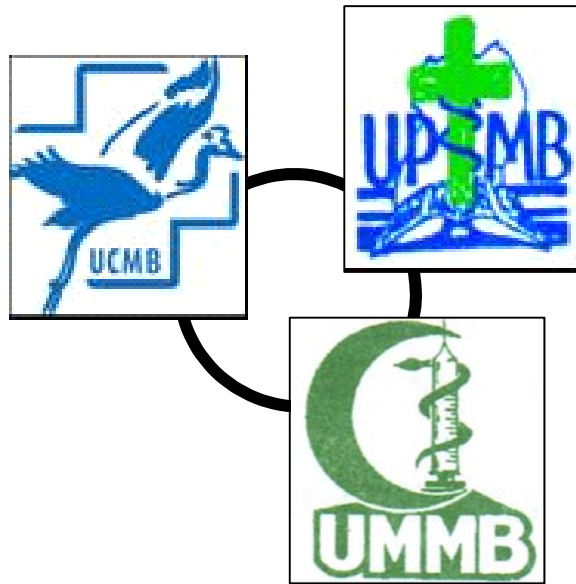


# UCMB – UPMB - UMMB



## FACTS AND FIGURES OF THE PNFPs

KNOWING AND UNDERSTANDING THE FACILITY-BASED PNFP HEALTH SUB-  
SECTOR IN UGANDA

AUGUST 2007

## Table of Content

<b>I. INTRODUCTION.....</b>	<b>5</b>
<b>II. WHAT IS THE “PNFP”, ITS SIZE, ITS FINANCES? .....</b>	<b>5</b>
<b>IIIA. WHAT IS THE “PNFP”?.....</b>	<b>5</b>
<b>IIIB. WHAT IS THE SIZE OF THE FACILITY BASED PNFP HEALTH SUB-SECTOR BUDGET? .....</b>	<b>6</b>
<b>IIIC. WHAT IS THE TREND OF GOU SUPPORT TO THE PNFP FACILITIES? .....</b>	<b>8</b>
<b>IIID. HOW DO PNFP FACILITIES FINANCE THEIR OPERATIONS? .....</b>	<b>10</b>
<b>IIIE. WHAT IS THE COST STRUCTURE OF THE PNFP FACILITIES?.....</b>	<b>12</b>
<b>III. WHAT IS THE PERFORMANCE OF THE PNFP SUB-SECTOR? .....</b>	<b>13</b>
<b>IIIA: IS THE PNFP SUB-SECTOR CONTRIBUTING TO PEAP HEALTH INDICATORS? .....</b>	<b>14</b>
<b>IIIB: HAS THE PNFP SERVED MORE PEOPLE? .....</b>	<b>14</b>
<b>IIIC: IS THE PNFP UTILIZATION BY VULNERABLE GROUPS IMPROVING?.....</b>	<b>15</b>
<b>IIID: ARE FEES DECREASING IN PNFP FACILITIES? .....</b>	<b>16</b>
<b>IIIE: IS THE PNFP SUB-SECTOR MORE EFFICIENT? .....</b>	<b>16</b>
<b>IV. THE HUMAN RESOURCES OF THE PNFP SUB-SECTOR .....</b>	<b>18</b>
<b>IVA: WHAT IS THE SIZE OF THE PNFP WORKFORCE? .....</b>	<b>18</b>
<b>IVB: HOW MANY ARE THE CIVIL SERVANTS DEPLOYED IN THE PNFP? .....</b>	<b>18</b>
<b>IVC: WHAT IS THE TREND IN WORKFORCE VOLUME AND QUALITY IN THE PNFP? .....</b>	<b>18</b>
<b>IVD: ARE THERE STAFFING GAPS IN THE PNFP? .....</b>	<b>19</b>
<b>IVE: HAS THE PNFP BEEN ABLE TO INCREASE THE PAY OF ITS STAFF?.....</b>	<b>20</b>
<b>IVF: HAS THE PNFP RECOVERED THE STAFF LOST? .....</b>	<b>21</b>
<b>V. CONCLUSION .....</b>	<b>21</b>
<i>ANNEX 1: Details on PNFP.....</i>	<i>23</i>
<i>ANNEX 2: Milestones of PPPH and PNFP.....</i>	<i>29</i>

## Figures

FIGURE 1: REVENUE RAISED BY PNFP AS % OF PUBLIC-PNFP RESOURCE ENVELOP FOR HEALTH (W/O PROJECTS) .....	7
FIGURE 2: REVENUE RAISED BY PNFP AS % OF PUBLIC-PNFP RESOURCE ENVELOP FOR HEALTH (WITH PROJECTS).....	7
FIGURE 3: TREND OF CUMULATIVE GoU ALLOCATIONS TO PNFP HEALTH FACILITIES.....	8
FIGURE 4: ALLOCATION TO PNFP IN VARIOUS MOFPED PROJECTIONS. ....	8
FIGURE 5: BUDGET ALLOCATION TO PNFP AS PERCENT OF GoU BUDGET (EXCL. DONOR PROJECTS) .....	9
FIGURE 6: GOVERNMENT BUDGET SUPPORT (PHC CG, DRUGS AND LAB) TO PNFP HOSPITALS .....	9
FIGURE 7: GOVERNMENT BUDGET SUPPORT (PHC CG, DRUGS, AND LAB) TO PNFP LLUS .....	10
FIGURE 8: SOURCES OF REVENUE FOR PNFP FACILITIES – ABSOLUTE VALUES .....	11
FIGURE 9: SOURCES OF REVENUE FOR PNFP FACILITIES – RELATIVE VALUES .....	11
FIGURE 10: TREND AND CATEGORIES OF MAIN EXPENDITURE AREAS OF THE PNFP – ABSOLUTE VALUES .....	12
FIGURE 11: TREND AND CATEGORIES OF MAIN EXPENDITURE AREAS OF THE PNFP – RELATIVE VALUES .....	13
FIGURE 12: PNFP CONTRIBUTION TO THE PEAP INDICATORS.....	14
FIGURE 13: TREND OF ACCESS (STANDARD UNITS OF OUTPUT) IN 65% OF PNFP HOSPITALS (MEDIAN VALUES) .....	15
FIGURE 14: TREND OF UTILIZATION BY POPULATION GROUPS .....	15
FIGURE 15: TREND OF EQUITY (MEDIAN FEES PER UNIT OF OUTPUT).....	16
FIGURE 16: TREND OF COST PER SUO IN 65% OF PNFP HOSPITALS .....	17
FIGURE 17: TREND OF SUO PRODUCED PER STAFF .....	17
FIGURE 18: TREND IN WORKFORCE VOLUME (INDEX) AND PROPORTION OF QUALIFIED STAFF .....	19
TABLE 19: ATTRITION RATES PER SELECTED STAFF CATEGORY IN SAMPLE OF 65% PNFP HOSPITALS .....	19
TABLE 20: ATTRITION RATES PER SELECTED STAFF CATEGORY IN SAMPLE OF PNFP LLUS .....	20
FIGURE 21: TREND IN AVERAGE WAGE PER STAFF IN 65% OF PNFP HOSPITALS.....	20

## Background

The Private-not-for-profit (PNFP) health sector is better known to most under the name of “Church” or “Mission” Hospitals and Dispensaries. By no means all the PNFP health units belong to Churches: nonetheless the largest majority of them do. These units have made the history of modern medicine in the Country and are most often found in the very remote rural settings. They were established to provide health care of good standards to the rural poor. Nobody who wants to make a business out of health care would dream of placing a hospital far from towns or in the areas of the Country with poorly monetized economies: those who founded PNFP health units did exactly what no business oriented mind would ever do. Evidently they had in mind the dire need of service of the rural poor. Quite often the result has been that – over time - small towns were born around the Mission settlements to which health units belonged. History has it that people move and settle where they find care and security: this is what has happened in many instances around PNFP hospitals. In the late colonial period the social function exercised by the “Voluntary Hospitals” (as they were called at the time) was recognized and “Grants in Aid” for recurrent wage, non-wage and - more rarely – development were extended to them. This support ceased in the seventies and was resumed only in the late nineties, following two concurring events. The first was that the PNFP sub-sector was no longer able to cope with the increased cost of service production, precipitated by the increased cost of labor related to the introduction of “lunch allowances” in the public sector. Forced to recover increasing cost from fees paid by patients, utilization was in free fall. On the other hand Government was not in position then (nor it will be in the future) to cover the gap left behind by the PNFP facilities. The second was the launching of SWAp in year 2000, thanks to which more funds had become available in the budget for the financing of the health sector; Government deemed it convenient to avoid the collapse of the PNFP sub-sector by extending to it support for recurrent expenditure (non-wage only, limiting the wage support to a small number of doctors employed by Government and posted to the PNFP Hospitals). Government’s wisdom with this move was demonstrated by the rapidity of recovery of functionality of the PNFP units, who immediately translated the support received into gains of access and a substantial and positive contribution to the achievement of the objectives of the sector’s plan and PEAP.

A specific policy for the newly established partnership (Public-Private Partnership for Health with the PNFP sector) was worked upon and reached its final stage with the presentation at the Joint Review Mission in 2003, ready for examination and adoption by Cabinet. All seemed set for a durable partnership meant to progressively and formally enlist the services of an important private sector with social orientation into the wide public health sector. On the other hand the PNFP never meant to vie for a total support of their recurrent expenditure by Government. The PNFP facilities are organizations of civil society. They are perhaps one of the most organized features of civil society. They intend to remain so and do not want to be “absorbed” and totally supported by Government. At the same time no health unit that wants to avoid exclusion of the poor

can rely on what the poor themselves can pay, hence public subsidies are needed and rightfully claimed. What needs to be identified is the right balance of things and the right mechanisms of support, something that the desired Policy tried to outline and prepare for.

Suddenly, with the budget 2004/5, everything changed. The budgetary allocations that had thereto progressively grown started stagnating and, later, decreasing. At the same time Government started investing more and more in its own employees. This decision has inflicted a severe blow to the PNFP and has triggered the appearance of downward trends that resemble, and will soon take up the proportion of, the deep crisis registered in the early nineties.

In better times, the PNFP health sector was defined as a “national asset” that the Country had to preserve through an adequate and focused support. Their demise, or their drifting towards a more “business oriented” rationale of operation, would occur only to the detriment of the poor people of the rural communities most of them serve.

This brief paper, a “fact sheet”, tries to present in few pages some basic evidences and facts that are deemed to be poorly known outside the network of the PNFP health facilities. It is not exhaustive and does not claim to be so. It is nonetheless quite informative. Everybody knows that church and faith based health units exist and operate, that they are a sizeable component of the system and that they aim at delivering health care out of a concern of equity and social justice. Quite often these units are known for being quite resilient and efficient. They have in fact been able to weather out difficult periods of the history of the Country without ever failing to provide their service to the people. Unfortunately, because they charge people for a proportion of the cost of the service they provide, they are equated to the private and business oriented sector, hence they are thought to be “well off”. This is a seriously wrong conception that needs to be corrected. The careful reader of these notes will certainly not fail to identify the signs of an ongoing and rapid worsening new crisis that can be averted only if major and bold policy decisions are taken and enacted.

The crisis will not fail to become apparent soon if the decision makers will ignore the basic facts and evidences presented here. In this sense, this paper intends to offer the basis of a renewed dialogue between the Government of Uganda and the PNFP health sub-sector, starting from evidence.

## I. Introduction

The PNFP health sector in Uganda is a group of large networks of service delivery points spread all across the Country. When considered together, this sub-sector is reckoned to provide about one third of the total volume of health services provided to the people of Uganda. It started operating towards the end of the XIX century and has kept developing in the first half of the XX century, long before the establishment of the national health system. It has reached its current size towards the end of the century and it has now somewhat stabilized. Despite its long tradition of service and the longstanding collaboration with Government, it has been noticed that some of the features and characteristics of the sector are either unknown or wrongly perceived by both the general public, decision makers and planners. The purpose of these notes is to provide a summary of facts and figures – largely quantitative data - that give background information about the PNFP sub-sector, to facilitate knowledge and understanding of the sub-sector, its achievements, its current critical constraints and problems. Data are drawn from information collected, collated and analyzed by UCMB. These notes are facts and figures presented around three thematic areas:

- Facts and figures on the PNFP health sub-sector **size and finances**
- Facts and figures about the PNFP health sub-sector **performance**
- Facts and Figures around **human resources** in the PNFP health sub-sector.

## II. What is the “PNFP”, its size, its finances?

### IIa. What is the “PNFP”?

The term “PNFP” is used, in this context, to refer to organizations that pertain to the realm of Civil Society, whose first and foremost reason of operation is the provision of health services and that do not aim at making profits for distribution to owners. The term PNFP does not refer to a formal common structure of co-ordination. It only refers to networks having a lot of common features but also important differences.

There are facility – based PNFPs and non-facility-based PNFPs. In this paper we shall discuss specifically about the facility-based PNFPs (i.e. those organizations characterized by a substantial investment of resources in a physical structure for the provision of health services to a well defined population on a permanent basis). Non-facility based PNFP are mainly (but not exclusively) operating as health programs with a defined time frame.

Facility-based PNFPs are for the largest majority belonging to religious denominations and are coordinated by three Medical Bureaus (Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau and Uganda Muslim Medical Bureau).

In this sense the three Medical Bureaus represent and coordinate three large networks of faith based health facilities.

The three networks own 44 (42.3%) of the 104 hospitals, 558 (22%) of the 2,536 lower level health facilities and 19 (70.7%) of the 27 nursing and midwifery training schools in Uganda. The majority of these facilities are rural. There are 44 hospitals categorized by MoH as

Level	Gov.t	PNFP	PFP	Total
Hospitals	56	44	4	104
HC4	143	8	3	154
HC3	650	147*	12	809
HC2	845	362	262	1469
Total	1694	558	282	2536
HT Schools	8	19		27

PNFP; they represent 42% of all the Country's Hospitals. With regards to affiliation, when hospitals and LLUs are combined, the bureaus account for 75% of all PNFP facilities<sup>1</sup>. This document provides information using data drawn from three quarters of the PNFP facilities, extrapolating for the others. It is nonetheless sufficiently informative about the general situation in the facility based PNFP health sub-sector.

### **IIb. What is the size of the facility based PNFP health sub-sector's budget?**

The total budget of the PNFP health facilities in 2005/6 was Sh. 84.4 billion. In 1998/99 it was of Sh. 39.1 billion. In eight years it has grown by a factor 129% (i.e. a growth of about 16% per year) – Fig 8.

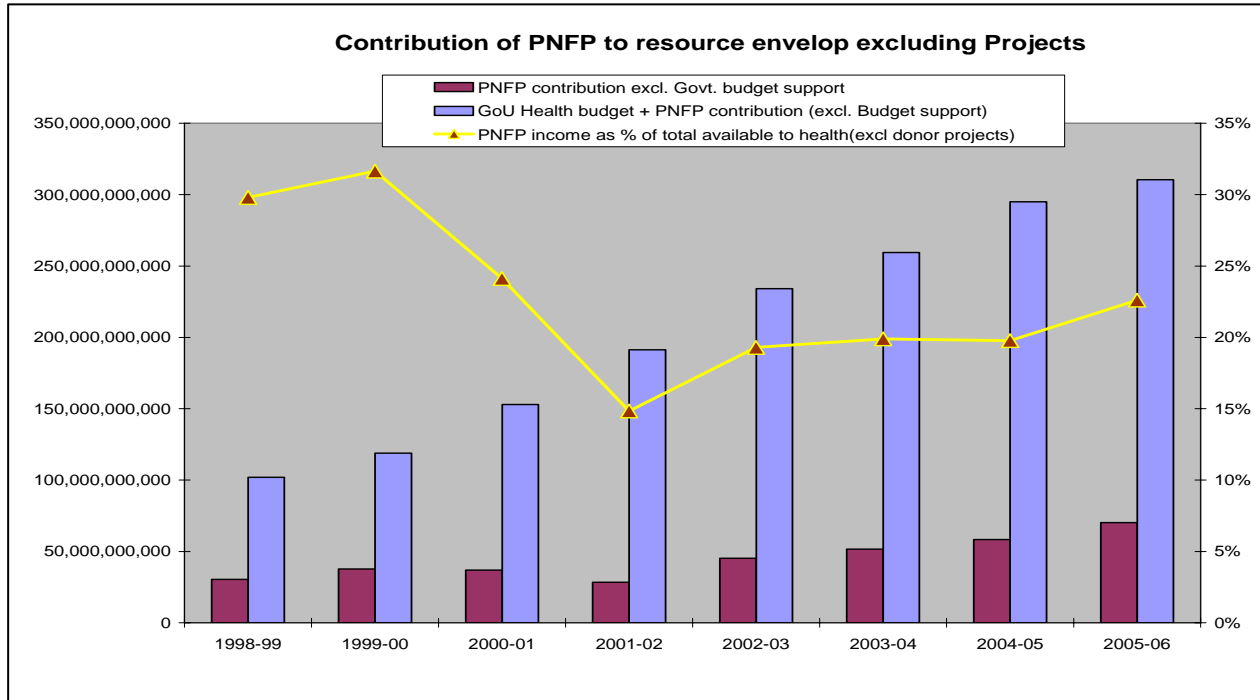
Although the PNFP health facilities receive government support (17.7 Billion Sh since 2004/5) they are to a large extent financed by resources mobilized by them. If the 17.74 billion shillings from government as budget support is discounted, revenue for health services raised through the facility-based PNFP under the three medical bureaus make up to about 23% of the resource envelope for health service available to both the PNFP and Public Sector (in 2005/6, if donor projects are excluded). In 2005/06 GoU health budget was 240.28 bn. PNFP raised 66.7 bn. If donor projects are considered (as part of the GoU health budget) then the PNFP contribution becomes 12% (2005/06) up from 8% in 2001/02. Considering all the outputs of the FB PNFP are captured by the national HMIS and reported as outputs of the system, the FN PNFP is a net contributor to the resource envelop. In either case the proportional contribution of the PNFP to the total resource envelop for health care has been increasing since 2001/2.

**This means that, for every shilling of the 17.74 bn that GoU allocates to the PNFP, the PNFP themselves add to the kitty of the envelop available for the provision of services 3 to 4 shillings.**

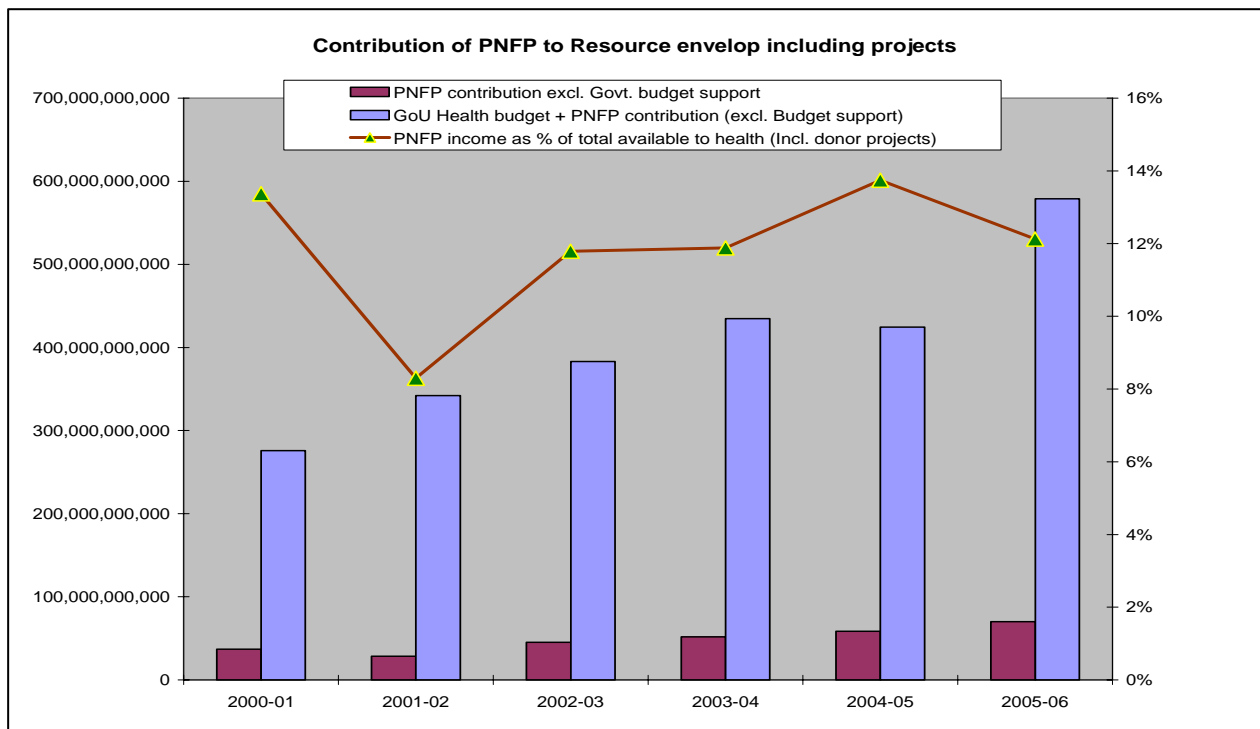
**(Fig. 1 and 2)**

<sup>1</sup> Source: List of allocations of PHC CG Non-wage Recurrent (2005/6 and 2006/7) to PNFP facilities.

**Figure 1: Revenue raised by PNFP as % of Public-PNFP Resource envelop for health (Without considering the donor projects)**



**Figure 2: Revenue raised by PNFP as % of Public-PNFP Resource envelop for health (With donor projects included)**



### I Ic. What is the trend of GoU support to the PNFP facilities?

Government support to the PNFP facilities went from 0.8 B Sh in 1997/98 to 17.2 B Sh in 2003/4 (reaching 20.4 B Sh if drugs are included) and has, since then, stagnated at the same level (Fig. 3 and following). According to the latest projections available from the Ministry of Finance, the foreseen allocations to the PNFP sub-sector will remain stagnant also in the next two financial years, even against a net increased of GoU health budget. This in sharp contradiction with earlier projections and it has not been justified by any declared change of policy. Hence it is totally incomprehensible to the PNFP sub-sector, especially if the sizeable returns Government reaps in terms of outputs for the targets of the Sector's Plan are considered (see Section III).

Figure 3: Trend of cumulative GoU allocations to PNFP health facilities

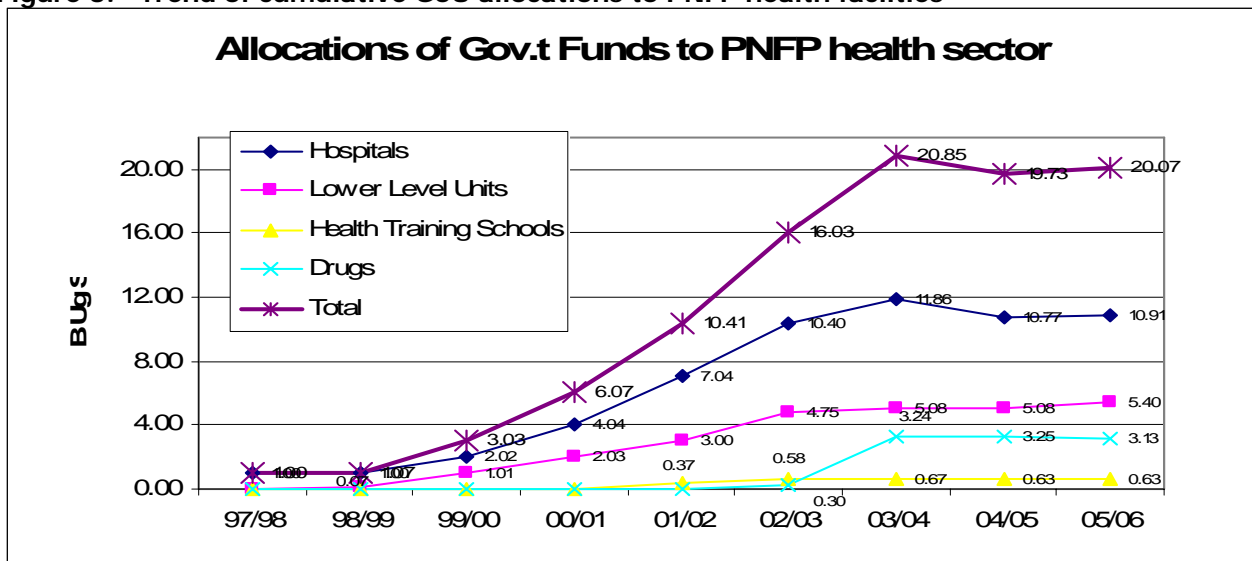
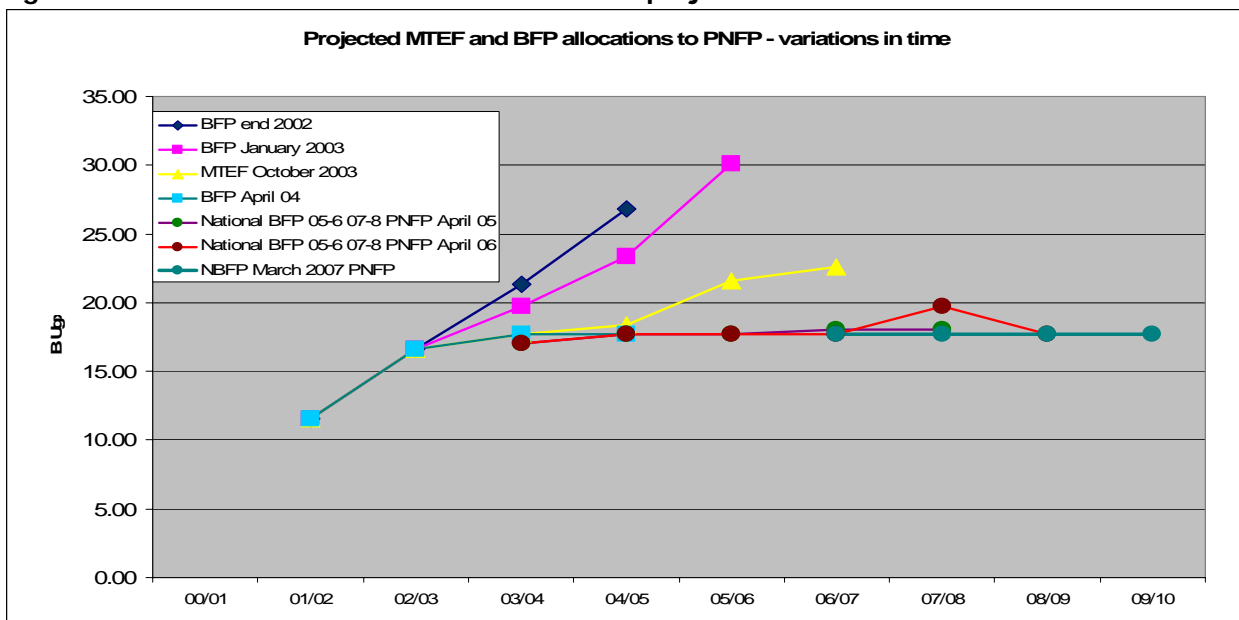
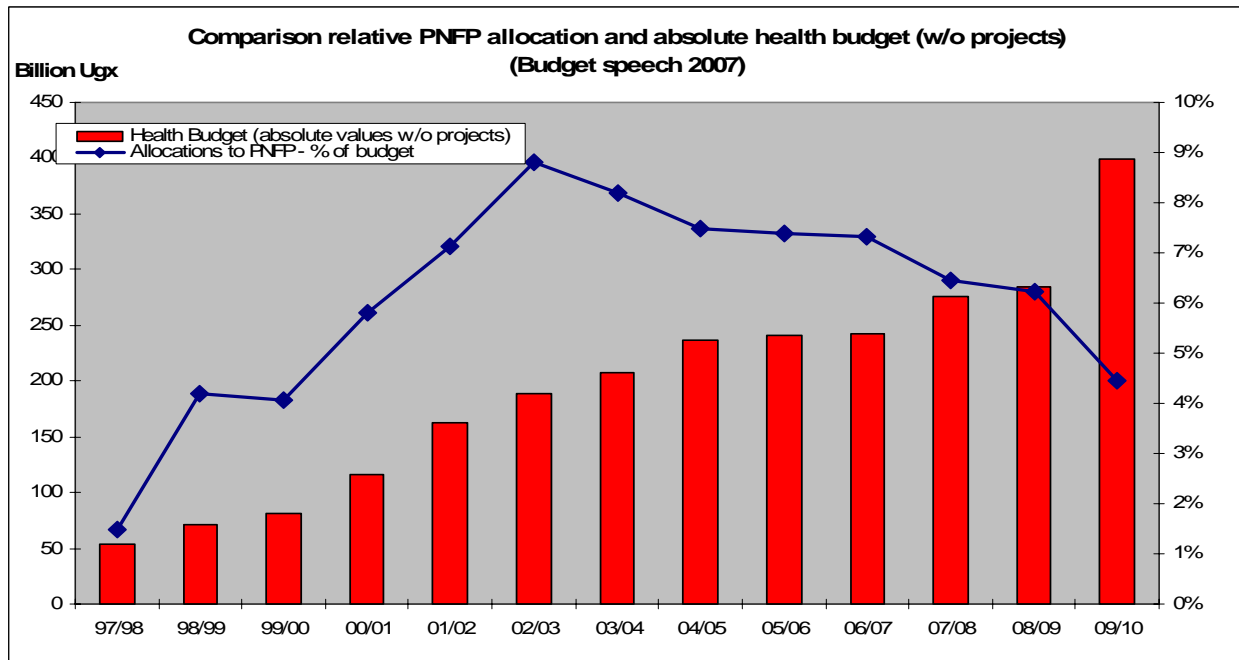


Figure 4: Allocation to PNFP in various MoFPED projections.



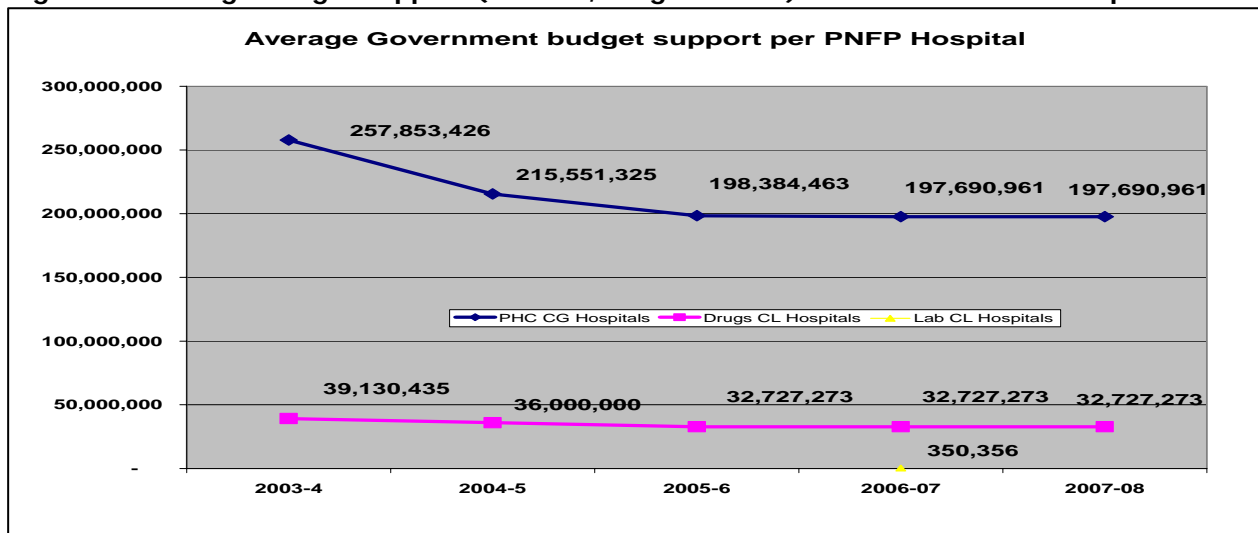


**Figure 5: Budget allocation to PNFP as percent of GoU Budget (Excl. Donor projects)**

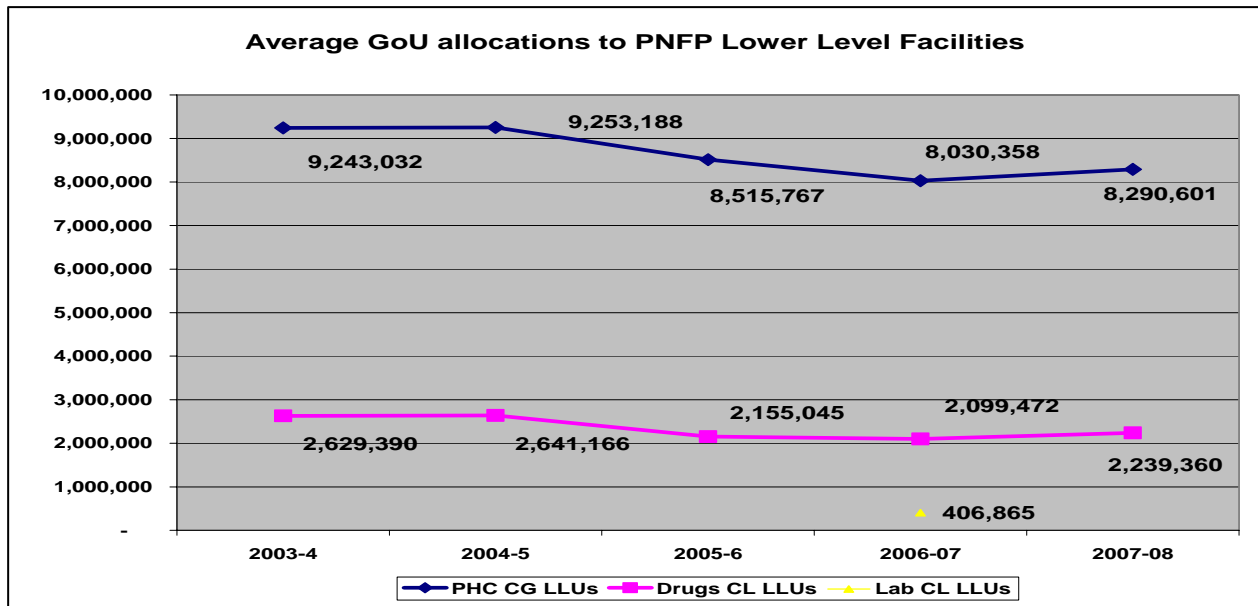


More importantly the average PHC Conditional Grant allocation per health facility is dropping due to increasing number of health facilities getting onto the list of “PNFP”. Some of these do not belong to the 3 networks mentioned here (Fig. 6 and 7). The increased number of beneficiary units at constant allocation translates into a net drop of Government contribution to the PNFP facilities. On average, a typical PNFP Hospitals was receiving, all included, 296 M Sh of Government support in 2003/4 and will receive 229 M Sh in year 2007/8 (-20%). For Lower Level Units the average went from 11.9 M Sh per unit in 2003/4 to 10.4 M Sh in 2007/8 (-12%).

**Figure 6: Average budget support (PHC CG, drugs and lab) allocation to PNFP Hospitals**



**Figure 7: Average budget support (PHC CG, drugs, and lab) allocations to PNFP lower level health facilities**



**IId. What proportion of recurrent cost of service provision is met by Government support and how do PNFP facilities finance their operations?**

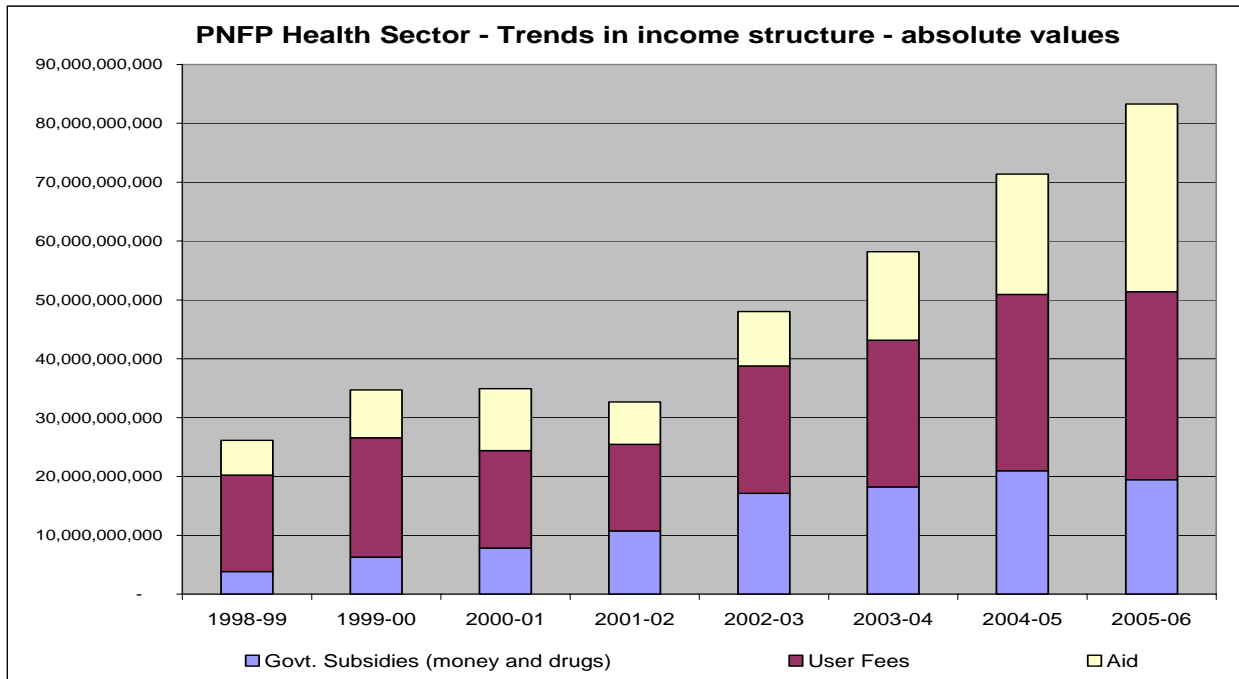
Financing of services in PNFP facilities occurs through three main sources: Government support (including PHC CG, drugs and personnel), user fees and a variety of donor support (mainly through projects, highly unpredictable, volatile and unsustainable in most instances) – Fig. 8.

The contribution of government support to PNFP financing expenditures rose from 15% of the total income in 1998/99 to a peak of 36% in 2002/03. It has since continued to drop to 23% in 2005/06 - Fig. 9. User fees were 63% of the revenues of the PNFP facilities in 1998/99 and have constantly decreased to reach a minimum level – 38% - in 2005/6. Donor support, that had remained constant around 22% of the income from 1998/99 to 2002/3, started increasing steadily to reach 38% of the income in 2005/6, at par with user fees.

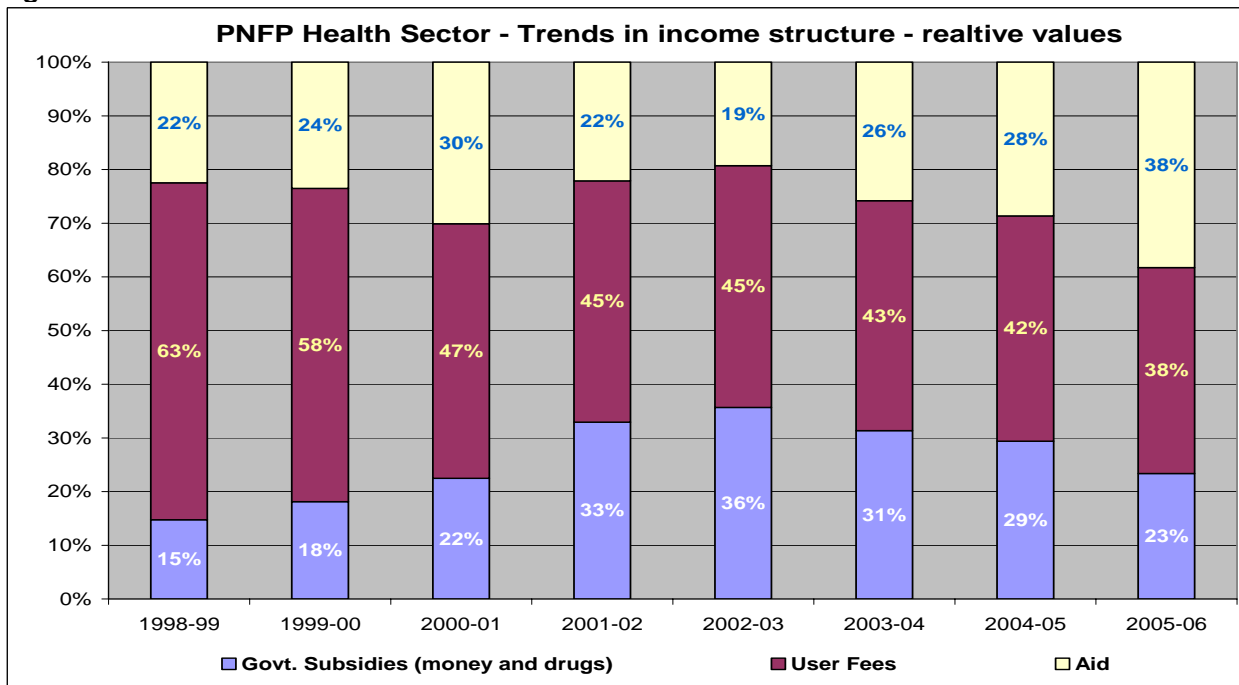
What figures do not say is that the source of donor income, contrary to the traditional donors of the sub-sector that had always been present but in very limited proportions, is now represented by disease oriented financing (Global Fund, Pefar etc...). This financing approach is extremely specific, targets a narrow scope of inputs, is unpredictable, short term and almost invariably excludes system cost like human resources. In addition the administration of these funds and the information systems they require are parallel to the standard HMIS and laborious. The unpredictable quota of income has therefore grown from about 20 to about 40% of the revenues in few years, having substituted both a proportion of user fees and government subsidies. This has

created a situation of high volatility and dependency from abroad in the financing structure of the facilities. The PNFP health sub-sector has never been exposed to such situation of incertitude about its sustainability.

**Figure 8: Sources of revenue for PNFP facilities – absolute values**



**Figure 9: Sources of revenue for PNFP facilities – relative values**



### 11e. What is the cost structure of the PNFP facilities and the observed trends?

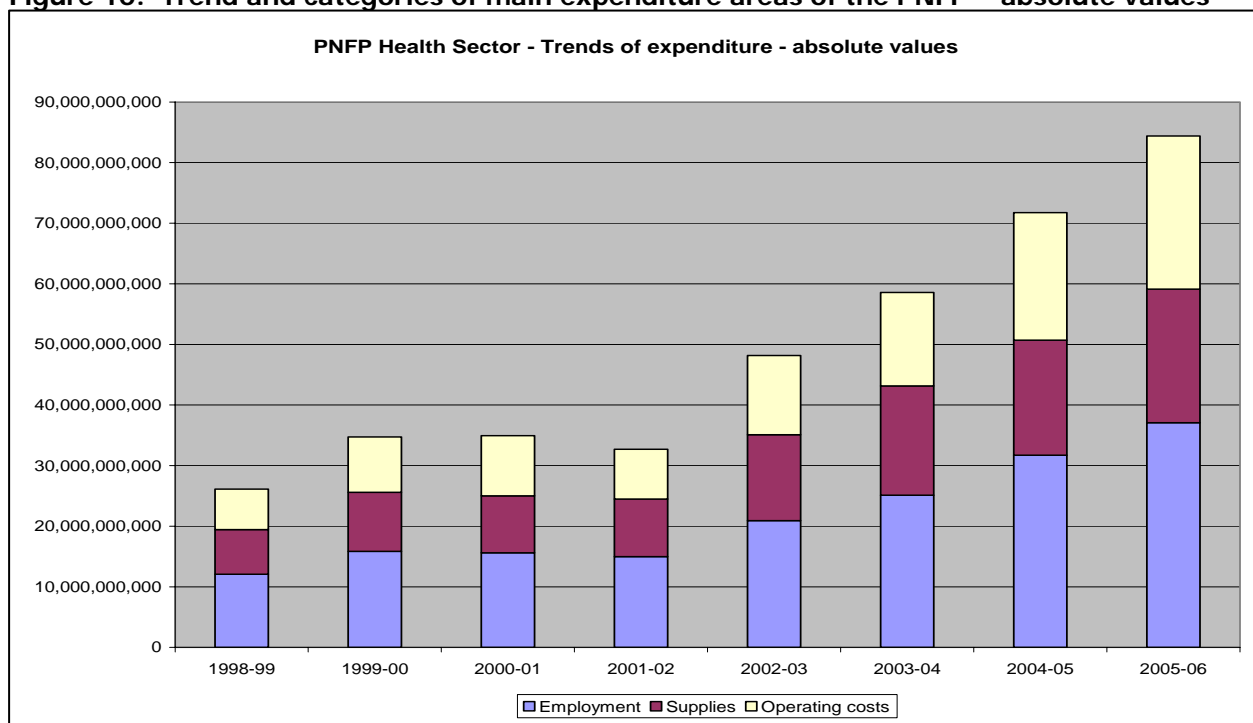
Income and expenditure are largely balanced in most facilities, with minor surpluses or debts. Excess of operating income is ploughed back on the following years' operation. Sometime facilities incur debts but, in general, expenditure is carefully kept within the amount covered by recurrent income.

Excluding capital (development) expenditure, cost data are grouped in three main areas: employment, supplies, operating cost – Fig 10.

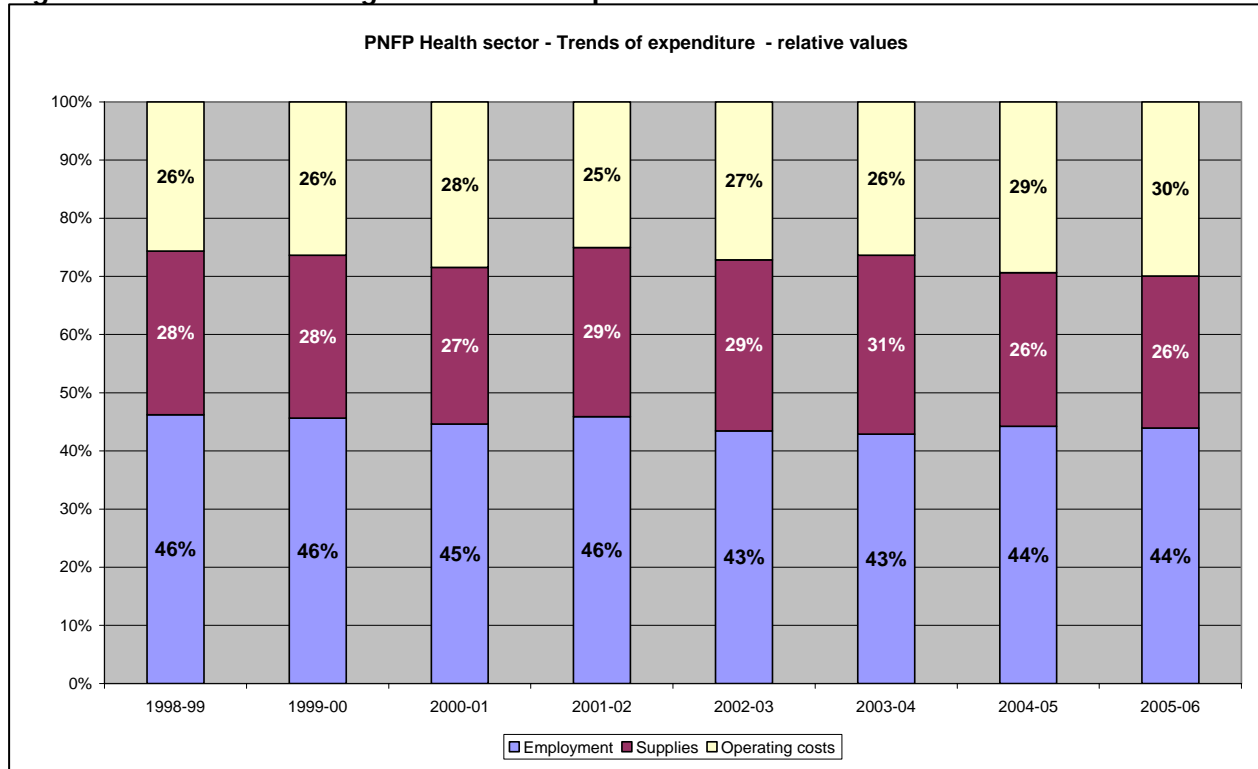
It can be noted that after a situation of relative stability registered by absolute values of around 30 B Sh annual expenditure until 2001/2, starting from 2002/3 and continuing with a steeper incline since 2004/5, overall expenditure went from 48 B Sh in 2002/3 to 84 B Sh in 2005/6. The main driver of the increase is the cost of labor, followed by the cost of operation (utilities, transport etc.) – Fig. 11.

The steep rise of total expenditures of PNFP coincides with the beginning of the Global Initiatives Projects (GF, PEPFAR, etc), and is marked by a concomitant increase of donor support from these sources (hence it is donor driven, following the increasing demand for scaling up of selected and supported interventions). On the other hand, employment takes the largest share of expenditure with 44% of the costs in 2005/6. Increases in this area are due to the attempt made by the sub-sector to match increased government salaries, in the rather futile attempt to curb attrition.

**Figure 10: Trend and categories of main expenditure areas of the PNFP – absolute values**



**Figure 11: Trend and categories of main expenditure areas of the PNFP – relative values**



### III. What is the performance of the PNFP Sub-sector?

In the frame of the Partnership (PPPH), GoU subsidies to PNFPs have been provided with the expectation, among others, that more people would be served (with attention paid to vulnerable groups) and that its employees would get a better remuneration. It is legitimate to ask if Government got what the provision of subsidies was meant to achieve.

The answer to this question can be provided in different ways. All have in one way or the other to do with performance of the PNFP sub-sector and its responsiveness to the national priorities.

In the first place it should be obvious that criticizing the PNFP sub-sector for charging people for services provided is incorrect. With government offering a subsidy of 25% of the cost of producing service, financial viability has to be achieved through additional measures to ensure the continuity of the PNFP health units. As no other avenues exist it is imperative, for the PNFP sub-sector, to charge fees. It is simply a necessity of life. It is simply a necessity of life.

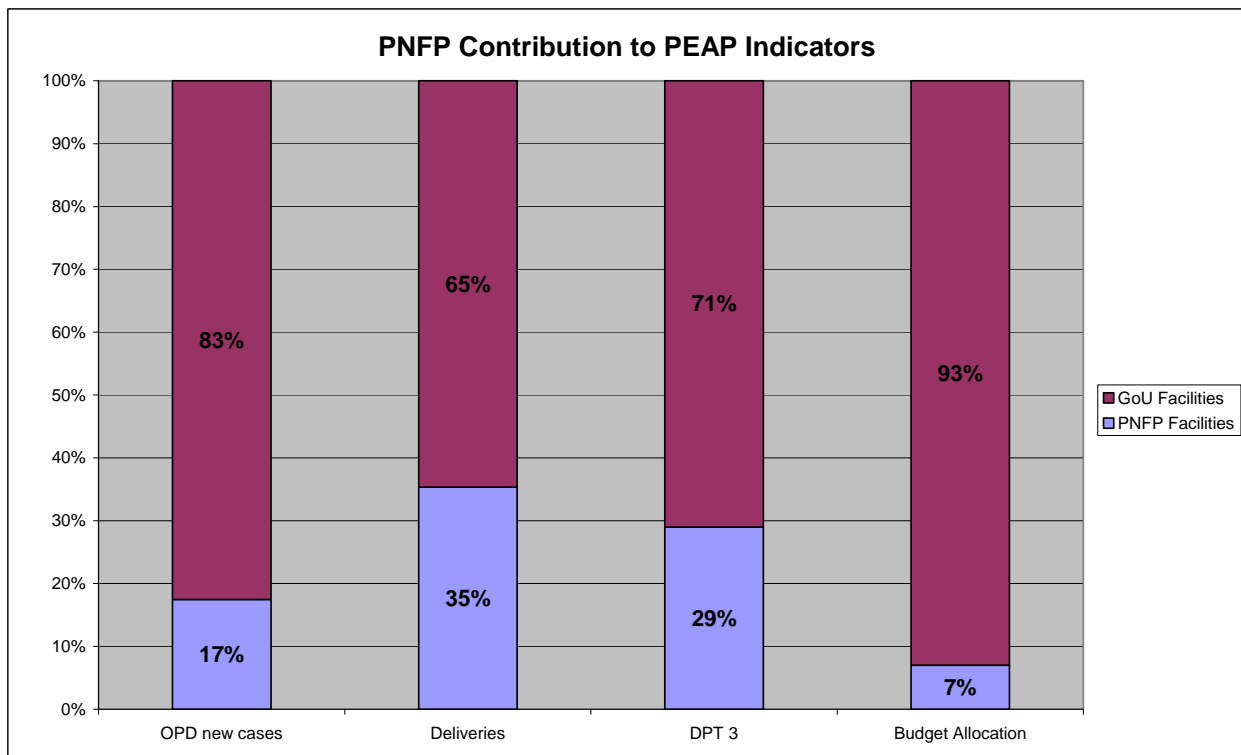
It is more interesting and sensible to ask whether government and people get a good bargain from the investment made.

### IIIa: Is the PNFP sub-sector contributing to the achievements of the PEAP health indicators? Is this contribution proportionate to the investment of Government?

In 2005/6 Government invested 7% of its budget in subsidies to the PNFP. In return she got a much larger contribution to the 3 key health indicators of PEAP, namely OPD new cases, DPT3 coverage and deliveries in health units.

For 7% of monetary investment Government got 17% of all OPD cases seen, 35% of all deliveries, 29% of all DPT3 doses. This means that Government got an incredibly good bargain (value for money) for its shilling given to the PNFP. In facts it reaps more benefits than those it paid for – Fig. 12.

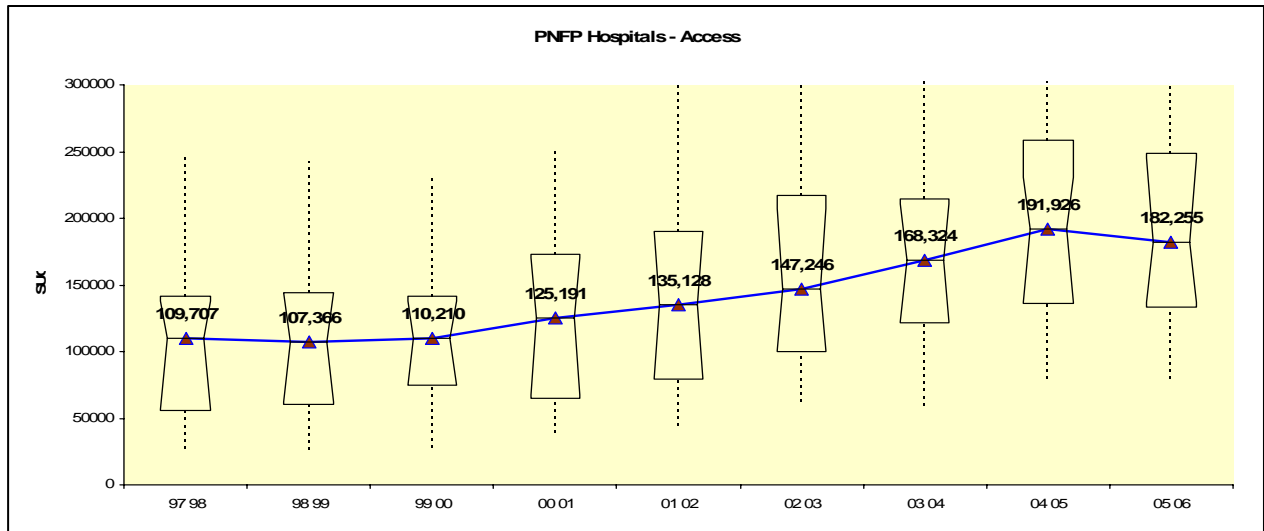
Figure 12: PNFP contribution to the PEAP indicators



### IIIb: Has the PNFP served more people?

Both hospitals and lower level facilities have steadily registered increases in Standard Units of Output (SUO) which is a composite index of IP, OPD attendance, ANC, Immunization and deliveries. The median value of volume of activities (SUO) – a proxy for access - from sample of 27 hospitals (65% of PNFP hospitals), shows constantly increasing values until 2004/5. The slight drop in 2005/6 is undoubtedly a consequence of the reduced support from government – Fig. 13.

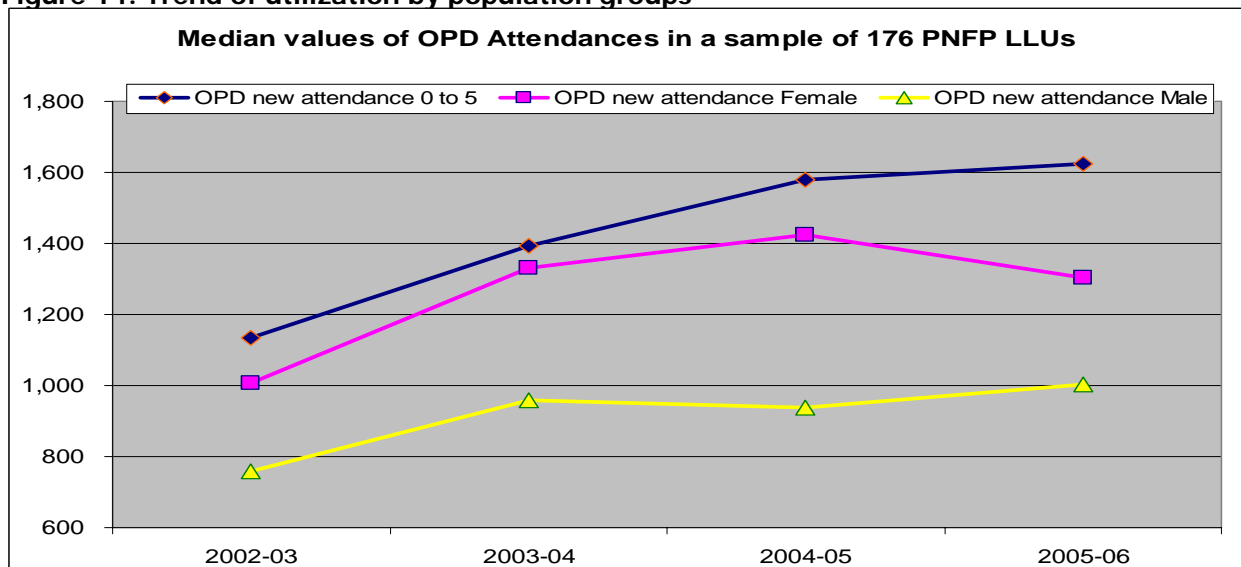
**Figure 13: Trend of Access (Standard Units of Output) in 65% of PNFP hospitals (median values)**



### IIIc: Is the PNFP utilization by vulnerable groups improving?

More and more women and children are using the facilities than before – Fig 14. This is both because of favorable changes in fee structures e.g. flattening of fees or reduction in absolute amounts, all leading to lowered fees indices, and improvement in quality of services. Unfortunately some of the positive trends observed earlier have started reversing, as explained earlier. Too much pressure on cost recovery from fees caused by the sudden surge of cost of employment and dwindling public subsidies is taking its toll.

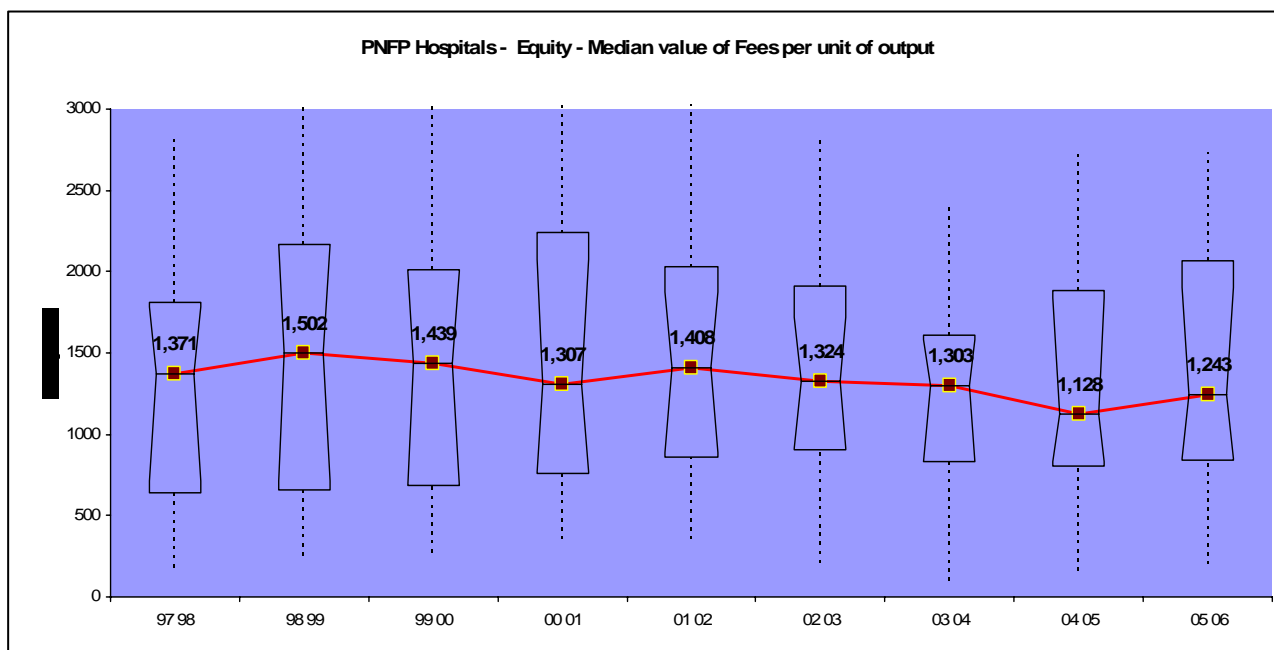
**Figure 14: Trend of utilization by population groups**



### III d: Are fees decreasing in PNFP facilities?

Data from 65% of PNFP hospitals show steady drop in fee per SUO over 8 years – Fig. 15. This has happened due to deliberate efforts of the PNFP facilities despite effects of inflation, rising cost of services reduced budget support. Drop in user fees makes the more vulnerable more able to afford services than before. A specific initiative aiming at reducing and flattening fees was undertaken with success in 2002/3, after a slight increase was noted. This restored the downward trend for fees, which lasted until last year. The mild increase of fees reflects the pressure on the sub-sector of the increased cost of service production and reduced government support. **It has to be noted though that people are paying now less than they were in 1997/98, even without adjustment for time discount. Indeed PNFP units are doing their level best to keep fees down: their pro-poor outlook cannot be seriously doubted by anybody who has a minimum of understanding of health economics.**

Figure 15: Trend of Equity (median fees per unit of output)



### III e: Is the PNFP sub-sector more efficient?

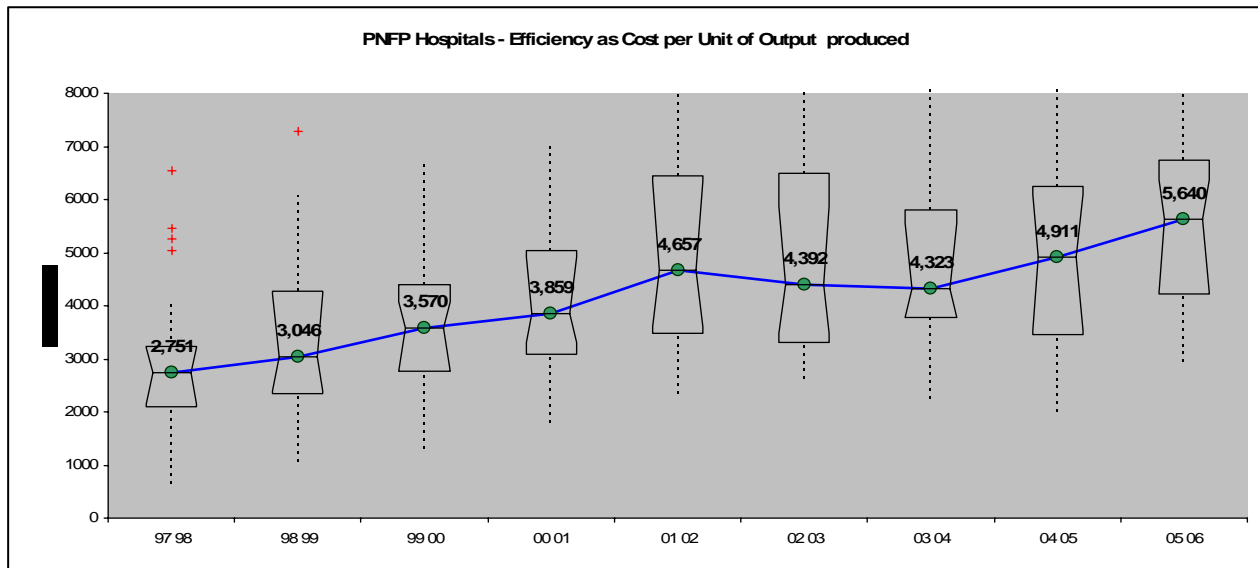
PNFP facilities have demonstrated their capacity to return value for money. Value for money is understood as *“a comparison of the input/costs against the volume of the outputs and a qualitative and quantitative judgment over the manner in which the resources involved have been utilized and managed”*. Efficiency here is looked at from the point of view of cost per unit of output (SUO) and as number of unit of output produced by each of the staff (productivity of staff). The PNFP facilities have registered continuous gains of efficiency both under the point of view of cost (with a reversal of trend in the last year) and productivity of staff – Fig. 16 and 17.



### Cost per SUO

During the initial years of budget support hospitals used the resources to improve on capacity to provide services. After reaching some stability resources have been used to subsidize fees of services so that for same cost more utilization hence more output was attracted and achieved. This has been less so in lower level facilities. However, with increasing cost of human resource, the cost per output unit (SUO) is increasing even in the health facilities as hospitals particularly increase salary levels in attempt to retain staffs.

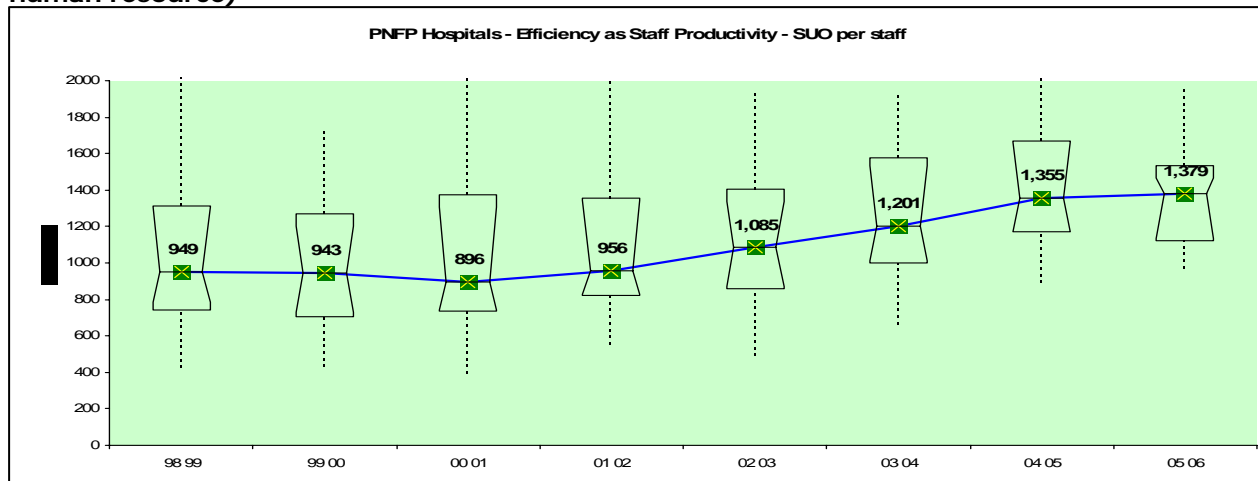
**Figure 16: Trend of Cost per SUO in 65% of PNFP hospitals**



### Staff productivity

Standard Unit of Output (SUO) produced per staff has steadily increased from 949 in 1998/09 to 1085 in 2002/03 to 1355 in 2004/05 even at a time when staff remuneration is much lower than in government and when budget support is falling. Not surprisingly, this efficiency gain showed a sign of flattening in 2005/06 as it rose minimally to 1379 only. This is because of the limit imposed on efficiency gains due to the increasing staff attrition.

**Figure 17: Trend of SUO produced per staff (upward trend showing efficiency in use of human resource)**



## IV. The human resources of the PNFP Sub-sector

### **IVa: What is the size of the PNFP workforce?**

The census of 2002 indicated that there were 59,680<sup>2</sup> people with either health occupation, or non-health occupation but working in the health sector (government, PNFP and private). This number included even those working in the private-for-profit sub-sector like private clinics, drug shops etc. But the ones working in the government and PNFP sub-sector are estimated at 30,000 – 35,000. The PNFP sub-sector employs about one third of the combined Government of Uganda and PNFP workforce, i.e. about 10,000 health workers.<sup>3</sup> (more details in Annex 1, Personnel)

### **IVb: How many are the civil servants deployed in the PNFP?**

Although it is difficult to get a precise datum, only a small proportion (about 4%)<sup>4</sup> of the 10,000 or so PNFP staff are civil servants, either deployed by the districts or posted by the Ministry of Health. The Ministry of Health “reserves” 118 posts for deployment to the PNFP sub-sector, mostly medical officers. During the past year the Ministry has made a deliberate effort to fill the numerous vacancies: in fact for a number of years only about 50% of the “reserved” post were filled. The Ministry of Public Service does not approve of this practice. While this practice is eagerly advocated for by the employed doctors themselves, it is not favored by the beneficiary units. It proves useful as a stop gap solution but for the managers of PNFP facilities, handling staff belonging to a different administration proves very difficult. Several times the PNFP sub-sector has asked Government to consider a different arrangement for human resources, whereby support from public funds could be used partly for wage expenditure and partly for non wage expenditure. This practice is not un-known and has illustrious precedents: it was in fact common practice in the fifties and sixties. Deployment of staff belonging to district administrations is occurring but the size of the phenomenon is yet unknown. It is a practice that has been disputed by the Inspector General of Government.

### **IVc: What is the trend in workforce volume and quality in the PNFP sub-sector?**

The sample of 27 PNFP (65%) hospitals indicates that over the last eight years there has been both an increase in the number of staff and in the percentage of qualified staff employed – Fig. 18. In the last four years the size of the workforce has been stagnating while the proportion of qualified personnel has been increasing slightly. In the attempt

---

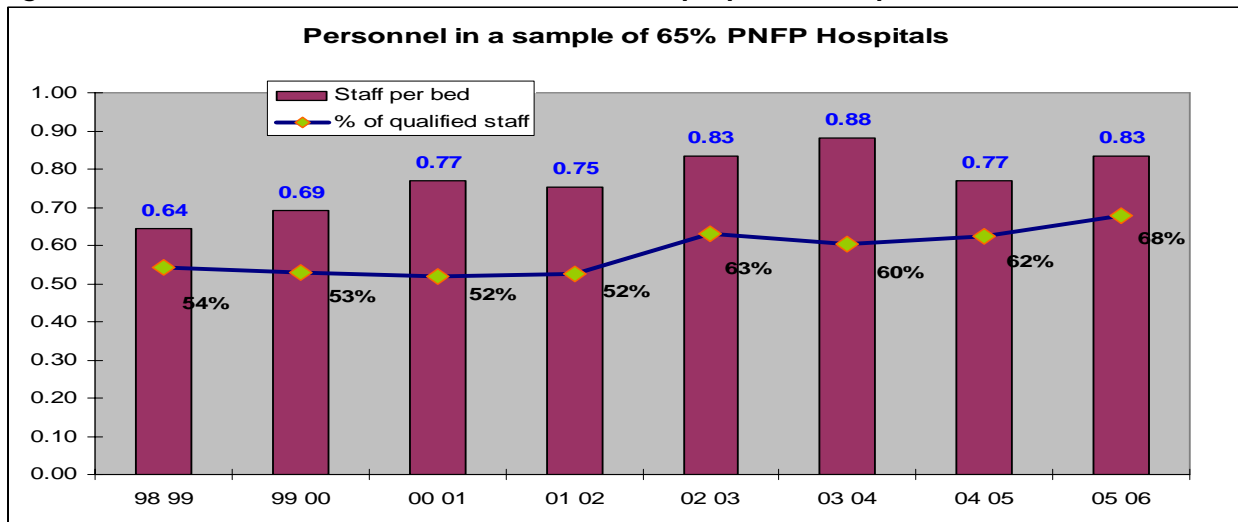
<sup>2</sup> MoH; Human Resource for Health Policy April 2006

<sup>3</sup> MoH; HSSP II

<sup>4</sup> A remarkable exception is Kilembe Mines Hospital. This is a hospital owned by a para-statal body (it belonged to Kilembe Mines – a para-statal enterprise) and managed by the Catholic Diocese of Kasese. It is for this reason considered a PNFP hospital. A very large proportion of staff are civil servants, a situation inherited from the previous arrangement.

of arriving at a better definition of the required establishment the PNFP pioneered the introduction of WISN. From the results of the WISN application it appears clear that the workforce of the PNFP units is undersized for the workload carried out.

**Figure 18: Trend in workforce volume (index) and proportion of qualified staff**



#### IVd: Are there staffing gaps in the PNFP?

According to the census carried out by MoH in preparation of HSSP II, the total HR gap in the sector (GoU and PNFP) was 4,909 units (4,582 medical / clinical and 327 others). Of these, PNFP gap represented a proportion of 54% (a gap of 1,974 of medical / clinical staff and 657 others). The gap exists for all considered cadres.

Since the census the number of staff (both total and per bed) has been further affected in the last two years due to the high levels of attrition especially of the key clinical staffs. Total attrition rate in the PNFP in 2005/06 was about 16%. At least 40% of these went to government. Another 34% did not state their destinations but it is likely most of these also joined government services. In fact their departure mainly coincided with massive recruitment by government. This is a result of the salary difference and active recruitment by government. 35% clearly left because of low pay. Another 26% left "in search of better opportunities" (which basically also means better pay). This means that at least 61% left because of low pay.

**Table 19: Attrition rates per selected staff category in sample of 65% PNFP Hospitals**

ATTRITION RATES SELECTED CADRES IN SAMPLE OF PNFP HOSPITALS			
	2003/04	2004/05	2005/06
Medical Officers	28%	21%	30%
Clinical Officers	22%	21%	36%
Enrolled Nurses	16%	17%	26%
Enrolled Midwives	15%	10%	34%
Registered Midwives	9%	11%	27%
Registered Nurses	5%	14%	11%
<b>Cumulative EN+EMW</b>			<b>29%</b>

Data from Lower Level Units are more difficult to get but the first evidence gathered is quite worrisome.

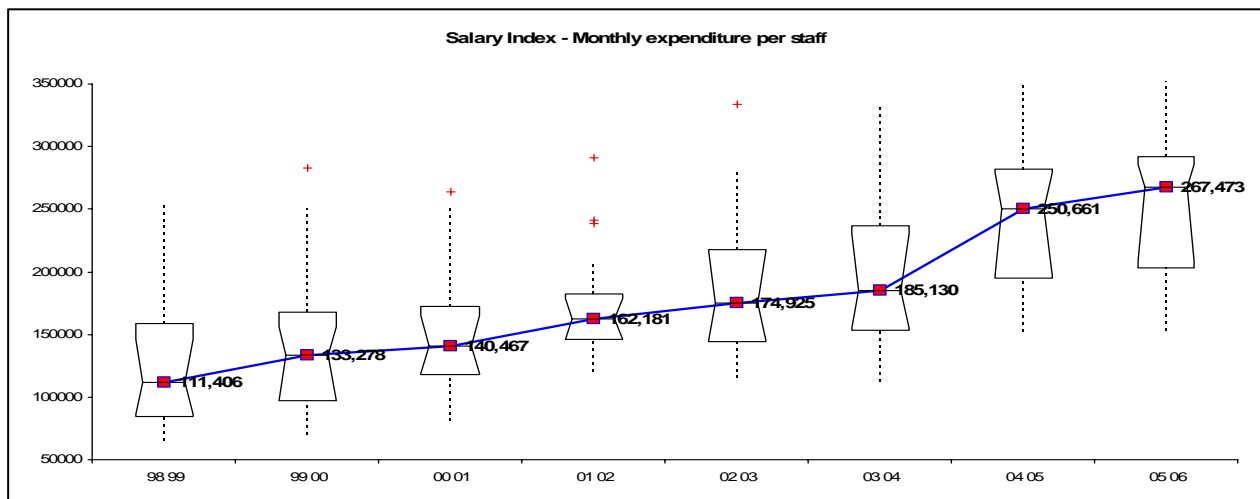
**Table 20: Attrition rates per selected staff category in sample of PNFP LLUs**

ATTRITION RATES OF SELECTED CADRES IN SAMPLE OF PNFP LLUs			
	2003/04	2004/05	2005/06
Clinical Officers			30%
Enrolled Nurses			45%
Enrolled Midwives			46%
<b>Cumulative EN+EMW</b>			<b>46%</b>

**IVe: Has the PNFP been able to increase the pay of its staff?**

Analytical data from a survey carried out in 2004 showed that, already at that time, employees of PNFP units were paid less than their colleagues in government. A remarkable exception was the pay of medical officers and consultants, who represented anyway only a tiny minority of the workforce. The increase of 2004/5 seriously exacerbated the difference of pay between PNFP staff and Government staff. In addition, government undertook major recruitment exercises, which have caused the high attrition reported. The PNFP facilities have made an effort at increasing their salaries over the years but have never been able to reach the levels paid by government – Fig. 21. Although the trend varies in individual hospitals, the overall trend as seen from the 65% of the network shows the steady growth as in the graph below. More recently a new competition front has been opened by the increasing number of NGOs and other organizations operating in the frame of projects for the fight against HIV/AIDS and other specific diseases. Sadly, quite often the investment made by PNFP facilities in the training of their personnel is rewarded with the loss of the very staff trained to “greener pastures”. This phenomenon, although not yet adequately documented, is on the increase.

**Figure 21: Trend in average wage per staff in 65% of PNFP hospitals**



#### **IVf: Has the PNFP recovered the staff lost?**

In an attempt to sustain service levels and quality, the PNFP facilities rapidly recruit new graduates from health training schools, only to lose them to government and other better paying organizations after a short period. In fact there has been no net reduction in the workforce but only a remarkably increased turnover. This datum, which may appear of little consequence, is instead a source of increasing concern to the PNFP sub-sector, whose strong point – and the reason of its resilience and perceived better quality and efficiency – is the organizational culture. It is very difficult to maintain a sound organizational culture in the midst of a continuously accelerated turnover of staff.

The PNFPs have – de facto - become like places for “industrial training” or “internship” for a good induction of new graduates destined to work in government and other organizations. What the PNFPs lose more is therefore the investment in training and experience than the absolute numbers. Data from the 65% of the PNFP facilities in 2005/06 showed that 30% of the staff lost had 3 or more years of experience, 47% had 1-3 years of experience, and only 23% had less than one year of experience.

### V. Conclusion

This brief paper, a “fact sheet”, has tried to present in few pages some basic evidences and facts that are deemed to be poorly known outside the network of the PNFP health facilities. It is not exhaustive and does not claim to be so. It is nonetheless quite informative. Everybody knows that church and faith based health units exist and operate, that they are a sizeable component of the system and that they aim at delivering health care out of a concern of equity and social justice. Quite often these units are known for being quite resilient and efficient. They have in fact been able to weather out difficult periods of the history of the Country without ever failing to provide their service to the people. More often than not, they are taken to be a “permanent feature” in the landscape of health service delivery, and indeed they are: it is a certain fact that quite a number of PNFP hospitals have reached its first century of life.

The contribution they give to the delivery of services has been documented. Informative notes about the structure of their financing and cost have been provided. The effort made at preserving equity has been demonstrated. The PNFP workforce size and the remuneration paid to the PNFP health workers have been illustrated. More than anything, this paper has shown how convenient it is for Government and the people of Uganda to have a privately owned and socially oriented health sector. The PNFP has a serious intention of continuing to be a permanent feature in the health system of the Country; nonetheless, the careful reader of these notes has certainly not failed to identify the signs of an on ongoing crisis that can be averted only if major and bold policy decisions are taken and enacted. This paper intends to offer the basis for such bold decision making.



## **The PNFP Health sector<sup>5</sup> in Uganda**

### **Historical Background**

The PNFP health sector<sup>6</sup> has a long history in Uganda<sup>7</sup> and has always had as prime concern the provision of services to the poor. Many mission statements<sup>8</sup> 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 services (thanks to the solidarity of sister Churches and denominations) at subsidized price for the people. It is also better organized through coordinating Bodies<sup>9</sup>.

Towards the middle of last century the (by then) colonial Government recognized the important social role exercised by this sector, deeply rooted in the rural environment, and decided to provide public subsidies to the sector. At that time the first coordinating agencies (Umbrella Organisation – the Bureaus) were established: UPMB in 1955 and UCMB in 1956.

These arrangements and co-operation lasted until the middle of the seventies, when the progressive weakening of the public administration lead to the cessation of public subsidies.

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”<sup>10</sup> developed during the emergency by this sub-sector have started showing their limitations in the middle of the nineties: at that time the Bureaus declared that the sub-sector was finding

---

<sup>5</sup> The PNFP health sector mentioned in this context is the Facility Based PNFP health sector, i.e. the sector constituted by hospitals and units of lower level. The PNFP health sector is also encompassing NGOs of various size and background that do not own health facilities.

<sup>6</sup> Most PNFP units belong to different religious denominations: Catholic, Protestant and Muslim denominations constitute about 80% of the PNFP health facilities.

<sup>7</sup> The first health facilities were established towards the end of the 19th Century.

<sup>8</sup> 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*”.

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

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

it progressively difficult to cope with the increasing cost of service production<sup>11</sup> and with the need to preserve access for the poor.

### **The Organizational set-up of the Sector**

The PNFP health sector is constituted by autonomous institutions (hospitals and lower level units). For religious-based institutions, the legal ownership and existence is by and large linked to the Trustees of the respective denominations at local level (dioceses for Christian denominations or districts for other denominations).

Governance is secured by Boards appointed by the legal owner which secure participation of various stakeholders including public administrators and local communities. The day to day running is entrusted to management committees, mostly composed by employees (with a variable degree of participation of the population in lower level units). The organizational and legal set-up of community based units and NGOs is very variable.

In summary, PNFP health facilities:

- Are private organisations operating under the guidance of a written charter
- Do not distribute surplus to their owners or directors.
- Are self governing organisations equipped with structures to control their own activities.
- Have substantial capital/infrastructural investment in static health units (“facility”)
- Have paid staff
- Have some meaningful voluntary component such as voluntary labour, management and income, provisions for subsidy of fees.

### **Size of the sector**

#### **Infrastructure**

The PNFP health sector constitutes a sizeable proportion of the Country health infrastructure.

#### **Number of health facilities by level and ownership in Uganda**

Level	Gov.t	PNFP	PFP	Total
Hospitals	56	44	4	104
HC4	143	8	3	154
HC3	650	147*	12	809
HC2	845	362	262	1469
Total	1694	558	282	2536
HT Schools	8	19		27

Most PNFP health facilities are found in rural environment (85%)<sup>12</sup>

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

<sup>12</sup> MoH, Facility Based PNFP providers: a quantitative survey, Nov 2001.



## Personnel

The size of the workforce employed by PNFP facilities is large. Although information is not always consistent, the most recent data would suggest that 33% of the workforce contributing to the health sector plan is employed by the PNFP facilities.

Deployment of civil servants to the PNFP sector occurs but is limited, by and large, to doctors. An analysis of RCC (UCMB) network (excluding Kilembe Mines hospital<sup>13</sup>) shows that in 2005-06 only about 4 % of the staff had been posted by government. With Kilembe hospital excluded, there were 111 government posted staffs in 24 hospitals. 39% of the postings were posted by Ministry of health and the rest by respective local governments. Doctors formed the bulk (43%) of civil servants posted to the RCC hospitals, followed by nurses / midwives (25%) then paramedics (10%). 79% of the doctors were posted by Ministry of Health and the rest largely by Local governments. On the contrary, Ministry of Health was the source of only 12% of the other cadres of posted civil servants while local governments accounted for 88%. In the UPMB network out of 3,630 by June 2007 there were 35 medical officers (9.2% of all staff) posted by government. UMMB had 8 staff (6 doctors, 1 Clinical Officer and 1 other) out of 611 health workers (1.7%) of the network being government posted. In most instances the posted staff, especially the doctors, receive both their government pay and a variable top up from the PNFP employer. In some ways, considering also the fact that PNFP (hospitals) are quite often located in rural and unattractive environment, this practice constitutes a "de facto" hardship allowance<sup>14</sup> but constitutes "special treatment" for civil servants who already receive salaries higher than counter parts directly employed by the PNFPs. The other cadres are, however, generally more poorly paid compared to their colleagues in government.

In the second half of 2006/07 government once again made central recruitment of doctors for posting to PNFPs. Most of the doctors recruited were already working in the PNFP facilities. But the government also continues to recruit out of PNFPs into government facilities.

While the PNFPs are grateful for the gesture of support shown by MoH, posting of civil servants to PNFP facilities is not a first choice as it carries with it a number of problems some of which eventually relate to causes of the increasing attrition from PNFP facilities. A more logical support that all parties should preferably work towards is to support the PNFPs to hire and manage their own staffs as part of a wider harmonization of human resource management between government and the PNFP sub-sector. These together will positively contribute to improving staff stability both in government and PNFP.

---

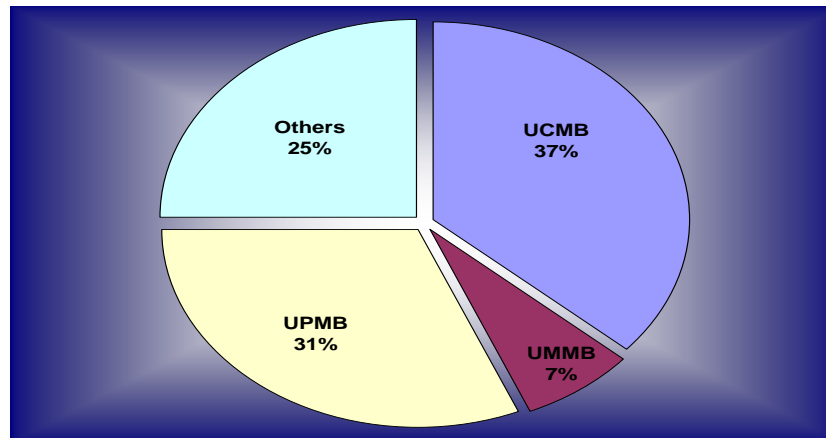
<sup>13</sup> Kilembe hospital has been excluded from this analysis because it is basically a government hospital managed by the Catholic Church and so almost all the staffs are government staffs.

<sup>14</sup> On the other hand, this practice has also been the historical cause of higher pays for doctors in PNFP hospitals: the need of preserving harmony among colleagues working in the same environment but belonging to different administrations has forced the PNFP to level the pay of its privately employed doctors on that of the cumulative amount accrued for civil servants.

## Coordination and networking of the sub-sector

The coordination of the PNFP facilities occurs through their established umbrella organisations (the Bureaus).

### Proportion of PNFP facilities (both hospitals and lower level facilities combined) by coordinating organizations<sup>15</sup>



Three years ago 41% of the PNFP facilities were coordinated by UCMB, 30% by UPMB, 7% by UMMB while the others were attached to other non-Bureaus organisations or not attached to any. Now the proportion coordinated by UMMB remains 7% while that coordinated by UCMB and UPMB have reduced to 37% and 31% respectively because of the increasing number of NGO facilities that MoH registers onto the list of PNFP.

It has to be noted that the Bureaus do not have jurisdiction over their respectively affiliated units. They can influence decision making processes in the affiliated units on the basis of their perceived usefulness (the services and advantages they are able to provide to the affiliated units). In this sense, the Bureaus need to be seen as brokers and catalysts more than real co-ordinating agencies in the strong sense of this word (see box).

In the past, the Bureaus were also the conduit of public subsidies to the affiliated units. When public subsidies to PNFP facilities were introduced in 1997/98, the Bureaus, taking stock of the changed (decentralized) set-up of the public administration, rejected the option of administering and disbursing them<sup>16</sup>. This conscious choice means also that the Bureaus have fully accepted the dynamic of civil society organizations. The Bureaus

<sup>15</sup> Computed from the list of “PNFP” facilities provided PHC CG by MoH in 2006/07.

<sup>16</sup> The acceptance of this administrative function would have provided the Bureaus with a larger say on the decision making processes of units and would have solved the problem of their (the Bureaus’) financing. In the past the Bureaus were allowed to levy 4% on the disbursed amount as administrative fee. On the other hand, this option would have created a parallel accountability line to that foreseen by decentralization.

utilize co-ordinating structures at local level (the Diocesan health co-ordinations for the Christian denominations) to enhance their functions.<sup>17</sup>

### **Finances of the PNFP sub-sector (see following table)**

The recurrent budget of the PNFP sector has apparently been growing very fast in the last 8 years (about 15-20% per year). Perhaps this fast growth is partly explained by the increased capacity of the sector to quantify and reflect in its budget resources in kind that in the past would not appear in the chart of accounts. Government and donors' inputs to the recurrent budget have grown much faster than user fees (a proof that whenever fees substitutes are identified, pressure on users is decreased). Capital investment (almost exclusively donor funded) has remained fairly constant.

On the expenditure side, employment cost, although growing very fast, is fairly stable at 40-45% of the entire budget.

Expenditure for medical supplies represents about 25% of the budget. The most interesting feature is that, in this picture of rapidly expanding budget, efficiency gains have been registered until last year.

#### ***In which way do the Bureaus exercise their functions of brokers/catalysts?***

*The absence of a direct jurisdiction of the Bureaus on the affiliated units is compensated by the provision of services in exchange for compliance with the priorities and points of action agreed at periodical meetings with the affiliated units, their managers and boards.*

*Examples of services offered are: advocacy and representation at national level, information, capacity building (under various forms), facilitation of procurement of medical supplies and drugs through the Joint Medical Stores, studies and research, technical assistance.*

*In exchange for these services affiliated units solicit an annual accreditation based on the achievement of pre-agreed criteria, harmonious with the National Policies and priorities. In this sense the Bureaus exercise a participatory form of regulation and accreditation, enhancing the limited regulatory capacity of Government.*

*From time to time the Bureaus launch specific initiatives to address critical areas of concern. In these ventures the Bureaus mobilize support from interested partners. Examples of the most important initiatives are:*

- *The launching of the Strategy for accelerated reduction of user fees in 2002*
- *The programs for strengthening Information, communication and data management*
- *The programs for training of managers of health services*
- *The equipment initiative for the improvement of maternal and child care*
- *The training of Health Units' Management Committees*

---

<sup>17</sup>With some degree of approximations it could be said that Dioceses are legally established entities of the Christian Churches holding the property titles of the physical assets of units and the ultimate liability. Most often than not Dioceses' administration encompass geographical areas covering more than one District. The effectiveness of diocesan co-ordinating structures vary from area to area and from denomination to denomination.

## Finances of the PNFP Sub-sector

<b>PNFP UNITS</b>	1998-99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
<b>INCOME</b>								
<i>Govt. Subsidies (money and drugs)</i>	3,850,432,415	6,281,977,547	7,841,001,881	10,747,239,112	17,148,336,487	18,242,380,344	20,970,000,011	19,458,282,653
<i>User Fees</i>	16,399,680,637	20,271,283,765	16,566,441,842	14,691,210,329	21,629,140,837	24,934,881,197	29,953,370,299	31,946,551,653
<i>Aid</i>	5,875,142,184	8,179,160,132	10,547,821,415	7,251,392,773	9,405,374,170	15,422,729,764	20,825,782,755	32,980,658,652
<b>TOTAL INCOME</b>	26,125,255,236	34,732,421,444	34,955,265,138	32,689,842,214	48,182,851,494	58,599,991,305	71,749,153,065	84,385,492,958
<b>RECURRENT EXPENDITURE</b>								
<i>Employment</i>	12,069,346,755	15,853,210,205	15,598,711,040	15,000,903,100	20,930,038,779	25,119,972,494	31,718,962,587	37,076,448,711
<i>Administration, property, utilities, transport</i>	5,327,213,993	7,468,510,363	7,484,094,936	5,849,235,541	8,750,807,264	10,398,126,464	11,225,162,644	13,566,068,764
<i>Supplies &amp; Services</i>	1,627,464,026	2,069,176,453	1,087,265,181	662,504,778	1,036,595,272	2,503,305,144	1,412,191,681	2,206,004,218
<i>Medical Supplies</i>	5,728,755,318	7,657,123,812	8,324,598,351	8,840,296,763	13,120,758,720	15,525,444,155	17,554,396,140	19,853,691,101
<i>PHC</i>	1,018,057,758	1,188,331,914	1,577,654,195	1,350,116,057	2,616,435,930	2,759,831,894	6,785,427,298	8,340,493,734
<i>Health training school</i>	354,417,588	496,068,687	882,941,309	986,785,974	1,728,165,131	2,293,223,251	3,053,012,715	3,342,786,430
<b>TOTAL REC. EXPENDITURE</b>	26,125,255,437	34,732,421,434	34,955,265,010	32,689,842,214	48,182,801,097	58,599,903,402	71,749,153,065	84,385,492,958
<b>CRR from fees</b>	63%	58%	47%	45%	45%	43%	42%	38%
<b>Capital investment</b>	8,092,409,948	9,201,865,162	9,797,961,236	6,470,256,369	14,259,298,423	11,654,343,119	7,947,242,460	6,371,724,324
<b>Employment cost rates</b>	46%	46%	45%	46%	43%	43%	44%	44%
<b>Medical Supplies cost rates</b>	22%	22%	24%	27%	27%	26%	24%	24%

## ***ANNEX 2: Milestones of PPPH and PNFP***

### **Public-Private Partnership and the PNFP health sector: milestones**

A collaboration between public and private health sector existed from the mid-fifties until the mid-seventies. In the period of turmoil the two sectors drifted apart. It is not until the middle of the nineties that a new momentum for collaboration and partnership is found. The milestones of the partnership between public sector and PNFP health sector can be summarized as follows:

#### **Remote past**

1954: The Frazer Commission recommends that public subsidies be introduced for the “voluntary health sector”

1955: The Umbrella Organisations for the two main Christian denominations are Gazetted under the names of Uganda Protestant and Uganda Catholic Medical Bureaus.

1986: The Health Policy Review Commission recommends that the collaboration between Public and Private providers be revived.

1993: the MoH White paper mentions the need of strengthening the collaboration with the private sector.

#### **Recent past**

February 1996: UPMB and UCMB submit a Memorandum to the Ministry of Health identifying their respective units as PNFP operating for social goals and denouncing an impending crisis of the sector. One PNFP hospital in a remote district documents the situation of impending insolvency and the consequences for the population of increased reliance on fees.

December 1996: the Minister of Health establishes a task force to study options and propose recommendations to Cabinet to justify subsidies to the PNFP sector.

June 1997: 800 M Ugx are earmarked in the GoU budget as subsidies to a group of Hospitals in poor districts.

1999: representatives of the PNFP sector participate in the launching of the SWAp at WHO Geneva.

1999: the National Health Policy declares that “Strengthening the collaboration and partnership between the public and private sectors in health’ is an important guiding principle of the National Health Policy”.

2000: Representatives of the Bureaus are members of the Health Policy Implementation Committee (now HPAC) and participate in the formulation of the Health Sector Strategic Plan.

2000: Launching of the HSSP. The HSSP reflects the policy option of 1999. *Referring to NGO health care providers it acknowledges the ongoing collaboration and states that “the plan envisages strengthening this collaboration through the development of service contracts and increasing subventions to the NGOs”.*

*In return the PNFP units agree to increase the scope of the service provided, improve the remuneration of their staff, reduce fees.*

*Since then subsidies have increased and extended to LLUs. Credit lines for Essential*

*Drugs have been opened at JMS for PNFP health units. All the outputs of the PNFP units reflect in the HSSP outputs and contribute to the outcomes. In every issue of the Health sector Performance report this contribution is accounted for.*

2000: a Desk for Public Private Partnership in health is established at the MoH, with support from the Italian Co-operation.

2001: during the April JRM the formulation of a Policy for Public-Private Partnership becomes an undertaking.

*The PPP working group formulates a draft policy for partnership and a draft is presented to the following October JRM. During 2002 and 2003 the draft is introduced to district stakeholders, enriched by their input, enlarged to address specific points for the non-facility based PNFP, for the Private Health Providers and for Traditional Practitioners. By the end of 2003 all the preliminary work is completed and the draft Policy for the PNFP (both facility and non-facility) health sector is presented at the Joint Review Mission. The cabinet decision of approval expected thereafter never occurs.*

2002: The Bureaus launch a strategy for accelerated reduction of user fees, based on preliminary studies on the effect of fees and their structure on utilization, and on pilot experiences.

*The results of the strategy are beyond expectation, keeping into account the fact that the strategy is launched at a moment when the subsidy increases start leveling. Yet the positive effects of such move, continue even after it is clear that GoU is unable to reward a “virtuous trend”.*

## **Present**

2004-2005: Under the pressure of a threatened strike, the MoH and GoU accept in principle to increase remuneration of civil servants. The Bureaus ask the Ministry to consider the negative effects that a unilateral increase coupled with the planned recruitment may have on the PNFP. They ask the Ministry to re-visit the frozen allocations. Between mid 2004 and mid 2005 the Bureaus, sometimes in collaboration with the PPP Desk at MoH, prepare a long series of documents giving the basic facts of the impending crisis. The Bureaus meet with the Hon Minister of Health in April 2005. The meeting produces no result: the budget 2005/6 does not award to the PNFP any increase, for the second year in a row. In October 2005 the need of addressing the imbalance of remuneration between civil servants and PNFP becomes an Undertaking n 1 of the XI JRM.

2006: the expected exodus of staff from PNFP occurs. At the TRM of April 2006, when it is clear that even the budget 2006/7 does not address the problem, the PNFP present a stern memorandum to MoH. The XII JRM retains the unachieved Undertaking for the year following. The PPP WG totally ceases to operate. It only meets once, to present the extension of the PPP policy to the traditional health sector. The data of FY 2005/6 show that the virtuous cycle triggered in 2002 with the launching of the strategy for accelerated fees reduction is spent. The first signs of a trend reversal appear.

2007: the Budget 2007/8, for the fourth year in a row, does not foresee any increase for the PNFP sector. Earlier on it had appeared that, should "additional money" materialize, the predicament of the PNFP sector would be kept into account. It would seem that new money was found (11 B Ugx) but that none of this is destined to the PNFP.