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## SPECIAL REPORT



PRO-POOR HEALTH SERVICES:  
THE CATHOLIC HEALTH  
NETWORK IN UGANDA

**SPECIAL REPORT:**  
Client Power: Making  
Services Work for the Poor

## Pro-Poor Health Services: The Catholic Health Network in Uganda

*By Daniele Giusti, Peter Lochoro, John Odaga, and Everd Maniple*

Most private not-for-profit (PNFP) health providers in Uganda are faith-based. They account for a sizeable proportion of the health services delivered in the country (Hutchinson 2001) and have as their prime concern the provision of services to the poor. During the last century this sector expanded substantially, especially in rural areas, providing services at subsidized prices, thanks to the solidarity of sister churches and denominations. These providers are coordinated through umbrella

organizations, such as the Catholic, Protestant, and Muslim Medical Bureaus and the Uganda Community Based Health Care Association.

During the era of socio-political upheaval and economic decline in the 1970s and 1980s, the PNFP sector continued to operate using several coping mechanisms aiming at cost containment—such as underpayment of personnel, reliance on unqualified staff, increasing working hours, and disregard for depreciation of capital assets and their maintenance—on the one hand, and at increasing reliance on support from external charities, on the other hand.

By mid-1990s both approaches showed their limitations. Attempts to restore physical and human capital occurred at the time when new service standards were introduced and when the civil service reform was increasing public sector salaries, creating considerable pressure on the PNFP sector. Furthermore, the AIDS crisis became apparent, and inputs from private charities started decreasing. The only possible option was a heavier reliance on user fees. But this caused a rapid decrease of utilization, accompanied by efficiency losses.

This article documents the experiences of the Catholic health network in Uganda and its umbrella organization, the Uganda Catholic Medical Bureau (UCMB) in making health services work for poor people. It demonstrates how the pro-poor ethos—derived from a longstanding tradition and the mission of “healing by treating and preventing diseases, with a preferential option for the less privileged”—supported by “soft” regulation and technical assistance from the umbrella organization can induce a process of change in a network of providers.

### **Preventing a crisis**

By mid-1990s many providers in the PNFP health sector were no longer able to cope with the increasing cost of service production. The UCMB estimated that, on average, the cost of producing one unit of output was increasing by 20 percent per year. Given the importance of the PNFP sector, a major crisis in health care countrywide was to be expected. A particular concern was that higher fees reduced access for the most vulnerable groups: women, children, and the poor. A clear sign of the crisis was the decreasing volume of services delivered, expressed in standard units of output relative to outpatients (*SUO op*). Data prior to 1997/98 showed a steep decline of various activity indicators; in several hospitals utilization was in a free fall. Also recognizing the signs of a crisis, the government agreed to support the PNFP sector by grants disbursed directly to individual providers (hospitals and health centers). Since then, subsidies have increased from about 5 percent of the operational cost of the sector to about 35 percent. Today the sector relies on user fees for about half of its operational costs. This intervention—a private-public partnership—was able to prevent a fatal crisis, reduce reliance on user fees, and, as a result, increase utilization.

### **Developing monitoring tools**

The UCMB was aware of the need to monitor closely developments in the delicate phase of transition. It was also aware that it needed to account for the public subsidies. For these reasons the Bureau undertook, since 1997/98, a systematic data collection effort from the affiliated hospitals, covering both inputs and outputs. The analysis of these data has permitted the observation of trends in critical

parameters (listed below). Since 2000/01 each hospital has received an annual feedback report, containing information on its own performance compared to other hospitals for each of the selected indicators. The aim of the feedback report is to help the hospital management take a critical look at their performance and compare it to that of the whole sub-sector, its peer group, and outliers. In the absence of realistic “gold standards” of performance, this approach stimulates comparisons and triggers processes of steered change in an environment long dominated by crisis management.

At the end of 2001/02, the following picture could be detected from the performance indicators:

- The volume of service outputs, measured by standard units of output relative to outpatients (*SUO op*), was increasing steadily, but so was the cost of the services produced. *SUO op* is a composite activity index weighted by the cost of each activity.
- The productivity of staff (*SUO op* per staff), remained stable, and in some cases showed a decline.
- Fees (per *SUO op*), which had been decreasing for three years, had started increasing again.

The interpretation that the UCMB gave to these observations was that the expansion of service volume had not been accompanied by the necessary efficiency gains, and that access by the poor was still a problem.

### **Accelerated reduction of user fees**

An earlier study commissioned by the UCMB had revealed that a small group of hospitals in the network was operating at higher efficiency levels (Amoné and others, 2000). A common factor for them was that they had introduced and maintained lower and flat fees for selected target groups (children, mothers, and female patients). In 2000 a severely underutilized hospital that had reached the verge of closure, was encouraged—on the basis of the evidence gathered through the study—to flatten and lower fees for children and pregnant women. The only support the UCMB was able to provide was a moderate degree of managerial assistance and the guarantee that financial losses, if occurring, would have been met through external aid. The experience of this hospital was a shocking revelation. In a few months patients started flocking back, without causing any financial shortfall (Santini, 2002).

Given this experience, the Bureau launched in 2002 a “strategy for accelerated reduction of user fees,” proposing it to all PNFP hospitals. In a nutshell, hospitals were asked to:

- Pay a closer look at fees actually paid by patients, with a systematic approach (that is, a baseline survey and follow-up);
- Reduce and/or flatten fees for children, mothers, and women; and
- Monitor utilization and provide this information to the UCMB for aggregation across hospitals.

### **Results**

In less than one year from the consensus reached among all affiliated health units in the Catholic health network, the following results could be documented:

- The annual increment of outputs has been the highest registered in the last 5 years
- For the first time in 5 years unit cost has decreased ([Figure 1](#))
- Productivity of staff has increased in the last year ([Figure 2](#))
- Fees per unit of output, which had started increasing again in 2001/02, have decreased and are at the lowest value in 5 years ( [Figure 3](#)).

Results are all the more remarkable if one considers that, contrary to the above pilot hospital, the UCMB was not able to offer any guarantee that financial shortfall could be met by external aid. Hospitals had to carry the risk themselves and financial subsidies from government, which had been growing rapidly in the previous years, were leveling off.

These results point to the fact that intrinsic motivation, or the “ethos” of these hospitals, matters. A similar inference was made for the PNFP lower level units by a comparative study of PNFP, private for-profit, and public health units in Uganda (Reinikka and Svensson, 2003). When an appeal to this ethos is accompanied by a rational argument, evidence, and some know-how, major changes are possible. The results documented thus far also provide some evidence that the hospitals have become more pro-poor. Although fee reductions were not targeted at the poor, it is known that utilization by the poor is more elastic to fee adjustments (McPake, 1993). This implies that fee reductions disproportionately favor the poor. Since the largest majority of Catholic health units operate in rural environments and a sizeable number of them in war-torn areas, it could easily be inferred that their increased utilization included more patients from poor socio-economic categories.

### **Improving information**

To provide further documentation of the processes under way, strengthen the rational argument, and improve the know how in view of limiting the degree of risk that hospitals have to accept, the UCMB with the other denominations' bureaus, went a step further and carried out a study in a sample of affiliated hospitals (Odaga and Maniple, 2003). Although the study did not yield conclusive results, it provided additional insight in the dynamics at play and led to some interesting findings, summarized here, and communicated to all hospitals:

- The majority of the hospitals have responded by reducing fees and adopting a flat fee structure. Only 8 percent of hospitals have not yet taken a decision to do so. Most hospitals have targeted services towards pregnant mothers and children.
- Fee reductions have generally resulted in increased utilization of all targeted services, and have especially favored children.
- Responsiveness in maternal services was consistently low, implying presence of other important barriers.
- Flattening of the fee structure reinforced the effects of fee reduction. However, the flat fee concept was not appreciated the same way in all the hospitals.
- Response was stronger where the community could understand (and perhaps predict) the new fee structure. Although most hospitals reported to have displayed their fees publicly in their premises, this alone was not effective in

informing the community. Methods that reach out to the community were found to be more effective.

- Many hospitals still lack the technical competence to monitor the process of user fee reductions, even though most of them reported to have them in place.

## Conclusion

Making health services work for poor people is not easy. The *2004 World Development Report* provides an extensive analysis of the actors and factors at play. It has also suggested that with altruistically motivated providers the inherent pro-poor ethos can be banked upon if combined with regulation and support. This article has documented how this can indeed happen. We would only like to add that managerial know-how is necessary to limit the risk that service providers take when they decide to be more pro-poor, in an environment where poverty is widespread and resources are extremely limited. Umbrella organizations can collect and make use of information to strengthen the pro-poor ethos and enhance self-regulation. They can also provide the much-needed additional managerial capacity so often wanting at the implementation level in a resource constrained environment.

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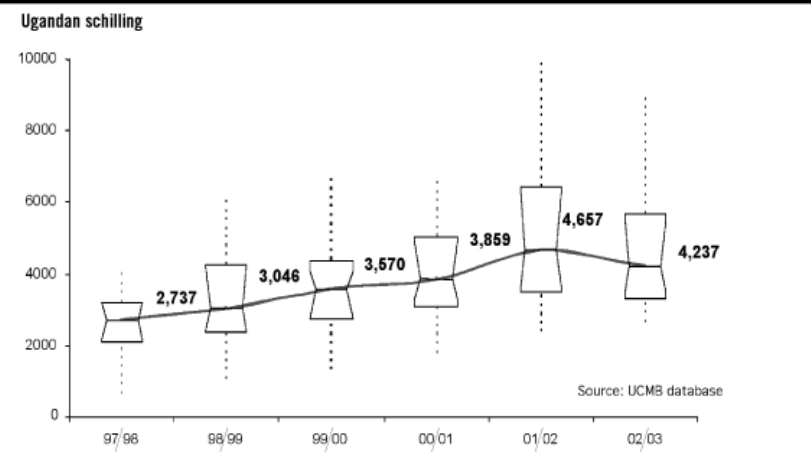
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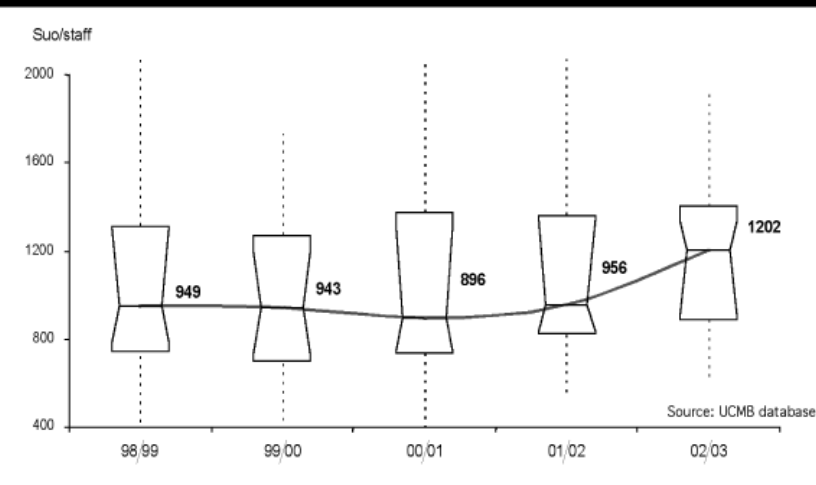
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**FIGURE 1—MEDIAN VALUES OF COST PER 1 SUO op IN 27 UCMB HOSPITALS**



**FIGURE 2—MEDIAN VALUES PRODUCTIVITY OF PERSONNEL IN 27 UCMB HOSPITALS**



**FIGURE 3—MEDIAN VALUES OF FEES CHARGE PER 1 SUO op IN 27 UCMB HOSPITALS**

