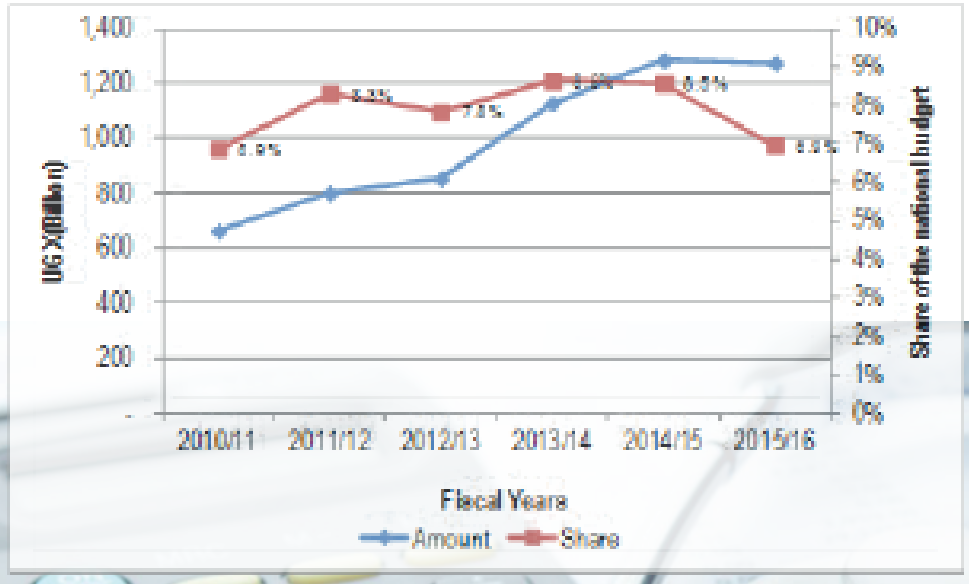
HEALTH SPENDING IN UGANDA

Implications on the National Minimum Health Care Package



Daniel Lukwago

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Implications on the National Minimum Health Care Package

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Cover Photo:

An illustration of Uganda's health sector budget allocations for the last 6 years.

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List of Acronyms

ACODE	Advocates Coalition for Development and Environment
CFO	Chief Finance Officer
CHI	Community Health Insurance
DCA	District Collection Account
DHO	District Health Officer
FY	Financial Year
GoU	Government of Uganda
HC	Health Centre
HSDs	Health Sub-Districts
HSDU	Health Service Delivery Unit
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committees
KCCA	Kampala City Council Authority
LG	Local Government
LGFC	Local Government Finance Commission
MDG	Millennium Development Goal
MDGs	Millennium Development Goals
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NHP	National Health Policy
NMS	National Medical Stores
NRH	National Referral Hospitals
OOP	Out-of-Pocket
PEG	Public Expenditure Governance
PHC	Primary Health Care
RRHs	Regional Referral Hospitals
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Services
UGX	Uganda Shillings
UNMHCP	Uganda National Minimum Health Care Package
WHO	World Health Organisation

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Executive Summary

This policy brief is part of Public Expenditure Governance (PEG) study of the health sector in Uganda. The overall objective of the research was to examine the links between public spending, governance, and outcomes in the health sector and the specific objectives of the study were to identify the actors and their roles in decision making regarding budget allocations and service delivery, develop indicators for assessing expenditure governance in the health sector, Identify and assesse the effects of budget allocation decisions on health sector performance and finally to identify and assess the efficiency of accountability mechanisms, including community participation, sanctions and rewards.

Funding remains the single most important constraint facing the health sector in Uganda. Although the Government budget allocation to the health sector has increased from UGX 660 billion in 2010/11 to UGX 1,271 billion in 2015/16, the sector share of the total national budget averaged 7.8% during the same period which is 2 percentage points short of the HSSIP target of 9.8%.

To provide the Uganda National Minimum Health Care Package, Uganda needs to spend over USD 28 per capita, currently per capita spending is about USD 12.0. With the current level of funding, the health sector will not achieve the targets indicated in the HSSPII. In addition, Uganda will not meet the health-related Millennium Development Goals (MGDs) of reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

Under the decentralization policy framework, Local Governments (LGs) are required to provide most of the health care services. On average, over the last four years (2010/11-2013/14), the central government transferred about UGX 216 billion. This constituted about 14% of the total central government transfers to LGs during the same period. The performance of health care services at local government levels is generally poor mainly due to poor funding of the health service delivery units, namely, hospitals and health units.

The amount of non-wage funds allocated at health service delivery units is very low. For instance, on average per quarter, general hospitals receive UGX 32 million, HCIVs receive UGX 3.0 million, and HCIIIs receive UGX 0.8 million. Besides funding being low, timely disbursement of these funds is still a challenge. There are significant delays in the release of funds to the health service delivery units. For example, the average time it took for the funds to move from District Collection Account (DCA) to the health service delivery unit (HSDU) account, was 48 days in Gulu, 9 days in Kamuli, and 17 days in Luweero (Kajungu D., Lukwago D., Tumushabe G., (2015)). The longest delay was between the DHO account and

HSDU Account. The delays in release of funds are one of the main challenges of effective health service delivery.

Due to low funding, the facilities (such as beds, wards, and delivery beds) at the HSDU are very poor and in most cases not functioning. In addition, the health facilities lack effective emergence services such as ambulances. The situation was further worsened by the fact that government policy stipulates that funding and staffing should be based on level of health facility rather than the population size served and demand.

This briefing paper makes several recommendations: First, Government should increase the share of expenditure on health in the national budget. This is because health is a right, a major contributor to, a key determinant of productivity, which contributes to human development, economic growth, wealth creation and poverty reduction. Second, the health sector should maximise the efficient utilisation of allocated funds and resources. The LGs should ensure efficient delivery of funds especially between the DHO account and HSDU Account. Third, the health sector should re-structure its budget to ensure that budget allocation to local government health services take over 60% of the sector budget given that the bulk of primary healthcare services are delivered at this level. In addition, LGs should be given some flexibility in the utilisation of funds. etc. list the major recommendations some of which have already been articulated in the related paper on health, for completeness.

1. Introduction

This policy brief is part of Public Expenditure Governance (PEG) study of the health sector in Uganda(Kajungu, Lukwago, & Tumushabe, 2015). The overall objective of the research was to examine the links between public spending, governance, and outcomes in the health sector. The specific objectives were to identify the actors and their roles in decision making regarding budget allocations and service delivery, develop indicators for assessing expenditure governance in the health sector, Identify and assess the effects of budget allocation decisions on health sector performance and finally to identify and assess the efficiency of accountability mechanisms, including community participation, sanctions and rewards.

The research covered health facilities (hospital and health centres) in the districts of Luweero, Gulu and Kamuli. One of the major findings of the study was dismal public funding of health services at local government level. In addition, to the funding being meagre, it was untimely and most health facilities were unable to provide expected services to communities effectively.

The 2002 Health Financing Strategy estimated that in order for the sector to be able to provide the Uganda National Minimum Health Care Package, USD 28 per capita expenditure would be required. However, for FY 2013/14, only USD 12.0 per capita (which includes donor projects and Global Health Initiatives captured in the MTEF) was available. This is still below the recommended per capita government expenditure on health of US $ 34 per capita as per the WHO Commission of Macro Economics and Health (CMH). It is also below the HSSIP target of per capita government expenditure on health of US $ 17(MoH, 2014).

The low funding to the sector adversely affects more the poorest people who cannot afford alternatives to health care other than from government health facilities. The Uganda National Household Survey 2012/13 showed that 4 in every 10 persons (40%) suffered from an illness or injury and this proportion has not changed since 2005/06 (Uganda Bureau of Statistics [UBOS], 2014). The same survey showed that 42 percent of patients visited Government health facilities. Poor households utilize more of the government health facilities than the non poor. Over 51.1% of the poorest households (lowest welfare quintile) went to government health facilities compared to 21.9% for the non-poor households (highest welfare quintile)(UBOS, 2014).

This brief is organised as follows. Section 2 highlights the overall health policy frameworks and delivery of health services while Section 3 analyses government spending on the health care services in Uganda with special emphasis on lower

level health care services. Section 4 provides recommendations on how to improve the situation and also provides the strategic way forward and conclusion.

2. Overall health policy framework and delivery of health services

The Health Sector Strategic Investment Plan (HSSIP) 2010/11-2014/15 is the medium-term plan guiding the health sector focus on achieving the objectives of the 2nd National Health Policy (NHP II) 2011–2020. The NHP II prioritises the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP), more efficient use of available health resources, strengthening of public and private partnerships for health, and strengthening of health systems(MoH, 2010a).

According to the NHP II, the UNMHCP which has been developed for all levels of the health system for both public and private sectors and service delivery is based on this package. The government of Uganda health system consists of the district health system (communities, Village Health Teams (VHTs) or health centres: HCs I, II, III and IV and general hospitals, Regional Referral Hospitals (RRH) and National Referral Hospitals (NRH). The RRH and NRH are semi-autonomous institutions. District health services are managed by local governments. The district health system is further divided into Health Sub-Districts (HSDs). Each HSD is supposed to have a referral facility being either a HC IV or a general hospital(MoH, 2010b).

The Ministry of Health Facility Inventory 2011, reported 2,679 public health facilities in Uganda [1,588 (59%) were HCIIs, 859 (32%) were HC IIIs, 166 (6%) were HC IVs and 66 (2%) were hospitals]. There was a 16.4 percent increase in the number of public health from 2,301 in 2006 to 2,679 in 2011. The increase was principally driven by construction of new health centres by the government in its drive to improve access to health services. Although health infrastructure has expanded, the vast majority of health facilities are not fully functional, lack equipment and staff, and are poorly maintained.

The Health Sector Strategic Investment Plan states that, "Local Governments have the responsibility for the delivery of health services, recruitment, deployment, development and management of human resource (HR) for district health services, development and passing of health related by-laws and monitoring of overall health sector performance"{MoH, July`, 2010}. This implies that local governments are responsible for the delivery of the majority of frontline health services to Ugandan households.

However, the NHP II recognises that the Local Government health management capacity is still weak. Leadership skills, health services management and specialist skills are inadequate at all levels. High levels of attrition curtail capacity development initiatives. While Community Health Departments (CHDs) exist at RRHs to support districts, systems to carry out this function are not yet fully operational (MoH, 2010b).

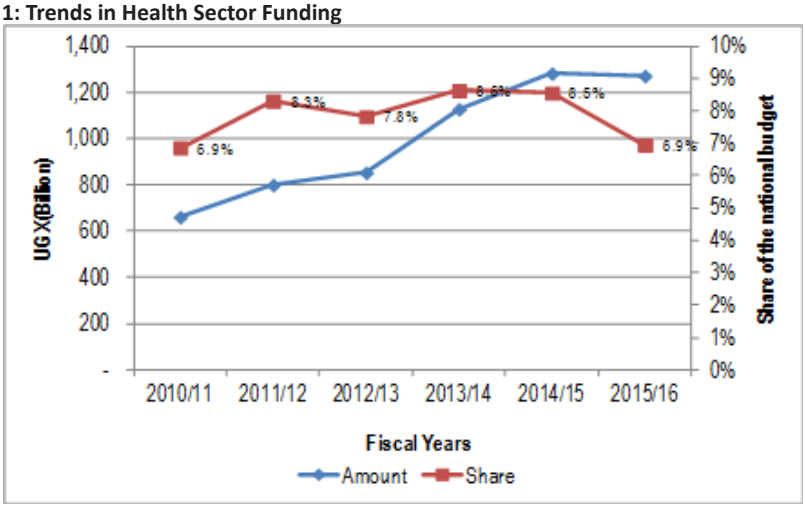
3. Health Sector Budget Allocations

3.1 Overall sector allocation

Public spending in the health sector occurs both at the national and local government levels. At the national level, the key institutions include: MoH Headquarters, Uganda AIDS Commission, Uganda Blood Transfusion Services (UBTS), Health Service Commission, Butabika Hospital, Mulago Hospital, Uganda Cancer Institute, Uganda Heart Institute, National Medical Stores and KCCA. At the Local Government level, spending is mainly through conditional grants which include PHC Salaries, PHC Non-Wage, District Hospitals, PHC NGO Hospital Non-wage, NGO Wage Subvention, and PHC Development and Regional Referral Hospitals.

In absolute terms, Government budget allocation to the health sector has increased from UGX 660 billion in 2010/11 to UGX 1,271 billion in 2015/16. However, the sector share of the total national budget (see Figure 1) averaged 7.8% during the same period which is 2 percentage points short of the HSSIP target of 9.8%.

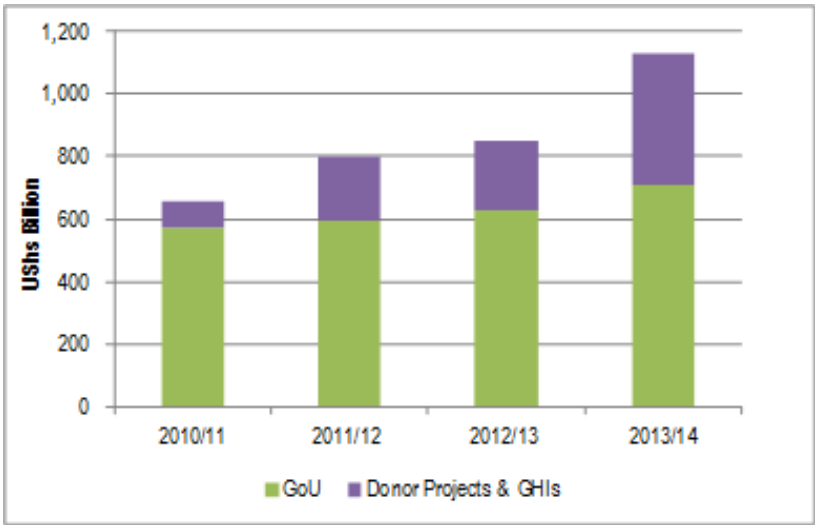
Figure 1: Trends in Health Sector Funding



Source: Author's computations based on the data on MTEF (MoFPED, 2010/11-2015/16).

Donor funding represents a substantial contribution to the health sector financing. During the FYs 2010/11 – 2012/14, donor funding accounted for about 26% of the entire sector budget (see Figure 2). Dependence on donor projects in supporting Uganda's health system is a big challenge in ensuring sustainability of the health interventions. The amount of donor funds (on-and off-budget) poses sustainability concerns given the fact that external funding is usually unpredictable in several ways: (i) it is not always evident when the funds will be disbursed; (ii) the period over which funds commitment will be sustained is not always clear; (iii) in some cases failure of Sector Development Partners to disburse aid commitments that are recorded in the government's Medium-Term Expenditure Framework (MTEF) causes uncertainty in the operational funds and disrupts implementation of programmes; (iv) aid may be politically tied. Thus, any funding cuts by donors can adversely affect health service delivery.

Figure 2: Composition of Health Sector Funding



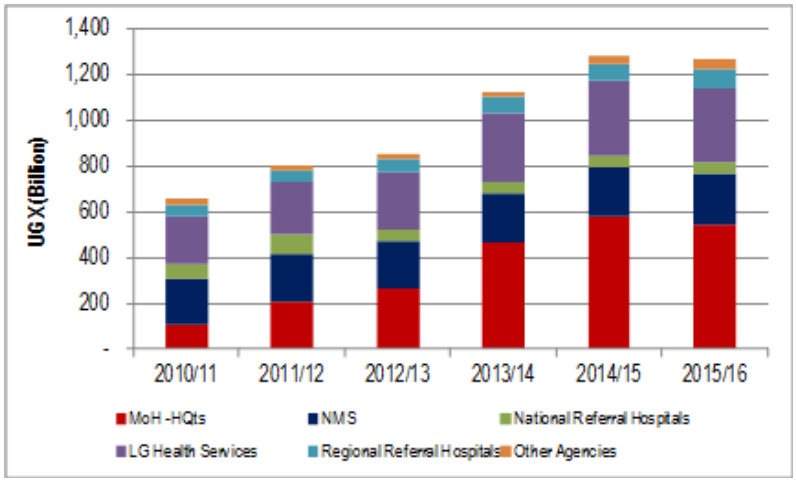
Source: Author's computations based on the MoH ASPRs (MOH 2010/11-2013/14)

3.2 Intra-sectoral allocations

As Figure 3 shows, during 2012/13 - 2015/16, the biggest share of the Health budget has been allocated to MoH headquarters, followed by LG health services, mainly on primary health care services, and National Medical Stores. The high allocation to the MoH headquarters might be attributed to the fact that most donor projects are implemented by the headquarters. The sharpest increase in health funding in both MOH Headquarters and LG Health Services was during 2012/13 -2013/14. However, funding to regional referral hospitals remains inadequate and has remained fairly constant during 2010/11 - 2013/14. With

meagre resources, majority of the regional referral hospitals are increasingly finding it difficult to provide reasonable healthcare services.

Figure 3: Trends in Health Intra-Sector Budget Allocations



Source: Author's calculations based on the MOFPED, Approved Estimates of Revenue and Expenditure. (MoFPED 2010/11-2015/16)

3.3 Local Level Health Funding

Under the decentralization policy framework, Local Governments (LGs) are required to provide most of the health care services. To enable LGs provide health services, the central government provides funding through transfers in form of conditional grants to LGs. On average over the period 2010/11-2013/14, the central government transferred about UGX 216 billion. This constituted about 14% of the total central government transfers to LGs during the same period (see Figure 4). The districts receive conditional grants whose amounts are predetermined by the MoFPED. The conditional grants do not give chance for flexibility in terms of budgeting for specific and unique needs at the health service delivery unit (HSDU).

Consequently, the performance of health care services at local government levels is generally poor; there is over preference for selective primary health care (This approach refers to elimination of disease by mobilising health services to curb the most prevalent diseases) to comprehensive health care. Therefore, much of the funding goes into construction of health facilities. There is less focus on strengthening the health promotion and disease preventive measures(UDN, 2007).

The situation is worsened by the weak capacity at local government levels to implement primary health care services - low staffing levels and inadquate facilities at HCs.

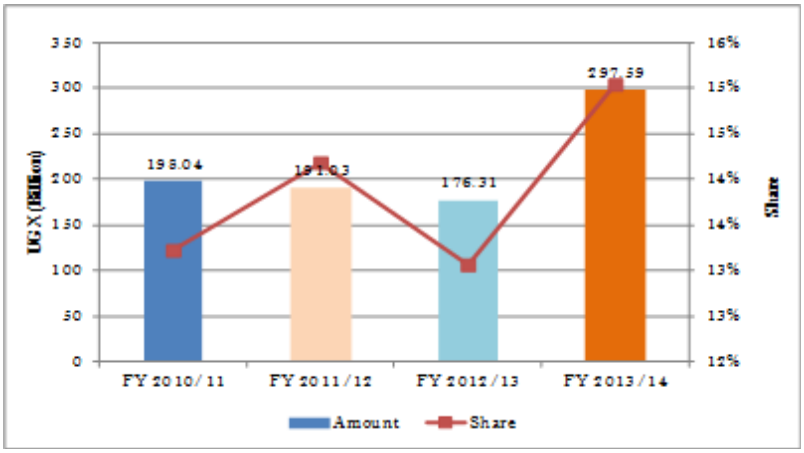


Figure 4: Trends in central government Health sector transfers to LGs

Source: Author's calculations based on data from MoFPED and LGFC releases to LGs (2010/11-2013/14)

On average over the four- year period 2010/11-2013/14, Gulu, Kamuli and Luweero district received about UGX 3.8 billion, UGX 3.1 billion, and UGX 2.4 billion respectively from the central government. In addition, health transfers to Kamuli have generally been on an upward trend (see Figure 5).

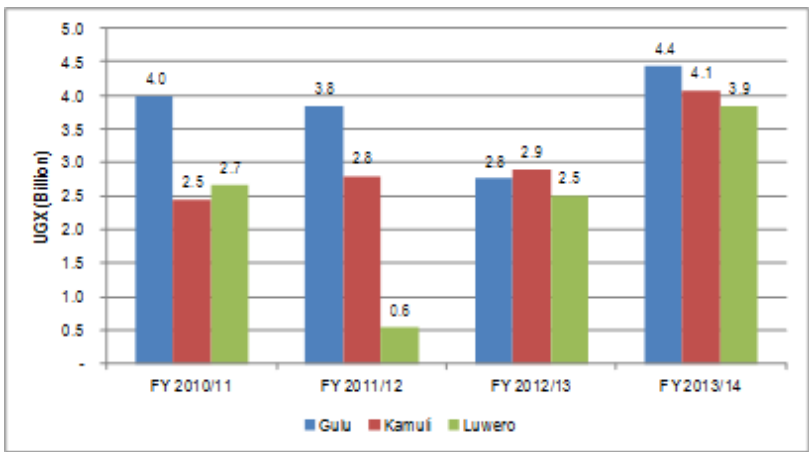


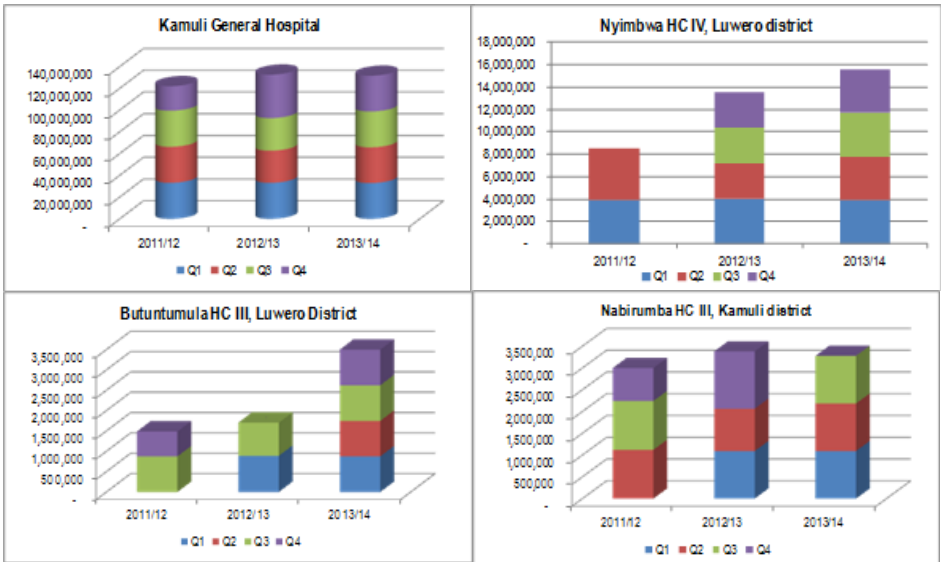
Figure 5: Trends in CG health sector transfers to Gulu, Kamuli and Luweero district

Source: Author's calculations based on data from MoFPED and LGFC releases to LGs 2010/11-2013/14.

Since LGs largely depend on central government transfers, their budget allocation towards the health sectors mirrors the central government transfers, the exception being Kamuli. Based on the available information, on average over three FYs (2011/12-2013/14) Gulu, Kamuli and Luweero district allocated UGX 3.7 billion, UGX 4.1 billion, and UGX 2.7 billion respectively of their total budget towards health. Majority of the health sector budget is spent on Healthcare Management Services which includes salaries and wages and arrears instead of procurement of drugs, equipment, and other infrastructural costs; a situation observed to be a critical impediment to effective service delivery.

The amount of funds (non-wage- meant to run the facility) allocated at health service delivery units (hospitals and health units) is very low. For instance, the PEG health study found that on average per quarter Kamuli hospital received UGX 32 million, HCIVs received UGX 3.0 million, and HCIIIs received UGX 0.8 million (see Figure 6). These funds are supposed to cater for general running of the facility, outreaches and immunization, fuel for ambulance, pay for utilities, support supervision of lower facilities, HUMC allowances, among others. Besides being meagre, funding for health facilities are conditional in nature and this limits the flexibility of managers in the utilisation of these funds. Due to low funding, health facilities are unable to provide effective health care services for citizens.

Figure 6: Trends in Health Unit funding (non-wage)



Source: PEG in Health study year 2015.

From the figures above, it is revealed that Kamuli General Hospital quarterly amounts of non-wage funds do not vary much from year to year over the three-year period 2011/12 -2013/14, Nyimbwa HC IV missed quarterly non-wage funds for quarter three and four but the funds for the preceding two years (2012/13-2013/14) gradually increased, Butuntumula HC III missed funds for quarter four and three in year 2011/12 and in year 2012/13, they missed funds for quarter one and three but in year 2013/14 they received funds for all the quarters and finally Nabirumba Health Centre III missed non- wage quarterly funds for quarters one, three and four in year 2011/12, 2012/13 and 2013/14 respectively.

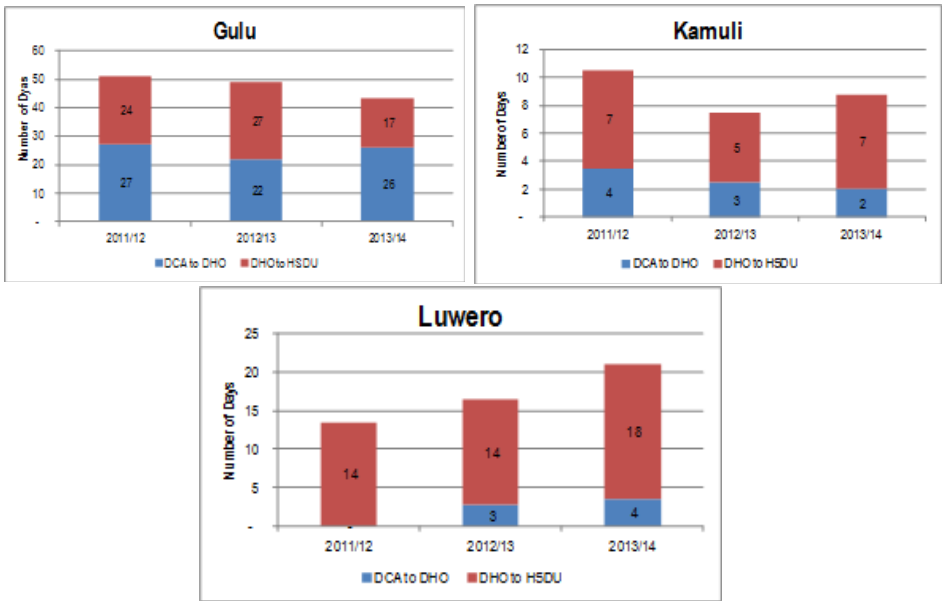
3.4 Flow of Health Funds

Health service delivery happens at the front line service delivery unit, which is the hospital or health centre. Therefore, non-wage funds have to be transferred from the central government to the health service delivery unit. The mechanism of transfer of funds involves release of funds by the MoFPED to LGs (District Account), then to the District Health Office (DHO) account and then to the HSDU account.

The district officials interviewed during the PEG in Health study noted that there was a significant time lag between when the MoFPED announced the releases and when they get the funds. There are delays between the national treasury and commercial banks in terms of reconciliation of release schedules and amounts transferred to the bank account of the districts. For instance, the CFO has to pick the hard copies of release schedules from MoFPED in Kampala and s/he has to reconcile the release schedules and amounts transferred on the bank account, and this usually takes time. In some instances, the amounts received are not consistent with the releases schedule, which causes more delays, since the district has to then get clarification from MoFPED.

The PEG in Health study found that during the three financial years (2011/12-2013/14) the average time it took for the funds to move from District Collection Account (DCA) to the health service delivery unit (HSDU) account, was 48 days in Gulu, 9 days in Kamuli, and 17 days in Luweero. The longest delay was between the DHO account and HSDU Account (see Figure 7). Such delays are caused by the DHOs office, who for one reason or other takes long to sanction transfer of funds to health units. The delays in release of funds to the front line service delivery units are one of the main challenges of effective health service delivery.

Figure 7: Flow of funds (average number of days)



Source: PEG in Health study

3.5 Implications inadequate health sector funding

With the current level of funding, the health sector will not achieve the targets indicated in the HSSPII. Almost every item of the budget is suffering from the resource constraint. The effect of the funding constraint has been described by various stakeholders within the sector as frustrating, because it is "systematic" and "systemic", affecting both service delivery at the districts as well as supportive services at the Ministry of Health. With this level of funding it is envisaged that the sector is probably going to achieve less during the HSSP II than it was able to achieve during HSSP I. This is especially because the allocation to the sector is likely to be less over the coming years in real terms, yet the cost of service delivery and the population are rising (Odaga & Lochoro, 2006).

The inputs most affected by low sector funding are mainly human resources, drugs and other medical supplies-the essentials for any basic healthcare interventions. Inadequate staffing and drug shortages in public health care facilities imply that poor people will continue to pay for health care services. The recent Uganda Health Accounts report, per capita out of pocket (OOP) expenditure increased from UGX 41,026 in 2008/09 to UGX 60,385 in 2012/13(MoH, 2012). This is probably due to relatively the poor quality of health services in public facilities compared to private facilities. Other factors include inflation and exchange rate developments which can adversely affect the prices or volumes of imported medicines and equipment.

Due to budget constraints the sector has not been able to recruit health workers. In most cases, the health staffs are over-burdened and are unable to deliver services effectively. In addition, supportive services such as support supervision are not being effectively done because there are no funds provided for them.

At the health service delivery units, the quality of facilities (such as beds, wards, and delivery beds) are very poor and in most cases not functioning. In addition, the HCs lack effective emergence services such as ambulances. Most of them do not have an ambulance and those who have, the ambulances are not functioning well and lack funds to repair them. The situation was further worsened by the fact that government policy stipulates that funding and staffing should be based on level of health facility rather than the population served and demand. For instance, Luweero HC IV being on highway and in an urban centre is receiving funding for HC IV yet; the services provided were that of a hospital.

With the current level of health sector funding, Uganda is on track to meet the health related Millennium Development goals such as reduce under five child mortality ratio by two thirds and combating HIV/AIDs, malaria and other diseases but the process of reducing maternal mortality ratio by three quarters between 1990 and 2015 is stagnant {MoFPED, September 2013}

4. Recommendations and Conclusions

4.1 Recommendations

Based on the above-mentioned findings we recommend the following:

- The Government of Uganda funding to the health sector needs to be tremendously increased rather than banking on unpredictable donor projects/ funds. The health sector budget should be increased to over UGX 2.2 trillion. This will enable government to effectively implement the Uganda National Minimum Health Care Package.

- The LGs should ensure timely delivery of funds especially between the DHO account and HSDU Account. This will maximise efficient utilisation of allocated funds and resources.

- The health sector should re-structure its budget to ensure that budget allocation to local government health services take over 60% of the sector budget. In addition, LGs should be given some flexibility in the utilisation of funds. This will enable them improve health service provision especially primary health care.

- Since government abolished cost-sharing health facilities in Uganda because they cannot respond to the legitimate needs of the citizens. Government needs to expedite the health insurance scheme or promote Community Health Insurance (CHI) [such as Rwanda's Mutuelles (Mutuelles is a community- based health insurance program, established since 1999 by the Government of Rwanda as a key component of the national health strategy on providing Universal health care.)) material, important as it is, should be in the literature and not come late here in recommendations]. CHI are run on a not for profit basis, targeting informal sector and applying the basic principles of risk-sharing and members' participation in management.

4.2 Conclusion

Funding remains the single most important constraint facing the health sector in Uganda. Although the Government budget allocation to the health sector has increased from UGX 660 billion in 2010/11 to UGX 1,271 billion in 2015/16. However, the growth in the sector budget is not commensurate with the population growth. To provide the Minimum Health Care Package, Government needs to spend at least USD 28 per capita however; government spent only USD 12.0 per capita in 2013/14.

Due to low funding to the health sector, the amount funds (non-wage) allocated

at health service delivery units (hospitals and health units) is alarmingly low. For instance, on average per quarter general hospitals receive UGX 32 million, HCIVs receive UGX 3.0 million, and HCIIIs received UGX 0.8 million. Besides funding being low, timely disbursement of these funds is still a challenge. There are significant delays in the release of funds to the health service delivery units. For example, the average time it took for the funds to move from District Collection Account (DCA) to the health service delivery unit (HSDU) account, was 48 days in Gulu, 9 days in Kamuli, and 17 days in Luweero. The longest delay was between the DHO account and HSDU Account.

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