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VOTING WITH THEIR FEET: WHAT LESSONS CAN BE LEARNT FROM INCREASED CONSUMPTION OF PUBLIC SERVICES IN UGANDA?

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Abstract

Uganda is a long way off achieving its Millennium Development Goals (MDGs). Persistently high child and maternal mortality reflect to some extent the poor performance of the health sector. The poor health service performance is itself a reflection of the chronic low expenditure on health and the inefficiency in the way in which resources are raised, allocated and managed. However, since 2000, there has been a small revolution in the health sector. Through sector wide approach, (SWAP) and the abolition of user fees, basic services have improved significantly and the use of public services has dramatically increased, as indicated by the doubling of outpatient attendances and immunization rates. The lesson learnt here is that a Government led SWAP can deliver significant social benefits. The budget support method is ultimately a more efficient way of financing social services than project funding or user fees. Investment in SWAP and sector targeted technical assistance in addition to budget support are the critical factors in the health sector revolution.

Introduction

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)[i] and MDG targets. See table 1.

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

Indicator	1995	2000	PEAP 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 inefficiently. 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[ii].
- 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.

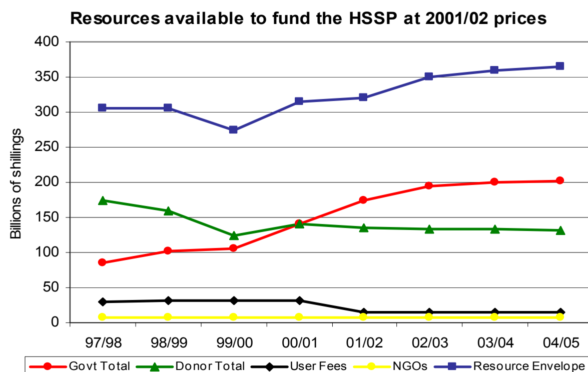
Time for a New Approach

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

This definition[iii], in emphasising 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.



From project to budget funding

Right from the outset of the SWAp, the GoU stated that general budget support was its preferred donor financing mechanism. An increasing number of development partners have concurred with this approach and have switched 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[iv]:

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

Investing in management

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

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.

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[vi] 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[vii] 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.

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.

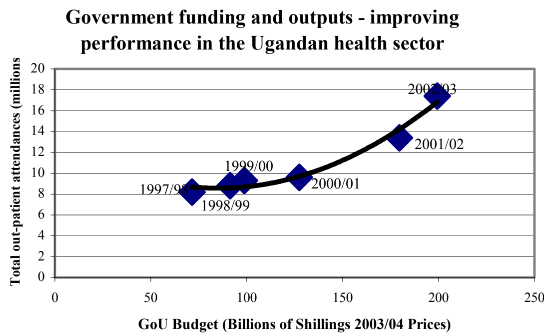
Results of the Reforms

The radical reforms in the Ugandan health sector, outlined above, have been phased in over the last 3 years[viii]. During this period no national health outcome[ix] statistics have been 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 15% 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.[x] Nationally coverage has increased from 41% in 1999/2000 to 84% 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 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[xi]. 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 channelled through the health budget.[xii]

Potential threats to future improvements in sector performance

This paper concentrates on what Ugandan health reforms have been undertaken and what results have been achieved. How these reforms came about, in terms of analysing the conducive policy environment, governance issues, the role of individual players etc. will be the topic of another discussion document. However, it should be noted at this stage that all there are risks associated with all of these enabling factors which threaten the viability of the reforms.

Perhaps the greatest threat to continued improved performance in the Ugandan health sector remains chronic under funding. Regrettably, current projections in the Medium Term Expenditure Framework indicate that adequate finances will not be forthcoming. In fact, real per capita budget funding is set to fall marginally over the next three years. This is of great concern to stakeholders in the health sector as efficiency gains alone will not be able to sustain progress. Substantially more resources are required too.

The reasons why the health budget is not growing faster are complex and include poor domestic revenue collection, an inappropriately low budget allocation to health, macroeconomic and political concerns by the GoU limiting the proportion of the budget funded by donors and donors not meeting their budget funding commitments, leading to further concerns about dependency on donor contributions.

From a technical perspective, the Ministry of Health is arguing that increasing the health budget to fund imported health commodities will not adversely affect the macro-economy. However, it is clear that considerable efforts will also be required by donors and the GoU to manage political and economic risks if budget constraints are to be relaxed. The future of the Ugandan health reforms depends on this happening and the sector securing a greater proportion of the funds available.

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.

Lessons for governments in poor countries

Previously failing social sectors can be turned around - they should not be treated as a lost cause; 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; government led SWAps can deliver significant returns relatively quickly; 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.

Lessons for donors

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.

End Notes

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

[ii] 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.

[iii] Overseas Development Institute Working Paper 142

[iv] HSSP is the Health Sector Strategic Plan for 2000/01 to 2004/05

[v] 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.

[vi] Notably the Uganda Participatory Poverty Assessment Project (UPPAP) Report of 2000. Ministry of Finance Planning and Economic Development

[vii] With the exception of private wings in hospitals

[viii] The SWAp's Health Sector Strategic Plan was officially launched in August 2000.

[ix] For example infant, child and maternal mortality rates

[x] 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.

[xi] Even for outpatient services volatile monthly statistics suggest that supplies of commodities (especially drugs) are not meeting the increased demand

[xii] Ministry of Health, Health Financing Strategy, 2002