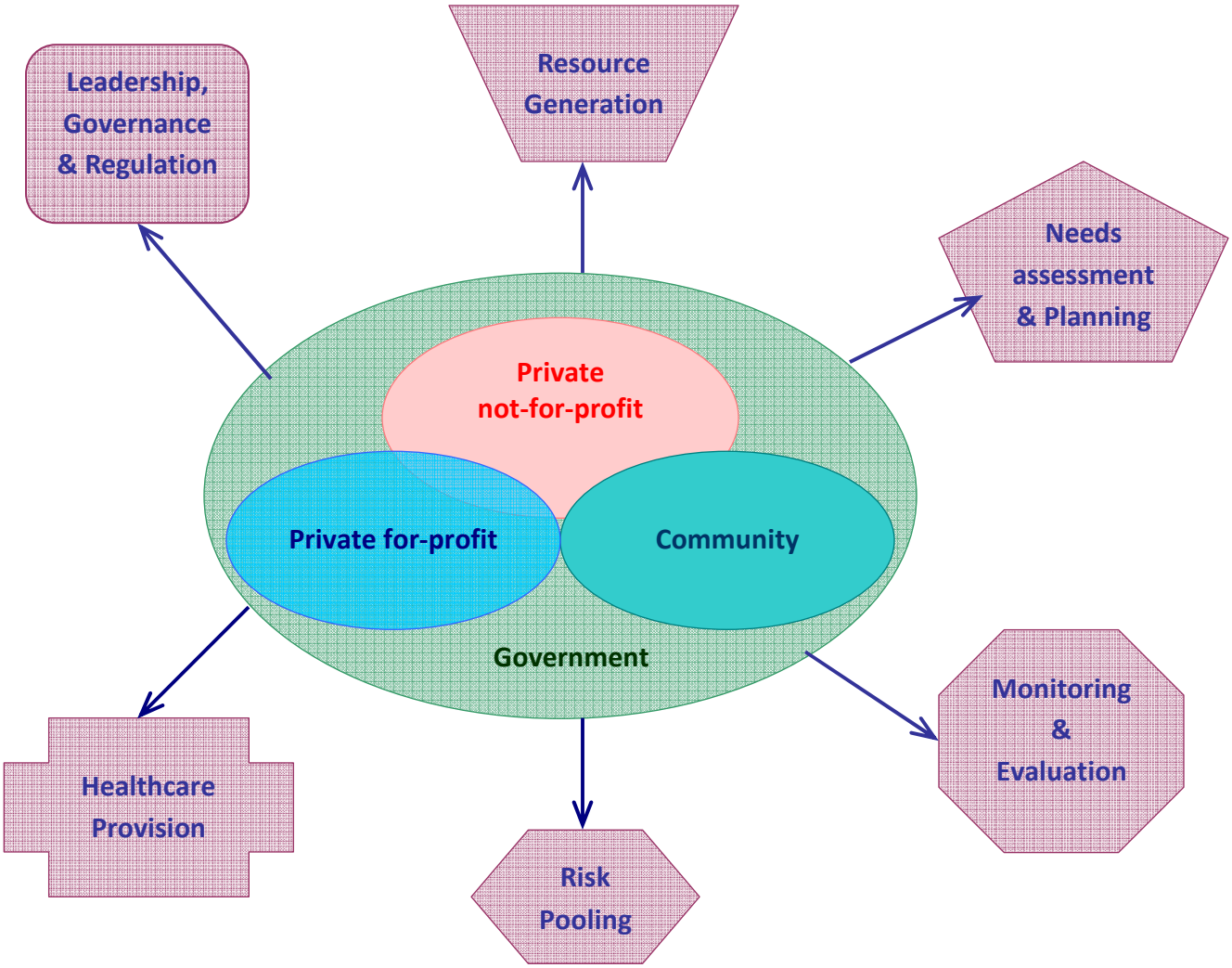
FINANCING CHANNEL	FINANCING SOURCES USED	INSTITUTIONAL MECHANISM	KEY INSTRUMENT
Government	Government budget	Direct purchasing	MoH budget
	External resources		Hospitals
	Household resources (payment ward)		Districts
			Demand side financing (cash transfers)
NGOs	Government budget (subsidies)	Direct purchasing	Hospitals
	External resources		
	Household resources (user fee)		
	Philanthropic resources		
	NGO resources		
Community-based	Household resources	Insurance	Community-based
	NGO resources (subsidy)		Provider-based
	Government budget (indirect through subsidies to NGOs)	Banking	Community-based credit
Private	Employer resources	Insurance	Provider-based insurance
			Formal insurance
	Household resources		Micro insurance
		Direct purchasing	Employer-run facilities
		Banking	Micro-credit

- Private sector (both for-profit and not-for-profit) has significant presence in health care provision, pooling (insurance) and financing (employer-based)
- Different variants of community-based financing mechanisms exist, but are based on local solidarity and risk pooling
- Philanthropic resources exist in different forms, but are not well coordinated.

Given these observations, the government is in a better position to lead the proposed integrated system with adequate private participation in health care provision, pooling and resource mobilization; communities could bring in social and financial capital. The framework for such an integrated health financing system is shown using Figure-24; it includes four major actors and six health financing functions. All the health financing functions are to be carried out under one umbrella to be steered by the government.

Figure-24

An integrated framework for financing health in Uganda



Since four different actors with four different characteristics are involved, the institutional arrangements need to be carefully worked out through a consultative process. Attainment of universal coverage requires an optimal and coordinated combination of all these actors and their mechanisms. The resource potential and institutional mechanism of these sources have not been analysed or utilized so far in Uganda. What was presented earlier in this report (Table-15) only indicates crude potential of each actor. Therefore, relative merits of each mechanism need to be documented so that their comparative advantage could be fully utilized. The potential merits of community-based mechanisms and microfinance have not been fully analysed. Since they are of relatively recent origin (with about 10 years of existence for some of them) and are on a upward trend, their potential needs to be carefully estimated. Micro

finance, for instance, has started its operation in Uganda in the mid-1990s. It started with micro-credit and is evolving into micro saving and insurance. Given its current growth, their full potential may be fully realized in about 10-15 years' time. Similarly, many community-based financing mechanisms currently functioning emerged during the late 1990s.

Given the context, one area that requires immediate attention is a mapping of actors, functions, strengths and weaknesses vis-à-vis community health care needs. Government, NGOs and communities carry varied potential and it is necessary to map them district wise before the system is designed and developed. The district health officers may be a in a position to map them in their own districts and could be consolidated at the national level for planning appropriate health financing strategies for the rural areas. Moreover, health financing has three major functions viz., resource mobilization, resource/risk pooling and purchasing and system needs to focus the attention on risk pooling and equitable and efficient purchasing in addition to resource mobilization. There are existing alternative channels (community, NGO, etc.) in addition to the government channel, which may be useful to carry out the other two tasks. For instance, they may act like a catalyst in the assessment of health care needs, targeting of beneficiaries, follow up of treatment practices, management of health care institutions, risk pooling, and resource organization. Some may be useful in needs assessment or targeting people while others could be involved in other aspects of health financing system management according to their potential and merit.

This mapping could be used to map out their potential roles in the new configuration. Through the mapping, three scenarios may emerge:

- There could be two or more actors carrying out similar activities and may be competing for the same stake. An example in this regard is the co-existence of government and private for-profit health care providers in urban areas.
- There may be areas where none of the actors are present in certain functional areas. An example in this regard may be financing of care of the disadvantaged populations.
- There may be areas where all the actors complement each other. An example in this regard is the co-existence of government and private not-for-profit health care providers providing complementary care.

A clear plan for the involvement of each actor as indentified in this report for each of the six functional areas concerning different sub-groups of population needs to be drawn in order to fix appropriate responsibility. Depending on the ability to perform the management role, a region or district could be used as a basic planning unit. Such an unit could draw plans for the entire geographic area and population under its jurisdiction. This unit, under the leadership of an appropriate government body, could be represented by members from all the four key actors depending on their presence and strength in the respective areas. Activities of these units, facilitated as a sub-pool at the appropriate geographic level, should be integrated and pooled at the national level. Such an integrated system could pool budgetary (available for

districts), community, NGO, employer and philanthropic resources. At the same time, it is necessary to raise government resources for health because they are going to be the major financing source for health in the years to come. Even with an increased growth of GDP and personal income, the scope for increasing revenue through alternative financing methods is not promising. The next health financing strategy needs to work towards reducing or streamlining the household out-of-pocket spending due to its negative effect on equity.

12.3 How to proceed?

Mapping of key actors and their functional areas should aim to answer the following questions:

- Resource mapping - What type? Where do they exist? In what form? How big?
- Resource organization - What is the primary source of each type? How are they organized? At what cost? Are they prepaid or post paid? Who holds the funds?
- Resource mobilization - What are the community needs? How often should the government undertake needs assessment (5 years, or 10 years?)? Who does the assessment? How to involve community and NGOs in needs assessment? What is the best way to mobilize resources at least cost? Which mechanism is best suited to do it? Who should hold the fund? At what level?
- Resource pooling - How to define an optimal risk pool and sub-pool? How to optimally integrate insurance and banking approaches (banking for outpatient care and insurance for inpatient care? How to integrate the sub-pools? Who manages the pool and the sub-pools? How to estimate the premium or initial payment for different sub-pools? How to plan risk equalization and subsidies?
- Purchasing - Who provides care? At what price? How to define the service package? Should the package be different for different sub-pools? Or should it remain the same? How to package additional services? Should there be a deductible or co-payment? If it is credit-based, should there be an interest? How to plan demand side transfers, if they have to be used to reach out to the extreme poor?
- Potential role for different stakeholders and resource channels - How to integrate the roles of different stakeholders performing varied roles? How to organize community-to-community leaning of experiences?

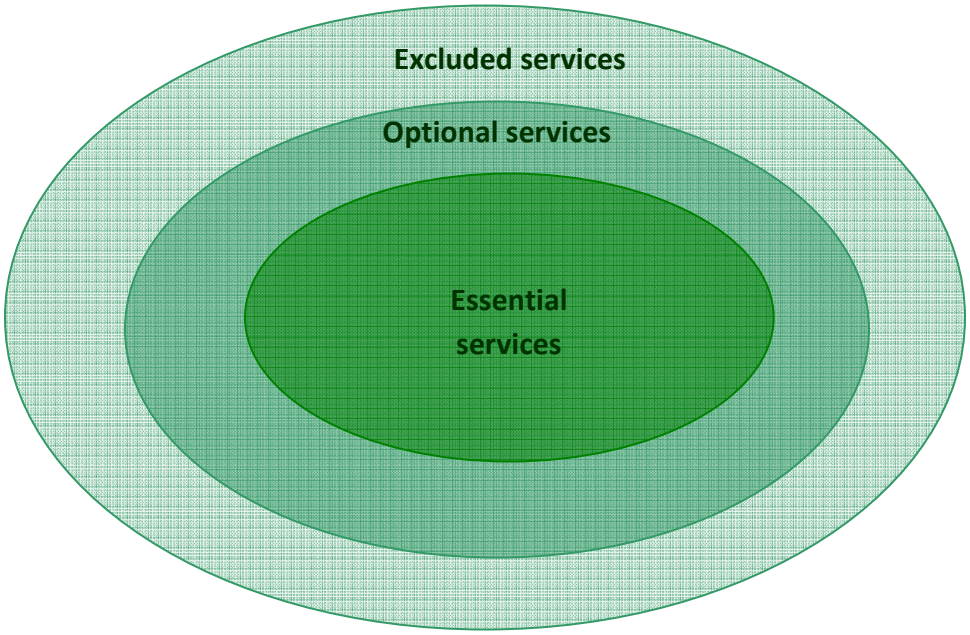
These are only lead questions and there could be others that could be added to the list provided above; additional questions will crop up during the design and piloting stage.

The second step is to define the package of benefits. The Uganda National Minimum Health Care package (UNMHCP) could serve as a starting point. The package needs to strike an optimal balance between needs and the resource base. A suggested framework for a differential

package of services is given in Figure-25. While every one will and should receive the essential service package, others could be given an option of choose a set of optional services (such as branded medicines, private ward, etc.). Some services will be excluded from the package. While the essential package should be uniform, the premium or payment for such package should be decided by each sub-pool along with the strategy to pay subsidy for the poorest.

Figure-25

Suggested packaging of services



It is ideal to include every Ugandan citizen/resident and provide health insurance (identity) cards to everyone. The price of the card (to be borne by the resource pool fund) will be determined differently by each sub-pool (geographically determined); it could even be graded according to the socioeconomic or geographic status of the people. Geographic targeting is easier than income targeting. The card would entitle the holder similar health care services irrespective of their socioeconomic or Geographic status; S/he is different only in terms of financing, not in terms of health care benefit. In this way, disadvantaged people will continue to receive free care under the changed system. Moreover, the card allows collecting, compiling and storing of certain valuable socioeconomic, health, and health care data of the entire Ugandan population.

The third step would be to design the participatory and integrated system with a role for each stakeholder under a defined responsibility and accountability matrix. The system could be developed first in a few districts to start with and could be nationalised later. Once the system is developed and in place, it could be an annual affair to develop priorities and work plan for the entire district using all potential sources of finance, not just government finance.

According to the integrated framework, each Ugandan resident will be clearly enrolled with one of the four actors, viz. government sector, private for-profit sector, private not-for-profit sector and the community-based mechanisms. While people could be given an option to enrol with any one of them, they should have the option to seek care from any health care provider, who is contracted by the integrated system. While the financial contributions and use of finance under each actor could be jointly determined by a local committee, the fund holding role could be performed by individual actors or by a board as appropriate to the local context. Overall, conditions for fund raising, health care provision/purchasing, health care seeking, fund holding and use of funds could be locally determined, but nationally linked.

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