UGANDA DEBT NETWORK

UGANDA'S POVERTY REDUCTION STRATEGY PAPERS AND RESOURCE ALLOCATION TO THE HEALTH SECTOR

Uganda Debt Network
P.O Box 21509
KAMPALA UGANDA
TEL: 256-41-543974
E-MAIL: info@udn.or.ug

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Acronyms

BFP –Budget Framework Paper
CSO- Civil Society Organization
DHSP - District Health Services Pilot Project
DPT – Diphtheria Poliomyelitis Tetanus
EF – Economic Functions
GDP -Gross Domestic Product
GNP - Gross National Product
HIV/AIDS –Human Immuno-Deficiency Virus/ Acquired Immune Deficiency Syndrome
HSSP – Health Sector Strategic Plan
IEC – Information, Education and Communication activities
IMF - International Monetary Fund
IMR - Infant Mortality Rate
LGDP –Local Government Development Programme
MDGS –Millennium Development Goals
MFPED –Ministry Of Finance Planning and Economic Development
MMR - Maternal Mortality Rate
MOH - Ministry of Health
MTEF –Medium Term Expenditure Framework
OPD-Out-Patient Department
PAF-Poverty Action Fund
PEAP – Poverty Eradication Action Plan
PHC - Primary Health Care
PNFP - Private Not For Profit
PRSC – Poverty Reduction Strategy Credit
PRSP – Poverty Reduction Strategy Paper
SDR – Special Drawing Right
SS – Social Services
STI - Sexually Transmitted Infections
SWAP –Sector Wide Approaches
SWG –Sector Working Group
UDHS - Uganda Demographic Health Survey
UDN –Uganda Debt Network
UPPAP –Uganda Participatory Poverty Assessment Programme

Executive Summary

In 1999, the World Bank and IMF introduced the PRSP approach to strengthen low-income countries' efforts to fight poverty, by encouraging pro-poor budgeting, implementation of poverty-focused policies and aligning donor support. This provided a window of opportunities to improve the heavily under-financed health systems in these countries. In 2003, the Uganda Debt Network (UDN) took a closer look at whether the PRSP process in Uganda[1] delivers on these expectations and contributes to increasing investments in the health sector. The case study is based on a desk review and interviews with government representatives, civil society organisations and donors.

Health indicators in Uganda are showing a mixed picture. Successes are booked in reducing the HIV prevalence rate from 6.8% in 1999 to 6.2% in 2000 and reversing the decline in immunisation rates in the 1990s. The coverage of health facilities has increased considerably. Progress has been made in malaria, TB, guinea worm and measles reduction campaigns. The abolition of user fees in 2001 contributed to a remarkable increase in service utilisation (OPD attendance) from 41% in 1999 to 84% in 2002. On the other hand, infant, child and maternal mortality rates are stagnating, with infant mortality among the poor being 80% higher than among the non-poor. The number of assisted deliveries is declining from 25% in 1999 to 20% in 2002. Service quality is poor, due to lack of (qualified) staff and shortage of drugs especially in the remote areas. Only 53% of approved posts are filled with trained health staff.

The poor are proportionately more likely than the non-poor to use the public sector. In 2002, for instance, of households in the poorest quintile who consulted a health facility, 44% used a public facility, whereas only 19% did so in the top quintile. Poor women are less able to access care for the problems associated with childbirth.

Uganda's health budget shows an increasing trend since 2001. Currently, 3% of its GDP and 9.5% of the government budget is allocated to health. Total per capita expenditure is around 15 USD, of which 9 USD is public spending. The Ministry of Health estimates that around 28 USD per capita is needed to cover a basic package of health services through government and NGO units, as indicated in the Health Sector Strategic Plan (HSSP) covering the years 2000/1-2004/5. The HSSP initiated a shift in budget allocation from secondary and tertiary services to primary health care. Allocations to district health services[2] have increased from 32% of the government health budget[3] in 1999/00 to 54% in 2003/04 while the share of hospital services declined from 22 to 12%. The share of the sector's expenditures financed by donor projects (as opposed to Government revenue and budget support) has fallen from 59% of the 1999/2000 budget to 31% in 2003/4.

The overall financial requirements for HSSP implementation are far from met. This translates into significant under-funding of HSSP priorities including reproductive health services, human resources and health infrastructure.

[1] Uganda calls its PRSP the Poverty Eradication Action Plan (PEAP)

[2] Including district lower level health units, district health management, district hospitals and Private not-for Profit hospitals and lower level units

[3] Including development partner budget support, but not project support

Uganda prepared its first PRSP or Poverty Eradication Action Plan (PEAP) in 1997, which was revised in 2000 and is under revision now. The PEAP is widely praised as a comprehensive yet realistic poverty reduction strategy grounded in a Medium-Term Expenditure Framework (MTEF). Spending on key poverty-reducing activities, such as Primary Health Care, is protected through the Poverty Action Fund (PAF), ensuring that policy promises are backed up with financial resources. However, concerns about its implementation are beginning to emerge. Recent figures show that growth targets have not been met, the public deficit is rising, and that the gap between rich and poor is increasing. For Uganda to reach its poverty targets, the economy will need to grow by 7% per annum; at present, the growth rate is 4.5%.

The PEAP recognises health as key to poverty reduction and focuses on the development of basic health services and disease control programmes. But neither the analysis nor the strategies presented in the health component of the PEAP is consistently poverty focussed. There is a lack of disagregated data, limited discussion on the causes of health inequality and financial barriers for the poor, and issues like non-communal diseases and disabilities remain un-addressed. The PEAP neither has indicators to monitor short-term progress in implementation, nor does it mention indicators for the health impact of reforms in other policy areas like employment. There are no details on financial requirements and options for resource mobilisation for the implementation of the HSSP.

The health sector comprises the Ministry of Health and various partners. It exists to promote better health outcomes through the monitoring and provision of preventive and curative health services. Its responsibility stretches not only to the public provision of services but also to supervision of the private sector, which provides a significant proportion of health care in Uganda.

The allocation of the health sector budget is a participatory process, based on discussions with stakeholders in the health sector and based on principles and strategies derived from the PEAP and the Sector Wide Approaches (SWAPs) through Sector Working Groups and the MTEF. The determination of the overall health budget however, is noted as non-participatory. Sectoral budget ceilings are set in the MTEF which is developed by the Ministry of Finance Planning and Economic Development (MoFPED) with little or no participation of line-ministries and other stakeholders.

The MTEF ceilings reflect the fiscal targets for maintaining macro-economic stability as a condition for accessing IMF loans[4]. The IMF is requesting Uganda to control inflation at 5% and reduce the fiscal deficit to 6.5% of GDP by 2009/10. These targets require a limit on total government spending. This policy has lead to a ceiling[5] on expenditures in 'non-productive' sectors, including health, based on the argument that both increases from donor inflows and limited absorptive capacity in these sectors would disturb the already vulnerable macroeconomic fundamentals.

The opportunity offered by the application to the 60m USD grant from the Global Fund grant for combating HIV/AIDS, TB and Malaria,[6] which is delivered outside the MTEF, to raise

[4] IMF provides 'soft' loans for low-income countries under the Poverty Reduction and Growth Facility (PRGF)
[5] Ceiling refers to 'caps' on health expenditures for each financial year based on a macro economic estimate of a 'non-inflationary' limit.
[6] Funding is for a 5-year period.

additional resources for health, has led to resistance by MoFPED. The Ministry argues that the influx of additional funds into Uganda's economy would lead to excess liquidity, 'Dutch disease' and macro-economic instability[7]. A number of policy analysists and macro-economists have contested this argument. They feel that macro-economic and security concerns are being given priority over human development in PEAP implementation. They point out that spending restrictions are a key limitation on the ability of social sectors such as health to achieve their PEAP objectives.

Regarding the way forward the resource gap as indicated in the 2001 HSSP was not solved, despite recent increases in the health budget. Health ceilings are based on macroeconomic assumptions rather than health needs. This means that Uganda will not be able to meet the Millennium Development Goals (MDGs) health targets and human rights obligations.

The macroeconomic concerns used to restrict further increases in health spending (by accessing additional donor funds) are over-exaggerated. MoFPED and donors should realise that meeting ambitious economic growth targets requires a healthy population and therefore adequate investments in health. Health must not be regarded as an outcome of economic growth, but as a prerequisite.

The trade-offs between macroeconomic targets and investments in health and poverty reduction should be assessed and made subject to public debate, part of the PEAP review process.

The PRGF, Country Assistance Strategy (CAS) and other PRSC programmes that support PEAP implementation should be developed with full involvement of line ministries, parliament, civil society, and be subject to public scrutiny.

The revised PEAP (and MTEF) should reflect the budgetary requirements for the health sector plan. The government should increase domestic resource mobilisation (through progressive taxes). But with a GDP of 300 USD per capita, Uganda's domestic resources are too limited to cover the financing gap for health. Donors should support the ministry of health to increase its spending capacity and make sufficient funding available. Civil society should monitor implementation of the budget and service delivery at local level.

It is important to appreciate health and its rightful place as 'productive' investment. Keeping with the specific focus of PEAP, health sector policy should not lose sight of the pro-poor focus in planning. It is necessary to involve all stakeholders to ensure ownership of the entire process of resource allocation starting with planning.

[7] The government contests that Uganda will turn down all future offers of donor aid because of the impact on macro-economic stability. Instead, it will focus on the quality rather than the quantity of its donor support.

Introduction

There is widespread concern and skepticism among civil society organizations that the PRSPs have not made a positive difference to the lives of the poor. This paper concentrates on the resources made available to health through the PRSP process, and on the role of the IMF in particular, on budget decision in Uganda in relation to commitments to poverty reduction and achieving the millennium development goals.

The objective of this country case study is to provide civil society organizations that are lobbying national government, creditor and donor policies related to the PRSP process and national budget formulation, with insight in:

- Whether and how the PRSP process contributes to increased national budget allocations to the health sector
- The influence of fiscal policies and conditions on the health budget, with special focus on the role of the IMF.

The paper is structured along four issues: macroeconomics and health; how the PRSP affects the health budget; quality, ambition level and gaps/challenges related to health in the PRSP; and the role and influence of the different actors in the budget formulation process.

Methodology

The scope of the review was restricted to the PRSP and budgetary allocation to Health. Secondary information was sourced from government documents from Ministry of Finance, Planning and Economic Development, Ministry of Health and World Bank website. Interviews were contacted with officials from Ministry of Health, Ministry of Finance, Planning and Economic Development and Parliamentary Budget Office.

The analysis involved trend and comparative analysis. In this respect the trend and proportions were analyzed. Presentation of data is in form of tables and graphs.

1.0 Uganda's PRSP: Macroeconomic Aspects

The expenditure and financing decisions in the Ugandan context are made within an agricultural and industrial focus mainly to boost the export potential. Controlling inflation and maintaining the exchange rate are thus key macroeconomic fundamentals that override any social sector related investment such as in health. The strict observance of these fundamentals thus imposes severe financial constraints on investments that are a pre-requisite to the attainment of the poverty reduction objectives – the very essence of PEAP.

The progress in the implementation of the PEAP has been clouded with significant shortfalls in the key macroeconomic and social targets with rising public deficit and the gap between the rich and poor increasing. The GDP growth rate averaging 4.5% per annum is far below the target of 7% needed to realize the poverty targets[8]. External debt service as a percentage of domestic revenue is on the rise (22.8% as of 2003). A number of the social indicators are not showing either stagnating or worsening with associated increasing disparities between the north and the rest of the country and between rural and urban areas.

[8] Background to the Budget, 2003/04

The view of officials within the Ugandan Ministry of Finance, Planning and Economic Development (MFPED) with strong backing from the IMF and World Bank is that Uganda is too dependent upon donor aid and that further increases in aid will lead to overvaluation of the currency and risk inflation. Thus it is necessary to place ceilings on budget expenditures and on donor aid. But the Ministry of Health, other line ministries, and NGO advocates assert that growth in budget expenditures are necessary to achieve the country's commitments under the Poverty Eradication Action Plan, and that the country can and should absorb more aid in order to combat crises such as HIV/AIDS and other infectious diseases, which is necessary in order to sustain economic growth in the long-run.

This is affirmed by the importance of health as described in the Millennium Development Goals (MDGs, UN 2000b) upon which targets were set to reduce mortality rate among children under five by two thirds; reduce by three quarters the maternal mortality ratio; halt and begin to reverse the spread of HIV/AIDS and halt and begin to reverse the incidence of malaria and other major diseases by 2015[9]. For Uganda's case, some indicators such as HIV prevalence rates and number of deliveries at health centers are far from being achieved. In fact the indicators show either a worsening trend or stagnant rates. This definitely has direct and indirect bearing on the poverty reduction efforts given the close linkage between health and poverty.

It can be observed that there has been massive and chronic under-investment in health services in developing countries[10]. The minimum financing needs of the health sector is around \$30 to \$40 per person per year to cover essential interventions, including those needed to fight the AIDS pandemic. However at present actual health spending in Uganda is quite low averaging around \$11 per capita with budget funding currently contributing only \$6. The financing gap of around \$20 per capita translates into significant shortages in human resources, drugs and health infrastructure (BFP 2002/03).

Although increased aid flows confronts recipients and donors with macroeconomic challenges, such as budget and monetary policy management, the net gains remain strongly positive if supported by appropriate economic policies in the recipient country, and thus there is need for increased aid particularly for developing countries pursuing sound macroeconomic polices[11]. According to MFPED, it is not in their interest to allow donor inflows directly into earmarked sectors such as health because they feel that this will undermine the macroeconomic fundamentals.

A more relevant argument is the extent to which increased aid inflows are utilized to support key poverty reducing sectors like basic infrastructure and social services. Over the medium term, if aid inflows support public expenditure which augments the aggregate supply potential within the economy (through the provision of infrastructure such as road rehabilitation, or institutional reforms to agricultural marketing) and increases the productivity of labour (through improved health and education provision), the short run 'Dutch Disease' effect will be offset, as both the tradable and non-tradable sectors of the economy will be supported. In other words, it depends mainly on the composition of the expenditure. Thus if aid is utilized mainly to support expenditure in non-direct poverty

[9] UN Millennium Development Goals
[10] Commission for Macroeconomics and Health (CMH)
[11] DFID, The macroeconomics of increased aid, 2003

reducing sectors such as public administration, then the cost to economy will be high. As Jeffrey Sachs rightly stated it:

"The budget should make ample room for all donor financed grants for health that Uganda can attract. Artificial ceilings on health expenditure, in the name of macroeconomic stability, are a false economy. There is no true stability without health, and the Ugandan economy can fully absorb massive increases in foreign grants for health than the donors are likely to make available" Sachs (2002)

Given that the health sector spending has a huge imported component (drugs, diagnostic equipment, personnel) there is no adverse exchange rate consequence. The risk of currency overvaluation from donor-financed health spending may not arise.

In case additional resources to the overall resource envelope become available in the course of the financial year, they are reallocated according to the pending priorities. The allocation procedure involves a call circular to the accounting officers of the ministries informing them of the availability of the funds with an instruction to budget for non-funded programmes within the indicated amounts. The allocated amounts are decided by the MFPED according to the MTEF ceilings for each sector. In this regard, the proportion allocated finally depends on the negotiative power of the ministry concerned. The MFPED have the allocative power and thus finally rule on how much each ministry is allocated out of the additional resources.

A suggestion that donor funds other than the Global Fund be accessed directly by the Ministry of Health met strict resistance by the officials of MFPED citing macroeconomic concerns. The major concerns include budget and monetary policy management. In the first instance they state that the relevance of the MTEF ceilings becomes invalid. The purpose of the ceilings according to MFPED is to facilitate budget management and avoidance of the associated adverse consequences on fiscal policy management.

In instances where counter part funding is a condition for accessing donor funds, there is a likelihood of rejection of the funds by MFPED. The argument given by the MFPED officials is that it is pointless to access earmarked funds when the government cannot afford counterpart funding because the donation will not serve the intended purpose and hence will be wasted yet other countries that have the ability to absorb these funds are in need. They have been instances where the donor funds have been rejected by the MFPED.

The MFPED argues that donor funds earmarked for health if channeled to the sector directly are associated with increased liquidity in the economy as the funds are spent locally. This can cost the government a lot of money needed to mob-up the excess liquidity. Bank of Uganda does this through issuance of Treasury Bills or Bonds. Commercial banks have increasingly turned to buying Treasury bills instead of lending to the private sector because government lending is considered risk-free. This has led the banks to increase the commercial bank borrowing rates. In the medium term the process of mobbing up the excess liquidity increases the cost of borrowing and eventually discourages investment. If the trend is sustained, then it might constrain the already low internal revenue collections. Eventually, this may reduce the GDP growth rate further destabilizing the macro economy.

In our view this is not a realistic argument given that this process of excess liquidity mobbing has been going on with the restriction on donor funds going directly to the health sector. So essentially, if government considers it a problem then it has nothing to do with the decision to allow more funds to health. The problem is definitely associated with some other sector.

While macroeconomic concerns abound, it should be noted that the link between health status and economic growth is very strong. Health status has a direct effect on productivity of labour, but also influences life cycle savings, and capital accumulation and the expected returns to and investment in education. The potential productivity depends on work experience, health status, as well as years of schooling. All these can be heavily influenced by the health of the individual past and present, and even the health status of previous generations (Bloom et al. 2001)

2.0 Position of Health in PRSP

The PRSP is basically the Poverty Eradication and Action Plan (PEAP). The PEAP provides a framework within which the government's development framework effort is conducted. The principles set out in the PEAP guide the formulation of Sector Wide Approaches (SWAPs), such as those which have been or are being prepared in education, health, water and agriculture, and the drafting of plans at the district level. The public expenditure implications of these SWAPs are implemented through the budget under the Medium-Term Expenditure Framework.

Ugandan PRSP is built on the existing poverty eradication plan. Poverty is mainstreamed in the new strategic health sector plan. The most critical issue in the health sector financing is the overall level of resources. Although the health sector share of total public expenditure has grown from 6 to 8 percent of total government budget, its contribution is about 3 percent of GDP. Uganda is heavily dependent on donor resources to finance health programs. The health sector has attracted an increasing share of total international aid allocation to Uganda from 13 to 22 percent corresponding to US$ 60M to US $ 110M from 1995 to 1997. The Financing Strategy document (1999) estimates that donors contribute 34 percent of the recurrent health budget and 82 percent of the development health budget. And to confirm a consistent trend, the Health Policy Statement 2003/04 estimates that donors contribute about 81 percent of the FY 2003/04 development health budget.

The expenditure implications of the PEAP are supposed to be translated into concrete spending decisions through the Medium-Term Expenditure Framework, which has been developed to provide a clear analysis of the links between inputs, outputs and outcomes while ensuring consistency of expenditure levels with overall resource constraints. Within sectors, the adoption of SWAPs allows flexible and rational use of resources, reducing duplication and the divergence of cost structure between projects and other activities. Much as this approach has allowed the budgetary process to become more strategic and also more participatory, it has not yielded significant budgetary allocations to key health sector inputs such as drugs, infrastructure and health workers.

The mission of the Ministry of Health of providing a network of functional, efficient and sustainable health infrastructure for effective health care services delivery closer to the people has not been adequately realized. Rehabilitation and upgrading of existing health facilities has been sluggish. Only 21 out of 170 HC IIIs to HC IVs have been completed as of 2003. Access to health services within a radius of five (5) Kilometres of households is still about

one half of the 80% by 2005. As of 2002 about 40% of the sites have health units within the Government's definition of accessibility of 5 km[12]. Even within the 40%, lack of transport and poor roads to the units, worsen the accessibility. This is further exacerbated by shortfalls in ambulance services to transport seriously ill referral patients to higher levels of care. Acquisition of appropriate medical equipment for referral hospitals in the country has not been successful due to the required huge investment.

The process of formulating the HSSP, in accordance with the PEAP, has helped the health sector clarify its role in improving health and eradicating poverty in Uganda. The financial requirements indicated in the Health Financing Strategy (MOH 2002) indicate that in order to implement the HSSP, 550 bn shillings is required annually immediately, rising to 1.4 trillion shillings in 2010/11 as shown in figure 3 below. Current financing from all sources, including households, is only 343 billion as indicated in Health Financing Strategy (2002). This implies that the medium term financing target of $28 per capita estimated in the HSSP will not be feasible in the near future.

The Uganda's PRSP highlights the trends in notable health outcomes such as on mortality, and AIDS. Some analysis of the link between incomes and mortality is explored and some quantified targets are set. The PRSP also reports aspects related to health status indicators (life expectancy, IMR, MMR) but also immunization rates and access to safe and clean water. It does not however identify clear strategies to achieve the indicated health targets except where it features in the HSSP. Without knowing the plans and strategies it is not possible to assess whether any of their strategies have changed as a result of the PRSP process.

The strategies focus on development of health services and disease control programmes. One overlooked aspect of poverty-health related issue is health expenditure bill by the poor especially, which tends to make them poorer. Yet the UPPAP[13] reports highlight the fact that paying for health care, especially hospital admission is a cause of poverty and debt, and a priority concern for the poor. Access to health care is limited for many poor people, particularly those with limited assets and large families, due to the costs of the services and the unavailability of proximal, well-equipped and staffed facilities. The existing health facilities are overloaded, and local people stressed the need for more health units located closer to the community. Medical costs, especially for private clinics utilised when services are lacking in government facilities, were often cited as one of the major household expenditures, making poor households poorer when sickness hits the family (UPPAP I and II reports). This may imply that the wider community should think more about whether the existing solutions (essential packages, more resources to rural PHC) give adequate attention to this issue.

The PRSP should include the resource allocation for health and this should provide an opportunity to get agreement from central decision makers and the multilateral agencies on the level of funding and spending priorities within the sector. This could have taken place in the process of agreeing a MTEF, in which case the PRSP could be expected to reflect MTEF allocations. However, there is very little on allocations in the recent PRSP. The PRSP has more detail on public spending plans. The PRSP shows the MTEF figures, with the health budget broken down into 10 components (by level of care, type and source of spending).

[12] UPPAP II report, 2002
[13] UPPAP II report, MFPED

The PRSP does not clearly bring out these health related issues. The PRSP refers to changes in procurement and civil service pay and staff management reforms. What is noticeable in most cases is the lack of adequate measurable indicators and hence any way of estimating the likely impact of these issues on the health sector. The PRSP uses mortality rates and identified process indicators: the DPT3 immunisation rate; the percentage of health centres with qualified staff; the percentage of health units without stock-outs; and perceptions of services. There are also some more direct outcome indicators relating to the prevalence of AIDS and malaria. It is during the PRSP preparation process that these estimates can be reviewed and health sector actors can try to influence decisions and to take these cross-sectoral plans into account in sector planning.

The monitoring indicators in the PRSP are deficient in terms of whether they monitor proposed health strategies, and secondly on whether they have the scope to monitor the impact of the health strategy on poor people. The key monitoring indicators reflected in the PRSP include: Per capita level (facility type) and age-specific outpatient department utilization; Percentage of children under one year with DPT3 immunization according to schedule; and Proportion of health centres by level with minimum staffing norms. The PRSP did not build in any indicators that would monitor the impact on poor people or regions. Equally, the PRSP does not contain plans to include poor people in a participatory monitoring process even though UPPAP reports suggest that Health Unit Management Committees (HUMCs) can be used as one way of ensuring accountability and monitoring by the community.

Whilst there may be a longer term need to monitor mortality rates, they are not likely to be a useful indicator of performance either in the short term of one-year appraisal of progress against the PRSP, or the three years for the whole PRSP, and neither will they be measured this often. There are no defined activity indicators (with dates for completion) in such a way as to make it mostly easy to establish whether or not they have taken place (e.g. introduce revolving drug funds; implement central medical stores reforms; integrate AIDS and TB control programmes) although some will be more difficult to assess (e.g. introduce essential package; 'implement management and incentive reforms' to address staff shortages). These could all be more clearly defined as a basis for subsequent monitoring.

In order to improve value for money, there has been a shifting of resources from the secondary and tertiary sectors to primary health care services, and within the hospital sector from government units to NGO units. This has translated into improve health indicators such as improved percentage of facilities without any stock-outs of essential drugs from 54.9% in 2000 to about 60% by 2002; improved equity and access from 49% to about 60% in the same period and access to effective malaria case management from 27.6% to about 40% in the same period[14]. This has been done by the reallocation of resources between budget lines and, more importantly, by the introduction of new budget lines as explained below. Two new budget lines were introduced in 1997/98: PHC conditional grant; and Support for NGO hospitals. This reflected concerns about the dramatic decline in government spending on primary health care from district revenue (which fell from over 4bn Shs in 1994/95 to just

[14] MoH Ministerial Policy statement 2003/04

over 1bn Shs by 1996/97), with significant disparities between districts, and the difficult financial position faced by a number of NGO hospitals[15].

According to Pearson (2002), the two additional budget lines introduced were done to remove the incentive for government employees to work in hospitals and encourage them to move to lower-level units, and also to encourage existing workers in lower-level units to be more productive (staff in hospitals already received such allowances and they represented a major proportion of total remuneration). It was also recognised that lower-level NGO units were in financial difficulty and that by providing financial support at that level more services could be provided, reducing some of the burden on the hospital sector and reducing overall costs of health care. However, this has proved to be extremely cumbersome and has taken time to become effective due to the inherent disinterest by health workers to relocate to the districts.

It can be observed that neither the analysis nor the strategy presented in the health component of PRSP is consistently poverty focused. There are also some significant gaps regarding the strategy to reach the poor. Key issues not addressed well include:

- There is lack of attention to the role of the private sector (profit and non-profit), who are often the main health providers for the poor. This is also a key criticism of Sector-Wide Approaches (SWAps).
- There is limited discussion of financial barriers to care, the difficulties associated with exemption schemes, and the impoverishing impact of catastrophic illness or accident.
- A focus on people with disabilities – often the poorest of the poor in low-income countries. There are rarely strategies to address their needs.
- Non-communicable diseases, such as those caused by smoking are not addressed.

The Primary Health Care Policy needs a clear outreach framework to reach all communities, particularly those without adequate health facilities. Provision of training for health care workers, construction of health units in underserved areas, development of health services at the community level, and facilitation of effective outreach would provide an excellent platform from which to launch prevention and control messages and approaches. Also, the LC system is a feasible means of reaching the community in order to promote better health, and as a consequence, reduced poverty. There is little evidence of pro-poor targeting or attempts to adapt national strategies to meet the needs of the poorest in the health components of the PRSP such as a strategy to improve health services in rural areas. Though targeting may seem not technically feasible, because of lack of disaggregated data or technical capability to collect it something could be done. Given that the Ministry of Health receives statistics on district performance on service delivery indicators. The lack of disaggregated data could be sorted out through incorporating the sub county statistics in the district reports sent to MoH. Disaggregated service delivery data at the sub county level would be more informative regarding pro-poor health targeting.

3.0 Uganda's Health Sector; HSSP

The Health Sector Strategic Plan (HSSP) was launched in August 2000 and covers the financial years 2000/01 to 2004/05. It aims to make a basic minimum package of health services available to the entire population through the rehabilitation and construction of

[15] Pearson (2002, Allocation public resources for Health

health units, provision of essential drugs, recruitment of new staff and training of unqualified staff. The objective is to improve access, so that 80% of the population is within 5 km of a health facility by 2005. It is planned that every health Sub-District (serving approximately 100,000 people) should have a health centre (called a Health Centre 4) staffed by a doctor with a small theatre for operations such as caesarean sections and repair of hernias. The HSSP also aims to ensure the availability of essential drugs, other medical supplies and logistics at all levels of health care delivery.

In order to monitor the progress of HSSP implementation, a number of inputs, process and output indicators have been developed. Some progress has been registered in some key health indicators such as the revitalization of the Malaria control program, massive Measles campaign, an increase in TB treatment success rates and the near-complete eradication of guinea worm infection in the country. The health sector's performance in managing epidemics has also improved as evidenced by the achievement of the lowest case fatality rate of Ebola epidemic in 2000/01.

Immunisation rates show positive trends, thereby stemming the sharp decline of the late 1990s. DPT 3 coverage rates have reached 70% as per 2002. This could be attributed to the increased advocacy though numerous social mobilization activities. But still financial sustainability continues to be a big problem which translates to high drop-out rates (DPT1 to DPT3 of 21% and BCG to measles of 25%) according to the Ministerial policy statements 2003/04.

Health service utilization has increased, partly due to the abolition of cost sharing as already noted, but also aided by the construction of new health facilities. A total of 210 health centres (HC) IIs have been constructed since HSSP inception. The construction of new health facilities is critical in increasing geographical access. Amidst this positive trend of infrastructural development, UPPAP II documents continued poor service by health staff due to understaffing, poor conditions, delayed and low salaries. Community members recognised that qualified staff were concentrated in urban communities, and that they did not like working in remote areas. Further, lack of supervision and quality standards were felt to be lacking.

Notwithstanding the multiple factors affecting infant and maternal mortality, the health sector has recognised key areas where it can intervene to improve reproductive health. To strengthen access to adequate reproductive health services, emphasis is needed on improving the emergency maternal referral system at the Health Sub-District level and the quality of maternity care available. Also, the proportion of deliveries taking place in a health facility and attended by a skilled health worker needs to increase and efforts need to be made to sensitise communities on the value of delivery care and to ensure adequate availability of the necessary human and physical resource capacity.

The share of skilled health workers in approved filled positions has increased from 33% in FY 1998/99 to 48% as of 2003 and training of Nursing Assistants has continued and as of 2003 about 4200[16] nursing assistants have been trained. However, the UPPAP II report highlights lack of adequate qualified staff generally. The shortage is mainly in the following

[16] MoH, Policy Statement, 2003/04

cadres: doctors, anaesthetic staff and laboratory technicians. In 2000, only 40 percent of health units had trained staff - a lower level than the PRSP/PEAP target of 55 percent. There is need for a further investment in human resource capacity in the health sector. In particular, efforts to attract and retain staff in hard-to-reach areas need urgent attention through some kind of incentive mechanism design which focuses on improved working conditions and pay.

Despite the success stated in the MoH policy statement such as improved DPT3 coverage and outpatient attendance increase from about 14 million in 2001/02 to about 19.5 million as of 2003 by the health sector in implementing the HSSP thus far, a number of challenges remain. First and foremost, the Health Financing Strategy, which outlines the costs required to fully implement the HSSP, identifies a significant gap in funding to the sector. Highest on the list of under-funded priorities include drugs, reproductive health and human resources. Thus, there is need for more concerted effort and financial support in order to realize the stated targets for the HSSP indicators in the sector. It is not surprising that the UPPAP report indicates overstretched and poor quality health services at the district health centers.

As Kadama et al (2002) noted, the proportion of the health budget allocated to cost effective district PHC activities has increased from 14% in 1999/2000 to 42% in 2002/2003 implying that a more efficient mix of human, infrastructure, equipment and consumables has been achieved as far as PHC is concerned. This has led to improvements in sector indicators as illustrated in the Table 1 below. They observed that increases in utilization rates in 2001/02 are due to spectacular increases in absolute numbers of patients consuming health care services.

Table 1: PEAP/PRSP Health Indicators

Indicator	**Baseline Value 1999/2000**	**2000/01**	**2001/02**	**2002/03**	**2004/05 target**
OPD attendance per capita	0.4	0.43	0.6	0.72	0.7
DPT3 / Pentavalent vaccine coverage	41%	48%	63%	84%	85%
Percentage of deliveries taking place in Health Facilities (Govt and NGO)	25.2%	22.6%	19.0%	20.3%	35.0%
Proportion of approved posts filled by trained Health Workers	33%	40%	42%	48%	48%
National Average HIV Sero-prevalence as captured from ANC Surveillance sites	6.8%	6.1%	6.5%	6.5%	5.0%

Source: PRSP report 2002

The health indicators depict mixed outcomes in the sense that some show improvements like OPD attendance while some are either stagnating or worsening such as percentage of deliveries at health centers and HIV prevalence. HIV prevalence has now stagnated around 6.5%. This highlights the inadequacy of the sensitization efforts as has been cited in the UPPAP reports. Community members still need more sensitization on HIV/AIDS and health workers also lack adequate facilitation for outreach activities in terms of transport and allowances. In addition, the health workers face accommodation problems and poor or lack of equipment at the health units (UPPAP, 2002).

The HIV prevalence rate stagnation may imply that there is a limit to the extent to which the advocacy efforts through the various media can significantly impact on sexual behavioural

change. This may necessitate complimenting it with intensive health promotion and education and coordination of health messages being communicated by different stakeholders. The STD/AIDS Control Programme in Uganda is an integral part of the Minimum Health Care Package and aims to prevent further transmission of HIV/AIDS and to reduce the individual and community impacts of the disease. Condom promotion is a key element in the IEC strategy and in the year 2000/01, up to 60 million condoms were distributed by Ministry of Health, social marketing groups and the private sector.

Efforts to expand the provision of Anti-Retroviral Drugs have continued and there has been a dramatic reduction in the price of ARVs through consultation with pharmaceutical companies. Though the price of ARVs has reduced by 94.5% from 1 million shillings per month in 2001/02 to Shs 55,000 by 2003[17], it is still way beyond the reach of the ordinary poor. This means that HIV/AIDS will continue to claim the majority of the country's population unless some form of subsidy by government to further lower the price of ARVs to say about Shs.5, 000 per month.

Earlier evidence on behavioral change documented by Karungari et al (1996) noted that nearly 35 percent of all household survey respondents, especially those with no formal education, were uncertain about their risk of HIV/AIDS. Men (44 percent) were more likely than women (33 percent) to consider themselves *not* at risk. This may explain the stagnating HIV prevalence figures despite the sensitization efforts. It implies that the sensitization efforts may not be reaching the majority of the people with little or no formal education. This also confirms their finding that those with the least education and those in the younger age groups were the least likely to report a change. The majority listen to the radio HIV/AIDS programs but few are likely to have behavioral change due to it.

Despite a sexual and reproductive health (SRH) minimum package defined to address reproductive health issues by MoH, contraceptive use is as low as 23 percent and 50 percent of the population marries before the age of 18 according to the 2003 State of Uganda's Population Report. The challenge is worsened by the high fertility rate, estimated at 6.9 percent, which has been attributed to low levels of education, low incomes and social status, early marriages, low contraceptive use, religious and cultural beliefs as well as the need for old-age security.

The worsening trend of the percentage of deliveries at the health centers could be attributed to problems of physical access to essential obstetric care, poor facilities in most of the community health centers and also cultural factors. This is despite the report efforts by the Ministry of Health targeted on reproductive health programme such as training of reproductive health workers in most districts including the community level. In addition, MoH documented that activities in public information and education were intensified with emphasis on danger signs in pregnancy, labor and on the use of institution delivery services[18]. There is also evidence that the presence of private health facilities has been the factor most strongly associated with contraceptive use in urban areas, perhaps because they improved the availability of methods (Katende et al, 2003). Given that private health facilities are not accessible in most rural parts, it is not surprising that the reproductive indicator depicts a worse trend despite Ministry of Health efforts.

[17] MoH, Policy Statement, 2003/04
[18] MoH, policy statement, 2003/04

Full responsibility for this poor performance does not lie entirely within the mandate of the health sector as other factors influence health outcomes such as household income, female education, access to clean water, security, gender disparity, cultural practices and nutrition. For example, using a wealth index constructed from household characteristics available in the UDHS data set, it is revealed that infant mortality is almost 80.0% higher amongst the poorest 20.0% compared with the richest 20.0%. This is further supported by the regional trends in infant mortality whereby infant mortality has risen in the Northern region in line with an increase in poverty and insecurity while the converse is true for the Central and Eastern regions.

A controversial aspect of health policy has been cost-sharing (patient fees), which was abolished in March 2001, after findings from both the Inter-ministerial Review in 1999 and PPA 1 that it was not good for the poor. However, the policy change has also put an increased pressure on the health service supply with frequent drug stock outs throughout the system. To counter against this occurrence, government has increased its releases to health facilities and in the health sub-districts in which 50% of the funds are allocated to the purchase of drugs. Furthermore, the Ministry of Health (MoH) temporarily allowed districts to purchase drugs from any source, rather than restricting purchases to National Medical Stores. But still this has not solved the problem as expected. There is evidence of significant drug leakage into private clinics as documented in UPPAP II report. This has pushed the patients to seek treatment from private clinics, hence paying far higher than before policy change. About 46 percent of the sick in 2000 used private facilities, and 23 percent relied on public facilities, compared with 35 percent and 22 percent, respectively, in 1997. Apart from the associated cost to patients, lack of health facilities is compounded by lack of specialized services in some existing facilities both in district public and private health centres. UPPAP reports indicate the lack of maternity services, antenatal care, family planning, laboratory, X-ray machines, surgery, and outreach in some district health centres.

In order to improve management, accountability and community participation, the HSSP envisages the establishment of Village Health Committees and a strengthening of the role of Health Unit Management Committees (HUMCs). However, little has been done so far to make Village Health Committees a reality, while funding for the establishment of HUMCs is very limited. In scattered cases, HUMCs exist like in Rakai and are appreciated for monitoring the utilization of drugs, and connecting health workers to communities[19].

Overall, the take-off of the HSSP has accelerated the institutionalization of policies, structures and systems for effective implementation of its programs. The successful development of a number of policies has been completed. These include strategies for Public-Private Partnership, In-Service Training, the National Pharmaceutical Sector and Health Financing. The process of cleaning the Primary Health Care payroll is ongoing in consultation with the Ministry of Public Service.

4.0 Budget Process and Participation of Health Sector and Other Stake Holders

The revision of the PEAP is becoming closely linked to the revision of the HSSP. A number of working groups are involved in the revision covering different sub sectors such as drug

[19] UPPAP II report, 2002

procurement; human resources and public-private partnership; supervision and monitoring; infrastructure; finance and procurement; research and development; and decentralization. Each group is chaired by an official from Ministry of Health and involves all development partners (donors and civil society). In order to guide the overall revision of the HSSP and provide input into the PEAP there is a core group out these various sub-groups who propose input for the health component of the PEAP and propose a budget. It is worthy noting that the MFPED has a final say as to whether this material is incorporated or not. In this respect, there is an increasing involvement of the stakeholders in the design of the health related strategies in the PEAP.

The Macroeconomic Framework and hence the MTEF design is essentially an IMF/World Bank model which still appears to retain significant input of these two institutions. So in this context the framework is adopted by MFPED and BoU for budgetary planning with the set macroeconomic targets already factored in. The implementation of the budgetary component of the set scenarios is entirely by the MFPED. One can thus infer that the indirect influence of the Bretton Woods Institutions is quite strong; ranging from the design of the framework to the observance that implementation is adhered to.

Ministry of Health participation in the budget formulation process is restricted to the MTEF ceiling for the sector. Once, the ministry receives the call circular from MFPED, they then budget for the identified priorities within the given MTEF ceiling. Much as it has been documented in the PRSP and Background to the budget that the MTEF formulation is participatory involving key sector technocrats, the practice seems to be different. The initial MTEF ceiling amount is given by the MFPED and based on the sectoral expenditure growth rate and other macroeconomic factors, the MTEF ceiling is annually revised by MFPED. It can thus be inferred that the participatory aspect of the budgeting process is chocked by the MTEF ceiling.

The budget process should be bottom-up and participatory. It should be formulated on the basis of national priorities and needs as expressed by the people and then presented to the donors in case a budget deficit exists. However, under the influence of the International Financial Institutions the opposite is the case[20]. First a Country Assistance Strategy (CAS) is developed, from which the budget is derived. When Uganda makes agreements with the IMF for borrowing or rescheduling existing debts, she is committed to structuring the economy to generate a primary surplus. As the opportunity for painless, rapid economic growth is generally not available this translates as cuts in social spending and investment and an increase in debt service payments. To the IMF the government of a country consists of the Ministry of Finance. But agreements made at this level have an impact on all other departments and levels of government.

The influence of international donors has also been stressed by Jim Schultz[21] who explained that in many countries the budget ceilings are set by international donors and creditors. In this regard, Uganda's MTEF and budget ceilings are incidentally a result of a significant input from the IMF and World Bank and therefore the two institutions have significant influence on

[20] http://www.internationalbudget.org/index.htm
[21] From the Democracy Center in Bolivia

the PRSP. An excerpt from the PRGF operational rules of the IMF stresses the extent of IMF influence on budget issues[22].

"*The Fund staff will take the lead in areas of its traditional mandate and responsibility. This would include promoting prudent macroeconomic policies; structural reforms in related areas, such as exchange rate and tax policy; and issues related to fiscal management, budget execution, fiscal transparency, and tax and customs administration*".

It can be inferred that it is more of the IMF conditions than the macroeconomic concerns of the officials of MFPED that have significant impact on the allocation process. This is because the MFPED officials can only operate within the IMF set guidelines and macroeconomic indicators which define the MTEF ceilings. For instance it was not possible to get a straight answer as to whether a revision of inflation target from the current 5% to 7% would be associated with a significant macroeconomic destabilization. It is apparent that the concern may not necessarily be the absorptive capacity of the ministries but the fear of violating the IMF conditions.

It can be observed that health expenditures are determined mainly by national income. Each 1 percent rise in income leads to a slightly more than 1 percent rise in health spending[23]. The poorest countries are shockingly poor by the standards of the high-income world, and their health spending, as a result, is shockingly low. Even if poor countries allocated more domestic resources to health, such measures would still not resolve the basic problem: poor countries lack the needed financial resources to meet the most basic health needs of their populations. At $30 to $40 per capita for essential interventions, these costs would represent more than 10 percent of GNP of the least- developed countries, far above what can in fact be mobilized out of domestic resources.

The civil society has been involved in the PRSP process though a series of consultations both at national and regional levels. They have participated in regional meetings attended by community representatives and local leaders from all the districts. The meetings have been successful in bringing together a cross section of community leaders to discuss the working draft of the Poverty Eradication Action Plan and have their inputs included in the revised document. They have made an input into the PRSP on various sectoral issues such as Education, Environmental, Disaster Management, Peace and Conflict Resolution, Water and Sanitation. Civil society has also been involved in public dialogues and discussions in the media.

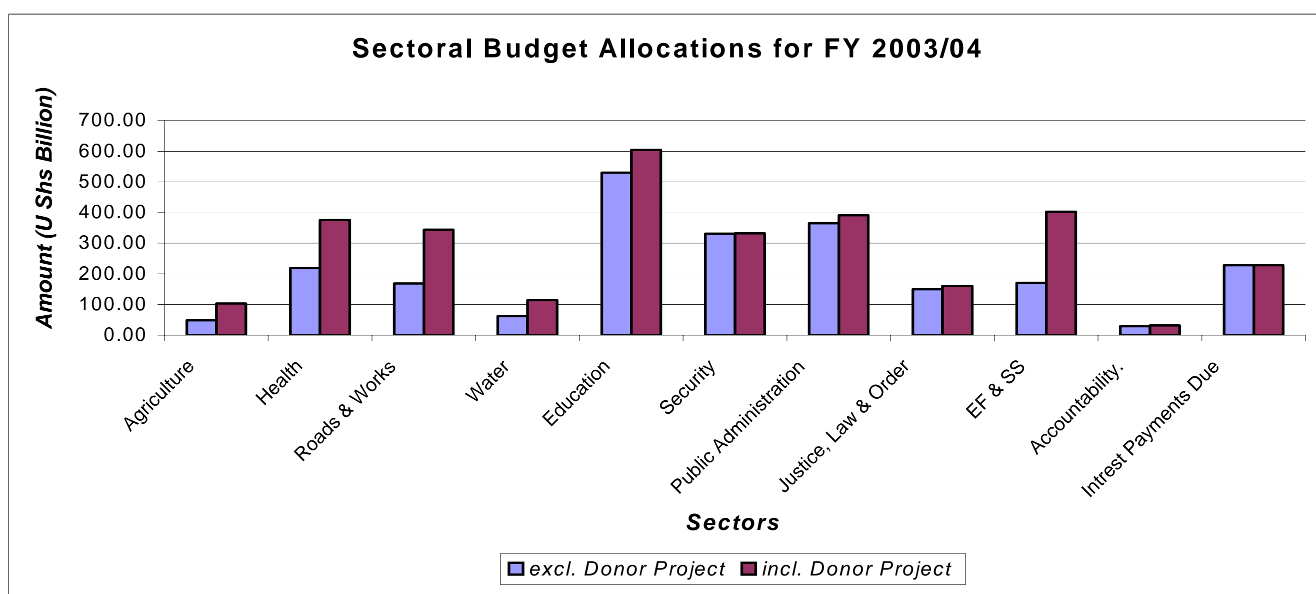
Budget Consultative workshops and work within Sector Working Groups (SWGs) are part of the process of making critical choices on expenditure priorities and resource allocation. This process increases government ability to analyse and evaluate progress in implementing the poverty reduction strategy. The changes promoted by the PRSP are supposed to be reflected in the revised MTEF. We can infer that to the extent that there has been a slight adjustment of the MTEF ceiling upward, funding inadequacy in the health sector voiced in the PRSP could have had some impact.

5.0 Budget Trends

[22] http://www.imf.org/external/np/pdr/prsp/poverty2.htm#III
[23] Macroeconomics for Health, 2001

There is a positive trend in the allocation within the MTEF of finances to education and health sectors. A good number of these allocations are covered under PAF for universal primary education and primary health care respectively. Judging from Figure 1 below for the FY 2003/04 budget allocations, we can observe that the allocations to security and interest payments still take a huge junk. Key sectors in the context of poverty reduction such as agriculture, health, works, water, education and social services are heavily supported by donor aid for which the implied loan component will contribute to the already heavy debt burden. Already interest payments take more than twice the amount allocated to agriculture and water alone.

Fig. 1



Source: Draft estimates of revenue and expenditure, 2003/04

Figure 1 above illustrates the implied ranking of the budgetary priorities in the budget as opposed to the indicated ranking in the PRSP and budget speeches.

Though sector ceilings for 2003/4 tend to portray a positive move towards increasing budget allocations to key poverty reducing sectors such as roads, health, water etc. a keen observation of this ceiling paints the grim picture in which security, public administration and interest payments receive the largest. A key observation is that a minimal change in ceilings which does not level out the imbalances in budget allocations in this context is not desirable. The table shows an increase in ceiling level for the health sector by 19 percent from 311 in FY 2002/03 to 371 in 2003/04. This change reflects a positive trend regarding the allocations to healthbut it is still well below the required funding to deliver the minimum health care package of strategic interventions according to Ministry of Health officials. It is a good start if it can be maintained.

Notable in Table 2 is the high ceiling for public administration relative to the critical sector such as health. This is due to the increasing number of government commissions and institutions which include State House, Ministry of Foreign Affairs, local governments (unconditional grants), the URA, the legislature, public service (including pensions), the Electoral Commission, and the MFPED, Office of the Prime Minister, and the Local

Government Finance Commission. In addition, the excessive number of the Members of Parliament who have the negotiative power and the resident district administrators. The MPs have recently demanded pay increases, and given their negotiative power, there is a high chance of it being approved at the expense of other critical sectors of the economy.

The negative percentage change indicates that the ceiling for public administration was scaled down slightly. This, in my view, is not good enough since the ceiling is still high compared to health, roads and water for example. This is made worse by the supplementary allocations that are usually witnessed for public administration and security.

Another noticeable feature is the 23 percent increase in the ceiling for interest payments due. This is an indication of the extent of the debt burden arising from excessive borrowing to finance the budget deficit. This puts excessive fiscal pressure on the productive sectors such as basic infrastructure and social services. For example, in the mid-1990s, Uganda spent $3 on health for every $17 it paid in debt service, most of which went to multilateral lending institutions[24]. The debt burden statistics reflect a worsening situation. The Interest payments/GDP ratio increased from 0.2 in 2001 to 0.4 by 2002 while Total debt/GDP ratio increased from 65.9 to 69.9 in the same period and Total debt service/exports ratio increased from 4.2 to 10.8 (World bank, 2003).

Table 2: MTEF Ceilings FY 2003/04

Shs Bn	**2002/03 Projected Outturn w/ Donor Projects**	**2003/04 Projected Outturn w/ Donor Projects**	**% Change**
Security	296	334	13%
Roads and Works	264	367	39%
Agriculture	101	108	7%
Education	536	587	9%
Health	311	371	19%
Water	82	95	16%
Law and Order	145	159	10%
Accountability	26	29	10%
EF & SS	365	402	10%
Public Administration	401	390	-3%
Interest Payments Due	180	221	23%
Total	**2708**	**3063**	**13%**

Source: MFPED, 2003

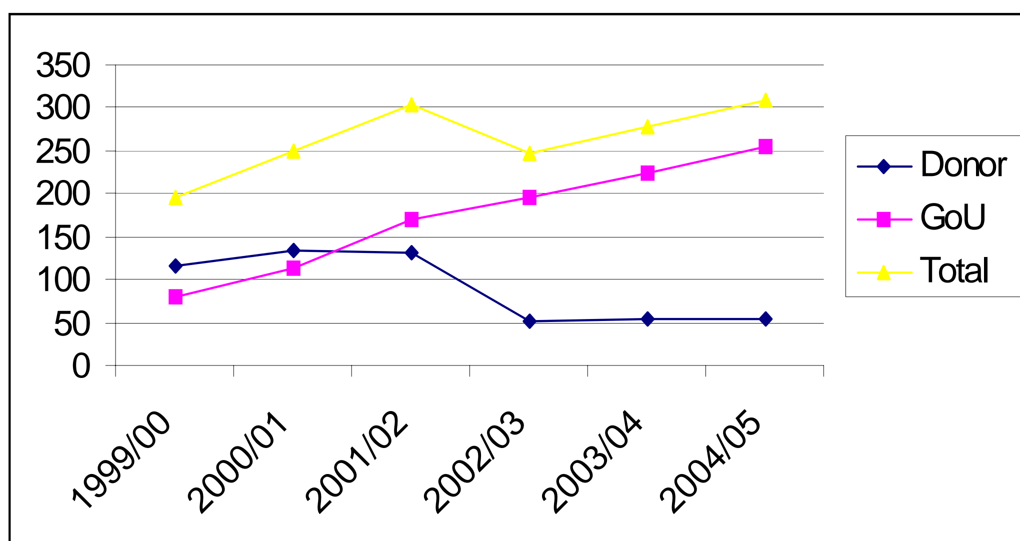
It is imperative that the country borrows to meet her development, social, and policy reform challenges. This certainly requires substantial external financing given the budget deficit. But it is important to minimize excessive debt burden which exceeds the country's absorptive capacities. Borrowing itself is not problematic if the foreign funds are channeled, either directly or indirectly, into productive investments such as infrastructural development,

[24] http://www.50years.org/factsheets/debt.html

agriculture and social service sectors like health and education that enable the country to grow and generate future export earnings so it can repay its creditors.

The government budget allocation to health is cast within a low tax and stringent fiscal policy framework. This limits what is possible for the public sector to do, especially in terms of salaries, supplies and drugs. Due to largely small-scale peasant and informal sector activities, tax revenue is low and collection systems are inefficient. Although financing a small share of the health services, Uganda's growing economy and increasing revenue has allowed the government to allocate an increasing share of its budget to health over the past five years.

Fig. 2: Trends in Health Financing



Source: Health Budget Framework Papers, Planning Department, Ministry of Health

It can be observed that the donor contribution to the health budget has been fluctuating and shows a tendency to reduce as shown in Figure 2 above. The contribution of the government of Uganda has been on the increase. The donor contribution reduced from about UShs 224 billion in 2001/02 to an average of UShs 50 billion. Though the total resource allocation to health shows an increasing trend, there is a huge funding gap to be met.

The Per capita Expenditure (PCE) on health over the years has been greatly improved although much of the contribution is by the private out of pocket spending as shown in Table 3 below. In 1994/5 FY, private spending accounted for 60.76% but dropped to 56% in 95/96 but again has risen to 58% in 1997/98 FY. The PCE has improved from US $ 9.86 in 1994/5 to about US $ 14 by the year 2000. It should be noted that sharp increases in PCE on health may not be evident given the relatively high population growth rate in Uganda. This is attributed to the government's policy of provision of a minimum basic health care package through an integrated PHC approach of which donors too have been supportive.

Table 3: Per Capita Expenditure on Health

	1994/95	1997/98	2000/01
Per Capita Expenditure; Ug.Shs	10,847	13,664	23,100
Per Capita Expenditure; US $	9.86	11.37	14
Total GDP (Millions)	5,482,313	7,413,708	8,655,881

Source: Health Planning Department

The inadequate financing means that there is a growing list of unfunded and under funded priorities including some items under District Primary Health Care, recurrent and development for referral hospitals, national service delivery programmes and contribution to the X-ray imaging equipment (ORET) project co-funded by the Dutch Government. Due to limited size of the overall resource envelope, some of the targets in the HSSP have been scaled down for example the construction of the planned 250 HC IIs which will not be undertaken.

The total resource envelope for MoH is further constrained by the fact that it includes the funds for the AIDS Commission which is under the President's Office and with its multi-sectoral approach; it deals with various sectors including Ministry of Education, MOGLSD and Ministry of Agriculture among others. Including the AIDS commission budget appears to reflect a higher amount than actually goes to Ministry of Health, Mulago Hospital, Butabika Hospital, Regional Referral Hospitals, general hospitals, PHC and NGO health units excluding AIDS Commission.

6.0 Budgeting within the Health Sector

The total resource health sector resource allocations this FY 2003/2004 is Shs.429.36bn/= (for both recurrent and development estimates including donor support projects) compared to Shs.337.92bn/= received last FY 2002/2003. This represents 27% increase. Of this, Government of Uganda contribution this FY 203/2004 is Shs.236.197bn/=. The Government total expenditure on Health has increased from Shs.202.51bn/= to Shs.236.197bn/= since June sector ceiling. This resource envelope covers Ministry of Health: Butabika Hospital, Mulago Hospital, Health Service Commission, Uganda AIDS Commission, NGO Health Units, Primary Health Care, General Hospitals and Regional Referral Hospitals. Table 1 below shows the MTEF allocations to the various health units.

It should be noted that the existing system of financial management does not facilitate full expenditure tracking and matching with heath priorities regarding funds for health activities in the districts. About half the health budget the MoH issues an expenditure directive to MoLG via the MFPED on how these resources are to be. In this regard, MoH does not have any actual control over release of funds. The control over release of funds is by the MFPED whose requirement for processing requests is 'receipts' against allocations rather than a match between expenditure items and MoH guidelines[25]. Thus the MoH does not have a strong mechanism to 'enforce' the health agenda here. There is thus need to institutionalize financial and expenditure management for health allocations.

Table 4 below shows that the allocations to District Health Service (PHC) have gradually increased while allocations to National and Regional Hospitals decreased. The budget allocations to hospitals support the following categories: 2 National Hospitals (Mulago and

[25] WHO (2003), Uganda's PRSPs: A case study.

Butabika); 10 Regional Referral Hospitals; 43 District General Hospitals and 19 NGO not-for-profit Hospitals[26].

Table 4. The Health Sub-Sector allocations in percentages FY 1999/2000 to FY 2003/2004

Budget Area	**1999/00**	**2000/01**	**2001/02**	**2002/03**	**2003/04**
District Services (PHC)	32%	44%	48%	49%	54%
MOH Headquarters	30%	30%	26%	28%	24%
National Hospitals	22%	13%	14%	12%	12%
Regional Hospitals	14%	10%	11%	8%	8%
Other Agencies	2%	2%	2%	2%	2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Background to the Budget, various issues

To assess the allocative efficiency of the Ministry of Health, the budget allocations to the health sector are presented in Table 5 below. The table shows how the composition of the GoU budget has changed to reflect the need to improve allocative efficiency. It can be inferred that over the period 1999/00 - 2003/04, funding for district services has increased by a factor of 4.5 and its share of the budget has increased from 32% to 54%. On the other hand though, the allocations for central hospitals have fallen from 22 to 12%.

Table 5: Changes in Resource Utilization 1999/2000 - 2003/04

	1999/2000		2000/2001		2001/2002		2002/2003		2003/2004	
	Ushs bn	%	Ushs bn	%	Ushs bn	%	Ushs bn	%	Ushs bn	%
District services	25.3	32	50.6	44	81.3	48	96.4	49	115.4	54
PHC	15.5	19	37.6	33	60.9	36	71.1	36	84.7	40
PNFPs	3.3	4	6.7	6	11.6	7	16.6	8	19.7	9
Dist Hosp	6.5	8	6.3	6	8.9	5	8.7	4	11	5
Regional Hosps	11.2	14	11.8	10	18.6	11	16.2	8	17.1	8
Central Hosps	17.9	22	15.2	13	23.2	14	23.9	12	25.4	12
MoH HQ	24	30	34.8	30	43.6	26	55.8	28	51.3	24
Other agencies	1.4	2	1.8	2	3.3	2	3.7	2	3.9	2

Source: Health Planning Department, MoH

Resources have also been targeted to achieve maximum health benefits with special emphasis being given to services provided at Health Centre IVs and IIIs and at PNFP Health Centres and Hospitals. PHC and supervision guidelines have also been improved to assist individual units to concentrate their resources on cost effective interventions for tackling high burden of disease problems.

The health sector still needs to increase the coverage of services and concentrate resources on cost effective activities. This would mean increasing the proportion of resources to district services (including PNFP providers), where the vast majority of the population live. In addition, resources would need to be targeted at communicable diseases and child and maternal health services.

[26] MoH Policy Statement, 2003/04

The budget allocation to Health Sub-District (HSD) Service Delivery has been increased by 60% over the funding for the FY 2001/02 to 17.17bn and 50% of this is to be used for drugs and other medical supplies at the Health Centre IV (HC IVs) and lower level units (LLU). The non-wage recurrent budget for district, Regional Referral and National Referral hospitals will also increase by 15% and 30% of non-wage funding at this level is used for drugs. This is justified since Drug stock–outs are a big problem at all levels of health units throughout the country, especially with reported increase in attendance since the abolition of user-fees.

Activities under Reproductive Health will put particular emphasis on recruitment of midwives and provision of contraceptives. According to the MoH, Health Centre (HC IVs) have been identified as points of referral for maternity services and the bulk of the funds for District PHC Development will be utilized at this level. Shs.3.9billion was provided for consolidation of HC IVs during the FY 2001/02. A provision has been made for theatre equipment (6 billion) and transport (2.03 billion for 86 vehicles) for HC IVs. Funds (shs.1.55billion) have been allocated for the upgrading of HC IIs to HC IIIs to provide for the badly needed maternity services in 31 sub-counties in the country. This has left unfunded priorities in the infrastructure development such as new HCIIs, upgrading of more HCIIs to HCIIIs as well as staff accommodation. The available funding also cannot cater for provision of equipment needed at HC IIs and HC IIIs estimated to the tune of 2.5bn/=.

There are ten (10) Regional Referral Hospitals and 56 District Hospitals, all Government-Aided. The ten (10) Regional Referral Hospitals are now self-accounting directly to Treasury. These Referral Hospitals include: - Masaka, Jinja, Mbale, Soroti, Gulu, Arua, Hoima, Kabale, Lira and Fort Portal. The main constraint affecting regional referral hospitals, among other things, is inadequate funding. Funds to Government Hospitals can enable them purchase drugs and sundries which last for only two weeks in a quarter, and for the remaining period, patients are made to buy their own drugs.

Some Non-Government Hospitals and Health Centres receive grants-in-aid. In FY 2003/04, NGOs hospitals were allocated a total of Shs.17.72bn/=[27]. NGO Health Units are supported by Government so that they can reduce the charges on services delivered to patients. Given that government support is just about 25 percent they have to charge fees to raise about 50 percent for sustainability while about 25 percent is filled in from donor contribution. The government subsidy is too low to generate significant outcomes. NGO budget line is a PAF line, whereas hospital rehabilitation is non-PAF,

Although the Poverty Action Fund (PAF) has protected resources provided for health sector and the quantitative targets have been broadly met, there remain service quality and cost-efficiency concerns. While health user fees were abolished and access increased, service quality has deteriorated. The policy change has also put an increased pressure on the health service supply with frequent drug stock outs throughout the system worsened by the reported drug leakages from public health centers.

Table 6 illustrates an improved trend in health PAF expenditures for Primary Health care overall. Conditional PHC grants constitute the greatest proportion followed by PHC service delivery programmes. Support to Aids orphans and children's rehabilitation receives the least expenditures.

[27] MoH, Ministerial Policy Statement 2003/04

Table 6: PAF Expenditures: 1999/00 - 2004/05

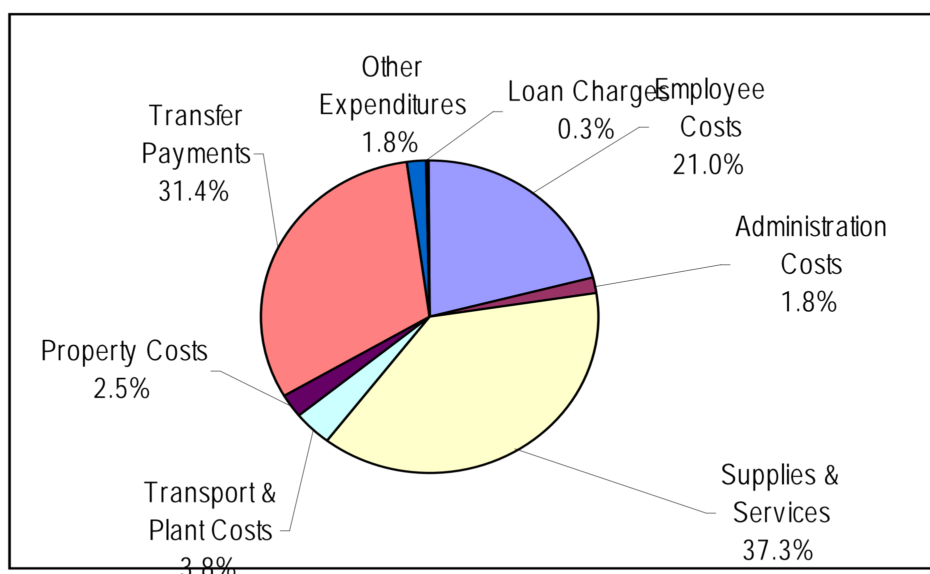
	1999/00 Approved	1999/00 outturn	2000/01 Approved	2000/01 outturn	2001/02 Approved	2002/03 Approved	2003/04 budget	2004/05 Projected
PHC-Ministerial Dev't Budget	7.48	7.48	7.26	6.52	7.38	8.73	9.84	10.75
National PHC Delivery Prog	-	-	13.85	13.19	20.85	25.55	32.61	40.33
PHC Conditional Grant - Wage	12.31	2.78	9.62	5.16	35.04	41.6	45.76	50.33
-Non-wage Recurrent	5	5.01	8.82	8.81	14.87	19.67	22.16	24.21
-Development	-	-	9.96	10.01	10.98	15.73	20.14	25.01
-NGO	3.3	3.3	6.72	6.54	11.59	16.61	17.72	26.4
Support to Aids Orphans rehab.	0.05	0.03	0.5	0.5	1.5	2	2.63	3.45
Primary Health Care SubTotal	**28.14**	**18.6**	**56.73**	**50.73**	**102.21**	**129.89**	**154.41**	**180.48**

Source: Background to the budget, various issues

One noticeable aspect of the PAF expenditure trend is the apparently significant and increasing administrative component retained at the Ministry Headquarters relative to say, the marginal support to AIDS orphans rehabilitation. Since, it is common knowledge that there is an increasing number of orphans due to the current trend of the AIDS scourge, it is rational that it is given more priority over the seemingly unproductive administrative component.

Looking at the composition of the recurrent expenditure in health affirms this assertion.

Figure 3: Composition of Health Recurrent Expenditure 2001/02



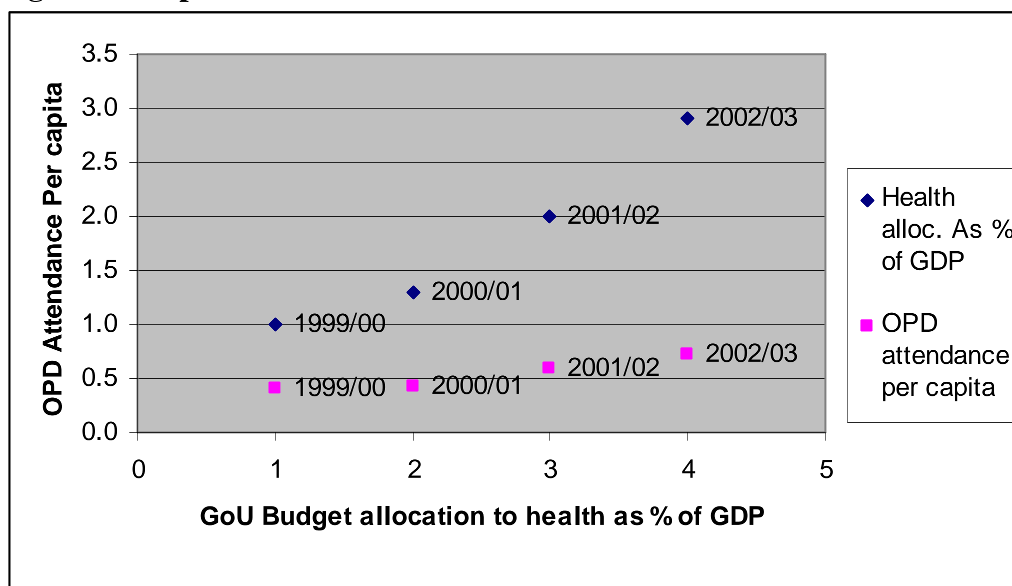
Source: Draft estimates of revenue and expenditure, 2001/02, MFPED`

As can be observed from Figure 3 above, much of the recurrent expenditure in the health sector is attributed to supplies and services (drugs and equipment), about 37.3 percent followed by transfers (31.4 percent) to the district as part of the conditional grants for primary health care and employee costs (e.g. salaries) with 21 percent while administration is just under 2 percent. This shows that increased allocation of aid inflows to the health sector will not be associated with significant macroeconomic distortions given that most of the drugs and equipment or their inputs are imported.

The allocative efficiency within the health sector is relatively good in the sense that greater weight is given to supplies and equipment. Regarding the operational efficiency, there is no clear empirical evidence yet that supports a high capacity of the health sector to absorb allocated funds effectively. But judging from the good level of allocative efficiency and over 90 percent utilization rate of funds, one may infer that the health sector has the potential to effectively utilize allocated funds.

Given the observed increasing trend in GoU Budget for the Health Sector, we can observe a positive relationship with the OPD attendance. It is noticeable from the figure below that OPD attendance seems to respond to increase percentage allocation to Health sector as percentage of GDP. The sluggish response could be explained by the inadequacy of drugs and lack of required medical equipment which patients perceive as poor service delivery and so seek alternative treatment options. It is certain that these deficiencies at the health centers can be addressed by increased allocations especially to the district health budget.

Fig 4. Per Capita Correlation of allocation and OPD attendance



Source: Department of Planning, MoH.

The clear message we can draw from the OPD attendance and Health sector allocation as percentage of GDP is that more funds are still required to the health sector to induce noticeable improvements in some of the health indicators such as OPD attendance.

Growth in health expenditure is essential if Uganda is to meet its poverty eradication goals. It would be desirable to increase health spending to at least 12 percent of GNP in order to achieve the health essential needs but given the huge budget deficit, external support seems the feasible alternative in the medium term. Uganda's health expenditure stagnated averagely around 1 percent of GDP from 1997/98 to 2000/01 and saw an increase in 2002/03 to a paltry 2.9 percent. Currently, health expenditure as a percentage of GDP is under 3 percent, quite below the desired 12 – 15 percent suggested by the Commission for Macroeconomics for Health as shown in Table 7 below.

Table 7. Proportion of the health expenditure in GDP

	1997/78	1998/99	1999/00	2000/01	2001/02	2002/03
Health (Shs bn)	60.24	72.46	79.87	109.29	169.79	337.93
GDP(current prices) Shs bn	6888.60	7351.60	7753.40	8217.60	8702.10	11691.40
Percent of GDP	0.9%	1.0%	1.0%	1.3%	2.0%	2.9%

Source: MTEF and Background to the budget, MFPED, *various issues*

According to UPPAP II report, the health of the people is a key ingredient in poverty eradication and thus the development process[28]. Without increasing the per capita expenditure on health to $35-$45[29] (i.e. 12% – 15% of per capita income), not only will Ugandans suffer massive numbers of unnecessary deaths, economic growth will also be affected severely.

7.0 Recommendations

There is need for defined activity indicators (with dates for completion) in such a way as to make it mostly easy to establish whether or not they have taken place (e.g. introduce revolving drug funds; implement central medical stores reforms; integrate AIDS and TB control programmes) although some will be more difficult to assess (e.g. introduce essential package; 'implement management and incentive reforms' to address staff shortages). These could all be more clearly defined other than just stating them as a basis for subsequent monitoring.

Given that the Ministry of Health receives statistics on district performance on service delivery indicators. The lack of disaggregated data could be sorted out through incorporating the sub county statistics in the district reports sent to MoH. Disaggregated service delivery data at the sub county level would be more informative regarding pro-poor health targeting.

The Primary Health Care Policy needs a clear outreach framework to reach all communities, particularly those without adequate health facilities. Provision of training for health care workers, construction of health units in underserved areas, development of health services at the community level, and facilitation of effective outreach would provide an excellent platform from which to launch prevention and control messages and approaches.

Efforts need to be stepped up to sensitize communities on the value of delivery care and to ensure adequate availability of the necessary human and physical resource capacity. In particular, efforts to attract and retain staff in hard-to-reach areas need urgent attention through some kind of incentive mechanism design which focuses on improved working conditions and pay.

To allow the MoH to enforce the health agenda through control over actual releases of funds to districts, there is need to institutionalize financial and expenditure management for health allocations between MoLG and MoH.

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[28] UPPAP reports
[29] This is computed as a percentage of per capita GDP (approx. $300)

8.0 Conclusion

Inadequate funding, shortage of trained health personnel, an inadequate network of functional health infrastructure, and serious shortages in drug supplies are the biggest challenges in the health sector. Even under the current improved budget funding, resource envelope (excluding private spending) is US$9 per capita compared to the US$28 estimated minimum needed for delivering the minimum package.

Since a large proportion of inputs in the health sector have to be imported, such as pharmaceuticals, medical equipment and vehicles, there is no likely negative impact on macroeconomic fundamentals. In this context, the macroeconomic concerns are over exaggerated. Given that over 90 percent utilization rate of allocated funds is realized in the health sector, one may infer that the health sector has no absorptive capacity.

The allocated amounts are decided by the MFPED according to the MTEF ceilings for each sector. In this regard, the proportion allocated finally depends on the negotiative power of the ministry concerned. In the same vein MFPED has a final say as to whether the input for the health component of the PEAP and proposed budget by the SWAPs is incorporated or not. In this respect, there is an increasing involvement of the stakeholders in the design of the health related strategies in the PEAP. Thus the participation of MoH in the budget process is restricted.

One aspect that needs refinement following the PEAP are clear strategies to achieve the indicated health targets. Without knowing the plans and strategies it is not possible to assess whether any of their strategies have changed as a result of the PRSP process.

The health indicators depict mixed outcomes in the sense that some show improvements like OPD attendance while some are either stagnating or worsening such as percentage of deliveries at health centers and HIV prevalence. HIV prevalence has now stagnated around 6.5%. This highlights the inadequacy of the sensitization efforts as has been cited in the UPPAP reports. Community members still need more sensitization on HIV/AIDS and health workers also lack adequate facilitation for outreach activities in terms of transport and allowances. Some progress however, has been registered in some key health indicators such as the revitalization of the Malaria control program, massive Measles campaign, an increase in TB treatment success rates and the near-complete eradication of guinea worm infection in the country. The health sector's performance in managing epidemics has also improved as evidenced by the achievement of the lowest case fatality rate of Ebola epidemic in 2000/01.

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