MARCH 2006 • HEALTH DIVISION

Health Division Document 2006:1
Issue Paper on NHA

Use of National Health Accounts – the Case of Uganda

Content

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Published by Sida 2006
Department for Democracy and Social Development
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Printed by Edita Communication AB, 2006
Art. no.: SIDA26891en
ISBN 91-586-8260-0
ISSN 1403-5545
This publication can be downloaded/ordered from www.sida.se/publications

Executive summary

National Health Accounts (NHA) is a tool specifically designed for policy makers and managers of the health sector. It is designed to help them in their efforts to improve health systems performance and make evidence based policymaking by providing useful information of the current use of financial resources. This report describes the use of health expenditure data for health policy purposes in Uganda. It is based on interviews with people involved in the Ugandan health sector, on policy documents and other published literature. The interviews were conducted in Kampala during September 2005.

The health sector in Uganda has undergone tremendous changes over the past 20 years and multilateral and bilateral donor organisations have gradually moved from project to budget support over the period. The findings of the latest Annual Health Sector Performance Report support that the performance of the Ugandan health sector is improving. In 2005, however, the Global Fund to Fight AIDS, TB and Malaria was temporarily suspended due to suspected misappropriated use of funds.

The first round of NHA in Uganda covered the financial year 1997/1998 and was published in year 2000. It was financed by Sida, USAID and WHO and produced by the Ministry of Health (MoH) and the Economic Policy Research Centre (EPRC) at Makerere University. The results from the second round were published in 2004 with data covering the financial years 1998/1999–2000/2001. The second round was financed by Danida and WHO and produced by a team of members from the MoH, WHO, EPRC, Religious Bureaus and Uganda Bureau of Statistics.

Although two rounds of NHA have been produced and results from NHA are being used by the MoH as well as by multilateral and bilateral donor organisations the NHA process is not institutionalised in Uganda. There is in-country capacity to produce the accounts but there is no single person or unit that has the responsibility, commitment as well as capacity to lead the process. Both the MoH and development partners foresee a need for a third round. A third round of NHA is believed to facilitate the implementation of the second Health Sector Strategic Plan (HSSP) in Uganda and the evaluation of the first HSSP and the health Sector Wide Approach (SWAp). NHA results are believed to provide good information about the impact changes in the health sector have had on health care financing.

A number of obstacles for the production of a third round, including difficulties in prioritising among different tasks at the ministry level and overall low level of funding in the health sector, have been identified in this study. Based on the results from this study it seems appropriate to conduct a third round of NHA covering the years 2001/02–2004/05. When conducting a third round efforts should be made to collect data from the informal sector. A third round could also preferably cover regional spending and sub accounts for one area, e.g. reproductive health.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
Danida	Danish International Development Agency
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
ECSA	East, Central and Southern Africa
EPRC	Economic Policy Research Centre
EU	European Union
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-Districts
HSSP	Health Sector Strategic Plan
IDA	International Development Agency
MDG	Millennium Development Goals
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental Organisation
NHA	National Health Accounts
NHP	National Health Policy
PEAP	Poverty Eradication Action Plan
PER	Public Expenditure Review
PNFP	Private Not-for Profit
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
Ushs	Uganda Shillings
WB	World Bank
WHO	World Health Organization

1. Introduction

1.1. Background

Many countries in the developing world face poor health conditions and increased burden of disease. In the East, Central and Southern Africa (ECSA) many countries are reforming their health care systems to provide efficient health care services that better meet the needs of the population. Policy makers need tools to wisely manage the health care resources. National Health Accounts (NHA[1]) is an internationally recognised tool providing information about a country's total expenditure on health. NHA is a tool specifically designed for policy makers and managers of the health sector to help them in their efforts to improve health systems performance and make evidence based policymaking by providing useful information of the current use of financial resources. It is important to note that NHA provide only a financial dimension of the health system and that it has to be combined with other non-financial form of data such as health care output and health care outcome in order to get a comprehensive picture of the health sector performance.

Today, about 80 countries around the world have developed and implemented NHA and approximately half of those have institutionalised NHA, i.e. conducts NHA on a regular and sustained basis [1]. It is not enough to make the accounts once; they have to be up-dated regularly in order to provide decision makers with accurate information to base policy decisions upon. Previous experiences show that political will to produce and use NHA can be found in several countries that have succeeded in institutionalising NHA. One of the most important factors in the institutionalisation process is the government's actual use of the NHA results. The government's perception of the NHA results can be of major importance. There is a risk that the data is being suppressed and kept in draft form rather than being recognised officially if the results not are in line with the expectations of decision makers. Further, if methods and sources of data used when conducting NHA can be questioned the results also risk not being recognised [2, 3].

Uganda and nine other countries in the ECSA region[2] completed their first round of NHAs in the late 1990s/ early 2000s. The production of the first round of NHA involved the formation of the ECSA NHA

[1] Expenditures are organised in a set of tables that in a comprehensive manner gives a picture of the flow of funds within the health sector, i.e. the sources of funds, how the funds are channeled, and how the funds are finally being utilised.

[2] The other nine countries were Ethiopia, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Zambia and Zimbawe.

network in year 1997. The network was established by the World Health Organization (WHO) and institutions such as Partnerships for Health Reform (PHR), who introduced NHA in the ECSA region. In November 2000 the Commonwealth Regional Health Community Secretariat (CRHCS) established a Health Care Financing Programme. Later a strategic plan was formulated within this programme that includes institutionalisation of NHA as one of the major activities. The major challenges for the NHA development in the ECSA region include restricted knowledge about the relevance of NHA for policy and planning purposes, low technical capacity and limited financial resources to collect appropriate data, according to a recent report [4].

1.2. Objective, method and structure of the report

The objective of this study is to describe the NHA process and the use of health expenditure data for policy purposes in Uganda. The study is based on policy documents and other published literature and on interviews with nine representatives at institutions and organisations involved in the Ugandan health sector. All representatives were potential users or producers of NHA. The interviews were semi-structured and involved discussions regarding the production and use of NHA and potential problems and advantages connected to the use of health expenditure data for health policy purposes. The interviews were conducted in Kampala, in September 2005.

In the next chapter of this report, some background information about the country and an overview of recent reforms, the structure and the stakeholders in the Ugandan health sector are given. Chapter 3 gives a presentation of the development of the Ugandan NHA. In chapter 4, a picture of how the NHA and other data are used for health policy purposes is presented. Problems connected to the development of NHA and use of results for policy purposes in Uganda are outlined and the need for a third round of NHA is discussed. Conclusions are drawn in chapter 5.

1.3. Limitations

The respondents in this study are limited to those that were available for interviews in Kampala during September 11–23, 2005. Unfortunately, it was not possible to meet with representatives from the Ministry of Finance, Planning and Economic Development (MoFPED) or any organisation representing the Non-governmental Organisations (NGOs) involved in health care in Uganda. Further, the study includes no opinions from one of the most important development partners identified; Danida.

2. Overview of the Ugandan Health Sector

In this chapter an overview of recent reforms in the Ugandan health sector is presented as well as the different stakeholders and the structure of the health sector. The chapter is based on available policy documents and other published reports.

In 1986 the National Resistance Movement (NRM) took control over the country after a turbulent period of conflict. By that time the health sector was near a collapse with rundown and ill-equipped public health care facilities and demoralised personnel [5]. This situation was worsened by the re-emergence of diseases that had earlier been controlled such as sleeping sickness, tuberculosis (TB), guinea worm and measles. HIV/AIDS also emerged at that time. Health services were mainly sought from Private Not-for Profit (PNFP) facilities and from Private Health Practitioners. Donor support was channelled through Non-governmental Organisations (NGOs) and specific projects due to lack of confidence in the public institutions. From 1986 and onwards Uganda has introduced several reforms in the health sector. As in many other developing countries examinations of alternative health financing mechanisms have been encouraged by donor organisations. Bilateral and multilateral donor organisations have increased their budget support to public institutions, especially in the health sector [5, 6]. The Global Fund to fight AIDS, TB and Malaria (GFATM) was temporarily suspended in 2005 due to suspected project mismanagement by the Ugandan health ministry [7]. Box 1 and Table 1 gives an overview of the development and the current status of the health status in Uganda.

Box 1. Health status in Uganda

By 1986 the health indicators in Uganda were among the worst in the world. Since then, there have been gradually improvements but the northern part of the country is lagging behind due to conflicts. The humanitarian situation in the north part is disastrous and affects approximately 2.3 million people. According to the latest available statistics, almost 40 percent of the Ugandan population live below the poverty line. The leading causes of morbidity and mortality in the country are communicable diseases. More than 60 percent of the disease burden can be explained by poor perinatal and maternal conditions, malaria, acute lower respiratory infections, HIV/AIDS and diarrhoea. Skilled health staff attended no more than 39 percent of all deliveries in 2001. Malnutrition, malaria, diarrhoea, measles and pneumonia are the major causes behind the high under-5-mortality rate. The HIV-prevalence is 5.4 percent and HIV/AIDS is the leading cause of death in adults followed by Tuberculosis (TB) and malaria. The health infrastructure is poor all over the country, particularly in the rural areas. Around 51 percent of the households do not have access to health care. According to the second NHA report, referring to a health facility mapping done in 2000, 57 percent of the people lived within 5 km radius to a health facility. There were, however, significant variations between the districts. In 2002, 56 percent of the population had access to safe water.

Source: Uganda NHA 1998/99–2000/01; World Development Indicators Database, World Bank [5, 8]

Table 1. Development Indicators for Uganda

	1987	1990	1995	1998	2000	2003
Population, total (million)	15.5	17.4	20.3	21.9	23.3	25.3
GNI per capita (Atlas method current US$)	320	320	230	290	270	250
Life expectancy at birth, total (years)	48	47	46a	42b	42c	43
Fertility rate (total births per woman)	7	7	7a	N/a	7c	6
Infant mortality (per 1,000 live births)	N/a	93	92	N/a	85	81
Child immunisation against DPT						
(% of children aged 12–23 months)	30	45	59	54	58	81
Child immunisation against measles						
(% of children aged 12–23months)	38	52	57	53	61	82
Under 5 mortality rate (per 1,000)	N/a	160	156	N/a	145	140

Source: World Development Indicators Database, World Bank [8]

a1992, b1997, c1999

2.1. Recent reforms in the Ugandan health sector

The Government of Uganda (GoU) elaborated a Poverty Eradication Action Plan (PEAP) in 1997. The PEAP is Uganda's national planning framework with the overall objective of reducing the proportion of the population living below the poverty line to 10 percent by year 2017 and

to improve the general wellbeing of all Ugandans. The PEAP rests on five pillars; strong economic management; enhancing production, competitiveness and income; strengthening security, conflict resolution and disaster management; strengthening governance; and strengthening human development [9]. In 1998, the Government was approved a debt relief under the Highly Indebted Poor Countries (HIPC) initiative. This resulted in the creation of the Poverty Action Fund in Uganda whereby additional government funds from the HIPC initiative should be channelled towards prioritised areas identified in the PEAP.

In 1999/00 a ten-year National Health Policy (NHP), covering the years 2000/01 to 2010/11 was launched [10]. A five-year policy implementation plan, the Health Sector Strategic Plan I[3] (HSSP I) covering the years 2000/01–2004/05 was launched in year 2000 [11]. The NHP and HSSP sought to address the problems in the Ugandan health care sector by:

- Delivering the Uganda National Minimum Health Care Package (UNMHCP) composed of cost-effective treatments to address the major causes related to the burden of disease. The UNMHCP was calculated at USD 28 per capita, excluding the cost for anti retroviral (ARV) therapy for HIV and pentavalent vaccine.
- Strengthening the health care delivery system (e.g. the legal framework, strategic policies and information management systems) at both the national and district as well as sub-district levels to provide the UNMHPC in an integrated manner.
- Developing a sustainable Health Financing Strategy, where funds should be allocated and utilised in an effective and equitable manner consistent with the PEAP. Stronger donor co-ordination should be achieved through a Sector Wide Approach (SWAp) for health development.
- Empowering communities to take responsibility for their own health and participate in the management of their local health services.
- Recognising that the private sector has specific advantages when it comes to health care delivery and to make use of this by a Public Private Partnership for Health (PPPH). The PPPH project was initiated by the Ministry of Health (MoH) in 1997.

Decentralisation of health services, collaboration with the private sector and the SWAp were central concepts in the implementation of the HSSP I. A Fiscal Decentralisation Strategy was adopted in 2002, whereby the Ministry of Finance, Planning and Economic Development (MoFPED) allocates the total district budget to each district on a monthly basis [9, 13, 14].

Steps towards a Ugandan Health SWAp commenced already in 1993 with the development of a document, which stated that the funding of the Ugandan health sector was far below the needed level. In 2000, a Memorandum of Understanding (MoU) for HSSP I was signed by the Government and development partners. The intent of the MoU was to guide the Government and development partners through the implemen-

[3] The targets of the HSSP I was set at reducing infant mortality rate from 97 to 68 and under five mortality rates from 147 to 103 per 1,000 live births; reducing maternal mortality rates from 506 to 354 per 100,000 live births; reducing the HIV/AIDS prevalence by 25 percent; reducing the fertility rate from 6.9 to 5.4; reducing stunting due to malnutrition from 38 to 28 percent; and to reduce disparities in those indicators among the different income groups of the population.

tation of the HSSP I. When developing the health SWAp in Uganda, it was limited to the activities undertaken by the MoH and the Local Governments (see section 2.2 and 2.3). This means that the health sector is narrowly defined in the SWAp. It would have been possible to include activities such as water and sanitation as well, i.e. responsibilities of other ministries than the MoH. Shortly after the MoU was signed the development partners turned to general budget support and thereby the support is channelled through the MoFPED, as opposed to sector support, which in this case would be channelled through the MoH [15]. During the HSSP I several development partners turned from project to budget support and the number of development partners participating in the SWAp has increased since the first MoU was signed. A Health Sector Strategic Plan II covering the period 2005/06 to 2009/10 was developed and disseminated during 2005 and a new MoU, is being developed based on the HSSP II [6].

The latest Annual Health Sector Performance Report (AHSPR) covers the financial year4 2004/05 [18]. It evaluates the health sector performance and is based on five performance indicators given by the PEAP and other indicators agreed on among stakeholders in the health sector. The indicators include outpatient attendance, trained health workers, deliveries at health care facilities, effectiveness of family planning, child immunisation, and one HIV/AIDS indicator. In short, the assessment indicates a year of improved performance.

2.2. Provision of health care services

The formal health sector in Uganda is composed of both public and private providers. It should be noted, however, that there is also a large informal sector providing health care services.

The public health sector is composed of three levels; the national level, the district level and the health sub-district level. At the national level the MoH sets policies and overall objectives within the health care sector. There are three National Referral Hospitals and eleven Regional Referral Hospitals, which are semi-autonomous institutions under the MoH. The district level is composed of 70 districts that operate health care units. The districts also have other responsibilities such as water and sanitation. The District Health System contains Health Sub-Districts (HSD) responsible for the provision of health care services to the population in their respective catchments area. There are three levels within a HSD: referral facility level (with a hospital or a upgraded Health Centre owned privately or by the government, Health Centre IV), which has the leading role in the HSD, Health Centre III level, and Health Centre II level. Health Centre I is the community or household level and is outside the formal health system. The three levels have all a defined package of services to deliver. There are a total of 214 HSDs in the country.

The private sector is composed of facility-based PNFP providers, non-facility based PNFP providers, private health practitioners and traditional and complementary medicine practitioners. Approximately one fourth of the health care facilities in Uganda are PNFP [5]. In terms of funding, the PNFP facilities receive less than 10 percent of the overall health budget, whereas they account for between 25 and 35 percent of the total outputs of the national health system [6].

[4] The Ugandan financial year runs from July to June.

2.3. Funding of health care services

The sources of health funds in Uganda are the Government, donors, parastatals, Private Not for Profit organisations (PNFP), households and private firms. The bilateral donors contributing most to the health sector in Uganda are the Danish International Development Agency (Danida), the Department for International Development, UK (DFID), United States Agency for International Development (USAID), Italy and the Swedish International Development Cooperation Agency (Sida). The main multilateral donors are the European Union (EU), the World Bank (WB) and WHO.

Funds within the public sector are allocated as global budgets from the MoFPED with proportions for each sector specified. The Local Governments in the districts are then to allocate the funds to each sector, e.g. health and education, and each sector is to allocate its funds to the different units within the sector. The Local Governments are allowed to re-allocate ten percent of the given proportions for each sector, with the exception of the proportion of the recurrent budget allocated for drugs in the health budget. According to respondents at the MoH, funds are released fairly on time to the districts but there are large variations within the districts regarding the timeliness of release of funds to the different sectors. The delay in release of funds is further increased within each sector when it comes to allocating funds to different units, i.e. health care units in the health sector. Every district makes its own budget and work plan according to a ceiling set by the MoFPED. Each sector and district is obliged to provide a financial report each month to the Local Governments and the MoFPED respectively, in order to receive funding for the upcoming month.

The fact that donor funding is channelled through the MoFPED has given the Government a very strong ownership of the SWAp [15]. The Government adheres strictly to budget ceilings outlined in the Medium Term Expenditure Framework5 (MTEF), which, according to the respondents, has led to much debate over the past years. The debate has focused whether the budget ceiling for the health sector should be more flexible and whether certain activities could be considered above the ceiling. There are three major explanations to the strict adherence to budget ceilings; macroeconomic balance and growth as stated in the PEAP; to use sector ceilings as an effective instrument for budget discipline in Government; and to avoid dependence on donor support that might effectively deduce Ugandan ownership of the development agenda [6].

Donors appear to be willing to supply funds above the ceilings stipulated in the MTEF, which leads to a) donors frequently seek to provide 'additional' funding above the ceilings, and b) developing partners compete over funding opportunities. Since all funding is to be captured under the sectoral ceilings, global initiatives6 compete with funds provided under budget support. Although the funding from these global initiatives are much needed in order to meet the health needs of the Ugandan population they might actually lead to a crowding out effect

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[5] A MTEF is a tool for linking policy, planning and budgeting over a medium-term period (normally 3 years) at the government level. It consists of a top-down resource envelope and a bottom-up estimation of the current and medium term costs of existing policies. [17]. Swaroop, V. Medium Term Expenditure Framework: What is it? in PREM Week Thematic Session. 2001. Washington, DC.

[6] For example GFATM, an international, independent public-private partnership designed to attract and manage funding to fight the mentioned diseases; the Global Alliance for Vaccines and Immunization (GAVI), a public-private alliance formed to harness the strengths and experience of multiple partners in immunization; and the President's Emergency Plan for AIDS Relief (PEPFAR), a US five year $15 billion global initiative to combat the HIV/AIDS epidemic.

whereby budget support is pushed out of the health sector. Budget support can easily be re-allocated to other sectors whereas project support cannot [6]. This would undermine the intent of the SWAp, namely funding through budget support and that the Government is in control of setting priorities in the health sector.

3. Uganda NHA

In this chapter the NHA process and major results from the two published NHA reports for Uganda are provided. The chapter is based on the two NHA reports, other published data and information obtained by interviewing stakeholders in the Ugandan health sector. Comparisons of results between the two reports should be interpreted carefully since the data collection method differs between the first and second round. The second NHA is more comprehensive and detailed than the first one.

3.1. First round of NHA

The first NHA report in Uganda, covering the financial year 1997/98, was published by the MoH and the Economic Policy Research Centre (EPRC) in June 2000 [19]. A collaborative team from the EPRC, the MoH and the MoFPED collected the data. Still, some respondents argued that the process of conducting NHA has been donor driven to a great extent. The exercise was financed by Sida, USAID and WHO. The estimates of household health expenditures were based on results of the Uganda National Household Survey of 1997 conducted by the Department of Statistics at the MoFPED. Data from the United Nations Development Programme's (UNDP) 'Uganda development co-operation report' of 1997 was also used. Three ministries were surveyed, i.e. the Ministry of Education, the Ministry of Defence and the MoH.

According to the NHA results for the financial year 1997/98, total health care expenditure amounted to Ushs 310 billion (US$ 269 million) corresponding to 4.7 percent of GDP. The primary sources of health care funding 1997/98 were donors, households and the government, as illustrated in Figure 1.

Foreign donors contributed with Ushs 129 billion to the Ugandan health sector in 1997/98. The largest contributions came from the International Development Agency (IDA), United States Agency for International Development (USAID), United Nations Children Fund (UNICEF), African Development Fund (ADF), Sweden (Sida), Denmark (Danida), and the UK (Dfid).

The main part (71 percent) of total health expenditures was passed through financing intermediaries while the remaining part (29 percent) was transferred directly to health care providers. The major financing intermediaries included the MoH, district health services and NGOs. Private health insurance constituted a very small proportion of total health expenditures.

One of the findings in the 1997/98 report was that the foreign flow of donor funds needed improved coordination. Five ways in which donor funds were channelled were identified in the report, i.e. to the MoH through MoFPED, directly to the MoH, directly to NGOs, directly to providers (mainly NGO hospitals), and directly to district health services.

The largest proportion of spending by function was curative services (24 percent). Pharmaceuticals, capital development and preventive services together accounted for 14 percent of total health expenditure, technical and administrative support for 17 percent and research and training for 2 percent.

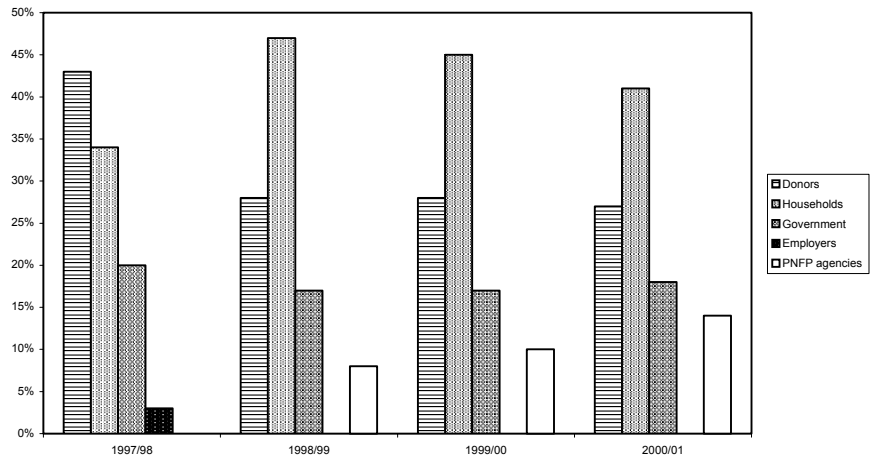
3.2. Second round of NHA

The second round of NHA, financed by Danida and WHO, was conducted in 2003/2004 with data covering the financial years 1998/99–2000/01. The NHA team, composed of members from the MoH, WHO, EPRC, Religious Bureaus and Uganda Bureau of Statistics, used the methodology in the Producer's Guide [20], adjusted by the Technical Committee to suit Ugandan conditions. The work was coordinated by the MoH. The second round, in contrast to the first, relates the expenditure data to health outputs. There is even an evaluation of efficiency related to health expenditures at district level included for the financial year 2000/01.

The NHA findings show that total health expenditure has increased during the period, from USD 402 million in 1998/99, USD 411 million in 1999/00 to USD 423 million in 2000 /01. The corresponding per capita health expenditure was USD 19, USD 18 and USD 18 respectively. This figure is far beyond the estimated figure required to provide the minimum health care package in Uganda, i.e. USD 28, excluding costs for antiretroviral therapy and pentavalent vaccine.

The financing sources identified were Government, donors, parastatals, PNFP (NGOs), households and private firms. The major financing sources for all three years were the households, donors and central government, as illustrated in Figure 1. Figure 1 also includes data from the first round of NHA, financial year 1997/98. Note, however, that the sources are not consistently defined in the two reports. PNFP is not a separately defined source in the first round and was then most likely included in the donor category. Further, employers are not defined as a separate category in the second round.

Figure 1. Sources of health care funding in Uganda, 1997/98–2000/01



The following financing agents were identified: MoH, other ministries and national and regional referral hospitals, district health services, parastatals, private health insurance enterprises, households, facility-based PNFP, non-facility based PNFP and private firms. The bulk of the funds spent were from private rather than public financing agents and the most significant providers were private for profit clinics and drug shops. The public providers included the National Referral Hospital, District Hospitals, provision and administration of public health programmes and the MoH.

The efficiency analysis at district level showed that the average technical efficiency score for all districts was 70 percent. This means that on average the districts could produce 30 percent more output without increasing inputs.

Two factors are mentioned in the second round of NHA as limitations, which should be addressed in a future Ugandan NHA study [5]:

- Lack of information from NGOs. Many NGOs register but then closes down as soon as funding is approved. Many not-facility based PNFP are registered as working within the health sector but in reality they are not working with health programmes. A central database of all NGO Annual Reports should be created so as to make such information available.
- Difficulties in obtaining information from the donors. Some of the donor support is based on the programmes´ time span and thus it is difficult to obtain data for separate financial years.

4. The use of Health Expenditure Data and NHA in Uganda

In this chapter, opinions regarding and use of health expenditure data is presented. One section is devoted to discussion of possible use of NHA data for evaluating the health SWAp. Potentials and obstacles for a third round of NHA in Uganda are also presented. The chapter is primarily based on information obtained during interviews with stakeholders in the Ugandan health sector. Where possible, the information is supported by concrete examples and available policy documents.

4.1. Opinions regarding health expenditure data

Health expenditure data covering the public sector, including donors was believed to be available and of high quality. One issue was brought up regarding information from donors, i.e. that some donors do not use the same financial year as the Government. This constitutes a problem when data is to be compared.

Data for the private sector and households was considered to be of poor quality and difficult to access. Accurate data for the informal sector was believed to be even more difficult to access. There seems to be a belief within the MoH that the formal sector covers a much larger proportion of all health services delivered than it actually does. This might hamper the efforts to collect data from other sources than the public and thus the production of NHA. The formal sector (including PNFPs) does not include the entire Ugandan health sector. According to some respondents the informal sector is of considerable size and importance. Unless efforts are made to collect data from the informal sector, the NHA will not be complete. This was not addressed in either the first or the second round.

4.2. The use of NHA in Uganda

4.2.1. Who use NHA and for what purposes?

The MoH, as well as developing partners, i.e. donors and multilateral organisations, use NHA results. Results from the first round of NHA were used when developing the HSSP I, according to the second NHA report, and results from the second round were used when developing the HSSP II, according to the respondents.

The first round of NHA revealed that the flow of funds within the Ugandan health sector was not managed in an efficient way. Information about the poor coordination of donor funding was used in the process of developing and implementing the health SWAp. Furthermore, the first

NHA report provided the MoH with concrete evidence of the low level of funding in the health sector. According to respondents at the MoH, there was a belief among the donor community that the level of health care funding was higher than it actually was prior to the first round of NHA.

According to the respondents other data used for making decisions in the health sector includes the Public Expenditure Review (PER), MTEF, the Demographic and Health Survey (DHS), and information from the Health Management Information System (HMIS).

4.2.2. Positive and negative factors contributing to the use of NHA

The respondents at the MoH as well as the developing partners were generally positive towards using NHA. Three factors contributing to the use of NHA results within the MoH was brought up during the interviews:

- The MoH has good knowledge of the potentials of NHA since they were involved in the making of the second round of NHA.
- Two rounds of NHA are now available, providing data for four financial years. Thus, there is trend data available for the financing of the Ugandan health sector.
- Major policies have been implemented in the Ugandan health sector and enough time has passed to evaluate the impact of these policies. NHA is believed to be a good tool for evaluation.

Other respondents said that NHA presents unique data in the sense that it provides figures on actual expenditures on health. This makes NHA results different from the PER, MTEF, and HMIS, which primarily generates information about the flow of funds. Several respondents mentioned, however, that it is difficult to link NHA results to output measures, i.e. how and what health services are delivered and related effectiveness and efficiency indicators.

Another shortcoming of the Ugandan NHA mentioned was that the concept of NHA, i.e. to give a picture of total health care expenditures from both the financing side and the provider side, is not fully accomplished in Uganda. NHA only provides information about health care services in the formal sector. In Uganda, a large part of all health care services are delivered in the informal sector and that is not accounted for in the NHA. Thus, NHA does not provide a complete picture of the Ugandan health sector.

4.2.3. Can NHA results be used to evaluate the health SWAp?

Based on the information given by the interviewees, NHA results can be used in the process of evaluating the SWAp process. NHA results alone, however, are not enough. At least three kinds of data are required, i.e. input data, output data and outcome data. In addition, it is essential to have this information for different periods of time, i.e. time series data is needed.

NHA provides good financial input data. Such data is already available for the period 1997/98 to 2000/01. Conducting a third round of NHA, covering the period 2001/02–2004/05, would thus provide comprehensive and comparable time series data on health care financing for the period 1997/98–2004/05, or at least 1998/99–2004/05 bearing in mind that the quality of the first round can be questioned.

DHS provides good output data. There is one DHS report available covering the financial year 2000/01 and the upcoming DHS report will

cover the financial year 2004/05 and be disseminated during 2006 or 2007. Thus, by 2007 the latest, there will be output data available for two different time periods, one before and one after the implementation of the SWAp. This implies that if a Ugandan NHA 2001/02–2004/05 is conducted, there will be both input and output data available, covering the time before and after the implementation of the health SWAp.

What is needed to be able to fully evaluate the SWAp is an improved process to obtain outcome data, such as information about changes in disease burden and linkages between changes in disease burden and overall macroeconomic indicators [6]. One respondent mentioned Demographic Surveillance Sites (DSS) as a good tool to use when combining NHA data with other information to get a comprehensive picture of the health sector[7].

4.3. Future of NHA in Uganda – a third round?

So far there has been two rounds of NHA produced in Uganda but the process is not institutionalised. The responsibility of producing NHA lies at the MoH, at the Health Planning Department. According to the second NHA report, the financial years 2001/02, 2002/03 and 2003/04 should be included in the third round of NHA in Uganda. Producing a third round of NHA was included in the MoH work plan for 2004/2005 but was not carried out. It is also included in work plan for 2005/2006 and whether a NHA study will be commenced this period remains to be seen.

A third round of NHA is believed to be needed in order to facilitate the implementation of HSSP II and the evaluation of HSSP I. The Ugandan health sector has undergone major changes during the past five years when the HSSP I (and the SWAp) has been implemented and NHA is believed to provide good information about the impact regarding health care financing that these changes have had. The health information system suffers from lack of data on health output but this will be presented in an updated DHS [6]. It is necessary to complement the NHA results with these output measures. Much is expected from the coming DHS. It will cover data from 2005 and is planned to be released in the end of 2006 or in the beginning of 2007. Results from the DHS will be of importance for the NHA report since it provides information about households.

Some respondents argued that the process of conducting NHA has been donor driven to a great extent and that additional donor funding is needed if a third round is going to be initiated. Other respondents stated that it is not lack of funding but low commitment within the MoH that constitutes a problem. Since there is in-country capacity to conduct NHA and no external technical assistance is needed, it is more a matter of priority of work among those in the NHA-team. The NHA team includes members from different organisations and institutions but the work is coordinated by the MoH. One respondent argued that it is up to MoH if there will be a third round of NHA in Uganda, since it is the MoH that sets priorities.

According to the respondents there are at least two possible explanations to why the commitment might be low within the MoH. One is the low level of funding in the health care sector. The UMBHCP is estimated at USD 28 per capita, excluding ARV-treatment and pentavalent

[7] In 2005, the Makerere University inaugurated collaboration with two health districts on the implementation of a DSS project. A DSS is a centre for continuous collection of household data such as births, deaths, age and health related information [21].

vaccine. Including these two treatments the estimated cost per capita is USD 40. This may be compared to the available annual per capita expenditure on health of USD 18 (public USD 10) and there is a question regarding what can actually be achieved with such a low funding level. It is not as interesting to look at changes in financing as long as the health sector suffers from severe under-funding, as it would have been if the funding levels were more appropriate.

Another possible explanation to the low commitment for the production of a third round is that NHA provides limited added value since information about the health care financing within the public sector (including donors) is of such good quality. On the other hand, since this data is of good quality and easy to access, the production of a third round of NHA in Uganda is relatively easy. NHA is primarily needed for information about the NGOs and PNFPs but for Government spending the figures are already present in existing reports.

Another aspect brought up during the interviews was that a third round preferably also could include regional spending patterns and sub accounts for a specific area, such as reproductive health or HIV/AIDS.

5. Concluding Remarks

Two rounds of NHA have been produced in Uganda and both the MoH and the development partners are using NHA results. Results from the first round of NHA were used when developing the HSSP I and results from the second round were used when developing the HSSP II. The NHA process is, however, not institutionalised. There is in-country capacity to produce NHA but no single person or unit that has the commitment and the capacity to lead the process.

Identified problems connected with the production and use of the existing NHA reports includes difficulties in obtaining data from the informal sector. The informal health sector in Uganda is of considerable size and importance but available NHA reports only incorporate data from the formal sector. Furthermore, data from some of the donors is difficult to obtain. The fact that the process has been donor driven, although the MoH is highly involved, can also be viewed as a problem.

There seems to be a demand for a third round of NHA due to a number of reasons. The Ugandan health sector has undergone major changes during the past five years and NHA is believed to provide good information about the impact regarding health care financing that these changes have had. More specifically, a third round of NHA is believed to be needed in order to facilitate the implementation of HSSP II and the evaluation of HSSP I (including the SWAp). NHA is needed for providing financial information about the NGOs and PNFPs but for Government spending the figures are already present in existing documents.

Several obstacles for producing a third round have been identified in the study. Firstly, conducting NHA does not appear to be prioritised within the MoH. The perceived need for a third round seems to be limited since information about public health care expenditures is already available and of good quality. On the one hand, easy access to high-quality data is a prerequisite for a smooth NHA process, while on the other hand; NHA provides limited extra information since much data already is available. Furthermore, there is an overall low level of funding in the health care sector. It is not as interesting to look at changes in financing when the health sector suffers from severe under-funding, as it would be if the funding levels were more appropriate. In addition, the process of conducting NHA has to a great extent been donor driven and additional donor funds are needed for a third round to be initiated. Based on the

results in this study, if a third round of NHA is initiated in Uganda, it would be beneficial to keep the following in mind:

- A third round of NHA should preferably cover the years 2001/02–2004/05 in order to be able to link input data from the NHA with output data, which will be provided for year 2005 through the next DHS.
- In order to get complete NHA and to provide a complete financial picture of the Ugandan health sector, efforts have to be made to collect data from the informal sector.
- NHA can facilitate an evaluation of the HSSP I and the SWAp of health in Uganda but information on outcomes is needed to get a complete evaluation. An improved process of producing outcome data is needed if to fully evaluate the SWAp.
- To cover regional spending and sub accounts for one area could preferably be an issue in a third round.

In this study, a demand for a third round of NHA in Uganda has been identified along with possible obstacles for conducting such a study. Perhaps the most important obstacle is the difficulties in prioritising among different tasks at the ministry level. Conducting NHA was included in the MoH workplan for 2004/05, but the exercise was not carried out. It is again included in the new workplan for 2005/06, but whether it will be carried out or not remains to be seen.

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