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Resource Mobilisation in the Context of Moving towards Universal Health Coverage

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Key Messages

1. Government budget allocation to health has consistently been low. External funding and household out-of-pocket expenditure for health is dominant. This raises sustainability, access to services, and financial catastrophe concerns.
2. To achieve Universal Health Coverage (UHC) in Uganda, resources for health must be increased. Some of the approaches to increasing funds for health include:

    - Adoption of alternative financing mechanisms to increase funding for health. These may include: tax reform to incorporate alternative tax measures such as 'sin-tax'; tapping into the informal sector resources; and promoting health insurance.
    - Improvement of efficiency gains, especially by streamlining procurement systems, monitoring and supervision, and enhancing absorptive capacity within the health sector.
    - Strengthening the resource coordination mechanisms that bring together external funds in a basket will improve planning and implementation, the alignment of funds to essential or priority national health interventions and programmes, and reduce duplication

of resources and effort. In the longer term, the government should gradually reduce dependence on external funding.

- Establishment of a special "Health Fund" will ensure that adequate resources are available which can be tapped into to deliver on the health sector priorities. A Health Fund would be devoid of the politics involved in budget allocations.
- Strengthening the Public Private Partnership for Health (PPPH) framework to include mechanisms to tap into private organisations' corporate social responsibility (CSR) obligations and channel them into health. This will increase resources into the health sector in Uganda.

Chapter overview

Health financing is defined as "raising adequate funds for health in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them"(1, 2). This chapter presents resource mobilisation – one of the core functions of a health financing system. The chapter describes the evolution of health financing in Uganda since the 1960s, and how this evolution has been influenced by political, epidemiological, demographic and global health policies and dynamics. We discuss how each of the changes came with opportunities and challenges, and their impact on resource mobilisation policy issues. The chapter then delves into the various approaches to resource Mobilisation in Uganda and how these various approaches address the policy concerns of efficiency, equity and sustainability of generating sufficient resources, and access to health care by the population. We then place this discussion in the context of UHC – a current global health policy agenda.

Evolution of health financing in Uganda (1960-2015)

Health financing in Uganda has evolved over time. During the 1960s, the health system was fashioned on the United Kingdom's universal model of health care – a model of public funded and provided health services. The period following independence (1970s to the 1990s) was characterised by political unrest and civil conflicts which resulted in economic decline. This led to a decline in government revenues and health sector investments that

resulted in poor infrastructure and health services, and brain drain. Health facilities were characterised by lack of health workers, medicines and supplies (Kirunga et al. 2006). Health workers migrated to other countries and the private sector within in search of better work environment and remuneration (3).

Some development partners withdrew funding for the health sector, making it more difficult for the government to sustain the already established programmes/initiatives (3). Devaluation of the Uganda currency (shilling) and the increased cost of debt servicing contributed further to a reduction in government spending on the health sector. The problem of resource scarcity for health was further exacerbated by the emergence of the HIV/AIDS scourge in the late 1980s and early 1990s. Following the National Resistance Movement (NRM) ascendance to power in 1986, there was focus on providing the basic minimum public services as the process of re-engineering the economy got underway. Bilateral and multilateral donor agencies became major funding sources for health but this presented several challenges because support was disease - or programme-specific and fragmented, and did not take into consideration contextual issues (3).

The 1990s were characterised by renewed interest in increasing funding for the health sector and the role of international development partners. User fees were introduced in the 1990s as part of the Bamako Initiative to raise funds for the implementation of comprehensive primary health care. User fees were introduced basing on the concept that individuals should own and participate in health production. Additional resources raised would be used to improve quality of care and to advance equity of access. User fees received great support from the development partners, who dominated and directed the development and health policy dialogue at that time (4). Drug revolving funds were piloted at government health facilities in 1998. The aims were: to ensure a constant availability of essential drugs that are easily accessible; to promote community ownership and involvement in health service delivery; to strengthen the capacity of the district health system to deliver health services; and to promote the sustainability of good quality health services in the district (5).

However, there were heated debates on the capacity of user-fees and drug revolving fund approaches to equitably generate the substantial revenue needed to sustain health service delivery. Evidence from user-fee evaluation studies showed that the amount of revenue from user fees was insignificant and levels of inequities rose. The exemption facility did not work as anticipated.

The poor and most vulnerable sections of communities were constrained in accessing care. The revolving drug fund approach was perceived to be a deterrent and disincentive to seeking health care (3). Charging patients fees at government health facilities became controversial when government policy was free-of-cost health services to the population resident in Uganda. Both user fees and the drug revolving fund were abolished in 2001.

During the 1990s to 2000s, the government and development partners prioritised health service delivery and increased resource allocations to the health sector (6). The policy documents spelt out the minimum health care package (MHCP) as a reference point for the prioritisation and allocation of resources within the health sector. A donor coordination mechanism was institutionalised with the concept of sector-wide approach (SWAP) where donors and the government were to jointly plan and align funding to agreed plans. Subsequent years witnessed further moves to strengthening partnerships with development partners through International Health Partnerships and Related initiatives (IHP+) which was built on the Paris Declaration and the Accra Agenda for Action to ensure: one result-focused National Plan, one monitoring and evaluation framework and one process of focusing on results and mutual accountability.

Structural Adjustment Programmes (SAPs) in Africa in the 1980s and 90s included an IMF stabilisation loan with conditions. The stabilisation package addressed monetary and economic issues in an attempt to address inflation, reduce the government's budget deficit, and balance-of-payments problems. It incorporated measures to reduce government and private domestic demand. SAPs promoted production and resource mobilisation through the promotion of commodity exports, public sector reform, market liberalisation and institutional reform. It sought to limit the role of government in the economy, promote private sector operations and remove restrictions in the economy and ensure market-determined prices. Some of the effects of the SAPs were: removal of subsidies on food staples; widespread retrenchment of workers; high cost of social services and goods; low wages of workers and exodus of health workers from developing to developed economies (7).

Uganda's current health financing landscape

Uganda's economy has grown at an average rate of 5.5 per cent per annum since 2010, but the country still operates a deficit budget. The total government budget gradually increased with time but allocations to the health sector have

not increased proportionately. It has remained relatively constant at about 8 per cent (HFS 2016).

The trends in government allocation to the health sector for the fiscal years 2010/11 to 2014/15 is shown in Table 8.1.

Table 8.1: Government allocation to the health sector 2010/11 to 2014/15

Indicator	2010/11	2011/12	2012/13	2013/14	2014/15
GoU funding (USh. bns)	569.56	593.02	630.77	710.82	748.82
Donor projects and GHIs (USh. bns)	90.44	206.10	221.43	416.67	531.50
Total USh.	660	799.12	852.20	1127.49	1280.32
Per capita public health expenditure (USh.)	20,765	25,142	23,756	32,214	37,130
Per capita public health expenditure (US$)	9.4	10.29	9	10	13.5
PHE as % of TGE	8.9	8.3	7.8	8.7	8.5

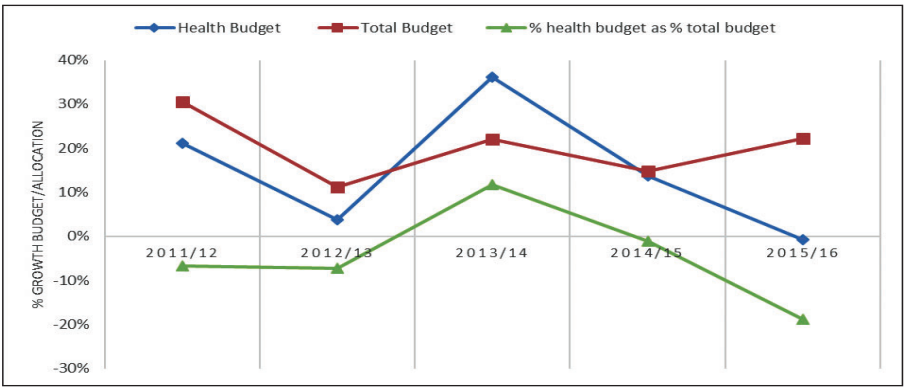
Source: *MoH, Annual Health Sector Performance Report for Financial Year 2014/15*

Estimates show that countries require US$60 to US$86 per capita to finance a Minimum Health Care Package for providing UHC (8). The per capita public expenditure on health in Uganda is estimated to be between US$ 4 and US$ 7. This is far below the estimated funding for the provision of a Minimum Health Care Package.

To raise per capita public expenditure on health to the required estimates of between $60-$86 will require a radical financing reform and a significant appreciation of the need for funding health care as a priority in Uganda. Publicly financed and provided health services are accessible to the entire population and perceived to be equitable but the health sector must compete with other sectors for a share of the national annual budget. This makes Uganda's current allocation to the health sector very inadequate, especially given that changes in government priorities are in favour of security, infrastructure and growing the economy. Health is not among the top priorities; yet, a healthy population is critical for their achievement. The positive impact in terms of productivity and the multiplier effect on economic growth that emerges from social sectors has not been fully appreciated.

The recent growth in both the Gross Domestic Product and total national budget has not been reflected in the growth of the health budget, as shown in Figure 8.1.

Figure 8.1: Health sector budget growth compared to govt budget



Source: *MoH – Health Financing Strategy*

Funding from the national budget is vulnerable to changes in political priorities and/or external shocks. Uganda has a small tax base, development partners are gradually increasing project budget support, leaving on-budget support stagnant or even declining, and health is not taken as a priority among policymakers. Uganda has a small tax base and does not have a mechanism for earmarking taxes (hypothecated taxes), say from economic 'bads' (e.g. alcohol, tobacco etc.) for health care provision. These largely underpin the existing underfunding and poor quality services(9). In the existing situation, the Government of Uganda does not have the capacity to allocate 15 per cent of the total budget as recommended in the Abuja Declaration. Realisation of universal health coverage while using government funding is not possible in the foreseeable future unless the Ugandan government increases her budget allocation to the health sector, and implements essential financial reforms.

The proportion of Official Development Assistance (ODA) relative to the government budget has been declining. The observed increases in total health expenditure (THE) are attributed to the increased contribution of global health initiatives, specifically the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines

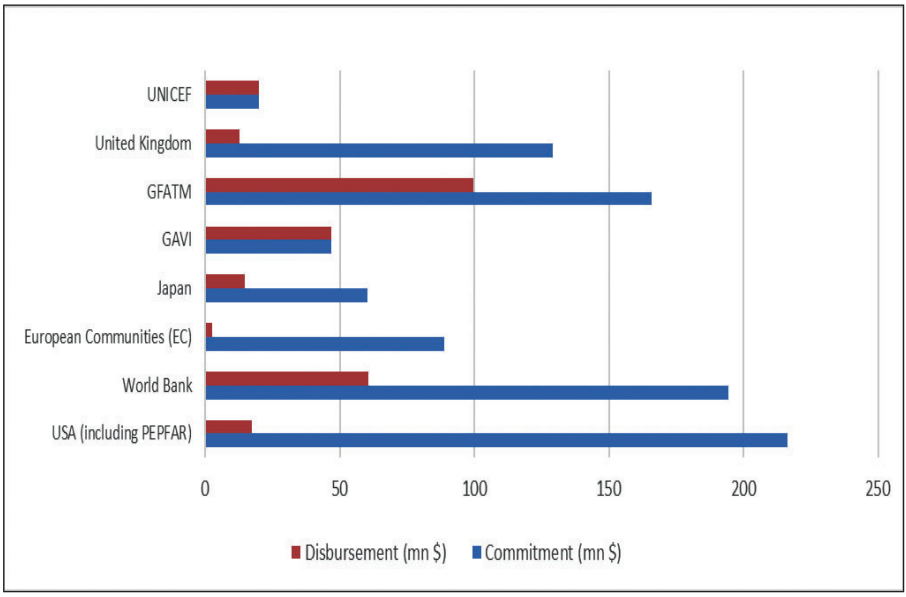
Initiative (GAVI). Overall, the main sources of funds for the health sector in Uganda are: general government budget (15.3 per cent), development partners (46.5 per cent), private sources especially households and health insurance (38.4 per cent) (10).

External funding for health

Funding from development partners is an important component of health financing in Uganda. According to the National Health Accounts (2013), development partners contributed 46.5 per cent of the total health expenditure. External support is in the form of loans, grants and donations. Development partners contribute funds for health through the government budget (on-budget support) and/or directly to funding specific programmes within the health sector (off-budget support). On-budget support goes directly to the centralised pool at the Ministry of Finance, Planning and Economic Development (MoFPED). It allocation to health or any other sector is subject to the allocation processes of government and so how much goes to which sector is not guaranteed. Off-budget support typically manifests in particular projects that are implemented by NGOs or the Ministry of Health. The Health System Assessment Report 2011 showed that off-budget donor contribution alone represented between 40-50 per cent of combined government and development partner support to health expenditure (HSA 2011). Quite often, data on off-budget support is not captured.

External sources of health funding come from multilateral, bilateral, financial institutions and philanthropic agencies. Multilateral development partners include WHO, UNICEF, UNFPA, UNAIDS, the Global Fund and GAVI. Bilateral development partners include the European Union, the United States Government (USAID and CDC), DFID, CIDA, DANIDA, SIDA and JICA, among others. Philanthropic development partners include the Red Cross and Red Crescent, the Bill and Melinda Foundation, Médecins Sans Frontières (MSF), the Carter Center, and the Clinton HIV/AIDS Initiative, among others. The financial institutions include the World Bank and the Africa Development Bank. Figure 8.1 shows aid commitments and disbursements from selected development partners in Uganda's health sector. The leading development partners in terms of honouring funding commitments are GAVI, UNICEF, the Global Fund (GFATM) and the World Bank. Statistics reveal that most donors do not honour their commitments to fund health, as reflected in Figure 8.2.

Figure 8.2: Development aid for health to Uganda by partner (million US dollars) 1990-2012



Source: *Computed using AidData for Uganda (1990-2012).*

Over the past 15 years, development aid or external financing worth over 3,200 billion (UGX) constituting more than 36 per cent of total health budget was channelled to support the health sector (10).

Funds from development partners have mainly been used in health infrastructure development and maintenance, reproductive health, HIV/AIDS interventions, malaria, human resources for health, medicines and commodities/supplies. For example, development partner funding has been instrumental in the introduction and sustenance of ART/HAART, ITNs and pentavalent vaccine. Development partners are becoming less inclined to provide on-budget support than fund specific vertical health programmes, as seen by a steady increase in off-budget support for health and a stable on-budget support.

Table 8.2: Development partner assistance for health and domestic funding in Uganda (2000/01-2016/17)

Year	External financing (aid) (USh. – Bns)	Domestic (government) funding (USh. – Bns)	Total health financing (USh. – Bns)
2000/01	114.77	124.23	239.00
2001/02	144.07	169.79	313.86
2002/03	141.96	195.96	337.92
2003/04	175.27	207.80	383.07
2004/05	146.74	219.56	366.30
2005/06	268.38	229.86	498.24
2006/07	139.23	242.63	381.86
2007/08	141.12	277.36	418.48
2008/09	253.00	375.46	628.46
2009/10	301.80	435.80	737.60
2010/11	90.44	569.56	660.00
2011/12	206.10	593.02	799.12
2012/13	221.43	630.77	852.20
2013/14	416.67	710.82	1127.49
2014/15	532.50	748.64	1281.14
Sub-Total (2000/01-2014/15)	3293.48	5731.26	9024.74
2015/16**	187.87	782.46	970.33
2016/17**	48.66	835.08	883.74

Source: *National Budget Framework Paper (NBFP - 2015/16) and Annual Health Sector Performance Reports (AHSPR- FY 2010/11, 2014/15)*
*** MTEF budget estimates – NBFP 2015/16, Ministry of Finance Planning & Economic Development*

Most projects supported by development partners often have either a fixed time requirement that will not allow the "finish" date (the date the activities scheduled is expected to end, beyond which it is anticipated the resources

would not be needed anymore) to be exceeded or a fixed resource constraint that does not allow for exceeding the amount of resources allocated. Extra resources to compensate for slow progress or other factors that hinder timely completion of projects must be available. These projects are unlikely to be sustained by the government, leaving beneficiaries unable to continuously enjoy the health benefits of the project. This raises issues of sustainability of project benefits after the end of donor support to the project. Besides this challenge, external funding has in most cases been programme- or disease-specific, majorly supporting vertical programmes, less coordinated, with little or no consideration of local MoH priorities. For many stakeholders, this has often distorted the long-term health systems strengthening agenda (11).

Development partners' support to vertical programmes has largely been targeted to malaria, HIV/AIDS and tuberculosis. This excludes other diseases, such as what WHO classifies as 'neglected tropical diseases' (e.g. onchocerciasis, schistosomiasis and trachoma) and non-communicable diseases that contribute heavily to morbidity and mortality in Uganda. Funding from development partners further causes reductions in government budgetary allocation to the health sector. This is because of the assumption that the health sector is already well financed by development partners. Development aid is earmarked to specific interventions and may not fund-essential basic health care needed by the poor and vulnerable groups – which raises equity and access to care concerns. Under these circumstances, there are potential long-term challenges of sustaining expensive health interventions financed by development partners such as antiretroviral drugs (funded by the Global Fund, PEPFAR) and vaccines (funded by GAVI), running and maintaining the health infrastructure that vertical development partner-funded programmes have put in place to achieve programme objectives and outcomes (12). Thus, external financing has a short-term advantage of supplementing government funding. In the long term, more reliable and sustainable health financing strategies need to be explored.

The aforementioned challenges notwithstanding, Uganda can still leverage on Development Aid for Health (DAH) to advance the agenda of UHC. It is, therefore, important that opportunities provided by DAH are considered to be fully tapped into and considered in the short run. Specifically, DAH resources are channelled developing critical areas in the health system, as preparations and options for sustainable financing mechanisms are pursued domestically, prioritising aid to focus on providing primary health care to poorer sections of the population, and aid coordination and pooling

to reduce fragmentation or duplication of support, and ensure that the wider population benefits (13).

Private financing for health

Private health financing increased following the near collapse of the public-funded and provided health services, especially in the 1970s and 1990s. The situation underpinned the emergence and growth of the private sector. Faith-based health providers (PNFPs) and the private-for-profit (PFP) health providers now play an important role in supplementing government efforts in health service provision. The Health Sector Strategic Plan indicates that almost more than 50 per cent of health services are provided or delivered by the private sector. The government enacted laws in 1995 to promote and regulate the private sector, and permitted more health professionals to operate private practice as previously only doctors and midwives were allowed to practise. More recently in 2012, the Public-Private Partnership for Health (PPPH) policy has been established. This policy provides a framework for public and private sector involvement and engagement in health (14). By and large, access to the services of private providers is at a fee determined by the facility itself. The government, however, has been providing subsidies to private-not-for-profit health providers as a way of subsiding the costs of service delivery and ultimately reduce access costs for clients. Private funds contribute up to 38.4 per cent of total health expenditure, and the main sources of private funds include households, employers and health insurance. Health insurance is discussed in detail in the resource pooling chapter.

Household out-of-pocket payments

This involves direct payment by households for the services rendered to them at the point of service delivery. The pattern of health financing shows that the largest proportion of private financing comes from household out-of-pocket payment (OOP). Whereas this model of financing can be utilised as an avenue of raising supplementary revenue for health, it has various challenges, including increasing the risk of catastrophic health expenditure. A study in Uganda found that over 25 per cent of households were experiencing catastrophic health expenditure and the majority of the households were from lowest socioeconomic quintile (11). According to data from the WHO, the incidence of catastrophic health expenditure varied by socioeconomic quintile

and across regions – with 24.8 per cent in the wealthiest quintile, and 28.3 per cent in the poorest quintile, 23.4 per cent in the eastern region compared to 38.1 per cent in the western region, an indication of disparities in the burden of financing (15). The incidence of catastrophic health expenditure among the poor steadily increased between 1996 and 2006. The increase was also observed even after the abolition of user fees in the public facilities. This has been attributed to frequent stock-outs of essential medicines in public facilities, forcing the poor to purchase more expensive options from the private sector, and informal payments that are often reported at public facilities (16). The high out-of-pocket expenditure on health care negatively impacts on households' incomes and affects household demand for, and access to, health care. Households in disparate situations opt to either make high-interest borrowing or sell their assets, if any, so as to finance health care for a sick family member. The negative impact of both actions is a compromised ability to afford other basic human needs. Relying on OOP often promotes inequity in health care access and utilisation, reduces solidarity between the healthy and unhealthy individuals, and the rich cannot subsidise for poor and vulnerable people who cannot afford health care. Under these circumstances, UHC cannot be achieved. The evidence available shows that a reduction in out-of-pocket health expenditure characterises health systems that have been successful in attaining universal health coverage.

Commercial and (or) corporate entities, and charitable organisations

Commercial, corporate entities, and charitable organisations have played an important role in financing health care in Uganda. Companies or firms, for example, in addition to being a source of paid employment, contribute to their workers' health care needs. This is either through private insurance contributions (for an employee and/or including their immediate family) or direct contributions in cases of sickness, emergencies and ill-health. Companies also provide resources for health through corporate social responsibility, and organising and participating in events that raise funds for specific causes, for example banks, telecommunications etc. Rotarians have often provided support for health systems strengthening, funding individual patients for specialised care etc. While funding from this source is limited and its contribution to health financing is minimal, it is a strategic area that could be harnessed to generate more resources, if appropriate mechanisms are established to ensure this source is mainstreamed.

Conclusion

Uganda is experiencing both an epidemiological and demographic transition, characterised by a high burden of communicable and non-communicable diseases, and a fast growing population at a rate of 3.02 per cent annually. The health system is already burdened and currently cannot deliver all required essential health services as promised by the government. The pressure exerted on the already limited budget allocations to the health sector will likely increase going forward. There is urgent need to increase Uganda's fiscal capacity and, particularly, domestic space. An area of focus here could be the possibility of improving efficiency in revenue collection without necessarily introducing new taxes, or suggesting changes in tax rates, or generally introducing new tax measures. Beyond these traditional fiscal measures, however, it is also important to look within the system to identify areas of resources waste and establish mechanisms to leverage resource savings due from improved implementation efficiencies. In addition, a move towards a reduction in the contribution of direct out-of-pocket payments to prepayment-based methods of resource mobilisation, including health insurance, and harnessing the untapped potential existing in the informal sector, may suffice. While an argument for increased external support looks attractive, it may not be feasible to increase resources for health through external financing on a long-term and sustainable basis. Ultimately, expanding the domestic fiscal space may answer the long-term demand for resources for health. Whichever the financing approach, an equitable strategy for resource mobilisation for health is a key element of the road map to universal health coverage in Uganda.

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