Ugandan health units are reporting a doubling in patient visits. What lessons can be learnt by other sectors and by DFID?

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Abstract

Uganda is still a long way off achieving its health MDGs. The latest figures, from2000, showed infant mortality rates at 88 per 1000 births and maternal mortality rates at 505 per 100,000 births. These statistics, to some extent, reflected the poor performance of the health sector during the 1990s. In particular, they reflected chronically low expenditure on health services and high levels of inefficiency in the way resources were raised, allocated and managed.

However, since 2000, there has been a small revolution in the Ugandan health sector. Through implementing a Sector Wide Approach (SWAP), the Government of Uganda has managed to improve the supply of basic health care services to its population. In addition, it has stimulated demand for these services by almost totally abolishing patient charges. As a result, out patient attendances have soared by 87% (now more than double 1997/98 levels) and immunisation rates have grown by 78%. However, not all output indicators have improved and the fact that only 1 in 5 women give birth in health units shows that quality levels need to improve further.

Overall, the assessment is that the people of Uganda have "voted with their feet" and are now consuming significantly more health services than before. Given the scale of the increases, there are high expectations that health outcomes (infant and child health MDG targets) will start to show signs of improvement soon.

What lessons can be learnt from these reforms? For developing country social sectors, the key message appears to be that Government led SWAPS can deliver significant returns relatively quickly. In particular, tackling a broad range of supply side and demand side constraints simultaneously appears to be beneficial. Furthermore, the Government budget appears to be a much more efficient and equitable financing mechanism than project funding and user fees.

For DFID and other development agencies, key lessons involve mechanisms for financial support and technical assistance. In the case of reforming Governments, it would appear that budget support is proving an efficient mechanism to support social sector development. However budget support alone may not be sufficient. DFID has also invested heavily in the SWAP process, through targeted sectoral assistance. Stakeholders in Uganda acknowledge that this has been an important factor in enabling the Government to manage its reform process effectively. A mixed strategy of "budget support plus" may therefore be an appropriate aid mechanism to secure good returns on investments in reforming social sectors.

1. Background the Ugandan Health Sector pre 2000

For a country at the forefront of development reforms, the 2001 Uganda Demographic Health Survey figures (based on 2000 data) were extremely disappointing.

They showed that since 1995, infant mortality figures had deteriorated and maternal mortality figures had hardly changed. These statistics were significantly off track for achieving the country's own Poverty Eradication Action Plan (PEAP)[1] and MDG targets. See table 1.

Table 1: Stagnating health indicators in the 1990s in Uganda

Indicator	1995	2000	REAP target (2005)	MDG target (2015)
Infant mortality rate (deaths < 1 year per 1000 live births)	81	88	68	41
Maternal mortality rate (deaths per 100,000 live births)	527	505	345	131

It is universally recognised, that it is not the sole responsibility of the health sector to deliver the health related MDGs. However, the sector clearly has an important role to play and to some extent, the health status figures must reflect the poor performance of Ugandan health services during the 1990s.

A wide range of factors contributed to this poor performance but financing and management problems were particularly implicated. Towards the end of the decade, there was a realisation that the sector was chronically underfunded and that what little resources were being spent were being utilised very inefficlently. A breakdown of the estimated $6 per capita spent on public and NGO health services in 1999/2000 showed that:

- The majority of the Government budget (66%) was allocated to large hospitals and the central Ministry of Health, which tended to benefit the urban (and therefore better off) population.
- Donor projects tried to stimulate the development of primary health care services but proved relatively ineffective and inefficient[2].
- Patient fees throughout the system raised little revenue, exemption schemes did not work and as a result, utilisation of services by poor people was very low.

Due to these financing conditions, very little (at most $2 per capita) was being spent on basic health care inputs (drugs, health workers salaries, health centre maintenance etc) in rural areas. As a result, the coverage and quality of services was inadequate. People in rural communities, being rationale consumers, and facing charges for these services, not surprisingly tended to stay away. Sadly this remains a common picture across the continent.

2. Time for a New Approach

Radical action was required and this is why the country embarked on a Sector Wide Approach (SWAP) towards developing the health sector.

"The defining characteristics of a SWAp are that all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting

[1] In effect Uganda's Poverty Reduction Strategy Paper (PRSP)

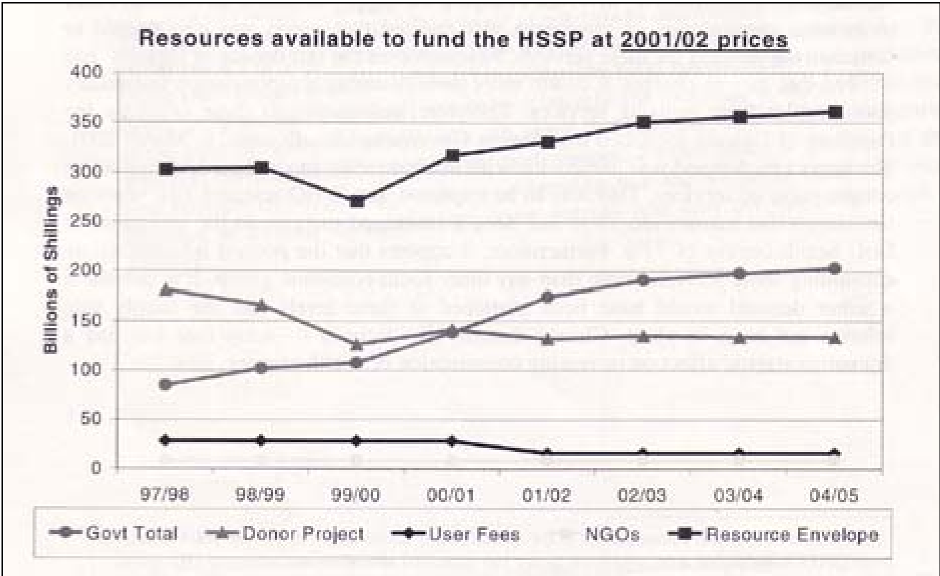
[2] A recent analysis from the Ministry of Health has shown that for five large donors providing project support only 32% of funds are spent on basic health care inputs as opposed to 68% on technical assistance, project management costs and high cost investment goods and services.

common approaches across the sector and progressing towards relying on Government procedures to disburse and account for all funds."

This definition[3], in emphasizing a shift towards reliance on Government financing mechanisms to fund a coordinated policy and expenditure programme, sums up the essence of the Ugandan Health SWAP. However, it does not do justice to the breadth and depth of the reforms undertaken during the last three years. Annex 1 lists some of the elements of the reforms which have gone to make up the overall SWAP. It is difficult to single out which of these policies and activities have been the most important factors in improving performance but those discussed below appear to have been significant.

2.1 Development partners switching from project funding to budget support

Right from the outset of the SWAP, the GoU stated that general budget support was its preferred donor financing mechanism. DFID concurred with this approach and with other partners, began switching resources from projects to GoU budget systems. As a result, the GoU budget has doubled in real terms since 1999/2000 and since 2000/01 has become the primary financing mechanism for the sector, see graph below[4]:



Now that the GoU controls more of the finances flowing into the sector, it has been able to allocate these resources more efficiently[5]. In particular, there has been a dramatic increase in funding for primary health care services with district budgets increasing seven times.

2.2 Investment in better management systems to improve the supply of essential inputs

Allocating funds more efficiently was not sufficient: attempts also had to be made to improve management systems concerning all health care inputs. This included:

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3 Overseas Development Institute Working Paper 142
4 HSSP is the Health Sector Strategic Plan for 2000/01 to 2004/05
5 The Ministry of Health's presentation to the annual Public Expenditure Review in 2003 (available from DFIDU) highlights areas where the sector has Improved allocative and technical efficiency.

Financial management: improving the disbursement of budget funds to districts so that 93% of the budget was released on time in 2002.
Drugs: Ringfencing 50% of the district non-wage budget for drugs and supplies and changing supply systems to be more demand driven.
Human resources: Recruiting 2700 primary health care workers; increasing doctors salaries by 60% and computerising the whole health payroll system to ensure prompt payment of salaries.
Infrastructure: Selective investment in maternity services at large health centres and constructing 130 small health centres in underserved areas.
Performance Management: Introducing coordinated monitoring of district services including the production of district league tables for PEAP indicators.

2.3 Abolishing user fees in Government health units

All the factors listed above, involved changing the supply of health services. In order to increase consumption of services it was realised that action was also needed to stimulate the demand for these services. Research over the last decade in Uganda[6] had showed that patient charges at health units were deterring the population (especially poor people) from utilising services. Therefore, responding to these concerns the President of Uganda abolished user fees in Government health units[7] in March 2001. The impact on demand was immediate, with many districts reporting a doubling in the consumption of services. This was to be expected, but WHO research two years on has shown that nationwide, there has been a **sustained** increase in the utilisation of GoU health centres of 77%. Furthermore, it appears that the poorest households are consuming these services more than any other socio-economic group. It is debatable whether demand would have been sustained at these levels had the supply side reforms not been in place. Clearly though, the decision to scrap fees has had a dramatic catalytic effect on increasing consumption of health care services.

2.4 A Genuine Public Private Partnership

During the decades of civil conflict in Uganda, public health services collapsed and for many people, NGO (mostly church based) services were their only source of health care. To this day, NGO health units remain important players, accounting for 25% of all health units. For the SWAP to be implemented efficiently and equitably, the NGO health services need to improve too. This has been accomplished by building a genuine public-private partnership in the health sector which now includes annual public subsidies (from the GoU budget) to the private sector, of $9 million. Interestingly the NGO units are increasingly choosing to use their grants to lower their fees and attract more poor patients, rather than use all their funds to improve service quality for their existing clients.

3. Results of the Reforms

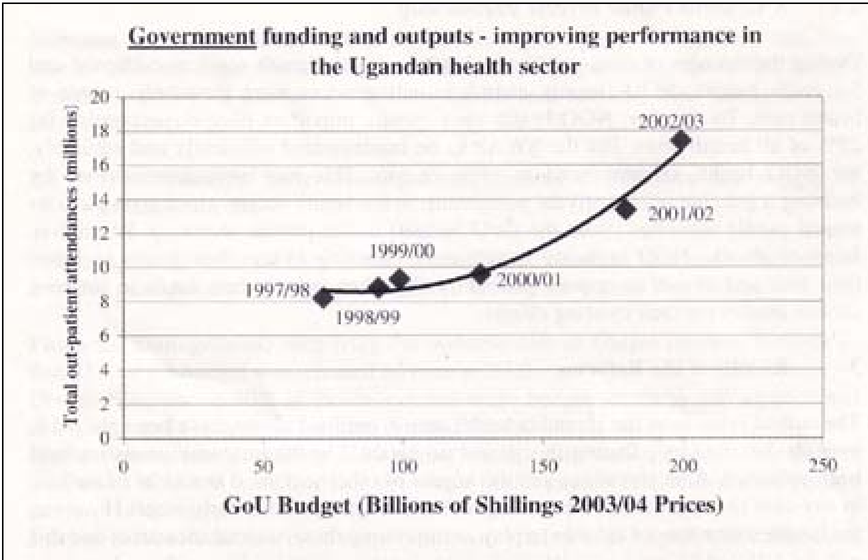
The radical reforms in the Ugandan health sector, outlined above, have been phased in over the last 3 years[8]. During this period no national health **outcome**[9] statistics have been

[6] Notably the Uganda Participatory Poverty Assessment Project (UPPAP) Report of 2000. Ministry of Finance Planning and Economic Development
[7] With the exception of private wings in hospitals
[8] The SWAP's Health Sector Strategic Plan was officially launched in August 2000.
[9] For example infant, child and maternal mortality rates

collected. Also given lags and the impact of other sectors, it would be unrealistic in any case to expect significant changes in these figures at this early stage. However, the health sector has a vital role to play in improving these societal indicators and this will be fulfilled by more people consuming better quality health services. Improved **output** figures should therefore be regarded as essential precursors for better outcome data. Therefore, while we await the next set of outcome indicators in 2006, it would appear reasonable to use output data as a guide to whether the health sector is helping deliver PEAP and MDG targets.

Here results are encouraging for the consumption of basic out-patient services but not for more costly in-patient services.

The graph below shows a 115% increase in out-patient attendances (at GoU and NGO units) since 1997/98. It also shows how this increase appears to be correlated to the rising GoU budget over this period. Given that the **total** resource envelope (including donor projects and user fees) has been relatively flat (increasing only 12%, in real terms over the last five years), one can argue that it is the GoU budget mechanism which is driving the improved output performance. Furthermore the gradient of this line appears to be getting steeper - suggesting that the sector is becoming more efficient at turning its budget into more outputs (the cost per out-patient visit is falling).



The picture is similar for another PEAP indicator - immunisation rates for children[10]. Nationally coverage has increased from 41% in 1999/2000 to 73% in the last financial year. Furthermore 50% of districts are reporting coverage rates of greater than 75%.

However performance has not improved for all indicators. In the case of women giving birth in health units, the proportion of institutional deliveries has declined from 25% in 1999/2000 to 19% in 2001/02, only improving marginally to 20% last year. It is accepted that if significant improvements are to be made to maternal mortality figures (a MDG indicator) this situation must change. The reasons why more women are not delivering in health units are

[10] Specifically children immunized against Diptheria, Pertussis and Tetanus. It is arguable that an immunised child is a healthier child and so this indicator is in effect a health outcome measure.

complex but it is likely that concerns about poor quality are deterring many. Maternity services are more expensive than simple outpatient care. It could be argued therefore that Uganda's $4 per capita government health budget is able to meet, to some degree, expectations for the latter but not the former[11]. This is an important message for the Ministry of Finance and the broader development community. Significant improvements in all health related MDGS will require considerably higher funding levels for the social sectors. In health's case around $28 per capita will be required, of which $22 should be channeled through the health budget[12].

4. What has been DFID's Role?

The vast majority of the credit for the apparent successes of the Ugandan SWAP must lie with Ugandan stakeholders: notably key reformers in the Ministries of Health and Finance, the President (for abolishing user fees), Local Government officials and health workers in GoU and NGO units.

However, a number of key donors have also had a crucial role in developing and implementing the SWAP. Within this group, the role of DFID has been pivotal.

On the financing side, DFID has been the largest bi-lateral donor prepared to switch its previous project support into the GoU's preferred mechanism: general budget support. In the last three years[13] **total** budget support from DFID averaged £37 million per year. Whereas it is virtually impossible to allocate this sum across sectors, the GoU notionally attributed 39.8 billion shillings (£12 million) of its health budget to DFID in 2002/03. This represented 20% of the health budget. The financial impact of these contributions extends further than the actual amount donated though, as other partners have clearly followed DFIDs lead in joining budget support.

However, DFID's role has not been restricted to providing additional finance. In addition, DFID has been a (perhaps **the** most) important donor in assisting the Government to take on the responsibilities for managing the health SWAP.

DFID has been able to fulfill this role due to a high investment in targeted sectoral support, in a sector where DFID has a comparative advantage. Specifically, the DFID health advisor has been the key donor throughout the SWAP process by chairing the donor group and building excellent relations with reformers in the Ministry of Health. Being a budget support donor undoubtedly helped foster these good working relationships. Furthermore, technical assistance has been seconded into the Ministry to help develop management and financial systems (especially the budget) and assist in vital disease programmes. This technical support has been backed up by **limited** off budget financial assistance, most notably in the creation of a Partnership Fund with other donors to facilitate essential SWAP processes.

It is extremely unlikely that DFIDs' budget support would have had the same impact had the technical sectoral inputs not been present as well. Therefore to draw on language from the marketing world, perhaps DFID should be looking to supply an aidproduct of "budget support

[11] Even for outpatient services volatile monthly statistics suggest that supplies of commodities (especially drugs) are not meeting the increased demand
[12] Ministry of Health, Health Financing Strategy, 2002.
[13] Ugandan financial years

plus" to countries embarking on social sector reforms.

5. Lessons learnt

Given the scale of the reforms in the Ugandan health sector but looking at a relatively short time scale, it is difficult to draw cast iron conclusions at this early stage. However, it is the belief of most stakeholders, that a number of green shoots are emerging from the depressing landscape of the 1990s which need nurturing. To stimulate debate and further research, from the perspective of a participant over the last four years, it is suggested that the following lessons could be learnt. Note these lessons are likely to be applicable to other social sectors such as education and water.

5.1 Some lessons for social sectors in poor developing countries

- Previously failing social sectors can be turned around - they should not be treated as a lost cause
- Government led SWAPs can deliver significant returns relatively quickly
- Populations will respond to improvements in the supply of basic services
- Reforms are more likely to be successful if they address sector wide and Government wide constraints
- Sector wide reforms can catalyse changes in broader Government systems
- Budget financing can be significantly more efficient and equitable than project funding
- Working collaboratively with the private sector, including the provision of subsidies, can be extremely beneficial to the sector as a whole
- Where serious attention is being given to supply constraints, governments should consider stimulating demand by abolishing user fees for basic services

5.2 Some lessons for DFID and other development agencies

- In the case of reforming governments, general budget support can be a very effective mechanism to stimulate social sector development
- Government budgets can be much more efficient at allocating resources to basic services than project interventions
- Certain sectors may require targeted sectoral assistance to maximise returns on increasing budgets. This may be in terms of helping manage the SWAP process and/or technical assistance in areas where there is relatively low capacity
- Greater encouragement should be given to reforming governments to abolish user fees for basic services

DFID Uganda welcomes comments on this paper, which should be sent to:
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Annex 1: An Analysis Uganda's Health Sectors Reforms
Using WHO's Health System Functions Framework

1. Stewardship

System areas: Governance, strategic management, public-private partnership, regulation, SWAp arrangements, Inter-sectoral collaboration, consumer responsiveness.

Activities Undertaken in Uganda

- Extensive collaboration with other sectors in preparing the country's overall strategic development document: The Poverty Eradication Action Plan. This was the original Poverty Reduction Strategy Paper.
- Collaboration with a Ministry of Finance initiative to elicit the views of poor people concerning all aspects of Government policy. Ill health cited as the number one cause and consequence of poverty.
- National Health Policy Produced in 1999.
- Health Sector Strategic Plan produced for the period 2000/01 to 2004/05.
- HSSP concentrates on delivering the Uganda National Minimum Health Care Package (UNMHC). This packages focuses on providing cost effective services to tackle the greatest burden of disease experienced by the population. Special attention is given to meeting the needs of poor people, women and children.
- HSSP emphasises that responsibility for delivering UNMHCP services should be decentralized to Local Governments and establishes the basic unit of service delivery at the health sub-district level (population approximately 100,000).
- Health Financing Strategy produced in 2002.
- Memorandum of understanding signed between Government of Uganda and all donors supporting the Sector Wide Approach.
- Monthly meetings held of the Heath Planning Advisory Committee consisting of Government of Uganda ministries, donors and private sector representatives.
- 6 monthly joint reviews undertaken of the HSSP by GoU, donors and other stakeholders.
- Public-Private Partnership policy produced in 2003. Part of a genuine partnership arrangement which sees substantial subsidies being given to the private sector from the Government budget. ($9 million in 2003/04).
- MoH set to start funding an independent watchdog NGO, the Uganda National Health Consumers Organisation (currently DFID funded) from the central budget.
- Mid Term Review of the HSSP undertaken in 2003. The process is effectively managed by the MoH with good inputs from development partners. Finds that HSSP strategies are “relevant and appropriate” and that in some areas output performance has exceeded expectations. Report does not conceal areas where there is “much scope for improvement.”

2. Delivering services

System areas: operational planning, operational management including: human resources, pharmaceutical supplies, financial systems.

Activities Undertaken in Uganda

- Heavy investment in decentralised service delivery at the district level and below at 214 health-subdistricts. Central PHC funding for these services increased 6.5 times in five years to this financial year.
- Requirement that District Directors of Health Services possess an MPH degree. Health sub-districts managed by a qualified doctor, many with public health training.
- Annual planning processes improved: planning based on health sub district level activities and linked closely to the budget cycle. Indicative district budget ceilings provided 8 months before the start of the financial year.
- Emphasis has been on providing an integrated package of care at the district level rather than managing disparate vertical disease programmes.
- Following persistent complaints about late payments and health workers not accessing the payroll, the entire health sector payroll was centralised onto a computerised system. Joint reviews now report that payroll delays are no longer a significant problem.
- Doctors salaries increased by 60% to coincide with the abolition of patient fees in Government health units.
- Regulations and guidelines introduced to ring-fence resources for vital basic inputs. Drug availability identified as the key determinant of consumer demand so ring-fencing for drug expenditures set at 50% of the district primary health care budget.
- Pharmaceutical supply systems improved noticeably the performance of the National Medical Stores.
- To minimise risk and allow local procurements to make up for national shortfalls, funding for district pharmaceuticals split between national and district budgets.
- Central supply of kits replaced by demand driven system of district managed credit lines held at the National Medical Stores.
- In each financial year priority programmes have been identified for special attention and funding. These have included: EPI, Malaria, health education, reproductive health, HIV/AIDS and environmental health.
- There have been noticeable improvements in some programme areas notably: EPI (immunisation rates up from 41% to 72%), malaria (with the introduction of home based management of fevers) and HIV/AIDS (prevalence rates down to 6.5%).
- Quarterly monitoring visits to all Districts undertaken by Ministry of Health teams (including planning department, accounts staff, drugs management and disease programmes) to assess progress in implementing the HSSP.
- Following disappointing results concerning the rate of disbursement of PHC conditional grants releases systems were overhauled. Subsequently performance in dispersing PHC grants on time increased to 93% in 2002.

3. Creating resources

System areas: Resource allocation, efficiency, equity.

Activities Undertaken in Uganda

- Adhering to the principles of the HSSP and in compliance with Ministry of Finance budget regulations the vast majority of additional Govt resources has been channeled into health's three "Poverty Action Fund" budget lines. The allocative efficiency of the Government budget has therefore improved considerably with a demonstrable shift towards services for poor people in rural areas. Allocations for District PHC services increased from 32% to 54% in 4 years whereas central hospital allocations fell from 22 to 12%. Furthermore subsidies to NGO units (hospitals and health centres) increased from zero in 1997/8 to 17.6 billion shillings in 2003/04 (approximately $8.8 million dollars or 8% of the overall health budget).
- Substantial investment at the health sub-district level has preceded large scale investment at lower level units due to concerns about meeting recurrent costs at newly constructed health units.
- Annual revisions of the allocation formulae for district PHC grants has resulted in a more equitable allocation of budget resources. Apart for some lump sum allocations for district director's offices and health sub-districts, the entire PHC non wage budget is now allocated according to weighted populations. Factors taken into account when weighting a district population include: poverty, health needs, refugees, internal conflict, coverage of hospitals and the existence of externally funded projects. As a result the highest need district (Bundibugyo) now receives 63% more PHC funding per capita than residents of the capital, Kampala.
- Annual PHC grant guidelines negotiated with Local Governments have concentrated financing on basic health inputs most noticeably on drugs and human resources. For example 50% of the PHC non-wage budget is ring-fenced for drugs and systems have been established to monitor compliance with policy.
- As a result of increased budget funding, improved allocative efficiency and improved management systems, the Midterm Review of the HSSP was able to report the following increases in the supply of basic health care inputs in Uganda:

Per capita expenditure on drugs increased by 50% ($0.80 to $1.2)
2696 Primary health care workers recruited
4349 nursing assistants trained
129 vehicles procured for health sub-districts
130 health sub-district facilities upgraded
56 maternities upgraded at the health centre III level

4. Financing

System areas: Resource mobilisation, increased pooling to improve efficiency, fair financing mechanisms to address equity concerns, strategic purchasing.

Activities Undertaken in Uganda

- There has been a modest increase in resources flowing into the sector. Total resource envelope estimated to have grown 12%(real terms) in the last 5 years.
- Donors switching their financial support mechanism from project funding to budget support has significantly increased pooling of health sector finances in GoU systems. As a result the GoU health budget has doubled in real terms.
- Proportionately the health budget has grown the fastest of all line ministries in the last 4 years. Health's share of the overall budget has increased from 7.9% to 9.5%.
- In March 2001, the President of Uganda abolished user fees in Government health units with the exception of private wings in hospitals. This was in response to persistent demands from the population to abolish cost sharing.
- The Ministry of Finances second participatory poverty assessment project (UPPAP) clearly documents poor peoples satisfaction with the abolition of user fees.
- As fees were being abolished, the Ministries of Health and Finance implemented a package of complimentary measures to maintain service quality. This included releasing 1 Bn shillings earmarked for district drug procurement and temporarily allowing districts to purchase drugs locally.
- WHO and the Ministry of Health immediately initiated a research programme to investigate the effects of the policy to abolish user fees. This included an analysis of utilisation figures including a breakdown by socio-economic groups, age and sex of consumers, level of care and public/private ownership. The latest report shows a 77% increase in the utilisation of Govt health centres and a 4% increase in NGO units.
- The Health Financing Strategy re-costed the HSSP (estimate $28 per capita) and outlines a strategy to close the funding gap by 2019/20 concentrating on the GoU budget as the most efficient and equitable financing mechanism.
- As part of the Government's Health Financing Strategy, alternative financing mechanisms were evaluated against feasibility, efficiency and equity criteria. Of these social health insurance was deemed to be the only appropriate long term mechanism to complement GoU budget financing.
- With Ministry of Finance threatening to set sector ceilings to include project funds the MoH has started to analyse donor projects to assess their value for money. As a result a proposed $ 16.5 million dollar project (consisting of 99% technical assistance and overheads) was cancelled.
- The evolution of the system of conditional grants for PHC activities has in effect been an exercise in strategic purchasing with the central ministries purchasing from district providers. Initially grants tended to be linked to the provision of inputs but greater attention has recently been paid to output performance. District league tables are being produced for key output indicators (outpatient statistics and immunisation rates) and it is planned that these will be used in future contracting negotiations.