

## WHY THE HEALTH BUDGET MUST BE INCREASED?

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### 1. Introduction

The question for debate in this issue of the Uganda Health Bulletin is posed in such way that it will probably find few arguing to the contrary. If we decided to formulate the question in a slightly different way, the debate would surely become more heated. The gist of the matter (at least from the understanding I have reached in these last few months) is not whether health spending should increase but 1) how fast and 2) of how much should it increase.

Here two different positions emerge: the field is divided between those who think that health spend should grow fast and reach levels that would allow the public financing of the delivery of the basic package of health services within the current decade, and others that would favor a much more gradual expansion of public health spend (i.e. gauged on the growth of the economy), for fear that too fast and too generous health (social) spending could provoke a wave of macroeconomic instability.

What we see here is, in a nutshell, a dilemma: some of the opposite dynamics of the 1<sup>st</sup> and 4<sup>th</sup> Pillars of the Poverty Eradication Action Plan - PEAP<sup>1</sup> that, intrinsically on a collision course, have, as matter of fact, reached a point of collision much earlier than expected. At this juncture only a political discernment could close the debate by stating which of the two pillars has absolute priority and which has a relative priority. My only hope is that the necessary political discernment could keep into account the views of the technocrats but also those of society at large. The participation of society in the necessary discernment requires that issues be presented in comprehensible terms.

In this brief article (which I would prefer to call “viewpoint”) I would like to

1. outline the main features of the dilemma identified, with the declared attempt of avoiding jargon and making matters as simple as possible (accepting all the risks of simplification)
2. concentrate thereafter on another question emerging i.e. the justification (given the overall resource constraints) for public spend as subsidies to the Private not for Profit Health Sector.

This viewpoint is not “neutral”: it has indeed a partisan connotation. It nonetheless adds to the debate arguments that have not yet adequately been articulated. This, I hope, will add conviction among the technocrats and, hopefully, politicians about the convenience for all the stakeholders concerned of the current policy for partnership with the PNFP health sector.

### 2. The features of the dilemma

#### *2.1. Financial aspects of the health component of Pillar 4 of PEAP*

The Health Sector Strategic Plan (HSSP) forms the basis of the estimated financial requirements. The HSSP has been approved as consistent with the PEAP. The Plan defines the Minimum Health Care Package that citizens have the right to access. The current estimates of the cost of this package is 13.5 \$ per capita<sup>2, a</sup>. Health spending in the current financial year is reckoned to be 9 \$ per capita. This latter figure includes the amounts spent by Government

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<sup>a</sup> The costing of the package assumes an integrated delivery by all Government and PNFP health facilities, in line with the National Health Policy and with the HSSP.

through Budget (4.5 \$ per capita<sup>b</sup>), amounts spent through projects (3.7 \$ per capita), amounts contributed by NGOs/PNFP (0.3 \$ per capita – these are moneys that the NGO/PNFP networks are able to mobilize abroad), and amounts spent by households through user fees in both Government and PNFP units (0.5 \$ per capita).

A first set of consideration can be made at this point:

- The current overall spending (9 \$ per capita) is sub-optimal: in fact this is amply demonstrated by the inadequacies of service provision (e.g. drugs' shortage is perhaps the most visible feature, but certainly not the only one, of the inadequate spending)
- The estimated needed spending (13.5 \$ per capita) is the amount immediately necessary to correct the inadequacies reported. It is important to note here that expansion of service provision to improve coverage and access is not considered in the 13.5 \$ per capita.
- Government budget contributes 50% of the current spending (if the rate were calculated on the desirable spending this would be 33%).
- Spending through projects contributes 41 % of the current spending (if the rate were to be calculated on the immediately desirable spending it would be 27 %). It is important to note here that projects spending is not going to increase and perhaps is going to decrease in time.

In summary:

- the package of services that citizens are said to have the right to is not delivered at the moment;
- if this package had to be delivered at acceptable levels of quality at the current delivery points free of charge and extra 5\$ per capita would have to be made available by Government<sup>c</sup>;
- this would imply an immediate decision of Government to double its health budget, something that for the moment seems to be impossible.

It would be interesting to make some considerations about the need of increasing access and coverage but at this juncture this is somewhat an idle exercise. The estimates presented so far reach an expenditure per capita of 28\$ in year 2010/11. These estimates are not far from those calculated by the Macroeconomic Commission for Health<sup>3</sup>.

## *2.2. Macroeconomic constraints – Pillar 1 of the PEAP*

It is very likely that other, much more qualified voices, will explain these aspects better. For the sake of completeness an attempt is made here of voicing the concerns arising from the dynamics of the first Pillar of PEAP.

Poverty Eradication is deeply linked with economic growth. In Uganda the economy is expected to grow by 7% every year. To achieve this growth a mix of some macroeconomic parameters (money supply, interest rates, and inflation rates) need to be maintained stable. These parameters are influenced by how much money Government spends and how fast. Uganda has a very important structural problem: its fiscal revenues are very low in proportion of its Gross Domestic Product (the wealth produced, globally, by the Country). Government Budget is about twice as big: this is called “fiscal deficit”. In other words: Government spends twice as much as it is able to obtain through the various forms of taxation and other revenues. This deficit has to be financed in some way. Currently, the most important form of deficit

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<sup>b</sup> This includes spending financed through fiscal revenues and donors' contribution to Budget spending.

<sup>c</sup> This estimate assumes that 13.5 \$ is the immediate need, that Government health units and PNFP health units cease to charge fees, and that PNFP health units continue to mobilize resources other than fees.

financing is Foreign Aid and Loans. When this money is spent, in local currency, by Government, two side effects appear: the local currency gains value against foreign exchange and inflation increases. Both these phenomena hinder economic growth: here is where the art of maintaining a balance comes into play. But not all the tricks of the economic wizards work if the basic problem (the size of the fiscal deficit) is not controlled. Here appears the “budget ceiling(s)”. No matter how the fiscal deficit is financed, there are limits to Government spending that cannot be exceeded without consequences on factors that would eventually curb the economic growth. The Ministry of Finance has articulated all this in a much more professional way.

What is the situation in Uganda now?

- The local currency is already overvalued against foreign currencies, precisely because there is an excess of foreign currency flowing to the country to finance the fiscal deficit, related to the volume of foreign aid;
- As result, products of the local economy are not competitive on the international market, there is little export and the local production keeps on shrinking because the internal market too cannot absorb it.
- On the other hand, taxation on all imported goods<sup>d</sup> is in local currency: if the currency is strong all imported goods are undervalued and fiscal revenues from this source are lower.
- Although inflation rates are low at the moment, an increased spending of government would increase the volumes of money circulating and thus fuel inflation.

What is happening in health? Health spending depends already for its greatest part from external funding. Although far from the desirable (needed) levels of spending, and although a real potential for increased spending may exist (i.e. more donors would be willing to invest their grants in health) this cannot occur because it will have effects on the parameters mentioned above.

In a nutshell, the argument of the macroeconomists is the following: the Country cannot absorb more resources from outside without curbing the growth of the local economy, while the strength of the local currency applies a brake on the economic development and on the customs revenues that could help increasing the national budget by making more endogenous resources available for spending and decreasing the budget deficit. Hence the health budget is stuck. If it has to grow it can grow at the expenses of other budgets (e.g. education, public administration, agriculture etc....).

Macroeconomists argue further that the health sector should concentrate on more efficient use of the available resources rather than advocating for increased spending. Unfortunately, the funding gap is so large that no efficiency gain will ever bridge any sizeable proportion of it.

### *2.3. Conclusion*

The health sector estimates (quantification of financial need) may be questioned but it is very likely that an in depth scrutiny would reveal that they are on the conservative side. The ceilings placed on the overall budget reflect as ceiling on the health sector budget and would call for a reduction of the health sector needs downwards. This is not possible without 1) reconsidering the scope of the Minimum Package, applying substantial cuts to what people can expect and 2) revising the HSSP, and especially its projected infrastructural expansion. If this

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<sup>d</sup> Fiscal revenues from import taxation represent a sizeable quota of the total fiscal revenue of the Country, and therefore an important financial source for the Budget

rather drastic move is not practicable/acceptable, then the only possible answer to the basic question is that the budget for health must be increased. Besides: if health is a basic human right and if its local translation is the HSSP, then policy (and spending) needs to be consistent with it.

On the other hand the premises on which the macroeconomic constraint is argued are far from being beyond dispute. Recently two powerful voices have expressed dissent<sup>4, 5</sup>.

Perhaps there is need of sounder foundations for arguments brought forward by the health sector; there is definitely need for much sounder, uncontroversial and convincing foundations for the argument brought forward by the macroeconomists. It is also certain that a more open debate on the entire issue before final decisions are taken is necessary because it is difficult to ask the people of a Country to do away with the expectations created without a broad based consensus. There is also another, fundamental question that perhaps would provide the necessary horizon under which the debate could be conducted: how much would it cost to the Country not to invest more generously in the health of its population now?

### 3. Are subsidies to the Private not for Profit (PNFP) sector justified?

#### 3.1. *The Policy environment*

A first possible approach to answer this question is by looking at the National Health Policy<sup>6</sup> and at the Health Sector Strategic Plan<sup>7</sup>. Both documents are consistent and recognize that the private sector is part and parcel of the National Health System and contributes to the attainment of the sector's objectives and targets. For the PNFP health sector the HSS is more specific: *"The plan envisages strengthening this collaboration through the development of service contracts and increasing subventions to the NGOs"*.

Therefore subsidies are indeed justified first of all by the standing Government policy. Questioning their justification would mean questioning the soundness of the Policy and of the related Plan. To go a step further, both these documents are currently translated in a more specific Policy for Partnership whose declared goal is *"...contribute to strengthening the National Health System with the capabilities and full participation of the Private Health Sector to maximize attainment of the national health goals"*<sup>8</sup>. Few paragraphs further the same draft document declares as objective *"To establish a functional integration and a sustained operation of a pluralistic health care delivery system by optimizing the equitable use of the available resources and investing in comparative advantages of the partners"*<sup>9</sup>.

All Policy documents are consistent and provide abundant reasons for the Partnership and justification for the subsidies to the PNFP providers. In a resource constrained environment the Partnership with the private sector seems to be the most viable, wise and effective way to accelerate the attainment of the health goals. Our argument would be that even if the environment were not resource constrained the partnership would still hold as valid, for different reasons. The existence in the system of different providers makes it more resilient to shocks. Some historical memory would not harm here: it would be enough to ask people of a certain age where did they receive services in the era of socio-political upheaval, when Government health services had reached a stand-still? But this is not a "technical" argument. I would leave it for other types of fora.

#### 3.2. *Objections*

Whence the objections, then? Apparently these come from the political arena<sup>10</sup>, and follow the abolition of user fees in Government health units. This decision had not been foreseen in the formulation of the National Health Policy and Sector Plan and, as a matter of fact, threatens to slow down the pace of a process of convergence of two sub-systems (Government and PNFP)

that had been on a dynamic of progressive functional integration<sup>e</sup>. The arguments, stated in simple terms, are the following:

1. Why the PNFP Health sector is not decreasing user fees?
2. Why should public funding be provided to the PNFP sector when Government health sector is under-funded?
3. Why should people entitled to free health care pay for services if they happen to live in an area where the only provider is a PNFP health unit and have no other choice? This objection is usually followed by a claim to the establishment of a Government Health Unit in that area.

The first is a question of problem accountability or responsiveness, the second of allocative efficiency, the third of equity. These are three different levels of the basic question (the justification of public subsidies to the PNFP sector) and need to be addressed separately.

### *3.3. Accountability*

The answer to this objection is certainly the easiest because the objection has no foundation: evidence has demonstrated the exact contrary. There is in fact documented evidence that the PNFP health sector is indeed decreasing its fees, it is increasing the remuneration of its staff, it is showing increased utilization and increased provision of preventive services<sup>11,12</sup>. Perhaps the magnitude of the decrease in fees is not as large as desired by those objecting, but there is need to take into account that this objective had to be traded with other important objectives (i.e. increase of salaries to reach closer to Government levels and increased provision of public goods). All of these have implications of either decreased revenues or increased cost. In addition, it is not possible to avoid comparing the proportion of Government subsidies vis-à-vis the cost of production of services, which, in terms of allocation, would be ranging around 30%<sup>13</sup> (the actual disbursement may be less than that – the estimates of the PNFP sector give it a rate of 25%).

### *3.4. Allocative efficiency*

The answer to this type of objection is perhaps less intuitive: it is nonetheless easy. It is in fact the resource constraint that makes the provision of subsidies to the PNFP health sector desirable in the first instance. Those raising objection to it fail to see that services to the people are provided by Government, the PNFP and private health sectors, in proportions that seem to be equal<sup>14</sup>. The National Health System does not coincide with the Government owned health system. On the other hand the rationale of operation of the PNFP health sector makes it very similar to the public health sector<sup>15</sup>. The real question is whether subsidies provided to the PNFP sector give returns in terms of increased services' geographical access and quality. This is hardly questionable: with almost half of the Hospitals in the Country and a quarter of the lower level units it would be difficult to deny that, at least, geographical access has increased. In addition, it is undeniable that, for the cash starved health budget, the return of 100 % of the services<sup>f</sup> provided in exchange for 25-30% of their cost is, a very convenient arrangement for Government, especially if these services have lower costs of production than in Government units<sup>16</sup>. It is indeed a very convenient bargain for a Government that does not have the money to meet the targets it has set (that represent also the commitment in front of its population) if

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<sup>e</sup> Functional integration means that the functions exercised by the parties are complementary while their respective administrative autonomy is preserved.

<sup>f</sup> The PNFP declares through the Health Information System all their outputs. These contribute to the achievement of the National Health System targets.

one of the partners it has found on the way “hands over” 100% of its (cheap) outputs for 25 % of their cost. What is really strange is not that this is exactly what is happening, but that such elementary consideration eludes the grasp of so many!

### *3.5. Equity*

The objection arising from equity concerns is probably the most difficult to answer, because it requires the use of a more critical argument. Equity concerns are indeed understandable and thoroughly justified. Unfortunately, they need to be constantly gauged with the resources available for the pursuit of equity. It is not the case here to return on what has already been stated in the first part of this viewpoint: universal access to the minimum package of health services free of charge is not possible within the current and the foreseeable future resource envelope, no matter how desirable this would be. Therefore the argument that there is inequity if two populations, one served free of charge by a Government Health unit and the other served at a fee by a PNFP unit could stand only if the package of service provided were of the same scope and, I would add, of the same quality. Probably a more consistent adoption of exit polls to assess the satisfaction of users would give more strength to this counter-argument. For the time being it is only possible to mention the substantial difference in stock outs of drugs between the Government and PNFP units<sup>17</sup>. Equity is about comparisons and comparisons require an even ground: to be fair in making a comparison one should add to the “free” diagnosis and prescription in Government units the cost of purchasing drugs in a pharmacy or at a drug shop. Only if this resulted to be substantially lower than the fee paid in a PNFP health unit, then it would be possible to speak of inequity (perhaps not even then, because other considerations would have to be made such as the consistency of drugs purchased with the prescription etc...).

### *3.6. Other possible counter-arguments*

There is another possible approach to answering the objections presented. It is the approach of **“how much would it cost”**. It is a furthering of the allocative efficiency approach. We do not intend to pursue this approach also because too many elements are missing. Floating some questions is not anyhow out of place:

- how much would it cost to the Government budget to bring geographical coverage back to the current (already low) levels if the PNFP units opted out from the partnership? And how fast can this replacement occur?
- how much would it cost to replace (or to recruit) the human resources that the PNFP sector currently places at the service of the system? (at the moment the PNFP health sector employs about 9,000 people)
- how much would it cost to provide the same services currently provided by the PNFP sector? (here the answer is quite easy – at least four times the current cost to Budget)
- how much would it cost to Government to scale up training capacity for nurses? (training capacity of the PNFP nursing schools is at least 50% of the total Country capacity).

These and perhaps other questions alike could offer a less ideological and more factual argumentation. It is a lead that others can pursue if they think it worth the effort.

### *3.6. Conclusion*

The recourse to counter arguments that may appear overstated, and especially the recourse to arguments were failure and weakness of “the others” are brought to the fore is not part of the “culture” of the PNFP health sector. We have always preferred, and we still prefer, the road of

partnership (i.e. a relationship where two parties converge, at mutually agreed conditions, towards a common goal, drawing from their relationship mutual strength and advantages). This approach is already providing to the National Health System some of the efficiency gains the macroeconomists would like to see pursued with more determination by the health sector. The emergence, from different fora, of objections to the partnership that, although understandable, are poorly argued and, besides, does not stand the test of evidence, have forced us to clarify, somewhat unwillingly, our counter-arguments. We would like to abandon this approach as soon as possible: the sooner, the better. The challenges faced by the health sector (and by all providers in the sector) are of such magnitude that energies would better be spent in concentrating on other, more deserving, endeavors. Evidences justifying the subsidies to the PNFP health sector have been provided for those who want to see and take stock of them.

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<sup>1</sup> Ministry of Finance, Planning and Economic Development (2001). Poverty Eradication Action Plan 2001-2003, Vol 1, 4-5

<sup>2</sup> Ministry of Health, Health Financing Strategy for Uganda, Draft March 2002, table 5.1.

<sup>3</sup> WHO (2001). Macroeconomics and Health: investing in health for economic development, Report of the Commission on Macroeconomic and health Chaired by Prof Jeffrey D. Sachs

<sup>4</sup> Sachs J. D., Open Letter to the Government of Uganda, *The New Vision*, 23.5.2002 - 29

<sup>5</sup> Quote attributed to US Secretary of Treasury by Somerville G., Reuters, 28.5.2002

<sup>6</sup> Ministry of Health (1999). National Health Policy, par. 9.1 and 9.2, 22-23

<sup>7</sup> Ministry of Health (2000). Health Sector Strategic Plan, par. 3.3, 58

<sup>8</sup> Ministry of Health (2002). Draft Public Private Partnership for Health Policy, Part 1, par. 3.2

<sup>9</sup> Ministry of Health (2002). Draft Public Private Partnership for Health Policy, Part 1, par. 3.4

<sup>10</sup> Quote from the Introductory speech of the Hon. Minister of Health at the 6<sup>th</sup> Joint Review Mission, April 2002

<sup>11</sup> Giusti D., Lochoro P., Mandelli A.. (2002), Public Private Partnership in health: what is the effect on the performance of the health sector?, *Uganda Health Bulletin* vol 8 n. 1, 22-26

<sup>12</sup> Santini S., The Naggalama Initiative: how to revitalize a hospital, *UCMB Bulletin* vol 4 n. 2, (2002) 39-43

<sup>13</sup> Ministry of Health (2002), Draft Public Private Partnership for Health Policy, Part II, 1.4.3

<sup>14</sup> Hutchinson P., (2001). "Combating illness," in *Uganda's Recovery: The Role of Farms, Firms, and Government*. Reinikka and Collier eds. Washington, D.C.: The World Bank, Regional and Sectoral Studies.

<sup>15</sup> Giusti D., Criel B., De Bethune X., (1997), Viewpoint: public versus private health care delivery: beyond the slogans, *health policy and Planning*, 12(3) 193-198

<sup>16</sup> Ministry of Health, (1997). "Health Expenditure in Uganda." Government of Uganda: Entebbe, Uganda.

<sup>17</sup> Effects of the abolition of cost-sharing and government response, Presentation of a study by WHO, 6<sup>th</sup> JRM, April 2002