BMAU BRIEFING PAPER (30/22) DECEMBER 2022

Budget Allocations to Regional Referral Hospitals in Uganda. What informs these allocations and justifies the variances?

Overview

The Government of Uganda (GoU) has made tremendous effort in increasing the budgets of Regional Referral Hospitals (RRHs). These increased from Ug shs 90bn in 2017/18 to Ug shs 223.7bn in FY2021/22. The funds allocated to the RRHs were mainly (85%) earmarked towards running hospitals as wage and nonwage allocations.

These funds were equitably distributed among hospitals across regions, with 35% allocated to the Central Region (has more health facilities and catchment area compared to others) followed by North at 23%, West 22% and 20% for hospitals in the West. However, despite the budgetary increments and equitable distribution of resources across regions, the service delivery is different across hospitals even within the same region.

An increasing trend in variations in allocations amongst hospitals was noted with some getting more resources than others yet they are all expected to provide the same level of service to the defined catchment area. For several years, the allocation formula to RRHs has remained unclear even to the implementers including hospital directors and their management teams. Often times, resources are not allocated depending on hospital service outputs and defined outcomes.

The Budget Monitoring and Accountability Unit (BMAU) undertook a trend analysis of the last five years (FY 2017/18-2021/22) to establish the magnitude of the problem amongst the traditional RRHs. Analysis was restricted to hospitals expected to provide the same level of care. National referral, specialised and new hospitals were excluded from this analysis.

The purpose of this policy brief is to establish the trends, causes of allocative variations across hospitals, and provide recommendations to improve equitable and sustainable allocative efficiency among hospitals in Uganda.

Key Issues

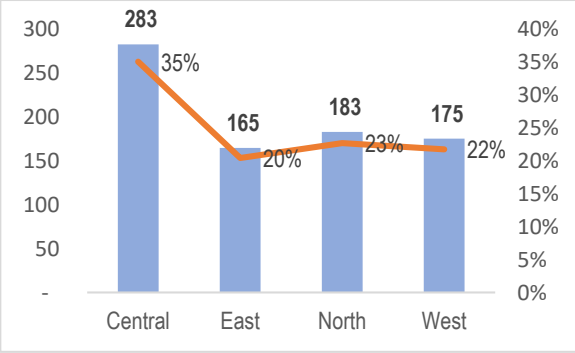
- Lack of a scientific formula to guide allocations to hospitals.
- Variations in wage and non-wage allocations were on the rise since 2017/18. Wage variances were caused by failure to attract and retain health workers in some RRHs.
- Selective donor support that is not guided by the need within the RRHs.
- Service provision outputs and outcomes not commensurate to financing of hospitals.

Background

According to the Ministry of Health (MoH), RRHs were established to support a high volume of transferred patients in the region with complex medical, surgical and trauma cases. They provide all services provided by a district level general hospital. In addition to specialised services in Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Eye Nose and Throat (ENT), Ophthalmology, Orthopaedics, Anaesthesia, Pathology, Psychiatry, Dentistry, and Community Medicine among others to a catchment population of 2 million people.

A total of Ug shs 806bn has been allocated to RRHs for the last five years (FY 2017/18 to 2021/22). These funds have been equitably distributed to RRHs across the four regions of Uganda as highlighted in Figure 1.

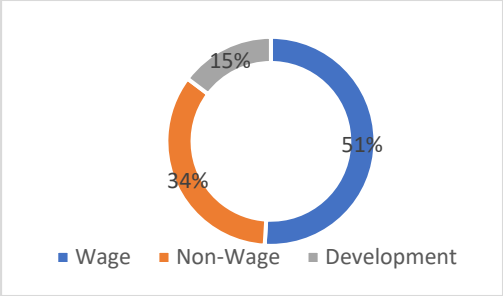
Figure 1: Budget Allocations to RRHs across Regions FY 2017/18-FY2021/22



Source: PBS Reports 2021/22

Approximately 85% of the allocations were geared towards hospital operations with wage at 51% and non-wage at 34%. The rest was allocated towards development initiatives as illustrated in Figure 2.

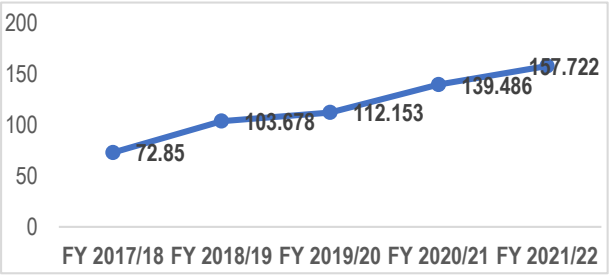
Figure 2: Budget allocations to RRHs by grant FY 2017/18-2021/22



Source: PBS Reports FY2021/22

Of the allocated funds, a total of Ug shs 585bn (73%) was released over the last five years with FY 2021/22 getting the most funds (Ug shs 157bn) and FY 2017/18, the least at Ug shs 72.8bn. This implies an increasing trend in both allocations and released funds (Figure 3).

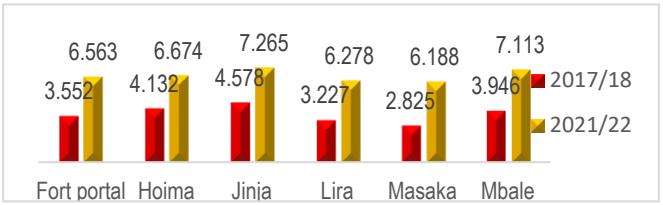
Figure 3: Trends in the cost of running RRHs in Uganda 2017/18-2021/22



Source: PBS Reports FY2017/18 and FY2021/22

Although the cost of running hospitals doubled, variations in allocations amongst hospitals were noted yet they were all expected to provide the same level of services across the country as stipulated by the MoH Service Delivery Standards. An increase in the trend of variations across hospitals was noted. Figure 4 illustrates wage variations across hospitals noted in FY 2017/18 and FY 2020/21.

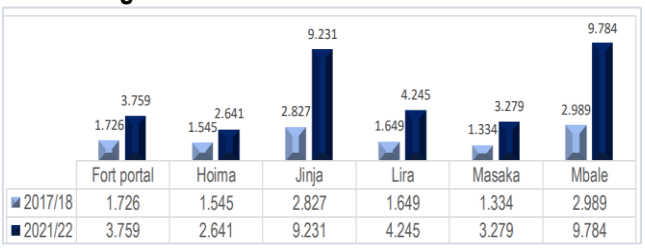
Figure 4: Variations in wage allocations of selected RRHs in Uganda 2017/18 and 2021/22[1]



Source: PBS Reports FY2017/18 and FY2021/22

The situation was the same regarding non-wage allocations. Figure 5 highlights significant variations with Mbale and Jinja receiving more non-wage compared to the other hospitals during the period under review.

Figure 5: Variations in non-wage allocations of selected RRHs in Uganda 2017/18 and 2021



	Fort portal	Hoima	Jinja	Lira	Masaka	Mbale
2017/18	1.726	1.545	2.827	1.649	1.334	2.989
2021/22	3.759	2.641	9.231	4.245	3.279	9.784

Source: PBS Reports FY2017/18 and FY2021/22

In FY2017/18, Jinja RRH and Mbale RRH received Ug shs 7.4bn and Ug shs 6.9bn respectively as both wage and non-wage allocations. This translated into 20% compared to the other RRHs that had received an average of 7%. However, both hospitals experienced lags in service delivery compared to others like Fort Portal which doubled the number of outpatients (General and Specialized) seen and diagnostic investigations during the period under review. It also admitted 4,469 more inpatients compared to Jinja, yet it got Ug shs 2.217bn less compared to Jinja RRH. Table 1: highlights variations in service outputs of selected hospitals in FY 2017/18.

[1] Fort Portal, Hoima, Jinja, Lira, Masaka and Mbale

Table 1: Variations in service outputs of selected[2] hospitals FY 2017/18

Hospital	Inpatients	Outpatients- General & Specialized	Laboratory Investigations
Jinja	25,349	219,754	139,860
Mbale	50,720	103,231	159,487
Masaka	32,833	216,694	322,542
Fort Portal	29,818	445,544	200,435

Source: Hospital Q4 Performance Reports FY2017/18

The trend continued throughout the FYs until FY2021/22 where the allocation sharply increased to Ug shs 16bn for the two hospitals (Mbale and Jinja) yet Hoima that is also expected to provide the same level of health service received Ug shs 9.3bn. A variance of over Ug shs 7bn was recorded yet Hoima provided 435,752 and 377,063 more diagnostic investigations than Jinja and Mbale respectively. The hospital also provided more general and specialized outpatient services. The same hospital admitted 4,226 patients more than Jinja and admitted 52% of the Mbale admissions. There is need for policy makers to justify whether 29,559 more admissions justify the variance of Ug shs 7bn. It is therefore important to establish the unit costs of service provision at standard levels of care in Uganda.

In FY2021/22, among the hospitals analyzed, the variations were more pronounced in Lira and Hoima. Table 2 highlights variations in allocations and services provided by selected hospitals in FY2021/22 (Table 2).

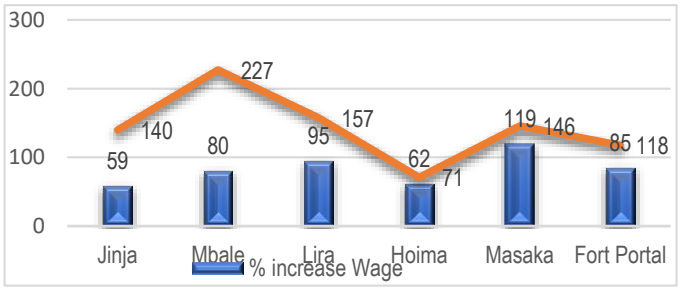
Table 2: Variations in allocations and service provision in selected hospitals FY 2021/22[3]

Hospital	Inpatients	General & Specialized Out Patients	Laboratory investigations	Wage	Non-Wage	Total
Jinja	27,439	188,215	118,781	7.265	9.231	16.496
Mbale	61,214	92,242	177,470	7.113	9.784	16.897
Lira	24,537	194,537	176,640	6.278	4.245	10.523
Hoima	31,665	158,945	554,533	6.674	2.641	9.315

Source: Hospital Q4 Performance Reports 2021/22

Over the years (2017/18 to 2021/22, Mbale received the biggest non-wage increment of 227%, followed by Lira 157%, Masaka at 146%, Jinja at 140%. On the other hand, Hoima already observed to have attended to the biggest number of patients and diagnostic investigations received an increment of 71% wage and 62% +of non-wage (Figure 6).

Figure 6: Wage and non-wage increment for selected hospitals FY 2017/18-FY 2021/22



Source: PBS Reports FY2017/18-FY2021/22

Functionality of lower health facilities contributes to numbers seen at RRHs. An analysis of the Health Management Information System (HMIS) data for FY 2021/22 indicated that Bugisu lower level facilities attended to 14% of the total outpatients, compared to those attended to in Busoga, Bukedi, Bunyoro and Lango.

Causes of allocation variation among Hospitals

Lack of a scientific allocation formula for RRHs: Although an allocation formula for allotting resources to local governments is available, RRHs lack one that informs allocations of these resources. The Ministry of Finance, Planning and Economic Development (MFPED) allocates funds incrementally on the basis of the existing budget, inflation and prevailing needs of the time. This leaves out important parameters including the number of patients, diagnostics, functionality of lower facilities, disease burden among others.

"We don't participate in the allocation of funds, we often receive Indicative Planning Figures (IPF) from MFPED and fit within the predetermined figures," anonymous Hospital Director.

Selective funding and donations from Development Partners: The United States Agency for International Development (USAID) through the Government to Government (G2G) supports some

[2] Selection was based on allocation and service output variances. Hospitals that exhibited bigger variances were selected.

3Variations were more pronounced in Lira and Hoima among facilities analyzed.

hospitals to finance HIV-related activities in various hospitals, of which Mbale is among the beneficiary hospitals. Despite the big allocation compared to the rest, the HIV prevalence recorded in the region was 4.3% compared to other areas like Kalangala at 18.8% which falls under Masaka Hospital. At the same time selected laboratories like Mbale and Fort Portal were supported by the East African Laboratory Project (EALP) funded by the World Bank to undertake diagnostics while other hospitals were not supported. This further increased allocations to the selected hospitals. There is a need to harmonise HIV and laboratory donor financing across hospitals.

Failure to attract health workers in some hospitals led to variations in wage for example, in the current FY2022/23, Soroti Hospital was allocated Ug shs 7.7bn, compared to Ug shs 9.3bn and Ug shs 12.5bn allocated for Mbale and Jinja respectively. All these hospitals are located within the same region (East). This implies that some hospitals have more health workers including interns, consultants and ultimately more pensioners entitled to pension and to gratuity. All this attracts more wage and nonwage funding. The situation is worsened by the practice of health workers applying for jobs in upcountry hospital stations and later request for transfers in other hospitals mainly in the central part of Uganda.

Uncoordinated infrastructure developments: Some hospitals were bigger than others, thus the varying requirements in terms of utilities and equipment. Jinja had two medical campuses with one at the main hospital grounds in Jinja, and another at Nalufenya under the same vote. Maintenance of campuses requires more funding. Same applies to other hospitals that had more equipment than others.

Historical set up: Creation of referral hospitals did not start at the same time, due to the fact that funds were allocated on an incremental basis, older hospitals received more funds than new ones. For example, Naguru Hospital completed in 2012 continued to receive less funds compared to traditional hospitals like Mbale hence reinforcing the inequality.

Variances in Non-Tax Revenue (NTR) collections: Hospitals with bigger private clinics tend to have more consultants and therefore collect and receive more non-wage collections. Implications of such variances leads to overloading health workers in hospitals that attend to more patients leading to burn out and demotivation. These are ingredients to compromised health service delivery.

Conclusion

It is evident that wage and non-wage allocations vary across hospitals. Some hospitals got a 227% increment of non-wage over the last five years, while Hoima got a 62% yet they are expected to provide the same level of services in their catchment area. Hospitals that were allocated fewer resources achieved more service outputs than the rest.

Justification of the allocations remains unclear to both MFPED and hospital managers across the country. However, findings highlight some reasons including lack of a scientific allocation formula, selective donor funding, variances in infrastructure and equipment among others. There is need for a scientific and well disseminated formula to reduce the variances established across hospitals in Uganda. Standardisation of services, wage, non-wage, human resource, infrastructure and equipment should not only remain on paper but explicitly put into practice.

Recommendations

- The MoH should establish unit costs of delivering services in various hospitals in order to justify allocations.
- The MoH Infrastructure Division should aim at moving from standardizing of infrastructure and equipment on paper or guidelines to actual work on ground. This can be achieved through development of a costed plan informed by a needs assessment in all hospitals to establish the gap and amount of resources required to achieve standardized health services at RRH in a phased manner.
- The MFPED through the budget department should ensure that all off-budget cash and in-kind is captured onto the IFMS and PBS to inform allocations of the subsequent FY.
- The practice of health workers applying for jobs in upcountry hospital stations and later requesting for transfer should be abolished to enhance retention of health workers. Otherwise, a top up allowance for health workers in upcountry stations should be introduced.

References

- MoH Service Delivery Standards.
- Uganda AIDS Commission HIV Prevalence Rate across Districts Map.
- Hospital Quarter Four Progress Reports (FY 2017/18 to 2021/22.
- Approved Budget Estimates FY 2022/23