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Conclusion Chapter: The Road Map to Universal Health Coverage

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Key Messages

- UHC is framed in terms of reducing catastrophic health expenditure among individuals and families and calls for treatment interventions at affordable costs. In contrast, good health and well-being (SDG Goal 3) calls for interventions that prevent ill health, and optimise happiness and social security. An effective balance needs to be struck between interventions for treating the sick and interventions for maintaining good health for the majority of the population that do not qualify for treatment services.
- Catastrophic expenditures for ill health turns the concept of UHC into one that applies at a personal level, thus justifying health insurance for individuals. UHC needs to be framed as a problem for a community, state or sub-national administrative zone. Consequently, health promotion and prevention interventions to "insure" the state, district or community from the risks of ill health and catastrophic spending will be identified and prioritised.
- Interventions to promote good health have major savings from health care costs to the economy and to communities. Unfortunately, these interventions have little or no place in person-level insurance and financing models for health care.

- Government financing remains the most effective model to advance coverage for population health and well-being through interventions like safe water and sanitation, vaccination, disease surveillance, health promotion and regulatory functions. Uganda, like many other countries, needs to prioritise these interventions.
- The agenda for health system strengthening and resilience has been narrowed to fixing the gaps at health centres to deliver treatment for the sick. Fewer investments have gone to systems that promote good health at community level. Accelerated attainment of good health and well-being requires expanding the community systems for health promotion, good nutrition, progressive lifestyles, and surveillance and response to health risks.
- The outcomes in health need to be viewed through a broader lens of health determinants, for more actors, agencies, networks and institutions to be effectively engaged in securing health and well-being. This plethora of stakeholders requires effective coordination to contribute to the common goals for universal health coverage. Politics, policies and leadership to suppress conflicting interests, to leverage investments in other sectors of the economy, to assign obligations and provide incentives for cooperation and interdependence are vital governance actions for advancing UHC.
- Escalating costs arising from new technologies and the push for better quality can inadvertently make UHC unrealisable for countries like Uganda with fewer revenues to afford the bourgeoning technologies in the health care industry. An institution to regulate technology adoption in Uganda is vital to ensure that cost-effective, affordable and feasible options are adopted for scale-up. The agenda for expanding services of good quality, more inclusive participation, commercialisation and application of technologies and innovations should be balanced with the need to control costs and ensure affordable health spending.
- The cost-effective road map to UHC should entail beating down pervasive causes of ill health and related social and economic losses to the country. Interventions to eliminate unintended pregnancies and diseases like malaria, diarrhoea and childhood illnesses are important. Health expenditures attributable to non-communicable diseases can

also be saved by promoting community actions and lifestyles that reduce obesity, smoking and similar behaviours.

- Family- and community-level prevention and health promotion activities should be enhanced to reduce the notion of looking at health facilities as reservoirs of good health to be visited frequently by everyone in the community.
- For more effective programming, close-to-community actors like local governments need to be enabled with resources and capabilities to plan and implement programmes in a more cost-effective manner and cross other key sub-sectors within the government and non-government settings.

Introduction

The framers of UHC seem conflicted about the "individual" versus the "society" as the main object for successful UHC programming. The agenda for UHC has in many ways inherited the focus of treating the sick person and mitigating the cost burden that arises to the individual or family. This micro-level view of UHC draws our attention to a limited set of interventions to help the individuals to get the treatment that they need and at a cost they can afford. From this perspective, the main interventions are health insurance with a broader package of services that address the major disease conditions. Indeed, the debate about indicators for monitoring country progress to UHC shows two camps – one group pulling in the direction of using catastrophic expenditures on health care and the other advocating health insurance coverage as the matrix for assessing UHC (1).

Although this micro-level perspective is important, and health insurance remains part of the intervention package, defining UHC at individual level does not cast the vision to the broader societal interventions that keep the majority of the populations in good health or well-being. The outcomes of good health and well-being do not sit well with health insurance solutions. For instance, they do not arise from waiting for people to get sick so that the treatment is less costly or affordable. On the contrary, well-being and good health require health promotion interventions like safe water, environmental hygiene, safe roads and many more. In economics, these are defined as public goods because they benefit many people who may not see the immediate value to pay for them.

Insurance markets are intentionally uninterested in public goods. Government interventions for health promotion are critical in such situations. If we frame UHC in terms of the broader societal perspective, interventions such as health awareness, managing population growth, regulations for safe consumption and products, elimination of disease vectors and reservoirs, environmental protection, and policies and programmes that support communities to protect themselves from diseases and stress become vital metrics for monitoring progress to UHC.

In this concluding chapter we explore, without exhaustively covering all priority actions, the vital elements in the road map for advancing UHC. The chapter emphasises actions on the determinants of good health and well-being at national and sub-national levels. This chapter is structured around the main tenants of universal health coverage: 1) introduction to safeguarding the population from the burden of ill health; 2) investing in affordable health promotion and care programmes while controlling cost escalation; 3) purposive expansion of intervention coverage for populations in most need; and 4) building the resilience of the health system to cope and sustain the gains at affordable costs. The specific interventions of strategic actions under each tenant are elabolarated below.

1. Reducing avoidable burden of services on the health system

The essential undertaking by countries like Uganda is to identify the most common causes of ill health and factors that lead to the use of health services and establish effective interventions to eliminate or control the causes. In Uganda, malaria and reproductive health burdens are major starting points to reduce the burden on the health system. There is a good precedent and evidence of the effective contribution of civic leaders to health promotion programmes as a means to mitigate the burden of ill health. For instance, Uganda has had top political leaders who have played vital roles in HIV prevention. In the recent past, they have been instrumental in educating communities about priority actions to improve health. For instance, the president in 2015 was quoted in the media as saying:

> Observe proper nutrition by eating healthy food, immunisation of children and other risky groups, observing proper personal hygiene and sleeping under treated mosquito nets among other things helps to prevent disease … the Ministry of Health (should) sensitise the public on disease preventive methods and how to live healthy lifestyles, saying that people need to be educated on how to avoid contracting preventable diseases (2).

These types of action need to be mainstreamed across all civil leadership programmes and activities to expand the sources of information for health promotion. Districts, local governments, schools and civil society leaders and groups need to take this up.

Malaria prevention

At the time of writing this book, malaria was known to be one of the main sources of stress to the communities, to the economy and to the health system. The study by Nabyonga et al. in 2012 found that malaria is responsible for a GDP loss of about US$ 49 million per year using 2003 data. Over the years the population afflicted by malaria has continued to increase and the interventions have become more costly – from low-cost treatment options in early 2003 to artemisinin-based combination therapies (ACTs) that are over 10 times more in medicines costs alone. Malaria still represents a big drain on the health system. It is estimated to be responsible for 39 per cent of outpatient visits and about 35 per cent of admission services. In economic terms, malaria is responsible for productive losses (lost labour hours). Educational achievement is affected by the time lost from school owing to malaria-related sickness and the associated anaemia (inadequate blood) that stunts the brain and physical growth. For these and more impacts on the economy, the National Development Plan (NDP) identified malaria elimination as one of the vital interventions to accelerate the social economic development of Uganda in its Vision 2040. Effectively controlling malaria and freeing the population and the health system of its ill health impacts can accelerate the realisation of good health and well-being among Ugandans.

Reproductive health services

A high rate of population growth is now recognised as one of the main causes of poverty in Uganda. A huge under-age and under-employed population – mostly children – and the high service demand that arises from reproductive health services such as antenatal and delivery care, childhood immunisation and the treatment of childhood illnesses, all draw a sizeable proportion of resources from the health system. Participation in gainful labour by pregnant women and women in active motherhood is much reduced – thus delaying the economic growth of households with many children. On average, it is estimated to take 10-15 years in the cycle of pregnancy and child care

for a woman with six children – the current average for Uganda (3). This period represents about half of the economically productive years of a family. Although childbearing and upbringing are valuable undertakings in society, the goal to reduce poverty and transform the economic well-being of communities should aim to reduce the time communities are unable to fully deploy themselves in gainful economic activities from which they can make savings and invest to improve their health and well-being. Surveys also show that unmet demand for family planning for married women remains high (2 in 5) – indicating a service gap for interventions like family planning that can reduce poverty as well as the service burden to the health system and promote good health and well-being.

Environmental hygiene and sanitation

Programmes that promote the health of the communities are more effective if organised closer to communities as opposed to being based at the health facilities. The health facility model of health delivery – which allocates resources and designs interventions from the perspective of the health facility – are unlikely to serve the health promotion agenda for good health and well-being. Improving access to adequate and safe water is vital for optimising health behaviours like hand-washing and safe drinking water in domestic settings. In turn, these are vital actions to mitigate recurrent epidemics that claim many lives and constantly burden the health system. Community self-help projects, health awareness programmes and environmental sanitation programmes work well if these are designed, organised and resourced at community level (4). Community-owned assets and the capacity to reduce the burden of illness can be better leveraged by health promotion activities that do not necessitate leadership from the health facilities. Leaders at community level ought to have an orientation about the basic health facts that support good health and well-being to empower them to lead the communities in these actions.

Non-communicable diseases (NCDs)

Lifestyle diseases like diabetes and hypertension, and road traffic accidents are common causes of the rapid increase in NCDs. A combination of actions across several sectors of society is vital for the effective control of NCDs. As reported in the chapter on NCDs, community-level surveys indicate that

diabetes prevalence is about 7.4 per cent among people aged 35-60 years (5) and many people with hypertension are unaware of their status (6, 7) – thus not seeking care to prevent complications. The control of NCDs requires working with many stakeholders to improve community-level awareness, to screen for the disease, and policy-level actions to prevent industry- and market-level incentives that encourage the development of pervasive habits, behaviours and practices. Achieving universal coverage for NCDs requires establishing a package of services for NCDs that is integrated at the different levels of the health system from primary care to hospital services. For cost control and effective management, specialised centres of excellence with enabling referral networks will be essential to mitigate the high costs of treating complications such as renal dialysis and transplant surgery that usually takes place in India or Europe for a minority of cases. Recent examples of multi-sectoral actions to reduce road traffic accidents – code named "Fika Salaama" – have demonstrated that a combination of enforcement of road traffic regulations, public awareness and safe driving and road construction designs can reduce traffic-related deaths and injuries by over 70 per cent. Purposive leverage of budgets and programmes such as road safety can contribute to reducing the burden of injuries on the health system and create savings that can be invested to improve coverage and the quality of other health services. This exemplifies investing in affordable health promotion while controlling costs.

2. Controlling costs while expanding service coverage

The agenda for UHC comes with the demand to expand services of good quality. In Uganda many innovations are introduced as pilot before they are considered for scale-up to higher levels of coverage. The findings in many chapters in this book indicate that there are missed opportunities in the processes of innovations and piloting. Many innovations arise as a result of financiers and entrepreneurs seeking to demonstrate the effectiveness of innovations – usually at high cost – covering a small scope and with heavy demands on the health systems.

Encouraging innovations with affordable scale-up plans

Most innovations are not designed with a scale-up mindset – a situation that has led to programme designs that are too costly to sustain, let alone expanding their coverage. For example, new vaccines have been introduced into the

national programmes for child-survival that are 5-10 times more costly, making poor countries fail to meet the financial deadlines for transitioning their financing from GAVI funding to domestic funding (8, 9). High-fertility countries that adopt a large number of vaccines with GAVI support were likely to face the greatest financial burden. Vital programmes for malaria control, such as indoor residual spraying (IRS), have been designed as high-cost delivery systems – with multiple non-essential but costly activities – all creating the illusion that IRS cannot be affordable by poor countries like Uganda (10). In their letter to the government, external donors supporting malaria control in the country voted to block Uganda's decision to secure a grant to scale up IRS even after overwhelming evidence emerged that IRS contributes 30 to 50 per cent additional effectiveness in averting malaria cases in the communities with nearly universal long-lasting mosquito nets. IRS withdrawal from northern Uganda precipitated a devastating malaria epidemic in 2015 with a six-fold increase in malaria cases and unprecedented incidence of malaria deaths (11, 12). In the same vein, Uganda has embraced new medicines and technologies that make the malaria treatment or care more costly for the country. The use of ACTs for malaria remains a nemesis to Uganda malaria control objectives. Despite its acclaimed effectiveness, the stock-out period for ACTs in the Ugandan health system has remained in the range of 40 to 50 per cent annually. The high cost of procurement and the dependence of this process on external financing and subsidies from the Global Fund, PMI, DFID and other agencies make the national malaria control programme fail to realise the optimal effectiveness of ACTs and, in the process, expose Ugandans to prolonged illness episodes of malaria. Likewise, the introduction of rapid malaria diagnostics to curb the use of expensive ACTs has inadvertently added to the costs by expanding the use of diagnostic technologies (RDTs) for every fever episode in the health system. In a study conducted by Batwala et al. (2011), the cost of testing every fever case without RDTs was found to be half compared to the practice of testing every fever with RDTs – each estimated at US$ 1.3 per test. Treatment protocols were subsequently changed to make every fever tested with RTDs in attempts to save a dose of ACTs, estimated at US$ 1.4 (13). Provider costs for a case of malaria were found to increase two to three times in contexts where RDTs were used to save costs or ACTs (14). If taken to scale, the use of RDTs impose a higher burden on the financing of the health system despite the savings on the ACTs.

Establishing an institutional framework to advise on new technologies

The cost escalation for health interventions in Uganda and similar countries can be attributed to the absence of legitimate institutions to systematically assess and set priorities for technology adoption in the health system. Countries faced with cost escalation in the health system have all introduced credible and legitimate institutions to provide guidance by appraising technologies and their cost-effectiveness and affordability once introduced in routine health systems. In the United Kingdom, NICE (the National Institute for Health and Care Excellence) guides the adoption of new pharmaceutical and biopharmaceutical products by the National Health Services (NHS). In Uganda, an ad hoc committee and commercial lobbyists influence policy and guidelines on technology adoption with little regard for the scale-up implications for affordability and sustainability of programming within the domestic fiscal space. As concerns for the sustainable scale-up of programmes become central to UHC, governments need to establish institutions with legitimate roles for managing the processes of adopting new technologies in the health system with the overall goal of insuring affordable and sustainable expansion of coverage of these interventions.

Evaluating and preparing for the costs of regulatory interventions

Regulatory interventions such as price increases on unhealthy products like tobacco and fast foods can be useful (15). The costs of enforcing and curing regulatory avoidance behaviours are not small. In many cases regulatory interventions have been put in place without proper appreciation of the costs of enforcement. As exemplified by the lack of capacity by the Ugandan police to enforce the Tobacco Control Act and the difficulty of sustaining interventions like "Fika Salaama" operations to reduce traffic accidents, the financing of these regulatory interventions needs to be increased for the appropriate duty bearers to implement them on an effective scale. Within the health sector, the distribution and sale of fake medicines are a large industry with huge risks to the quality of services the communities receive and are now recognised as contributing to the development of antibiotic resistance by many microbes.

3. Governing and coordinating actors for effective programming

One of the salient issues across most chapters in this book is the escalating growth in the constellations and number of actors in the health system.

This presents opportunities for more sectors and legitimate agencies – both within the health sector and beyond – to play useful roles in improving health. The growth in the number of actors also poses major questions about the efficiency of resource use, competition over institutional mandates and overall governance in the health system.

Managing the proliferation of agencies involved in service delivery

Many chapters in this book illustrate the inevitability of the congested state problem – where many agencies are actively involved in the realisation of population health objectives such as UHC. The "congested state" problem arises especially in a situation of complex policy goals that require widely distributed actions or a multitude of actors to bring together resources and synergistic capabilities to the realisation of common goals (16, 17). Aid agencies, fund-holders, civil society and private corporations have found it lucrative to join the health service industry (18, 19). This growth in the number of actors and agencies is both an opportunity and a challenge. Many players bring additional resources and capabilities – but also different interests and costs. Commercialisation of health care is also attracting many agencies to the industry to make money (20, 21). Many serve as intermediaries for funding agencies and others as bridging international NGOs connecting the global to sub-national networks for diseases like HIV, malaria and others. These partnerships divert a significant amount of money into administrative costs and profits – money that would have gone directly into improving coverage and quality services (19, 22). The corporatisation of health delivery systems with both local and international NGOs absorbs substantial resources and increases the costs of service delivery by designing programmes that bypass existing and low-cost institutions, such as central and local governments (23, 24).

Effective governance of policy outcomes usually requires that special-purpose institutions be established to coordinate these networks of organisations that are contributing to the common goals. The Uganda Aids Commission (UAC) is an example of this effort to coordinate the multitude of agencies that came to play vital roles in HIV prevention and treatment programmes (25). The growth in the number of state and non-state agencies in population health is not limited to HIV. Decentralisation of service delivery has escalated in tandem with the growth in the number of districts, with local governments (districts and municipalities) multiplying from 37

to 130 for the period 1990 to 2018. To achieve coordination, governance in this system requires participative decision-making as opposed to command-and-control models of erstwhile government bureaucracies (26). Where necessary, the proliferation of agencies in the service delivery space needs to be managed to reduce the magnitude of resource-shifts from service delivery to administrative activities and corporate profits (27). The creation of many small districts that Uganda has witnessed has, in effect, taken funds away from service delivery, including the recruitment of additional health workers, to paying salaries for administrative personnel.

Decentralisation and Accountability

Findings in Chapter 6 noted a number of efforts towards capacity enhancement for decentralised governance at the generic and health system levels. Although the policy of decentralisation intended to broaden the participation of communities in their affairs – including health programmes – the powers and resources to implement the decentralisation policy have remained at the central level and among agencies that disburse government and donor funds. Conditional grants constitute the major source of funding to local governments – a situation that limits the decision space of the latter in serving local needs and demands. Revenue sources for local governments have shrunk as the central government handles most of the revenue collection and/or has abolished revenue sources that were more in line with the needs and aspirations of local governments. In line with the sources of funds, most local governments have to make upward accountability to upstream ministries and donor agencies, instead of downward accountability to their communities (21). The proliferation of local governments over the last decade has stretched the financial, logistical and technical capacity of the central government – including the Ministry of Health – to provide the necessary support. The administrative costs of running the local governments have expanded by way of displacing the operational funds necessary for service delivery. The number and budgetary provisions for the administration of local governments have expanded faster than the number and budget provisions for the health workforce in the country (36). The implications of this pattern of government choices are what some observers have referred to as a patronage state – seeking loyalty from local governments instead of empowering them to deliver services to their communities.

Leveraging policies and programmes in other sectors to improve health

Health-in-All-Policies (HiAP) is a major requirement for successes in programming for health improvement and well-being. HiAP is vital for whole-of-government actions to ensure that the main determinants of good health are well invested and legitimate organisational and institutional frameworks are developed to enable effective complementarities and interdependencies(28). Effective coordination usually eludes government programmes – partly due to the organisational structure and incentives that supports competition and not collaboration (29). The agenda for UHC will require that the governance systems boost coordination of the many agencies that come to contribute to UHC. Incentives to collaborate are vital in the resourcing of interdependence agencies. Outcome mapping, joint planning, programme budgeting and inter-agency monitoring programmes are examples that enable cooperation and collaboration (26). Special programmes for leadership training will be required to prepare the participants in health governance to the new realities for governing UHC programmes and networks.

4. Building system resilience to support expanding provisions

There are findings that are common to the chapters on infrastructure, the workforce and laboratories – i.e. the lack of systematic investments and sub-optimal functionality to support health service delivery. The government has expanded the physical infrastructure and made these more proximal to communities, with statistics indicating that most (80 per cent) of Ugandans live within a 5 km distance of a health facility (both government and faith-based). This progress is commendable in terms of infrastructure if defined as buildings. However, if defined as access to a service package, the health facilities are a mixed bag – some are more capable of providing a wider service package, especially among hospitals and level IV health centres, but limited services at the lower-level facilities (30). Some facilities, especially the faith-based ones, charge some fees for the services they provide – making universal access less equitable for populations proximal to non-government facilities. The policy of providing non-government facilities with grants or subventions to mitigate the costs of services they provide to the community is commendable and needs to be expanded. Since inception, the primary health care (PHC) grants provided to private-not-for-profit (PNFP) providers have declined in absolute amounts and real value (31). In the face of evidence for

escalating costs of interventions and the fact that PNFPs contribute about 35 per cent to the aggregate service outputs in the health sector (31), the government should markedly increase these grants and specify better the results it expects. The reduction of fees to the user community and priority services to be provided using these grants would help to advance strategic purchase for UHC. This policy should also have differentiated targeting to expand effective coverage by giving more grants to PNFP facilities in rural settings and for communities that are under-served by other health facilities. For family planning and related health promotion services that are not well provided among public facilities and PNFPs in rural settings, the government should commission and finance community-level organisations to provide these services under the supervision of the district health department.

Improving the functionality of health investments

Making the available infrastructure and equipment functional at optimal level is a major challenge in the effort to realise great service quality and coverage. The workforce shortages and the challenges of providing sufficient resource inputs for workforce performance count among the constraints on health systems strengthening. Government's failure to directly invest in workforce development/training of most health professionals has been associated with gaps in the skill mix, workforce stock and distribution. Although the private sector is now doing most of the training, the quality and regulation of private training institutions require more vigilance if the quality expected of health professionals is to remain adequate and trusted. In the meantime, the private sector provides an increasing platform for service provision, especially in urban centres. These provide opportunities for a good number of health workers to be fully employed as private sector workers or to supplement the meagre salaries of those employed in the public and faith-based sub-sectors. Beyond providing the workforce with ready skills, the functionality of health facilities requires increased investments in the support systems. These include adequate medicines and diagnostics supplies and equipment, transport and communication capabilities and utilities like water and electricity. Chapters 11 and 14 illustrate the benefits of improving diagnostic equipment and infrastructure to the performance of the health system. For instance, many expensive therapies have been adopted in the health system – a situation that has necessitated proper diagnostics technologies to reduce waste. The balance between the costs of diagnostics and the costs of new therapies is

a constant dilemma, especially since the agenda for quality and coverage stretch beyond the available resource envelope. While hospital buildings have gotten renovated and expanded lately, the recurrent budgets to run these hospitals have not been adjusted to suit the new service expectations (32). The recurrent cost problem is a real concern as expansions in care packages, coverage and quality requires sustaining over time (33).

5. Financing of the UHC intentions

At the time this book went to press, the establishment of national health insurance (NHI) was high on the public policy agenda. Although those proposing the establishment of NHI point to the additional funds to be collected from the currently employed groups, the inadequate provisions to address the majority of people outside formal employment concern the opponents to the policy. The public perceives the operational management of the proposed National Health Insurance Fund (NHIF) in relation to the corruption that has in the past beset similar funds, as evidenced by the NSSF scandal in 2010 – a time when the National Insurance Bill was being debated by the Parliament of Uganda. In addition, debates about NHI illustrate the challenges of the poor quality of health services currently being offered across the country – generating unwillingness by the eligible groups to contribute to NHI. Countries that have instituted national health insurance ahead of Uganda, such as Tanzania, Kenya and Ghana, have experienced frequent strikes by contributors to the insurance owing to poor service quality and inadequate service coverage, especially in remote communities. Health providers in these schemes have also staged frequent industrial action to protest the inadequate compensations, delays in the reimbursement of expenses and unsatisfactory governance of the national health insurance operations (34, 35).

The range of reforms necessary to ensure more autonomy, accountability and provider effectiveness have been less integrated into the national health insurance design. More prominent concerns about NHI are the inadequate preparation among health providers to service a more emboldened community of beneficiaries and a small pool of formally employed workforce. Health providers take long to meet the expectation of entitlements that arise from membership of the NHI scheme. This lag in provider readiness needs to be systematically addressed by supporting key capabilities among health providers. Costing and proper pricing of services, standard service protocols for the benefit packages and clearly designed community awareness

programmes need to accompany the efforts to establish NHI. Private health insurance and community-based insurance schemes, and the recent efforts to pilot results-based financing, are all promising efforts to build the readiness of health providers and health systems for the implementation of NHI. A learning agenda to support the readiness of the health system for major reforms like health insurance should be well designed and invested in for the successful roll-out of NHI. The widespread informal economy, with less than 10 per cent of the population in formal employment, generates a structural problem for mobilising adequate resources for NHI. The cost burden of collecting insurance premiums from a population with mostly informal employment works against the efficiency objective of collecting and pooling funds. Recent policy precedents, such as the abolition of graduated tax and road licences on vehicles, were all premised on the high cost and inefficiency of collecting taxes from ill-organised constituencies (36). Until the situation of formal employment has improved, the prospects for a viable compulsory NHI remain bleak.

Government financing – whether by way of NHI or directly as a budget allocation to health providers – remains a viable option for extending coverage to the population and addressing quality assurance gaps. Equitable access with sustainable financial protection requires stable government financing and resource allocation (37). Ghana is one country that has moved back to government-financed NHI – where the government pays the health premiums of the majority of Ghanaians (34, 38). This development underlines the centrality of government financing of health care, especially in countries similar to Uganda and Ghana. Before the economies are robust in terms of adequate employment and tax revenue generation, government financing remain the most stable and viable way to progress to UHC. Advocacy and political willingness to improve the allocation of government revenues to the health sector should take priority in efforts to advance UHC in countries similar to Uganda.

6. Political economy of UHC

Good health and well-being and the agenda for UHC will entail political choices and decisions, such as distributing social benefits to those who are not yet covered, and also engender resource allocation for programmes that promote health and prevent ill health. As indicated above, there are many actors in the UHC space. Many are motivated to improve the population's health but some are motivated by self-interest and aim to gain private

benefits. Social values always require that public goods and programmes are expanded and well resourced. The politics of resource allocation is vital for UHC to succeed. In Uganda the financial allocation for health programmes demonstrates a positive trend, especially due to national debt relief in the early 2000s by the IMF and increasing donor funds, especially for a handful of diseases, from global health initiatives. In the last 10 years, the government allocation to health has shown a troubling trend. The health budget has been a target in all events of budget cuts since 2011 and has been left out of nearly all events that required a supplementary budget. The main exception was in the 5th Parliament when USh. 36 billion was added to the health budget after an unprecedented parliamentary debate to increase funding to support maternal health services in Uganda. Health needs in the health system are increasing from year to year owing to population growth that encompasses maternal health and child health programmes with millions of service beneficiaries. New technologies for these services are increasingly being adopted with price tags that are multiple times those of the technologies being replaced. Herein lies the dilemma of expanding coverage and quality with the inelastic and declining domestic resources.

Investing in health promotion is usually less politically visible compared to investments to control raging epidemics of cholera, typhoid or Ebola. In most cases, this lack of visibility is due to current measurement and surveillance tools that emphasise disease and ill health. One of the vital actions for improving good health and well-being should be the innovation in measuring the benefits of good health and populations that remain free from ill health. By investigating the direct and indirect causes of less than optimal health and well-being, society will be better able to identify causal pathways to ill health and design and target interventions that promote and maintain good health. This approach would also help to prioritise the population groups with great need for health programmes to address the equity issues through affirmative action in the UHC road map.

Political actions in the form of building influence and power-bases to support health promotion and expanding health programmes that mitigate the impact of ill health are critical. Political influence is achieved through building coalitions with other groups in society with similar concerns. The power of collective action can be vital for community self-help programmes. Politics is vital to ensure that the purposes remain beneficial to the community and society as opposed to the self-interest of the few. Political mobilisation is vital to ensure that cooperation with and loyalty to legitimate institutions,

and laws and norms that guide acceptable behaviour are instituted and maintained. For example, industrial pollutants require politics to ensure that the benefits to private enterprises do not create burdens and risks to the communities.

Political economy interests at the level of global health have escalated and engender far-reaching effects at the national level. Global health actors are increasing in number and capturing more influence through financing, conventions and regulatory tools. The interests of global stakeholders in many cases are well motivated but commercial interests commonly foil the implementation of these good motivations. For instance, interests related to selling medicines to the Global South may delay actions to produce vaccines to eliminate the diseases that help to sell the medicines (39). Funds that are earmarked as aid to the poor countries are known to boomerang – i.e. provide more benefits to the countries that provide the aid (23). As the organisations and aid architecture explode around Global Health Initiatives (GHIs), there is a need for global politics and policies to ensure that these organisations add value to UHC in Uganda and similar countries as opposed to syphoning resources away from vital programmes (40, 41).

Global security is an emerging policy issue whereby countries like Uganda are required by international conventions to provide effective security to the rest of the globe by investing in the control of diseases of pandemic potential. Tools such as Joint External Evaluation (JEE) for pandemic preparedness are now vigorously pushing countries like Uganda to prioritise the surveillance and control of Ebola and other pandemics of global interest despite Uganda having many deaths and illnesses from waterborne epidemics like cholera. By implication, the political choices to serve global interests should be negotiated to provide resources to the local needs where these are paramount for UHC.

A recent push to introduce new products into the health systems in developing nations has been dressed up in charitable grants for policy influence to move nations from lower cost to higher cost options. New vaccines, diagnostics technologies and treatment protocols, especially for HIV, malaria and TB, are examples with expanding technologies that are unsustainable, given the national budgetary provisions. As the corporate interests and greed to capture health care markets in countries like Uganda intensify, the financial resources made available for health from the government and donors are likely to buy fewer and fewer services. The UHC agenda will require attention to and control over social entrepreneurship to curb greed, ensure sustainable options and control cost escalation. Overall, the best and

most cost-effective solution is to finance health prevention and promotion interventions better. Domestic financing and community-based investments in good health should be given more priority than is evident from recent trends. Smart ways to leverage investments in other sectors that contribute to health should be seized. Safe water, environmental sanitation, road safety and good nutrition should be leveraged to improve good health and well-being. Universal health coverage will require the whole-of-government approach to improve good health and well-being. This requires effective leadership, multi-sectoral collaboration and effective governance. All these efforts will need increased financing for health interventions both within the health sector and in other related sectors of the economy, including the reduction of poverty.

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