National Health Accounts for Uganda

Tracking Expenditure in the Health Sector – both public and private

FY 1997/ 98

FINAL REPORT

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ACRONYMS

AAR	Africa Air Rescue
ADF	Africa Development Fund
DCR	Development Cooperation Report
DISH	Delivery of improved services for health
DHS	District Health Services
DHSP	District health services project
EPRC	Economic Policy Research Centre
FY	Financial year
GDP	Gross domestic product
GoU	Government of Uganda
HIPC	Heavily indebted poor countries
HIS	Household integrated survey
IDA	International Development Agency
IEC	information education and communication
IHS	Integrated Household survey
MoD	Ministry of Defence
MoES	Ministry of education and sports
MoFPED	Ministry of Finance planning and Economic development
MoH	Ministry of Health
MS	Monitoring Survey
NHA	National Health Accounts
NGO's	Non-governmental organisations
NRM	National resistance movement
N.S.H	National specialist hospitals
OECD	Organisation for economic cooperation and development
OOP	Out of pocket
PHC	Primary health care
UBOS	Uganda bureau of statistics
UNDP	United Nations Development Program
UNICEF	United Nations International Children's' Educational Fund
UPMB	Uganda protestant medical bureau
USAID	United States Agency for International Development
UShs	Uganda shillings
US$	United States dollars

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PART 1

1. Introduction

I.1 Objectives

Objectives and Structure of the Uganda NHA report

This report presents results from a study of Uganda's National Health Accounts for the Fiscal Year 1997/98. The study set out to describe the flow of funds in Uganda's healthcare system, including both public and private sectors. Using a comprehensive view of the health sector and standard definitions of entities and spending, NHA estimates can performed on an annual basis and can provide valuable data for policy-relevant research and analysis to support decision making in the health sector. This NHA Study is the first such study in Uganda, and hopefully is one that will be repeated on an annual basis, using an institutional capacity to execute them.

1.2 Organisation of the report

After a description of the analytical framework below (see 1.3), there is a brief overview of Uganda's health sector and economy in Section II. In Section III a detailed report on the findings concerning health expenditures according to the NHA framework are laid out. Section IV provides a detailed review of estimates for the major institutional components of the health sector, and Section V reviews the principal findings.

The detailed results of the study presented in Section III, show the flow of funds ("sources to uses") presented in matrices and illustrated by accompanying flow charts. The flow chart (Figure 2) depicts the flow of funds from primary sources to financing intermediaries. The second and third flow chart (Figure 4A and 4B) shows the flow of funds from financing intermediaries to the providers, public and private respectively. The fourth flow chart (Figure 5) shows how providers allocate the funds received by function. Primary sources of funds are divided into three general categories, namely:

- Government
- Private sources (households and employers)
- Donors

Financing intermediaries are those entities, which have as their major roles the receipt, and expenditure of funds for health care functions or services, such as ministries of the government, private health insurance companies, private and parastatal employers. Providers are categorized according to the familiar typology of various discreet service delivery organizations (MOH hospitals and clinics, private hospitals and clinics, etc.).

Health expenditures are defined on the basis of their primary purpose, regardless of the primary function or activity of the entity providing or paying for the associated health services (Berman 1999). Only those activities whose primary purpose is to improve health status have been included in the analysis. These include all activities conducted by the MOH and curative services, clinic-based preventive services (family planning, immunisation, etc), capital development for health care facilities and medical training and research conducted by other organisations. Thus the focus is on the function of the expenditure. Expenditure on nutritional programs, water and sanitation programs which is directly under the Ministry of Health is included in the analysis, however, expenditure on these activities by NGOs' and donors is put separately in table 5. Expenditure on water and sanitation programs data under the National Water and Sewage co-operation is not available.

1.3 Analytical Framework

National Health Accounts (NHA) is a descriptive tool designed to estimate total health expenditure within a country. It provides a detailed analysis of flow of funds from sources to uses within the health care system, presented in the form of matrices linking sources of funding to financing intermediaries and from those intermediaries to providers of health services. This analytical framework provides comprehensive data to allow for informed policy decisions, in general, and to measure real allocation of resources against stated priorities, in particular.

The analytical framework consists of three essential elements. First, it requires the calculation and presentation of national estimates in a general matrix format depicting "sources (in columns) and uses (in rows)". Second, it allows for extensive desegregation of the sources of spending beyond the general categories of "public" and "private". Thirdly, it provides a systematic framework for defining uses according to several important, and mutually exclusive, functional classifications, namely:

- In-patient and outpatient
- Preventive and promotive services
- Administration
- Training and research (Berman, 1997).

The matrix approach requires that all expenditures from each source be allocated to specific uses (either by financing intermediaries or by providers), and that all spending on health services provision be traceable back to specific financing intermediaries and ultimately to primary sources. The totals and subtotals must add up and be consistent. The matrix facilitates analysis not only of the subtotals and their aggregates, but also an understanding of the flow of funds through the healthcare system. It stresses the need to know in an integrated way who pays, how much, and for what, rather than simply separating who from what. It is for this reason that the NHA approach includes the intermediate category, financing intermediaries, that defines the institutional boundary, where it exists, between the funding of services and provision of services. It also highlights the direct nature of payments where such a division does not exist (as when individuals and employers pay providers directly for their services).

PART 2

II. UGANDA: A BRIEF COUNTRY PROFILE

2.1 Political Background

Although Uganda now enjoys relative political stability and significant economic growth, it's post -independence period was characterised by political upheavals, civil strife, and economic recession and destruction of infrastructure.

During the period between 1971 and 1979 when Amin's government was in power, the country suffered a general lack of essential commodities, a breakdown in public social services and public health systems. The main causes were low economic growth resulting from the country's exclusion from the global economy, poor management of its human and financial resources and, the destruction of its infrastructure.

Between 1976 and 1986, Uganda experienced a civil war that brought development in any sector of government to a halt. This culminated into economic decline associated with budgetary deficits and dependence on external assistance. In the health sector, community participation was reduced to individual payment for treatment. Perhaps the health seeking behaviour and high private health expenditure currently found among the people of Uganda could be explained by the situation pertaining in Uganda at that time.

Since 1986, under the leadership of the National Resistance Movement (NRM) Government, Uganda has realised a period of renewed and sustained economic growth from an extremely low starting base. This growth has facilitated improvement in social sector spending and rehabilitation of the country's infrastructure. Sound economic policies implemented by Government in the last 10 years account for this change. The main pillars that have led to this development include liberalisation of the economy; privatisation; infrastructure development; universal primary education and modernisation of agriculture.

2.2 Socio-economic and health status indicators

Uganda's current population is estimated to be around 21.9 millions with an annual population growth rate of 2.5%. It is a low-income country, with an average annual GDP per capita of US$ 300. The current public health expenditure per capita remains low at US$ 4.0[1]; this cannot finance the essential health package as recommended by the World Bank/ World Health Organisation, which stands at US$ 12 per capita.

Although there has been an improvement in the health status of the population in general, improvement in health indicators has remained slow. Infant mortality rates improved from 127 to 97 per 1000 live births between 1991 and 1995[2] implying the need for improvement in the access, availability and quality of care.

The demand for healthcare continues to increase due to a high population growth rate and the HIV/AIDS pandemic; both of which pose a challenge to the health system and the limited resources. External sources have been predominant in financing health service delivery and, this raises important questions of sustainability and affordability.

[1] MoFPED 1999/2000background to the budget

[2] Population Census,1991, and Uganda Demographic Health Survey, 1995.

PART 3 NHA RESULTS: ESTIMATES OF HEALTH-CARE EXPENDITURES IN UGANDA, 1997/ 98

3.1 NHA Total Health expenditure.

Total health care expenditure in Uganda for the FY 1997/98 amounted to UgShs310 billion (US$ 269 million). This is equivalent to 4.7% of GDP. Government ministries and other public sector entities accounted for 20% of this total. Individuals and private sector entities accounted for the 37%. The primary sources of funding were

- Donors (internal and external) (43%)
- Households (34%)
- Government (20%)
- Employers (3%)

Because the NHA methodology is more comprehensive and includes data gathered from surveys not previously undertaken, the NHA estimates are considerably higher than the most recent estimate of national health expenditures of UgShs 279 billion or (US$243 Million). Table 1 shows the major sources of differences between the two estimates. Some of these are accounted for by simple year-over-year growth in sector spending, but most of them are due to different estimates of spending because of data that was not previously available or included.

Comparison with other countries

3.2 Comparison with Other Countries

International comparisons including GNP per capita, health expenditure per capita and health expenditure as a percentage of GNP per capita percent are given in Table 2.

3.3 Sources of funds:

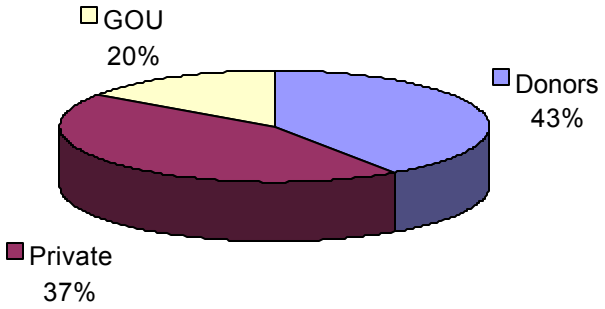
Both private and public sources play significant roles in Uganda's health care financing. For the FY 1997/98, donors both internal and external were the most important sources accounting for 43% of all payments. Households accounted for 34%, employers, 3%, and government, 20% (see Fig. 1).

3.4 Flow of Funds from Primary Sources to Financing Intermediaries

3.4.1 Introduction

Table 3 shows the flow of funds in the health sector from primary sources to financing intermediaries. This is graphically illustrated in the first flow chart (Figure 2 Annex G), which shows the pathways by which funds flow from sources to intermediaries. Note that a substantial portion of funds spent by primary sources (29%) does not go through intermediaries, but is transferred directly (by individuals and employers) to providers, as will be seen in Table 4 and Figure 4B and Fig 4B in the Annex H&I. Clauses 3.4.2 and 3.4.3 summarise the distribution of all primary sources of funds and funds channelled through financing intermediaries.

Figure 1. Sources of funds for Uganda's health sector



3.4.2 Public and private share of financing intermediaries:

Public financing intermediaries include various government ministries, District Health services and the National specialist hospital. These accounted for 38% of transfer through intermediaries. Private financing intermediaries include NGO's, which accounted for 33%.

3.4.3 Major Financing Intermediaries:

Out of the total expenditure of UgShs 310 billion on health, 71% passed through financing intermediaries while 29% was transferred directly to providers for health services. The major financing intermediaries included:

- MoH, 21%;
- District health services (DHS), 10%;
- Non-government organizations (NGOs) 33%.

Private health insurance was only 0.3% of total expenditure. Of the funds transferred directly to providers, households accounted for 91% of the transfer, and employers accounted for the remaining 9%. Figure 3 shows the distribution of flows of funds among the main intermediaries (as percentages of the totals channelled through any intermediaries).

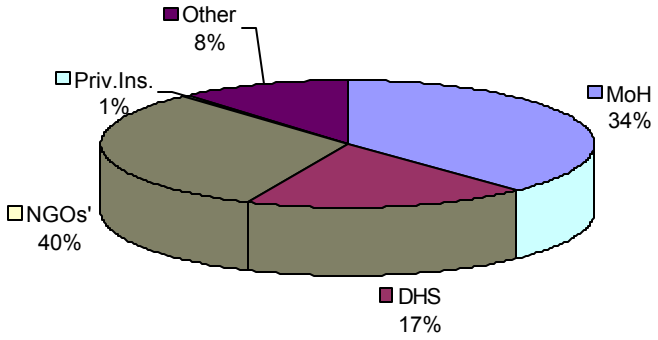
3.5 Major Pathways from Sources to Financing Intermediaries & Providers:

A review of the data illustrated in the first flow chart (Figure 2 Annex G), show the major pathways by which primary sources link up with providers who deliver the goods and services paid for.

The first pathway consisted of government funding sources (MoFEP and local governments). Here of the total government payments of UgShs 60,698 million, 66% passed through intermediaries (which included MoH, Ministry of Defence, Ministry of Education and Sports, and Uganda Police Services). The remaining 34% was transferred directly to providers, particularly

National specialist hospitals, NGO facilities, and education and training institutions. Government sources accounted for 20% of total health-care spending.

Figure 3 Percentage transfers through the main intermediaries (excluding direct payments to providers)



The second pathway was from external and internal donors: of the total of UgShs134,550 million, 31% passed through MoH, 57% passed through NGO's, and 11% through DHS. Only 1% was passed directly to providers (national specialist hospitals and police services). Donors accounted for 43% of total health care financing.

The third pathway was from private and parastatal employers. Of the total of UgShs10,842 million, 91% was passed directly to providers of healthcare, while 9% went through an intermediary (private health insurance), which accounted for 3% of total health care financing.

The fourth pathway was from households: of the total of UgShs103,710 million, all[3] consisted of out-of-pocket spending paid directly to providers (private facilities and doctors, MoH hospitals, traditional healers and private pharmacies). This total accounted for 34% of total health-care spending.

3.6 Flow of Funds from Fiscal Intermediaries to Providers

Table 4 shows the matrix describing the flow of funds within the health sector from financing intermediaries (and some directly from primary sources) to providers. This is graphically illustrated in Figures 4A& 4B given in Annex H&I. Figure 4A shows the flow from public sector financing intermediaries (a total of UgShs 117,717 million, or 38%), and Figure 4B shows the flow in the private sector (a total of UgShs 192,083 million, or 62%). Thirty eight percent (Ushs 119,044) of the total funds received from all sources was distributed to public sector providers. The remaining 62% (Ushs 190,752) went to private sector providers.

3.7 Flow of Funds from Fiscal Intermediaries to Functions

[3] There are not now known to be any amounts being paid by households (as employees) for premiums and contributions for employer-provided health benefits, which is sometimes purchased from commercial insurance companies. Such contributions are not uncommon in other developing countries, and they may, in the future, become another channel of funding from households (deducted from employee paychecks), especially as health care costs grow and employers seek out cost-sharing with employees.

Table 5 gives the matrix describing the flow of funds in the health sector from financing intermediaries to function (type of goods and services delivered). This is graphically illustrated in Figure 5 (Annex J) (see also Fig 6), which respectively show the flow and distribution of payments by function.

As seen in Figure 6, the highest portion of spending by function is accounted for by curative services sharing 24% of total health expenditure. Pharmaceuticals, capital development and preventive services all claim 14% of total health expenditure. Technical and administrative support accounted for 17%, and research and training was only 2%.

Figure 6. Spending by financing intermediaries according to function.

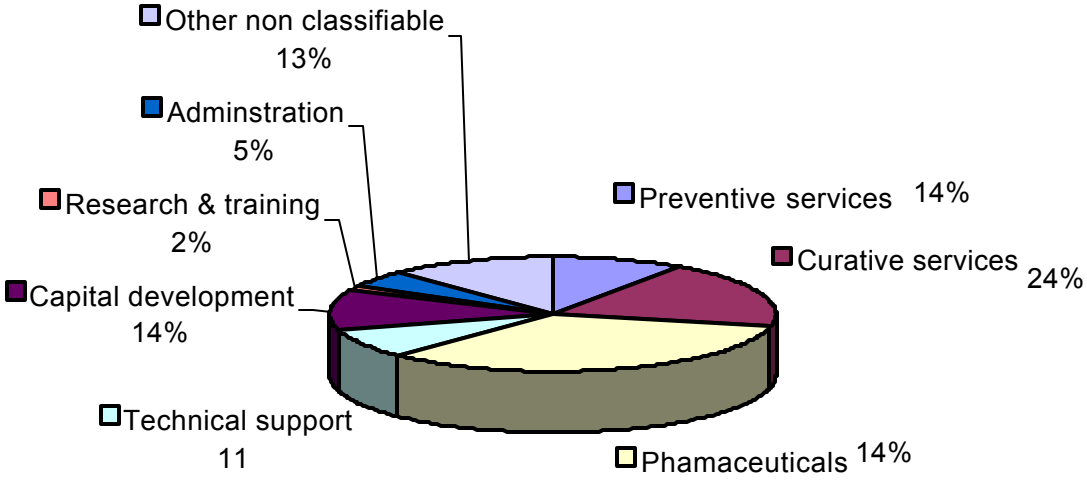


TABLE 1
A COMPARISON OF NHA RESULTS, FY1997/98 AND NATIONAL HEALTH EXPENDITURE ESTIMATES, FY1996/97

Estimated National Health Expenditures, FY 1996/97

Million UgShs

SOURCES FINANCING INTERMEDIARIES	*Government*	*Donors*	*Private*	TOTALS
TOTALS	**52,080**	**68,115**	**159,020**	***279,215***
Percent	**18.7%**	**24.4%**	**57.0%**	

Estimated National Health Accounts, FY 1997/98

TABLE 1

SOURCES FINANCING	*Government*			*Donors*			*Private*				
INTERMEDIARIES	MoFEP	Local Govts	**Subtotal**	External	Internal	**Subtotal**	Households	Employers	**Subtotal**	**TOTALS**	**PERCENT**
Ministries & NSH	42,520		**42,520**	42,674	31	**42,705**			**0**	**85,225**	**27.5%**
DHS	15,980	1,434	**17,414**	14,954	124	**15,078**			**0**	**32,492**	**10.5%**
Subtotal PUBLIC	*58,500*	*1,434*	***59,934***	*57,628*	*155*	***57,783***			***0***	***117,717***	***38.0%***
NGOs	764		**764**	71,595	5,172	**76,767**			**0**	**77,531**	**25.0%**
Employers			**0**			**0**		9,909	**9,909**	**9,909**	**3.2%**
Private health insurance			**0**			**0**		933	**933**	**933**	**0.3%**
Household out-of-pocket			**0**			**0**	103,710		**103,710**	**103,710**	**33.5%**
Subtotal PRIVATE	*764*	*0*	***764***	*71,595*	*5,172*	***76,767***	*103,710*	*10,842*	***114,552***	***192,083***	***62.0%***
TOTALS	59,264	1,434	**60,698**	129,223	5,327	**134,550**	103,710	10,842	**114,552**	**309,800**	**100.0%**
Percent	19.1%	0.5%	**19.6%**	41.7%	1.7%	**43.4%**	33.5%	3.5%	**37.0%**	**100.0%**	

Table 2: International Comparison of Health Expenditure[4]

Country (year data published)	GNP per Capita (US$)	Health Expenditure Per Capita (US$)	Health Expenditure as a Percentage of GNP per Capita		
			Public	Private	Total
Kenya (1994)	250	25	3.3	6.7	10.0
Uganda (1997)	**300**	**11**	**1.7**	**1.9**	**3.6**
South Africa (1993)	2,980	243	3.2	4.9	8.1
Egypt (1991)	610	30	2.0	2.7	4.7
Zimbabwe (1990)	680	42	3.2	3.0	6.2
Zambia (1995)	400	19	3.3	1.5	4.8
Sub-Saharan Africa (1990)	310	14	2.4	2.1	4.5
East Asia & Pacific (1995)	800	28	1.5	2.0	3.5
OECD (1995)	24,930	2,470	6.0	3.9	9.9
Note: Public expenditure in this table includes foreign assistance to countries.					

[4] Sources: MoFPED, *Background to the Budget 1999-2000*, Uganda; McIntyre, 1995; Eliya, 1997; *World Bank Development Reports 1995, 1996, 1997*; Department of Economics of the University of Zambia (1996).

TABLE 3

FLOW OF FUNDS FROM PRIMARY SOURCES TO FINANCING INTERMEDIARIES

UgShs million (FY 1997/98).

	Primary Sources								
	Government		**Donors**		**Employers**		**HHs****		
Financing Intermediaries	**MoFEP**	**Local**	**External**	**Internal**	**Private**	**Parastatal**		**TOTAL**	**PERCENT**
Public Sector									
Ministry of Health	24,303		41,619	31				65,953	21.3%
DHS	15,980	1,434	14,954	124				32,493	10.5%
Ministry of Defence	2,522							2,522	0.8%
Ministry of Education			11					11	0.0%
Nat. specialist hospitals	15,450		821					16,270	5.3%
Uganda Prison Services								0	0.0%
Uganda Police Services	245		223					468	0.2%
Subtotal Public Sector	*58,500*	*1,434*	*57,628*	*155*	*0*	*0*	*0*	*117,717*	38.0%
Private Sector									
HH out-of-pocket							103,710	103,710	33.5%
NGO's	764		71,595	5,172				77,531	25.0%
Private Health insurance***					733	200		933	0.3%
Private firms					7,189			7,189	2.3%
Parastatals						2,720		2,720	0.9%
Subtotal Private Sector	*764*	*0*	*71,595*	*5,172*	*7,922*	*2,920*	*103,710*	*192,083*	*62.0%*
TOTAL	**59,264**	**1,434**	**129,223**	**5,327**	**7,922**	**2,920**	**103,710**	**309,800**	100.0%
Percentage	**19.1%**	**0.5%**	**41.7%**	**1.7%**	**2.6%**	**0.9%**	**33.5%**	**100.0%**	

Financing Intermediaries

Public Sector								Private Sector								
MOH	**DHS**	**MoD**	**MoE**	**N.S.H**	**Prisons**	**Police**	***Subtotal***	**HH out-of-pocket**	**NGO's**	**Health Insurance**	**Private Employers**	**Parastatal Employers**	***Subtotal***	**TOTAL**	**PERCENT**
36,678							***36,678***						***0***	**36,678**	**11.8%**
	18,327						***18,327***						***0***	**18,327**	**5.9%**
	9,861						***9,861***	41					***41***	**9,902**	**3.2%**
	4,305					120	***4,425***	37					***37***	**4,462**	**1.4%**
		793					***793***						***0***	**793**	**0.3%**
2,319			11			5	***2,335***		3,201				***3,201***	**5,536**	**1.8%**
328							***328***						***0***	**328**	**0.1%**
				16,270			***16,270***						***0***	**16,270**	**5.3%**
							0						***0***	**0**	**0.0%**
						120	***120***						***0***	**120**	**0.0%**
7,288							***7,288***						***0***	**7,288**	**2.4%**
4,637							***4,637***						***0***	**4,637**	**1.5%**
14,703							***14,703***						***0***	**14,703**	**4.7%**
65,953	*32,493*	*793*	*11*	*16,270*	*0*	*245*	***115,765***	*78*	*3,201*	*0*	*0*	*0*	***3,279***	***119,044***	***38.4%***
							0	30,880	6,322	270			***37,472***	**37,472**	**12.1%**
							0		58,663				***58,663***	**58,663**	**18.9%**
		1,729					***1,729***	30,610	4,000	112			***34,722***	**36,451**	**11.8%**
						223	***223***		3,983				***3,983***	**4,206**	**1.4%**
							0	25,748		271			***26,019***	**26,019**	**8.4%**
							0		42				***42***	**42**	**0.0%**
							0	4,520					***4,520***	**4,520**	**1.5%**
							0						***0***	**0**	**0.0%**
							0					2,720	***2,720***	**2,720**	**0.9%**
							0				7,189		***7,189***	**7,189**	**2.3%**
							0	11,875	1,321	280			***13,476***	**13,476**	**4.3%**
0	*0*	*1,729*	*0*	*0*	*0*	*223*	***1,952***	*103,632*	*74,331*	*933*	*7,189*	*2,720*	***188,805***	***190,757***	***61.6%***
65,953	**32,493**	**2,522**	**11**	**16,270**	**0**	**468**	***117,717***	**103,710**	**77,532**	**933**	**7,189**	**2,720**	***192,084***	**309,801**	**100.0%**
21.3%	**10.5%**	**0.8%**	**0.0%**	**5.3%**	**0.0%**	**0.2%**	**38.0%**	**33.5%**	**25.0%**	**0.3%**	**2.3%**	**0.9%**	**62.0%**	**100.0%**	

strict Hospitals
of health workers, referral expenses and treatment abroad.
medical supplies and equipment
cludes funds for purchase of other medical materials.
ammes for preventive services.
mes/ Immunisation/ Malariacontrol/ STI activities.
ch goes to which porgramme was not easy to work out because NGO's put the whole expenditure under preventive health programmes.
consultation fees. This is monthly household health expenditure

Table 5

FLOW OF FUNDS FROM FINANCING INTERMEDIARIES ACCORDING TO FUNCTIONS

UgShs million

	Financing Intermediaries														
	Public Sector							Private Sector							
Functions	**MoH**	**DHS**	**MoD**	**MoE**	**N.S.H**	**Prisons**	**Police**	*Subtotal*	**HH out-of-pocket**	**NGO's**	**Private Insurance**	**Private** Employers**	**Parastatal** Employers**	*Subtotal*	**TOTAL**	**PERCENT**
Preventive services	17,123	13,009					223	***30,355***		13,983				***13,983***	**44,338**	**14.3%**
Curative services		10,940					240	***11,180***	56,706	6,322	541			***63,569***	**74,749**	**24.1%**
Phamaceuticals*	7,288		1,729					***9,017***	30,609	4,000	112			***34,721***	**43,738**	**14.1%**
Technical support***	2,847	3,884						***6,731***		28,374				***28,374***	**35,105**	**11.3%**
Capital development	19,904	3,226			1,172			***24,302***		20,289				***20,289***	**44,591**	**14.4%**
Research & training	2,319			11			5	***2,335***		3,242				***3,242***	**5,577**	**1.8%**
Adminstration	14,703							***14,703***		1,321	280			***1,601***	**16,304**	**5.3%**
Other non classifiable	1,769	1,434	793		15,098			***19,094***	11,875			7,189	2,720	***21,784***	**40,878**	**13.2%**
Traditional healers									4,520							
TOTAL	**65,953**	**32,493**	**2,522**	**11**	**16,270**	**0**	**468**	***117,717***	**103,710**	**77,531**	**933**	**7,189**	**2,720**	***192,083***	**309,800**	**98.5%**
PERCENT	**21.3%**	**10.5%**	**0.8%**	**0.0%**	**5.3%**	**0.0%**	**0.2%**	***38.0%***	**33.5%**	**25.0%**	**0.3%**	**2.3%**	**0.9%**	***62.0%***	**100.0%**	

* and other medical purchases

** All expenditure was on curative services but, it can not be disegregated to show how much was on phamaceuticals

*** This includes funds to MoH planning unit/ HSSP/ DISH project and technical support by NGO's to districts.

TABLE 6

Expenditure on water/ sanitation and nutrition programs.					
	Ugshs Million				
	Sources				
Program	Donors				
	External	Internal			
Water&Sanitation	1,572				
Nutrition	127	0.7			

Table 7: Monthly Household Health Expenditure Statistics: 1997[5]

Region	Total Health Expenditure (UShs Billion)			Share of Health in Total Expenditure (%)		Average Share of Traditional Care in Household Health Expenditure (%)
	Excluding Traditional Care	Traditional Care	Total	Excluding Traditional Care	Including Traditional Care	
Central	37.50	0.99	38.49	3.65%	3.76%	1.39%
Eastern	27.56	1.65	29.21	5.31%	5.72%	2.17%
Northern	11.10	1.05	12.15	4.17%	4.47%	1.31%
Western	23.03	0.84	23.88	4.73%	4.95%	1.78%
TOTAL	**99.19**	**4.52**	**103.71**	**4.47%**	**4.72%**	**1.69%**

Table 8: Poverty and household health expenditure

	Contribution of the poor to health expenditure (%)		***Share of the poor in total expenditure on traditional care*** (%)*
	Excluding traditional care	Including traditional care	
Uganda	27.81	27.48	20.20
Central	17.78	17.49	6.37
Eastern	39.64	38.65	22.00
Nothern	40.74	39.06	21.29
Western	23.75	24.02	31.51

Source: Generated by John A. Okidi from the 1997 national household survey data

* Poverty status is defined using the poverty lines and the adjusted household expenditure data calculated by Appleton (1999) from the national 1997

[5] Source: Generated by John A. Okidi from the 1997 *National Household Survey* data.

Table 9

Mean consumption per adult equivalence at each decile (1989 shillings per month)
National level

Decile	IHS (1989)	MS1(1991)	MS2 (1993)	MS3 (1995)	MS4(1997)
1	2453	2920	2898	2802	3164
2	3234	3627	3682	3650	3991
3	3955	4319	4403	4492	4798
4	4687	5004	5143	5214	5593
5	5474	5777	5919	6097	6442
6	6384	6745	6792	7114	7535
7	7556	7962	8064	8538	9019
8	9294	9745	9937	10636	10945
9	12237	12946	13748	14905	14503

Source: Changes in poverty in Uganda, 1992 - 1997, Simon Appleton
IHS: Integrated Household survey
MS: Monitoring surveys carried out every after 2 years

PART 4: METHODLOGY

4.1 Definitions

Health expenditures are defined on the basis of their primary purpose regardless of the primary function or activity of the entity providing or paying for the associated health services[6] (Berman 1999). Only those activities whose primary purpose is to improve health status have been included in the analysis. These include all activities conducted by the MoH and curative services, clinic-based preventive services (family planning, immunisation, etc), capital development for health care facilities and medical training and research conducted by other organisations. Thus the focus is on the direct purposes and function of the expenditure. Activities that are indirectly involved in health status and treatment, such as nutrition programs and water and sanitation programs, are not included in this analysis[7] but are referred to in table 6.

Broad categories of originating sources of health expenditure and financing intermediaries' breakdowns used in earlier applications of the Harvard approach have been retained. The classification scheme for healthcare providers has been modified to suit the Ugandan context, although they still conform to the Harvard Revised provider's classification. Identification of public and private ownership has been included where possible. In addition the Harvard Revised functional classification more relevant to low income countries has been used in this analysis with only slight modifications. See Annex E for the NHA Guidelines draft and Harvard revised classification modifications used in NHA Uganda study.

4.2 Time period

Data presented in this report is primarily for the FY 1997/98.[8] Estimates of household health expenditures are based on survey results of the Uganda National Household Survey of 1997 conducted by the Department of Statistics of the MoFEP. Another source of data was the United Nations Development Programme's *Uganda development co-operation report* of 1997. This report includes data on contributions made by international donors to the Uganda health sector during the calendar year. The donor disbursements to the health sector report from the MoFPED Aid Liaison Office contains donor support categorised according to functions for the FY1997/98. Firms, donors, insurance companies and ministries surveyed have all provided data for FY 1997/98.

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[6] The specific definition followed the Harvard methodology, which is very similar to the OECD standard, and is described in the appendix, the specific definition is: "Health expenditure are defined as all expenditures or outlays for prevention, promotion, rehabilitation, and care; population activities; nutrition and emergency programs for the specific and predominant objective of improving health. Health includes both the health of individuals as well as of groups of individuals or populations. Expenditures are defined on the basis of their primary purpose, regardless of the primary function or activity of the entity providing or paying for the associated health services. Expenditures for the purpose of training or education of health sector personnel, which impacts health-sector specific knowledge and skills, as well as health-related research[and administration], are defined as being for the purpose of health improvement when applying this definition.

[7] Spending on nutrition, water, and sanitation services do, of course, have indirect impact on health, and, therefore, are relevant to a comprehensive calculation of health-related spending. Such spending could indeed be included as a part of an NHA study, while not explicitly included in the final health sector total. The health-related portion of such health-related spending is difficult to quantify on a consistent year-over-year basis. Expenditure on such programs directly under the MoH has been included and that under NGOs' and donors has been put separately.

[8] The fiscal year begins July 1st and ends June 30th.

4.3 Currencies

All amounts are given in Uganda shillings (Ushs). Foreign currencies were converted to UgShs using the exchange rate for the FY 1997/98 as given by MoFPED.

4.4 NHA Entities

4.4.1 Ministries:

The NHA Team (together with the EPRC) conducted interviews with officials from the relevant ministries to ascertain the sources, amount of revenue, and expenditure for health related activities.

4.4.2 Donors:

There was variation in the amount of donor funds reported by the three different sources namely; the UNDP Development Co-operation Report Uganda 1997, Donor Disbursements to Health Sector report for the FY1997/98, and records from MoH (health expenditure analysis). In this study, data from the Donor Disbursement to Health Sector Report (which shows disbursement according to function and financing intermediary) has been used for the analysis. Meetings have been held with some major donors and officials from the MoFPED and, concurrently a questionnaire (See Annex A) has been administered to review and verify data sets on donor spending. Because most data sources used here were from budget and/or plan documents, and not reports on actual disbursements and spending, the latter were assumed to be lower than budgeted and/or planned amounts.

4.4.3 NGOs:

The NGO sector functions as a financing intermediary and provider of health services. These receive funds from foreign donors, Government of Uganda, and income generating activities. Some NGOs fall under four religious organizations, namely:

- Uganda Protestant Medical Bureau
- Uganda Catholic Medical Bureau
- Uganda Muslim Medical Bureau
- Islamic Medical Association

In addition to these, thirty NGOs were surveyed. The NHA Team held interviews with officials in these organisations and, in addition a questionnaire was administered (see annex B) to capture disaggregated information. Useful information on sources of financing and use of funds by these organizations was obtained.

4.4.4 NGO Sampling:

Due to resource and time constraints this study did not attempt to obtain a country wide representative sample of NGOs. Instead two districts (Kampala and Iganga), were selected to represent an urban and rural setting. We were unable to access a comprehensive list of NGOs from the NGO board because of the high level of bureaucracy encountered. Instead, a list of NGOs compiled by the District Health Services Project (DHSP) was used as the sampling frame for this study. This list primarily consisted of NGOs that had submitted proposals to the MoH for funding. This means a number of NGOs that would otherwise have been relevant to our study but were not on the list, were not sampled. However, the study also surveyed additional

NGOs' not included on the list but were operating in at least two districts according to district revenue reports.

The sampling methodology used the formula below to determine the appropriate sample size of NGOs in the selected districts of Kampala and Iganga. The formula is valid for simple random sampling for a finite population of N NGOs.

$$e = \sqrt{1 - \frac{n}{N}} \sqrt{\frac{p(1-p)}{n}}$$

The term: $\sqrt{1 - \frac{n}{N}}$

is referred to as the *finite population correction.* It essentially depends on the *sampling fraction* $\frac{n}{N}$.

Where n is the sample size needed to achieve a 5% standard error, e, for a proportion $p = 50\%$ and population size N.

Using this formula, 33 NGOs were randomly selected out of a total of 47 in Kampala district. Similarly, 21 NGOs were selected out of a total of 26 in Iganga district.

Out of the 33 NGOs' selected in Kampala 9 were found to be non existent; 7 were private health facilities whose funding was already captured under Household expenditure; 4 started operating after the FY considered in this study. In the end the survey interviewed 13 NGOs in Kampala district.

The same scenario more-or-less repeated it self in Iganga District. Out of the 26 NGOs' selected 7 were private clinics and 5 started operating in the FY 1998/99. Six were found to be non-existent; one turned out to be a one man operation and he was not available for the interview. Thus a total of 7 NGOs' were actually interviewed.

In addition to the randomly sampled NGOs in the districts of Kampala and Iganga, the research team an ad-hoc selection of 14 NGOs was selected. This ad-hoc list included key umbrella organisations. The criterion for their selection was extent of coverage. These were NGOs operating in more than 2 District having their headquarters in Kampala.

In total 34 NGO's were sampled and gave useful information on sources and uses of funds. An effort was made to ensure that funds from the same source are not counted twice; this was through collaboration with donors and NGO senior officials.

4.4.5 Employers:

Data on expenditures on healthcare by parastatals and private companies on behalf of their employers (and dependants in some cases) are non-existent. Thirteen big Government parastatals and, 33 private firms were selected. The Selection of private firms was done in collaboration with the department of statistics MoFPED. To sample the 33 private firms registered with the Uganda Bureau of statistics (UBoS) (1995 Data), a stratified sample was created to reflect the distribution of workers according to type of sector (industrial, agricultural and service). The survey attempted to canvass only large firms i.e., those employing 100 employees and above. The NHA team administered a questionnaire (See annex C) to these firms to capture the type of medical benefits for employees and total expenditure on health. Medical allowances have not

been included in the analysis as this is captured under Household surveys. See Annex III for questionnaire.

4.4.6 Private Health Insurance:

A survey of private health insurance firms was conducted to determine premiums for health insurance and, capture disaggregated information on payouts. (See Annex D for Questionnaire).

4.4.7 Household Health Expenditure[9]:

To capture information on household health expenditure, results from the Uganda National Household Survey provided by Uganda Bureau of Statistics (UBoS) have been used. Out- of-pocket (OOP) expenditures in district and referral hospitals were obtained from the summaries of average monthly fee for service/user charges collection. The breakdown of OOP expenditure by type of service was obtained by applying the shares found in the household survey to the estimated OOP total.

4.5 Review of entities included in the NHA Study

4.5.1 MINISTRIES

Three ministries were surveyed;

- The ministry of Education is responsible for training medical personnel through its colleges. Training was carried out under MoH and was only transferred to MoE in the following financial year. However MoE received UgShs 11 million from UNICEF for medical training. MoH incurred expenditure on medical treatment for MoE workers.

- The ministry of Defence finances and operates it's own health facilities. It offers curative and preventive services; and spends money on training, referrals and treatment abroad. A detailed break down was not available from MoD records but total expenditure amounted to UgShs 2.522 billion. The NHA team was not able to access the amount of money spent by MoD on preventive health services.

- Ministry of Health receives money from foreign donors, MoFPED and appropriation in aid; this amounted to UgShs 66 billion in the FY1997/98.

Uganda police finances it's own health facilities. Expenditure on health services amounted to UgShs 0.468 billion.

4.5.2 DONORS.

Foreign donors contributed UgShs 129billion (US$112million) to the Health sector in Uganda n the FY 1997/98.

Fig 7 shows percentage distribution of donor contribution to the Health sector according to source. The international development agency (IDA) had the highest contribution at 19%,

[9] These are monthly household expenditure figures.

followed by USAID at 16% then UNICEF at 11%. Fourteen other donors combined to account for the remainder.

Figure 7. Percentage distribution of Donor funds to the Uganda Health Sector According to source (FY 1997/ 98

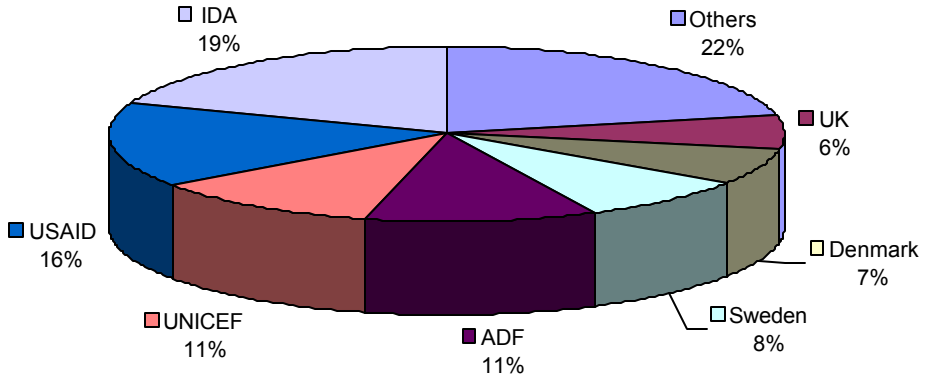
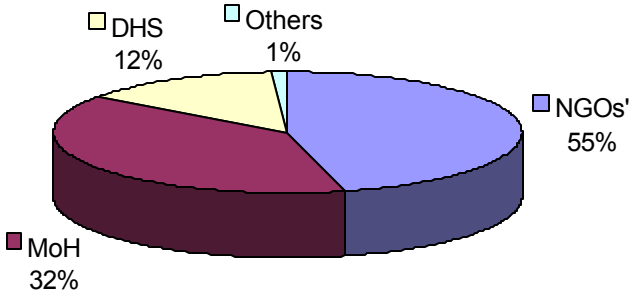


Fig 8 shows percentage distribution of donor funds according to financing intermediary. At 55% NGO's were the highest beneficiary of donor support, followed by MoH at 32%, while District health services (DHS) received 12%. The 1% went to other ministries and National specialist hospitals.

Figure 8. Percentage distribution of donor funds according to financing intermediaries.



Sources of data included the Donor Disbursements to Health Sector Report from Ministry of Finance (MoFPED) Aid Liaison office; Uganda Development Co-operation Report (DCR 1997) produced by the United Nations Development Program (UNDP). Within the Disbursement to Health Sector Report, donor support was categorized according to functions (technical support, capital dep't, drugs, training, research, and technical programs). Some of the financing intermediaries were specified in the report. Missing intermediaries were identified through interviews with local donor representatives, MoH officials and DHS report on revenue. Donor

spending on local administration to support their health programs in Uganda is not included in this analysis.

Interviews were held with officials from four religious umbrella organizations namely, the Uganda Protestant Medical Bureau, Uganda Catholic Medical Bureau, Uganda Muslim Medical Bureau and Islamic medical association. Information on sources of Financing and use of funds by these organizations was obtained. This same information was sought from 30 other NGOs.

Some local NGO's get money from cost sharing schemes and income generating activities (internally generated funds). This amounted to UgShs 5.3 billion.

4.5.3 EMPLOYERS

4.5.3.1 Parastatals

Survey questionnaires were used to obtain data on health care expenditures by parastatals on behalf of their employees (and dependants in some cases). Thirteen (13) of the largest parastatals were sampled. Of these 11 gave usable responses covering 95% of the 15,347 workers employed in the 13 parastatal firms in 1997/98. The remaining two firms paid medical allowances as part of employee salaries. Since these benefits are monetary and can be used for any purpose (including, but not limited to, the purchase of health services), they were considered part of household spending and were not included in this analysis.

The 11 parastatals made payments to insurance companies and, directly or indirectly to providers. They spent UgShs 2.92 billion; payments to insurers amounted to UgShs 0.2 billion (7%), those made directly or indirectly to providers amounted to UgShs 2.72 billion (93%).

All the money was spent on curative services but it is not possible to provide disaggregated data on expenditure according to ownership (private or public sector) and, according to functional category (inpatient, drugs and outpatient services expenditure), as this was not available from firms' records.

4.5.3.2 Private firms.

Thirty-three (33) big privately registered (with Dep't of statistics MoFPED 1995 data) firms, employing 20,916 workers in 997/98, were sampled. They were stratified according to sector (agriculture, service, and industry).

Of the 33 firms contacted 32 employing 98% of the workers gave usable responses.
Payments for health care amounted to UgShs 7.38billion. Payments to insurers amounted to UgShs 0.733(9%) billion and, those made directly or indirectly to providers amounted to UgShs 7.18 billion (91%).

All spending directly or indirectly to providers was on curative services. Purchase through private providers amounted to 0.5 billion UgShs (7% of total expenditure on health care by private firms), while that in the public sector amounted to 0.08 billion UgShs (1%). Expenditure for on-site facilities amounted to 6.6 billion UgShs (92% of total health care expenditure by private firms). Details of expenditure according to functional category could not be obtained.

4.5.4 INSURANCE:

4.5.4.1 Parastatal:

There is only one state owned insurance company. Premium for the financial year 1997/98 amounted to UgShs 0.306 billion and payouts amounted to 0.404 billion UgShs. There was no interest earned and, details of reimbursement were not available.

4.5.4.2 Private firms:

The two companies sampled were Health management/ maintenance organizations insuring 174 companies and 2578 individuals.

One of the companies registered people as individuals so much as it insured 173 companies, we could not work out how many of the 2578 people were insured as individuals, and how many were insured under companies. The other organization only insured companies and catered for only one company though the number has risen to 10 in 1999/2000. Total premium collected for the financial year 1997/98 was UgShs 0.432 billion and pay out was UgShs 0.466 billion.

Expenditure on drugs amounted to 0.057 billion UgShs (12%), Private hospitals accounted for 0.13billion UgShs (28%), while administrative costs amounted to 0.28 billion UgShs (60%)

4.5.5 Households:

As pointed out earlier the national household Survey data for 1997 has been used in this study. The monthly Household expenditure statistics show that total health expenditure was 103.71 billion UgShs. Share of health in total monthly household expenditure was 4.72%. Details of regional health expenditure and expenditure on traditional care are also given. Table 8 shows the details of poverty and household health expenditure. The poverty status is defined using the poverty lines and the adjusted household expenditure data calculated by Appleton (1999) from the national Household survey 1997. It shows that the poor contribute 27.48% to health expenditure. Reliance on traditional care in Uganda is known to be expensive. The results in table 7 do not appear to have adequately captured this given the low figure of UgShs 4.52 billion. Explanation for this could be that traditional care is relatively inexpensive such that, its being widely consumed does not necessarily result in a big bill. Alternatively, accurate information on costs of traditional care is hard to come by and may not have been captured adequately by the survey. Table 8 shows that contribution to health expenditure by the poor is just about the same when you include or exclude traditional care, this implies that prices for traditional care for the poor is relatively less; much as the poor may use traditional care more they pay less than the rich do. The low percentage expenditure on traditional care by the poor in the central region can be explained by easier access to modern health facilities.

Note: These are monthly household health expenditure figures.

Table 9 shows the mean consumption per adult equivalence at each decile in 1989 constant prices. The mean consumption per adult equivalence was progressively higher in HIS (1989) and increased from deciles 5 to 1. The results for deciles 9 to 6 were mixed. Annex H shows the mean consumption per adult equivalence at each decile for National Rural and Urban areas. (1998 shillings per month).

4.5 Data Limitations and Constraints

There were five main limitations to the quality of data obtained during the team's research.

- There were no final (audited) accounts reports and data had to be retrieved from vouchers which was a tedious exercise. Donor data, in particular, is thought to be unreliable and may include some degree of over-counting. This may or may not have led to double counting in some categories.

- The accounting procedures in some organizations do not capture desegregated costs. So, it was not easy to classify expenditure according to function. This was put under non-classifiable expenditure.

- The many levels of bureaucracy were a big hindrance factor. This made the data collection procedure lengthy because, a questionnaire has to go through different departments before approval to access financial data was granted. Inevitably, this lengthened the time required gather and analyse the data.

- Lack of cooperation in some sampled organizations was a big constraint.

- In a few cases officials concerned with the availing of data were absent from offices most of the time thus, slowing down the exercise

Specific constraints are given in Annex F.

4.6 Summary of Findings

This study has attempted to provide a picture of the total amount of resources spent on health care for the financial year 1997/98 and who the financiers of these activities were. The study so far shows that donors were the most important sources of funds followed by Households.

Much as government emphasis in the past has been to increase expenditure on preventive services, curative services had the highest share of expenditure at 24% followed by capital development, preventive services and pharmaceuticals at 14%. Technical support accounted for 11%, while expenditure on research was the lowest at 1.6%. Due to time and resource constraints it was not possible to desegregate hospital services due to time and resource constraints, so expenditure under hospitals has been put under curative services. Expenditure on promotive services (such as health education, IEC, behavioural changes) has been put under preventive services; the structure of accounts in many of the organisations and ministries surveyed can't capture desegregated costs.

The two private firms surveyed were Health maintenance/management organisations. Estimates obtained may not give a true picture of use of health insurance.

There is need to coordinate flow of foreign donor funds. This will ease subsequent NHA studies and hence yield more reliable donor fund estimates. This study has identified four pathways of donor funds, these include:

- Foreign aid through MoFEP to MoH.
- Foreign aid to MoH.

- Foreign aid sent straight to NGOs'.
- Foreign aid sent straight to providers and, these are mainly NGO hospitals.
- Foreign aid sent straight to DHS.

Results of household survey carried out by MoFPED dep't of statistics in 1997 have been used in this study. Un official charges in public facilities are significant but were unfortunately not captured. It may not be easy to give percentage expenditures in the public, private and traditional sector from this household survey. However, studies done earlier by Paul Hutchison "Healthcare in Uganda Aug 1999 and Household demand for health services in Uganda July 1999" showed that; 60% - 70% of household expenditure was in the private sector. This could have been accounted for by a preference to use non-governmental and private services because they offer better quality services. The break down for household contributions has been done using ratios derived from the household survey 1997 and estimates from Paul Hutchison's studies.

4.7 Issues for policy and programs:

4.7.1 Health planning:

NHA is useful for planning purposes, tracking the flow of funds from all sources shows where the different sources put emphasis and public funds can reallocate accordingly.

4.7.2 Monitoring:

NHA is useful in financial monitoring. The NHA Team is preparing NHA FY 1998/99, this is a monitoring tool that is being developed by the MoH/GoU and HSPH. As an extension of NHA, the tool will monitor HIPC Debt relief funds.

As a means of institutionalising NHA, the MoH plans to disseminate NHA results to all stakeholders.

ANNEX B: NGO QUESTIONNAIRE

Form ID No.___/___

The information provided will be treated with strict confidentiality

1. Preliminaries

Name of NGO: ……

Name of respondent: ……

Position of respondent: …….

Date of interview: …….

Location: ..……

2. Indicate in the table below that amount of revenue obtained by your organisation in FY 1997 according to source.

Source of Revenue	Amount in Millions of Shillings
	FY 1997
Cost-Sharing Schemes	
Grants from GoU in:	
• Cash	
• Kind (estimates)	
Foreign Assistance in form of:	
• Loans	
• Grants / donations	
Others (specify):	
Total	

3. Indicate in the table below the amount your organisation expended on the following activities in FY 1997.

Activity	Amount in Millions of Shillings
	FY 1997
Primary Care Services	
Secondary / Tertiary Care Services	
Training	
Research	
Information, Education and Communication	
Administration	
Other (specify):	
Total*	

ANNEX C: EMPLOYER INTERVIEW FORM (DRAFT)

Form ID# :_____

Firm Name:_____ Date:_____

Name of Person Interviewed: _____

Type of Firm (circle one)

1 = State-Owned / Para-statal 2 = Private Sector, for-profit

1. Provide a brief description of your firm's activities

2. How many employees in your organisation?

3. Does the government or any other organisation make a contribution to health care benefits provided by your firm?

4. What types of health benefits do you offer your employees? (circle all that apply)
   a. Insurance coverage (answer number 5)
   b. Medical allowances or reimbursements (answer number 6)
   c. On-site health care (answer number 7)

5. Please respond to the following questions regarding health insurance benefits provided to your employees in the fiscal year (FY) 1997:

   a. Name your firm's insurance company.

   b. How much did your firm pay in premiums?

   c. Do your employees contribute to private health insurance? If so, how much?

   d. Which types of health care services are covered? What exclusions are there?

   e. Are all employees included in the insurance scheme? How many are not included and what health benefits do they receive?

6. Please respond to the following questions regarding direct reimbursements made to your employees for health care for FY 1997:

   a. How much did your firm provide to employees in direct reimbursements?

   b. Which types of health care services does your firm reimburse? Circle all that apply:
      1 = inpatient 2 = outpatient 3 = drugs

   c. Does your firm keep records on the amount spent to reimburse for services purchased at private and public health care facilities? If so, I'd like to know how much was spent at these facilities.

      Public facilities = _____

      Private facilities = _____

7. Please respond to the following questions regarding on-site health care for your employees:

   a. How many health care facilities does your company provide? Where are they located?

   b. What types of health services are available in these facilities? (inpatient, outpatient, drug dispensary)

   c. How much did your company spend in FY 1997 to provide on-site health care services?

   d. Does the government or any other non-governmental organisation make contributions which support your health facilities? If so, how much?

   e. Do employees pay for services and/or medication offered in these facilities? If so, what are the prices? How is the revenue used? How much revenue from fees was earned in 1997?

ANNEX D: HEALTH INSURANCE QUESTIONNAIRE

Form ID No.___/___

The information provided will be treated with strict confidentiality.

1. Preliminaries

Name of insurance company: ……

Type of insurance company (circle one):

1. State-owned / Para-statal
2. Private for-profit
3. Private not-for-profit

Name of respondent: ……

Position of respondent: ……

Name of interviewer: ……

Date of interview: ……

2. In the table below please indicate the number of subscribers (for health insurance only) to your organisation in fiscal year (FY) 1997.

Fiscal Year	Number of subscribers under:		
	Group / Company	Individual/ Family	Others (specify)
1997			

3. In the table provided below, indicate your organisation's total revenues and reimbursements/pay outs made for FY 1997.

Fiscal Year	Revenue Raised (Millions of Shillings)	Reimbursements/ Pay-outs (Millions of Shillings)
1997		

4. Indicate in the table below that amount of revenue obtained by your organisation in FY 1997 according to source.

Source of Revenue	Amount in Millions of Shillings FY 1997
Group/Company Premiums	
Individual/Family Premiums	
Grants from GoU in:	
• Cash	
• Kind (estimates)	
Foreign Assistance in form of:	
• Loans	
• Grants /donations	
Others (specify):	
Total*	

* Total should match amounts in Column 1 of Table 3.

5. Indicate in the table below the amount your organisation paid in reimbursements/pay-outs to the following institutions in FY 1997.

Recipient of Reimbursement / Pay-out	Amount in Millions of Shillings FY 1997
GoU Hospitals	
Other Government Facilities	
Private-for-profit Hospitals	
Other Private-for-profit Facilities	
Private Non-profit Hospitals	
Other Private Non-profit Hospitals	
Others Facilities (specify):	
Do Not Know, Reimbursement Made Directly to Premium Holder	
Total*	

* Total should match amounts in Column 2 of Table 3.

ANNEX E: HARVARD CLASSIFICATION MODIFICATIONS

E.1 Sources

Expenditure was classified according to four main sources:

- general government expenditure (MoFPED, local government);
- expenditure on health-care by employers and firms (para-statals and private firms), including direct and indirect expenditure on health care benefits;
  - direct out-of-pocket household expenditure;
  - expenditure by other organisations, including foreign aid through the MoFPED Aid Liaison Office, foreign aid to NGOs and foreign aid to DHS.

E.2 Financing Intermediaries

There were four primary intermediaries for the general government (public) financing of medical care:

- MoH and other relevant ministries (MoD, MoES, UPS)
- District Health Services
- Para-statal firms[10]
- National Specialist Hospitals

Similarly, the private financing of medical care was classified into four intermediaries:

- Private Health Insurance;
- private household out-of-pocket payment;
- expenditure on medical care by private firms;
- NGOs.

E.3 Health-care Providers' Classification

Both public and private providers were classified according to the following:[11]

- Government-owned hospitals;
- health centres;
- dispensaries;
- maternity units;
- sub-dispensaries;
- aid posts.

For private providers, there was the following additional classification:

[10] Expenditure on medical care by para-statals is not purely under public expenditure because it may be treated as private in terms of employee benefits.

[11] The amount of money spent below hospital level is the PHC Conditional Grant though we are not able to desegregate it.

- private hospitals (both profit and not-for-profit).

On pages 40a through 40g, the Harvard Revised Financing Intermediaries Classification Scheme is described in more detail.

ANNEX F: CONSTRAINTS

F.1 Ministries

Two ministries, i.e. the MoD and the MoES, together with the Uganda Police Services (UPS) have been surveyed so far. In the MoD, expenditures are put under votes, and are thus recorded as a lump sum; desegregated data were not available.

F.2 Donors

Donor support information available from the UNDP's *Development Co-operation Report* 1997, *Donor Disbursement to Health* report from MoFPED's Aid Liaison Office, and the MoH report entitled *Health Expenditure Analysis* had marked variations. In this study, data from the first-mentioned report, *Donor Disbursement to Health,* which shows disbursement according to function and financing intermediary, has been used for the analysis.

Secondly, the arrangement in UPMB is that donor funds move from foreign donors directly to NGO hospitals. Thus, gathering data about donor assistance to these hospitals would call for visits to these individual (and widely spread) organisations. Given the time constraint, this has not been done, although UPMB officials admitted that the amounts involved are substantial.

F.3 NGOs

Some NGOs run health programs in different districts and yet do not have a centralised accounting system. Retrieving and compiling data from all the different districts takes time and may lead to some inaccuracies.

Record keeping in some NGOs was almost non-existent. The officials concerned admitted that the figures availed could be under-estimates.

F.4 Employers

In some firms, there was no record keeping for the FY 1997/98. This led to repeated changes in sample selection.

In some other firms (mostly para-statals) expenditure is lumped together under "health". Therefore, it has not been possible to obtain the details of expenditure by function and ownership. However, most private firms have provided data about expenditure according to ownership and the analysis has been done under section (ii) under employers.

Some employers considered the exercise to be a waste of time, so obtaining data from them took a long time. Indeed, some of them refused to co-operate at all.

F.5 Insurance

Each of the companies surveyed insured one-group client so information obtained from them may not be representative.

- Africa Air Rescue (AAR) maintains records on an individual basis so much as it insured 2,578 individuals and 173 firms. However, we could not work out how many people were insured under companies and how many were insured as individuals.

- One company provided expenditure data as a lump sum payout, and details of expenditure according to ownership and function were not available.
- One company, a major insurance provider for the financial year under study, has since closed their medical operations.
- Lack of clear policy as to who is authorised to release the required data in many of the sampled organisations was a serious problem, and moving from office to office caused unnecessary delays.

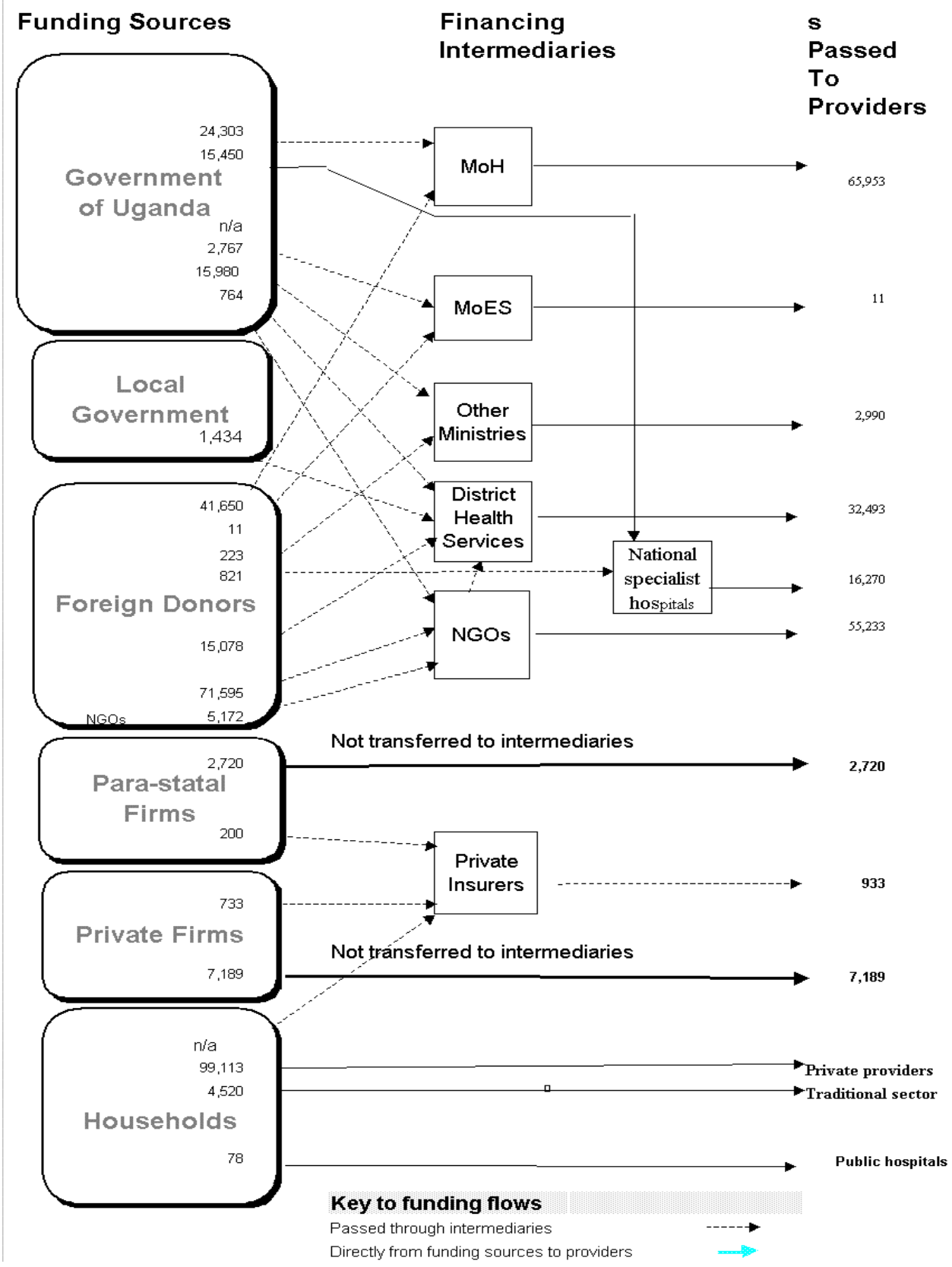
ANNEX G: MATRICES

Pages 42 through 45 on the following pages contain four matrices illustrating the data given in the main part of this document.

Please note that in the matrices, all figures given are in UShs million.

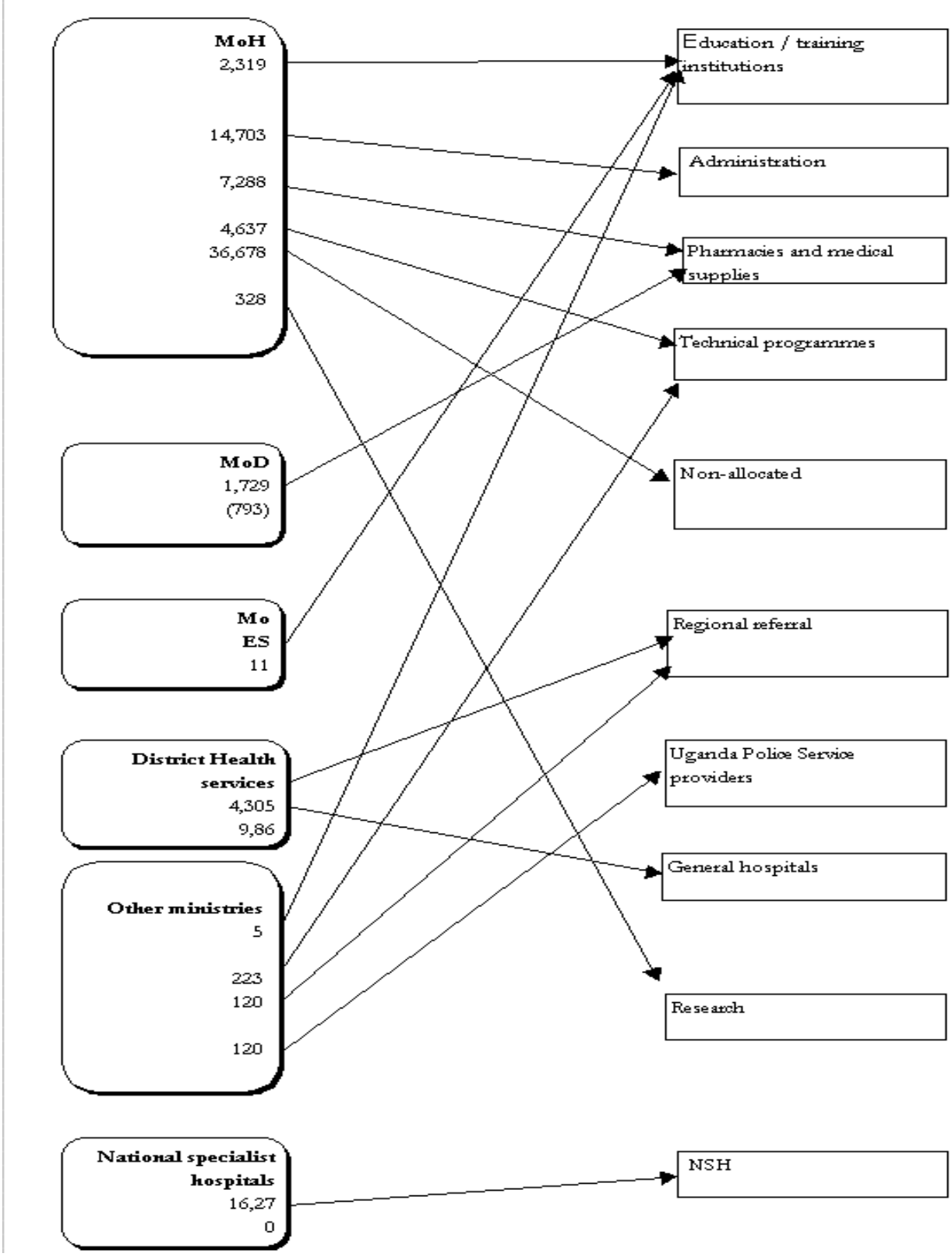
ANNEX G.a

FIG 2: Flow of Funds Between Sources and Financing Intermediaries: 1997/98



ANNEX H

FIG 4A: Financing Intermediaries to Providers: Public Sector Financing



ANNEX I

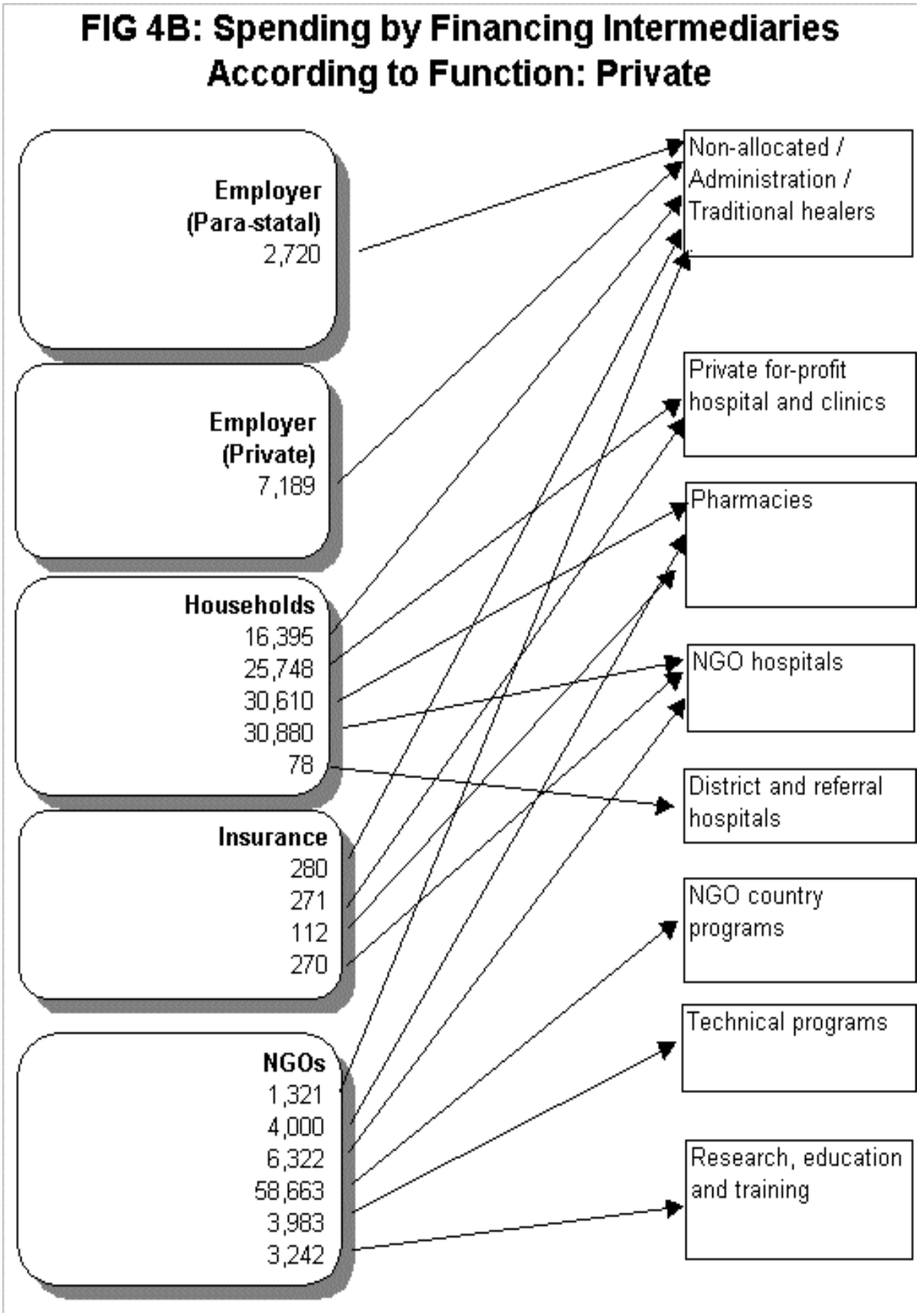
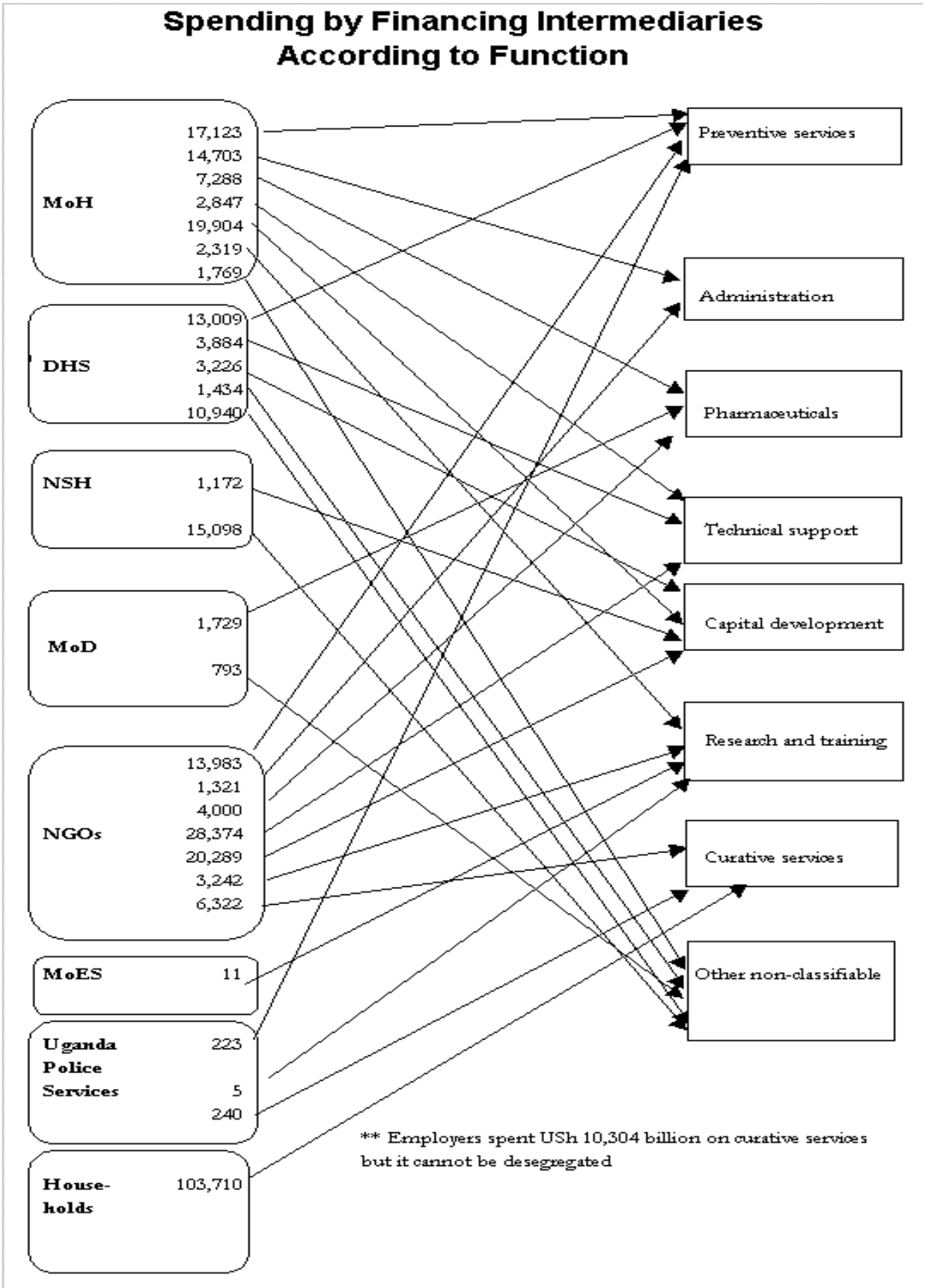


FIG 4B: Spending by Financing Intermediaries According to Function: Private
Employer (Para-statal) 2,720
Employer (Private) 7,189
Households 16,395 25,748 30,610 30,880 78
Insurance 280 271 112 270
NGOs 1,321 4,000 6,322 58,663 3,983 3,242
Non-allocated / Administration / Traditional healers
Private for-profit hospital and clinics
Pharmacies
NGO hospitals
District and referral hospitals
NGO country programs
Technical programs
Research, education and training

ANNEX J


Spending by Financing Intermediaries According to Function
MoH
17,123
14,703
7,288
2,847
19,904
2,319
1,769
DHS
13,009
3,884
3,226
1,434
10,940
NSH
1,172
15,098
MoD
1,729
793
NGOs
13,983
1,321
4,000
28,374
20,289
3,242
6,322
MoES
11
Uganda Police Services
223
5
240
House-holds
103,710
Preventive services
Administration
Pharmaceuticals
Technical support
Capital development
Research and training
Curative services
Other non-classifiable
** Employers spent USh 10,304 billion on curative services but it cannot be desegregated

ANNEX K: MEAN CONSUMPTION PER ADULT EQUIVALENCE AT EACH DECILE

Table H.1: Mean Consumption per Adult Equivalence at Each Decile: 1989 (Rural Level)

Decile	UShs per month				
	IHS (1989)	MS1 (1991)	MS2 (1993)	MS3 (1995)	MS4 (1997)
1	2,382	2,787	2,777	2,688	3,072
2	3,092	3,443	3,544	3,506	3,810
3	3,777	4,096	4,222	4,267	4,531
4	4,418	4,765	4,909	4,962	5,293
5	5,155	5,407	5,583	5,658	6,081
6	5,941	6,256	6,391	6,529	6,961
7	6,958	7,194	7,381	7,604	8,066
8	8,402	8,566	8,857	9,415	9,705
9	10,724	10,815	11,751	12,487	12,575

Table H.2: Mean Consumption per Adult Equivalence at Each Decile: 1989 (Urban Level)

Decile	UShs per month				
	IHS (1989)	MS1 (1991)	MS2 (1993)	MS3 (1995)	MS4 (1997)
1	4,121	4,804	4,467	4,688	5,179
2	5,414	6,304	6,206	6,487	6,969
3	6,679	7,810	7,360	8,231	8,650
4	8,112	9,604	8,964	9,688	9,935
5	9,748	11,505	10,732	11,812	11,873
6	11,435	13,453	13,484	13,816	13,577
7	13,761	15,941	16,421	16,647	16,121
8	17,648	19,950	20,997	20,575	21,199
9	24,513	26,723	31,006	28,338	29,873