

MAKING THE SERVICES WORK FOR POOR PEOPLE

The role of altruistically motivated organisations for making services work for the poor
The experience of the Private not for Profit Health Sector in Uganda

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1. Introduction

The struggle against poverty has led Uganda to embark on a wide range of reforms across all sectors of society and of its administration. The reforms in the health sector, started over a decade ago and framed in the larger context of the administrative decentralisation, have deeply changed the context within which health care delivery takes place.

The reforms enacted have been accompanied and supported by development partners, who have provided substantial amounts of the resources required. While these resources were channelled in the past towards focused interventions aimed at addressing specific determinants of health, over time it became evident that only a sector wide approach would obtain those structural changes necessary to sustain the struggle over time. It is undoubted that health spending¹ in Uganda has increased in the past years. It is not altogether clear and uncontroversial that services to the people have improved, and it is not clear if these services reach the poor.

The health sector in Uganda is constituted by different actors² and Government health sector, though sizeable³, needs the support and the co-operation of other sub-sectors if long lasting results disease burden's alleviation have to be achieved. This need is recognised both in the National Health Policy and in the Sector Strategic Plan.

The emergence and sustained development of the (formal) private health sector is a relatively new phenomenon⁴, which exploded in the middle of the nineties. Due to its tumultuous development and its volatility, information on this sub-sector is scanty. Its regulation proves altogether difficult for the Regulative agencies⁵. It is in any case an important actor that needs to be known better.

The Church⁶ related health sector (and the PNFP health sector at large) is a major actor in this context: it has a long history in Uganda⁷ and has always had as prime concern the provision of services to the poor. Many mission statements⁸ and institution's constitutions specifically mention this aim. Along the last century this sector has found ways and means to continue operating and expanding, especially in rural environment, while providing

¹ Both public and private.

² Traditionally the health sector is subdivided into public and private. This grid of classification is inadequate. The private sector can be subdivided into non-profit and for-profit (or private practices). Each of these can still be sub-divided according to different criteria (e.g. "facility based and non-facility based", "formal and informal", "western and traditional", etc...).

³ In the absence of more detailed information, it is at the moment assumed with a certain degree of confidence that the three sub-sectors contribute equally to the delivery of services to the people.

⁴ The definition of private practice is somewhat uncertain. More often than not private practitioners (both medical doctors or nurses/allied professionals) are both public functionaries and private entrepreneurs.

⁵ The Medical, Nurses/midwives, Allied Professional and Pharmacy council.

⁶ Church or denominational health facilities affiliated to the Catholic, Protestant and Muslim denominations constitute about 80% of the PNFP health facilities.

⁷ The first health facilities were established towards the end of the 19th Century.

⁸ The Mission Statement of the Catholic Health Services states: "*The mission of the Catholic health services in Uganda is derived from the mission of the Church which has a mandate, based on the imitation of Christ and His deeds, to promote life to the full and to heal. These services are committed to a holistic approach in healing by treating and preventing diseases, with a preferential option for the less privileged*".

services (thanks to the solidarity of sister Churches and denominations) at subsidised price for the people. It is also better organised through co-ordinating Bodies⁹.

It is noteworthy that during the era of socio-political and economic upheaval between the seventies and eighties, this sector has continued operating, securing the provision of essential health services to the people. This historical datum and evidence, that proves the resilience of the sector, is too often ignored. The “coping mechanisms”¹⁰ developed during the emergency by this sub-sector have started showing their limitations in the middle of the nineties: at that time the Bureaux declared that the sub-sector was finding it progressively difficult to cope with the increasing cost of service production¹¹ and with the need to preserve access for the poor.

The decision of Government to intervene in support of the PNFP sub-sector through an increasing but (still) limited budgetary support has avoided an immediate crisis. It also opened the door to a wider participation of the PNFP sector to policy formulation and development. Yet, the overall environment still remains determined by conceptual frames of reference that do not envisage a clear/major role for the PNFP sub-sector, despite its size and importance in the Country. The entire “voluntary/altruistic” health sector (and this statement would perhaps apply beyond the health sector) lives and operates in a sort of “limbo” that hampers the full exploitations of its potential and actual contribution to the fight against poverty.

On the positive side it must be said that the closer collaboration developed and the opening to participation have posed questions and raised issues that have not yet been adequately addressed by policy makers and implementers. In fact few of these questions/issues have found an answer yet. Some arise from the newly established collaboration, while others have a wider outlook. Although they are presented as separate questions/issues, many are deeply interlinked. They will be proposed in these notes as subject for discussion.

It is a deep conviction of the presenter of these issues that too little attention has been paid so far to the knowledge, understanding, enhancement and support of this sector that does not fall within the current dichotomous frame that opposes the welfare state to market and claims to be something altogether different¹² from either. Making its acquaintance through the contradictions and dilemmas it meets every day is a possible angle of approach.

2. Issues note

2.1. Can an integrated health system be pluralistic?

The structures that provide health services to the people are defined in their “globality” as health system. Per se, the notion of system evokes the idea that all the elements in it operate and participate to the same goal and exercise functions that are well defined, complementary and integrated, without functional voids or overlaps. In fact, this hardly ever happens in reality. When the word system is used, at best it refers to a set of service delivery’s facilities/levels (elements of the system), each of which should be technically

⁹ The Catholic, Protestant, Muslim Medical Bureaux and the Uganda Community Based Health Care Association are the main co-ordinating agencies of the PNFP health sector operating through health facilities.

¹⁰ The coping mechanism developed by the sector were thus defined by their respective Bureaux: underpayment of personnel, maximisation of personnel working time, disregard for the depreciation cost of the capital assets.

¹¹ The main factor contributing to the increase of cost of service production are the increased wage levels applied by Government.

¹² By altogether different we means that it is not something in the middle between state and market, but an entity/subject with its own originality.

adequate (in terms of infrastructure, equipment and skill mix)¹³ to provide the expected scope of services for the level. It is clear that the package of services that the population may expect to receive cannot be provided in its entirety at the same point of delivery¹⁴. Hence the need for a tiered structure responding to criteria of technical efficiency. A good proportion of the planning efforts in Ministries of Health in poor Countries in Africa consists in finding local adaptation to the model (the district health system) described by WHO¹ and in finding ways and means to make it operational. In doing so they end up by planning for the public health sector alone. When other sub-sectors fall within the picture, this occurs almost by accident even when and if, like in Uganda, these “others” represent a sizeable proportion of the entire health sector. This approach does not take into account that in a decentralised environment even the public sector belongs to public legal entities that are increasingly diversified and respond to different dynamics and priorities¹⁵.

The basic question that should be answered here is whether an integrated health system (i.e. the type of health system that seems the most appropriate for responding to the needs of people) can be made up by more than one actor (be pluralistic). In other words:

- is the reference to an ideal model (the integrated health system) compatible or incompatible with a pluralistic health system?
- is it possible to envisage a functional integration of different elements/actors without an outright “absorption”¹⁶ into the public health system?
- which are the tools that make it possible to obtain a functional integration and avoid absorption?

The experience of collaboration between the PNFP health sector and Government in Uganda could be described with an imaginable scenario: we are in the middle of the ford while the water level is increasing.

The following issues presented should clarify the recourse to this image.

2.2. Should access to health services be regulated, or should choice prevail?

In terms of scope of services in the minimum package, some definition has been provided for the components of the package that have to be delivered by each level of care in the system, but each higher level adds new elements of the package to those of the lower level, and does not exclude any. In addition, little effort is made to define how these different levels of service integrate and complement their functions, and how users “move” through the system (not only in physical terms). The basic assumption is that people will seek for those services that are closest to them. This assumption is hardly supported by evidence. Whenever possible people opt to seek for services where they feel they will get what they wish to get, regardless of considerations of technical efficiency. If the model of integrated health system (whether pluralistic or not) is adopted then a regulation of the movement of people is necessary. In Uganda this does not happen. At the moment people can obtain (and indeed they do) immunisation and other preventive services or treatment for uncomplicated malaria at the National Referral Hospital as well as at any HCII. It is not clear either what is right. The question that requires answer here is the following:

- Should choice be the “engine” of the system or else?

¹³ For example in Uganda the following levels are envisaged for the public health system: the village level, Health centre II, III, IV, hospital (district, general), referral hospital, national hospital. For each of these levels standards of infrastructure, equipment and staff have been defined (but not often respected).

¹⁴ This statement is true for the current definition of Minimum Service Package applied in Uganda.

¹⁵ For example, in Uganda, public health units may belong to central government, to districts or to sub-counties.

¹⁶ By functional integration we intend here an integration of functions by different actors (different legal entities) where the basic autonomy of management of each is preserved.

The only known case of an attempt of directing the flow of patients according to a systemic rationale has occurred, ironically, in a PNFP hospital¹⁷. This experience has never been evaluated and it is not known if the hospital works better because of this choice or not.

2.3. Competition or integration? Accountability to whom?

This issue is related to the previous. The private sector moved by commercial aim tends to identify the type of services that are more in demand, and for which people are ready to pay, regardless of the Minimum Package. It banks on the choice of users and takes responsibility only for the people who choose its services rather than for a geographically defined population. Its offer is therefore highly responsive to the demand of service expressed by the users rather than to objective need. This makes this sector extremely flexible but also volatile. Private practices open up and close very fast depending on local market for services. Whenever possible, it tends to “cream skim” less expensive and more lucrative type of services (e.g. treatment of uncomplicated episodes of disease), leaving other types of services – and more complex case-mix - for the public or PNFP sector. The PNFP health sector in Uganda, due to its mission, history and to the demands of services it had to meet, has developed and operates in a way that is very similar to that of the public sector and tries as much as possible to structure itself in the multi tiered levels of the public sector. At the same time about half of the cost of service provision in the sub-sector is covered by use fees¹⁸. This places the sub-sector in a unique position: it provides services according to “socially oriented goals”¹⁹ and, at least as tendency, according to a systemic rationale of operation. At the same time it has to preserve a high degree of awareness for market dynamics. In this way it is “exposed” on two sides. It is also true that at the moment the sub-sector is subject not only to a double exposure, but also to an increasing pressure on two sides: the demand for a progressive integration in the public health system and the pressure/need of competition of the private sector.

The acceptance of this double “exposure” introduces also a double line of accountability²⁰ for the PNFP health sector. Perhaps this mixed accountability, which intuitively could be cause of weakness, is also the reason for its resilience and perceived higher quality. The experience made in Uganda by Government health services at the time when user fees were charged seems to point at the validity of this assumption.

If this is true, then the question would be:

- how it is possible to maintain a double line of accountability for all the elements of the health system (not only for the PNFP)? Which tools should be used?
- is it a question of who pays the bill?, a question of “mission”? both?
- what is the right mix of accountability (for each type of sub-sector)²¹?

For the PNFP health sector the answer is relatively easy. It is mainly a question of mission. In fact this “accountability” existed also in the period of socio economic upheaval, when many PNFP health units took upon themselves not only the provision of curative services, but also that of preventive services, at their own cost, actively soliciting funds for them. The example provided earlier, of the PNFP hospital that has attempted, even in the absence of public subsidies, to operate within a systemic rationale by directing the flows of patients

¹⁷ In this hospitals patients utilising its services after referral from a lower unit would obtain higher subsidies than those opting for self referral. Thus doing the hospital attracts, “de facto”, a more complex and costly case-mix.

¹⁸ With almost perfectly balanced budgets, the sub-sector recovers at the moment 50% of its cost from user fees, 25% from public subsidies, 25% from a external mix private donors and denominational charities.

¹⁹ This includes the notion of need before that that of demand.

²⁰ Accountability here refers more to a “giving account by fulfilling the expectations” and less to a formal process of “giving account for resources used”. It is possible to be accountable by doing what one has accepted to do, even in the absence of formal checks. It is matter of emphasis rather than contradiction.

²¹ It is important not to try to simplify this issue. The identity/awareness of mission is an important element at play. Therefore it has to receive due consideration also in determining the mix of accountability demanded.

through differentiated fees further testifies an “altruistic” behaviour that is absolutely de-linked with monetary incentives.

2.4. The package (public and merit goods) and fees – who should pay what?

Earlier on, reference was made to the minimum health care package²². There exist a policy commitment to devote the greater proportion of the health budget to the package, and of assuring its provision to all the population, with emphasis on the poor, women and childrenⁱⁱ. At the time when the policy was approved user fees were still a practice in all sub-sectors. Since last year user fees were abolished in the government health units. In any case, public funding has always been well below the actual cost of the package. Recent estimatesⁱⁱⁱ would place the cost of the package at service delivery point at 13.5 US\$ per capita²³. Health spending in the current financial year is reckoned to be 9 \$ per capita. This latter figure includes the amounts spent by Government through Budget (4.5 \$ per capita²⁴), amounts spent through projects (3.7 \$ per capita), amounts contributed by NGOs/PNFP (0.3 \$ per capita – these are moneys that the NGO/PNFP networks are able to mobilize abroad), and amounts spent by households through user fees in both Government²⁵ and PNFP units (0.5 \$ per capita). These estimates do not include the private sector. Government budget therefore contributes 50% of the current spending. It is clear at this point that the current spending (9 \$ per capita) is sub-optimal (in fact this is amply demonstrated by the inadequacies of service provision in the government sector - e.g. drugs’ shortage is perhaps the most visible feature, but certainly not the only one, of the inadequate spending).

Hence a series of legitimate questions:

- Should/can the entire minimum package be provided free of charge to the users?
- If not all, which components of the minimum package should be funded by public money?

Answers are somewhat redundant. There are evidences that point at the only possible answers. Yet very little attention is devoted to the re-definition of the package that should universally be accessible without charge. The absence of clarity on such type of questions is having serious consequences on the PNFP sub-sector which is increasingly pressurised (because of its partial - 25% - funding from government budget) to provide the entire package without recourse to user fees²⁶. The PNFP sub-sector has repeatedly voiced its concern for this ambiguous state of affairs and declared that more clearly defined terms of the partnership would be necessary. The issue of “what does public money buy” is very high in the agenda of the PNFP sub-sector, so much so than times and again it has

²² Components of the Uganda National minimum Health Care Package (UNMHCP): a) Control of communicable diseases (malaria, STI/HIV/AIDS, Tuberculosis); b) Integrated management of childhood illness, c) Sexual and Reproductive health and rights (essential ante-natal and obstetric care, family planning, adolescent and reproductive health, violence against women); d) other public health interventions (immunization, environmental health, health education and promotion, school health, epidemics and disaster prevention/preparedness/response, nutrition, interventions against diseases targeted for eradication); e) mental health services); f) essential clinical care (injuries and other common conditions, disabilities and rehabilitative health, palliative care, oral/dental health).

²³ It is important to note here that this estimate is based on an analysis of cost based on the existing infrastructure (both government and PNFP) and does not take into account the need of expanding services to improve coverage. When this extrapolation is carried out the per capital cost reaches 28 US\$ per capital, closer to the figures provided by the Macroeconomic commission for health.

²⁴ This includes spending financed through fiscal revenues and donors’/lenders contribution to Budget spending, within the SWAp arrangement, in almost equal proportions.

²⁵ With the abolition of user fees private services were established in government units on the assumption that those who could afford to pay would get a faster track service of the same quality. It is not clear if this assumption has been confirmed by practice.

²⁶ Despite the existing evidence to the contrary (see annexes), the PNFP sub-sector is accused of not having responded positively to government subsidies. On the ground of these unfair allegations coming from the political arena, the entire rationale of public subsidies to the sub-sector is currently being questioned.

requested government to shift from the current “administrative approach”²⁷ towards better defined forms of relationship in order to lessen the weight of bureaucracy and reduce the scope of unjustified expectations. Unfortunately the experience on alternative approaches (contractual approaches, relational contracts etc.) is very limited for sub-saharan Africa^{iv}.

2.5. Technocrats and politicians: two worlds apart?

The most serious objections to the public funding of the PNFP sub sector (even in its partial and limited form) come from the political arena^v, and follow the abolition of user fees in Government health units. This decision had not been foreseen in the formulation of the National Health Policy and Sector and, as a matter of fact, threatens to slow down the pace of a process of convergence of two sub-systems (Government and PNFP) that had been on a dynamic of progressive functional integration. The arguments, stated in simple terms, are the following:

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

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

a. Accountability

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

b. Allocative efficiency

The answer to this type of objection is perhaps less intuitive: it is nonetheless easy. It is in fact the resource constraint that makes the provision of subsidies to the PNFP health sector desirable in the first instance. Those raising objection to it fail to see that services to the people are provided by Government, the PNFP and private health sectors, in proportions that seem to be equal^{ix}. On the other hand the rationale of operation of the PNFP health sector makes it very similar to the public health sector^x. The real question is whether subsidies provided to the PNFP sector give returns in terms of increased services? geographical access (and access to the poor) and quality. This is hardly questionable: with almost half of the Hospitals in the Country and a quarter of the lower level units it would

²⁷ By administrative approach we intend here a form of partnership where the PNFP sector is equated to the public sector and asked to adopt all Government regulations (especially those related to financial management) in exchange with a (partial) budgetary support.

be difficult to deny that, at least, geographical access has increased. In addition, it is undeniable that, for the cash starved health budget, the return of 100 % of the services²⁸ provided in exchange for 25-30% of their cost is, a very convenient arrangement for Government, especially if these services have lower costs of production than in Government units^{xi}. It is indeed a very convenient bargain for a Government that does not have the money to meet the targets it has set (that represent also the commitment in front of its population) if one of the partners it has found on the way “hands over” 100% of its (cheap) outputs for 25 % of their cost. What is really strange is not that this is exactly what is happening, but that such elementary consideration eludes the grasp of so many!

c. Equity

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

2.6. Cost

The PNFP health sector has always operated in a situation of resource constraint. In some way it could be said that cost consciousness is part and parcel of the institutional culture. Expenditure is kept in line with revenues and budgets are balanced. Commitments match revenue forecasts and debts are hardly ever incurred. The management of PNFP units has a relatively ample discretion in deciding upon allocation of resources and virements within the established budget. When, at the beginning of the nineties cost started escalating, the sector developed some “coping mechanisms” which have been effective for some time²⁹ but had to be eventually abandoned as not sustainable. Since then and in particular in the last few years budgets have substantially increased³⁰. This has most probably occurred also in the public and private sector commercially oriented. But only in the PNFP sector it has been documented^{xiii}. It would be interesting to observe trends of expenditure per unit of output all across the sectors and compare them.

²⁸ The PNFP units declare through the Health Information System all their outputs. These contribute to the achievement of the National Health System targets.

²⁹ These coping mechanisms were: underpayment of staff, employment of less qualified staff, delayed investment in infrastructure and equipment maintenance.

³⁰ For the Catholic Hospitals in Uganda an increase of 70% over 6 years has been observed, as shown in the graphic in annex 1. In the same graphic it is also visible how government subsidies have displaced user fees as source of income.

Taking a close look at the structure of budgets along time the striking evidence is that the cost of labour is the single most important cause of cost escalation. But this, in itself, is a hardly surprising evidence. The main competitor on the market labour for health staff is the public sector, whose remuneration has kept increasing in the last few years. When, in 1999, the ban on recruitment of civil servants was lifted, the PNFP sub-sector witnessed a critical exodus of qualified staff. *Ironically both the increases in the public sector and the new recruitment were made possible, within the frame of SWAp, by donor money and debt relief.* Understandably, the PNFP sector had to apply sharp increases the remuneration of its own staff. Average salaries in the PNFP sector are about 30% less than those of their colleagues in civil service. This may even reflect some kind of altruistic motivation in the work force of the PNFP units. But this altruistic motivation does not hold if the conditions of work become too unequal.

The issue here is not whether it is right or not to pay health staff more. There is enough evidence that underpayment of staff is a common feature both in the public and PNFP sector. The issue is, rather, if policies affecting the cost of labour could and should be decided without taking into account the larger health sector, especially if these policies are made possible by donors' money (and, perhaps, they are not extremely sustainable).

2.7. Identity and institutional culture

The angle of approach chosen for the presentation of these issues did not allow to bring to the fore all of the issues that would account for the "altruistic" character of the PNFP sub-sector. A simple list does not give honour to the complexity of the argument but helps in capturing features that have not been mentioned so far:

- The fact that most of the PNFP sub-sector (86%) operates, by choice, in rural environment where the proportion of the poor is higher^{xiv}.
- The fact that, despite the need of charging user fees, these are kept to the minimum necessary to secure sustainability³¹.
- The fact that, with levels of exclusions of the poor from services comparable to those of public health units, preference of the better off quartiles of the population goes to Government health services and not to PNFP^{xv} (see also graphics in annex 2).
- The fact that a high degree of "discipline" is obtained through spontaneous net-working and accepted co-ordination from the umbrella organisations (the Bureaux)³².
- The fact that new ways of approach to problems encountered are developed and tested³³.

All of these features would constitute an odd behaviour by the standards of the private sector. What explains this kind of behaviour, then?

Elsewhere we have mentioned the Mission of the catholic health services in Uganda. Similar statements can be found in the charters of units' from other denominations. Other PNFP services are moved by different sets of values. In any case there is constantly a reference to an ideal that has to be pursued because it is considered "good" in itself^{xvi}. The issue here is whether this ideal reference is duly considered as inherent value of the sub-sector (and therefore respected and protected) or not.

2.8. Welfare state, market or welfare society?

Many of the issues presented swing between to ideal models of reference: that of the welfare state and that of the market. Perhaps at this juncture it is necessary to float the idea

³¹ In effect, whenever an alternative source of funding is available, this latter displaces fees, as shown by the graphic in annex.

³² For example, over 96% of the units affiliated to the Bureau have an updated license for operation, a ratio absolutely unparalleled.

³³ Just two examples: the development of community based approaches, of the home based care for HIV/AIDS patients, of community financing mechanisms largely stemmed from the PNFP sub-sector.

that another reality (not a model) exist: that of welfare society. It has not been planned: it simply exists. It is the fruit of the initiative of individuals, communities, associations PNFP health units are born in this way. They start humbly and grow, often beyond expectation. They take care of the needs of people because they stem from the social experience of people themselves. All they need is to be recognised as a subject on their own, with their dignity and identity. When their social value is evident and the services (especially that sensitive area of service that are directed to the human person) they provide are evident, they need to be supported. In other words they require a correct understanding of the principle of subsidiarity³⁴. And, of course, they require a conducive environment for their development, made of a suitable legal set-up, fair allocation of resources, flexibility....

The issue here is:

- How far the concept of welfare society is accepted?
- How far are policy makers (both in Government and in large multi-bilateral organisations) ready to revise their paradigms?

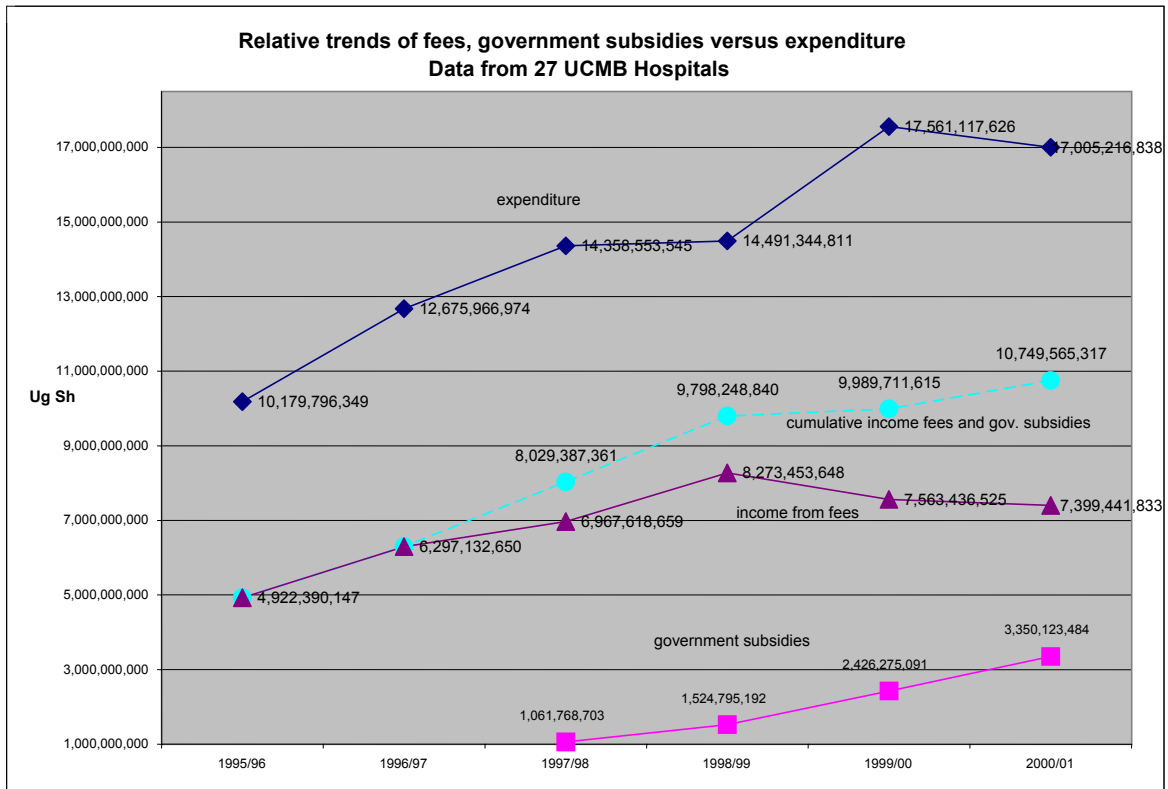
Conclusion

The PNFP health sector is an important actor in service delivery in sub-saharan Africa and perhaps elsewhere. It is certainly an important actor in health in Uganda. In most instances it started off and still exists to provide services to the poor. But reaching the poor is not easy. Certainly there are issues of internal weakness and inconsistencies in the sector. Of this we are aware and we have set our hands to addressing the prevailing problems. Our task is made more difficult by an ambiguous or poorly consistent policy environment, by practices inconsistent with policy, by clear resource constraints, by the inadequacy of prevailing paradigms.....

We have reached a point in history when a clear consensus has been reached that poverty can be defeated or, at least, lessened. If this goal has to be brought closer to its achievement, it is necessary to bank on the energies of all, starting from those (persons, institutions and organisations) that have made the response to the need of the human person, and especially of the person of the poor, a key reason of their existence. Too often what happens is the exact opposite. It is possible that the beginning of this new millennium will also mark the time when the energies that exist within society could be unleashed. But this requires the unravelling of the issues raised, and perhaps more.

³⁴ *"It is indeed true, as history clearly proves, that owing to the change in social conditions, much that was formerly done by small bodies can nowadays be accomplished only by large corporations. None the less, just as it is wrong to withdraw from the individual and commit to the community at large what private effort and action can accomplish, so, too, it is an injustice, a grave evil and a disturbance of right order for a larger and higher organization to arrogate to itself functions which can be performed efficiently by smaller and lower bodies. This is a fundamental principle of social philosophy, unshaken and unchangeable, and it retains its full truth today."*, Pius XI *"Quadragesimo Anno"*, 1931, Part II Par 5

Annex 1



Data from UCMB database

NOTES

Expenditure has increased 70% over a period of 5 years (ab. 15% per year).

Last financial year (2000/01)

Revenues from government subsidies cover ab 20% of expenditure

Revenues from fees cover ab. 44% of expenditure

Revenues from other sources (mostly private charitable aid) cover 36% of the expenditure

It appears clear that revenues from government subsidies have displaced user fees.

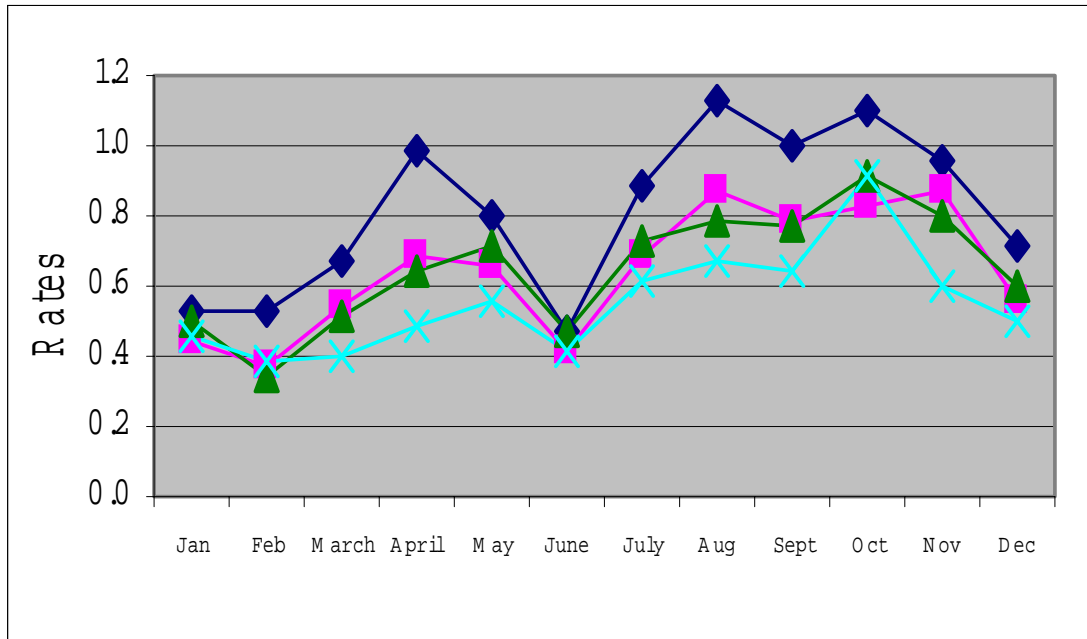
Annex 2

UTILISATION RATES BY SOCIOECONOMIC GROUPS

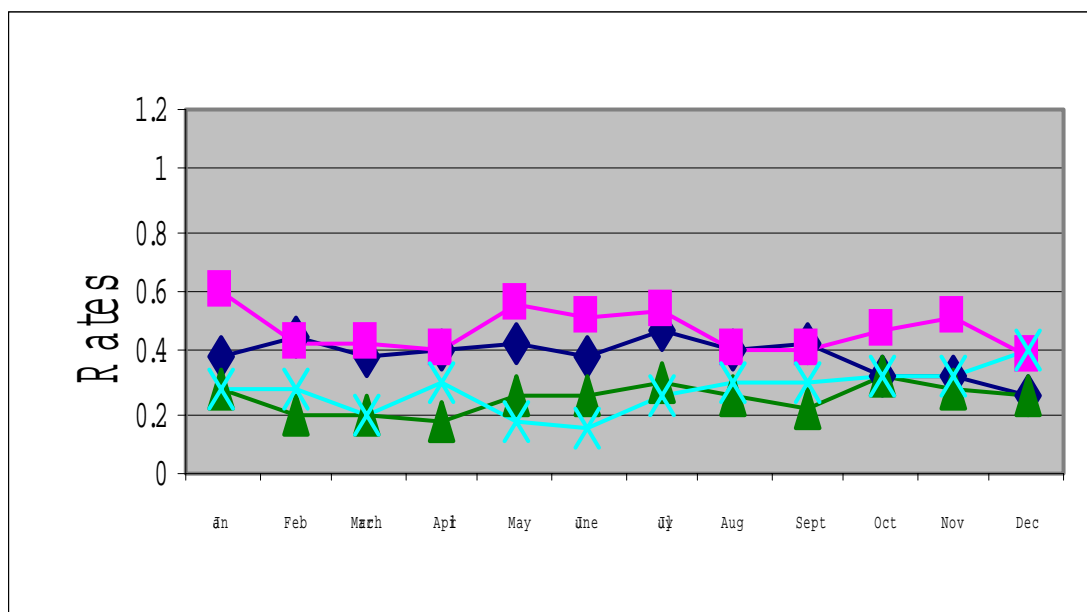
Legenda

- ◆ Poorest quartile
- Less poor quartile
- X Best off quartile
- ◆ Better off quartile

GOVERNMENT UNITS



PNFP UNITS



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