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Social Protection and Health: Experiences in Uganda

*Jenny Yates, Ros Cooper and Jeremy Holland**

There is an interesting and continuing debate on the nature and role of social protection in poverty reduction. Within the health sector, discussion has focussed on the drawbacks associated with fee exemption schemes and community-based health insurance, with much less attention paid to the policy option of abolishing user fees. This paper reviews empirical evidence on the impact of the Government of Uganda's decision in 2001 to abolish user fees for health services. The paper finds that this policy intervention has had a significant positive impact on health-seeking behaviour in Uganda and concludes that this policy measure can make an important contribution towards a more 'promotional' policy approach to social protection.

1 Introduction

There is an interesting and continuing debate on the nature and role of social protection in poverty reduction (Norton et al., 2000; Shepherd et al., 2004; Devereux and Sabates-Wheeler, 2004), accompanied by commentaries on the limited ambition of strategies for social protection in Africa (Hickey, 2005a, b). Within the health sector, while the drawbacks associated with fee-exemption schemes for vulnerable groups and community-based health insurance have been recognised in the social protection literature (World Bank, 2001a, b), abolishing fees for health services as a social protection measure has received much less attention.

As in other countries, evidence from Uganda suggests that illness is one of the major risks to people's livelihoods and that ill-health is responsible for keeping people in poverty. The Ugandan Government has attempted to assist its population to manage the risk of ill-health in three different ways. First, during the 1990s, it introduced exemptions for poor and vulnerable groups from user fees for health services. From 1995 to 2002, it also supported community-based health insurance schemes. Its third approach, in 2001, was to abolish fees for health services, combined with reforms in the health sector to improve the provision of basic health services.

This article discusses these three different approaches in turn, since these experiences from Uganda may be useful to others considering how best to address the risks associated with ill-health. Given the relative lack of attention to the subject, the article focuses mainly on the abolition of user fees for health services, drawing together

* Jenny Yates and Ros Cooper work for the Department for International Development of the UK Government. This article reflects their personal views and does not necessarily reflect the views of DFID. Jeremy Holland is a social development consultant for Oxford Policy Management. Corresponding author: Jenny Yates, FCO (Kinshasa), 1 King Charles Street, London SW1A 2AH (j-yates@dfid.gov.uk).

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the evidence emerging from combined research methods and data in Uganda to analyse the impact of this policy change. Section 2 reviews some of the theoretical literature on social protection, with a focus on the conceptual shift from a residual welfarist approach to social transfers to a more 'promotional' vision of social protection. Section 3 reviews the evidence linking health shocks, health service delivery and poverty outcomes in Uganda, and documents experiences in the 1990s with user fees and Community-Based Health Insurance Schemes that led up to the government's decision in 2001 to abolish user fees. Section 4 focuses on evidence generated on the poverty impact of this abolition, taking into consideration accompanying supply-side changes in the health sector. Section 5 briefly concludes.

2 Approaches to social protection: theory and practice

During the past decade, the social welfare dimensions of social development have become far more nuanced in support of 'promotional' rather than residual approaches to social protection. In this section we review this shift and the changing theoretical discourse that underpins it.

The international development community has united behind a renewed focus on poverty reduction which is powerfully reflected in the common objectives presented by the Millennium Development Goals (MDGs). This consensus has been accompanied by increasingly 'theory-driven' (as opposed to poverty-line-driven) approaches to poverty reduction, with new dynamic and powerful analytical frameworks emerging amongst the international donor community. These frameworks have incorporated to varying degrees an operational focus on rights and empowerment approaches to development. The approaches have evolved from work by Sen (1981, 1985, 1997, 1999) on entitlements and capabilities, from the food security literature of the 1980s (Devereux and Maxwell, 2001) and later work on sustainable livelihoods (Scoones, 1998) and on vulnerability (Swift, 1989; Moser, 1998). The frameworks share a conceptualisation of poverty as multidimensional and complex and introduce a more dynamic and entitlements-focused analytical approach to poverty assessment.

This theory-driven approach has enabled development agencies to engage, with varying degrees of forcefulness, with what Moore and Putzel (1999) call the 'politics of poverty', focusing on the relationship between individual and group agency on the one hand and institutional structures on the other. Policy statements, such as the 1998 SPA[1] status report on poverty in sub-Saharan Africa, emphasised the role of public policy in investing in a broader range of assets and tackling the 'political deficit' of the poor (World Bank, 1998). The UNDP (2000) has been instrumental in pushing the rights and entitlements agenda within development agency discourse. Similarly, the OECD notes the importance of a rights approach which 'links empowerment to international agreements on human political as well as economic, social and cultural rights' (OECD, 2000), while the World Bank's *World Development Report 2000/1* promotes a version

1. Established in 1987, the Strategic Partnership with Africa (SPA) is an informal association of donors and African partners that works to improve the quality and increase the quantity of assistance to Africa (see www.worldbank.org/...).

of material empowerment that goes beyond the 'cheap talk' of community empowerment (Moore, 2001).

Convergence of thinking is reflected in a new consensus on how to reduce poverty, recently described as a 'new "New Poverty Agenda"' (Maxwell, 2003), and captured broadly by the *WDR 2000/1* with its 'three-legged' approach of opportunity (through growth), security (through measures to manage risk more effectively) and empowerment (through participation and increased responsiveness amongst state institutions). This has shifted the international position considerably from that laid out by the World Bank in 1990, a position which focused more narrowly on economic growth as the engine of poverty reduction, supported by investment in human capital and accompanied by safety-net provision. The most recent outputs of the World Bank, including the *WDR 2006* on Equity and Development, emphasise the importance of building agency through investment in assets and creating equality of opportunity through institutional reform (Alsop et al., 2005; World Bank, 2005).

Within this shift in donor discourse a changing approach to social protection is clearly reflected (Devereux and Sabates-Wheeler, 2004). Social protection, conventionally regarded in terms of targeted welfare transfers to the poor in line with the *WDR 1990*, is now more commonly conceptualised as a subset of social policies that assist people, households and communities to protect themselves against risk. Operational frameworks, including the social risk management framework presented in the *WDR 2000/1* (World Bank, 2001a) and the ILO's use of a promotional framework for social security (Guhan, 1994), reflect this move away from residual welfarism. There is now greater operational ambition to implement a developmental approach to social protection that builds on an understanding of the strategies that poor people adopt to invest in their assets and capabilities, diversify their livelihood strategies and insure themselves against risk.

The World Bank's Social Risk Management framework, developed by Jorgensen and Van Domelen (1999) and presented in the *WDR 2000/1*, breaks down strategies into: *risk reduction* strategies introduced before a shock occurs in order to reduce the probability of risk; *risk mitigation* through livelihood diversification or risk-spreading in the form of insurance mechanisms, introduced before a shock occurs in order to mitigate its impact; and *risk coping* strategies to relieve the impact of a shock once it has occurred, usually through dissaving/borrowing or through reliance on public or private transfers. The ILO framework differentiates social protection measures in terms of: *protective measures*, which have the specific objective of guaranteeing relief from deprivation; *preventive measures*, which directly seek to avert deprivation in various ways; and *promotional measures*, which aim to enhance real incomes and capabilities (Guhan, 1994; Devereux and Sabates-Wheeler, 2004).

These theoretically-driven operational frameworks raise significant implications for social protection in the health sector (Fisher et al., 2001). To protect the health of the poor and to ensure access to health without generating greater poverty, a social welfare approach that considers what can be done *for* the poor is not enough. It becomes important to support what the poor do for themselves to maintain health, to generate health-creating environments and to cope with illness. This means building into health and poverty reduction programmes a greater understanding and recognition of the reality of poor people's lives and livelihood strategies (WHO, 1999). More specifically,

it demands ensuring affordable and accessible health care for the most vulnerable, within a comprehensive framework of supporting people's strategies to prevent, mitigate or cope with health risks.

During the latter part of the 1990s, donor declarations on user fees and social policy provided a commentary on the importance of effective health and education coverage for poverty reduction and the trade-offs presented by the widespread introduction of user fees. This included the development of guidelines for adoption by the SPA donors in their dialogue with African partner countries on the role user fees might play in the reform and development of public education and health services (ODA, 1995). For the SPA Working Group, user charges in primary health care were considered at best a pragmatic response to public capacity constraints, and the Group recommended that the poor should, where possible, be exempted from such charges. The suggested guidelines recognised the need to prioritise allocations of scarce public resources, emphasising primary allocations to primary services, and to consider the balance between public and private funding. They acknowledged the widespread criticism attracted by the introduction of user fees, accompanied by evidence on their negative, and often gendered, impact on access to health and education amongst the poor. The Working Group concluded that user charges are inferior to general taxation if considered purely in terms of raising revenue for the budget, but, when collected and retained at the local level, they might play an important role in mobilising resources to improve the coverage and quality of services;

> The main revenue argument for collecting charges for primary services is the pragmatic one that Government may otherwise be unable to get resources to the periphery. If the system of budget allocation were working effectively, the revenue raised might not be worth the effort. (ODA, 1995: 3)

Since 2000, the discourse has expanded beyond considerations of cost and access to primary health care to address the role of primary services in promoting development. Recent debates consider the extent to which the World Bank's presentation of the Social Risk Management framework reflects a truly radical shift in public sector function beyond the traditional safety-net role of consumption smoothing in response to declining or fluctuating incomes. Devereux and Sabates-Wheeler, in criticising the Bank's position, argue for a much broader range of social protection interventions than narrow resource transfers, including 'transformative' measures that tackle more effectively the institutional basis of vulnerability and exclusion.

The significance for poverty reduction of health interventions that are 'promotional' is underlined by research on the impact of health shocks on poverty outcomes. Quantitative panel data such as those presented for Uganda below, complemented by qualitative data from the first generation of national Participatory Poverty Assessments (PPAs), for example, provide cumulatively compelling evidence that health shocks are one of the most significant causes of vulnerability, removing wage-earners from households and/or diverting resources in a way that prevents people from sustaining and investing strategically in their asset base. In the remainder of this article we analyse the evidence elicited from a sequence of research instruments that

throws light on the relationship between user fee exemption policy and health outcomes in Uganda.

3 Health, poverty and user fees: Uganda's experience in the 1990s

In this section we review the evidence accumulated from a range of research methods and data that show a strong association between health shocks and poverty outcomes in Uganda, exacerbated by lack of access amongst the poor to appropriate health care services. We then review Uganda's experience with user fee exemption schemes and with community-based health insurance schemes. User fee exemption subsidies have tended to be captured by wealthier groups, while user fees themselves failed in any case to generate significant revenue for the government. Uganda's experimentation with community-based health insurance schemes has shown them to be ineffective and inefficient, prompting the Ministry of Health not to scale up the experiment.

3.1 Health, risk and chronic poverty in Uganda in the 1990s

Uganda's success in reducing the national incidence of income poverty in the 1990s is well known. However, panel data indicate that this net aggregate reduction was accompanied by substantial mobility into and out of poverty (Okidi and McKay, 2003).[2] A majority of those who were poor in 1992 had escaped by 1999, but a considerable minority stayed poor while many others fell into poverty over this period (Lawson et al., 2003).[3] Analysis of the panel data shows that health status played a major role in determining whether households moved into or out of poverty and that ill-health was a factor keeping households poor.[4]

For the period 1992-9, Lawson (2004) found that households headed by a sick[5] individual in 1992 were statistically more likely to move into poverty; 16% of such households moved into poverty between 1992 and 1999, compared with approximately 10% of all Ugandan households. He also found sickness to have a negative impact on the growth of household income. Household heads who were sick and undertook agricultural subsistence work as their main working activity, were statistically more

2. The nationally representative *Integrated Household Survey* (IHS) of 1992 and the *Uganda National Household Survey* (UNHS) of 1999/2000 form the basis of a two-wave panel (1992-2000) which covers 1398 re-interviewed households (Lawson, 2004).
3. Within the 1992-9 panel the poverty incidence fell from 48.6% of households in 1992 to 29.3% by 1999. 18.9% of these panel households were chronically poor (i.e. poor in 1992 and still poor in 1999), while nearly 40% experienced transitory poverty during this period, with 29.6% of households moving out of poverty and 10.3% slipping in (Lawson et al., 2003).
4. These findings for Uganda are similar to those for other countries. Krishna, reporting on a study of poverty dynamics in Rajasthan, India, notes that ill-health and health-related expenses are one of three principal factors responsible for moving people into poverty. He also notes that Wadley (1994) reports a similar close linkage between ill-health and poverty in rural Uttar Pradesh, and Christiaensen et al. (2002) for a group of countries in sub-Saharan Africa.
5. Sick is defined as 'sick at any one point in the last 30 days' (prior to survey).

likely to be chronically poor (poor in both periods). Households headed by a sick person commonly had substantially greater reductions in asset levels between 1992 and 1999:

> For example, sick households moving into poverty experienced chicken number decreases by up to one third compared to a 50% increase for the non-sick. This suggests a depletion of assets during the process of immiseration. (Lawson, 2004)

Similarly, Deininger and Okidi (2003) found that households that were affected by health problems in 1992 experienced growth of income or consumption 1.2 to 1.8 percentage points lower than for those which were free of health problems, and that households suffering from health problems in 1992 were characterised by higher levels of poverty in 2000. Deininger (2001) found that good health is particularly important in improving the prospects of escaping poverty.

Deininger and Okidi note that the data point to a significant increase in the number of days lost to illness by the average household in the month preceding the surveys, from about 8 days in 1992 to 12 days in 2000. They attribute this to worsening access to health services in the 1990s due to higher levels of cost recovery, and stress that local supply of health services is one of the most important determinants of ill-health (referring to Deininger, 2001).

These findings using quantitative data accord with those of Uganda's two major participatory poverty assessments (PPAs), carried out in 1998/9 and 2001/2. In both of these PPAs, the most frequently cited cause of poverty was ill-health, and this was also seen as an important reason why people move into poverty (MFPED, 2000, 2002). People explained that time lost when sick, and, for women especially, time spent taking care of the sick, reduces productivity, while the cost of care uses up savings and leads to sale of assets. Participants decried user fees, and 'cost sharing is not for the poor' became one of the key messages from the first PPA.

3.2 User fees and user-fee exemptions for the poor

User fees were introduced on an *ad hoc* basis by districts and health units in Uganda from the late 1980s, against a background of a poorly funded and poorly functioning health system and donor support for patient charging.[6] Districts and health units set their own exemption policies, mainly exempting civil servants, local councillors and soldiers from fees (MoH, 1997), although, according to the Ministry of Health (MoH), those unable to pay were to receive free services. The passing of the Local Government Act in 1997, which gave district authorities revenue-raising powers, led to the formal adoption of user-fee policies by most districts. Simultaneously, the MoH issued guidelines on the collection, management and utilisation of user fees and on exemptions and waivers. These stated that treatment for highly communicable diseases and immunisations was to be provided free of charge, while those unable to pay could be granted fee waivers by health unit management committees (MoH, 1997).

6. For example, the World Bank's 1987 *Agenda for Reform* called for increased private sector provision of health care, user charges, and health insurance (World Bank, 1987).

However, an inter-ministerial task force investigating the effects of user fees in 1999 found that poor people were frequently not being exempted from charges (MoH, 1999), confirming the findings of the PPA and other studies (for example, Kivumbi and Kintu, 1999). The conclusions of these studies are similar to those reached in analysis of exemption schemes elsewhere. The *WDR 2000/1* notes that 'few developing countries … have successfully implemented price discrimination in health services through sliding scale fees. In most African countries such exemptions tend to benefit wealthier groups (such as civil servants)' (World Bank, 2001a).

In addition to this failure of exemption schemes in Uganda to protect the poor and the less than satisfactory experience with community-based health insurance discussed below, user fees failed in any case to raise much revenue. Fees were raising about $6 million, equivalent to approximately 10% of the government's health budget in 2000/1 (MoH, 2002). This served to persuade the Minister of Health and the senior MoH management that fees should be abolished, and the Ministry began planning abolition measures in 2000.

3.3 Experimenting with community-based health insurance schemes

From 1995 to 2002, the MoH, with a grant from the UK Department for International Development and some government funds, supported a major experiment with 8 community-based health insurance schemes implemented by private health-care providers (mostly mission hospitals). In an attempt to build on existing risk pools, and avoid problems associated with adverse selection,[7] these schemes were concentrated in the South-West of the country where there is a tradition of mutual self-help groups in the form of burial societies called 'engozi'.

A series of reviews of the schemes concluded that they were not financially viable (Wilson, 2002; Wheeler et al., 2002; Arube-Wani et al., 2002). Seven of the eight schemes did not even cover the members' treatment costs, let alone the considerable administration costs.

Moreover, the schemes had not been effective in providing social protection for vulnerable groups in their catchment areas. To limit membership fees, they did not cover the treatment of chronic conditions and routine maternity services, which resulted in the exclusion of vulnerable groups. Furthermore, a socio-economic breakdown of the members (and therefore beneficiaries) of the schemes by Arube-Wani et al., showed that the poorest group was considerably under-represented:

> The poor generally cannot sustainably afford the schemes; those who can afford [them] are mostly in the middle [wealth] category, with some steady income from produce or other more regular earnings like salaries and wages. (Arube-Wani et al., 2002)

Since the schemes do not cover their costs and are failing to reach the poorer members of the communities they serve, they are using public money to subsidise

7. Adverse selection means that households with greater health risks are attracted to the schemes, which jeopardises their overall financial viability.

access to services by the somewhat better-off.[8] This conclusion on equity is accompanied by a significant one on efficiency. Exemption policies can be justified on efficiency grounds if it can be calculated that the social costs of failing to prevent infectious diseases are higher than the private costs. Where exemptions and insurance fail and where the poor do not attend the centres where disease control effectively takes place, the outcome in terms of social costs is highly inefficient.

Given these concerns about equity and efficiency, the obvious failure of the schemes to attract large and sustained memberships and to reach poorer groups was one factor that persuaded senior management in the MoH that user fees for government services should be abolished. As a result of the evaluation findings, the MoH has also decided not to pursue actively a policy of scaling up community-based health insurance across the country (see MoH, 2002).

The findings on the Ugandan community-based health insurance experiment should come as no surprise. They are common in private health insurance programmes. Although the Ugandan schemes and others like them around the world are referred to as 'community' schemes, in effect they are private insurance schemes, since membership is voluntary and they therefore tend to lack the ability to cross-subsidise poorer, sicker members by using contributions from healthier, wealthier members.

The problems exemplified by the Ugandan schemes are recognised in the World Bank's Social Protection Strategy paper, *From Safety Net to Springboard* (World Bank, 2001b). This notes that community-based health insurance schemes suffer from problems of adverse selection, limited risk pools, the difficulty of voluntary schemes catering for catastrophic illness, and regressive flat premiums. It also notes that 'poor families may not always be able to afford to put aside resources for health-specific insurance funds'. The strategy therefore recommends that in order to address health risk, particularly in Africa where government capacity is low, the public sector should concentrate on providing basic health services. It recommends that if health insurance is to be provided, it should focus on catastrophic illness and be compulsory.

4 Abolishing fees for health services

In this section we examine the evidence on the impact of the government's decision to abolish user fees for government health units in March 2001. Qualitative and quantitative data portray a large and immediate impact of increased attendance by the poorest households, sustained by accompanying improvements in supply-side efficiency and delivery (despite continuing inadequate public funding). The data show early signs of equity and efficiency gains in rural areas: improved health outputs and the potential for reduced private costs through risk prevention and mitigation, and accompanying reduced social costs in the shape of improved immunisation rates. However, continuing

8. Private not-for-profit providers (PNFPs) have received grants from the MoH since 1997, and these have risen rapidly in recent years. The premiums charged by the community-based health insurance schemes are set according to the fees charged to other PNFP users, which are reduced by the government subsidies to the PNFPs. During the period of the DFID grant, the scheme beneficiaries were thus receiving a double subsidy: first through the direct subsidisation of the schemes and premiums by DFID, and secondly through the government subsidy to the PNFPs which had the effect of reducing the PNFP user fees and therefore also the community health insurance premiums.

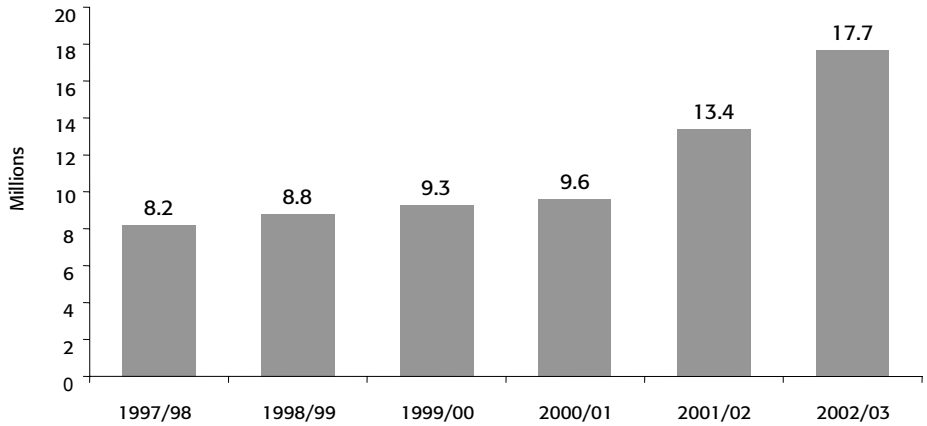
underfunding and a policy approach that fails to address the social construction of risk mean that a more promotional approach to social protection through effective health-care delivery is still some way off.

4.1 The reforms

Addressing a popular concern and major election issue in March 2001, President Museveni scrapped user fees for government health units.[9] Significantly, the political imperative for this decision meant that the abolition of user fees occurred under conditions that were less than favourable,[10] making the results, discussed below, even more impressive than they already were. However, the combined effects of abolishing fees and increasing the supply of health services, discussed below, have been dramatic.

Immediately there was a surge in demand for public health services countrywide. Figure 1 shows an 84% increase in outpatient attendances between 2000/1 and 2002/3 (note that patient fees were abolished towards the end of the 2000/1 financial year), with some districts reporting a doubling, as illustrated by Kisoro District.

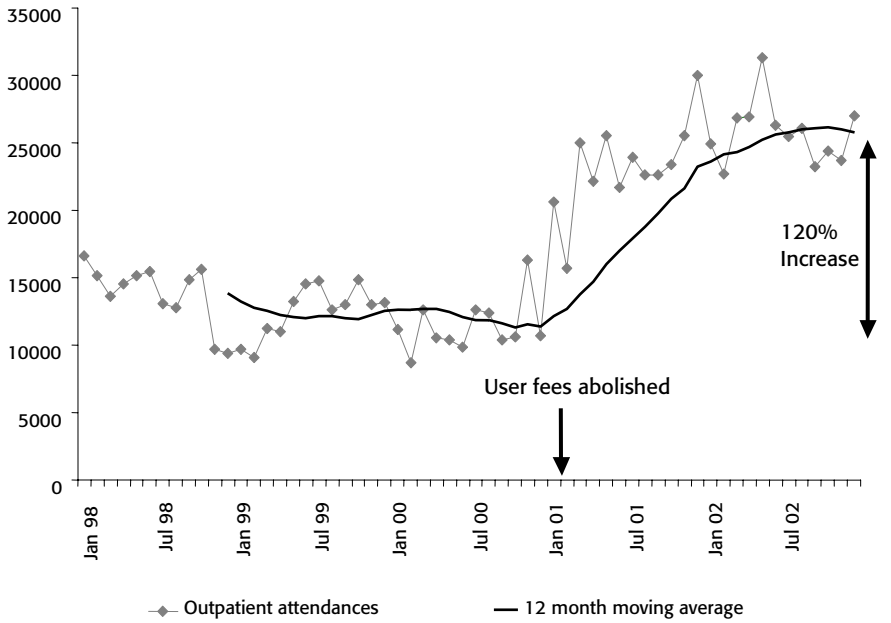
Figure 1: New outpatient attendances in government and private not-for-profit health units



Source: MoH (2003).

9. With the exception of private wings in government hospitals.
10. Specifically, this decision disrupted the Ministry's existing plan for phased abolition, with the phasing in of alternative funding, so that it resulted in a loss of ready cash for health units in the short term. Museveni's failure to take account of the referral hierarchy also caused big problems for the outpatient departments of the hospitals (David Booth, pers. comm.)

Figure 1 cont'd: Total monthly outpatient attendances, Kisoro District 1998-2002



Source: MoH Planning Department.

This rapid increase in the consumption of government health services, in the absence of any other shocks at the time, indicates that fees had been suppressing demand. Utilisation of both government services and NGO units has increased since fees were abolished, and utilisation of private clinics also appears to have gone up.

Ongoing research undertaken by WHO and the MoH has shown that, relative to the 2000 calendar year, small government health centres reported a 77% increase in utilisation in 2002 and referral units a 55% rise. For NGO units the figures were 8% and 5% respectively (WHO and MoH, 2003).

It should be noted here that the reforms in health systems are still relatively recent, and it remains to be seen whether the increased supply will continue to provide services of sufficient quality to sustain current utilisation rates and, critically, lead to improvements in health outcomes. The improved performance figures reported by the Ugandan health sector are restricted to outputs rather than outcomes, and the impact of abolishing fees and the supply-side reforms on health outcomes will not be known until the results of the next demographic and health survey are available in 2006.

This said, these early indications are encouraging. The increased demand for government services is not due to a 'squeezing out' of private services, since there appears to have been a net increase in overall consumption. However, those in the poorest income quartile do appear to be using private services less now, and consequently spending less on health care, a development that is to be welcomed

amongst the poor. Lawson's analysis of the household survey data indicates an increase in the utilisation of private clinics between 1999 and 2002 by the three upper-income quartiles as well as a (smaller) increase in utilisation of public facilities, while the poorest quartile registered a decrease in usage of private clinics and the largest increase by any group in utilisation of public facilities (Lawson, 2003).[11] These changes were particularly marked amongst poor women. As discussed in section 4.4 below, expenditure on health care by poorer groups has fallen significantly, while aggregate household health expenditure has increased slightly, suggesting that those who are better-off may have opted out of the public system in favour of private providers (Deininger and Mpuga, 2004).

Other government outpatient services have also seen substantial increases in output statistics. For example, the proportion of children receiving their third DPT immunisation increased from 48% to 84% between 2000/1 and 2002/3. Although immunisations were supposed to be provided free before fees were abolished, the increase in immunisation rates can in part be attributed to the abolition of fees. This is because most immunisations take place in health units, which people are now visiting in greater numbers due to the abolition of charging.

In-patient statistics have remained fairly static, however, which is a major concern, given the importance of maternity services in reducing high maternal mortality rates. In fact, the proportion of women delivering their babies in health units has decreased from 23% to 20% over the 2000/1 to 2002/3 period. Overall though, given the composition of the burden of disease in Uganda, the large increases in outputs for outpatient services are seen as important indicators of improved sector performance.

Official user fees do not appear to have been replaced with increased unofficial payments when charges were abolished. In the Village Census accompanying the second PPA, only 9% of respondents reported paying bribes in government health units (MFPED/UPPAP, 2002); an analysis of the 2002-3 *Uganda National Household Survey* reported only 4% of households making payments (Deininger and Mpuga, 2004).[12] The trustworthiness of these findings is increased through the use of combined methods to triangulate data and respondents.

The increase in demand for services with the abolition of fees put considerable pressure on the Ugandan health system, but it would appear that concurrent supply-side reforms helped sustain consumption at higher levels following the abolition of fees. In particular, increased budget allocations for pharmaceuticals, particularly for primary health care units in poor rural areas, and improvements in drug supply systems appear to have been important factors in sustaining demand. These supply-side reforms were made possible by a major switch from project funding for the health sector to funding

11. There are limited data on utilisation trends for private drug shops and traditional healers. The Village Census found an increased preference on the part of poor people for government health units after fees were abolished, and a reduced preference for traditional healers. In contrast, the better-off were found to have a reduced preference for government units and an increased preference for NGO units (MFPED/UPPAP, 2002). It should also be noted that the MoH has grave concerns about the quality of service in private drug shops and clinics, which are not adequately regulated at present. Patients in these facilities are often treated by unqualified staff and may receive inappropriate or insufficient prescriptions.
12. However, it should be noted that patients are still sometimes faced with costs for supplies. For example, it is common for women to have to provide their own gloves and cotton wool etc. for deliveries.

through the government budget from 2001/2. However, it needs to be noted: a) that demand for services has been sustained and supply of services increased with only a modest increase in the total resources available to the health sector, indicating considerable efficiency gains in the sector;[13] and b) that funding is still completely inadequate to provide the basic minimum package of services envisaged in the government's Health Sector Strategic Plan. Currently, the government spends $4 per capita on health services, although the Ministry of Health estimates that $22 per capita would need to be spent through the government budget to provide the minimum package (MoH, 2002).

It is difficult to determine how much of the sustained rise in the consumption of services can be attributed to the demand-side changes (abolishing user fees) and how much is due to longer-term supply-side reforms. Arguably, the decision to abolish fees gave the supply-side reforms added impetus, given the political imperative to see this policy succeed. For example, in the immediate aftermath of abolishing fees the government provided $500,000 to the districts for emergency drugs procurements, increased doctors' pay by 66% and speeded up the reform of payroll management systems. Furthermore, in the two years following the abolition of fees the health sector received the biggest proportionate rises in its sector budget from the Ministry of Finance.

4.2 Assisting the most vulnerable

The poorest people are those least able to protect themselves against risks occurring and to deal with shocks that do occur. As noted in section 3.1, the poorest members of society are particularly vulnerable to the risks associated with ill-health. The evidence indicates that it is this group that has benefited most from the abolition of user fees and the other health reforms.

The WHO/MoH research has disaggregated health centre out-patient data by wealth category at selected units (having performed a wealth-ranking exercise with the community in the village surrounding the facility). This analysis shows that, since the abolition of user fees, the poorest quartile has consistently used government health centres more than any other group. For example, in the 2002 calendar year the poorest quartile used these facilities at a rate of 0.99 visits per person, whereas for the wealthiest group the rate was 0.77. There are only limited data available for the period preceding the abolition of fees, but the average utilisation rates for the months of January and February 2001 were 0.52 and 0.42 respectively.

Confirming these findings, Deininger and Mpuga, in their analysis of the 1999/2000 and the 2002/3 household surveys, show that poorer income groups have increased their utilisation of services more than richer groups. For hospital services, the

13. In 2002/3, total resources available to the health sector had increased by only 9% compared with 1998/9, although the share of total resources allocated through the government budget had increased from 32% to 56% in this period (information provided by MoH Planning Department). Regarding the claim that efficiency has improved in the health sector, this will only hold true if the quality of services has been maintained. The intention of the supply-side reforms has been to improve quality of services. Although it is difficult to measure quality objectively, the large increase in utilisation of services would indicate that quality standards have not been seriously compromised.

rate of increase of consumption for the poorest two quartiles was double that of the richest group. They conclude that this is a direct result of the abolition of user fees, as 'the share of those who quoted cost reasons for not attending a hospital when sick decreased by about 20 percentage points in the bottom three quintiles but by much less for the top quintile' (Deininger and Mpuga, 2004: 12).

It would therefore appear that abolishing user fees has made health care more accessible to poor people, and consequently they have increased their consumption of these services.

4.3 Risk prevention

As discussed in section 2, risk prevention strategies are measures taken to reduce or eliminate the probability of a shock occurring. In the context of risks associated with ill-health, these strategies often relate to the provision and consumption of preventive health care services.

Immunisation services, in preventing communicable diseases, particularly in children, are a good example of an effective risk prevention strategy in the health sector. As noted above, immunisation rates for DPT3 have increased by 75% since 2000/1, similar to the increase in outpatient attendances (84%). There are no data disaggregated by income group for immunisation services, but it would appear reasonable to assume that consumption patterns for the different socio-economic groups will be similar to those for outpatient services.

People also now have free access to the expanded antenatal package and the Integrated Management of Childhood Illness approach, introduced in recent years and which include preventative as well as curative elements.[14] This is particularly important for children, as frequent episodes of ill-health dramatically increase the chances of mortality from any one illness episode.

Another area of risk prevention is health education. It is arguable that in attending health facilities in greater numbers, poorer people are being exposed to more health education messages.

In improving access to health services for poor people, abolishing user fees may be resulting in people seeking health care at an earlier stage in their illness, hence reducing their risk of experiencing a serious episode of ill-health. Evidence here is limited, but in looking at changes in the rationing of health care (meaning the proportion of people not seeking formal care when sick), Deininger and Mpuga conclude that 'the abolition of user fees reduced the incidence of rationing, particularly by the poor' (2004: 19). Since 2002, in an attempt to reduce the risks associated with untreated malaria, the MoH has been rolling out a programme of free home-based malaria treatment for children under five exhibiting the symptoms of malaria. Early results suggest that targeting vulnerable groups with free services has resulted in reduced malaria admissions and deaths in pilot districts.

14. For example, the antenatal package includes provision of iron and folic acid supplementation, deworming, presumptive treatment of malaria, tetanus toxoid vaccination and syphilis testing. All these interventions reduce the chances of maternal and neonatal mortality. Prevention of mother-to-child HIV transmission is also being introduced.

4.4 Risk mitigation

Risk mitigation involves putting in place prior mechanisms to cushion the impact of a shock when it happens. Abolishing fees for health services has mitigated to some extent the consequences of the risk of being ill, by reducing the cost of health care. Poor people are now suffering lower financial outlays when their family members require treatment. This is due to the direct effect of their receiving free services in government units and their reduced utilisation of private services where fees are still charged. Deininger and Mpuga provide evidence of the reduced financial burdens of health care. Their analysis of household expenditures between 1999/2000 and 2002/3 shows that aggregate household expenditure increased marginally. However, for the lowest two income quintiles there was a statistically significant reduction of monthly expenditure from $1.71 to $1.49 (13%) for the poorest quintile and $3.13 to $2.55 (19%) for the second lowest quintile.[15] Therefore, as well as consuming significantly more health care than in 1999/2000, poor households have benefited financially by having to pay significantly less for their health care.[16]

4.5 Limitations

While abolishing fees and the concomitant supply-side reforms in the Ugandan health sector have increased utilisation by the poorest groups and mitigated to some extent the consequences of the risks of being ill, the reforms clearly have their limitations from the point of view of social protection and social risk management. Abolishing fees obviously does not eliminate the actual risk of becoming ill, although it may help to limit future illness episodes, as discussed above. Inadequate financing of the health sector, combined with the socially constructed constraints on changing health-seeking behaviour, limit the extent to which the reforms prevent or mitigate health risks.

Inadequate financing means that physical access to health services is still constrained. Only 57% of Ugandans live within 5km of a health centre (and this definition includes health units without delivery services) (MoH, 2003). Provision of special services for some particularly vulnerable groups, for example the disabled and the elderly, is very limited. Poor quality, charges for supplies, and lack of access, especially for delivery services, deter utilisation of some services such as maternal services, so that women are still exposed to very high levels of risk in childbirth.

The reforms do not address directly the social factors that inhibit access to services and thereby increase risk. For example, women's lack of control over their time, movement and resources, limits their ability to use services themselves or to ensure that

15. At constant 2002 prices.

16. It may also be the case that the increased demand for and consumption of health services have reduced the number of working days lost due to sickness. The household survey data show a reduction in days lost due to ill-health from 8.3 in 1999/2000 to 7.0 in 2002/3 with a similar reduction across all income quintiles (Deininger and Mpuga, 2004). However, the reduction could be due to seasonal or sampling factors in the surveys, particularly as it appears odd that the reduction in days lost due to sickness is the same across all income quintiles.

their children receive health care[17] (although, as noted in section 4.1 above, utilisation of public health services has increased most on the part of poor women since fees were abolished).

5 Conclusion

In Uganda, in the context of a strong association between health shocks and poverty outcomes, health user-fee exemption policies and community-based health insurance schemes have proved both inefficient and regressive, having failed to help the poor to prevent or manage the risk of ill-health. The government's more recent decision to abolish primary health user fees and largely to reject household financing mechanisms for public services has been significant in its early impacts; however, it also points to the need for the government health budget to be increased considerably if services are going to meet rising demands.

Abolishing user fees shows strong signs of being an important contribution towards 'promotional' social protection, supporting the shift away from residual social welfare approaches to health delivery and indicating the need for this policy to receive much more attention in the social protection literature and debate. This attention has certainly been lacking to date. As noted above, the World Bank's flagship social protection strategy paper *From Safety Net to Spring Board* recognises the drawbacks of both community-based health insurance and fee exemptions. It notes that, in sub-Saharan Africa, the best way to manage risk is likely to be through strengthening basic health services. However, the strategy advocates waiving fees for health care for poor people only during an economic crisis. This fails to recognise that ill-health is often a crisis for poor people and one that occurs repeatedly, driving them into poverty. It also fails to acknowledge the extent to which fees are likely to be suppressing demand for health services by the poor and thus increasing systemic inefficiency through higher social costs.

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17. Kasente et al. (2002) note also that kinship-based social protection tends to exploit women, with women notably taking on the role of caring for HIV/AIDS orphans.

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