SURE Rapid Response

What would be the appropriate Health Financing Strategy for Uganda?

August 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key Messages

An appropriate health financing approach for Uganda would involve a mix of strategies, maximizing on the benefits of each.

- Resource mobilization- options for additional revenue include: prioritizing health in the already existing spending in its budget, expand (new or diversify existent) sources of domestic funding, and/or increase external financial support.
    - However, there is a need to estimate resource needs before going out to mobilize them.

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SURE Supporting the Use of Research Evidence

REACH Regional East African Community Health Policy Initiative

MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES

EVIPNet EVIDENCE-INFORMED POLICY NETWORK

Who requested this rapid response?

This document was prepared in response to a specific question from a Senior Health policymaker in the MOH Uganda.

! This rapid response includes:

- **Summary of research findings,** based on one or more documents on this topic
- **Relevance** for low and middle income countries

X Not included:

- Recommendations
- Cost assessments
- Results from qualitative studies
- Examples or detailed descriptions of implementation

What is the SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

- Pooling of funds - A relatively good and sustainable health financing strategy is dependent on a blend of pooling methods. Policy makers need to analyze and consider what contribution each method can make, and in what proportions in order to achieve universal access to care and financial protection.

- Resource allocation and purchasing of services – The government needs to improve on the current allocation and budgetary process although cautiously. Allocation should be more pro-poor/pro-rural and there is a need to do more strategic rather than passive purchasing of health care and services as to make the process more efficient and achieve more value for money.

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research on the topic. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Introduction

Globally, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line due to health care costs; this is up to 11% of the population in some countries (1). In Uganda it is nearly 5% of households that are experiencing catastrophic payments while 2.3% are impoverished because of medical bills (2). Recognizing this unacceptable situation, member states of the World Health Organization (WHO) committed in 2005 under resolution 58.33, to develop their health financing systems so that all people have access to services (universal health care coverage) and do not suffer financial hardship paying for them (3).

Coverage for all people does not necessarily mean coverage for everything but working out how best to expand or maintain coverage in three critical dimensions: who is covered from pooled funds; what services are covered; and how much of the cost is covered and furthermore making the health services timely. For such arrangements, trade-offs are inevitable to be able to strike a balance. A recent estimate of the cost of providing key health services, which was produced by WHO for the high-level Taskforce on Innovative International Financing for Health Systems, suggests that low-income countries would need to spend just less than US$ 44 per capita on average in 2009, rising to a little more than US$ 60 per capita by 2015 (4). This is up from the Commission on Macroeconomics and Health's 2001 estimate that basic services could be made available for about US$ 34 per person (5), close to what Rwanda is spending now.

The challenge for Uganda like many other low income countries is to develop and implement policies that allow it to mobilize sufficient resources and provide for health services in a way that not only reduces inequality and provides financial protection against impoverishment caused by catastrophic health costs but is also sustainable. In light of the increasing costs of health care due to population growth, and demographic and epidemiological changes which lead to an increase in demand for health care, coupled with improving technology and medical interventions, Uganda's policies should also ensure that there is flexibility and sufficient fiscal space to accommodate adjustments in health spending when needed. The government currently spends 8.9% of GDP on health, while it spends about 24.4% as a percentage of total health expenditure (6). This is mostly derived from taxes (mostly indirect) and government natural resources.

The National Health Policy (NHP) and the Health Sector Strategic Implementation Plan (HSSIP) are the basis for the health financing policy of Uganda: they highlight the need to ensure equity in access to health care for the entire population in order to contribute to economic development (7, 8). The NHP says that 'Efforts shall be made to explore alternative health financing mechanisms like health insurance but take into consideration equity concerns'. The government pledges to among other things increase budgetary allocation to the health sector in line with the 2000 Abuja Declaration, promote alternative health financing mechanisms other than government budgetary provisions including national social health insurance and other community health financing mechanisms, implement financing mechanisms that promote private sector growth for example through generous tax breaks.

This paper aims to look at the options that the Ugandan government can employ in a sustainable health financing strategy. It acknowledges that there is not one single option that is sufficient and that a mix is what might form an optimal strategy.

Summary of findings

Resource mobilization

A systematic review of studies done to assess different experiences with resource mobilization approaches defines a resource mobilization strategy as a mix of mechanisms the government employs in order to directly finance its own production and delivery of health care (and indirectly ensure non-government provi-

sion of health care) in a manner that is efficient, equitable, sustainable, transparent and improves quality of care (9).

There is a need to estimate resource needs before going out to mobilize them. This helps set goals and targets, helps in planning and also in evaluating efforts. Many budgets in the past and currently are formulated historically with adjustment for inflation and epidemiological trends but it is more useful to assess based on actual needs and supply potential. This would require among other things, assessing the current health care situation, and then the demand for health care followed by the supply capability. It would then lead into calculating the unit cost of health care services and eventually calculation of the requirement of total funds, adjusting for available resources and estimate what is still required.

The direct tools available to the government to mobilize revenue for health care include taxes (direct and indirect), donor funding, user fees, and insurance. Government may employ one or a mix of these. Research has shown that none is efficient on its own. However for a choice to be made, there is need to understand and critically analyze the context especially the past resource mobilization patterns, looking at the potentials and limitations of each. There is also need to look at current trends in terms of availability, distribution and sustainability of resources and their direction of flow. And this should be done in the public and private sectors and in both formal and informal sectors.
When considering the option of additional revenue for health care, there are generally three options government can choose from: prioritize health in the already existing spending in its budget, expand (new or diversify existent) sources of domestic funding, and/or increase external financial support.

Prioritizing health in the government's budget is influenced or hindered by several reasons, ranging from political to fiscal, but overall, the priority health is given in the budget is a reflection of the degree to which the leadership is committed to the health of the population as a whole including the different marginalized groups.

Increasing external support is a necessary strategy for the short term in developing countries like Uganda but all governments should be working towards eventually reducing the percentage of donor contribution and increase their own contribution towards health care. This is because in terms of sustainability, donor funding is unpredictable and volatile.

Expansion of domestic funding for health can be done in one of two ways: allocate more of the existing financial resources to health or vary existent sources or find new methods to raise funds. Improving revenue collection is more problematic for many lower-income countries due to the existence of a large informal sector but even with this

studies have shown that tax compliance is better when citizens believe they are getting a good deal from the government, despite the importance of punishment as a key factor in compliance. Collecting taxes and insurance contributions more efficiently would effectively raise additional funds.

The government has to explore new ways of raising domestic funds too (10); Uganda can consider taxing specific profitable sectors or big corporations as an additional source of revenue. This is comparable to the bank levy imposed by Brazil and proposed by the UK in its 2010 spending review and the mineral resources rent tax levied in Australia. This additional revenue could join the general revenue pool for the government or could be collected specifically to go to health resources. However when implementing such a strategy, the government has to be careful and keep in mind that there is a need to strike a balance between generating more and adequate revenue and upholding incentives for investment.

Uganda could also consider excise tax on harmful products like tobacco and alcohol also referred to as sin taxes. The consumption of these goods contributes to health care costs. These kinds of taxes have long been seen as a mechanism by which additional government revenues may be secured and used for health related programs. WHO estimates that an increase in price of 10% on the goods would lead to a decrease in their consumption by 6%, reducing on the health care burden they cause but also raising additional revenues for the government.

Another strategy is financial transaction-related taxes like the currency transaction tax that is levied on currency exchange markets or levies on bank account transactions. For example Zambia introduced a medical levy on all gross interest earned in any Savings and Deposit Accounts, Treasury Bills, Government Bonds and other similar financial instruments at a rate of 1%on the interest earned. The revenues support government efforts to increase access to HIV treatment. In 2009 this levy raised $3.9 million. Other strategies are shown in the table below.

Domestic options for innovative financing

Mechanism	**Fund-raising potential**	**Limitations**	**Other considerations**
VAT with a share earmarked for health sector	$$–$$$	High administrative and compliance costs (especially if exemptions and multiple rates)	Potentially regressive, especially if there is a uniform rate of VAT
Sector-specific ("Big corporation") taxes	$$–$$$	Context specific. Opposition from business interests.	Pro-poor
Tobacco excise taxes	$$	Opposition from business interest	Regressive
Alcohol excise taxes	$-$$	Enforcement, Opposition from business interests	Regressive
Excise taxes on foods which may contribute to an unhealthy diet	$-$$	Limited research to date on their potential. Concerns around definition of products to be taxed. Opposition from business interests.	Regressive
Levy on currency trans-	$$–$$$	Might need to be coordinated with	Pro-poor

actions		other financial markets if undertaken on a large scale	
Financial transaction tax	$$	May be perceived as an obstacle to trade	Pro-poor
Diaspora bonds	$$		Likely to be progressive
Tourism and travel related levies	$	Challenges around enforcement and regulation. Administration costs may be considerable.	Moderately pro-poor, particularly if the mechanism targets high income travellers
Luxury taxes	$		Pro-poor
Levies on mobile phone use	$$	Administrative costs are likely low.	Pro-poor if voluntary, less so if mandatory.
Selling franchised products	$		Pro-poor
General philanthropy [1]	$		Pro-poor

$, low fund-raising potential; $$, medium fund-raising potential; $$$, high fund-raising potential;

Source: Karin Stenberg et al, 2010 (10)

User fees: The World Health Organization (WHO) annual Global Health Report of 2010 titled, "Health Systems Financing: the Path to Universal Coverage" has urged governments to move away from direct payments to prepayment when mobilizing resources for health care (11). The continued reliance on direct payments, including user fees it is noted, is by far the greatest obstacle to progress towards universal coverage of health care and yet a large body of evidence shows that mobilizing funds through required prepayment is the most efficient and equitable base for increasing population coverage

Compared to tax based revenues and user fees, insurance *(seen more in pooling resources section)* in whichever form has a greater potential of contributing to revenue collection as it usually involves some mandatory fees. It is also sustainable provided the quality of the services does not decline, and administrative costs are kept in check. Furthermore it has the potential of improving the sustainability of health systems and services, reducing the government's financial burden but also increasing equity and efficiency.

[1] *There is a growing presence of philanthropy in low- and middle-income countries. In India with its booming economy, the government established the Public Health Foundation of India as a public-private partnership to address public health education and research: contributions from Indian philanthropists amounted to $20 million. In Pakistan, private philanthropy totals over a billion dollars.*

Pooling of resources

Pooling of resources is important as in there lies strategies for the poor being subsidized by the rich and the ill being subsidized by those in better health. In addition, in some countries as the population grows older one may talk of the old being subsidized by the young. In Uganda the common forms of pooling are through the government 'basket' or private insurance forms. There are different kinds of insurance including private and social forms and the strategy would be to make use of both forms.

A systematic review done to assess the impact of social, private and community-based health insurance arrangements in low-income countries in Africa and Asia concluded that the available evidence is very fragmented (12). Factors assessed included social inclusion, utilization, resource mobilization, financial protection, community empowerment and quality of care. Although acknowledging that there were diverging research methods, perspectives and a lack of longitudinal data which complicated the comparability of studies, the study found the following: a positive impact of health insurance was found on utilization (Social Health Insurance-SHI, Community Based Health Insurance-CBHI), financial protection (SHI, CBHI) and resource mobilization (CBHI); the impact of health insurance (SHI, CBHI) on social inclusion was inconclusive while the number of observations for Private Health Insurance (PHI) was too limited to draw any concrete conclusions. It was also found that the impact of health insurance on community empowerment, quality of care and resource mobilization was under researched. The study concluded that if compared to the existing evidence on other health financing methods in low and middle income countries, available evidence for both Africa and Asia suggests early indications of positive contributions to at least utilization and financial protection.

Voluntary Health Insurance-this is in form of CBHI and/or PHI

The private is commonly in form of community financing schemes or voluntary private health insurance. Community financing schemes and private health insurance have a number of similarities (13): both rely on voluntary membership but this membership is small unless the effective risk pool is enlarged for example through reinsurance or establishment of a federation with other schemes; furthermore, they depend on trust: members must have confidence that contributions will lead to benefits when needed. They are also vulnerable to insurance market failures such as adverse selection, cream skimming, moral hazard, and free-rider phenomena. They however also differ in some ways: CBHI schemes have been seen mostly where governments were unable to reach the rural poor and urban informal sector workers and so are often linked with rural loans, savings, and micro insurance programs. Many in fact benefited from a boost from donors during start-up. They usually serve the poor, and their benefit packages are constrained by their

limited resources unless they receive a government or donor subsidy. By contrast, private voluntary health insurance schemes are often set up by large enterprises in the hope that access to health care would cut illness-related absenteeism and improve labor productivity and therefore these schemes serve formal sector workers and provide benefits that are often generous compared with those provided by community financing schemes or publicly financed government programs. Also noteworthy is that whereas community financing schemes tend to be non-profit, many private voluntary health insurance schemes are for-profit.
PHI is especially embraced by the middle to higher income groups in the population, who can either afford the premiums or are employees of companies that will provide for this, therefore defining the employment based plans and direct purchase plans. PHI is indirectly advantageous to low income and disadvantaged sections of the population in such a way that when wealthier households take it up they reduce their use of the public finance system and move to the private sector, thereby reducing cost and congestion in the public facilities freeing them up for to be used by the poorer households (14). Its feasibility in poorer populations is still in question but one of the conditions necessary for demand of PHI is a relatively high level of unpredictable out-of-pocket payments which is very present in LIC. Household survey data in these LIC has shown that there is a willingness and ability to pay for health care even among the poor and that in fact they do understand the concept of subsidization and this may be the basis for success of CBHIs which are in fact some form of PHI.

CBHI- considering this as voluntary not for profit in low income countries, a systematic review done to assess the evidence of the extent to which CBHI is a viable option for health care financing in low income countries concluded that there is little convincing evidence that CBHI on a voluntary basis can be a viable option for sustainable financing of PHC in LIC (15). The amounts of funds mobilized under this arrangement have been found to be insufficient. However it also concluded that CBHI provides financial protection by reducing out-of-pocket spending and by increasing access to health care as seen by increased rates of utilization of care. This however may be compromised and cancelled by low population coverage. Furthermore there is evidence that these schemes still exclude the poorest and yet perhaps most in need. Despite this there are a few successful schemes that have operated for several years which may point to a contextual issue. Factors associated with successful CBHI programs include rising incomes due to economic growth therefore people are able to afford the contributions they have to make to the fund and increased government revenues which may mean increased government tax revenues and support to scaling up these schemes; reinsurance to address the risk of scheme bankruptcy due to unpredictable fluctuations in demand; characteristics of the population covered (age structure, socio-economic status, relative sizes and trends of urban and rural populations). For example urbanization is a barrier to CBHI; health system efficiency (and deficiencies)-care under such schemes may be limited in many cases limiting the feasibility of a beneficial package; sufficient managerial and technical expertise to develop and expand these

schemes may also be limited as there is limited experience with these kinds of schemes in LIC. There is need for high levels of solidarity which may be lacking due to other issues like political affiliation, family wrangles, etc that are usually seen in these communities. Political stewardship and governance are important factors, which may even water down technical expertise and other factors (16). A recent synthesis of the literature cited the following as ingredients for success and they include: ability to address adverse selection, accommodate irregular revenue stream of membership, prevent fraud, and have arrangements for the poorest; (ii) good management with strong community involvement; (iii) organizational linkages between the scheme and providers; and (iv) donor support and government funding. The table below summarizes successful and unsuccessful design features (17).

Table 1: Determinants associated with effective revenue collection and financial protection

	Design features	
	Supporting effective revenue collection and financial protection	**Undermining revenue collection and financial protection**
Technical design characteristics	❑ Addressing adverse selection through group membership ❑ Accommodating irregular income stream of members (allow in-kind contributions, flexible revenue collection periods) ❑ Sliding fee scales and exemptions for the poor make schemes more affordable	❑ Non-compliance, evasion of membership payments ❑ Adverse selection ❑ Lack of cash income ❑ No cash income at collection time
Management characteristics	❑ Community involvement in management can exert social pressure on member compliance with revenue collection rules ❑ Extent of capacity building ❑ Information support	❑ Provider capture – high salary of providers at the expense of service quality improvement ❑ Weak supervision structures increase the chance of fraud with membership card ❑ Poor control over providers and members contributes to moral hazard, cost escalation, and undermines sustainability of the scheme
Organizational characteristics	❑ Linkages with providers to negotiate preferential rates raises attractiveness of schemes and contributes to successful membership	❑ Fragmentation between inpatient and outpatient care leads to inefficiency and waste ultimately resulting in loss of membership
Institutional characteristics	❑ Government and donor support make the schemes more sustainable and pro-poor.	

However Japan and Germany provide examples in which the national social health insurance schemes that are currently in place were borne out of consolidating small scale village level voluntary in-

surance schemes eventually leading to universal coverage (18). This points to the fact that CBHI may be used over several years to provide a framework on which a national SHI scheme can eventually be built with steady and increasing coverage, especially in a context where a big part of the population is in the informal sector providing very few strategies of how to mobilize funds from this group.
Scaling-up of these schemes, it is noted, is a non-linear process that depends on several things including strengthening the capacity of the health system, socio-economic development, and ensuring good governance at all levels. CBHI is useful in countries with low public expenditure on health and high out-of-pocket payments.

It is widely acknowledged that the private sector plays a major role in health service delivery; private spending and delivery of health services often composes up to 80 percent of total health expenditure in many countries; in Uganda it comprises about 37% (6). Private voluntary health insurance is another form of insurance that is merely an extension of nongovernmental ways to deal with the risk of illness and its impoverishing effects. Developing countries' governments need to provide appropriate incentives for populations to enter into risk-sharing arrangements like these. In Uganda pooling of resources is still very minimal, and even where and when done majority of it is not in the private sector but with government resources and some partial pooling with donor funds that are contributed for the government budget support (14). Prepaid and risk-pooling plans contributed only 0.2% of private health expenditure in 2007 and only 2% of the 30million Ugandans had some form of health insurance at the time. By 2009 only about 3% of people were covered by private health insurance in Uganda.

A World Bank review of the existing and potential role of private voluntary health insurance in low- and middle-income countries done in 2006 (13), noted that community financing schemes in rural and slum areas contribute to financial protection against illness and increase low income rural and informal sector workers' access to health care but that they do have limitations: they mobilize only few resources from poor communities, frequently exclude the poorest of the poor without some form of subsidy, have a small risk pool, possess limited management capacity, and cannot offer the more comprehensive benefits often available through more formal health financing mechanisms and provider networks. What is pointed out here applies to private voluntary health insurance as well. But these can be handled. The same review shows that use of community rather than individual risk-rated reinsurance as a way to address some of the weaknesses of community financing schemes; standard techniques of reinsurance can be applied to micro insurance in health care and these are especially relevant when the risk pool is too small to protect a scheme against expected expenditure variance.

Social Health Insurance-SHI (14)

The World Health Assembly in 2005 passed a policy resolution calling on health systems to move towards universal coverage using SHI as the strategy for mobilizing more resources for health, pooling risks, providing more equitable access to health care for the poor, and delivering better quality health care. The WHO promised to provide technical support to help nations develop SHI and several other international aid agencies including the World Bank and the German Agency for Technical Cooperation have expressed support for the SHI policy.

Literature shows that if implemented well SHI could achieve or contributes to the following:

a) freeing up public funds so they can be targeted to public health goods and services;

b) targeting public funds to subsidize premiums for the poor rather than financing and providing universal health care for all;

c) shifting public subsidies from the supply side to the demand side to improve the efficiency and quality of health care thereby separating the responsibilities for collecting and managing SHI financing from the responsibilities for providing health care to patients (services are contracted from providers that are separate entities and providers are required to be accountable to patients for the quality of services); and

d) facilitating the use of the capacity of the private sector (nongovernmental organizations (NGOs) and private providers) to improve access by the insured to health care by means of contracting out services to these and improving partnerships.

Currently no low income country has achieved universal health insurance coverage yet. However Thailand, a lower middle income country has achieved universal coverage since its inception in 2001 by committing general tax revenues to pay the premiums for all the poor, near-poor, self-employed, and informal sector workers; by 2008 approximately 75% of the population had its premiums paid for through SHI (19). In the same year 2001, and under a lot of political pressure, Ghana, a low-income developing country also embarked on developing and implementing a National Health Insurance Scheme (NHIS) to replace out-of pocket fees at point of service as a more equitable and pro-poor health financing policy (20). By 2007, 38% of the population had been registered in the NHIS, but only 21% had been issued with identification cards and were effectively protected from out-of-pocket fees at the point of service use by the NHIS (19).

Despite being a good policy initiative and mobilizing additional funding for health care, SHI only offers a partial solution to the problems of health systems in developing countries. There is no guarantee that the increased revenue will be transformed into more and effective services. For example, India spends 6% of GDP on health care, but its health system is unable to provide effective services for the poor and yet when compared to Sri Lanka which spends only 3.7% of GDP, Sri Lanka's health system produces better

results in terms of health status and financial protection for the poor population (20). This may be attributed to governance and management of the scheme.

Besides concerns of failing to use the additional funding appropriately, these developing countries still have to solve all other systemic problems that pose barriers in access for the poor and especially rural populations. Often facilities are built and staffed and funds are spent but they are not located where everyone especially the poor, can access them (20). Governments persistently establish primary care centers at the sub-district and district levels, quite far from most rural residents. These facilities usually do not provide the services that people demand or need most and often operational funds do not reach them on a timely basis, resulting in facilities that regularly run out of drugs and supplies.

Studies have also shown that most developing countries' governments allocate a big proportion of resources for health to public hospitals in urban areas and semi urban areas (21, 22). These public facilities, especially tertiary-level hospital services, are used mostly by more affluent urban residents resulting in the rich being the disproportionate beneficiaries of public funds (20). This is not any different in Uganda.

There are problems with establishing SHI for developing countries because they have large informal sectors in which it is hard to get individuals to join the insurance system (since it is usually payroll based). If one does manage to involve the informal sector, it still leads to large administrative costs. In addition it remains to be seen whether the national solidarity in Uganda is not too low to aid the easy establishment of SHI (23).

Generally in order for a low income government like Uganda to progress towards a single risk pool (mandatory insurance & tax) it has to work on crucial factors that affect this and they include the general level of income and economic growth, the size of the formal sector, the level of urbanization, administrative capacity and skill including actuarial information systems, the extent of social solidarity and acceptability of cross-subsidies to those participating (14). In addition whether 'opting out' is permitted or not is important because with such liberty many people with low risk will opt not to pay premiums and this will leave a pool of people with only high risk individuals.

A policy brief that reported the findings of a series of systematic reviews assessing the impact of different health financing policy options on access to health services, especially for poor populations, found that few examples existed of social health insurance schemes operating at a large scale in low income countries and even fewer had evidence related to their impact (24). It however pointed out that without careful design and implementation developing social health insurance may in fact have unforeseen negative impacts on equity. A systematic review done to assess the impacts of social health insurance schemes on health outcomes and healthcare payments within LMIC settings found no evidence on the impact of social health insurances on changes in health status (25). It however found some evidence that health insurance

schemes increased healthcare utilization in terms of outpatient visits and hospitalization and also weak evidence to show that health insurance actually reduced out-of-pocket health expenses.

Allocation of resources and purchasing of services

The National Health Policy pledges to ensure that public resources prioritize financing of the Uganda National Minimum Health Care Package with preferential allocation to the preventive and promotive health interventions including diagnostic services in the package (7). It also pledges to revise and expand contracting mechanisms with the private sector to improve efficiency in service delivery and general support services.

Resource allocation is not yet optimal in Uganda. Local governments (LGs) depend on transfers from the central government for financing health service delivery. On average, these transfers are now about 90% of all LG Income, with the amount of local revenue hardly of any substantial amount. This makes the dependency very high. In addition, the budgeting process is a collaboration between the central government authorities and lower level units at the district level which are given the mandate to budget for their facilities under (26)(26)decentralization but this budgeting is controlled centrally.

There is a proposed intention to increase the degree of local autonomy allowing for more local involvement in local expenditure allocations; this is proposed in the Fiscal Decentralization Strategy of 2003 and to increase discretionary powers given to local governments in allocating resources towards both recurrent and development activities, providing direct financial incentives for local governments to increase local revenue, and ensuring that local revenue contributes meaningfully to local development (27). These are good gestures but are cause for concern in a country where there is still rampant misuse of public funds with limited capacity for monitoring public offices.

The Ministry of Finance, Planning and Economic Development has put a ceiling on all sectoral budgets in an effort to maintain control on line ministry related spending, and therefore sustain a strong macroeconomic environment (26). The ceiling put on the Ministry of Health budget has led to a number of anomalies as a result, with some donors who wish to put more funding into health services turning to project aid to get around the Ministry of Finance limits.

Another challenge that the ministry has to address is that the expenditures do not keep pace with inflation as measured by the consumer price index and with the rate of population growth (26, 28). This has been attributed to the fact that the government is faced with problems of revenue constraints combined with a high population growth rate (3.2%), making it impossible to keep adjusting accordingly (29).

For monitoring and evaluation of budget trends, there is a tracking and auditing system to keep budget expenditures in check; the National Audit Act 2008 empowers the Auditor General to decentralize internal audits to all levels auditing every local government council and every administrative unit annually and reporting the findings to parliament (30). This is a good and necessary gesture; however it is still not able to keep a good tag on issues because in general these law enforcement institutions are weak.

It is noted that relatively more resources are allocated to higher levels of care yet considering the country's burden of disease, more benefit would be achieved from equipping lower level units for PHC. There is a need to channel more funds to lower levels which are closer to the population, and the allocation should be sensitive to the needs of the local people. In countries where allocation of resources follows historical hospital spending rather than people's needs, it has been shown that public resources are poorly targeted. This is the case in Uganda and the government has to reorganize the allocation structure.

Uganda could also explore other ways of resource allocation; for example using conditional cash transfers. In this arrangement the government provides money to poor families dependent on certain behavior, usually investments in human capital, bringing them to health centers. The approach is both an alternative to more traditional social assistance programs and a demand-side complement to the supply of public services like health services. A systematic review done to assess the effectiveness of conditional monetary transfers in improving access to and use of health services, as well as improving health outcomes, in low and middle-income countries, found that this strategy was successful in increasing use of health services and improving nutritional and anthropometric outcomes and preventive behaviors, but that their overall effect on health status remained less clear (31). The study noted the need for further research to investigate the impact of conditional cash transfer in different settings and to assess the pathways by which any effects are achieved. The authors also highlighted the need for more research that would clarify the cost effectiveness of conditional cash transfer programs and better understand which components play a critical role, and the potential success and desirability of such programs in low-income settings, with more limited health system capacity.

Purchasing refers to the process by which funds (either pooled or not) are paid to providers in exchange for health care goods and services. It is broadly classified as passive and strategic (21). It specifies for and from whom, services and goods will be bought, how much will be paid and how this payment will be made to maximize satisfaction on the demand and supply side.

Choices made in the purchasing arrangement are important as they have an effect on quality of services provided, how efficiently this is done, access and therefore equity for the population served and indicate how satisfied the demand and supply parties are. The choices have to be sensitive to the resources available and the problems of the different populations served. The extent to which purchasers integrate

health needs assessment into purchasing is important in improving health status, equity and allocative efficiency but despite its widely recognized importance, and despite being routinely done in many of the health systems, health needs assessment findings are not fully incorporated into purchasing decisions (32).

Strategic purchasing involves active searching for the best health services to purchase, the best providers to purchase from and using the best payment methods and contracting arrangements (21). In Uganda, like most low income systems where the mechanisms for strategic purchasing are absent, a lot of passive purchasing is what is done at almost all levels. It implies following a predetermined budget or simply paying bills when presented (21). This will in most cases not give value for money.

Purchasing may follow several arrangements depending on both the payer and the service provider. An important element in a purchasing arrangement is the types of method chosen for provider payment and how the different types are mixed. The main types of provider payment methods that the government of Uganda can choose from include capitation, fee for service; salary, global budgeting, line-item budgeting, case-based payment, and diagnosis related groups (DRGs). A summary of these is shown in the table below including their incentives for different kinds of behavior.

Table 2: Types of provider payment with respective incentives for provider payment

Mechanisms	Incentives for Provider Behavior		
	Prevention	Delivery/Production of services	Cost containment
Line item Budget	+/-	-	+++
Fee-for-service	+/-	+++	---
Per diem	+/-	+++	---
Per case e.g DRGs	+/-	++	++
Global budget	++	--	+++
Capitation	+++	--	+++

Source: R. Mijumbi, 2009 (14)

None of the methods shown is used in isolation. Most systems will use a combination of the methods depending on the facility, the services, or the level at which payment is being made. Furthermore choices will also depend on the advantages the given method provides. For example, ***Capitation*** is one method that provides an incentive for preventative services. Capitation means that the provider is prospectively allocated a fixed amount of money to spend on health care services for the patients registered to their facility in a given period of time, say annually (33). It may be physician based (sum of money is historically adjusted) or patient based (sum is adjusted according to the number and type of patients registered to the facility). Capitation forces the provider to become more accountable to their clients and respond to their needs, and provides no incentive for delivering unnecessary services like carrying out a

large amount of tests. It is therefore also good for cost containment. However, critics argue that capitation encourages providers to register only low-risk individuals in a bid to keep their expenditure at a minimum and that they would spend more time trying to attract potential clients rather than caring for the existing ones (34).

Fees-for-service is a widely used method in low income countries and under this arrangement, an additional amount of money is paid to the provider for each service they provide (34). It may refer to intermediaries like insurance companies making the payment or to individuals. The most common method of purchasing health services in developing countries and especially at lower levels is usually a simple transaction where fees are exchanged for a service at the point of receiving care, with the use of out-of-pocket fees which were referred to earlier in this section. The out-of-pocket fees may also be in the form of cost sharing or user charges where individuals pay part of the cost of care and the other part is met by government, direct expenses for self treatment for example pharmaceuticals, or un-official fees for goods or services that should be otherwise funded from pooled revenue (also referred to as envelope or under-the-table payments); a small proportion is due to co-payments on insurance coverage (35, 36). Although able to keep spending and moral hazard in check, the disadvantages of out-of-pocket fees in poor populations are enormous leading to impoverishment for households as seen earlier in this section.

The Fee for service mechanism has drawn controversy among policy makers. Although widely used, it is argued that the costs of this system outweigh the benefits (37). This is because although it may give an incentive to increase the volume of services, the incentive to do this would be only if the payment will exceed the provider's cost of providing the services. It provides no incentive at all to contain costs on the provider's side.

Performance based payment is a policy that is increasingly attracting attention as a mechanism to improve the effectiveness of achieving specific health targets in low income countries (38). It is defined as the transfer of money (or payment) conditional upon achieving a predetermined performance target (39). Currently there are projects in some low income countries using the mechanism; the countries include Haiti, Rwanda, Uganda, Afghanistan, and Cambodia, among others. Majority of the reviews on PBP praise the mechanism for increasing efficiency and accountability in additional to improved quality of services (38). However, the reviews also note that the system requires strong political and administrative support as well as a strong health information system providing legitimate, consistent and reliable figures.

With the different choices seen above, health systems in developing countries have still not been able to carry out strategic purchasing of health care services due to several factors that have pushed them into choosing options that do not make use of the advantages that different methods would otherwise provide. There are situational factors that include high and ever changing levels of inflation, and unstable political situations which are both common sights in developing nations. These are usually transient events

but they influence the policies and purchasing processes significantly. Institutional features like the demographic structures of developing nations which are characterized by high dependency ratios with the employed or the economic bases including the labor force being low; in most cases many of these are in informal employment if employed at all; for example in Uganda the dependency ratio is high with 47.7% of the population being in the productive age group; this is compromised further by the national unemployment rate which stands at 3.2% while that of the youth is 22.3% ; furthermore less than 10% of the population is in formal employment, most employees are employed in the informal sector (2). In addition, issues of political institutions being dogged by corruption compromise the already small revenue bases (40). Therefore purchasing mechanisms that require a high tax base or those that require advanced skill and institutional capacity to run might not be an option in such a country despite the advantages they offer.

Last but by no means least, many of the systems will usually be faced with events that are outside their sphere of control but greatly influence them like war and conflict, and others like cultural beliefs and norms that have a large bearing on their establishment and sustainability

Conclusion

A relatively good and sustainable health financing strategy in developing countries is dependent on a blend or mix of tax-based financing, mandatory insurance for the formal sector, private insurance, CBHI, formal user-fees and informal contributions. Policy makers need to analyze and consider what contribution each method can make, and in what proportions in order to achieve universal access to care and financial protection. Furthermore pooling of funds needs to be encouraged and supported so as to spread out both financial and health risks and in turn, reach the poor and sick populations that might be disadvantaged in the current arrangements. Allocation of funds needs to be done in a way that targets the rural and poor more, and purchasing of resources should be more aggressively strategic than the current passive form it takes.

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Conflicts of interest
None known.

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