The overriding aim in setting an essential or minimum health care package (MCP) is for the state to guarantee free access to its population of a set of health services it can afford. In essence, the minimum health package represents a health insurance that the state provides its population (WHO 2002). The purpose of developing and using the minimum package approach was to assist in resource allocation in the health sector especially in the face of a huge and growing health burden that has to be addressed with small public budgets, that characterize developing countries like Uganda. Due to demographic changes, lifestyles like obesity and smoking, and new technology and information, the health care needs are increasing at a pace that is not matched by the growth of the national budgets.

The MCPs are an explicit rationing of health services by the state. Services that fall outside the boundaries are not guaranteed to the population and therefore additional financing (e.g. private insurance or out-of-pocket payments) are needed (World Bank 1995). The flip side of this is that, by defining a minimum package, commits itself to make this package available and effective to all those in position to benefit from it. The aim of establishing MCP is also to achieve equality of access by identifying those at risk of being left behind and group bargaining approaches. In Uganda, the application of minimum services that is written into the sector plan has turned to be more than the resources available in the medium term. At the operational level, the delivery of the minimum package has been rendered ineffective and inefficient, by trying to attain universal access with $ 8 per capita instead of $28. System capacity constraints for effective and equitable delivery of the MCHP are traced at the infrastructure-based planning and in explicit and implicit re-prioritization and rationing within the minimum package.

Introduction

The socio-political dimensions of priority setting

Resource allocation is essentially a socio-political process although technical inputs such as cost-effectiveness are important for evidence-based policy making (Wal 1996). Political expediency tends to drive the package beyond the available resources due to the distasteful concept of rationing in the political debates especially due to strong lobby groups such as women and human rights activists (Temps 1995, Maynard 1998). Universal access to all possible care is commonly seen as a right in the health system that the health system is planned, financed, and its overall capacity greatly reduces this scope by adjusting both service quality and availability. As a product of the cost-effectiveness approach to priority setting in health care, a list interventions are identified that provide the best value for money in achieving the most reduction in the disease burden. The overall principal in constituting the minimum package is to balance the package of effectiveness in the local circumstances and have turned out to be beyond the reach of available resources as reflected in figure 1.

The process of providing the minimum health care package (MCP) seem to have been understood as equalizing health budgets to project resources for Health Sector Strategic Plan (HSSP) without duly considering the interventions as envisaged in the HSSP. This seems to be the best explanation for the near perfect match between cost projections in HSSP and the resources that have been allocated overtime. But as shown in figure 1, efforts in 2001/02 to cost out the needs of HSSP in the health financing strategy (HFS) indicate a technical flaw in identifying the minimum package, i.e. that the minimum package is set before its costs (and presumably its effectiveness) are fully understood. Should the government commit itself to provide a minimum it can not afford?

Rationing within the package

Given the inadequacy of the resources to shoulder the MCP as designed in the HSSP, there is a re-prioritization with an explicit and implicit rationing process within the package of services and across population coverage. It is this prioritization which is at the core of the problem, that have been produced in the absence of effective mechanisms to make the package available.

Abstract

Essential/minimum health care packages (MCPs) have appeared on the primary health care scene as a means of setting priorities for national health budgets. A technical approach of cost-effectiveness was sought to guide the political process of setting priorities for essential health care services within the Ugandan health sector. However, the implementation of the minimum package in Uganda, the application of minimum services that is written into the sector plan has turned to be more than the resources available in the medium term. At the operational level, the delivery of the minimum package has been rendered ineffective and inefficient, by trying to attain universal access with $ 8 per capita instead of $28. System capacity constraints for effective and equitable delivery of the MCHP are traced at the infrastructure-based planning and in explicit and implicit re-prioritization and rationing within the minimum package.

System financing and the minimum health care packages

The minimum health care package (MCHP) is only available from functional Health Center III and at hospital levels. Hospital services are by plan mostly in major urban centers. With the majority of the people living in rural areas with significant costs for time and travel to attend hospitals in towns, the infrastructure plan ration hospital care using distance, travel and time costs. The National Household Survey 2002/03 indicate that the mean distance to a hospital for the urban poor and other population not covered is 4 km for rural households and between one and three kilometers for urban generally ignored although such costs tend to be much higher than usual charges paid to providers (Lavin, 2003). Service guidelines that recommend multiple clients visits to the facility to receive interventions are bound to have compliance problems or are likely to attract the wealthier groups (Boru 2003; Okello 1990; Muller 1998).

On average, 49 percent of Ugandans are within 5 km distance from a health facility. Given that health facilities have different service profiles and capacity, the coverage and quality for the complete range of MHP is much lower. The National Household Survey 2002/03 indicates that only about 12% of the total population have easy access to a functional Health Center III and at hospital levels. Many districts are far from the functional Health Center III with consultation fees ranging from $5 to $10 per visit.

The survey trends indicates that curative service utilization at the Health Centers has increased by four fold between the 1999 and 2002 while hospital OPD utilization reduced by a half. This trend represent an optimistic trend of taking the essential health care services by the population.
This utilization pattern implies a mixed system of service provision and a failure of universal access to provide free services as implied in MHCP. The predominance of out-of-pocket sources of medical care implies high health care costs to households with their attendant effects of impoverishment and inequity (Wagstaff 2002).

Inequitable pattern of access in the utilization pattern across different social-economic groups is illustrated by access to specific interventions in the minimal package assessed in the Uganda Demographic and Health Survey 2001/02 (Figure 3). The households in the wealthiest twenty percent of the population (quintile) consume more of these interventions in the minimum package than their poor counterparts. This finding illustrates the equity implications of the rationing process that takes place due to the combined factors of Infrastructure plan/geography, information/education, and socioeconomic status.

Rationing quality of services

Although rationing on the basis of quality is ethically unacceptable, it is implied in the MHCP approach adopted in Uganda. The operational policies have explicitly sought for low-cost substitutes to health care with clear quality tradeoff. For example, huge investments were directed to bring down maternal mortality while little efforts were paid to scaling up midwifery training, motivating rural deployment nor provider performance incentives (Kyaddondo 2003). At the inception of the TBA approach, cost-effectiveness was implied (WHO 1982, Hoff 1997).

In the last couple of years, the Ministry of Health has sunk over two billion shillings "professionalizing" nursing aids as another explicit strategy for substituting professional cadres in hard to reach areas. These operational policy decisions to delegate professional tasks to less competent cadres are examples of how quality of care is explicitly rationed by the state. Other forms of rationing are more implicit. The budget cuts that are imposed on the planning units by the treasury is an implicit form of rationing. The effect this has is usually felt in terms of shortages of drugs and supplies at the facility levels but also outright ineffective therapeutics options dispensed. Health providers through their autonomy in clinical judgment assign patients of different social-economic status to different treatment options. For example, patients with ability to pay receive prompt care procedures while the poor ones wait longer or never receive some of the standard services.

In the short term, efforts to expand and commit resources to outreach services can reduce the inherent barriers to accessing a large number of interventions in the minimum package. The innovations in the delivery strategies not implies that benefit analysis should be applied to population of beneficiaries i.e. the groups that stand to benefit most in improving the aggregate population health (Tengs 1996).

In the Oregon experience, the goal was to focus resources to meeting the needs of the poor and vulnerable groups. An explicit and vigorously pursued targeting is needed. As the rationing experiment in the Oregon state in USA showed, it is cost-effective to narrow the benefit package and pull into the system the poor and vulnerable groups than to fling the gates open for universal access, especially when the system resources can not cope (Maynard 1998). The relative success of the Oregon experience implies that benefit analysis should apply to population of beneficiaries i.e. the groups that stand to benefit most in improving the aggregate population health (Tengs 1996).

As the findings on the infrastructure plan indicate, targeting the most needy should encompass a policy decision to reduce access costs to services for the rural poor. PHC "without walls" approach is needed to take the action at the level of the beneficiaries. Such a policy would entail a pro-community planning and financing as opposed to the facility-based approach. For example, Naamcheng Health Project in Ghana has succeeded in taking services of nurses and midwives to the communities with impressive health results. After about 3 years, the community-based approach to service delivery reduced childhood mortality by 38 percent among remote district population (Phillips 2003). A community-based approach has the potential to identify workable strategies in different localities to effectively link with facility-based services.

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References

- Burr D. 2003; "Analyzing the primary of distance in the utilization of health services in the Acholi-Anso south district, Ghana". International journal of health planning and management 18: 293-311
- MOH/2002; "Draft Health Financing Strategy". Ministry of Health Kampala