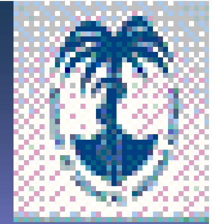


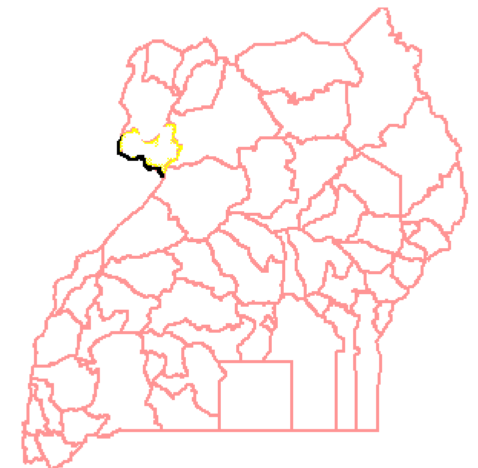
Geneva Health Forum

The private-Not-For-Profit Health Sector in Uganda

A life thread under threat

Dr. Sam Orochi Orach M.D.
Presented by Josefien van Olmen
Executive Secretary
Uganda Catholic Medical Bureau

April 19th – 22nd 2010



Outline of presentation

- Explain the “PNFP” concept in Uganda
- The growth of the PNFP and contribution to National Health System
- Strength and weaknesses of the PNFP
- Challenges /threats faced by the PNFP
- Conclusion

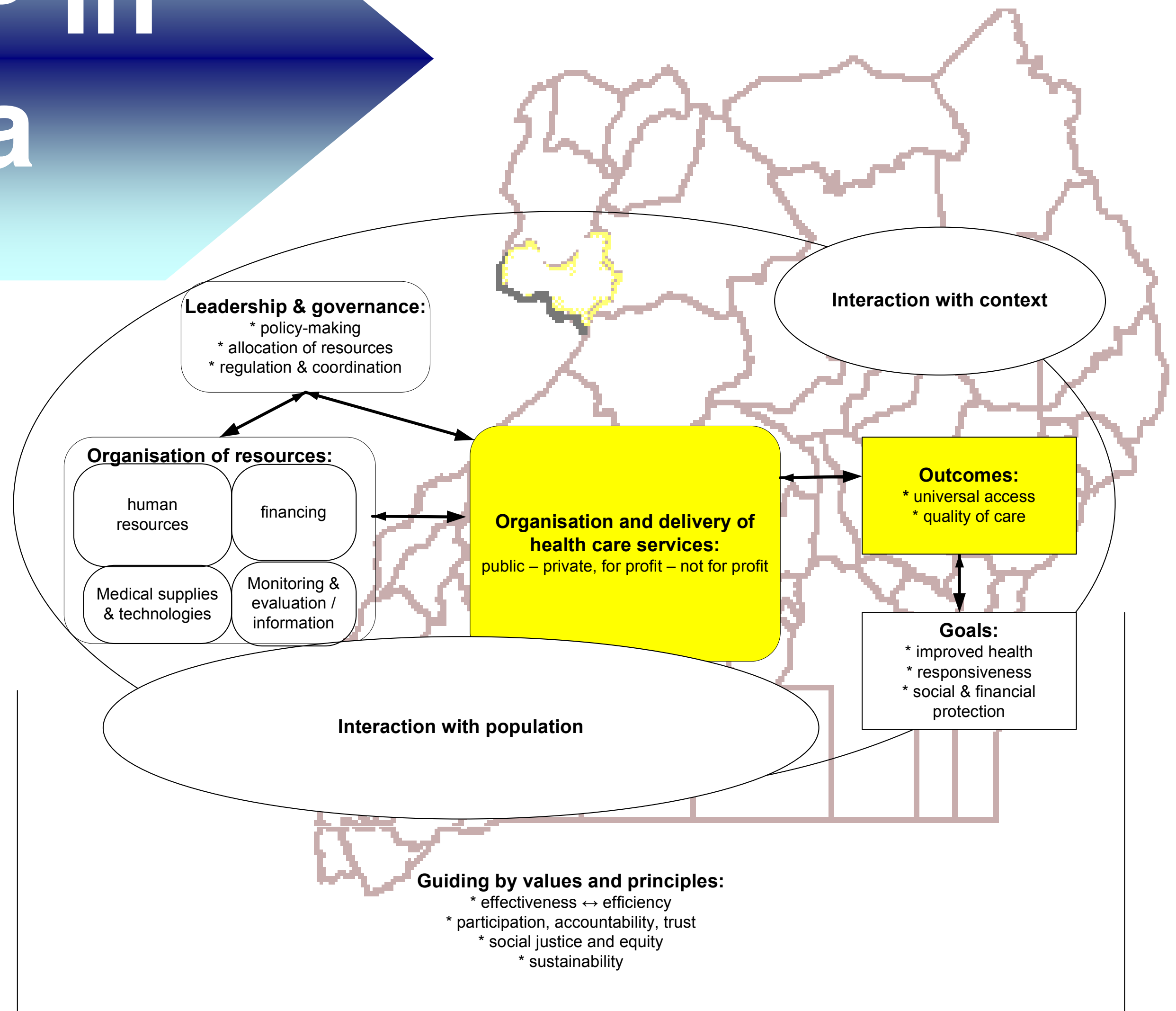
Who are the PNFP?

- Private ownership but serve the public
- Aim not to make profit
- Need money to meet cost of services
- Surplus is not distributed or shared by owners
  - Used to improve services
  - Or reserved for development that improve services

PNFP and Government

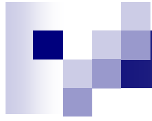
- Same goals and objectives
- Similar principles

The PNFP in Uganda



Two major categories of PNFP

- Facility based PNFP:
  - Largely faith based
  - Have a sizeable capital investment in place; i.e. Health Facilities
  - 75% are organized under national umbrella organizations: the 4 medical bureaus

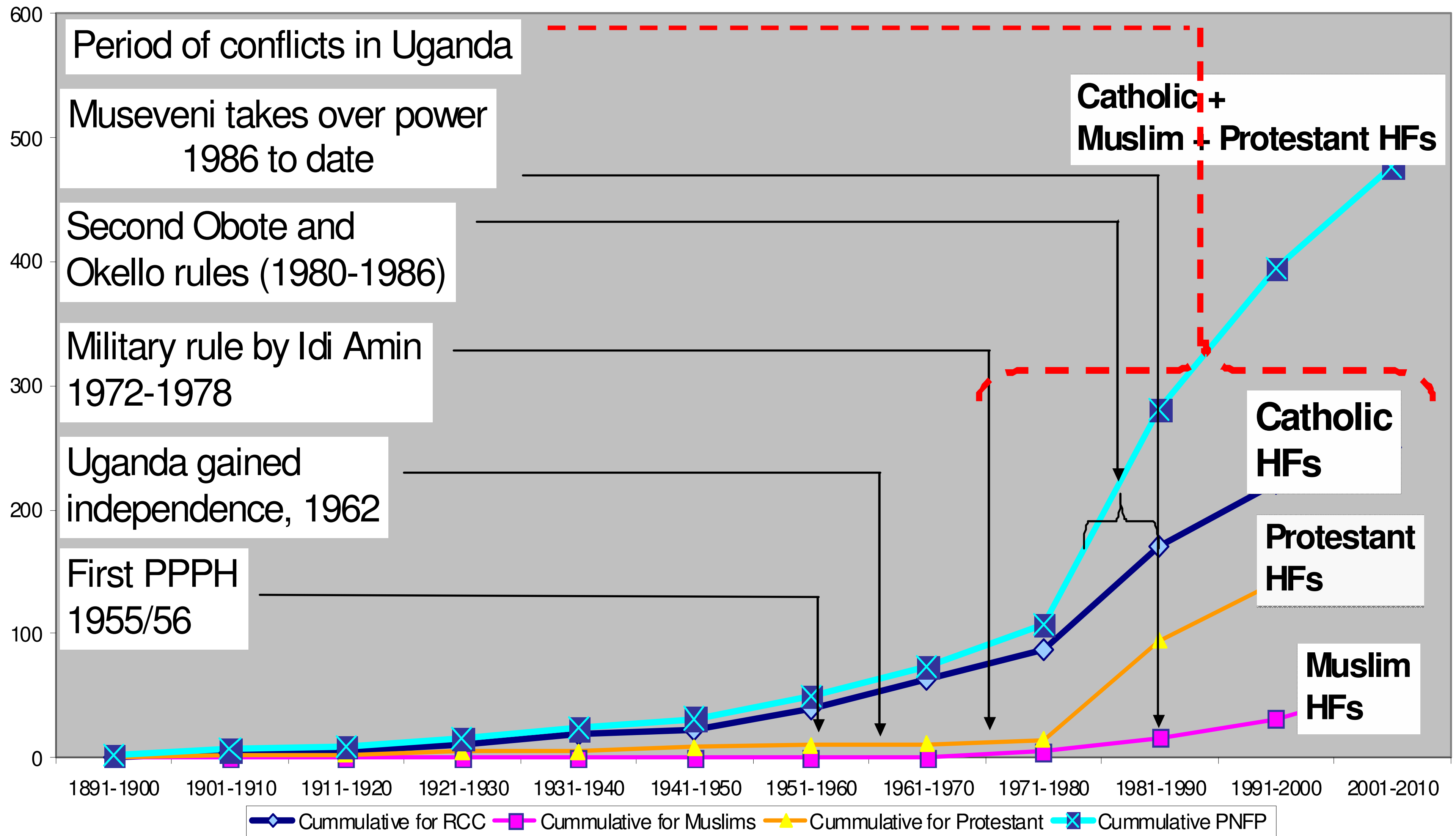


- Non facility based PNFPs:
  - Do not directly own or operate health facilities
  - Support/undertake health development activities in partnership with government
  - Include international, national and local NGOs/CBOs

PNFP Coordination structures

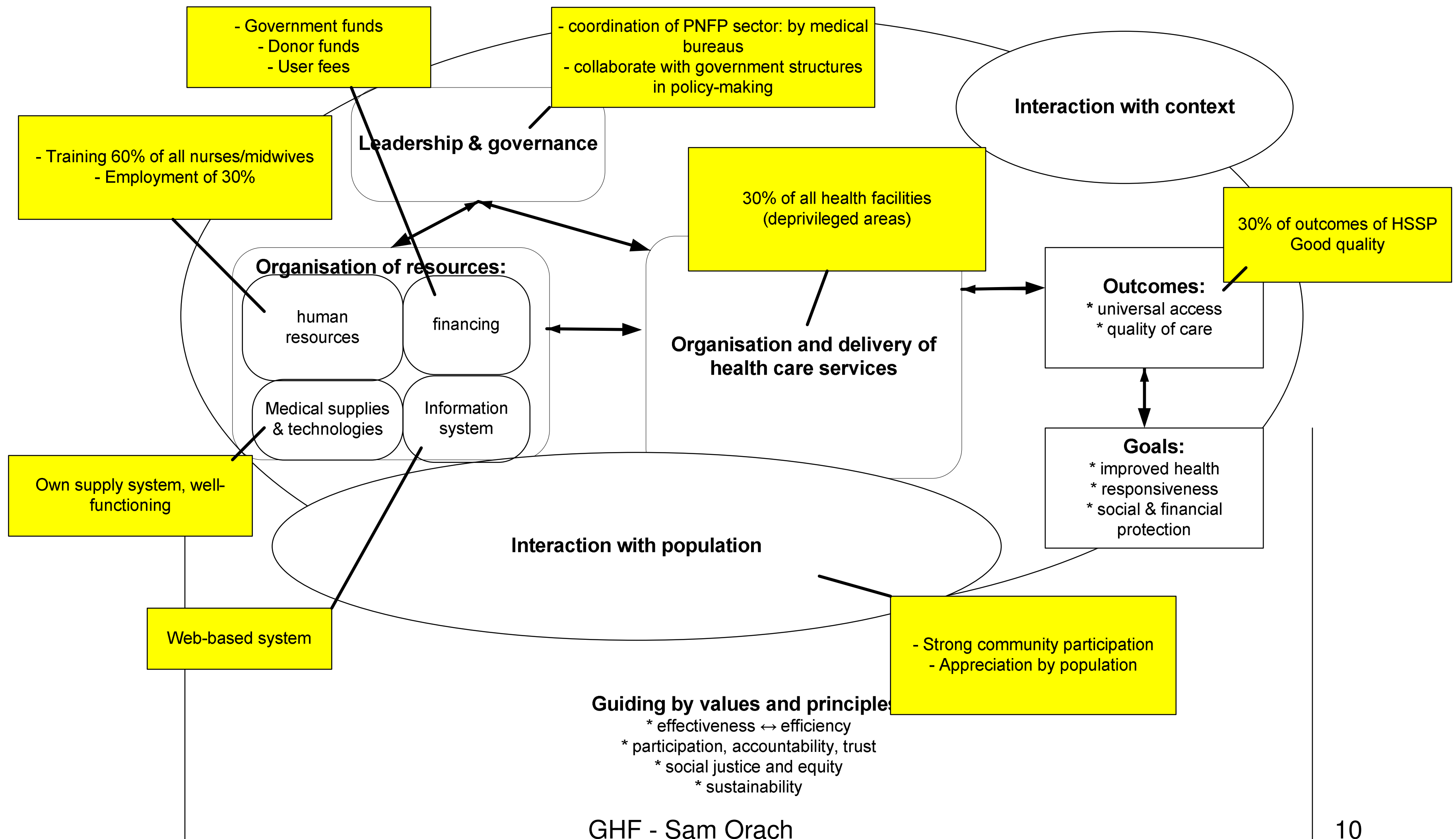
- Facility based PNFP mainly coordinated by the religious medical bureaus:
  - Uganda Catholic Medical Bureau(1956)
  - Uganda Protestant Medical Bureau (1957)
  - Uganda Muslim Medical Bureau(1998)
  - Uganda Orthodox medical bureau(2009)
- Non Facility based PNFP:
  - Ad hoc coordination structures
  - Disease specific coordination
  - Uganda health NGO network?

Trend of growth of Catholic, Protestant and Muslim founded health facilities in Uganda



Sam Orach - based on data from UCMB, UPMB and UMMB, May 2009

PNFP Contribution to the Health System

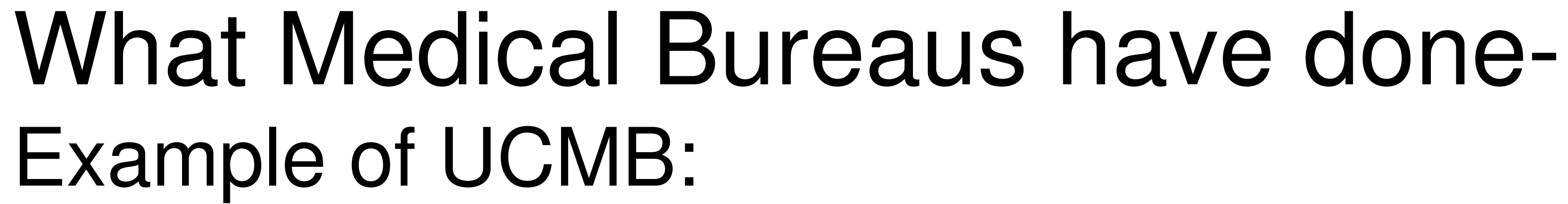


PNFP Contribution to the Health Sector

- Policy development (*Health Policy Advisory Committee and its working groups*)
- Health service delivery
- Financing
- Community participation
- Human resources:
  - Over 11,000 *(govt ≈ 26,000)*
  - Training / Development

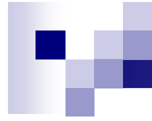
Key strengths of PNFPs

- Principle of subsidiarity works well with decentralisation policy
- Governance is closer to management – faster response
- Clearer focus on health systems strengthening
- FB-PNFP have strong coordination structures (national and sub-national)
- Technical level good in advocacy
- Services very much appreciated by community



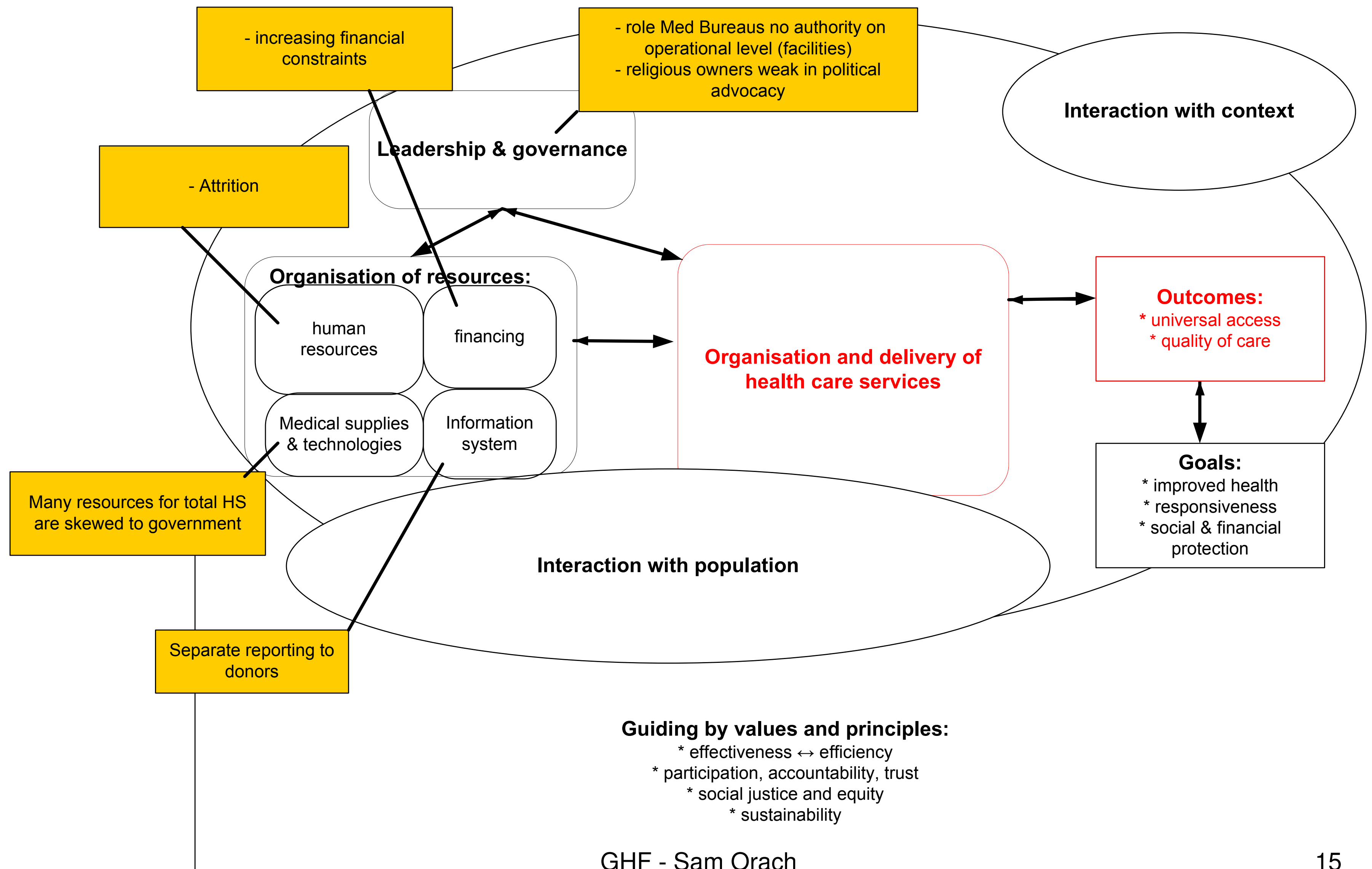
What Medical Bureaus have done- Example of UCMB:

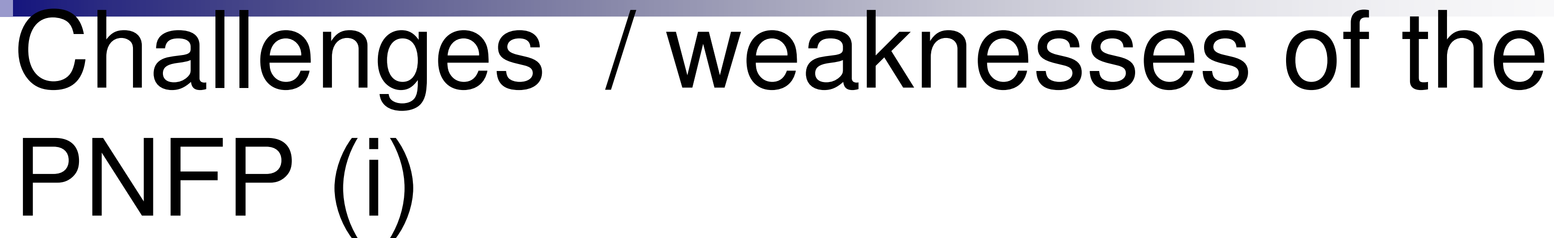
- Training in good Corporate Governance
- Development of Governance and Management tools
  - Assessing utilisation of tools
- Accreditation system – *Non in government*
  - Criteria include fulfilling key governance and management processes
- Strengthening downward and upward accountability
  - Mandatory report to Boards and Trustees
  - Encourage Annual Health Assemblies at district / sub-district level
  - Mandatory external audit



- Functionality of HMIS incl. web-based HMIS in FB-PNFP
  - Better than that of government
- Strengthening patients safety practices as a way of improving efficiency in resource utilisation
- Trying to improve HR retention
  - Improving HR management
  - Use of HR MIS to improve HR management
  - Training / scholarship
  - Non-monetary benefits
- Advocacy for harmonisation of HR management and Terms and Conditions of employment with government

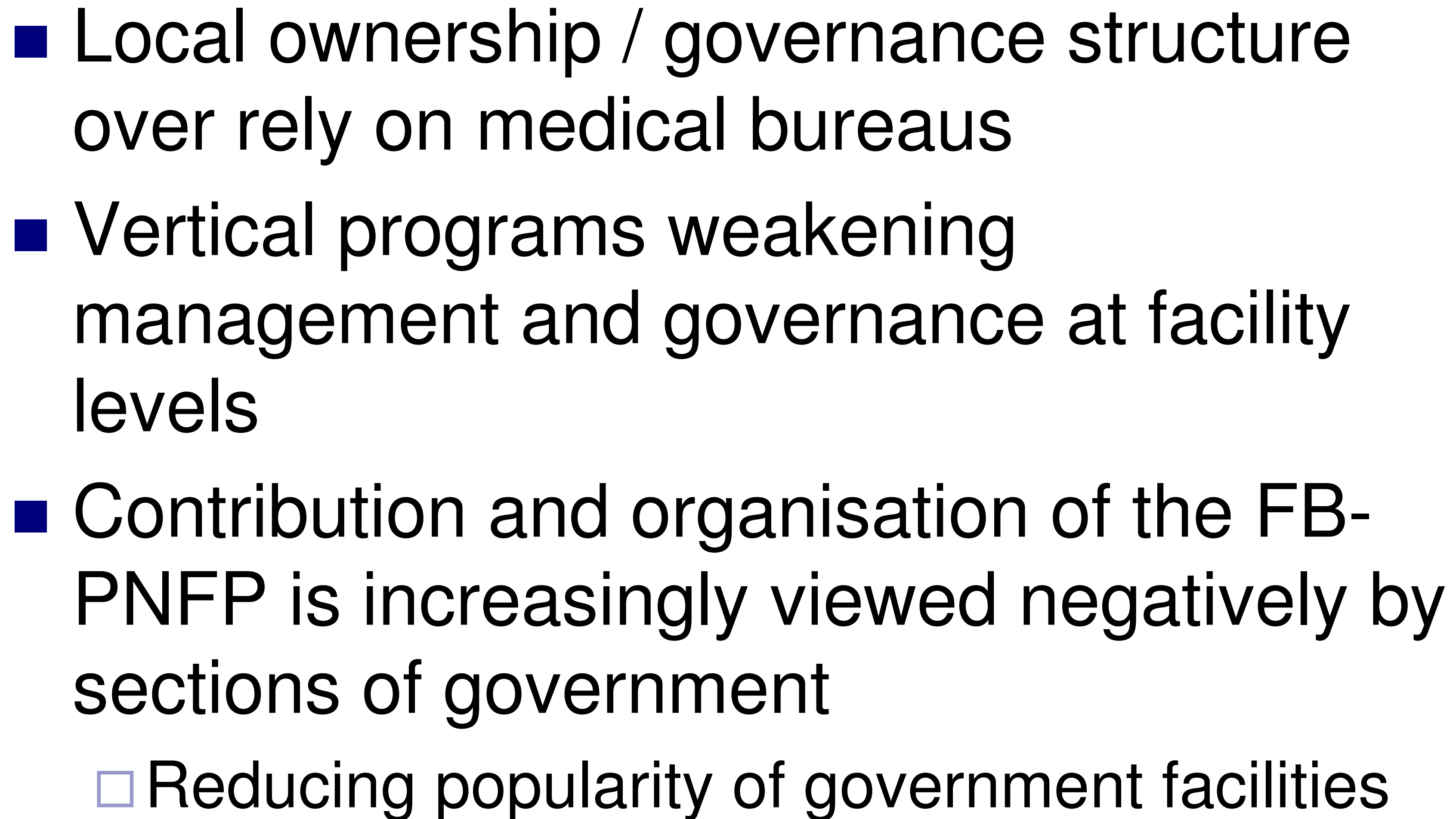
The strains on the PNFP subsector





Challenges / weaknesses of the PNFP (i)

- Medical bureaus have no direct authority on diocesan health departments and facilities
  - Require a lot of carrot-and-sticks
- Increasing financial constrain amidst increasing demand and
  - Increasing unit cost of service output
- Resources received for the nation mainly used to *"strengthen"* government system

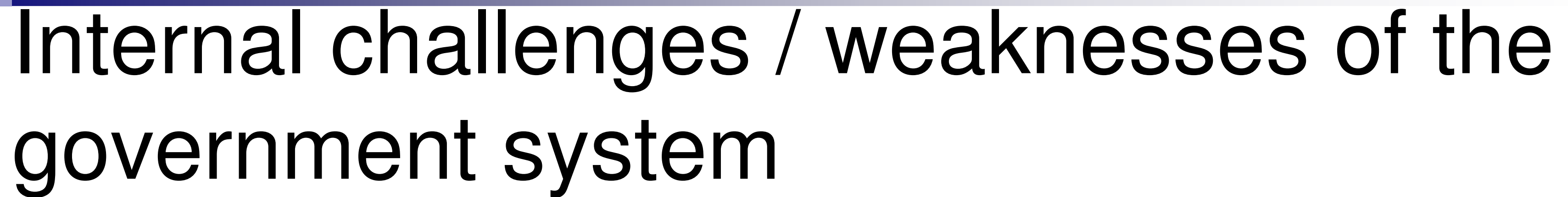

Local ownership / governance structure over rely on medical bureaus
Vertical programs weakening management and governance at facility levels
Contribution and organisation of the FB-PNFP is increasingly viewed negatively by sections of government
Reducing popularity of government facilities

Challenges / weaknesses of the PNFP (ii)

- Non-FB PNFP
  - Very diverse and weak coordination
  - Absent central collation of information
  - Mainly reporting to funding agencies / donors
    - Hence largely invisible yet big contribution
    - (*The "invisible visibles"*)

Strength of government system

- Large resource base
  - Favoured by bilateral and multilateral donors
  - Difficult to close shop
- Direct bureaucratic authority on districts and health facilities



Internal challenges / weaknesses of the government system

- Weak leadership
- Weak oversight
- No clear focus on strengthening Corporate governance and management
- Very wide and increasing accusation of massive corruption and mismanagement
- Weak resource management esp. HR & FR
  - Very unproductive workforce - absenteeism around 40% (*World Bank 2008*)

Conclusion

- Uganda is a good example of how:
  - PNFP can complement the National Health System
  - Multiplicity of players is important especially in states of instabilities
- But the good work of the PNFP is now its undoing
  - The effort to redeem government facility is leading to negative attitude towards PNFP
    - Reduction of budget support
- The government system can not be strengthened by simply weakening the PNFP
- Govt policies to reduce support to PNFP is counterproductive to the nation