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A case study of the Uganda National Minimum Healthcare Package

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The role of Essential Health Benefits in the delivery
of integrated services: Learning from practice
in East and Southern Africa

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Executive summary

The Essential Health Benefit (EHB) policy interventions aim to optimize efficiency while extending coverage by increasing equity of access to the defined benefits. Uganda's EHB is referred to as the Uganda National Minimum Healthcare Package (UNMHCP) introduced in the 1999 Health Policy. The UNMHCP is composed of cost efficient interventions against diseases or conditions most prevalent in the country.

This report compiles evidence from published, grey literature and key informants on the UNMHCP since its introduction in Uganda's health system, and findings were further validated during a one-day national stakeholder meeting. It includes information on the motivations for developing the EHBs, the methods used to develop, define and cost them, and how it has been disseminated, used in budgeting, resourcing and purchasing health services and in monitoring health system performance for accountability. It was implemented in an EQUINET research programme through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), in association with the ECSA Health Community, supported by IDRC (Canada).

Three main factors motivated introduction of the UNMHCP. First, Uganda, along with other low-income countries, was unable to implement holistically the primary healthcare (PHC) concepts as set out in the Alma Ata Declaration. Second, the macro-economic restructuring carried out in the 1990s, which was an international conditionality for low-income countries to access development financing, influenced the trend towards more stringent prioritisation of health interventions as a means of rationing and targeting use of resources. Third, the government sought to achieve equity with a service package that would be universally available for all people.

The process of developing the UNMHCP was long and contentious, involving a cross section of stakeholders at central and local government levels, with consensus not fully gained across vertical programmes. The UNMHCP became feasible when consensus was gained to adopt a sector-wide approach in planning and implementation.

Applied throughout the country's health sector, the UNMHCP intended to be available to all social groups. It covers services from community and primary care to hospital level. It covers most critical public health interventions, such as health promotion, disease prevention and community health initiatives, including epidemic and disaster preparedness, maternal and child health and prevention and management of communicable and non-communicable diseases.

The cost of delivering the UNMHCP was determined from the costing of the inputs required to deliver it at different levels of healthcare. In 2000, this was estimated to be US\$28 per capita. A further comprehensive costing using a similar methodology done in 2009 estimated the per capita cost to deliver the package at \$41.2. This later figure was higher due to inflation and other socioeconomic dynamics.

The public/government, private and development partners finance the UNMHCP. The public funding is from tax revenue, grants and concessional loans from development agencies, projects, global health initiatives and direct district financing. Private sources of funding include households, private firms and not-for-profit organisations. Some development partners fund through budget support while others provide off-budget support.

Financing the UNMHCP is a major implementation challenge. The Ministry of Health budget as a share of the total government budget has declined from 11.2% in 2004/5 to 6.4% in 2015/16, and out-of-pocket payment remains high at 40%, especially for private sector services. Over the last six years, government spent an average of US\$11 per capita on health. This is much lower than the earlier target of US\$28 per capita estimated to be the amount required to provide the UNMHCP. The

inadequacy and skills deficit in the health workforce are also key bottlenecks in implementing the UNMHCP, and there are challenges in the retention, motivation and performance of health workers.

The UNMHCP has been used to set priorities for inclusion in general and health-sector planning, budgeting, resource allocation and in negotiations on financing with the country's Ministry of Finance/or Treasury and key development partners. Due consideration is given to the package in determining the allocation of public funds to health, other essential inputs and the human resource establishment to run the health programmes. The UNMHCP has guided development of key sector performance indicators used to monitor sector performance, supported development of national treatment guidelines to rationalise medicine use and essential drug lists, with these measures prioritising the elements within the minimum package. It informed the design of the proposed benefit package for the National Health Insurance Scheme and was referred to in discussions on service delivery programmes.

In the public sector, purchasing relies on disbursement of funds through conditional grants or budgets to central-level institutions, district local governments and health facilities. All public health facilities are expected to provide the UNMHCP to the population free of charge, although this is often not the case. The government also purchases health services from private, not-for-profit faith-based health facilities through provision of grants for specified services based on agreed deliverables. In the private sector, purchasing is mainly by households and individuals through payment of fee-for services. Health worker services are purchased through monthly salaries, usually fixed according to cadre and seniority and not based on workload or performance

The UNMHCP is relevant despite limited resources, but the design needs to be reconsidered and aligned to current realities and to international and global commitments, such as the 2013 UN Sustainable Development Goals (SDGs). Broader discussions on how government can holistically address health challenges, bringing on board sectors responsible for addressing the underlying social determinants of health and household life-cycle needs, should be considered.

The UNMHCP could be revised to reflect as much as possible affordability issues, current epidemiological patterns and existing international commitments. It could consider priority public health conditions, including risk factors that contribute to the disease burden such as alcohol, environmental degradation, air pollution, nutrition, smoking and occupational hazards, among others. They should be considered not only for their relative morbidity burden, but also in relation to the cost of inaction.

Another alternative would be to have a shift in policy away from the traditional package to one that integrates health in all sectors through public policy reforms and through a multisectoral approach. This would also address the underlying social determinants of health, and be geared towards the attainment of Universal Health Coverage, as set out in the UN Sustainable Development goals (SDGs).

1. Background

An Essential Health Benefit (EHB) is a policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. EHB policy interventions aim to optimize efficiency while extending coverage through targeting to increase equity of access to the defined benefits. Many east and southern Africa (ESA) countries have introduced or updated EHBs in the 2000s. Recognising this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), in association with the East Central and Southern Africa Health Community (ECSA-HC) and national partners in the region, is implementing research to understand the role of facilitators and the barriers to nationwide application of the EHB in resourcing, organising and in accountability on integrated health services. The International Development Research Centre (Canada) supported the work through EQUINET.

This case study report compiles evidence on the experience of EHB policies at national level in Uganda under the auspices of the Ministry of Health. It contributes to both national and regional policy dialogue on the role of EHB policies. It presents information on the motivations for developing EHBs and the methods used to develop, define and cost them. The report further elucidates how the Uganda EHB has been disseminated and communicated within the country, how it is being used in budgeting, resourcing and purchasing health services and in monitoring health system performance for accountability and the facilitators and barriers in implementation.

1.1 Context

According to the 2014 Population and Housing census, Uganda has a population of 34.9 million and an average annual population growth rate of 3% (UBOS, 2014). The average household size is 4.7 persons, with a sex ratio of 94.5 males per 100 females. An estimated 72% of the population lives in rural areas and 28% in urban centres. Forty-nine percent (49%) of Uganda's population is under the age of 15 years and 18.5% of the total population is under-five years of age. The life expectancy at birth is 63.3 years (UBOS, 2014). The demographic data is summarised in *Table 1*.

Table 1: Demographic data, Uganda, 2014

| Population | Number in millions | % |
|--|--------------------|------|
| Total | 34.9 | 100 |
| Children aged 0-59 months (under five years) | 6.6 | 18.9 |
| Women of reproductive age (15-49 years) | 7.3 | 20.9 |
| Population that is under 15 years of age | 17.0 | 48.7 |
| Population of adolescents (10-19 years) | 8.6 | 24.5 |

Source: UBOS, 2014

Uganda is a low-income country with estimated gross national income per capita of \$660 (UBOS, 2014). The increase in annual gross domestic product has averaged around 5.5% per annum over the years of implementation of the National Development Plan 1 (2010/11-2014/15), a decline from the growth rate of 8% in the period 2006-2010 (GoU, 2016a). Poverty levels, the percentage of people living on less than US\$1 per day, have reduced from 56.4% in 1992 to 19.7% in 2012, according to the recent State of the Population Report (GoU, 2016d).

Administratively, the country is divided into 124 districts that constitute district local governments. According to the 1995 Constitution and local government law, the mandate for management of district health services is decentralised to district local governments (GoU 2000b). They are responsible for implementation and for managing the resources and inputs needed to deliver the service package at district health offices, general hospitals, health centres and community level. As

far as health is concerned, a district is further subdivided into health sub-districts (HSD) with headquarters at Health IV (GoU, 2010a).

1.2 Health, morbidity and mortality profile

According to the global burden of disease estimates, HIV, malaria, lower respiratory infections, meningitis and tuberculosis cause the highest numbers of years of life lost in Uganda (WHO, 2015). On their own, these five killers are responsible for just under half (48%) of all mortality in Uganda (GoU, 2015b). Apart from malaria, the mortality due to these top five killers combined is reducing, with lower respiratory tract infections having the largest decline (by 53%) from the 1990 levels to the year 2016 (GoU, 2016a). The most recent demographic and health survey revealed improvement of maternal, infant and under-five health outcomes as summarised in *Table 2* (UBOS, 2016).

Table 2: Uganda mortality profile, 2006, 2011 and 2016

| Year | 2006 | 2011 | 2016 |
|--------------------------|--------------|--------------|--------------|
| Maternal mortality ratio | 435/ 100 000 | 438/ 100 000 | 336/ 100 000 |
| Under-5 mortality rate | 137/ 1 000 | 90/ 1 000 | 64/ 1 000 |
| Infant mortality rate | 76/ 1 000 | 54/ 1 000 | 43/ 1 000 |
| Neonatal mortality rate | 29/ 1 000 | 27/ 1 000 | 27/ 1 000 |

Source: UBOS, 2016

1.3 Organisation of health system

The health system in Uganda is decentralised. One of the core aims of decentralisation is to ensure that districts are able to direct resources to address local priorities. At the apex of the health system structure is the Ministry of Health, which is responsible for policy formulation, planning, quality assurance, epidemic response, international relations, resource mobilisation and monitoring and evaluation (GoU, 2016b). District local governments are responsible for managing the district health system and all healthcare providers under their jurisdiction. The district health system includes district health offices, general hospitals, health centres, village health teams and other community health initiatives. Some districts are divided further into health sub-districts, administered at the Health Centre (HC) - IV level (GoU, 2016c). The districts and health sub-districts are responsible for leadership in planning and managing the health services under them (Kamwesiga, 2011). *Figure 1* overleaf shows the organisational structure of the health system used to deliver services.

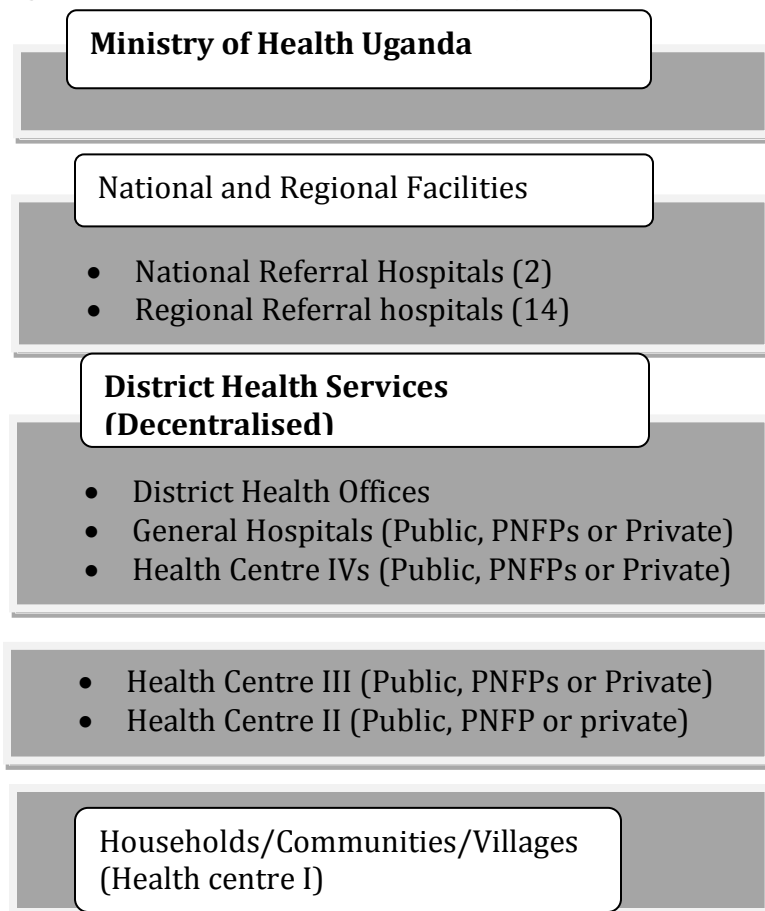
The delivery of the UNMCHP is through public, private-not-for-profit (PNFP), private health providers and traditional/complementary medicine practitioners (TCMP) (GoU, 2016b). The PNFP facilities are predominantly faith based, administered by the religious bureaus at national level in partnership with local diocesan boards (GoU, 2016b). The private health providers, which comprise hospitals, health centres, outpatient clinics, drug shops, are managed privately by respective owners but are licensed and supervised by regulatory boards and councils. Most of the hospitals and health centres are government owned (GoU, 2012a). A summary of health facilities by ownership and level of care is shown in *Table 3* overleaf.

In addition, the central government co-ordinates and supervises specialised semi-autonomous institutions to deliver public health services. These include Uganda Heart Institute, Uganda Virus Research Institute, Uganda Cancer Institute and Uganda National Research Organization (GoU, 2010a). The other national-level institutions are National Medical Stores, National Drug Authority, National Blood Transfusion Services, Central Public Health Laboratories, Malaria Research Council and the Chemotherapeutic Research Institute.

The health system is financed by government, households, private firms and health development partners (GoU, 2016b). In the public sector, delivery of the UNMHCP is largely financed through government disbursements, concessional loans and grants from development partners. The average general government allocation for health as percentage of total government budget has been around

8% from the year 2010 to 2016 (GoU, 2016a), less than the Abuja target of 15% (GoU, 2015b). The per capita expenditure on health from all sources was 56% in 2015, lower than the WHO recommended minimum level of \$60 and much less than the Health Sector Development plan set target of \$73 for the period (GoU, 2015a; 2016a).

Figure 1: Organisational structure of the health system



Source: Adapted from Kamwesiga, 2011

Table 3: Health facility ownership in Uganda by level of care

| Level | Ownership | | | | Percent of all levels | Services provided |
|----------------------|--------------|------------|--------------|--------------|-----------------------|---|
| | Public | PNFP/NGO | PHP | Total | | |
| Hospital | 63 | 64 | 20 | 147 | 3% | Inpatient and outpatient care, specialist services, teaching and research |
| Health Centre IV | 170 | 15 | 8 | 193 | 4% | Comprehensive Emoc plus back up referral to lower level facilities |
| Health Centre III | 916 | 264 | 70 | 1,250 | 24% | Basic preventive, promotive and curative services, laboratory and maternal care |
| Health Centre II | 1,695 | 520 | 1 395 | 3,610 | 69% | First interface between formal health services and communities |
| Total | 2,844 | 863 | 1,493 | 5,200 | 100% | |
| Percentage Ownership | 55% | 17% | 29% | 100% | | |

Source: GoU, 2012a; Emoc = Emergency obstetric care PHP= private health provider

In the public sector, purchasing of health services relies on the government's quarterly release of funds to public and PNFP health facilities, district local governments and central-level institutions to support delivery of services. Government pays for health services through direct provision of resources for health workers' salaries, pharmaceuticals and operations (GoU, 2016b). A resource allocation formula based on standard unit of output expected to be delivered by the health facility or institution is used to apportion funds to non-wage recurrent, wages and development expenditures. Meanwhile in the private sector, purchasing of services is mainly on a fee-for-service or out-of-pocket payments by individuals or households (GoU, 2014). However, government also purchases health services from PNFP health facilities through provision of grants and secondment of staff based on agreed undertakings.

Regarding human resources for health, although staffing levels have been improving they are still inadequate to meet the population and health system needs. The percentage of approved posts filled by health workers in public health facilities increased from 56% in the financial 2010/11 to 63% in 2012/13, and to 71% in 2015/16 (GoU, 2016a; WHO, 2009). However, the number of doctors, nurses and midwives per 1,000 people is 0.74/1,000, far below the WHO threshold of 2.3 doctors, nurses and midwives per 1,000 people. Broken down further, doctors are 0.03/1,000, midwives 0.25/1,000 and nurses 0.46/1,000 (GoU, 2016a).

In summary, the country adopted the EHB policy to ensure that the available limited resources are concentrated on demonstrably cost-effective interventions, in order to have a large impact on reducing morbidity and mortality and enhancing equity (GoU, 2010b).

2. Methods for the case study

The case study followed a protocol developed for the regional EQUINET project by TARSC and IHI, with input from all the country sites to allow for later regional comparisons. This study was conducted for one year, from May 2016 to May 2017.

Evidence was searched through: in-depth desk review of key Ministry of Health policy and strategic documents, annual sector performance reports, mid-term review of strategic plan reports, quarterly ministry of health performance reports, evaluation studies and reports. Additional reports included: Uganda Bureau of Statistics, overall government reports and documents related to health such as the National Development Plan and Millennium Development Goals (MDGs), official government communications and unpublished documents and literature and published research papers. In addition, internet searches of published and grey literature from a wide range of databases were conducted, including international literature such as WHO reports, UNICEF, UNFPA, USAID, Joint Assessment of National Strategic Plans report, World Bank reports and other strategic partner review information. Online journals such as PubMed/Medline, Bioline International and Popline were also searched. The documents reviewed were from 1995 to 2017.

The internet search strategy used terms such as Uganda minimum healthcare package, essential healthcare packages, essential service package in Uganda, evaluation of Uganda national minimum healthcare package, implementation of Uganda national minimum healthcare package, motivations for implementing Uganda national minimum healthcare package and challenges, costing of the Uganda minimum healthcare package. Open access electronic documents were included.

The documents were reviewed for content relevance to the study areas. Those found to be relevant were further analysed for evidence according to the thematic sub-topics and objectives of the study. Quality control measures to identify omissions and errors in the literature review included review of relevant documents and summarising the key findings independently by each team member and

thereafter sharing the findings in debriefing meetings amongst team members. The agreed upon evidence was then included in the write-up by the country lead for the study.

Eleven key informants were interviewed to complement the desk review. Information obtained from our key informants addressed some of the following gap areas: the policy purpose of the package; the consultation process when designing the package; issues pertaining to the use of the package for strategic purchasing and promoting accountability; the role of the private sector; and the overall relevance of the UNMHCP. Informed consent was sought to conduct key informant interviews with the identified persons on the understanding that their participation and responses would be kept confidential. *Table 4* summarises the portfolios and the key informants interviewed, most of whom also participated in the consultative meeting to validate the report.

Table 4: Summary of key informants interviewed

| Institution | Department/Portfolio | Number of Key Informants |
|-----------------------|----------------------------|--------------------------|
| Ministry of Health | Planning | 3 |
| | Budget and Finance | 1 |
| | Public/Private Partnership | 1 |
| | Human Resource | 1 |
| | Pharmacy/Medicines | 1 |
| | Nursing | 1 |
| | Maternal and Child Health | 1 |
| Implementing partners | | 1 |
| Civil society | | 1 |

The content of key informant interviews was analysed and the findings integrated into the overall report. A national stakeholders meeting was conducted to validate our draft report.

3. Development of the essential health benefit

3.1 Timeline

Uganda's EHB, referred to as the Uganda National Minimum Healthcare Package (UNMHCP), comprises interventions that are demonstrably cost effective with the largest impact on promoting health, preventing disease and reducing morbidity and mortality (GoU, 1999; 2010a). It was established in the first National Health Policy of 1999/2000-2009/2010 (GoU, 1999), and subsequently operationalised in the country's Health Sector Strategic Plans of 2000/01-2004/05 and that of 2005/06-2010/11 (GoU, 2000; 2005b). Health sector policy documents have continued to focus on the pivotal concept of the UNMHCP, including the Second National Health Policy of 2010-2020 (GoU, 2010b). The package was further restated and emphasised in the country's Health Sector Strategic and Investment Plan 2010/11– 2014/15 (GoU, 2010a).

3.2 Motivations for development of the essential health benefit

The motivations for development of the minimum package included:

- *Inability to implement primary healthcare holistically:* Uganda, along with other poor countries and their health development partners, adopted vertical selective packages of primary care because they were unable to implement the PHC concepts as set out in the Alma Ata Declaration (GoU, 1999; 2000a). The earliest EHB policies include Essential Drugs Programme and the Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization, in short GOBI programme for Maternal and Child Health (MCH) rolled out by UNICEF (GoU, 2002; WHO, 2002; Marcos, 2004).
- *International conditionality:* Macro-economic restructuring of the 1990s was an international conditionality for poor countries, such as Uganda, to access development financing and influence

the trend towards more stringent prioritisation of health interventions as a means of rationing and targeting use of resources (GoU, 2001). The World Bank Report 'Investing in Health' documented these practices and articulated a scientific rational approach for prioritising interventions based on a standard measure of intervention efficiency. This was expressed in terms of disability-adjusted life years (DALY's) saved per unit of currency, and it promoted the concept of using cost effectiveness of health sector interventions and the burden of disease as the basis for defining essential packages of clinical and preventive care (World Bank, 1993).

- *Limited resources*: Implementation of cost-effective interventions would help achieve value for money in face of limited resources coupled with high disease burden (GoU, 2010a; Ssengooba, 2004).
- *The high burden of disease*: According to the 2000 Health Sector Strategic Plan that operationalised the first health policy, a burden of disease and cost-effectiveness study was done in Uganda in 1995. The study found that over 75% of life years were lost due to premature death because of ten preventable diseases, namely perinatal and maternal conditions, malaria, acute lower respiratory tract infections, AIDS and diarrhoea (GoU, 2000a). At that time, together these diseases accounted for over 60% of the total national burden of mortality. At the top of the list were diseases that included tuberculosis, malnutrition and measles. Apart from the heavy burden of infectious disease, Uganda was experiencing a marked upsurge in the occurrence of non-communicable diseases that needed to be addressed (GoU, 1999).
- *Reduction of poverty*: Ill health and out-of-pocket payments for health are drivers of poverty. When the minimum package was introduced, the Ministry of Finance reported high levels of poverty among the population, with an annual GNP per capita of \$300 and approximately 46% of the people living in absolute poverty (GoU, 2000b). Poverty was recognised to be the main underlying cause of poor health in the country. During the introduction of the EHB policy, the country was struggling to recover from decades of civil strife and was severely constrained and overburdened by debt, making it imperative to plan carefully, to prioritise judiciously and to rationally allocate the limited available resources. In response to the high poverty levels, the government embarked on a major poverty eradication action plan with PHC being among the priorities (GoU, 1999).
- *To address equity*, since the minimum package was to be made available to every person with similar need regardless of age, gender or location (GoU, 2010a). In a way, the UNMHCP was guaranteed by the government and funded by tax revenue and accessed freely.
- *To overcome the limited coverage and accessibility to health services* (GoU, 1999): The rural population, where the majority of the poor lived, were constrained in terms of access to healthcare by distance and geographical physical features such as rivers, marshes and hills. Access to healthcare was limited geographically, with an estimated 49% of the population living within five kilometres of a health service unit and only 42.7% of parishes having access to any form of health facility (GoU, 2000b). Rural communities were particularly affected mainly because health facilities were mostly located in towns along main roads. In addition, there were *marked variations in access to healthcare* both within and between districts. Even where the facilities existed, access to basic healthcare elements was far from optimal. As a result of many years of civil strife and neglect, a massive backlog of dilapidated infrastructure developed, compromising efficiency and discouraging utilisation. In addition, the quality and range of care provided at existing health facilities required a lot of improvement.
- *Political considerations and accountability* were factors in motivating policy development (GoU, 2005b). The package described clearly the services to be provided at all levels of healthcare delivery. It is a useful tool to hold government, policy makers, healthcare providers and all other players accountable. Moreover, the performance of the minimum package is reported quarterly and annually to all key stakeholders, including oversight agencies such as Parliament, donors, local governments and civil society (GoU, 2001).

4. The current design of the EHB

4.1. Policy purpose

The purpose of the EHB policy in Uganda was to optimize delivery of essential benefits through cost-efficient health interventions, while extending coverage by targeting sub-populations and by level of care for improved equity of access to care.

Specifically:

- i. The UNMHCP was designed to address the limited resource envelope for the health sector and to ensure that the government meets the essential healthcare needs of the wider population at a minimal cost, addressing the most prevalent preventable diseases (Colenbrander et al., 2014; Zikusooka et al., 2009).
- ii. It sought to rationalise funding priorities by focusing on health services that are demonstrably cost effective, acceptable socially, politically and culturally and affordable and that have the largest impact on reducing mortality and morbidity (GoU, 1999; 2010a; 2013). Since there is no public insurance for health services in the country, the minimum health package represented a kind of health insurance that the state would provide to its population (Ssenigooba, 2004).
- iii. Revising and regrouping its contents were designed to foster increased co-ordination in planning, budgeting and implementation and to ensure efficiency and implementation of cost-effective interventions in an integrated manner at all levels of the system (GoU, 2016c).
- iv. It aimed to support implementation of the country's decentralisation policy by ensuring that district local governments implement policies and plans that deliver the elements of the UNMHCP to the population/citizens (GoU, 2008).

4.2. Content

The 1999 and 2010 national health policies and their accompanying strategic plans explicitly state that the minimum healthcare package in Uganda would consist of the most cost-effective, priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector (GoU, 1999; 2000a). The following diseases/conditions were considered priority elements of the UNMHCP: malaria, STI/HIV/AIDS, tuberculosis, diarrhoeal diseases, acute lower respiratory tract infections, perinatal and maternal conditions attributable to high fertility and poorly spaced births, vaccine preventable childhood illnesses, malnutrition, injuries and physical and mental disability.

The contents of the UMHCP were informed by the 1995 burden of disease study in Uganda. According to the Health Sector Strategic Plan 2000/01-2004/05, the study found the top ten causes of morbidity and mortality to be preventable communicable diseases, perinatal- and maternal-related conditions such as malaria, acute lower respiratory infections, HIV/AIDS and diarrhoea, tuberculosis, malnutrition (under-nutrition), anaemia, Intestinal infestations, trauma/accidents, skin infections, mental health and cardiovascular diseases (GoU, 2000a).

Specific priority programmes were selected for inclusion in the UNMHCP based on their contribution to the national disease burden and socioeconomic impact on the population (GoU, 2000a). The priority programmes were:

- i. Control of Communicable Diseases: malaria, STD/HIV/AIDS, tuberculosis
- ii. Integrated Management of Childhood Illness
- iii. Sexual and Reproductive Health and Rights
- iv. Immunisation
- v. Environmental Health
- vi. Health Education and Promotion
- vii. School Health

- viii. Epidemic and Disaster Prevention, Preparedness and Response
- ix. Improving Nutrition
 - x. Interventions against diseases targeted for elimination or eradication
- xi. Strengthening Mental Health Services
- xii. Essential Clinical Care

The elements of the UNMHCP were revised in the second National Health Policy 2010 and further regrouped in four clusters in the accompanying Health Sector Strategic and Investment Plan 2010/11-2014/15 (GoU, 2010a), as follow:

Cluster 1 – Health Promotion, Disease Prevention and Community Health Initiatives

Cluster 2 - Maternal and Child Health

Cluster 3 - Control of Communicable Diseases and

Cluster 4 - Control of Non- Communicable Diseases/Conditions.

The application of the UNMHCP has been re-defined in Guidelines to the Local Government Planning Process for Essential Health Packages for the different levels of health service delivery aligning it to the structure of Uganda’s health system (GoU, 2016c). It specifies the services expected to be delivered at each level of care as indicated in *Table 5*.

Table 5: Content by level of care for the revised EHB for Uganda

| Service level | Coverage population | EHB content by level of care |
|--|------------------------------------|---|
| Primary (Community Level/ Health Centre I) | Provides coverage to 1,000 people | Mobilisation to improve people’s health, data collection, health promotion, hygiene and sanitation, nutrition and child growth monitoring and model homes. |
| Health Centre II | Provides coverage to 5,000 people | Immunisation fixed and mobile, antenatal care, health education, sanitation and disease prevention, screening for health risks/diseases, family planning, basic first aid, monitoring service delivery, general OPD services, emergency deliveries, plus all functions of Health Centre I. |
| Health Centre III | Provides coverage to 20,000 people | Minor surgery, maternity services, inpatient services, sanitation, treatment of common diseases and illnesses, static immunisation, minor dental treatment, sexual reproductive health, basic laboratory services plus functions of Health Centre II. |
| Health Centre IV | Provide coverage to 100,000 people | Supervision of Health Centre III and II, centralized data collection, analysis of health trends and disease surveillance, simple surgery including Caesarian section and life-saving surgical operations, blood transfusion, ultra sound examinations for abdominal conditions, standby ambulance, mortuary, plus all functions of Health Centre III for the target population. |
| General Hospital | Covers 500,000 people | Plain X-Ray examinations, all general medical and surgical conditions, specialist services, plus all functions of Health Centre IV. |
| Regional Referral Hospital | Covers 1,000,000 people | General and specialist services such as psychiatry, ear, nose and throat (ENT), radiology, pathology, ophthalmology, higher level surgical and medical services including teaching and research |
| National Referral Hospital | Covers >1,000,000 people | The national referral hospitals provide comprehensive specialist services and are involved in teaching and health research. |

Source: GoU, 2016c

4.3 Methods and processes in the design and issues faced

The process of developing the UNMHCP was reportedly long and contentious, as well as participatory and consultative (GoU, 2000a). The health sector stakeholders involved in the design and prioritisation of the UNMHCP also discussed Sector Wide Approach to health (SWAp). (Kirunga et al., 2006). One of the Uganda peer reviewers of the case study observed that:

Consensus on the contents of the UNMHCP took more than 3 years because of strong dissenting views among stakeholders on resourcing and financing the system to deliver the packages from a multiplicity of vertical programmes. The UNMHCP only became feasible when consensus was gained to adopt a SWAp... The integrated planning, budgeting and implementation approach called SWA, was the enabler of the UNMHCP implementation.

The consultations and discussions on the UNMHCP were undertaken with a wide range of stakeholders, including local government leaders, faith-based organisations, development partners, civil society and other line ministries. The approval process passed through the Uganda's relevant health sector governance structures, namely the different technical working groups, senior management committee of the Ministry of Health, the health policy advisory committee for the health sector whose membership includes civil society, health development partners, representation of district health officers, ministries of finance, and social development sector ministries, faith-based health sector providers and the private sector and the top management of the Ministry of Health (GoU, 2000a; 2012b).

4.4 Costing of the essential health benefit

Identification of the resources, capital and recurrent cost of the UNMHCP:

The cost of delivering the package was determined using the 'ingredients approach,' which involved costing the inputs required to deliver the package at different levels of healthcare from a providers' perspective, in this case the Government of Uganda (GoU, 2001; 2005b). It involved identifying all inputs required to provide a service, quantifying and attaching a value to each input separately and getting a cumulative value (Zikusooka et al., 2009). The inputs for the recurrent costs of delivering the minimum healthcare package included clinical personnel, drugs, vaccines, hospital beds, laboratory supplies, x-ray supplies, office supplies, travel expenses, utility, maintenance, support staff, supervision allowances, information, education and communication (IEC) and social marketing, in-service training, and national management support (GoU, 2005b).

The costing of the UNMHCP was largely facility based except for the estimated costs at central level (GoU, 2000a; 2005a). The costing applied to both government and NGO facilities and assumed that irrespective of whether the facility is government or NGO, the requirements for the same facility level were similar. A summary of the estimated per capita recurrent cost of delivering the UNMHCP from primary care to national referral facility is shown in *Table 6*.

Table 6: Estimated annual recurrent US\$ cost per capita for UHMCP, public sector, 2000-2006

| Service Level | US\$ /capita estimate 2000/1- 2005/6 |
|--|--------------------------------------|
| Primary (community level) | 248 |
| Health centres II, III & IV | 146 665 |
| Secondary (district hospital services) | 363 289 |
| District health management team | 84 405 |
| Tertiary (provincial/regional referral hospital) | NA |
| National level/quaternary | 2 363 391 |

Source: GoU, 2000; NA= not available

As part of the development of minimum service standards and using similar ingredients methodology, an additional comprehensive costing was done in 2009. The costing reported that implementation of the full UNMHCP to the entire population of Uganda in the current norms and

standards carried a heavy price tag per capita of \$41.2 for 2008/09, estimated to rise to \$47.9 in 2011/12 (Brown et al., 2009). *Table 7* shows a summary of estimated total and per capita cost of UNMHCP from the year 2008/09 to 2011/12 (Brown et al., 2009).

Table 7: Total and per capita cost of UNMHCP

(at constant exchange rate: \$1=1,750)

| | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|--|---------|---------|---------|---------|
| Annual total cost (billion Uganda shillings) | 2 134.1 | 2 310.9 | 2 540.6 | 2 750.7 |
| Per capita cost (US\$) | 41.2 | 43.1 | 45.8 | 47.9 |

Source: Brown et al., 2009

Furthermore the costing done in the development of the minimum service standards estimated that about 92% of the total costs of the UNMHCP would be made up of recurrent items (e.g., human resources, utilities, transport, medicines, vaccines and other operational costs) and 8% was capital items (e.g., health infrastructure, equipment, vehicles, hospital beds etc) (Brown et al, 2009). These estimates were comprehensive costs of all inputs required for delivery of health services, including costs of key health systems functions like supervision, in-service training, monitoring and evaluation, and direct inputs for service delivery, as listed above. Costs per head were calculated by dividing total cost of the package (for a given year) with the corresponding projected population for that year. The costs were then categorised by level of care as shown in *Table 8*.

Table 8: Cost of UNMHCP by level of care: Cost per capita (US \$), 2008-2012

(at constant exchange rate: \$1= 1,750)

| Facility level | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|-----------------------------|-------------|-------------|-------------|-------------|
| Community level | 0.39 | 0.41 | 0.45 | 0.48 |
| HC II | 6.38 | 6.91 | 7.46 | 8.10 |
| HC III | 5.56 | 5.94 | 6.40 | 6.81 |
| HC IV | 4.66 | 4.87 | 5.35 | 5.61 |
| General hospital | 6.71 | 6.89 | 7.38 | 7.53 |
| Regional referral hospital | 3.72 | 3.78 | 4.00 | 4.09 |
| National referral hospitals | 6.71 | 6.81 | 7.11 | 7.29 |
| Autonomous institutions | 0.14 | 0.48 | 0.48 | 0.48 |
| District director's office | 3.12 | 3.22 | 3.32 | 3.51 |
| Ministry of Health | 3.80 | 3.79 | 3.82 | 3.98 |
| TOTAL | 41.2 | 43.1 | 45.8 | 47.9 |

Source: Brown et al., 2009

The subsequent costing of the Health Sector Strategic and Investment plan 2010/11-2014/15 and the most recent Health Sector Development Plan 2015/16-2019/20 did not directly cost the inputs required to deliver the UNMHCP (GoU, 2010b; 2015b). It costed programme areas and investment domains required to implement the strategic plans in general rather than the specific elements of the UNMHCP. The investment domains were categorised along health system blocks, namely health products and technologies, health workforce, health infrastructure, governance, information and service delivery and logistics management. This costing approach might limit the focus and resource flow to the specific elements of the UNMHCP.

5. Current use of the essential health benefit

5.1 Use and dissemination

The UNMHCP is currently used:

a. In designing services:

- It has set service priorities for inclusion in the overall National Development Plan and specific health sector planning, health budgeting, resource allocation and negotiations on financing with the treasury and key development partners (GoU, 2015b).
- It has guided the human resource establishment and placements to run the programmes (GoU, 2008). It has helped raise and augment negotiations for the wage bill for recruitment of critical human resources for the sector and financing issues for effective delivery (WHO, 2008). It has been useful in designing the national health insurance scheme and its related benefit packages and is shaping discussions around the proposed results-based financing being considered for implementation in the sector. The health insurance scheme is due for implementation once the national assembly approves it (GoU, 2015a).

b. In resourcing services:

- The UNMHCP is referred to in planning and resourcing district local governments. It guides the district health management team during development of strategic and operational plans and budgets within the Mid-term Expenditure Framework (MTEF) (GoU, 2010a). Through regional planning meetings, the ministries of health and finance support district local governments in planning to ensure district health plans are aligned with national health priorities, focusing on prioritisation of UNMHCP implementation.
- The UNMHCP has been helpful in structuring discussions and resource allocation in the health SWAP (GoU, 2015b). In recent years, the UNMHCP remains centre stage in the health sector planning documents even though many programmes have found alternative funding from Global Health Initiatives (WHO, 2008; Wright, 2015).

c. To support implementation of health services:

- The UNMHCP has been considered in the development of disease- and programme-specific strategies and plans such as the national expanded programme on immunisation, national TB strategic plan, malaria control strategic plan, HIV/AIDs prevention and control strategic plans, reproductive, maternal, new born and adolescent health plan, Uganda National Health Laboratory policy; and national Quality Improvement Framework and Strategic plan, among others (GoU, 2015c).
- The package has been a resource in developing national treatment guidelines for common conditions and diseases in the country, and its implementation has been helpful in developing essential drug lists, prioritising the components of the minimum package (GoU, 2012d). The Uganda Clinical Guidelines (UCG) aims at ensuring rational use of the available essential medicines and health supplies and standardising treatment protocol. All health workers and prescribers are expected to adhere to the UCG while treating their patients. It has also been useful in the development of infrastructure and equipment requirements for each level of healthcare.

d. To support monitoring and review of services:

- Development of key health sector performance indicators used to monitor health sector performance takes into consideration the elements of the UNMHCP. The performances of these indicators are the basis for additional government resource allocation to districts where there are more interventions (GoU, 2013). This additional support, however, does not take into account the direct partner/direct financing to districts. The UNMHCP has acted as a platform from which to discuss service delivery with programmes; for example, it has influenced the debate about the ultimate closure of stand-alone leprosy and TB services (WHO, 2008).

An important mechanism for disseminating the minimum package has been to embed it in key policy and strategic documents that are officially launched, published and shared with key stakeholders,

including other line ministries, local governments, district local authorities and all health providers. Involvement of key stakeholders in the development and design of the UNMHCP ensured ownership, knowledge and information sharing. Other modes of dissemination include annual and quarterly reports, electronically, during regional planning meetings/ trainings for district technical and political leaders and supportive supervision to the local governments.

5.2 Implementation

The UNMHCP has been implemented in the country for about 17 years. According to the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15, the package is delivered by public and private sectors, as it was developed for all levels of healthcare (GoU, 2010a).

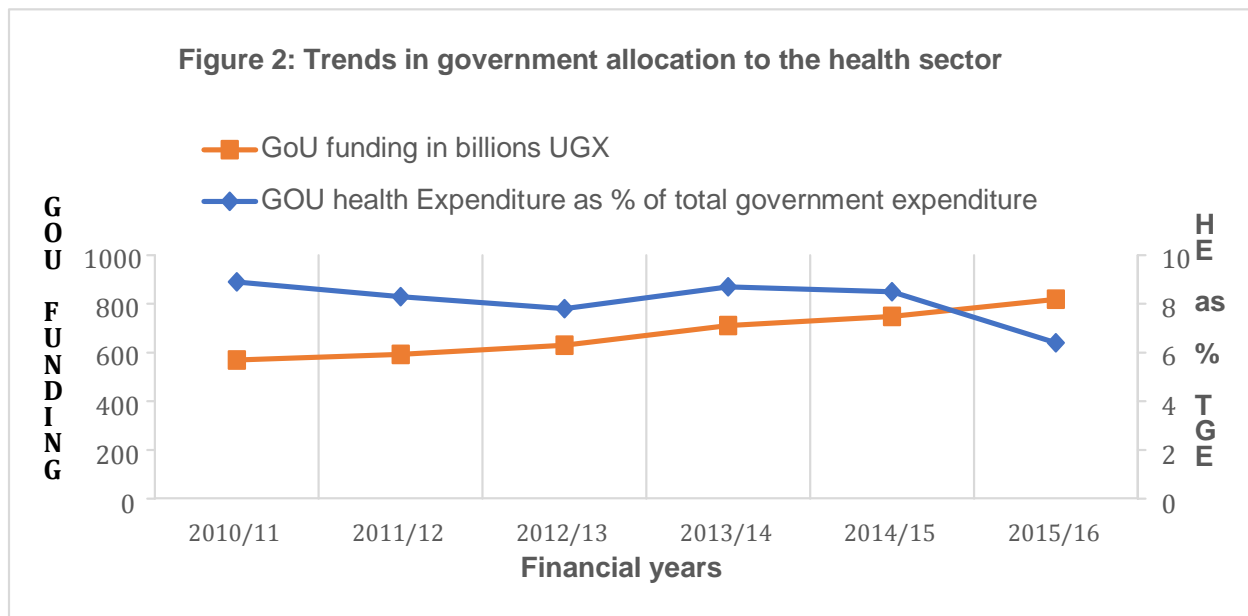
Public sector purchasing of health services relies on government making quarterly disbursement of funds to health facilities, local governments and institutions (GoU, 2016b). A significant proportion of the funds disbursed are conditional or earmarked, so there is no flexibility in their use. The funds for purchasing non-salary inputs at the health facilities have been largely constant over the years, although their needs have been increasing (GoU, 2016b). The per capita public expenditure on health from financial year 2010/11 to 2015/2016 has averaged around \$11, the highest amount was \$13.5 in 2014/15 and the lowest was \$9 in 2012/13, a fluctuating trend (GoU, 2016a). Public sector health funding has thus remained below the earlier target of \$28 per capita estimated as the amount required for provision of the UNMHCP (Ssengooba, 2004; Zikusooka et al., 2009). Households are the main purchasers of private health services through out-of-pocket payments since there is no national health insurance yet; however, government provides subsidies and grants to the private sector as a way of lowering costs (GoU, 2016b). For instance, government subsidises antimalarial medicines sold at private pharmacies through the so-called affordable medicines facility. Government and development partners fund the delivery of the UNMHCP through health grants, concessional loans, projects, direct district support and Global Health Initiatives such as Global Fund and Gavi alliance (GoU, 2016a; 2011). Private sources include households, private firms and not-for-profit organisations.

Financing the minimum package is a major implementation challenge. Government funding has increased in absolute terms from Uganda shillings 569.56 billion (US\$178 million) in 2010/11 to Uganda shillings 818.86 billion (US\$256 million) in 2015/16. However, the share of the health sector as percent of total government expenditure has declined in recent years (GoU, 2016a). The government expenditure on health as percentage of total government expenditure has declined from 8.9% in 2010/11 to 6.4% in 2015/16, as illustrated in *Figure 2* overleaf (GoU, 2016) .

Tracking expenditures of the most recent national health accounts (NHA) found that public health financing represented only 17% of the total health expenditure, development partners support 41% of health expenditure, mainly off budget, and the private sector, including households, 42% (GoU, 2016a). The NHA found the out-of-pocket payment to be as high as 40%. Much as the UNMCHCP was designed for the whole health sector, the private sector does not have capacity to deliver all components and charges a fee for each service.

Decentralisation of services introduced in the 1990s constrained the delivery of the minimum package because of the low resourced and unskilled districts responsible for planning and delivering health services, most often with a constricted human resource structure and budget (Matsiko, 2010). The roles and functions devolved to local governments not only demanded a clear understanding of the reform process but also requisite skills and behaviour that facilitate the functioning of local governments. For instance, district service commissions (DSCs) are mandated to recruit the right health workforce for implementation of the UNMHCP as part of the district health system; but, most often the DSCs are not well constituted and facilitated to perform their functions professionally. Much as the decentralisation policy has reportedly increased utilisation of health facilities, it failed to

improve drug shortages, inefficient utilisation of resources and low morale among hospital staff (Anokbonggo et al., 2004).



Source: GoU, 2016a. UGX = Uganda shillings; HE = health expenditure; TGE = total government expenditure.

There are a number of constraints to the implementation of the UNMHCP. According to one key informant:

...other policies have affected implementation of the UNMHCP. The most notable is the fiscal ...decentralisation in early 2000s where a block sum of money is disbursed to district local governments. The district local councils would then decide on the allocations according to their needs/priorities. Since health was not protected and remained in the basket funds, the district local councils would allocate it less funds and more money taken to infrastructure for instance. This weakened the district health system.

Another participant during the national stakeholders validation meeting observed that:

...there was restructuring of the positions and functions of staff at the district local governments in which the Health Inspector's role in water safety and quality was removed from them to a new department of water; this incapacitated field allowance and motorcycles for the health inspection for field supervision. Diseases of sanitation as a result shot up with dwindling latrine coverage.

Uganda's constitution does not explicitly state that health is a right (GoU, 1995). Rather the constitution states in objective XX under Medical Services that the state shall take practical measures to ensure the provision of basic medical services to the population. This somewhat disadvantages health, and limits the degree to which citizens can agitate and advocate for healthcare resources. The high population growth rate has also affected implementation because the available budget cannot meet the population demands.

As a consequence of an inadequate wage bill, the health workforce remains a key bottleneck for implementation of the UNMHCP and provision of health services in general, with challenges in adequacy of numbers and skills, attraction, retention, motivation and performance (GoU, 2015b). "A country comprehensive attraction, motivation and retention policy/strategy to guide recruitment,

deployment, remuneration and training of health workers is in place, but it is poorly implemented. The policy has never been reviewed,” said one key informant. The shortage of health workers is worse in rural areas where most people reside, as 70% of all doctors are practicing in urban areas, raising serious equity issues (WHO, 2009). However, efforts by the central government and partners have facilitated recruitment of much-needed staff, increasing the proportion of approved posts from 56% in 2010 to 71% in 2015/16 (GoU, 2016a).

With regards to health infrastructure, physical access to health facilities of the population living within 5 kilometres has improved to current 75% (GoU, 2016a). Despite this improvement, major inequities in availability of facilities remain, ranging from a low of 0.4 facilities per 10,000 people in some remote districts like Karamoja to a high of 8.4 facilities per 10,000 people in Kampala, the capital city (GoU, 2016a). There are also issues with availability and maintenance of medical equipment essential for delivery of the package. Debate is ongoing whether to consider leasing equipment to private actors to overcome equipment maintenance challenges.

As much as physical access to health services has improved over the years of implementing the UNMHCP, functional accessibility and quality of care remains a constraint. According to the National Service Delivery Survey report, the proportion of households reporting an increase in the overall quality of services provided at public facilities was modest, rising from 41% in 2008 to 46% in 2015 (UBOS, 2015). On the other hand, the proportion of households who rated the availability of medicines as high declined between 2008 and 2015, since most often essential supplies are out of stock.

Delivery of some aspects of the UNMHCP have continued to be managed in a more vertical way rather than fully integrated into its delivery, much as there is an overall department which exists as a framework for integration of disease control (GoU, 2008). The vertical programmes include: national malaria control, AIDs control, TB/leprosy control, expanded programme on immunisation to deal with vaccine preventable diseases, reproductive, newborn, maternal and child health and non-communicable diseases.

5.3 Use in strategic purchasing, resourcing and resource allocation

Purchasers of healthcare services include the public sector (the Ministry of Health and district local governments) and the private sector (households, NGOs and health insurers) (Wright, 2015). According to the Ministry of Health’s health financing strategy, the public sector represents 24% of total purchasing, NGOs 28%, individual purchasing by household through direct out-of-pocket payments 42%, and health insurers about 1% (GoU, 2016b).

In the public sector, purchasing health services relies on quarterly disbursement of funding for recurrent and capital expenditures, estimated using a resource allocation formula based on, among other factors, the population coverage of the facility and to some extent workload (GoU, 2016b). The performance of selected key indicators derived from components of the UNMHCP form a basis for resource allocation to districts/facilities. All public health facilities are expected to provide UNMHCP elements to the general public free of charge, though often this is not the case. Health workers’ services are purchased by payment of monthly salaries that are usually fixed and not based on performance or workload. However, performance contracts have been introduced in the health sector for heads of departments/heads of referral hospitals guided by key outputs linked to the delivery of UNMHCP (GoU, 2015). Performance targets assess individual performance against set targets and deliverables agreed upon by the head of department and his/her immediate supervisor. Achievement is appraised at the end of the year. Satisfactory achievement of the agreed upon targets forms the basis for renewal of the individual’s contract. This is a human resource management approach aimed at better productivity and is linked to salary payment but not overall financing of the institution.

Funding for medicines and essential health supplies, including equipment for the entire health sector is disbursed by the Ministry of Finance directly to National Medical Stores (NMS), a government institution for procurement, storage and distribution of these supplies (GoU, 2014). Essential health supplies are disbursed to health facilities based on a budget allocated to them and held by NMS upon submission of requisite order forms (pull system). However, Health Centre III and II receive medicine kits that are 'pushed' to them based on a pre-determined design. In essence, as regards medicines health facilities are also purchasers.

The government/Ministry of Health is both a provider and purchaser of healthcare services (Wright, 2015). Although the mandate of the ministry and local governments provides for purchaser-provider split, this has not yet been achieved (GoU, 2016b). The lack of a purchaser-provider split limits strategic purchasing and is associated with inefficiencies. In addition, the country has limited capacity for purchasing and regulating pricing of services in the private sector and measuring quality of the purchased services.

The government also purchases health services from PNFP health facilities through provision of grants for specified services based on a memorandum of understanding aimed at addressing mainly components of the minimum package, such as maternal and child health, immunisation, malaria, TB/HIV, among others. The agreement provides for greater subsidies in these areas and in outreach care and health education and promotion (GoU, 2016b). The government seconds and supports health workers to PNFP providers.

Households mainly purchase private sector services on a fee-for-service basis, and this explains the high out-of-pocket payments in the country (GoU, 2016a). However, government also purchases services from the private sector through subsidies and subventions in selected areas. For instance, the government subsidises the cost of first-line antimalarial medicines to private pharmacies and drug shops to make it affordable to the public (GoU, 2011).

To some extent, the minimum package has guided resourcing for the health sector, especially as the components are categorised as primary healthcare (PHC). Funds for PHC activities are considered poverty alleviation funds. These funds are highly prioritised in the country and are ring fenced and protected from budget cuts within the sector. All the programmes under the UNMHCP hold vote functions under which financial resources are appropriated. With the exception of government funds, there are no clearly defined resource pools. As a result, resources are highly fragmented, lack mechanisms for income and risk cross subsidisation and equalisation among the different sources of revenue. Limited alignment of donor funding to health sector priorities often leads to inefficiency and inequity and weakness in predicting donor funding (GoU, 2016b). Allocation of public funds and other essential inputs, such as medicines and equipment, are based on a standard unit of output expected to be delivered by a health facility. This output includes the number of outpatient cases, which is related, to some extent, to the minimum package and population coverage of the facility.

5.4 Use in monitoring performance and accountability

The indicators derived from the programmes under the minimum package of services are used to monitor health sector performance. For instance, the National Service Delivery surveys that assess overall government performance, including the health sector, use these indicators for its evaluation. This type of survey was conducted in 2004, 2008 and 2014 (UBOS, 2014). Under the joint budget support framework co-ordinated by the office of the Prime Minister, government and key external funders of budget support donors agreed on joint assessment framework indicators to monitor progress on set targets. As part of the budget support framework's accountability process, specific health indicators aligned with the UNMHCP, such as immunisation coverage, are monitored and regularly reported on, including impact indicators like maternal mortality, infant mortality and under-five mortality. The Uganda Bureau of Statistics also does periodic surveys for impact and coverage indicators and service delivery assessments.

The Ministry of Health conducts quarterly and annual performance reviews of its programmes and departments by assessing achievements of key indicators as set out in the workplan. Mid-term review of the overall sector strategic plan and programme plans analyses progress and recommends remedial actions (GoU, 2012c). The published progress reports are shared widely, including with oversight agencies such as Parliament. As part of its oversight function, the Parliamentary committee on health closely scrutinises health sector performance. Furthermore, mandatory maternal and perinatal death reviews are conducted as part of accountability for women's and children's health and the reports are discussed at the Ministry of Health for follow up.

In addition, mTrac, a mobile phone system, is a mechanism for client feedback/redress under an anonymous complaints hotline, toll-free number. People may call or SMS to express opinions about health service-related issues such as good services, closed health centres during working hours and stockout of essential supplies. The same mechanism delivers information about services in the community and feedback on developmental issues, improving accountability on service delivery (GoU, 2014).

6. Discussion

Uganda's form of essential health benefit, the UNMHCP has been designed explicitly to address the most prevalent diseases/conditions using the most cost-effective and affordable interventions because of the limited resource envelope. The components of the UNMHCP focus on communicable and non-communicable diseases. It is, however, silent on the social determinants of health and other underlying risk factors and on the life-cycle needs of households. The components have not fundamentally changed overtime to reflect emerging challenges such as the epidemiological transition, new or re-emerging health threats and international and global commitments that would require incorporation into and harmonisation with national policies. The new and re-emerging health threats facing the country include viral haemorrhagic fevers (Marburg, Ebola) and other diseases like hepatitis E, C and B, Nodding syndrome and the upsurge of non-communicable diseases, notably cancers. Uganda has also signed on to the UN Sustainable Development Goals (SDGs).

A focus on only a minimum package primarily providing communicable disease prevention and control interventions will mean that the Uganda health sector is not responsive to these changing realities. Health system challenges can hold back progress and also need to be addressed. The UNMHCP may need to be revised to address these realities, including the risk factors contributing to the disease burden such as alcohol, lifestyle changes, environmental degradation, air pollution and occupational hazards.

The UNMHCP applies to all social groups. It is expected to cover services from community and primary care levels through to secondary and up to tertiary level free of charge in public facilities. However, this may often not be the case. Public health facilities charged user fees for communicable disease programmes and non-communicable diseases, reproductive, maternal, new-born, child and adolescent health programmes, emergency services such as blood transfusion and laboratory tests, although these were abolished in 2001.

The cost of delivering the Minimum Healthcare Package was determined using the ingredients approach that costs the inputs required to deliver the package at different levels of healthcare from a providers' perspective, in this case the Government of Uganda. It involved identifying all inputs required to provide a service, quantifying each input separately required for service delivery and attaching a value to each. The total sum of the cost of each input became the cost of delivering a given service and was largely facility based except for the estimated costs at central level. It put a price tag to deliver the package at US\$28 per capita, rising to a recent estimate of US\$41 per capita. In reality, the costs of delivering the minimum package might be even higher in view of inflation and

high commodity prices. Doing another costing taking into consideration outputs and results to be delivered might be an option. Costing of the minimum package could be done in line with the strategic plans every five years.

Uganda's health sector funding has remained significantly lower than the earlier minimum target of US\$28 per capita estimated as the amount required to provide the UNMHCP. The government MTEFs has instead showed a slower rate of growth for the health sector budget, with the share of the national budget progressively declining in recent years. Much as the UNMHCP has been used as a means of setting priorities for inclusion in the overall government and health sector planning, budgeting and negotiations on financing with the treasury and key development partners, it has not been successful in attracting bigger budgetary allocations. High out-of-pocket expenditures are a reminder that the UNMHCP is not meeting its objective of being free for all services. Inadequate financing of the elements of the UNMHCP remains a major implementation challenge.

Another bottleneck in effective delivery of the minimum package is the health workforce. The country is grappling with workforce challenges in adequate numbers and skills, plus attraction, retention, motivation and performance and inefficiencies arising from staff absenteeism. Staff shortages have most severely affected the hard-to-reach and hard-to-stay remote districts. Some efforts have been made to provide accommodation for health workers by constructing staff houses in hard-to-reach areas. Nevertheless, more needs to be done to address staff remuneration, training and other social amenities, among other motivating factors.

The government/Ministry of Health and local governments are both providers and purchasers of healthcare services. Ideally, the mandate of the Ministry and local governments provides for purchaser-provider split, although this has not yet been achieved. The lack of a purchaser-provider split limits strategic purchasing and contributes to inefficiencies. In addition, the country has limited capacity for purchasing and regulating pricing of services in the private sector and for measuring quality of the purchased services. Payment of the health workers is not based on output or performance, but on fixed monthly salary. This raises the issue of motivation to deliver more quality outputs or results. Results-based financing is not being implemented in the sector yet. Another challenge is that individual households are the main purchasers of health services, making cash payments to private sector services and contributing to high out-of-pocket payments. The risk of catastrophic expenditures is high and the guarantee on the quality of these services purchased is limited.

During implementation of the UNMHCP, the health sector registered marked improvement and positive progress. This may be attributable to targeted interventions of the UNMHCP elements as exemplified by the improved performance of the following key health indicators in the last decade:

- The maternal mortality ratio has been reducing at a rate of 5.1% in the past 10 years according to the recently released WHO World Health report (WHO, 2015). The Uganda Demographic and Health Survey reports indicate a decline in the maternal mortality rate, from 438/100,000 live births in 2011 to 336/100,000 live births in 2016 (UBOS, 2011; 2016).
- The under-five mortality rates declined from 128/1000 live births in 2006 to 90/1000 live births in 2011 to 64/1000 live births in 2016 (UBOS, 2006; 2011; 2016).
- Reduction of infant mortality rates from 71/1,000 live births in 2006 to 54/1,000 live births in 2011 and 43/1000 in 2016 (UBOS, 2006; 2011; 2016). Neonatal mortality rate has stagnated however at 27/1000 live births since 2011.
- The overriding impact of all this has been an improvement in the life expectancy at birth in Uganda, from a low of 46 years in 2000/01 to 56 years in 2011 and to 63.3 years in 2014 (UBOS, 2014).

Despite these achievements and although the prevalence of these diseases has generally declined, as reported in the 2015 global burden of disease report (WHO, 2015), the pattern of disease has not changed significantly from the one prevailing when the UNMHCP was first introduced. HIV/AIDs, malaria, lower respiratory infections, meningitis and tuberculosis are still estimated to cause the highest numbers of years of life lost in Uganda (GoU, 2015).

Finally, the package does not address the broader social determinants of health such as education, water, transport and agriculture, and the lifecycle needs of households. These important contributors to health are beyond the mandate of the health sector itself.

7. Conclusions

The potential of the UNMHCP to address the disease burden should continue to be exploited by allocating more resources for its implementation. The overall prevalence of targeted diseases has reduced and some diseases such as measles, neonatal tetanus, guinea worm, onchocerciasis and polio, almost eliminated.

Vertical programmes continue to deliver some elements of the minimum package. As much as integration has been achieved in planning, policy formulation and supervision, more needs to be done to further integrate at operational levels.

The UNMHCP has been useful in prioritising the available resource envelope. However, it has not been able to influence significantly an increase in overall financial resource allocation to the health sector. The revision and regrouping of the UNMHCP into four clusters included the addition of non-communicable diseases among the clusters. This implied that health sector policy makers are aware that the country is experiencing an epidemiological transition, with a double burden of communicable and non-communicable diseases.

The package is still relevant in the face of limited resources, but its design and alignment need to reconsider the current realities, given international and global commitments, such as the 2013 UN Sustainable Development Goals (SDGs) agenda. Broader discussions on how government can holistically address health challenges, bringing on board sectors that are responsible for the important social determinants of health and household lifecycle needs, should be considered.

As a way forward, the health system could benefit from UNMHCP revisions and reforms to reflect as much as possible affordability issues, current epidemiological patterns, existing international commitments and conditions of public health importance due to their burden, cost and importance. The revision process will need to consider the risk factors contributing to the disease burden such as alcohol, environmental degradation, air pollution, nutrition, smoking and occupational hazards, among others. A further consideration would be to shift away from the traditional package and to integrate health into other sectors such as to 'health in all policies'. This would apply a multisectoral approach aimed at addressing the social determinants of health and would be geared towards the attainment of universal health coverage, in line with the UN SDGs.


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Acronyms

| | |
|---------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ECSA-HC | East, Central and Southern Africa-Health Community |
| EHB | Essential Health Benefit |
| EQUINET | Regional Network for Equity in Health in East and Southern Africa |
| ESA | East and Southern Africa |
| GoU | Government of Uganda |
| HC | Health Centre |
| HIV | Human Immune Deficiency Virus |
| HSD | Health Sub-district |
| IHI | Ifakara Health Institute |
| MCH | Maternal and Child Health |
| MOFPED | Ministry of Finance and Economic Development |
| MOH | Ministry of Health |
| MTEF | Medium Term Expenditure Framework |
| NGOs | Non-Governmental Organisations |
| PHC | Primary Healthcare |
| PNFP | Private Not-for-Profit |
| SDGs | Sustainable Development Goals |
| STIs | Sexually Transmitted Diseases |
| SWAp | Sector Wide Approach |
| TB | Tuberculosis |
| UBOS | Uganda Bureau of Standards |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children Fund |
| UNMHCP | Uganda Minimum Healthcare Package |
| USAID | United States Agency for International Development |
| WHO | World Health Organisation |



Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; HEPS and CEHURD Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; SATUCC and NEAPACOH

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