



Macroeconomics and Health in Uganda

Mission Report to the World Health Organization (WHO)

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The authors are solely responsible for the content of this report.

This report presents the findings from the mission work as outlined in the attached Terms of References. Any opinions and conclusions expressed are those of the authors and do not necessarily reflect those of the Government of Uganda or the World Health Organization.

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Acronyms and Abbreviations

DAH	Development Assistance in Health
GoU	Government of Uganda
HSSP II	Health Sector Strategic Plan II
HSWG	Health Sector Working Group
IMF	International Monetary Fund
LIC	Low-Income Country
LMIC	Low- and Middle-Income Countries
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCMH	National Commission on Macroeconomics and Health
NCMH-U	National Committee on Macroeconomics and Health
NHP	National Health Policy
NPA	National Planning Authority
PEAP	Poverty Eradication Action Plan
PER	Public Expenditure Review
PRSP	Poverty Reduction Strategy Paper
SWAp	Sector-Wide Approach
UBOS	Uganda Bureau of Statistics
UNFPA	United Nations Family Planning Agency
UNICEF	United Nations International Children's Emergency Fund
WB	World Bank
WHO	World Health Organization

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Executive summary

This report presents the findings from a mission carried out by the authors in June, 2006. The purpose of the mission was to provide recommendations and input to the Ugandan preparations for a national program on macroeconomics and health. In particular, the mission looked at macroeconomic issues and developments, inter-sectoral allocations of resources and their potential effects on health outcomes, equity in health care utilization and spending, and a set of additional issues and questions that the government might want to consider during the next steps in the preparations for the program.

The main findings of the mission regarding the above issues are summarized as follows. As with most other low-income countries, Uganda is highly constrained in terms of policy space, mostly due to the very limited resources for health investments available. The mission notes the importance of using available resources as efficiently as possible, while scaling up interventions in a macroeconomically sustainable way.

A large share of the disease burden in Uganda is determined outside of the health sector. To the extent possible, it is the responsibility of the health community to highlight these relationships and point at cost-effective solutions. Nonetheless, it is the primary responsibility of the health professionals to focus on the sector itself for maximum impact of health interventions.

The recent abolition of user fees in the public health care system provided improved opportunities for using services at the time of need, also for the poorest sections of the population. Other inequalities in utilization, access, and outcomes remain and need to be addressed systematically by the health sector.

The mission recommends that a national program on macroeconomics and health in Uganda is introduced strategically by focusing on a prioritized set of issues and areas for maximum impact. Furthermore, the program should be developed with a clear view on bringing value-added to the policy development process. Among other things, this means that a core group of high quality members should be involved in the work, which should be based on the best available evidence of what works in Uganda, what doesn't, and why.

1. Introduction

This report presents the findings from a mission to Uganda by the authors during June 5 to June 14, 2006. The overall purpose of the mission was to make recommendations to the Ministry of Health and its development partners, including the WHO representative office in Uganda, on the further development of a national committee on macroeconomics and health in Uganda (NCMH-U). The specific tasks of the mission are set out in the Terms of References attached as Annex 1 to this report.

1.1 Background

In 2001, the Commission on Macroeconomics and Health (CMH) presented its report to the Director General of the WHO (WHO, 2001). The report, which was based on a set of specific analytical activities carried out in the preceding two years, made a strong case for the need to scale up investments in health in low- and middle-income countries (LMICs) for economic development and poverty reduction. One specific recommendation of the CMH-report was the setting up of national CMHs to discuss and agree on such investments at the country level. Since the launch of the report, a significant number of countries have acted on this recommendation and developed national commissions on macroeconomics and health (see WHO, 2006, for a list of these countries and the experiences of these activities to date).

1.2 Scope and limitations

This report is based on documentation that was made available to the authors prior and during the mission, and on the findings from discussions with the main stakeholders during the mission period in Kampala. In addition, the report draws on the experiences of the authors and on the available evidence as presented in publicly available reports, articles, and reviews on various relevant topics and issues.

While the authors have made every effort to fulfill the requirements and tasks of the mission as specified in the Terms of Reference, the limited prior knowledge about the past and current macroeconomics and health situation in Uganda has of course limited the ability of the authors to provide new or profound analysis of many relevant issues as they pertain to the Ugandan context.

Nonetheless, whenever noted, the authors have made observations that are discussed in the report and subsequently brought up in the Discussions and Recommendations sections of the report.

The outline of this report is as follows. The next section provides a situational analysis of the macroeconomics and health situation in Uganda. Based on the most recently available sources of data and information, the analysis looks at some of the key economic, poverty, health, and population outcome indicators for Uganda and the group of low-income countries that Uganda belongs to and also the regional averages for Sub-Saharan Africa (SSA). These comparisons are provided to place the situation in Uganda in a regional and income perspective. Section 3 assesses the current proposal for a macroeconomics and health program in Uganda as developed by the Ministry of Health in close collaboration with the WHO representative office (Annex 3). The review focuses on the feasibility of implementing the program and on the content of the proposal. Section 4 of the report addresses a set of topics that have been identified by the Ministry of Health and the WHO representative office as being of particular importance for the macroeconomics and health program in Uganda. In particular, the section discusses some macroeconomic issues, the integration of interventions for health and those of other sectors also affecting health outcomes, health equity, and some suggestions for additional support for macroeconomics and health. The findings of the report are discussed in section 5 and the report ends with a set of key recommendations for how Uganda might continue to pursue the macroeconomics and health option for effective policy development. The complete Terms of References are provided in Annex 1 and the list of meetings held during the mission in Uganda is found in Annex 2.

2. Situational analysis of macroeconomics and health in Uganda

This section contains a brief description of macroeconomics and health developments in Uganda, including tables with key indicators for economic development and poverty reduction, health care systems indicators, and health outcomes measures. For the most part, estimates for the period 1990 to 2003, or the most recent estimate available, are given. The data are taken from WDI 2005 and WHS 2005 or, whenever indicated, from other relevant sources. It should also be noted that the usual data caveats apply and the mission does not make strong suggestions based on any of the reported data. Due to time-constraints, any missing data from these sources have not been replaced by national or regional statistics.

For each of the various areas, the performance of Uganda is compared with the regional average and the average for the groups of low- and lower-middle income countries. Such comparisons should of course be made with great care as many indicators are determined by country specific factors. Nonetheless, they might provide some lessons for further analysis.

2.1 Macroeconomic indicators

Table 1 shows the level of gross national income per capita over the period 1990 to 2003. Among other things, it might be noted that as recent as 1990, Uganda had a GNI per capita not very different from the country income group average.

Table 1. GNI per capita 1990-2003

Country Name	1990	1995	2000	2003
GNI per capita, Atlas method (current US\$)				
Uganda	320	230	270	250
Low income	360	340	380	440
Sub-Saharan Africa	550	520	480	500
GNI per capita, PPP (current international US\$)				
Uganda	700	950	1230	1430
Low income	1160	1420	1800	2110
Sub-Saharan Africa	1370	1430	1600	1750

Source: WDI, 2005.

Table 2 shows real GDP per capita growth for selected years between 1990 and 2003.

Table 2. Real GDP per capita growth, 1990-2003

Country	1990	1995	2000	2003
Uganda	2.21	8.83	2.34	1.91
Low income	1.69	3.85	2.02	5.02
Sub-Saharan Africa	-2.36	1.02	0.83	1.64

Source: WDI, 2005.

The table shows that economic growth has been higher in Uganda than in other neighboring countries, but towards the end of the period significantly lower than in other LICs. The relatively low economic growth rate in Uganda in recent years is of course a cause of concern given the need for increased investments in most social sectors, including the health sector.

2.2 Poverty indicators

In terms of poverty and income distribution, Uganda has been able to bring down the level of absolute poverty over the past decades. Nonetheless, measured in terms of the international poverty lines, table 3 shows that poverty is still widespread in Uganda. Although few regional or country group averages are reported, it would seem that poverty in Uganda is more widespread than in the rest of the SSA-region, particularly at the higher level of poverty.

Table 3. Poverty and income distribution, 1992-2001

Series Name	Country Name	1992	1993	1996	1997	1999	2001
GINI index	Uganda	..	..	..	..	43	..
Income share held by highest 20%	Uganda	..	..	..	..	49.74	..
Income share held by lowest 20%	Uganda	..	..	..	..	5.94	..
Poverty gap at \$1 a day (PPP) (%)	Uganda	47.76	..	44.78	..	45.61	..
Poverty gap at \$2 a day (PPP) (%)	Uganda	70.44	..	69.2	..	69.16	..
Poverty headcount ratio at \$1 a day (PPP) (% of population)	Uganda	85.88	..	86.08	..	84.91	..
	Sub-Saharan Africa	..	44.1	45.6	..	45.7	46.4
Poverty headcount ratio at \$2 a day (PPP) (% of population)	Uganda	96.73	..	97.19	..	96.58	..
	Sub-Saharan Africa	..	74.6	75.1	..	76	76.6
Poverty headcount ratio at national poverty line (% of population)	Uganda	..	55	..	44	..	..

Source: WDI, 2005.

2.3 Health expenditure indicators

Uganda spends around 7.4 percent of GDP on health, which translates into around US\$18 per person per year (table 4). Although this is an increase since the late 1990s, it is significantly lower than in the comparison countries and regions and, moreover, is considered too low for its immediate health care coverage requirements, estimated at around US\$28 for the basic package of services. Also, the private share of total financing is higher in Uganda than in the other countries and regions, though on the other hand, the share of out-of-pocket (OOP) spending as a share of total private expenditure is lower compared with the selected comparatives. It is noted that the Long-term Expenditure Framework (LTEF) envisages central government expenditure increases for health to reach 15% by FY 2012/13.

Table 4. Health expenditure, 1998-2002

Type of Expenditure	Country/Region	1998	1999	2000	2001	2002
Health expenditure per capita (current US\$)	Uganda	15	17	16	18	18
	Low income	21	23	26	27	29
	Sub-Saharan Africa	34	34	32	31	32
Health expenditure, private (% of GDP)	Uganda	3.84	4.30	4.76	5.31	5.34
	Low income	3.45	3.77	4.04	3.98	4.00
	Sub-Saharan Africa	3.78	3.97	3.65	3.72	3.77
Health expenditure, public (% of GDP)	Uganda	1.56	1.90	1.74	1.99	2.06
	Low income	1.53	1.47	1.45	1.43	1.49
	Sub-Saharan Africa	2.70	2.61	2.60	2.57	2.57
Health expenditure, total (% of GDP)	Uganda	5.40	6.20	6.50	7.30	7.40
	Low income	4.98	5.24	5.49	5.41	5.49
	Sub-Saharan Africa	6.49	6.58	6.25	6.29	6.34
Out-of-pocket health expenditure (% of private expenditure on health)	Uganda	71	62	57	52	52
	Low income	96	96	96	96	96
	Sub-Saharan Africa	56	53	54	54	56

Source: WDI, 2005.

One area in health financing where Uganda exhibits a notably high share is development assistance in health (DAH). As can be seen in table 5, almost one third of total health spending in the country consists of external support, most of which comes in the form of grants, but not all of which is captured in the public finance statistics.

Table 5. External resources for health, share of total expenditure on health, 1998-2002

Country/Region	1998	1999	2000	2001	2002
Uganda	30.90	27.60	28.30	27.40	28.80
Low income	5.78	4.76	5.07	4.02	3.94
Sub-Saharan Africa	6.52	6.31	7.53	7.06	7.22

Source: WDI, 2005.

While Uganda is making attempts to limit and even reduce the high dependence on foreign grants to finance its health services and health care investments, it is likely that the country will continue to depend on this form of support for the coming 10 to 15 years.

2.4 Health care system indicators

In the main, the performance of the health care system and service delivery in Uganda seems to be on par or even exceed that of several of the other countries in the region. For example, immunization rates are significantly higher in Uganda than the regional average (table 6). This,

however, does not in any way implicate that the service delivery system in Uganda is not in need of significant additional resources and further management reform. Indeed, health care systems and service delivery reform should be at the center of any macroeconomic and health or similar initiative.

For example, the number of physicians per 1,000 inhabitants does seem to indicate a particularly difficult situation in terms of human resources for health in Uganda. Given the especially large need for skilled labor in the health sector, this is of course a cause for considerable concern.

In terms of some of the health related inter-sectoral indicators, it is of course a matter of some concern that the share of the Ugandan population with access to improved sanitation facilities has been reduced over the period 1990 to 2002. On the other hand, the share of people with improved water has increased substantially over the same period.

Table 6. Health care systems indicators, 1990-2003

Indicator	Country	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
ARI treatment (% of children under 5 taken to a health provider)	Uganda	..	..	..	..	..	61.40	..	..	..	..	..	66.50	..	..
	Low income	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Births attended by skilled health staff (% of total)	Uganda	..	..	..	..	..	37.80	..	..	..	..	..	39.00	..	..
	Low income	..	..	..	..	..	..	..	..	..	..	..	..	..	38.39
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..	..	38.54
Diarrhea treatment (% of children under 5 who received ORS packet)	Uganda	..	..	..	..	..	48.20	..	..	..	..	..	33.50	..	..
	Low income	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Immunization, DPT (% of children ages 12-23 months)	Uganda	45.00	49.00	53.00	56.00	60.00	59.00	57.00	56.00	54.00	54.00	58.00	61.00	72.00	81.00
	Low income	64.03	55.19	54.43	56.31	60.91	63.11	60.10	60.13	57.06	54.89	61.08	61.43	64.43	66.56
	Sub-Saharan Africa	56.67	48.69	49.14	49.10	53.66	52.55	50.24	53.35	47.57	45.20	52.05	52.40	54.53	58.69
Immunization, measles (% of children ages 12-23 months)	Uganda	52.00	54.00	56.00	57.00	59.00	57.00	55.00	54.00	53.00	57.00	61.00	63.00	77.00	82.00
	Low income	57.50	50.66	53.74	57.96	62.69	64.55	61.55	58.99	55.62	53.97	58.63	59.37	64.37	65.48
	Sub-Saharan Africa	57.10	53.48	50.20	51.17	54.60	54.20	53.92	59.19	53.26	49.08	54.87	56.08	57.45	60.77
Physicians (per 1,000 people)	Uganda	..	..	..	0.04	..	..	..	..	..	..	..	..	0.05	..
	Low income	..	..	0.51	0.44	..	..	..	..	..	..	..	..	..	..
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Access to improved sanitation (%)	Uganda	43.00	..	..	..	..	..	..	..	..	..	..	..	41.00	..
	Low income	20.43	..	..	..	..	..	..	..	..	..	..	..	35.52	..
Access to clean water (%)	Uganda	44.00	..	..	..	..	..	..	..	..	..	..	..	56.00	..
	Low income	63.62	..	..	..	..	..	..	..	..	..	..	..	74.94	..

Source: WDI, 2005. .. = not available.

2.5 Health outcomes indicators

Although several health outcomes indicators have improved in Uganda over the past two decades, the general health situation is of course still challenging. For example, acute respiratory infections and diarrhea are still common among children, and HIV-prevalence among women is higher than the regional average. Overall, though, HIV-prevalence in Uganda is lower than the regional average. Importantly, however, as has been shown in a recent study, HIV-prevalence is higher in the richest groups than in the poorest (as is the case in most heavily affected countries in the region; Mishra, 2006).

Child malnutrition is still a considerable problem in Uganda. For example, child wasting (low weight for age) is still a problem and suggest long-term implications for human development in Uganda. At the same time, child stunting (low height for age; a sign of early childhood malnutrition) in Uganda seems to have increased in the past decade.

Table 7. Selected health outcomes, 1992-2003

Indicator	Country/Region	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Female adults with HIV (% of population ages 15-49 with HIV)	Uganda	..	..	..	..	..	..	..	..	..	59.62	..	60.00
	Low income	..	..	..	..	..	..	..	..	..	41.20	..	41.12
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	57.13	..	57.32
Malnutrition prevalence, height for age (% of children under 5)	Uganda	..	..	..	38.30	..	..	..	..	..	39.10	..	..
	Low income	..	..	..	..	..	..	..	43.12	..	..	..	..
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..
Malnutrition prevalence, weight for age (% of children under 5)	Uganda	..	..	..	25.50	..	..	..	..	23.00	22.90	..	..
	Low income	..	..	..	..	..	..	..	43.72	..	..	..	..
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	..	..	..
Prevalence of HIV, total (% of population aged 15-49)	Uganda	..	..	..	..	..	..	..	..	..	5.10	..	4.10
	Low income	..	..	..	..	..	..	..	..	..	2.13	..	2.15
	Sub-Saharan Africa	..	..	..	..	..	..	..	..	..	7.31	..	7.25
Prevalence of undernourishment (% of population)	Uganda	24.00	..	..	..	..	26.00	..	..	..	..	19.00	..
	Low income	27.32	..	..	..	..	26.52	..	..	..	..	24.72	..
	Sub-Saharan Africa	31.37	..	..	..	..	35.21	..	..	..	..	31.88	..

Source: WDI, 2005.

2.6 Selected population indicators, 1990-2003

Table 8 shows a set of selected population outcome indicators. There are several important points to note. First, Uganda has significantly higher birth rates and fertility rates compared with the other countries and regions. The most recent estimates suggest that the country has a fertility rate of around 7 children per woman, which would put Uganda among the countries with the highest rates in the world. Given the strong effect that demographics and population developments have on macroeconomic growth and development, this is of course an important finding that warrants attention in a macroeconomic and health perspective.

Second, the high fertility and birth rates can partly be explained by the considerably smaller prevalence of contraceptive use in Uganda compared with other countries and regions (not shown). Third, the much lower life expectancy in Uganda than in the income group average is partly explained by the AIDS endemic which has taken a very heavy toll in life years lost throughout the SSA-region. An additional explanation for the low life expectancy in Uganda is the significantly higher child and infant mortality rates compared with other countries with similar national incomes.

Table 8. Selected population indicators, 1990-2003

Indicator	Country/Region	1990	1991	1992	1995	1996	1997	1998	1999	2000	2001	2002	2003
Birth rate, crude (per 1,000 people)	Uganda	50.32	..	50.20	..	..	47.90	..	..	..	..	44.30	43.98
	Low income	..	..	34.36	..	..	32.07	..	..	..	..	30.13	29.75
	Sub-Saharan Africa	..	..	43.32	..	..	41.30	..	..	..	..	39.25	39.07
Contraceptive prevalence (% of women ages 15-49)	Uganda	..	..	..	14.80	..	..	..	..	22.80	..	..	..
Fertility rate, total (births per woman)	Uganda	6.98	..	6.90	..	..	6.60	..	..	..	..	6.00	5.99
	Vietnam	3.62	..	3.25	2.67	..	2.40	..	..	1.90	..	1.87	1.87
	Sub-Saharan Africa	6.14	..	6.00	..	..	5.57	..	..	..	..	5.25	5.24
Life expectancy at birth, female (years)	Uganda	47.12	..	45.80	..	..	42.14	..	42.40	..	..	43.50	43.62
	Low income	56.86	..	57.31	..	..	58.64	..	..	..	..	58.95	58.94
	Sub-Saharan Africa	51.56	..	51.52	..	..	49.88	..	..	..	..	46.61	46.35
Life expectancy at birth, male (years)	Uganda	46.40	..	45.60	..	..	42.80	..	41.90	..	..	42.80	42.80
	Low income	55.55	..	56.01	..	..	57.23	..	..	..	..	57.26	57.26
	Sub-Saharan Africa	48.43	..	48.52	..	..	47.39	..	..	..	..	45.09	44.92
Life expectancy at birth, total (years)	Uganda	46.75	..	45.70	..	..	42.48	..	42.14	..	..	43.14	43.20
	Low income	56.18	..	56.63	..	..	57.91	..	..	..	..	58.08	58.08
	Sub-Saharan Africa	49.96	..	49.99	..	..	48.61	..	..	..	..	45.83	45.62
Mortality rate, infant (per 1,000 live births)	Uganda	93.00	..	..	92.00	..	..	..	..	85.00	..	..	81.00
	Low income	95.22	..	..	..	..	..	..	..	..	..	..	79.82
	Sub-Saharan Africa	109.83	..	..	..	..	..	..	..	..	..	..	101.04
Mortality rate, under-5 (per 1,000)	Uganda	160.00	..	..	156.00	..	..	..	..	145.00	..	..	140.00
	Low income	148.50	..	..	..	..	..	..	..	..	..	..	123.39
	Sub-Saharan Africa	186.98	..	..	..	..	..	..	..	..	..	..	171.15

Source: WDI, 2005.

The above discussion of the relative situation of Uganda as to the selected outcome indicators hides many important factors. For example, the distribution of poverty and health outcomes vary considerably across different parts of the country with the north-west probably coming out the worse compared with other regions. In addition, there are significant urban-rural differences in key outcome indicators. Parts of these differences are related to income and education differences, although an important factor in, for example, health service utilization is geographical distance to providers that makes it considerably more expensive to visit a provider if not sometimes impossible given the circumstances.

3. Proposal for a program on macroeconomics and health in Uganda

This section reviews the current proposal for a macroeconomics and health program in Uganda as set out in GoU (2006) and WHO (2006c). Before reviewing the proposal, a brief background is provided and it is noted that the government of Uganda has put macroeconomics and health high on the policy agenda. The section then looks at the proposal from the perspectives of coherence, relevance, realism, and content.

Partly as a response to the recommendation to set up a national CMH, the Government of Uganda (GoU) has decided to strengthen the macroeconomics and health program for health policy development and increased investments in health in the country. Specifically, the government states:

“During this financial year, the sector will strengthen the macroeconomics and health program through analysis of the links between investment in health, economic development and poverty reduction. A wider investment plan will be developed to expand the scope and scale up effective interventions into priority national health programs linked to PEAP and MDG targets. This will build on existing planning and financing framework. The key objectives of the program are analyzing links between increased investment in health and health related programmes, economic development, poverty reduction and macroeconomic framework.”

(Source: GoU, not dated, p. 48)

Over the past year or so, the government, through the Department of Planning at the Ministry of Health, has collaborated with the Office of the WHO representative for Uganda to develop a framework to concretize these intentions. The current version of the proposal is attached to this

report in Annex 3. The proposal provides a background to these plans by referring to, among other things, the CMH-report and specifically mentions the report's recommendation to set up national CMHs. More specifically, the proposal outlines the purpose, participation and organizational set-up, and the expected outcome of a National Committee on Macroeconomics and Health in Uganda (NCMH-U).

Given the fact that the current proposal is the product of several months of preparatory work, it is beyond the scope of this mission report to provide a detailed comprehensive analysis of this work. Nonetheless, as a result of reviewing the proposal, the following issues are noted. While the scope of work under a program on macroeconomics and health is inherently broad, the current proposal presents a very ambitious work program. Indeed, it contains a wide array of objectives, tasks, and steps. Moreover, it mentions an impressive number of issues and questions (such as, the links between health and economic growth and poverty reduction, provide a situation analysis, identification of priority areas, modalities for development assistance in health (DAH), among many other things) that the program should look at, each which would reasonably require substantial time, resources, and skills to assess coherently. It is furthermore difficult to appreciate exactly how the proposed Ugandan program on macroeconomics and health relate to the other key policy documents and processes. While the proposal mentions that the program activities will “build on existing efforts” (p. 10), one would assume that much of what is proposed as activities within the UCMH-U are already being done in some of those other efforts. More important, the proposal does not provide sufficiently compelling arguments for how a UCMH-U will add real value to the national health policy development process.

An additional observation that might be reconsidered by the Ugandan government is the rationale for undertaking a program on macroeconomics and health as outlined in the current proposal. While it is true that initiatives to undertake work on macroeconomics and health have been adopted by global and regional bodies, such proclamations are not a sufficient reason for doing so in any given country (in fact, they are not even necessary). Instead, any action plan to scale up work on macroeconomics and health needs to build on the specific demands for such an approach in any given country. On this point, the current proposal could provide more convincing arguments.

Section 4.4 of this report discusses additional issues and support to a national program on macroeconomics and health in Uganda.

4. Issues under review of the mission

This part of the report contains the review of the specific issues that are the subject of analysis under this mission as outlined in the Terms of References (Annex 1). The material presented in this section is based on the review of the specific documents listed in the Terms of Reference, the discussions held with key stakeholders during the mission, and on a brief assessment of other reports on health and related issues in Uganda. An important input to this work was the end-of-mission workshop that was organized by the Ministry of Health and WHO in Kampala. During the workshop, a number of subjects were discussed, one of which was the experiences of the Ghana macroeconomics and health initiative (GMHI; GoG, 2005). The experiences of that country will be further discussed in the final section of this report.

The first sub-section looks at macroeconomic issues, including health financing and economic sustainability. Sub-section 6.2 discusses the interactions between health and health related sectors. This is followed by an assessment of health and equity issues, including equity in access and outcomes. Finally, a set of additional issues that might be considered by the government in its continued efforts to implement a program on macroeconomics and health in Uganda are looked at.

4.1 Macroeconomic issues

This sub-section discusses some macroeconomic issues related to the CMH framework. The Terms of Reference specifically identifies the following two areas to be of particular relevance in the Ugandan context:

- Fiscal issues: Fiscal space, budget ceilings, budget support, and program/project support
- Monetary and debt issues: implications of debt reductions under HIPC

4.1.1 Fiscal issues: Fiscal space and stability

In some sense, the particular subjects identified under the rubric of fiscal issues all pertain to the question of whether investments in health can be increased without violating the overall macroeconomic stability of the country. Generally, macroeconomic stability refers to internal (i.e. central and local government budget balance and domestic debt burden) and external balance (i.e.

balance of payment and debt service payments to abroad) and monetary balance (i.e. inflation rate). At an overall level, health and health care might affect and be affected by any measure to achieve macroeconomic stability or failure to achieve such stability.

As shown above, the GoU finances between a quarter and a third of all health expenditures. In relation to all public expenditures, the health sector receives around 8-9%. This translates to around 2% of GDP, or approximately US\$18 per capita in 2002. While these shares are at or around the regional average or the average for the group of low-income countries to which Uganda belong, they are clearly insufficient given the high burden of disease in the country or the estimated costs for providing a basic package of health care services (estimated at around US\$28; GoU (2005b)). Clearly then, the government faces a substantial resource gap.

There are several alternatives at the government's disposal for filling this gap, each with particular drawbacks and advantages relating to the efficiency with which they can be made of use and the macroeconomic impacts they carry with them. It is beyond the scope of this report to provide a comprehensive analysis of the particular options that the GoU should use; nonetheless, some general observations might be of help.

With regard to the issue of "fiscal space", the following general observations are relevant also to the GoU.² First, in its broadest sense, fiscal space refers to the ability of the central government to provide additional budget resources for a given purpose without jeopardizing the overall public financial situation. Put differently, the government does not engage in any unfunded reforms. This suggests that the government can take certain actions to fund any given reform measure, and there are, in principle, five ways in which governments can create fiscal space:

1. Raise more revenues: taxation, fees
2. Reprioritize existing budget posts: cut "unnecessary" spending; increase technical and allocative efficiency
3. Borrow: external and/or domestic borrowing
4. Obtain grants: Development Assistance in Health (DAH)

² This section draws on Heller (2006, 2005) and Gottret and Schieber (2006).

5. Print money: seignorage

While each of these options carry with it certain implications in terms of the government's ability to make use of it or the amount of resources that can be raised, it is very much an empirical issue which set of options any particular government should exploit. It is far beyond the scope of this mission to provide any recommendations to the government as to how it should finance any increased health spending as that would require detailed analysis and knowledge of, among other things, the initial fiscal position of the government, the revenue and expenditure structure, and the nature of current debts. In the case of Uganda, the government has identified a need to raise more domestic resources. As noted above, domestic revenue in Uganda stands at around 12% of GDP (FY 2002/03; MTEF). Although it varies across countries, it has been suggested that any revenue-to-GDP ratio below 15% would seem to be below the minimum requirement (Heller, 2006, p. 75).

Regardless of the particular option that the government wishes to utilize, it would seem to be beyond doubt that, even in the medium- to long-term, Uganda will require relatively substantial inflows of DAH to finance parts of its health expenditure program. This then calls into question the modalities for those external inflows. Today part of DAH is provided in the form of budget support and part in the form of program or project support. One difficulty for the government is to capture some part of the support that is provided as project support as it is spent outside of the budget framework. It would seem a minimum condition that all donors provide the government with the necessary information so as to capture all DAH.

An additional issue that would make the aid spending more efficient is to require donors to commit themselves to providing DAH over the long haul so as to make such resources less volatile and more predictable. A requirement that the government would consider requiring from the donors is that they commit to a certain level of DAH (in some agreed upon form) up until 2015, the year the Millennium Development Goals (MDGs) are supposed to be achieved.

4.1.2 Monetary and debt issues: implications of the HIPC-initiative

The HIPC-initiative and other initiatives that build on it, call for a complete cancellation of the multi-lateral debt of the most heavily indebted poor countries, Uganda being one. The HIPC-initiative involves a two-step process where debt cancellation is conditional upon countries meeting certain

pre-specified targets. A key dimension of the HIPC-initiative is that countries should increase their “poverty-reducing expenditures”, i.e. spending on education, health, roads, and water and sanitation among other types of programs, specific to each country. Recent reviews of the effect of the HIPC-initiative show that the countries that have benefited from the initiative have been able to increase their spending on health, education, and water and sanitation and other activities that are thought to reduce poverty (IMF-IDA, 2006, Heller, 2006, World Bank-WHO, 2005).

Clearly then, the HIPC-initiative has been important in providing some “fiscal space” for the countries that have benefited from the initiative to increase spending in prioritized sectors. One advantage of this source of funding is that it is a predictable stream of resources as planned debt servicing is known for many years ahead. However, the real impact of the HIPC-initiative may not be as large as it initially seems. First, while the debts certainly constituted a significant burden on the affected countries, much of the cancelled debt was on very concessional terms involving relatively small real amounts. And second, although most of the debt service constituted a real economic burden, countries effectively financed these repayments with new loans from the multilateral agencies (Heller, 2006). In addition, while a debt cancellation does provide a country with a permanent stream of resources, it is of course only available for the duration of the debt repayment horizon, and it is a one-off measure as the debt can only be written off once.

In the case of Uganda, recent updates of the impact of the HIPC-initiative show that poverty-reducing expenditures have increased from US\$306 in 1999 to US\$915 in 2004, and it is projected that such spending will increase to US\$1,073 in 2008 (IMF/IDA, 2006). In terms poverty-reducing expenditures as a share of the total economy, it is projected that the HIPC-initiative will lead to roughly a doubling of such spending, from 5.3% to 10%. Alternatively, spending on priority sectors is projected to increase from around 40% before debt cancellation to 71% in 2008 (ibid.). Looking specifically at health spending, it was noted above that the Ugandan government has increased allocations to this sector over the past five years: from 6.7% in 1998 to 9.6% in 2002 and a further increase to around 12% in FY 2003/04. According to the discussions during this mission and the review of the available documentation, these increases have partly been due to the debt service payment reductions under the HIPC-initiative.

While it seems clear that the HIPC-initiative has provided Uganda with some much needed “fiscal space” for poverty-reducing expenditures, including spending on health and health care services, a few caveats are in order. First, it is not clear to this mission exactly how much real resources have been created as a consequence of the debt initiative, as the observed increases in health spending are surely due also to other factors than debt cancellation. Second, the debt situation of Uganda is of course far from ideal, as continued debt repayments will have to be made in the future. Also, new loans will add to the debt burden, the servicing of which will compromise any fiscal space created now. Finally, and related to the above, while the external debt position of Uganda has clearly improved, the domestic debt burden has increased and the service of that debt is now larger than that of the external debt. All of these factors have an impact on the fiscal space of the government and its ability to finance priority sectors, including that of health.

4.2 Integration of health and health related services

The issue of integration of health and health related services is apparent in health economics since inputs in the production of health are not restricted to *health care* inputs but rather to all inputs that relate to health irrespective of which sector of the economy these inputs belong to, e.g., water and sanitation, agriculture, communication and transport, and education. The issue is how much health and other benefits that would be the result of a given investment and in comparison to alternatives. Thus there is no doubt that coordination and planning across sectors are important in order to achieve improved efficiency in the allocation of resources both between sectors and within sectors. The problem, however, is that the health sector and other sectors may work more or less independently from each other which may lead to sub-optimization in use of resources, e.g., that less health outcomes are obtained than what is possible with the given amount of total resources.

In HSSP I some collaborative initiatives were tried between health and agriculture, education, water, gender etc. and in HSSP II, it is stated that the formed partnerships in the earlier plan will be strengthened. It is also pointed out that similar effort will be given to building partnership for improving nutrition, gender sensitivity, and in humanitarian assistance to internally displaced persons and refugees. In the Water Sector Strategic Investment Plan 2004-2015 (p.12), it appears from the strategic actions a integrated approach in which MoH together with MWLE and MoES signed a Memorandum of Understanding on Ministerial Responsibilities for Sanitation/Hygiene Promotion Activities in December 2001. It is unclear, however, whether this integrated approach will work in

practice and to what extent this will lead to improved efficiency, i.e., to get this work function, interventions in the health sector and other sectors needs to be considered and compared with each other with regard to costs and benefits. Exactly how this will be done is not discussed, for example, in the Water Sector Strategic Investment Plan.³

4.3 Equitable access to health care

This subsection provides a discussion of equity in health and recent time trends in Uganda. Beyond this we also give some comments on availability of data and future analyses. Much of the discussion below is based on relevant documents and a few scientific papers, which have been reviewed by us, especially World Bank (2004), from which relevant data have been taken. Although these data are not new, they represent the most up to date figures available for Uganda. The discussion of recent trends in equity in health in Uganda is of particular interest since user fees in public services was abolished in year 2001 and in recent years geographical access to health services have been improved in average for the Ugandan population, i.e. the proportion of people living within 5 km of a health facility have increased from 49 percent in 1999 to 72 percent in 2002/03. Both these changes may raise utilization of health services and may have favorable effects on inequalities in health outcomes. Other policies were also implemented during the same time period and that may also affect health, for example, the pentavalent vaccine was introduced in the expanded Program on Immunization and National and sub National Immunization Days were held for polio, measles and tetanus (HSSP II).

Equity in health can be looked at from many different angles: equity in financing of health care, equity in delivery of health care and inequalities in health outcomes. These concepts consider the distributive burden of financing, utilization of health care and health outcomes over different segments of the population. Equity in financing is not only an objective in its own right, but is intimately connected with the evaluation of the delivery and supply of health care system. Equity in delivery of health care is also not only an important objective in itself but is further an objective for alleviating poverty, i.e. provision of basic health services may be an important mechanism for mitigating poverty in a country. Health outcomes are affected by health services but are also dependent on initial endowments, such as genetics, and proximate determinants of health, such as safe water and sanitation, and distal factors, such as income and education. These distributional

³ As this is the only sector plan that was made available to the authors, the analysis is limited to this sector. The main points would, however, be relevant also for other sectors.

aspects can be studied along various dimensions of the population, e.g., socioeconomic groups, areas, gender (see Wagstaff and Van Doorslaer, 2000 for a discussion of equity in health). Below distribution of health care financing, health care utilization and health outcomes are discussed.

4.3.1 Distribution of user fees over socioeconomic groups

In Tables 9 and 10 annual per capita household spending on health care 2002/03 and 1999, respectively, are shown in total and disaggregated form on different quintiles of expenditures and is also disaggregated by type of spending. First, it appears, surprisingly, that household health care spending in total has increased between 1999 and 2002/03, i.e. after the fees in public facilities was abolished, total user fees increased by 4 percent in Uganda which is due to a contemporary shift from public to private providers during the period (see below). Second, and less surprisingly, the relative change in spending over the period varies substantially over socioeconomic expenditure quintiles. In the two poorest quintiles per capita household spending were reduced by about 47 percent while in the richest quintile spending increased by 98 percent. Most of the household spending was for drugs and hospital/clinic charges which together accounted for about half of total health care spending. In the poorest quintile spending were reduced by 40 percent and 60 percent, respectively, for drug and hospital/clinic charges while this increased in the richest quintile by 133 percent and 67 percent, respectively. It appears, therefore, that user fees are still a very large source of financing for health care in Uganda but that the financial burden of health care has been increasingly concentrated to richer households as was one intention of the Ugandan user fee policy.

Table 9. Annual per capita household expenditure on health care in 2002/03 (in 1999 Ugandan Shillings)

Variable	Consultation fees	Drugs	Hospital/clinic charges	Traditional doctors	Others	Total
<i>Expenditure quintiles</i>						
Poorest 20%	183.8	2020.9	1246.8	92.7	40.7	3585.0
2 nd quintile	276.3	2949.8	2127.1	181.3	13.5	5547.6
Middle	624.7	5227.5	3615.2	394.7	36.0	9898.0
4 th quintile	785.7	7405.8	7339.7	394.5	166.0	16091.7
Richest 20%	2490.6	19510.5	19188.0	4868.8	67.5	46125.4
<i>Residence</i>						
Rural	849.1	6550.1	5637.0	1284.3	60.0	14380.6
Urban	982.7	11646.8	11866.5	707.3	87.4	25290.8
Average	871.9	7420.7	8107.3	1185.8	64.7	16244.2

Source: World Bank (2004).

Health care spending increased for both rural and urban areas but relatively more for urban areas which can be explained mainly by that rich people are localized to a higher extend in urban areas. We note that available figures do not consider the potential role of informal user fees which patients may have to pay in order to receive proper health services and other costs that may prevent people to visit health facilities when they are in need, e.g., time costs and travel costs. These costs have been reduced in average of the population since geographical access has been improved in Uganda. However, in the 2002 National Household Survey (NHS), it was found that 46 percent in the poorest quintile still reported distance as a constraining factor for seeking health services as compared with only 25 percent in the richest quintile (World Bank 2004, p.xiv).

Table 10. Annual per capita household expenditure on health care in 1999

Variable	Consultation fees	Drugs	Hospital/clinic charges	Traditional doctors	Others	Total
<i>Expenditure quintiles</i>						
Poorest 20%	177.5	3364.0	3094.8	111.6	10.5	6758.4
2 nd quintile	470.9	3674.7	6013.3	262.4	29.3	10450.6
Middle	255.9	4360.2	6640.1	326.5	14.5	11597.1
4 th quintile	314.6	5705.4	8394.7	644.0	218.3	15277.0
Richest 20%	2057.2	8368.6	11470.6	1178.8	210.7	23285.9
<i>Residence</i>						
Rural	467.0	5117.5	7664.3	718.0	107.5	14074.2
Urban	3194.0	9283.6	10479.5	256.5	227.0	23440.6
Average	896.1	5773.1	8107.3	654.4	126.3	15548.2

Source: World Bank (2004).

4.3.2 Distribution of health care and health over socioeconomic groups

Tables 11 and 12, respectively, report proportions of the Ugandan population that do *not* use any health care and the proportions that *do* use some health services, and where the latter is divided into public services and private (for-profit or not-for profit) services, or others, and disaggregated on household expenditure quintiles (as a measure of income) and residence in rural or urban areas. The results show that there is a clear socioeconomic gradient in “no use” of health services. In the poorest category 27.2 percent reported in 2002/03 that they did not use any health care. This percentage reduces gradually from quintile to quintile and in the richest quintile the corresponding figure is 16 percent. However between 1999 and 2002/03, the reported figure of “no users” have been reduced in all quintiles and the reduction are relatively larger in the poorest quintile in which the proportion of “no users” reduced from 45.1 percent in 1999 to 27.2 in 2002/03, i.e. a decrease by 18

percentage points. The corresponding reduction in the richest quintile was 9 percentage points (from 25.5 percent to 16 percent).

Table 11. Trends in utilization of public and private facilities in 2002/03

Variable	None	Public	Private	Others
<i>Expenditure quintiles</i>				
Poorest 20%	27.2	32.0	40.7	0.1
2 nd quintile	21.4	28.0	50.2	0.5
Middle	18.0	24.7	57.3	0.1
4 th quintile	15.7	21.1	62.6	0.6
Richest 20%	16.0	16.3	67.0	0.7
<i>Residence</i>				
Rural	19.9	25.4	54.2	0.4
Urban	16.4	15.3	67.9	0.4
Average	19.4	24.1	56.1	0.4

Source: World Bank (2004).

Another important change that took place during the period was that the percentage that used public services increased, as expected, in the poorest quintile, i.e. by 9 percentage points (from 23.4 percent to 32 percent), although in the richest quintile use in public services dropped by 7 percentage points (from 23.3 percent to 16.3 percent) while increased by 17 percentage points (from 50 percent to 67 percent) in private services.

Table 12. Trends in utilization of public and private facilities in 1999

Variable	None	Public	Private	Others
<i>Expenditure quintiles</i>				
Poorest 20%	45.1	23.4	29.3	2.1
2 nd quintile	38.6	21.5	38.3	1.6
Middle	31.0	23.8	43.8	1.4
4 th quintile	28.2	24.2	45.9	1.8
Richest 20%	25.5	23.3	50.0	1.3
<i>Residence</i>				
Rural	31.4	24.4	42.6	1.6
Urban	24.0	16.3	58.8	0.9
Average	30.5	23.4	44.6	1.5

Source: World Bank (2004).

Thus there is a significant shift in the richest quintile from public services to private services when poor people increased their utilization of public health services. Interestingly, however, utilization of private services increased in all quintiles including the poorest quintile and, in fact, the increase was relatively larger in private services than in public services in the poorest quintile, i.e. 11 percentage points in private services versus 9 percentage points in public services.

According to the above figures, it appears that the distribution of health services has become more pro-poor in 2002/03 than in 1999 since non users of health care reduced more among poorer groups than in richer groups. It is important however to explain why especially rich people, but also other quintiles, shift from public services to private services when user fees on public services was abolished. Although available data is not rich enough to explore this issue, one possible explanation is that demand for public services increased far more than supply of public services which may lower quality in terms of increased waiting times to meet health care personal and/or underprovision of supplies and material, etc. According to the World Bank (2004, p. 133), the increased budget to the health sector was not sufficient to offset the income loss due to removal of user fees nor was the allocation sufficient to meet the increased utilization. This may also lead to dynamic problems in that informal fees may increase if this resource gap is not diminished over time.

A second potential explanation, especially among poorer quintiles, is that the demand for private services increases as a result of an income effect, i.e. when user fees in public services were eliminated, peoples real income was increased which in turn may raise demand for private services which may appear as a complementary good to public services. Along this line of reasoning, demand for other health related goods may also be influenced by this income effect, for example, demand for better nourishment and education. It cannot be ruled out, however, that also demands for “bads” (goods which have negative impacts on health) may increase, e.g., alcohol, cigarette smoking and other drugs when people gets “richer”. The total effect on health depends finally on the relative size of the income elasticities of these health related goods. Further, that richer people use more private services than poorer people makes that inequity in health care may be larger than what can be read directly from the figures above, i.e. since private services may be of higher quality in some sense than public services, but as was noted above not very much information are available on this. A third explanation to the increases in public and private services, especially for the poor is reduced time prices, i.e. a key factor in the demand for health care services is the geographic proximity to health

services. In a study by Reinnika and Svensson (2003), it was shown that proximity to health services was the most important factors affecting the decision to seek care in a government facility.

In the future, more studies needs to be performed on how quality of care may have changed over time, i.e. waiting times, staff availability or access to other health care inputs, and to study care-seeking behavior of individuals (households). Nabyonga et al. (2005) report positive effects on socioeconomic differences in health care utilization and with respect to quality of care they find that their were fewer drug stock-outs in 2002 compared with 2000 and 2001 but there was no deterioration of other quality indicators such as cleanliness, compound maintenance and staff availability. However, more studies are needed on this since it may be expected that the positive effect of user fees on use of health care may be weaker for very poor people as a result of that other care seeking factors becomes more important for this group, for example, travel costs or opportunity costs of time (reduced labor incomes). See also World Bank (2004, p.124ff) for further references.

Little evidence exists on the effects of the abolition of user fees for public health services on health outcomes. In a recent paper, however, Deininger and Mpunga (2004) used facility level administrative data and DHS data for Uganda 1999/2000 and 2002/03 in order to explore the impact of the user fee policy on different groups' ability to access health services and morbidity outcomes. They find that the abolition of user fees significantly improved access to health services especially by the poor and also that the incidence of morbidity was reduced.

4.3.3 Specific aspects relevant in the Ugandan equality of health

Data

A basic issue is to develop survey data systematically which are rich in health information and include most of the important behavioral variables of the individual like incomes and prices of health goods (monetary costs including informal fees, time costs, travel costs, quality information of health facilities) and that also include background characteristics, such as education and family variables. Many of these variables are already collected in existing surveys but not all required understanding differences in health and health care consumption over socioeconomic groups. For example, existing survey data no not provide enough data to assess the reasons behind the substantial decrease of nonusers and the shift from public services to private services. The data should also be collected at a regular basis with as short time interval as possible to facilitate monitoring of the health sector.

Further, it is important to build up these sets in long term and by longitudinal data and experimental data which are essential in the analysis of causal effects of variables of interest and policy measures as is currently planned by Uganda Bureau of Statistics (UBOS), i.e. longitudinal data are able to control for many empirical problems, such as heterogeneity, reversed causality, selection issues, which all, if they are not taken care of, may lead serious bias in the effects of interest. It is also vital to work strategically both in developing data and implementing policy programs. All programs should be implemented with an explicit intention of being evaluated, especially with regard to economic evaluations.

Analytical methods

It is important that the collected data are exploited by competent researchers using appropriate methods, such as impact evaluations, panel data analysis and instrumental variable techniques, in the analysis of health determinants, health investments and health programs. The advantage of these methods is that they account for unobserved heterogeneity, reversed causality etc.. There are also new methods in analyzing the factors that contribute to measured inequalities in health. For example, by which one may analyze the impact of prevalence of tuberculosis, and other factors, on inequalities in five-year adult mortality rate. The importance of tuberculosis on inequalities in mortality depends in this case on the effect of tuberculosis on mortality risk but also on the distribution of tuberculosis prevalence in the population. This kind of analysis indicates the effectiveness of different potential health programs specifically on inequalities in health.

Economic evaluations

An important aspect of the above mentioned strategic implementation is a stepwise procedure in which new health programs are implemented in a small scale with controls and careful studies before full scale implementation. These pilots may then be used in predicting costs and consequences of implementing the program in full scale in a way that cost-effectiveness of program's or package of complementary program's could be discussed.

4.4 Additional Support

In Section 3, the potential role of a national commission on macroeconomics and health was discussed. It was emphasized that the introduction of such a program needs to be conducted in such a way that real value added is provided to the policy development process, and that it should not be

allowed to merely layer-on to the existing structure. The section also looked briefly at the current Ugandan policy development process. Furthermore, Section 4 above reviewed the current proposal of the government of Uganda for a program on macroeconomics and health. It was noted that the proposal identifies a large number of issues that would seem to be central for the further development of the health sector of the country, and that it also describes the organization of the program. This section reflects further on the proposal and based on what this mission has found, it identifies a set of key issues that the Ugandan program on macroeconomics and health might want to focus on.

In terms of organization, this mission largely supports the set up of the Ugandan national program on macroeconomics and health as described in the proposal. The emphasis should be on high-level support and on creating an efficient body for policy discussions based on sound evidence and analysis of what works in Uganda, what doesn't, and why.

With regard to content, this mission advises the MoH and other stakeholders to focus on a limited set of prioritized issues and areas of strategic importance for the further improvement of health outcomes in Uganda and the contribution of health to economic development and growth. Thus, based on the reflections during the mission, a national program on macroeconomics and health in Uganda might usefully focus on the following issues.

1. Inter-sectoral issues: water and sanitation, nutrition, and education
2. Demographic and population issues: family planning, fertility rates
3. Evidence-based policy development: systematic use of high quality analyses
4. Implementation and learning: strategic implementation of programs and systematic use of impact evaluations

As can be seen, the issues and areas above refer to both content and methodology. Importantly, the list should not be seen as exhaustive in any way and may be subject to further discussions. The items do, however, reflect what can be seen as issues of fundamental importance for the further development of the health sector and improvements in the health of the Ugandan population. In particular, the inter-sectoral issues and the demographics and population issues are of critical importance for the further macroeconomic development of the country, both in the medium- and in

the long-term. As is well known, health outcomes are determined by many factors several of which are outside of the domain of the health sector itself. This, then, brings to the fore the question of what is the role of the health professional regarding these non-health sector effects on health outcomes. Although this is admittedly a complex issue, it has been suggested that at the very minimum, the health community should measure these effects and ensure that these issues are effectively communicated to the pertinent actors, be they other sector ministries or the central planning and financing ministry in the country. In a low-income environment with already highly constrained health systems, the capacity for such analysis and communication is of course limited. Given these resource limitations, priorities will necessarily have to be made and it would thus make much sense for the health sector to focus on its own actions and make sure that resources are efficiently utilized within the sector.

The current population of Uganda is approximately 27 million people. Given the high fertility rate of the country – at around 7 children per women – and the expected death rate (between 14 and 16 per 1,000 people) the population is projected to increase to around 36 million people by 2015 and 41 million five years later. There are at least two points to note in this regard. The first is that the high fertility rate puts a high pressure on women and families and is in itself an important health risk. For example, the lifetime risk of maternal mortality in Uganda is estimated at 1 in 13 (or, equivalently, one woman in 13 dies during pregnancy or childbirth; Save the Children, 2006). Bringing down fertility rates in Uganda would most likely lead to significant health benefits, not least to women and small children.

The second point about the demographics and population developments in Uganda is that the rapid population growth will put immense pressure on the available resources and only very high rates of economic growth will contribute to real improvements for every Ugandan. In addition, the long-term implications of the maternal and newborn ill health associated with very high rates of fertility are significant in that it will reduce the level and quality of human capital in the country. As discussed in section 3.1, such reductions will lead to impaired socioeconomic development and ultimately in reduced economic growth.

The point about developing evidence-based policies refer to the desire to base policy decisions related to, for example, health financing options, inter-sectoral allocation of resources, and other

development interventions, on a systematic assessment of the particular circumstances in Uganda. Knowing as exactly as possible what works in the particular context will, thus, be the point of departure for any subsequent policy discussion. Developing evidence-based policies should not, however, be taken too stringently; few if any policy in any country is introduced solely on the basis of qualitative or quantitative evidence as produced by analysts. It should, though, be the task of the relevant actors to provide such evidence to the policy decision makers when asked to do so, although the final outcome of the process may be influenced also by other “non-evidence” considerations.

The issue about implementing policies strategically refers to the alternative ways in which governments can introduce their programs. For example, a particular program can be introduced in a particular geographic area, and before rolling-out the program at the national level, the program is evaluated by means of appropriate methods. Moreover, the program can be introduced in an experimental or a non-experimental fashion, where the former method would allow for evaluation methods that, under certain conditions, may provide better evidence of the impact of the particular program.

In addition to the above specific issues and areas of relevance, a national program on macroeconomics and health would need to pursue any discussions on scaling-up the investments in health and health related sectors within the given overall economic framework. Specifically, any discussion on health sector reform needs to be broached with a clear view on the financing requirements that such investments would entail, also in the long-term. Such discussions should suitably be conducted within a broad over arching body with the relevant perspective on sectoral allocations of resources for maximum impact, such as that of the MoFPED and the NPA.

5. Findings and discussion

This section of the report discusses the main findings of the mission, with a particular focus on the overall macroeconomic and health developments of Uganda. It then briefly discusses the find implications for the continuation of the macroeconomics and health process of Uganda.

5.1 Main findings

5.1.1 Macroeconomic developments

Uganda has experienced relatively strong economic growth in the past decade or so, surpassing the regional average by some margin. This growth has been important for the reductions in poverty that has been achieved during the same period. Moreover, the country has performed sufficiently well to qualify for extensive reductions and cancellations of the foreign debt to multilateral institutions under the HIPC-initiative. The combined effect of strong economic growth and reduced debt servicing has provided the fiscal space for the Ugandan government to increase spending in health and other sectors. Despite these achievements, a critical point is clearly the insufficient resources available to the government for scaling-up investments in health and related sectors. A priority issue for the government is, thus, to increase the share of government revenue to GDP by improving its revenue raising capacity. Although such measures are critically important, Uganda will continue to be dependent on external resources for some time to come.

5.1.2 Health and health related developments

The increased investments in the social sectors – of fundamental importance for sustained economic development and prosperity – have contributed to improvements in several health and health related outcomes. By and large, these investments have been based on well developed policies that outline the strategy of the government to achieve its economic and social aims, including sustained economic growth, broad based poverty reductions, and increased social and human development.

Notwithstanding these achievements, the government faces many challenges that will most likely require enhanced policy development strategies. The comparatively high fertility rates will lead to strong macroeconomic effects through the demographic changes that will affect the population structure. The financial constraints of the government will require careful analysis of the most cost-effective approaches to scaling-up investments that will improve the health of the poorest sections of society. Related to this is the question of technical efficiency. For example, it is noted that around half of all government health spending is for administration (WB, 2004a). Although it is unknown to this mission exactly how this measure has been estimated, it would seem to be on the high end. Indeed, a recent review of the Ugandan health sector observes the scope for increased efficiency in the health sector (WB, 2004b).

5.2 Discussion

From the perspective of macroeconomics and health, this report has highlighted a number of important issues that may facilitate the future process of implementing a national program on macroeconomics and health in Uganda. The most important of these is the relatively high attention that policy makers pay to the issues that may usefully be discussed within such a program, including macroeconomic stability and the implications to the health and other sectors of the macroeconomic targets, the inter-sectoral implications for health outcomes, and the need for evidence-based policy making.

In addition to these issues, the mission also emphasizes the relative urgency for addressing the demographics and population issues that will arise when Uganda transitions from a high-fertility high-mortality to a high-fertility low-mortality society as the country manages to effectively tackle the major health threats. Such a demographic transition will have a strong macroeconomic impact.

In terms of effective policy making, Uganda is no exception from most low-income countries; it is in an excessively compromised situation both in terms of policy options and with regard to own resources. The MDGs and the fact that a significant share of spending in the health sector is from DAH puts significant pressure on the policy development process. A well prepared program on macroeconomics and health may be an effective tool for the government in aligning many of the challenges facing the health sector and contribute to a coherent set of prioritized initiatives.

Regarding the feasibility of a national program on macroeconomics and health in Uganda, this mission emphasizes the importance of the high-level of support that the initiative has received. The endorsement of the initiative from the President of the Republic (at the JRM in October, 2005) strengthens the case for implementing the program and greatly enhances the scope for its successful impact on the future health and health related development actions. Furthermore, bringing in, for example, the National Planning Authority (NPA) in the process would also provide an important link to the national Assembly, not least from an advocacy perspective, in addition to the technical competence that such an agency would bring to the process.

6. Recommendations

Based on what has been found during the mission, and on what has been put forward in the key policy documents reviewed within the scope of this mission, the following general recommendations are made:⁴

- Use the NCMH-U strategically by focusing on a well-prepared set of priority issues
- Focus on adding real value to the policy development process and discussions
- Emphasize quality in policy analysis
- Make the institutional and organizational framework of the NCMH-U effective in terms of process and scope
- Bring in stakeholders that can add value and quality to the policy discussions

The following issues and areas might be useful to focus on in a NCMH-U:

1. Inter-sectoral allocations for health and expected returns
2. Demographics and population issues
3. Evidence-based policy development and analysis
4. Strategic implementation of policies and impact evaluation

The rationale for these issues and areas was discussed in sub-section 5.4 above. It was emphasized that the list should be seen as non-exhaustive and subject to further discussions. In terms of specific analytical questions and areas of particular importance, these will have to be identified by the program in its early steps. The following is a list of such questions and issues that might be considered by a national program on macroeconomics and health in Uganda:

Inter-sectoral issues:

- What are the health returns to investments in other sectors?
- Which interventions provide the most benefit (in terms of health and other outcomes) for given costs?

⁴ Also see WHO (2006c) for more details on the issues discussed during the mission.

Equity issues:

- What is the effectiveness of different policies on equity in health care?
- What is the effectiveness of different policies on inequalities in health?

Demographics and population issues:

- What determines fertility choice in Uganda?
- Which interventions work for affecting fertility choice in Uganda?

Evidence-based policy making:

- What is the poverty quantitative impact of health care utilization in Uganda?
- What was the impact of the abolition of user fees for the very poorest segments of the population?
- What determines the pattern of health care seeking behavior in Uganda?
- What are the most cost-effective health interventions in the Ugandan context?
- What is the role of DAH in health policy making and in program implementation?
- What is the impact on health and health behaviors of specific fiscal policies in Uganda?

Strategic implementation of programs:

- What data are needed for evaluating the impact of various government interventions that affect health and health care behavior?
- What management and institutional capacities are needed for strategic implementation of programs?

It is emphasized that this list is merely based on what might generally be considered as relevant in a low-income setting; the exact specification of the research questions (and their analysis) will have to be further discussed within the NCMH-U.

6.1 The Way Forward

Based on the above and the experiences of other countries such as Ghana in implementing NCMH, the mission recommends **two alternative approaches** – an independent committee or an integrated “task-force” – that the government might consider in the proceeding efforts to develop the national program on macroeconomics and health in Uganda. These approaches build on what is outlined in the current version of the proposal for a macroeconomics and health program in Uganda. In particular, the overall organizational setup might profitably be further developed when considering

the next steps. Moreover, the mission emphasizes the importance of harnessing the experiences of the current WHO-WR from the GMHI; such first hand knowledge of the NCMH process is likely to be highly beneficial to the Ugandan government's own efforts. Finally, the mission strongly emphasizes the need to look at the macroeconomics and health approach as an integrated part of policy development regardless of the particular organizational set-up that is opted for. Unless care is taken to adhere to the overall policy environment, any such initiative may be counterproductive and lead to making the policy development process more inefficient.

6.1.1 An independent committee on macroeconomics and health in Uganda

The first alternative is to organize a separate and independent body that brings in all relevant stakeholders. This body should be co-chaired by high-level representatives of the ministries of, respectively, Health and Financing, Planning, and Economic Development. It should be charged with a specific set of tasks and report regularly to the Office of the PM (or, alternatively, to the Parliament). The advantage of this approach is the ability to achieve the necessary high level support for the initiative, while it may risk add another layer on the current process without due real value added to it.

6.1.2 An Integrated Task Force within the Current Policy Development Structure

Alternatively, the GoU might want to consider an integrated approach where a special task-force within the current policy development structure is set up with similar tasks, but that report to the respective Sector Working Groups, i.e. for health, and other health related sectors as identified by the pertinent stakeholders. The task-force should contain high-level representatives of the MoFPED and the NPA, and also report to these agencies. This approach would reduce the risk associated with the first approach, but at the same time miss-out on the opportunity for high level and inter-sectoral support that this program would require.

6.1.3 Key issues for optimal impact

The current proposal for the national program on macroeconomics and health outlines the overall organizational framework for the program. This part of the report highlights some related issues, including roles and responsibilities for ensuring that the impact of any macroeconomics health initiative is fully utilized. First, the program should aim at having a core group of competent technical staff organized in a CMH-Technical Team (CMH-TT). Although the exact number of people to be

included in this Team may be further discussed, it would most likely be beneficial to the efficiency of the work of the Team to be limited to around eight to ten people. In addition, the CMH-TT representatives should be drawn from the associated Technical Working Groups (TWG) that would be charged with a particular set of analytical tasks, including health, health related investments, demographics, and innovative implementation of programs. In terms of scope of work and relation to other existing bodies, it would be important that this core group is allowed to work independently from undue political or other interests and to make recommendations from a broad range of perspectives.

Related to the TT and TWGs is the Advisory Committee (AC) that would be charged with the general guidance and oversight of the work conducted in the respective working groups and in the Technical Team. The key role of the AC would be to provide the necessary link from the technical work to the policy contexts. Indeed, such feedback needs to be allowed to run in both directions. Importantly, the TT would be responsible for reporting on a regular basis to the AC on the progress of the various Technical Working Groups (see below for the time frame of the work). Finally, the AC (or, alternatively, the TT) might want to consider bringing in some external technical advisory services as deemed necessary. Ideally, such support should be a combination of national and international expertise in health, economic and poverty analysis for maximum impact.

In terms of overall responsibility of the output of the NCMH-U and the related processes, it is the strong recommendation of the mission that this be shared equally between the core policy making bodies: the Ministry of Health and the Ministry of Finance, Planning and Economic Development at the very least, and if deemed appropriately, other line ministries with a strong interest and capacity to contribute to the process. If possible and deemed acceptable, the government might consider providing the national parliament with a consultative role to ensure national interest and impact of the work of the NCMH-U.

6.1.4 Time frame and resource requirements

Regardless of the particular option that the government of Uganda chooses to implement the program on macroeconomics and health, it would seem pertinent that it adopts a long-term perspective on the work of such a program. This mission would thus recommend that the program be incrementally implemented over a five year period, during which a series of inter-linking steps are

taken with the view of developing carefully prepared evidence-based investment plans for health improvements. Specifically, the process involves the following parts:

Table 13. Time frame and steps for the implementation of NCMH-U

Part	Time frame	Purpose	Outcome
1. Preparations	6-12 months	Development of the overall scope of work and identification of specific analytical issues	- Scope of Work for AC - Action Plan for TT - Terms of References for TWGs
2. Analysis	6-9 months	Quantitative and qualitative analysis of identified issues	A set of stand-alone analytical reports
3. Dissemination and Discussion	3 months	Presentation of findings; obtain broad understanding of situation and policy implications	A Consensus document for health and development investment plan
4. Development of health investment plan	6 months		An evidence-based health and development investment plan
5. Implementation	24-36 months	Implementation of health and development investment plan	

It is emphasized that any of the identified actions need to build on existing structures and processes, including the sector working groups and monitoring and evaluation institutions like the government's special agency for M&E. It is thus expected that the macroeconomics and health program will develop evidence-based policy documents that will guide the further development of the health and related sectors. After the initial period, a decision should be taken, based on a broad discussion of the outcome of the first period, on the next steps. Although it is well understood that any increased investments for improved health will need to be looked at over the long-term, applying an incremental approach will most likely facilitate the actual implementation of the program.

In terms of resources required for implementing a broad program on macroeconomics and health in Uganda, the mission estimates that approximately US\$300,000 would cover the costs for the work period.⁵ This sum would include the costs for organizational arrangements, analytical work, and any external technical input that may be required. It is emphasized that the program would most likely require very high quality input from experts in various fields, such as public health, epidemiology,

⁵ It is emphasized that these estimates need to be made by the responsible stakeholders as this mission does not have sufficient information to make more than a general cost estimate.

health economics, economics, and methodologies. Specifically, the sum would cover the cost for the following categories of human resource inputs:

- Managerial support: 2-4 persons from MoH, MoFPED, NPA, and other line-ministries
- Principal analysts: 2-4 persons with economics, health, and other necessary expertise
- Assistant analysts: 2 persons
- Administrative support: 2 persons
- TA/Consultant support: 2-4 persons for various time periods as needed

In addition, the sum would cover the necessary implementation and dissemination costs associated with the program. Given the ad-hoc nature of a national commission on macroeconomics and health, it would seem appropriate that the resources for this program be raised from external sources.

6.1.5 Expected output

A national program on macroeconomics and health in Uganda should aim at developing an evidence-based long-term investment plan for health and health related interventions. As has been emphasized above, one of the most important components of such a plan would be the rigorous analysis for which investments are most cost-effective and thereby provide the most value for money in terms of health improvements. Provided that the plan is stringently developed, it will be an important tool for advocacy for enhanced investments for health, improve resource allocation, and increase funding effectiveness, including that of DAH. Importantly, the plan will provide up-to-date and context relevant evidence of what works in Uganda for improving health, what doesn't, and why.

In addition, the development of such an investment plan will provide the opportunity for the systematic training and practice in analyzing government interventions. It is likely that such training will be of high value in itself, and moreover, be of even higher importance in the future as demand for such analysis is likely to increase.

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Annex 1: Terms of Reference

TERMS OF REFERENCE FOR EXPERTS TO SUPPORT MACROECONOMICS AND HEALTH IN UGANDA

1. Background

The goal of the Macroeconomics and Health (MH) approach is to promote increased and more effective investments in health and health related sectors in low and middle-income countries to achieve sustainable and equitable outcomes for the health of the poor. The focus is to strengthening efforts by the government to complete the process of preparation of health investment plans in support of the Millennium Development Goals.

MH Uganda intends to use the expert to provide technical assistance within the context of the Health Sector Strategic Plan (HSSP II) and health related sector plans.

2. The expertise

The MH work entails two distinct sub-disciplines of economics: macroeconomics and health economics. While both are based on the general theories and principles of economics, they each require distinct knowledge and experience for each sub-discipline. Consequently, it has been suggested that Professor Ulf Gerdtham and Dr Björn Ekman, both at Lund University, jointly carry out MH support to Uganda. Ulf Gerdtham is professor of health economics with solid background in, among other things, health financing and health equity, while Björn Ekman has a PhD in economics with a major in health financing in low- and middle-income countries and with extensive background in macroeconomics and poverty analysis. It is expected that the two will be able to cover all relevant fields within macroeconomics and health through complementary and joint areas of expertise. The overall areas of responsibility for Ulf Gerdtham and Björn Ekman are, respectively, health economics and financing and macroeconomics and health financing. The two experts will work together with a local consultant with expertise in macroeconomics.

3. Mission objectives

- To assess the specific country situation relevant to the development of a macroeconomics and health programme;
- Facilitate the establishment of an institutional framework for national MH interventions;

- Facilitate dissemination and discussion on MH preliminary findings among major stakeholders.

4. Priority areas of focus

4.1 Macroeconomic issues

Efforts to increase health sector funding have been hampered by the country macro-economic policies. Subsequently the two experts will:

- Examination of the macro-economic framework, constraints and opportunities for the health sector: fiscal space, sector ceilings and implications of direct budget support and project funding; and
- Examine the impact of HIPC on health sector funding.

4.2 Integration of health and health related services

It is well acknowledged that improvement of health outcomes is a multi-sectoral responsibility. This must be delivered with in an agreed framework on interventions contributing to health to be delivered by the relevant sectors. In this regard, the experts shall:

- Review health related sector plans and interventions (education, water, sanitation and nutrition);
- Assess the level of dialogue and consultations between health and health related sectors;
- Assess how the health sector harnesses synergies of relevant sectors to improve health outcomes.

4.3 Equitable access to health care

The experts shall review available data in relevant ministries, major donors, selected NGOs, research institutes, and other organizations to assess:

- Current patterns of resource allocation, health outcomes and potential for improvements;
- Identify if the information in Uganda is sufficient for better pro-poor planning (disaggregated data on health information, resource allocation and poverty at the district level).

4.4 Additional support

The experts shall identify additional support needed for macroeconomics and health strategy.

5. Supervision

The supervision of the consultants will be carried out by the Dr. Francis Runumi, Commissioner of Planning on behalf of Dr. Sam Zaramba, Director General Health Services, MOH.

6. Documents to be reviewed

The experts shall, but not be limited to, review the following documents:

- Poverty Eradication Action Plan;

- United Nations Development Assistance Framework;
- National Health Policy;
- Health Sector Strategic Plan I;
- Health Sector Strategic Plan II;
- Annual Health Sector Performance Report, FY 2004/2005;
- Human Resource Policy;
- National Strategic Plan on Drugs;
- Macro Economic Reports; and
- Country Proposal on Macro-Economics and Health.

7. Expected outcomes

The key final product from the overall expertise is expected to be a report covering a situational analysis with focus on the priority areas and identification of information gaps for pro-poor and intersectoral planning. The report will also provide a basis to explore development partners' interest in funding or co-funding the country process based on an agreed upon country MH proposal.

The consultants are to make recommendations to the Health Sector on options to further support a sustainable MH process within the overall health sector reform framework of the country. The consultants are also expected to provide input into the MH plan of action and provide recommendations for the roles and responsibilities of relevant stakeholders in the health sector. The consultants are to make a de-briefing to health sector stakeholders.

8. Time plan

The consultants will be in place in Uganda from 5th – 14th June 2006.

The consultants shall make presentation of their preliminary findings in a stakeholder's workshop on the 13th of June 2006.

The final report including key issues and recommendations on the way forward is to be submitted to the MOH, not later than 3 weeks after the completion of the mission.

Annex 2: Meetings during the mission

Date	Organization/Individual	Comment
June 5, 2006	WHO-Uganda	Representative of Ministry of Health and Ministry of Finance, Planning and Economic Development
June 5, 2006	Ministry of Health, Dep. of Planning	
June 6, 2006	Ministry of Finance, Planning and Economic Development (MOFPED)	
June 8, 2006	Uganda Bureau of Statistics (UBOS)	
June 8, 2006	WHO-Uganda	Representatives from MoH, Dep. of Planning
June 8, 2006	Health Partnership Group (HPG)	World Bank, UNFPA
June 12, 2006	National Planning Authority (NPA)	
June 13, 2006	Workshop with invited stakeholders	See program.
June 14, 2006	WHO-Uganda	Dr. Dick Jonsson

Annex 3: Proposal for a national program on macroeconomics and health in Uganda

Macroeconomics and Health in Uganda

Budget proposal for the first year

2006 03 10

MOH the Republic of Uganda and WHO Country Office

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The Macroeconomics & Health Program in Uganda

Proposal for implementation of the program

1. Introduction

Improved health is not only an end in itself, but an essential means of reducing poverty and achieving sustained economic growth. In the WHO African Region, health outcomes must be significantly improved, since the current huge burden of disease stands as a stark barrier to poverty reduction and socioeconomic development.

In recognition of the above, WHO Director-General established a Commission on Macroeconomics and Health (CMH) in January 2000, to study the links between increased investments in health, economic development and poverty reduction. The findings of CMH were published in December 2001⁶. The Commission's analysis revealed that: ill-health contributes significantly to poverty and low economic growth. At least 12% of annual GNP lost due to HIV/AIDS, in malaria-free zones is at least 1% per year higher than in areas where malaria is endemic⁷ and that 10% improvement in life expectancy leads to 0.3% to 0.4% rise in economic growth per year. For every 8 million deaths prevented, US\$ 180 billion would be saved in indirect economic benefits. A few conditions account for the high proportion of ill health and pre-mature deaths. About 70% of deaths in the African region result from the ten causes, HIV/AIDS, lower respiratory tract infection, malaria, diarrhea diseases, and maternal and perinatal conditions.

The CMH therefore, recommended enhanced political commitment, at both national and international levels, to increased investments in 'Close-To-Client' (CTC) health systems and expanded coverage of cost-effective interventions in priority national health problems which can save millions of lives per year in the region. For example, In Uganda only 72 % of the population has physical access to primary health care services within 5 kilometers of a health facility² and less than 30% of the people have access to essential drugs. Cost-effective interventions include among others: insecticide treated materials, Daily Observed Treatment (for TB), condoms, vaccines against childhood diseases; yet not reaching most of the poor.

⁶ WHO (2001). Macroeconomics and health: investing in health for economic development. Geneva: WHO.

⁷ Draft HSSP II and Annual Health Sector Performance Report (AHSPR) 2003/4.

A ‘Close-To-Client’ (CTC) system is required to scale up cost-effective public health interventions targeting the poor. Developing an effective CTC system requires increased investments in infrastructure and health personnel capacity.

There is need to increase external resource inflows in the region and countries and to advocate individually and collectively at the international level for more resources. The countries also have to improve the management of resources and capacity to use the additional resources prioritizing benefits to the poor.

It is necessary to increase the investment in health-related sectors such as water and sanitation, education, agriculture, works and environment and natural resources that have an impact on health; on average 40.2% do not use improved water sources, 40% of adults in the region are illiterate, primary school enrolment is at 63%; secondary school enrolment is 21%.

The CMH recommended that each government in the developing countries should put up a National Commission on Macroeconomics and Health (NCMH) to address macroeconomics in the Health Sector. Four countries in Africa have established national commissions. These are: Ghana, Ethiopia, Rwanda and Malawi. Angola, Botswana, Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda. Senegal, Swaziland, Tanzania and Uganda requested support to engage in a cross-sectoral process leading to multi-year health investment plan.

The Fifty-fifth session of the World Health Assembly (WHA 55) in May 2002 commended the CMH action agenda as a useful approach to the achievement of the Millennium Development Goals (MDGs)^{8,9} and the ¹⁰New Partnership for Africa’s Development (NEPAD) targets.

A regional concept paper and country guidelines for incorporating Macroeconomics and Health into poverty reduction have been developed. The current focus of activities at regional level is on human resource and the support to countries. A critical milestone for regional advocacy efforts was the 53rd regional (RC) meeting of ministries of health from the 46 countries, which took place 1-5 September 2003 in Johannesburg, South Africa. During the (RC) meeting, the ministers of Health endorsed the recommendations of the report of the Commission on Macroeconomics and Health attaching great importance to the Report’s findings. They also commended the AFRO CMH strategy paper “Macroeconomics and Health: The way forward in the African region” and the resolutions contained within. On the last day of the meeting, the ministers adopted the resolution and the paper on Macroeconomics and Health.

2. Situation analysis

2.1 Socio economic profile of Uganda

⁸ Resolution No. 19 of the Fifty-Fifth World Health Assembly entitled “WHO’s contribution to achievement of the development goals of the United Nations Declaration”.

⁹ UN (2000). UN Millennium Development Goals (MDG). New York: United Nations.

¹⁰ NEPAD (2001). NEPAD’s Human Development Programme: NEPAD Health Strategy. Pretoria: South Africa.

Uganda's population is estimated at approximately 24.7 million persons, with 51.0% females and 49.0% males. The annual population growth rate is 3.4% by 2002, and a high fertility rate of 6.9 children per woman¹¹. The majority of the population of over 80% lives in rural areas, where the whole concept of development is engineered, yet accorded little attention in form of outreach. The national literacy rate is estimated to be 71% for males and 51% for females. Uganda's economy is primarily based on subsistence means of livelihood where 38% of the population survive on almost less than \$1 a day.

Uganda's economy has achieved marked real GDP growth of an average of 6% per annum in FY 2003/2004 up from 5.2% in FY 2002/2003. This is lower than targeted 7% but higher than the average growth achieved by the rest of Africa, estimated at 4.1% in 2003. Of importance, the inflation rate has been maintained at 5 %¹² less than the targeted 10%.

Despite these economic achievements, household incomes have remained low, though there has been a reduction in levels of absolute poverty from 66.3% in 1994/95 to 44% in 1997 and further to 38% in 2002. A component of this reduction is due to redistribution with observed widening inequalities between rural and urban and inter-regionally, with the North experiencing increases rather than decreases in poverty levels.¹³ Poverty in the North has risen by 8% between 1997 and 2000; leaving two thirds it's population below the poverty line¹⁴. Out of a set of 19 most frequently referred to causes of poverty by the participants of the Participatory Poverty Assessment (PPA) in PPA 1 and PPA 2 processes, poor health and diseases have persistently been sited as the number one cause of poverty (PPA-2)¹⁵. The percentage of Ugandan population sick in any 30-days period has increased nearly 7 percent points between 1992/93 and 2002/03¹⁶. Despite the prevalence of HIV falling from an average of 18% in 1992 to 6.2% in 2002, it is estimated that 70,000 persons are infected each year. In addition, AIDS has devastated the public service through absenteeism and death and the Ministry of Public Service reports that almost 90% of the civil servants who died in 1999, died from AIDS. Further more the total area used by households for crop agriculture decreased among affected households by 23.5% between 1997 and 2002 with resultant decrease in agricultural production. The private sector has not been spared as well. Of significance, the impact of AIDS on the GDP has been estimated to be one point of growth per annum over the last years. Malnutrition is a significant cause of morbidity with 38% of the children below five years stunted and 23% of the children underweight¹⁷.

2.2 Policies and health

A National Health Policy (NHP) and a five year Health Sector Strategic Plan 2000/01- 2004/05 (HSSP I) were developed as a collaborative undertaking of the Government of Uganda and

¹¹ Uganda Bureau of Statistics, Statistical Abstract 2003

¹² Background to the Budget 2004/5.

¹³ MoFPED. 2003 Uganda Poverty Status Report 2003.

¹⁴ MoFPED 2001 Background to the Budget.

¹⁵ MoFPED 2002. Second Uganda Participatory Poverty Assessment (PPA-2). Deepening the Understanding of Poverty.

¹⁶ Ssewanyana S et al, Demand for health care services in Uganda, implications for poverty reduction, Draft report, October 2004.

¹⁷ Common Country Assessment of Uganda, 2004.

within the framework of the Poverty Eradication Action Plan (PEAP). The objective of HSSP II is to reduce morbidity and mortality from the major causes of ill health, premature death and the disparities therein. This is to be attained through universal delivery of the Uganda National Minimum Health Care Package. The PEAP is Uganda's Comprehensive Development Framework and it has guided the formulation of government policy since its inception in 1997. Increasing the quality of life of the poor is one of the goals of the PEAP because it is acknowledged that poor health leads to poverty and poverty leads to poor health. The UN system has developed a joint Development Assistance Framework for Uganda (UNDAF) with reference to the national priorities in the PEAP and the health sector targets in the HSSP II.

The National Health Policy and Health Sector Strategic Plan II are directed at accelerating the improvement of the health of the population thereby contributing to poverty eradication and economic and social development in Uganda.

A Mid Term Review was undertaken 2003 to identify the achievements and the major constraints of the implementation of the HSSP I. The review indicated that although there had been a significant increase in primary care services, particularly to the poor, there had been no reduction in maternity and infant mortality.

There has been a previous attempt to advocate for increased investment in health. The Health Financing Strategy quantified the required per capita expenditure to deliver the National Minimum Health Care Package to justify investment in health, a case for bigger budget.

A new Health Sector Strategic Plan (HSSP II) for 2005/06- 2009/10 has been developed. The program goal is expanded economic growth, increased social development and poverty eradication. This is to be achieved through reduced morbidity and mortality from the major causes of ill health and pre mature deaths and reducing the disparity therein. This feeds into macroeconomics and health from the perspective of health as one of the most critical areas in the socio-economic development of every country. "It is a healthy body that works and produces", which has influenced the economies around the world to invest vast proportions of their national wealth in health work.

2.3 The health system

In Uganda the Government adopted the decentralization policy under the 1997 Local Government Act to bring decision powers and service delivery closer to the people by improving good governance and democratic participation. This has resulted in fundamental changes in structure and function of different levels. The MOH bears stewardship of the national health policy and system, while the districts through the health sub-districts bear the responsibility of service delivery to the communities. The 1997 Local Government Act empowers the Local Governments with responsibilities to integrate participatory planning; human resource management and development; establishment of sources of revenue and financial accountability. However, in practice decentralization has not yet been successful due to a number of factors for example, inadequate funding and limited management capacity in some of the decentralized units (districts) and a weak health information system. The districts have limited capacity to generate

revenue locally and continue to rely on central government funding. Worse still, the capacity and skills in public management are very limited.

The total health expenditure as a percentage of GDP by 2001 was 8.1%. The general government Total Health Expenditure (THE) is slightly less than US \$ 20 per capita. Public sources (GoU and Donors) contribute less than 50% of Total Health Expenditure. In FY 2003/04, the approved budget including donor projects was equivalent to US \$ 8.4 per capita. Of this US \$ 7.83 per capita were spent compared to US \$ 7.2 per capita spent in FY 2002/03.¹⁷ The private expenditure is estimated to be 54.4% of total health expenditures where of out of pocket spending is 53.4%. There is negligible social security expenditure in health as a percentage of general government expenditure on health. The ¹⁸high out of pocket expenditure leaves the poor vulnerable to catastrophic expenditure. The majority of the poor live in rural areas and constitute over 80% of the population. The major challenge therefore is to extend basic health care services to the entire population, while at the same time achieving significant reduction in the disparities in health status between the richest and the poorest segment of the population.

Under the decentralization policy, the proportion of the budget going to the district level increased from 33% in 1997/98 to 52% in 2001/02. The increment was largely in an effort to remove financial barriers to accessing services especially for the majority poor by abolishing user fees in government facilities on the first of March 2001.

The government is keen in development of an effective CTC; The NHP established the health Sub-District as a functional subdivision or service zone of the health system to bring quality essential care closer to the people. With a Health Sub-district at county level, Health center I at village level for every 1000 people, Health center II at parish level with 5000 people, Health center III at sub county level for every 20000 people, Health center IV at county level for every 100,000 people and General hospital at district level for every 500,000 people. Uganda has Health Centers, health posts and outreach points, capable of delivering the key cost-effective interventions such as insecticides among others, thus, Uganda operates a highly decentralized health care delivery system.

2.4 The health status of the population

The health status of the population in Uganda remains poor. The leading causes of morbidity and mortality are mainly communicable diseases. Over 75% of the life years lost is due to premature death from ten preventable diseases.¹⁹ Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total national death burden. The Uganda Household survey in 2003 indicates that malaria accounts for 54.6% of incidence of disease in Uganda. Others at the top of the list include tuberculosis, malnutrition (with 30% wasting among children), trauma and measles. The common non-communicable diseases include hypertension, diabetes and cancer, mental illness and chronic degenerative cardiovascular diseases.²⁰

¹⁹ Burden of disease in Uganda. Ministry of Health. 1995.

²⁰ National Health Policy 1999.

17. Annual Health Sector Performance Report 2004.

Table 1: Selected health indices from 1995-2004 in Uganda

Indicator	1990-1992	1995	2000-2001	2002-2004
Life expectancy at birth (years)	-	52	47	47
Infant Mortality Rate (per 1,000 live births)	122	81	88	82
Under 5 Mortality Rate (per 1,000 live births)	180	147	152	141
HIV/AIDS (%)	30	18	6.1	6.2
Malnutrition/stunting (%)	38	38	39	-
Immunization	38	47	38	63
Maternal Mortality Ratio (per 100,000 live births)	523	506	505	510
Total Fertility Rate (per woman)	7.1	6.9	6.9	6.8
Contraceptive Prevalence Rate (as a percent)	5	15	25	23
Access to safe water (as a percent)	24	36	57	68

Source: Uganda Demographic and Health Surveys 1995, 2000-2001, Population Secretariat Ministry of Finance and Economic Development 1990-2004, Health Sector Strategic Plan II 2005 –2010.

On a mere analytical state, the disparities in table 1 above for example, stimulate some questions related to the effectiveness and efficiency of the level of investment accorded to health. These questions also pertain to the relevance, opportunity cost, impact and sustainability of health care interventions that we are and continue to implement.

2.5 Millennium Development Goals

The position of the Government of Uganda in realizing PEAP objectives and the Millennium Development Goals (MDGs), mainly focus on incomes, poverty alleviation, food security and nutrition, health and mortality, reproductive health, education, gender equity, among others, all of which call for increased and sustained investment in health. The Uganda country status and the MDGs are presented in Table 3 in Appendix 1.

3. Challenges faced by the health sector

The major challenges facing both the MoFPED and the Health Sector remain maintaining a sound macroeconomic policy and raising the current level of government financing for health services. The government has to maintain the macroeconomic concerns while the health sector agenda is driven by the global initiative.

The current level of the total health expenditure per capita (US \$ 18) is far below the recommended level by the WHO Commission on Macroeconomics and Health (CMH) for financing basic services at the level of US \$ 30 to 40 per capita. Approximately 60% of the budget of the GoU is donor funded and the long-term commitment from donors to fund the sector is not assured. The current government expenditure on health is 9.5% of the budget despite the Abuja declaration by African heads of state, committing the government to spend 15% of its annual national budget on health.

The health system faces serious human resource problems with inadequate human resources numbers²¹ with poor coordination of training programs, no incentive systems especially to address the underserved areas. In regard to public and PNFP units, 86% of the approved posts are filled with trained health workers (nursing assistants included) and 68% nursing assistants excluded. Whereas in NFP Sub sector, there is no adequate information (HSSP II) but the situation may be worse. There is inequity of distribution of Health Workers with some districts falling below an average of 100 health workers per 100,000 populations. Those with less than 101 health workers per 100,000 populations are 5 districts of Sembabule, Kotido, Katakwi, and Kamuli. Districts with more than 175 Health workers per 100,000 population are 3 namely; Kampala, Mpigi and Jinja.¹⁶The most affected cadres being midwives with national average posts filled amounting to 44% and variation between districts varying significantly. Worse still in some districts, nursing assistants make up more than 50% of the work force. This may compromise the quality of health services.

Besides the human resource concerns, there is absence of clear prioritisation with the health care package, inadequate network of functional health infrastructure and shortage of essential drugs and most importantly, inefficient allocation and utilisation of scarce resources.²²

Expansion of CTC services with in the feasible investments in health pauses a major challenge. This will require investments in infrastructure and capacity building.

There is a challenge of scaling-up cost effective interventions to reach the whole population. The challenge is however hampered by intrinsic shortages of other resource inputs, for example, human resources both in numbers and skills, health infrastructure especially medical equipment.

4. PROPOSAL

4.1 Justification for the Macroeconomics and Health framework (MH)

Improved health improves the level of human capital to be used in societal production and thus affects productivity and socioeconomic development. Economic impact studies have documented

²¹ The national average staffing level in health facility is 52% of the recommended minimum staffing level (Annual health sector performance report, FY 2002/3).

²² Health Sector Strategic Plan Mid term Review Report, April 2003.

¹⁶ Sub National Health Systems Performance Assessment Report, MHO 2004 , Health Sector Strategic Plan II 2005/06 – 2009/2010.

the loss in GDP as a result of the high disease burden. Realizing PEAP objectives and the Millennium Development Goals (MDGs) that focus on incomes, poverty, food security and nutrition, health and mortality, reproductive health, education, gender equity, among others, calls for increased and sustained investment in health. This requires streamlining ongoing efforts to mobilize resources for the sector and promote advocacy for sustained investment in health. Efforts to salvage the poor under this initiative have to use epidemiological and economic evidence to target efficient and effective allocation of public resources to reach the majority of the population. There is also need to avail evidence to show that efficient gains in addressing the health sector needs reach the poor. This requires generation of evidence and detailed analysis hence the need of a macroeconomics and health program. The program will build on existing efforts in the PEAP, HSSP II, the Health Expenditure Reviews and the draft Health Financing Strategy.

4.2 Objectives

The overall objective of this initiative is to establish a national framework on Macroeconomics and Health and strengthening the Health Sector Working Group to inform the Health Sector Strategic Plan (HSSP II). Major tasks are to generate evidence based information for health policy making, planning and management through research and advocate for a culture of human capital development in promoting economic development, poverty reduction and health in line with the MDGs, which needs to be appreciated in the macroeconomics policy framework.

The specific objectives are:

- I. To analyze links between increased investment in health and health related programs, economic development, poverty reduction and macroeconomic framework;
- II. Strengthen existing institutional mechanisms with a purpose of improving the government stewardship in health;
- III. To generate evidence and information needed in improving the design of health policies and strategies, cost-effective essential health and health related interventions and service delivery in collaboration with the national research institutions;
- IV. To develop an investment plan to expand scope and scale-up of cost effective interventions into priority national health and health related programs linked to the PEAP and MDG targets; and
- V. Disseminate information and advocate for increased funding for health including suggestions on how additional resources can be mobilized.

4.3 Proposed strategy

In line with the recommendation by the WHO Commission on Macroeconomics and Health (CMH) that each government in the developing countries should put up a National Commission on Macroeconomics and Health (NCMH) to address macroeconomics in the Health Sector. The Ugandan Government has opted that the major work on Macroeconomics and Health (MH) should

to be carried out by the Health Sector Working Group (HSWG). In order to carry out the analytical and technical work and contracting out research the HSWG will be given the mandate to co-opt members from other sectors and development partners as necessary. A National Steering Committee (NSC) with members from the health related Line Ministries, CSOs, UN and development partners is going to be set up. The major functions are to improve stewardship, advocate and sensitize decision makers on the importance of health within the macroeconomic context and monitoring and evaluation as well as advice the MH works in the HSWG.

Most importantly, this endeavour is in line WHA 55.19 resolution recommending the CMH action agenda as a useful approach to achievement of the MDGs. Specifically this is further affirmed in the Regional Committee for Africa Resolution number 53 urging member states to establish institutional mechanism for implementing the recommendations of CMH, develop multi-year strategic plans for scaling up health investment into poor-health interventions and mobilise resources from domestic and external resources in a sustainable manner.

4.4 Proposed tasks for the Health Sector Working Group (HSWG) working on MH

- (1) To undertake a health and macroeconomic situation analysis with a purpose identifying information gaps and empirical research needed;
- (2) Identify the priority areas for scaling up health and health related interventions and the financing strategies to address those priorities;
- (3) Identify a set of essential health and health related interventions to be made universally available to the entire population on the basis of both public and private financing (with the requisite donor support);
- (4) Appraise a multi-year program of health-system strengthening, focused on service delivery at the local level and including training, construction, and bolstering of infrastructure, and management development to enable the health sector to achieve universal coverage of essential interventions in relationship to the current Health Sector Policy (2000-2010) and the Health Sector Strategic Plan II (2005/6-2009/10);
- (5) Propose time bound and realistic quantified targets for reductions in the burden of disease based on sound epidemiological modeling;
- (6) Identify key health synergies with other sectors (e.g., education, water and sanitation, agriculture, environment, works etc.);
- (7) Design medium to long-term plan by setting up multi-year strategy for scaling up, including the design of a medium to long term financing strategy based on domestic and donor resources bases on the findings; and

- (8) Propose ways of strengthening existing institutional mechanisms including research institutions with a purpose of improving the government stewardship in health.

4.5 Accomplishments to be undertaken

1. MOH and MOFPED will inaugurate the NSC and facilitate the HSWG; and
2. Technical Assistance (TA) will initially be sought from government departments, WHO and other UN bodies and World Bank office within Uganda before seeking further external assistance. Undertakings that require intensive fieldwork could be contracted out to consultants or institutions.

4.6 Proposed steps for operationalising the work on MH

Step 1. Consensus building on the relevance of findings and recommendations of the MH work in Uganda: MOH and MOFPED in collaboration with WHO country office, UNDP, UNICEF, European Union and The World Bank and will organize a meeting with key stakeholders to build consensus on the relevance of the CMH recommendations on national health situation.

Step 2. Setting up institutional arrangements to facilitate implementation: A National Steering Committee (NSC) will be in place and the Health Sector Working group (HSWG) will be empowered to carry out technical work. The NSC will guide the process of scaling-up priority interventions and advocate, at national and international level, for increased investment in health and harness multi sector efforts. Its membership will be from Ministry of Health, Ministry of Finance, Planning, and Economic Development, Ministry of Lands, Water and Environmental Protection, Ministry of Local Government, Ministry of GLSD, Parliamentarians, and Representatives of Civil Society, Private Sector, UN Agencies, Bi-lateral and Multi-lateral Development Partners active in the health and health related sectors. The HSWG has the right to co-opt members from related sectors and stakeholders including research institutions.

Step 3. Analysis and strategy development: The HSWG (with co-opted members) will first analyse the macroeconomic planning framework as laid down in the PEAP and other relevant documents:

- i) The first task shall involve MOFPED outlining the current economic framework, policies governing economic development, the national macroeconomic situation, the budget process and other relevant factors affecting mobilization and allocation of resources. The process of developing BFPs for line Ministries and other sectors is considered an important input in this process; and
- ii) The HSWG will also include analysis of the national health situation (risk factors), the national health policy and the health sector strategic plan (including recommendations of health SWAp working groups on human resource, finance, health benefit package,

supervision and monitoring). Also, other sectoral working plans from water, education and public service, among others, will be analysed. The plan will extend coverage of essential health and health related services. Indeed after taking into account synergies with other health producing sectors and ensuring consistency with a sound macroeconomic policy framework, should also provide the basis for filling information gaps through adequate investment in generating evidence.

The plan should at least contain (a) a health and health-related sectors situational analysis; (b) a set of priority national health problems; (c) a package of evidence based cost-effective “essential public health and health related interventions” for addressing the problems; (d) current levels of coverage for various essential interventions; (e) cost of scaling coverage of essential interventions to the desired targets (this should include the cost of strengthening “close-to client” health services) (f) an estimate of the current level of spending (broken-down by different sources) on the essential interventions; (g) an estimate of the expenditure gap, i.e. “f”- “g”; (h) an indication of how the gap will be financed (from the domestic and international sources); and, (i) monitoring and evaluation and research plan.

Step 4. Filling in expenditure gaps: The HSWG in liaison with the NSC will develop scenarios on how expenditure gaps could be bridged by considering:

- ❖ Reductions in technical and allocative inefficiencies within and between health and health related sectors and sub-sectors;
- ❖ Determination of most cost effective health and health related interventions; and
- ❖ Exploring modes of health financing.

Step 5. Use the plan developed in step 3 to revise the health and health sector development plans and the relevant components of PEAP: The health and health-related sectoral development plans (e.g. health, water and sanitation, education) and the relevant components of the PEAP will need to be revised to accommodate the scale-up plan developed in step 3. This will be at the timing of the PEAP revision.

Step 6. Implementation of the multi-year strategic plan: The ministries and agencies with primary responsibility for specific components of the strategic plan (e.g. health services, water, sanitation and nutrition) will scale-up their respective interventions.

Step 7. Monitoring, evaluation, research and reporting: The NSC would monitor the implementation of the strategic plan as well as the proposals developed by each lead ministry or agency. To that effect, the NSC might develop new key indicators together with HSWG and set up a frequency for reporting by using the national reporting mechanisms as far as possible. As a guide, the NSC may consider meeting every after four months, to review progress with implementation of the strategic plan and its relevant proposals.

4.7 Expected results

Process

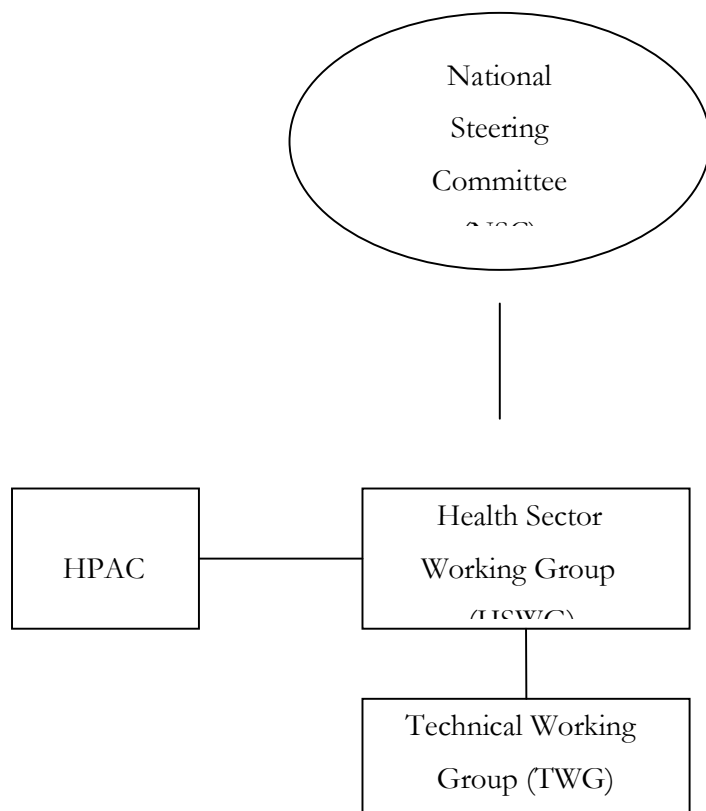
- TOR for the NSC and HSWG on MH program developed; and
- NSC will be in place and functional.

Output

- a) Health situational analysis and economic analysis of alternative health and health related interventions within the existing and proposed macroeconomic framework undertaken;
- b) Plan for scaling-up priority interventions and advocacy at national and international level for increased investment in health provided;
- c) Effective “close-to-client” (CTC) system for scaling-up cost effective public health interventions targeting the poor strengthened;
- d) Plan for mobilization of more domestic and external resources and efficient allocation of existing resources and strengthening government stewardship in health.

4.8 Functions of the NSC and HSWG

Figure 1: Organisational framework for MH in Uganda



The NSC is to be charged with advocating for what comes out of the fieldwork and studies done by the HSWG. While the HSWG work is mainly technical and includes fieldwork and contracting out work. The Hon. Minister of Finance, Planning and Economic Development will chair the NSC and the DGHS MoH and the PS MoFPED /Secretary to the Treasury, will be updated through the line of directors. They will also have the overall technical responsibility over this undertaking and provide briefs to the Hon. Ministers. The NSC will meet every 4 months and HSWG every 1 month.

4.9 NSC members

Hon. Minister of Finance (chairman);

Permanent Secretary /Secretary to Treasury, Ministry of MOFPED

(alt. chairman);

Hon. Minister of Health;

Hon. Minister of Education;

Hon. Minister of Water and Sanitation;
Hon. Minister of Agriculture;
Hon. Minister of GLSD;
Hon. Minister of Local Government;
Hon. Chairperson of Parliamentary Committee on Social Services;
Representative from UNCT/WHO;
Coordinator and any other representative of Development Patterns;
Chairman Health Consumers Organizations (UNHCO);
Representative PNFPS;
Representative of the Religious Council; and
Chairperson of HSWG.

4.10 HSWG members

1. Permanent Secretary Ministry of Health
2. Director General Health Services
3. Director Health Services (P&D)
4. Director Health Services (C&C)
5. 6 Commissioners of Health Services
6. Undersecretary MoH
7. Principal Accountant MoH
8. Members of the Health Planning Department
9. Health Desk Officer MoFPED
10. 3 representatives of the Health Development Partners
11. Director Mulago Hospital
12. Director Butabika Hospital
13. Secretary of the Health Services Commission
14. Director General of the Uganda AIDS Commission
15. Representative from the Ministry of Local Government
16. Representative of the Private not for Profit Medical Bureau
17. Representative from the Regional Hospitals
18. Representative from the District Directors of Health Services
19. Representatives from the District Hospitals

The HSWG has the right to co-opt relevant members from key ministries, bi lateral and multilateral agencies or CSOs etc where necessary.

The HSWG can delegate technical work to a Technical Working Group (TWG) reporting to the HSWG. Technical advisors from key ministries, bilateral and multilateral agencies, CSOs or research institutions will be co-opted where necessary.

Table 2: Uganda country status and Millennium Development Goals (MDGs)

MDG	Status	PEAP target	MDG Target (2015)
Halve the proportion of people living in extreme poverty by 2015	35% (2000)	10% in 2017	28%
Infant mortality reduced by two thirds, the under five mortality rate by 2015	IMR 88 (2000)	68 (2005)	31
	U5MR 152 (2000)	103 (2005)	26
	IMM against measles		
Maternal Health MDG target: reduce by three quarters, the maternal mortality rate by 2015	505	354 (2005)	131
HIV/AIDS; malaria and other Diseases MDG target: halt and begin to reverse, by 2015, the spread of HIV/AIDS		4% (2015)	7%
Primary School net enrolment	98 (2003)		100%
Reverse loss of environmental resources by 2015, halve the proportion of people without access to safe drinking water	55	100 (2015)	62%
Eliminate gender disparities in primary and secondary education by 2005		100% (2015)	

Table 3. First year budget for the MH work in Uganda

TBD.