AGHA -UGANDA

REPORT OF THE HEALTH ECONOMICS FORUM ON FIXED SECTOR CEILINGS

Are fixed ceilings standing in the way of realizing the right to Health?

At GRAND IMPERIAL HOTEL

13th July 2006

LIST OF ABBREVIATIONS

ARVs	Antiretroviral
CMH	Commission on Macroeconomics and Health
DHT	District Health Teams
DPT3	Diphtheria, Pertussis and Tetanus Vaccine
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HSSP	Health Sector Strategic Plan
ICECSR	International Convention on Economic, Cultural and Social Rights
MDGs	Millennium Development Goals
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
PEAP	Poverty Eradication Action Plan
PWA	Persons Living With Aids
TB	Tuberculosis
UNMHCP	Uganda National Minimum Health Care Package

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1. INTRODUCTION

1.1. Background and rationale

The government of Uganda has made commendable progress in building the country's economy since 1986. Part of this progress has been registered as a result of macro-economic reforms implemented since 1992 as a key element of the structural adjustment programme of World Bank/IMF. The inflation rate has been maintained below 10% per annum, the GDP per capita has grown at a rate of 3.4% per annum and GDP growth rate averaged 6% per annum between 1992 and 2005.

Despite the macro-economic stability, however, 80% of the populations who live in the rural areas still complain of extreme poverty. Sharp income disparities persist, both at individual and regional levels. Whereas there was reduction in absolute poverty levels from 56% to 35% between1992 and 2000, rural areas still experienced high poverty levels in the same period, and the reduction in the poverty levels in Northern Uganda was only 9%.

In response to high poverty levels in the country, government embarked on a multi-sectoral approach to poverty eradication, enshrined in the Poverty Eradication Action Plan (PEAP) which constitutes the major economic policy guidelines for the country. The PEAP looks at Poverty as a phenomenon that demands multi-sectoral interventions and near balanced expenditure on health, education, water and Sanitation, agriculture, public works, justice e.t.c. Hence no single sector is emphasized over the others.

It is this multi-sectoral approach to Poverty eradication that was the driving force for setting of budget ceilings by Government. The key argument at this forum, which was the driving force for the Health Economic Forum, is that the Health Service Sector Plan (HSSP) is largely under funded. This is in spite of the fact that access to health support is one of the most fundamental and inalienable human rights according to the International Convention on Economic, Cultural and Social Rights (ICECSR), which Uganda ratified as well as the 1995 Constitution. Whereas WHO recommends $28 per capita, as the minimum health care package, health spending currently affords only $8 per capita. This deficit in health spending is clearly reflected in low human development indicators registered by the country. As a result of inadequate remuneration of health staff, coupled with poor facilitation of public health institutions, the health sector still registers the highest rate of brain drain. The number of physicians per 100,000 people was estimated at only 5, compared to 14 for Kenya, also among the low human development category of countries, 443 for south Africa in the middle

human development category and 590 for Cuba in the High human development category, between 1990 and 2002, and the current situation is not expected to be a lot different. In addition, only 39% of births in the country were attended by skilled health personnel between 1995 and 2001. This has been largely responsible for the high infant mortality rate estimated at 67.83 infant deaths per 1,000 live births in 2005 as well as the high rates of birth-related HIV/AIDS infection.

The argument for increased health spending is justified not only by the unique contribution of the health sector towards sustaining human life, and by the fact that once a life is lost, no amount of spending can be enough to bring it back, but also the pervasive truth that investing in health makes a lot of economic sense. By maintaining a small health budget, the country incurs a high opportunity cost in terms of wide spread epidemics affecting productive members of society accompanied by labour inefficiency. Much as health may be regarded as an unproductive sector under the PEAP, it is our shared view that a healthy person is a productive worker and hence increased investment in health is necessary if sustainable economic growth rates are to be attained.

The direct relationship between economic growth and health expenditure ought to be given its due recognition when the ministry of finance is setting priorities and determining budget ceilings. Once a minimum health care package is provided, there would be a cumulative increase in the general economic productivity; economic growth and eventually this would increase the availability of resources for increased expenditure in all sectors of the economy.

It is not by coincidence that countries with high GDP levels are those that commit more resources to health and health related sectors. With the highest GDP in the world, USA registered the highest Total Health Expenditure (THE) as a percentage of GDP in 2001, estimated at 13% of GDP, followed by Germany at 10.5%, Switzerland at 10.2, Netherlands at 8.7 and U.K 6.7. In the same year, Uganda registered a dismal 3.7% of GDP as Total Health Expenditure. Though it can be argued that Health Expenditure increases with increase in GDP, there is nothing to suggest that High GDP registered by the High income countries has not been a result of increased health spending in those countries.

We appreciate the challenges facing the Ministry of finance, namely the need to maintain a stable macro-economic environment. Raising budget ceiling for health by way of diverting government funding away from the health sector and making room for donor-funded health projects may accelerate inflation and appreciation of the currency. This would hurt the export sector. However, this does not have to be so. Additional donor –funded health expenditure can be off set by a reduction in government spending to other sectors which though

important may not be of high priority. We hold the view that Health Spending is a matter of life and death, and even if th

about being affiliated with yet another non-governmental organization working with the MOH as an ally to keep the ministry in constant check.

In view of the topic for discussion by the forum, the honorable minister highlighted that the debate on table was very pertinent to fiscal space in relation to the competing health sector priorities and presented some of the achievements made by government in strengthening health systems in the last 20 years. These included improved accessibility, reduced HIV prevalence, increased access to ARVs and increased salaries of Health workers.

Hon. Dr. Richard Nduhuura officiating at the forum

In light of the insufficiently funded Health Sector, he maintained that it is not within the powers of the MoH to increase the Health Sector Budget but Health Sector spending is largely dictated upon by the fiscal ceilings. However, he added that the MoH is not being quiescent about advocating more money for the health sector but that the ministry operates under strict guidelines set by the MoFPED in a bid to have equilibrium in the macro-economy. He concluded on the note that the Health sector is committed to participate, let alone spearhead any discussions that are geared at improving the health systems. With these remarks, he declared the forum open.

3. PRESENTATIONS

3.1. Keynote Address

Dr. Ian Clarke as he delivers the keynote address

The key note address was delivered by Dr. Ian Clarke, the Chief Executive Director of International Hospital Kampala (see Annex 3). Dr. Clarke presented his argument from different angles. He spoke from the management, building, marketing and finance angles but specifically from the perspective of a proprietor of a private hospital. From a non economist perspective he presented two schools of thought that explain the macro economics of Uganda today. First, the school of thought that "**the dog wags the tail"** a phrase borrowed from a Mayan tale that the dog is smarter than the tail, in reference to Uganda's budgetary dependence on donor support to the tune of 40-50%. Secondly, the school of thought that **"the tail wags the dog"** in which the donors are compelled to sustain budgetary support, short of which exposes the poor to greater suffering. He submitted that he subscribes to the second school of thought where donors

are bound to continue budget support and concentrate on macro economic policy, yet with minimal influence on government policy and how the donor funds are spent.

Dr. Ian Clarke explained that the center of the problem of the poorly funded health sector and other sectors too is largely due to the general lack of systematic and effective accountability for public resource, resulting into the enforcement of fiscal ceilings by the MoFPED. He added that none the less, even within the provisions of the ceilings, there are neither clear terms of reference nor systems to measure outputs. To support his notion, he cited other problems such as the general lack of responsibility for the process and outcomes of government projects and the little effort by government to increase government income.

Lastly, he submitted that possible solutions for addressing the current macro economic challenges is to put in place and enforce proper systems and procedures for public accountability, make results oriented disbursements as a way of measuring impact, finance the budget based on the needs of the majority and set up Social Health Insurance after detailed planning balanced with financial and actuarial analysis. In summary of his submissions given above, he proposed three recommendations as follows, make the budget for the minimum government expenditure for the health of the population according to the best model available, but make civil servants accountable, make finance available for ethical, accountable private sector healthcare (but not reducing the budget in the public sector) and finally make finance available for results driven, impact orientated health project funding.

3.2. Health Sector Priorities and Unfunded Gaps

Dr.George Bagambisa at the forum

Dr. George Bagambisa, the Assistant Commissioner, Health Service, Planning and Development, MoH made the presentation of Health Sector Priorities and Unfunded Gaps (see Annex 4). A summary of his presentation included the Health Sector Priorities, Priorities for 2006/07 and Key areas that need urgent attention.

He explained that the Health Sector Priorities are Maternal and Child Health, prevention and control of communicable diseases including HIV/AIDS, TB and Malaria, prevention of Non-communicable diseases and health promotion and disease prevention with a specific focus on northern Uganda. However, given the inadequate funds priority for PHC

development budget, the 2006/07priorities will focus on; operationalization of HC IVs, maternity, completion of other health centres and infrastructure for DHT. He summarized the key areas for urgent attention as Human resources (Hard to reach areas), essential medicines and supplies, infrastructure, health education and promotion and emergency response. In conclusion, he estimated the Health Gap at 80.59 billion Shillings.

3.3. Justification for Macro Economic Ceilings

The Justification for the Macro Economic Ceilings was presented by Mr. Michael Olupot- Tukei, the Assistant Commissioner, Macro-Economics, MoFPED.

Mr. Michael Olupot- Tukei at the forum

In response to the presentation made by the previous presenters, he alluded to the fact that much emphasis had been laid on macro economic stability. He explained that the macro economic policy be conducive for economic growth and poverty reduction, but controlling inflation is just but one way of achieving the macro economic stability. Other macro-economic variables should be considered and their effect on macro-economic stability carefully analyzed. He argued that though the key note speaker rightly emphasized planning as the desired way forward, some of the macro-economic variables such as inflation and interest rates are highly volatile and their effect on the economy can not easily be forecast. He observed that inflation rate is a key indicator of macro-economic stability. He clarified that allocation of resources at a policy level is done by politicians and not MoFPED. He clarified that in order to cater for the budget short bfall; government borrows from external sources in either grants or loans. He added voice to the other presenters that the Grants must be utilized effectively and productively to reduce chances of perpetual borrowing and donor dependence. He further emphasized that where as effective utilization of available resources is key, there are evident leakages of these resources.

He noted that the Ministry has often times engaged in the debate of prioritizing sectors and it has been clear that preferring one sector to another is difficult, considering that they all play a major role in productivity. He illustrated that security for one is as important as education and health. He concluded on the note that all these sectors are interdependent, and therefore prioritization may not solve the problem of poorly funded budgets. He suggested that more efforts be geared towards effective and efficient allocation and utilization of available

resources. He stated that the health allocation can be expanded, but more importantly, the health sector must work within and optimally use the available resources and avoid pilferage.

4. OPEN DISCUSSION

The open discussion was facilitated by Dr. George Bagambisa. He called encouraged members of the forum to be open as possible and as direct as possible. The following were the issues raised in response to the presentations and recommendations made to increase health financing in Uganda.

4.1. The role of parliament in budget process

The Chairman, Parliamentary budgetary committee, Hon. William Oketcho thanked AGHA for spearheading the discussion on macro economy and health financing in particular and explained the role of parliament in the budgetary process.

Hon. William Oketcho as he responds to the presentations made

He explained that the parliament does not make the final input to the budget process but clarified that they make their submissions to the president and together with the cabinet make the final input for the MoFPED to read. However, the major setback is the limited resource envelope within which all sectors are catered for. He emphasized that the allocations are within the provisions of the MTEF, which does not give the parliamentarians mandate to increase the budget allocation to a given sector outside the stipulated guidelines. He explained further that the resource envelop for the budget 2006/07 totals to 4.2 Trillion shillings i.e. an increase of 18% from last year, and hoped that the discovery of the oil resource will increase the resource envelope. He added that health, on the other hand, is given due priority and was optimistic that the health sector funding can increase.

4.2. Health planning

It was brought to the notice of members that one of the major setbacks to health funding is lack of adherence to the stipulated timeframe and guidelines by medical officers especially at the health center IV level. The chairman, Parliamentary Budget committee explained that prior to the Parliamentary input to the budgetary process, MoH avails a policy statement which caters for all the Health needs. Sadly, many of the planners do not meet the requirements of the MoFPED and MoH and cited incidences when health superintendents do not bring in the requisitions in time and the needs of the people represented are not

met. He emphasized that whereas the health services are inadequate, the medical superintendents are not keen on participating in the planning, budgeting and justifying their needs so that the decision making bodies make informed decisions during the resource allocation process. He emphasized the importance of understanding the needs of a particular unit early enough.

It was also noted that another setback to adequate and appropriate health financing is the irresponsibility by many civil servants that submit previous budgets without considering the current needs, population growth, emergence of new diseases, and more expensive treatments such as malaria and HIV/AIDS treatments.

4.3. Health policies

Members noted that the health policy statement was made in 1999 and does not meet the current needs. It was proposed that it is reviewed to cover new and emerging issues in the health sector. In response to the concern raised, the Assistant commissioner, Health service, planning and development responded that every five years, the MoH makes strategic plans and every year they make an annual policy statement to guide the budget process. However, he added that much is being done about the delays and irregularities from the health sector in submission of plans.

4.4. Resource allocation and utilization

Members expressed dissatisfaction in allocation of health resources and more so its utilization. To add voice to the presentations made earlier, members emphasized that whereas there are limited resources allocated to the health sector, there is need for the meager resources to be spent judiciously. It was emphasized that if the approved resources were spent carefully to cover the planned interventions, it would be most likely that the following year, the whole sector would perform better in service delivery.

Ms. Rosette Mutambi, Executive Director, HEPS-Uganda, Making her submissions

Members were concerned about the need for the MoFPED to put an anti corruption strategy in place, so as to ensure proper resource utilization and public accountability. Furthermore, they envisaged that with proper public accountability, there would be adequate donor support to the national budget and this would hopefully increase the resource envelope for the health sector.

In addition to proper accountability of resources within the health sector, members proposed that the MoH looks into the possibility of investing in initiatives that greatly reduce government expenditure on health e.g. investment in Insecticide Treated Nets (ITN) which will reduce expenditure on malaria treatment and ultimately reduce health expenditure. To augment this argument, the Srilankan experience was cited where increased funding for reproductive health activities resulted in a reduction in infant and maternal mortality by 7%. The experience of Tanzania where infant mortality rate was reduced through investment in child health care programmes was also cited.

Still in advocating appropriate allocation of resources, members were informed that recent findings by HEPS Uganda showed that a health sub district was allocated 23 million shillings for medicine for the whole year. Ironically though, it was noted that more resources were allocated for 4 wheel drive vehicles to high ranking health officers within Kampala and the cost of each vehicle is well above the 23 million shillings allocated to the health sub district in Lira.

Lastly, members were of the view that in allocation of resources within the health sector, emphasis should be given to investment in human resource. Staff welfare such as housing and transport especially in out of reach areas should be given due priority so as to improve on service delivery. Reference was made to the 4 wheel drive vehicles given to health officers within Kampala, while the people in the field are not cared for. It was further argued that important structures such as the Village Health Teams (VHT) that live with and support the communities are not adequately facilitated but more emphasis is laid at higher level.

4.5. MoFPED Economic Theories

It was noted with concern that the presentation of the MoFPED was more representative of the central bank. The MoFPED was advised to divorce its self from the central bank and look at issues from a practical point of view rather than dwelling on theories which are detached from reality. This was further illustrated by the view that in basic economics, the equilibrium is obtained through interaction of supply and demand and yet the MoFPED focuses on demand alone. This was in reference to the MoFPED's insistence on tax administration as the only way to increase the resource

Mr. Robb Alistair, DFID, participating in the open discussions

envelope yet other factors such as reduction in interest rates, increase in savings, investment and employment rates play a key role in the economy. It was observed that if donors contributed more money and investment was not emphasized, we would not realize economic growth. However, in response to the view that interest rates are a reliable indictor for macro economic stability, the MoFPED representative explained that it did not apply in the Ugandan context because it is not the practice of Ugandans to keep money on accounts, and therefore inflation is a more practical indicator because it's more visible and much easier to handle. However, one would still argue that it is the duty of the ministry to sensitize the public on the importance of saving and ensure that financial services are accessible to as many people in the country as possible.

In view of the "rigid" policies, Dr. Ian Clarke added that government civil servants should start thinking outside the envelope but think about the budget more in terms of productivity and efficiency. He advised that the Uganda could invest in utilizing the expertise of Ugandans in the planning, monitoring and evaluation of the use of available resources.

4.6. Prioritization

Members were concerned about the sector being given fourth priority in the budget process. It was expressed that it was befitting for health to hold the second position after education as a healthy population impacts greatly on productivity and economic growth. Members raised concern that since Uganda subscribed to the Abuja declaration, the health budget ought to have been increased to 15% of the national budget that was read in June 2006.

Members were reminded that the parliamentary budget debates for the FY 2007/08 commence in October 2006 and therefore needed to plan in advance so as to articulate the needs and requirements of the health sector.

4.7. Public - private partnership

It was brought to the notice of members that an alternative to budget ceilings can be found. For example, health financing could be increased through public - private partnership. In Uganda, where government funds are inadequate, the public - private partnership to health is not exploited and the synergies are not utilized to improve service delivery.

The president of Uganda Women Medical Doctor's Association (UWMDA) was concerned that the association was marginalized and not allocated resources from the Global fund to reduce maternal mortality levels. it was generally

observed that the contribution of CSOs as allies of government is often not recognized.

In view of the need to promote Public - private partnership in health planning, financing and service delivery, the chairman of the session proposed that the panel be reconstituted and another forum be convened at a later date with a wider representation of stakeholders to tackle the issue of inadequate health funding. He explained that investment in the partnership is crucial for accountability and efficiency. He acknowledged that public funding alone can't meet the demands of the population and therefore the partnership is necessary.

5. CLOSING

Dr. Margaret Muganwa as she closes the forum

The forum was closed by the Dr. Margaret Muganwa, the Chairperson, AGHA Board of Trustees. In her closing remarks, she thanked all the members for their availability and constructive submissions made during the open discussion. She expressed her sincere gratitude to Physicians for Human Rights (PHR), represented by Ms. Sarah Kalloch, for their support and partnership in advocating improved health systems in Uganda, and the media for partnering with AGHA in their advocacy campaigns. Lastly, she urged all members present to work as a strong and formidable force to ensure increased health financing and better accountability of public resources. She proposed a follow up meeting with the parliamentary budget committee and other related parliamentary committees to advance the noble cause.

6. ANNEXES

Annex #1: Objectives of the Health Economics Forum and overview of the budget

Hon. Dr. Elioda Tumwesigye
Patron AGHA and Chairperson Parliamentary Standing Committee on HIV/AIDS

Available resource envelope

- In the 2006/07 – Government is to spend Shs 4,255 bn and 41% of this is to be financed by development partners.
- The Health sector including Uganda AIDS Commission is to receive only Sh 381.85bn ($212 million) which is 8.97% of the resource envelope (Abuja Commitment is 15%). For a population of 26.9 million, per capita expenditure on health is Sh 14,195 equivalent to about 8 dollars per-capita compared to MOH recommended $ 28 (Shs 50,400) required for delivery of a minimum health care package excluding ARVs. CMH recommends $34 per capita
- The minimum health care package of Shs 50,400 per capita means we need a minimum of Sh 1355.76 billion or
- $ 753 million per year for free health care minus ARVs
- According to the MTEF whose objectives include reducing the fiscal deficit, raising the domestic revenue/GDP ratio and improving the sustainability of external public debt, The health sector allocation is expected to reduce further to 351.26 billion in 2007/08 and only rise to 436.31 billion in 2008/09. Popn now 28.2M
- Needed- allow for an increase in the resource envelope & health sector proportion or reduction of other sector %.
- Multi lateral debt relief should improve health status

Fears of increased HIV/AIDS Funding on macro-economic stability

- Increasing government expenditure not marched by increased domestic revenues increasing fiscal deficit financed y loans and grants. A big budget deficit means government will depend on big borrowing. Money from donors increases domestic money supply which in turn increases inflation as money supply will be more than money demand. An attempt to mop up money will increase treasury bill rates which pushes up interest rates and deters investment. Also increased dollar inflows not

backed by economic activity cause appreciation of the shilling and this makes our exports expensive.

- Fear overshooting of the budget ceiling for health sector

Key issues to be considered

- Is mild inflation always incompatible with economic growth? Is very low inflation always good for economic growth? Is inflation in Uganda not largely determined by food prices & weather
- Isn't investment in the health of people of productive age group (mainly affected by AIDS) albeit with medium -term macro-economic instability not good for long-term macro-economic stability?
- What do poor countries like Cuba, Costa Rica and Sri Lanka manage to have good health indicators?

Recommendations

- Increase the health sector budget ceilings, Cater for costs of AIDS care including ARVs and drugs for opportunistic infections as well as research in our budgets.
- Strongly support alternative sources of local funding such as Social Health Insurance & Micro-health /Community health Insurance
- Explore reviewing the sector ceilings and still allow for more donor funds for AIDS including MAP 2 grant.
- Establish a separate Uganda AIDS Fund along the principles of the Global Fund or NSSF to which donors, government and others can contribute. Such a fund could be outside the MTEF ceilings but inflows into the fund should be monitored by the Central Bank .
- Improve Coordination, implementation efficiency, monitoring & evaluation & review drug regulations and procurement systems
- Money for Drugs and equipment and technical assistance can be spent externally so as not to affect our economy
- Need to plan for ways of long term sustainability of ART. How can we plan to wean people off free ARVs
- Continue to promote programs for wealth creation so that our people can have money to pay for their own drugs
- The right to health is a fundamental human right. We must do good and always do the best to preserve and prolong life. Let us be human in our economic planning. Let us think of micro-economic and social stability as well.

The general objective of the forum is to provide a platform for different stakeholders to meaningfully debate issues related to health spending Vis-à-vis an environment of limited resources and government commitment to maintaining a sound macro- economic environment.

The specific objectives of this forum are:

1. To create an alternative forum for an exhaustive and frank dialogue between the MoH and MoFPED on sector ceilings, fiscal policies and the health budget.
2. To provide opportunity for lobbying MoFPED to rethink the fiscal conditionalities of the fixed ceilings given the possible consequences.
3. To allow meaningful contribution on issues of fixed ceilings and health of the population from the wider civil society.
4. To explore opportunities for networking between various stakeholders continued engagement of MOFPED on fiscal policies and macroeconomics
5. To suggest a way forward for all the stakeholders, both individually and as a network, in their commitment to lobby government and international donor agencies for increased health sector spending

Annex #2: Speech of the Hon. Minister of Health

Our Keynote Speaker for today, Dr. Ian Clarke
WHO representative,
Ministry of Health officials,
Ministry of Finance Officials,
The Board, Executive committee and staff of AGHA Uganda
Distinguished participants,
Ladies and gentlemen.

To day we are here to discuss this important subject of fiscal space in relation to competing health sector priorities and indeed this is a very important debate.

Uganda like other developing countries is struggling to deal with limited resources given the different needs of the population that government would like to meet.

Over the last 20 years, this government has registered several successes in the improving the health status of the population of this country;
Physical access has improved so that the percentage of people living within 5 km walking distance of a health facility is now 72%.
Immunization coverage for infants for some antigens e.g DPT3 is 86 %.
HIV/AIDS prevalence has reduced from 30% in the 1980s to 6% now.
Access to ARVs is now at over 70,000 people
Health workers salaries have more that doubled in the last three 3 years.
All these have enabled our people to access good quality health services which is a basic human right.

As we speak the health sector is implementing the HSSP II and in here is the Uganda National Minimum Health Care Package is still under funded.

The Health sector is introducing Social Health insurance as an alternative to mobilizing domestic resources and improving access to health care.

We have to examine the immediate implications of limited fiscal space on investments in health and the opportunities that these investments would bring.

There is no doubt that a careful balance between investments into the health sector and macroeconomics is essential and needs to be done carefully.

Exercising fiscal discipline in form of macroeconomics is necessary curtail inflation and encourage industrial growth. The danger of stalling or even

reversing the progress already achieved on health outcomes and other determinants of health has to be balanced delicately with restricted sector ceilings.

Government will continue to prioritize the health of the population. The recent fears expressed in the media of the danger of stock outs for antiretroviral drugs will not occur and the procurement of Long Lasting Insecticide Nets (LLIN) is taking place.

In conclusion, government will continue to mobilize resources for increased investments in health and continue to allocate these resources more equitably for efficient health interventions.

I wish to declare this Health Economics forum officially open and wish you good deliberations.

For God and my Country.

Hon Dr. Richard Nduhura, Minister of State for Health (General Duties) and currently holding portfolio of Minister of Health.

Annex #3: Key note Paper on Fiscal Sector Ceilings, Health and Industrial Growth.

By Dr. Ian Clarke

Please note that this presentation has been transferred from a power point presentation to word and slightly modified to maintain the flow.

Introduction
I am a doctor, I am not an economist. I make that comment for the benefit of the economists from the Ministry of Finance or IMF or World Bank. However, I am a doctor who has had to understand other professions in order to practice my own profession within Uganda.

New Vision ran the story earlier this year that "**Dr Clarke takes up road construction"**. You can call me - Engineer Clarke but there is a serious point to this, in order for me to facilitate my good practice of medicine in Uganda I had to understand and develop skills in Management, building, marketing and finance

Therefore this talk is very much from the perspective of someone who has to make a business work. Since Uganda is a country which is not driven by the private sector, we do not have Uganda Inc. It is driven by government, which is financed by donors – it is obvious to any lay person that government can only balance its books because it gets a 40 - 50% subsidy from donors. Donor's rationale is that they then have more leverage with government, etc. But does the dog wag the tail? Or does the tail wag the dog? However, the least that the donors can do since they are already in bed with government, is to see that there is fiscal responsibility and that the books balance. This is the reason that even in an atmosphere of economic gloom

The IMF can produce an economic overview that is not all that gloomy, makes perfect financial and economic sense, that is responsible because Uganda is (was) one of Africa's models for sound economic development. If you still think the dog wags the tail!

However if you are of the "tail wags the dog" school then the government has got the donors in a headlock. If they reduce budget support, things will start to come apart at the seams and those who will suffer the most will be those already at the bottom of the pile – the poorest. So they are bound to continue support, even though their influence on government policy is minimal.

In the meantime politicians do what they do best. They get on with politicking by creating new districts, awarding of civil service posts – at the behest of 'The Minister' or State House, creating new cabinet posts to have 'regional balance' and still people are not satisfied with their rewards from the political band-wagan. But all of this costs money and the EU, the Irish, the British, the World Bank or the IMF have precious little say in how it is spent, so they concentrate on macro-economic policy i.e. controlling inflation, Fiscal policy and money supply.

In the meantime back at the ranch, the civil servants understand what is really going on and where the source of money is from. It is not in business (in wealth creation), it is in politics, which translates into government. Donors have enabled the creation within Uganda of a very strong and robust public sector.

The problem

So what is wrong with a very strong public sector? **Accountability!**

The Ministry of Finance cannot call such public servants to account. But they can do what? They can give them ceilings in order that the books balance and hence we have a Health Sector Ceiling. But within that ceiling, politicians and public servants have a great deal of latitude such as:

- no business-like terms of reference or measurement of outputs
- Interventions are measured in terms of activities and not impact
- No financial responsibility, as in having to work to a bottom line of profit or loss
- Initiatives which have not been thought through are driven on a political imperative
- There are terrible inefficiencies in the execution of projects, but it is all taken as normal
- No sense of final responsibility (the buck stops here) either with the politician, or the public servant.

No private business could survive with these practices!

In terms of balancing the budget and controlling inflation, I do not disagree with the principle. I disagree with the lack of attention to the micro-economics, while there is complacency with the macro-economic performance (6% growth, OK falling to 4- 5% this year because of the electricity shortage e.t.c.). It doesn't sound all that bad in the IMF report. But play back to who was at fault for the power crisis in the first place?

- Not the President
- Parliament, select committees, politicians, all with their hand out
- Civil servants who were slow and bureaucratic
- Environmental groups who jumped on the bandwagon
- World Bank who were slow in their processes

- The collapse of Enron and the energy sector with the pull out of AES

AES committed $70,000,000. they were five years behind, Self Interest prevailed at every level, everyone fiddled, while Rome burned and the funniest part is that AES was not corrupt. If they had been corrupt and handed out more favours, the project would have progressed much faster.

The Budget Cake is divided up into Finance – Line Ministries, Defense, Public, administration, Health, State House and Education. The problem is that people only see things in terms of the size of the slice of the cake they are getting and there is no serious effort by the government sector to bake a bigger cake but it is just a question of fighting over the slices while the cooks (the donors) look on. If there was a different view taken of how the ingredients were used to make this cake, we could bake a bigger cake – a more productive economy. Therefore the question is – how do we change?

Recommendations

1. ***Accountability***

- Much of what is spent in Uganda is given to those who have no sense of accountability
- Eg G.E. were planning to give equipment to Uganda worth $20,000,000 – to the government sector.
- My question to G.E. was: when it came to philanthropy, why did they use totally different criteria, than when they were running their own business.
- There were many better ways in which they could have given this equipment

2. ***Results Orientated Disbursement***

- Measure impact, not activities
- Government counts health centres
- But what impact are they having in infant mortality rates, or maternal mortality rates?
- Government counts classrooms
- But what impact are we having on educational standards?

3. ***The Bottom Line***

We have a situation where projects are not driven by the need to be accountable, or the need to have an impact, or the need to look at the bottom line because the project is perceived as politically driven and government servants simply look at the top line – who instructed not the bottom line – will it work?

4. *Social Health Insurance*

It was key on the NRM manifesto and in principle, its not a bad initiative but it needs a lot of detailed planning, consensus, and a balanced wish list with the financial and actuarial analysis. However, it has been announced loudly that it is happening, because it is perceived as having strong political backing and no meaningful financial analysis. A cabinet paper was passed, a law drafted, no real meaningful consultations with stakeholders was made, a wish list published and expectations already raised through articles in the newspapers and no bottom line to see if it would work.

The Kenyans looked and pulled back because the sums didn't work. However in the case of Uganda, no serious responsibility being taken – just get the pot of money and hope for the best.

Any good businessman takes his money and invests it in the most productive sector of the business that will yield the highest return. Conversely, government takes their money and allocates it according to political pressure and need to balance the books.

Currently the Health Sector Ceiling is at $ 8.0 per person and 3.4% GDP. Worse still, even that little is misspent. Were that money spent in ways, seriously targeted to make a difference to the health of the population, productivity would increase at all levels and the cake would get bigger.

The priority sectors are health, education and infrastructure however; it is spent on defense and public expenditure

So what should we do?

- Make the budget for the minimum government expenditure for the health of the population according to the best model available, but make civil servants accountable.
- Make finance available for ethical, accountable private sector healthcare (but not reducing the budget in the public sector)
- Make finance available for results driven, impact orientated health project funding.

Thank you for your attention.

Annex #4: Health Sector Priorities and Unfunded gap

Health Sector Priorities

- The Priorities of the Health sector are as identified in the National Health Policy and UNMHCP.
- The UNMHCP consists of;
  - Maternal and Child and child Health
  - Prevention and control of communicable diseases including HIV/AIDS, TB and Malaria
  - Prevention of Non-communicable diseases
  - Health Promotion and disease prevention

- Focus on northern Uganda

Priorities for 2006/07

Given inadequate funds priority for PHC development budget will focus on;

- Operationalization of HC IVs
  - Maternity
  - OPD
  - Staff houses
- Completion of other health centres
- Infrastructure for DHT

Key areas that need urgent attention

- Human resources
  - Hard to reach areas
- Essential medicines and supplies
- Infrastructure
- Health education and promotion
- Emergency response

The gap is 80.59 bn

Annex #5: Programme for the day

ITEM	TIME	PERSONS	CHAIR
Arrival and registration of participants	8:30- 8:45 a.m.	AGHA	
Welcome remarks/ about AGHA	8:45-9:00 a.m.	*AGHA Board Chair*	WHO Rep. (WR)
Objectives of the forum	9:00- 9:10 a.m.	Hon. Dr. Elioda Tumwesigye, Patron, AGHA	
Opening remarks	9:10-9:30 a.m.	Minister of Health	
KEY NOTE PAPER ON FISCAL SECTOR CEILINGS, HEALTH AND INDUSTRIAL GROWTH	9.30-10.00 am	Dr. Ian Clarke	
Presentation on Health sector Priorities and Un funded gaps	10:00 – 10:20 a.m.	CHS (P)	Director Health Services, Planning and development
Justification for macro economic ceilings	10:20 – 10:40 a.m.	Commissioner Macro Economic Policy Department, MOFPED	
Question time	10.40-11.10 am	DHS, Planning and development	
Tea break	11.10- 11:40 am	AGHA	
Discussion	11.40 – 2.00 pm	DHS, Planning and development	
Lunch and departure	2.00 – 3.00 pm	AGHA	

Annex #6: Participants' contact list

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