1.5. Macroeconomic equilibrium and the right to health in Uganda: two conflicting logics?

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Introduction

The right to health is the strongest, or at least the most cited, justification for state intervention in the funding and providing of health services to the population. This is also true in the vast majority of low-income countries, regardless of the actual capacity that their frail economies have of honouring the political, ethical and legal commitments made to the population. The Constitution of Uganda recognises that its citizens are entitled to the right to health and the Ministry of Health has developed the second of its strategic plans so that this right can be claimed at long last. As the halfway stage of this strategic cycle draws near, it is clear that many of the targets set by the plan will not be met. Equally elusive are the Millennium Development Goals (MDG) for health, which are also unlikely to be achieved[1]. It is also improbable that the interim goal contained in the Abuja Declaration will be met; this declaration required signatory states, including Uganda, to earmark 15% of their budget for health by 2015. So far Uganda has earmarked 7.8%. Alongside the commitment made by low-income countries to give its citizens the right to health, richer countries have also pledged to contribute with funding and other forms of aid. One particularly important stage of this pledge was achieved in 2005 with the Paris Declaration on Aid Effectiveness, which agreed that there was a need to promote support for state budgets as a form of aid. Parallel to this process, which aims to increase and harmonize flows of both bi – and multilateral aid, a wide range of global initiatives have been set up and developed over the last few years; although these so-called Public Private Partnerships (PPP)* have on one hand set aside a certain amount of funding for health interventions, they have also introduced major distortions within health systems. Resource management aside, since the publication of "Macroeconomics and health: investing in health for economic development" in 2001[2], there is a sort of wide consensus that seems to have led to considerable financial resources being made available to low-income countries in the medium – and long-term**, despite

* A certain confusion surrounds PPPs at global level and PPPs at implementation level. This article refers to both. As they are two partnerships with different logics and mechanisms, readers are asked to make due distinction between the two.

** "Seems to" is obligatory here. The author is unable to state whether the net flow of resources to Uganda, or to any other Sub-Saharan African country, has increased, shrunk or remained at previous levels. This inability is mainly due to a multiplication in the number of supply channels, all of which have a wide and unpredictable variety of timescales and distribution systems, making even the most approximate attempt to quantify resources impossible.

the grey areas surrounding fund allocation methods. It would seem that health has never had such favourable conditions, at least in terms of intention. This is certainly true for Uganda, as the two Strategic Plans drawn up since 2000 show; or rather it is true up to the point when it was discovered that there were restrictions and macroeconomic constraints on the growth of health expenditure. The nature of these restrictions and constraints, as well as their consequences, only became clear over time, and they are the subjects of this brief paper.

The imperative of macroeconomic equilibrium

Can a weak economy on the road to development driven by private sector growth improve if its currency is overvalued on the money market and if inflation has risen above the threshold of the growth rate of the country's Gross Domestic Product (GDP)? Can a weak economy develop if the fiscal deficit of its state budget stands at around 50% or sometimes higher, even though it is entirely financed by foreign funding (donations, not loans!)? These are the issues with which Uganda's Ministry of Health and other actors in the complex panorama of private-public health partnerships (including the author of this article) have to grapple. It started out as an incredulous, almost bemused, tussle due to the extraneous language and concepts put forward by the Ministry of Finance. However bemusement and incredulity soon faded away as it dawned that Uganda faced an insurmountable hurdle. In real terms, what is required by this desirable macroeconomic equilibrium, which is one of the five pillars of the Poverty Eradication Action Plan (PEAP), the Ugandan version of the Poverty Reduction Strategy Papers (PRSP)?[3] It requires a country to do everything it can to fight poverty without:

1. increasing fiscal deficit, in fact it has to be cut;
2. causing local currency to overvalue;
3. causing an increase in inflation.

These three "withouts" are easy to put into writing, but the real problem is that if these pillars of macroeconomic equilibrium are to be observed, donors' money cannot be spent! Or rather only very little, too little, can be spent. I shall leave the brave to tackle understanding the contorted paths that led to this conclusion, perhaps with the help of an authoritative article[4]. I shall instead proceed to illustrate the net result of this macroeconomic policy on the health budget, on a range of indicators and on a specific case which I hold dear: the fate of the private not-for-profit health sector (PNFP)[†].

[†] The PNFP sector (hospitals, dispensaries, nursing schools) comprises a considerable slice of Uganda's health system and provides about one-third of the services to the population; another third is provided by the public-government sector, while the remaining third is provided by the private for-profit sector.

The health budget

If we evaluate the health and government budgets[‡], including resources in the ordinary budget and in multi- and bilateral projects over the last ten years[§], the first thing we notice is that they have both shot up. However there is a telling difference between the increase in the health package and the total package: whilst health has seen its package double, the government budget has almost tripled. The gap is plain to see both in **Table 1** and in **Figure 1**. This consideration, however, is

Table 1. Uganda. Total State budget and Health budget, 1997-8-2007-8

	1997-8	2007-8	Increase (%)
Total health budget (B Ugx)	202.52	426.34	+110.5%
Total State budget (B Ugx)	1,220.38	4,744.60	+288.8%

SB Ugx=Uganda Shilling Billions*
Source: Ugandan Ministry of Health.

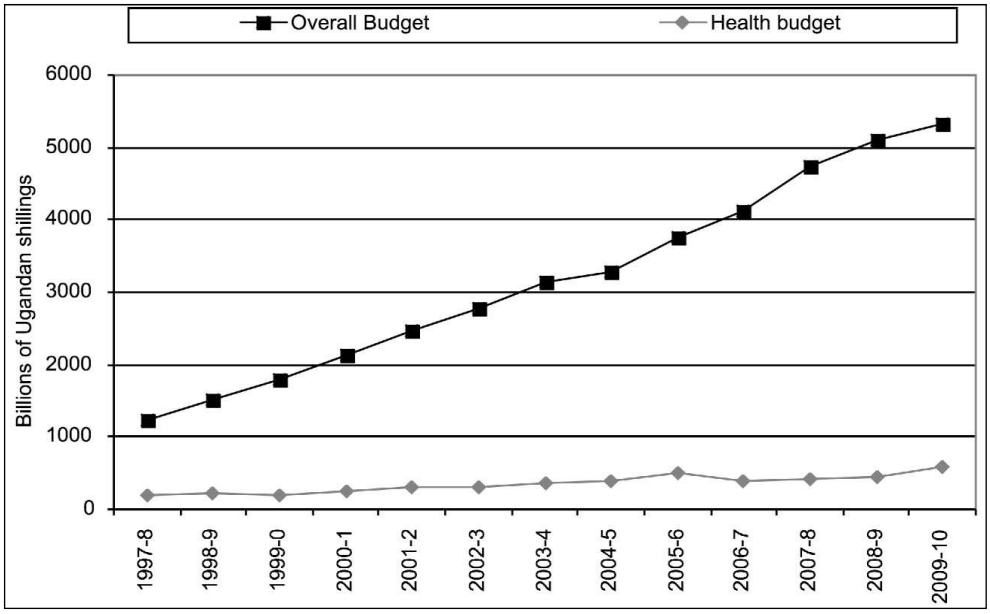

Figure 1. Total budget and health budget, including projects.

‡ The ordinary component of the budget corresponds to the allocation of funds that have come from taxation and from multi and bilateral donations to the budget. The component that here is called "projects" corresponds to flows of earmarked donations, which can only be used for specific interventions. Both components have expenditure ceilings that are compatible with macroeconomic equilibrium. In reality, the expenditure ceilings are applied to the entire state budget. As health is the sector with the highest potential for attracting donor funds, it is the clearest example of the problems posed by expenditure ceilings.

§ The figures for the 2007-2008 budget have been published. The projections for the subsequent years in the mid-term period (2008/9 and 2009/10) are merely estimates. Projection estimates have regularly proved to be more optimistic than the actual amount of funds allocated.

even more telling if we consider that on average Uganda's annual rate of inflation is 5%; in terms of purchasing power, this means that the health budget has not changed in the course of a decade. This may be a rough approximation, but judging by what occurs at implementation level on a daily basis it is actually very accurate. The impression that investment in health has not been particularly generous is further confirmed by the health expenditure per capita indicator, which shows an increase of 47.8%. After adjusting for inflation, this figure corresponds to a net fall in the resources available per inhabitant (**Table 2**).

Table 2. Uganda. Trends in health spending. 1997-8- 2007-8

	1997-8	2007-8	Increase (%)
Total health budget (B Ugx)	202.52	426.34	+110.5%
Population (in millions of inhabitants)	20.7	29.5	+42.5
Total public health expenditure per capita (Ugx)	9,785	14.463	+47.8
Ordinary public health expenditure per capita (Ugx)	2,579	9,344	+262.3%

SB Ugx=Uganda Shilling Billions*
Source: Ugandan Ministry of Health.

In reality, over the last ten years, the financial resources available in the ordinary budget (namely non-project resources) have increased considerably in both absolute and relative terms (+262.3%; **Table 2**). This fact has enabled the low budget to be managed better and thus some increases in efficiency to be obtained. It is thanks to increased resources in the ordinary budget, for instance, that the Ministry of Health has been able to set up a partnership with the PNFP sector. **Figures 2 and 5** show that this occurred in particular from 2000-2001 up to 2004-2005; these were the golden years of the Sector Wide Approach (SWAp), during which the increased financial availability in the ordinary budget drove health expenditure. It should be pointed out, however, that although there are considerable variations from year to year, about half of these funds come in foreign currency from donors. Between 2003 and 2004, the containment mechanisms of macroeconomic stabilization policy were triggered[5]. Since then, the ordinary health budget has remained almost stationary. The slight increase of the 2007-2008 financial year is due to intense negotiation between the Ministries of Health and Finance[††]. Original projections by the latter had the ordinary budget at stationary levels. Note that the project component continues to remain constant, except for a surge between 2005 and 2006, which has certainly contributed to justifying freezing any increases for

[††] Following pressure by the Ministry of Health, with the support of a section of Parliament, the Ministry of Finance provided an additional 32 billion Ugandan shillings. Unfortunately, much of this amount was spent on two national hospitals and on regional hospitals, as well as on a heart-surgery centre. Much less than half went on local districts. None was earmarked for the PNFP despite the fact that this sector was declared for two years running the top non-financed health care priority while it waited for additional funds in order to achieve a more just allocation. The additional funds did not arrive. Donors did not dispute it and they said nothing about the inconsistency between declared priorities and allocation choices.

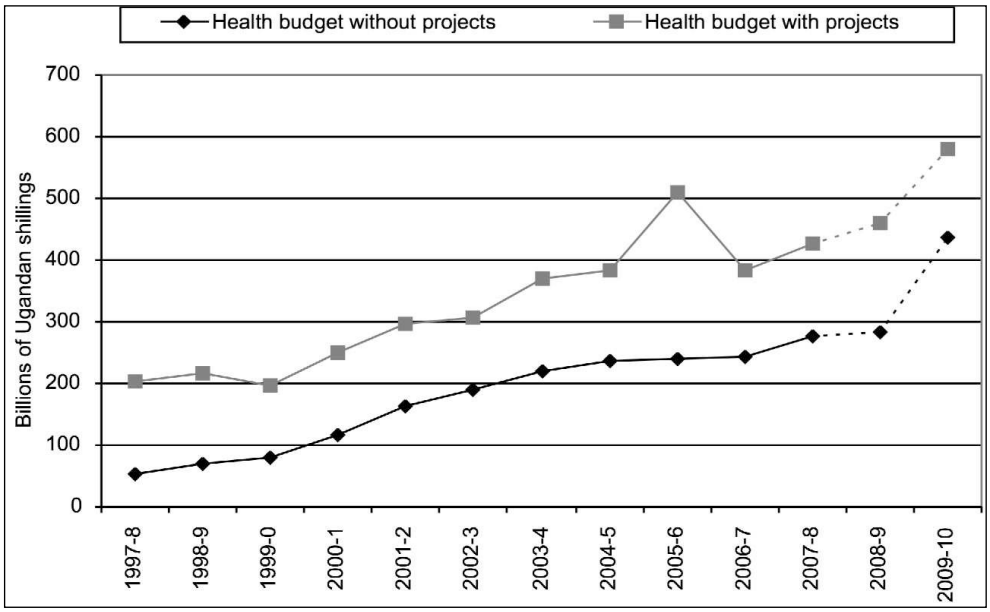

Figure 2. Health budget with and without projects.

health in the ordinary budget. This surge is due to resources brought in by initiatives such as the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR), which were principally earmarked for AIDS and, to a lesser extent, for malaria and tuberculosis. This surge, however, was clearly countered by a reduction in the ordinary budget.

In the last and current financial year, expenditure per inhabitant in US dollars has returned to figures recorded at the launch of SWAp (**Figure 3**). These figures contrast sharply with the estimates made by the WHO Commission on Macroeconomics and Health, which stated that 32 dollars per inhabitant would be the expenditure needed to deliver a minimum package of services (excluding antiretroviral medication); in loco estimates gave a more conservative amount of 28 dollars for the implementation of the second Strategic National Health Plan. However we look at it, the facts do not change: the health system is seriously and persistently under-funded in terms of both the estimated cost for delivering a minimum package of services and the growth in state budget, which clearly favours other types of expenditure. It is unclear, however, how much the availability of project funding, which today is mostly linked to the Global Fund and to the PEPFAR, has discouraged greater investment of the local resources in the ordinary budget. All of the attempts to show that Global Initiative requests for additional health-system funding are being observed (or ignored) have come to nothing.

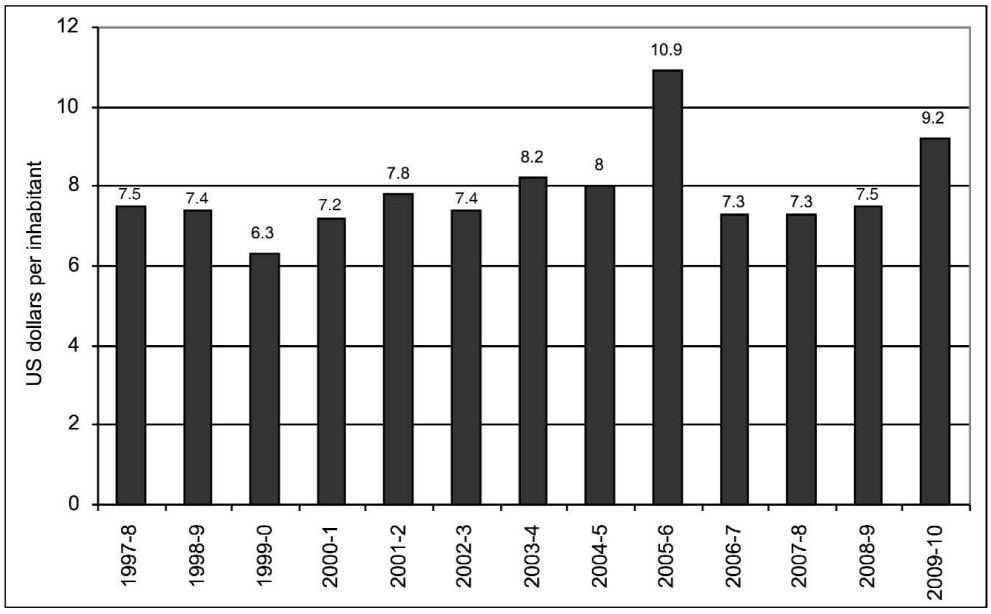

Figure 3. Public Health Spending (US$ per capita).

Health and health system indicators

It is very difficult to tie input to short – and medium-term results. Impact indicators seem to be improving, as illustrated by **Table 3**[6]. These figures most probably reflect the contribution of other sectors in addition to the increased efficiency of the global and health budgets in the previous five-year period. Besides, it is known that health impact indicators reflect a set of factors rather than the result of direct health interventions. More interesting are some indicators linked to health system performance[7], which show a lack of progress if not actual regression. **Table 4** illustrates a selection of indicators from the Health Sector Strategic Plan, updated to 2007, relating to the value of three years ago and to the target for 2009-2010. Though we may not be able to say that the indicators are worsening (although confidence intervals are missing), the health system is clearly unwell, limping and gasping for breath. It is clear that it will not manage to achieve many of the goals that have been set.

Table 3. Uganda. Maternal mortality, infant mortality, under-5 mortality 1995, 2000-1, 2006.

	1995	2000-01	2006
MMR	527/100,000	505/100,000	435/100,000
IMR	81/1000	88/1000	76/1000
U5MR	147/1000	152/1000	137/1000

Source: Bibliography note 6.

Table 4. Uganda. Health strategy plan. Selected indicators.

Indicator	Baseline value 2003/04	2004/05 value	2005/06 value	2006/07 value	2009/10 target
Percentage of Government of Uganda (GoU) budget allocated to health sector	11.6%	9.3%	8.5%	7.9%	13.2%
Total public (GoU and donor) allocation to health per capita	$ 7.8	$ 8.03	$ 10.2	$ 7.02	$ 18.0
Percentage of facilities without any stock outs of front line anti-malarial drugs/Fansidar, measles vaccines, Depo Provera, ORS and cotrimoxazole	40%	35%	27%	not available	80%
Percentage of children < 1yr receiving 3 doses of DPT/Pentavalent vaccines	83%	89%	89%	77%	90%
Percentage deliveries taking place in a health facility (GOU and PNFP) Deliveries supervised by a health professional	24.4%	20%	29%	29%	50%
Total Gov. and NGO OPD utilization per capita	0.72	0.9	0.9	0.9	1.0
Proportion of cases of Tb notified compared to expected	49%	50.3%	not available	49.6%	70%

Source: Ugandan Ministry of Health.

Resources and goals: the gap is widening

Uganda clearly does not intend to invest any more in health; the fairly optimistic projections for 2009-2010 (**Figure 2**) have been seen in each edition of the Medium Term Expenditure Framework (MTEF). What actually happens is that the optimistic projections are resized while the budget is being drafted. In real terms, neither the resources for the ordinary budget nor those for the projects increase. This may change in the fairly near future (though not that near) if the country's recently discovered oil supplies change the imperatives of macroeconomic equilibrium for the better. Additional confirmation of the strong tendency towards health savings comes from the recent formulation of the Human Resources for Health Strategic Plan, which provides very conservative targets for health-related training from now up to 2020. These targets are aligned with the financial availability envisaged in the long term by the Ministry of Finance[8]***. Thus, we can deduce that the medium-term macroeconomic belt-tightening will also run into the long-term. This means

***The PNFP's objections to the plan have been submitted to the Ministry of Health in a detailed letter and voiced during planning meetings on numerous occasions, but these objections have been ignored. Nor has there been as yet any reply from or mention of other worried or dissenting voices, not even those who promote the scaling up of services for patients with AIDS, tuberculosis and malaria.

no real increase in money and therefore no real in increase in health workers; consequently health input will remain more or less unchanged. What do vary, however, are the expectations of the population; indeed they increase exponentially. These expectations are due to the astounding promises of targets that need to be achieved, and these targets are why Global Initiative resources are mobilized. It is obvious that the Global Alliance for Vaccines and Immunisations (GAVI), as a result of its aid, will ask for increased vaccine coverage; it is also obvious that the Global Fund and the PEPFAR will ask for an increased number of patients to be treated with antiretroviral drugs; the same can be said for malaria and tuberculosis, for circumcision and access to condoms, for increased coverage of family planning etc. The list could continue, and is getting longer, because Global Initiatives and PPPs are multiplying. It is evident that none of these projects can allow itself the luxury of financing a 'status quo' or even the resizing of targets. Consequently targets and their indicators continue to grow and are added to government ones. The money, however, disappears because it is used to replace the money from the ordinary budget.

There is also an aggravating circumstance: the targets (and the political promises) do not remain within technocrat circles, but appear conspicuously in the national press and on the radio and television. The people are asked to remember who has given and why (transparency, and especially high-visibility, is paramount) and to claim their rights. People then come to claim what is due to them at the point of contact between the population and the health system, i.e. the health facility. Can anyone doubt how motivating and gratifying it must be for a doctor or a nurse to have a patient who has come to claim what he has been told it his right, but not be able to guarantee it because no resources are available, or they are disproportionate to the expectation created?

The not-for-profit health sector

The point of view expressed in this paper could very well stop here. However, it would be unfair to overlook that this precarious situation also includes a PNFP health sector that is under even greater pressure from the gap that has opened between resources and objectives. This is why the fate of the PNFP sector deserves a section of its own. This sector opted for functional integration in the national health system in 1997-1998. In the face of this commitment, which entailed progressive alignment with national health policy and sharing information on input and results, the government decided to provide this sector with subsidies[a]. By aligning its goals with national policy, the PNFP sector managed to reduce user fees substantially[10]. What this achieved for the health system is described in detail in a range of literature. This partnership proved convenient for users and extremely convenient for the government as with 7% of its budget it managed to provide

[a] These subsidies currently cover 20-25% of the production cost; 35-40% of the production cost is covered by user fees; the remaining 35-45% by donors.

30% of the services (**Figure 4**)[aa]; it was also convenient for the PNFP as it was able, at least until the recent past, to pursue its social mission and to achieve acceptable levels of efficiency[11].

Since mid-2004, this fruitful alignment process has lost its sense of direction. The implementation of the fiscal consolidation strategy claimed the health budget as its victim. To be more precise, its main victim was the population because the health workers employed by the public sector received a pay rise (and they will receive another in the coming financial year). Faced with a stagnation of resources, the Ministry of Health, driven by the threat of a strike, managed to overstretch its slim budget by favouring investment in human resources (with both an increase in salary and in health workers) and punishing investment in operational expenditure and the PNFP sector, which has seen its funding frozen for the last four years (**Figure 5**). The result is clear to anyone who has even minimum experience in management. This also triggered a fresh crisis in the PNFP sector, which had to deal with unprecedented levels of staff turnover. In the last two years, the loss of nurses stood at about 50% in primary care centres and at 30% in hospitals.

In brief, the PNFP health sector has been hit by a considerable part of this fiscal belt-tightening and has entered a crisis similar to that of the early 1990s. Increased

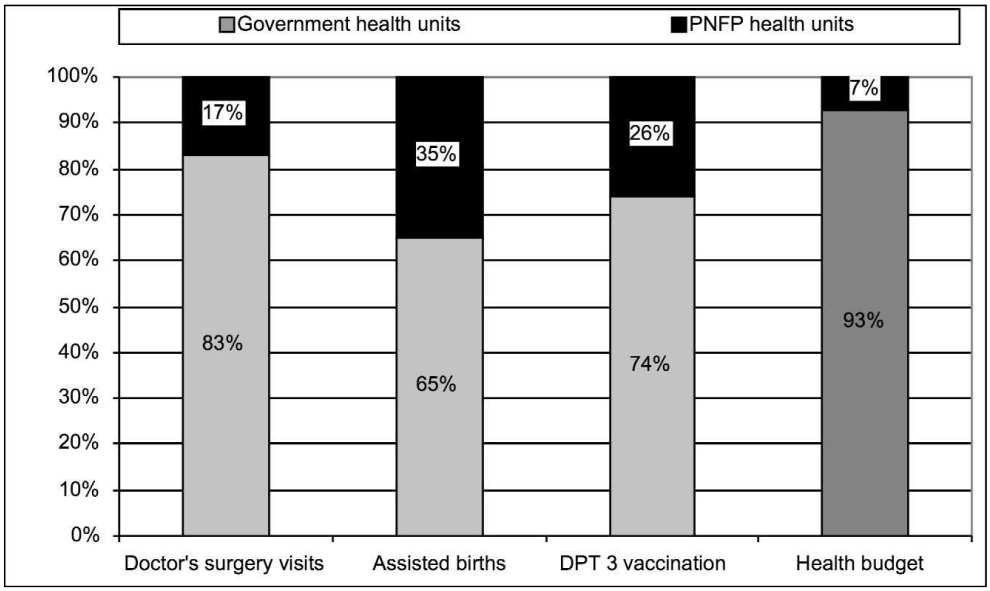

Figure 4. Contribution of PNFP sector to National health system (Government health units - PNFP health units - Outpatient visits - Assisted deliveries - Vaccinations DPT3 - Health Budget).

[aa] Figure 4 illustrates the share of the three key health indicators. These three indicators reflect the contribution of the Ministry of Health to the PEAP. Naturally there is much more evidence that is not reported in this paper. But the contribution to the targets on which the Ministry of Finance bases its evaluation of the health care sector has a particular political value.

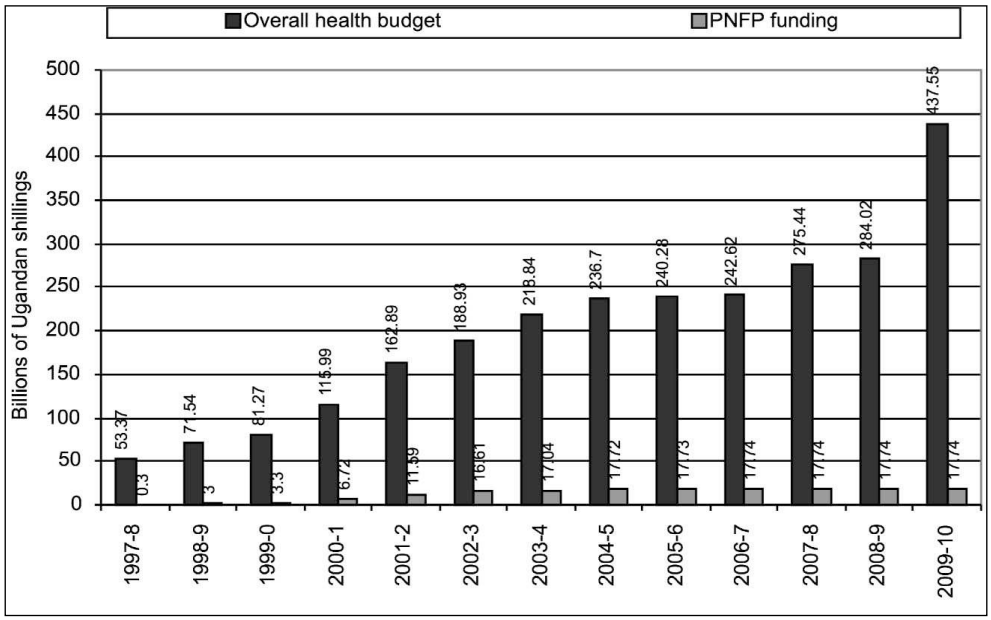

Figure 5. Funding for PNFP sector in relation to Health budget (total health budget, funding to PNFP).

donor contributions are of little help as they are mainly linked to Global Initiatives orientated towards specific services for the classic trio of AIDS, tuberculosis and malaria, which tend to unbalance the system at both micro and macro level. Calls have come from many corners to convert these vertical approaches into ones that are more respectful of the system. There is still no sign of this happening, but if it were to appear on the horizon, it would still have to overcome the hurdle of macroeconomic imperatives.

Conclusions

It is difficult to imagine that the population can be guaranteed a service that even vaguely reflects their rights. It is impossible to guarantee the right to health with health expenditure of 7-8 dollars per capita. It would be impossible even if double that amount were to be spent. At least four times that amount needs to be spent before some light will begin to appear at the end of the tunnel. We know, however, that this is not going to happen. It would not even happen if donors provided all the necessary funds tomorrow. It is impossible because the economy needs to develop in a specific manner; there are macroeconomic equilibriums to maintain. We have known this for several years, even though it took time to digest this bitter pill. Multi – and bilateral donors know it, as do the new PPP initiatives, which have asked for their resources to be used as a supplement to the budget, not

as a replacement. The donors' only reaction is to repeat that there is a principle to observe. However, the consequences of not observing this principle are overlooked. The Ministry of Finance has made no secret of the course it intends to pursue. I am unable to say whether the reasoning put forward by macroeconomists to justify their approach is valid or not; the manner in which it is presented certainly has a convincing logic and a certain strength. This is how things stand and up to now no one with a strong enough voice has dared to say otherwise. Consequently, at this point, the only right thing to do would be to resize the targets and to explain to the population what they can honestly expect and what will have to wait for better times. Surrounding this point, however, is a conspiracy of silence among the exponents of the systemic approach and those of the vertical or selective approach. The targets are still around and are on the increase. Is it any wonder that the health system is showing clear signs of suffocation? In the midst of this is a subsystem, the PNFP, which has started to show clear symptoms of sufferance after recovering from a serious crisis several years ago. Religious leaders have raised their voices to denounce this state of affairs[12bb], but their calls have still not been answered.

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bb "It is worth reminding everybody, though, that currently the national budget provides less than one quarter of the moneys necessary to provide the minimum package of care that Government desires to give to people, and which they have been told to expect. Sadly, we understand that this amount is not going to grow proportionally to the increasing population and to the promises of broader and ever improving services. Sadly still, the Millennium Development Goals (MDGs), also those related to the fight against HIV/AIDS, TB and Malaria that many Countries, including Uganda, have subscribed to, have been transformed into a platform for over-ambitious political statements not backed by consistent budgets and resource mobilisation. The Mid-term-expenditure-framework (MTEF) and Long-term-expenditure-framework (LTEF) we have seen are not likely to allow us to reach the MDGs. We have heard that Government Budget is subject to macroeconomic constraints and that there are concerns about its sustainability, but we do not hear this message translated in terms that common folks can understand. Commitment to reach the MDGs has to be both political and financial. The Hospitals, Health Centres and the health system in general cannot deliver more if there are no adequate resources in terms of money, personnel and structures. If they are continually pressurised to deliver more against a net resource deficit, they will end up by being severely de-stabilised. This applies both to government owned institutions as well as to our institutions. We are seriously concerned more about these latter because they are severely constrained and we are ultimately legally responsible for them. We therefore denounce all statements and promises that increase peoples' expectations and yet are not backed by adequate provision of resources now and in the unforeseeable future as mere demagogy. We need to remind politicians at all levels and of all political orientations who promise what they cannot fulfil of the serious moral responsibility they take upon themselves".

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