



**GRADUATE SCHOOL OF DEVELOPMENT STUDIES**

**HEALTH SECTOR REFORMS (HSRs) IN UGANDA: A VIABLE STRATEGY  
TO EFFECTIVE HEALTH CARE DELIVERY?**

*A research paper presented by*

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## **Abbreviations**

AIDS:	Acquired Immune Deficiency Syndrome
CBOs:	Community Based Organizations
GDP:	Gross Domestic Product
LGs:	Local Governments
GoU:	Government of Uganda
HC:	Health Centre
HMIS:	Health Management Information System
HSR(s):	Health Sector Reform(s)
HUMC(s):	Health Unit Management Committee(s)
HIV:	Human Immuno-deficiency Virus
HSSP:	Health Sector Strategic Plan
IMF:	International Monetary Fund
IMR:	Infant Mortality Rate (per 1000 live births)
MFPED:	Ministry of Finance, Planning and Economic Development
MoH:	Ministry of Health
NGOs:	Non Governmental Organizations
NPM:	New Public Management
SSA:	Sub-Saharan Africa
SAPs:	Structural Adjustment Programmes
TBAs:	Traditional Birth Attendants
UNICEF:	United Nations Children's Fund
WHO:	World Health Organization



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## **ABSTRACT**

At the time of independence, Uganda had of the best health care delivery systems in Africa. The country's economy was also one of the most vibrant in Africa. However, the decades of misrule by Idi Amin (1971-79) and Obote II (1980-85) led to a collapse of the country's health and economic structures. By 1986, when National Resistance Movement (NRM) captured power the whole economy was in ruins with high trade deficits, debts, high inflationary levels and poor health indicators.

Owing to economic difficulties, coupled by the "mystical faith" in the "free-market" paradigm after the mid 1980s, concerns started to shift away from equity issues to efficiency and sustainability. Within the realm of health care, the neo-liberal paradigm led to adoption of the health sector reforms (HSRs) as a "panacea" of all health sectors' ills. The major HSRs adopted included cost-sharing, decentralization, civil service reforms, re-organization of Ministry of Health (MoH), Partnerships with non-state actors, Health Management Information Systems and privatization. The adoption of these policies had an "inspiration" from the neo-liberal thinking through IMF and World Bank, the New Public Management (NPM), the Alma Ata Declaration as well as the Bamako Initiative. Ever since their adoption, controversy has surrounded them. Many critics argue that HSRs have created more evils by worsening the health care delivery and utilization, thus being anti-people. At the same time, protagonists argue that HSRs have increased health care quality, delivery and utilization, thus being pro-people.

This research analyses the trajectory of HSRs and their effects on health care delivery and utilization in Uganda. Indeed, the research reveals that many benefits/achievements have been registered as a result of HSRs. These include reduced distance to health units as more health units are built, efficiency in health sector management by Health Unit Management Committees (HUMCs). Others include availability of drugs and auxiliary services for those who can afford; quick response to disease outbreaks by districts, integration of traditional healing and traditional medicine into main stream health care delivery system, etc. However, these benefits/achievements have been attained with "costs" to society. Some of these costs, although cannot be attributed solely to HSRs, the

implementation of the programme has exacerbated its effects on Uganda. They include drug over-prescription, self-prescription and self-medication, human resources constraints, corruption, drug-leakage, consumer exploitation, informal health providers and inadequate funding.

It is important to note that different segments of society have been affected differently by the reforms. It is therefore difficult to quantify the benefits and problems and put them in a continuum. However, what is clear from the research findings is that HSRs when properly implemented are a viable strategy to improve health care delivery. Implementation demands efforts at regulating the private sector as well as the public health care providers through supervision and monitoring, meaningful community participation, capacity building as well as political will and commitment.

## **CHAPTER 1: GENERAL INTRODUCTION**

### **1.1 Introduction to the Problem**

At the time of independence Uganda had one of the best health care services in sub-Saharan Africa. However, the economy experienced economic and political turmoil especially in the late 1970s and 1980s, as the “whole” health sector was shattered. The health infrastructure was destroyed during the wars in 1980s and health personnel fled the country to Kenya, South African countries, United States of America (USA) and Europe for either “greener pastures” or political asylum.

In January 1986, the new National Resistance Movement (NRM) government captured power. But this government was against IMF and World Bank’s Structural adjustment Programmes (SAPs) that the country had adopted in 1980. Later, the NRM government realized that it was inevitable to adopt fundamental reforms for economic recovery. The health sector experienced a wide range of reforms that were supplemented by the 1997 Local government (LG) Act which emphasized decentralized health care delivery system.

Critics argue that Uganda’s policy reforms have increased health care burdens like high medical costs to the poor and generally led to a reduction in the quality of health care. On the contrary, the government, like IMF, World Bank and major donors consider Uganda’s HSRs as one of the global best practices (Odaga,2004). This research sheds more light regarding the validity of these contradictory views.

### **1.2 Problem Statement**

HSRs have become a buzz word among the developing countries especially in the era of new international economic order. During the 1980s, Uganda like other developing countries especially in SSA adopted the SAPs on the prescription of World Bank and IMF. The major reasons for the adoption SAPs was to revive the economies that were experiencing macro-economic disequilibria. By 2001, there were about 90 SAPs adopted in Uganda –ranging from economic, social to political (Bariyo,2003:99).

This study focuses on HSRs, paying particular attention to (health) decentralization. With decentralization, the central government aims at transferring power, authority and responsibility to local governments to perform certain responsibilities and activities like staff recruitment, health data collection and dissemination as well as supervising and funding operations of health units that were formally in the government's domain. In Uganda, formally the health service delivery was centrally planned, funded, coordinated and monitored. When the 1997 LG Act on decentralization was enacted, Districts/LGs were given the mandate to offer certain health care services like disease prevention, health promotion, curative and rehabilitative services, vector control and health education. Other responsibilities assigned to LGs were recruitment and management of personnel for district health services, provision of safe water and environmental sanitation (Government of Uganda-GoU:1999,2000) among others, in their areas of jurisdiction.

With the adoption of HSRs, more new actors (private commercial and NGOs/CBOs) have come onto the scene. The health sector has experienced improvements in health service delivery and utilization. For instance, the number of private health units increased from 28% in 1994-95 to 48.7% in September 2001<sup>1</sup>. The number of people living within 5 Kms of health units increased from 27% (1980) to 48 % (2004). Immunisation rates, disease surveillance and outbreak control as well as the numbers of patients treated at various health units increased tremendously. Public health unit's management has improved through community participation.

However, critics of HSRs argue that the quality of health care services when critically assessed from two perspectives:- of health service providers' and that of users' (Chabot et al.,1995:127) has declined. From the health service providers' perspective, health care quality has been negatively affected by loss of morale among health workers due to poor payment, lack of professionalism, poor infrastructure, unavailability of drugs and other supplies (like gloves, bandages) as well as lack of adequate training and supervision (Lindelov et al.,2003:23). From the users' perspective, critics further argue that drugs at

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<sup>1</sup><[www.health.go.ug](http://www.health.go.ug)>

government health units are inadequate, health care services are costly and most public health workers are rude to patients. Thus, HSRs have made health care delivery and utilization more difficult.

In addition, the health sector is facing many serious problems/challenges like poor health care, poor staff remuneration (exemplified by rampant labour strikes and reduced morale), inadequate health care funding, existence of quack doctors, illegal clinics manned by untrained personnel, drug leakages, high medical costs which have led the poor people to turn to traditional healers *etc.* It is important to note that most of these problems have come about as a result of central government's inability to fully finance the sector, regulate and monitor the activities of the multiple actors arising from HSRs. Where the LGs are given mandate to regulate and licence health units, they are usually unable to do so due to lack of appropriate skilled personnel. Where appropriate skilled personnel exists, illegal health units still emerge due to corruption among health workers and legislators. So this research tries among others to find out the effects of health sector reforms in Uganda.

### **1.3 Research Objectives**

The over all research objective is, to examine how effective the HSRs have been in improving health care delivery and utilization in Uganda. While Specific objectives are:

- (i) To document rationale for carrying out HSRs in Uganda
- (ii) To asses if and how people (community) are benefiting more from the HSRs as well as to explain the role of different players in health care service delivery
- (iii) To document the ways in which the local community participates in a new health care sector
- (iv) To identify the problems/challenges of new health care service delivery

### **1.4 Research Hypothesis and Specific Questions**

The research hypothesized that HSRs adopted in Uganda have improved healthcare delivery and utilization, though with costs on society. Specific research questions are:

- (i). Where did the impetus for HSRs in Uganda come from?

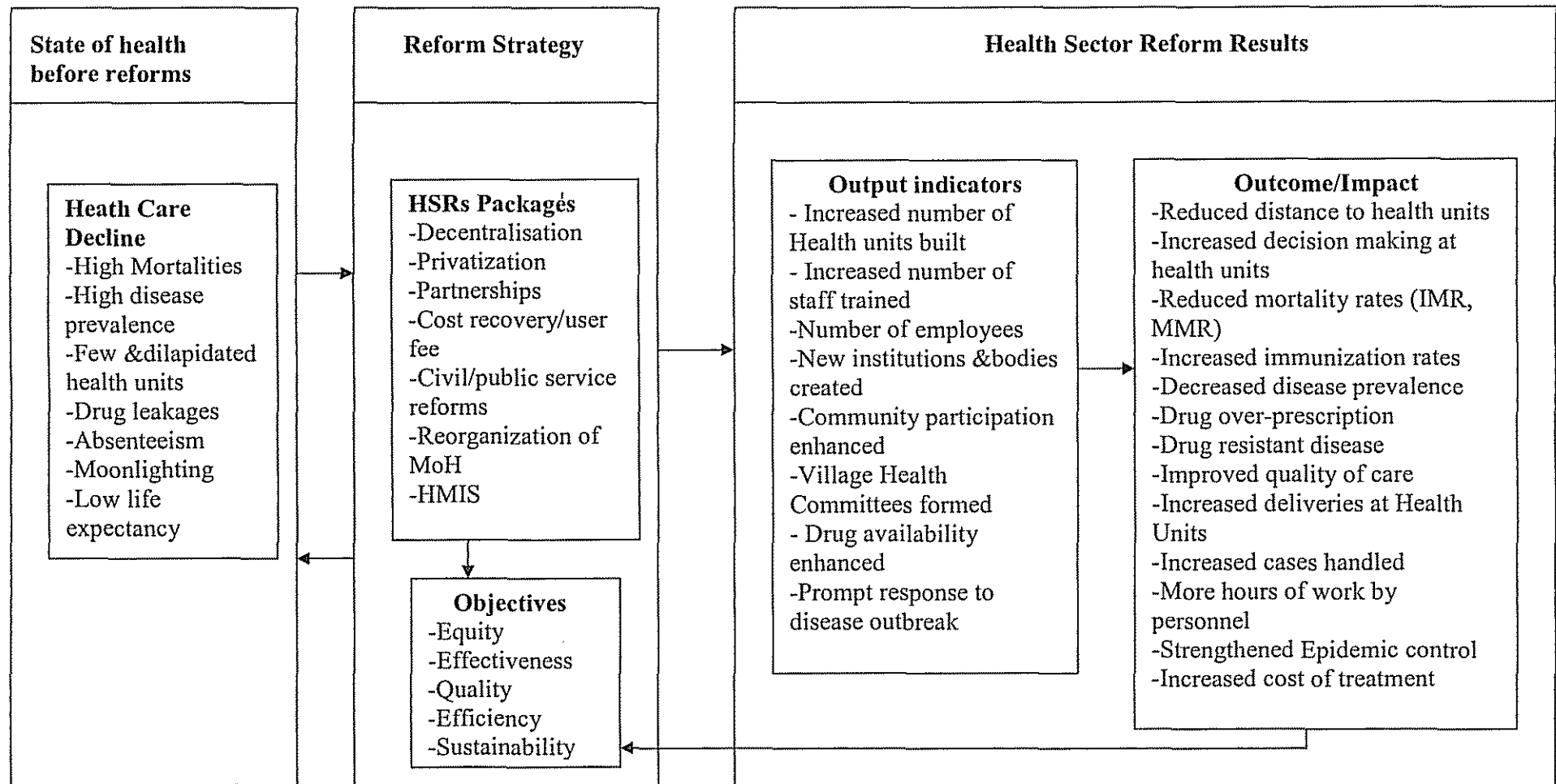
- (ii).What are the major HSRs that were adopted in Uganda?
- (iii).What has been the positive and negative impact of HSRs with respect to policy, funding, management and health service delivery and utilization?
- (iv).What new actors have come into the mainstream health care delivery system and what role do they play?
- (v).What role must Central/ Local government play in the new health service delivery?

### **1.5 Operationalization of Research Concept and Analytical Framework**

The operationalization and analytical framework of this research is divided into three: the state of health care before reforms, the reform strategy (HSR packages together with their objectives) and the HSRs results shown by output and outcome indicators in figure 1.



Figure 1 Analytical framework



Source: Author's own construct

Having hypothesized that HSRs adopted in Uganda have improved health care delivery and utilisation, the reform strategy of the analytical framework examines two HSR theories: NPM and the Neo-liberal theories and three models (Primary Health Care, World Bank Approach, and the Bamako Initiative) together with their propositions (most of which are contained in the HSR packages). Thus, the analytical framework of the study helped to analyse various ways through which the theories and models of HSRs in Uganda have affected service delivery. For instance, has service delivery and utilisation improved, stagnated or declined after HSRs? Have the benefits of HSRs been proportional to all segments of the society? What has improved, quality or quantity of service delivery? What challenges are facing the health sector?

To validity the hypothesis and draw conclusions and lessons, the research analysed secondary data on policy, activities and practices of different actors in health care delivery and utilisation. The research collected data on HSRs results (output and outcome indicators) and examined how they have been influenced by the ideologies imbedded in the theories, models and practices. The results' indicators were both qualitative and quantitative in nature. They were obtained from health sector studies in Uganda other developing countries. World Bank publications, MoH, and GoU documents provided a rich database for this research

### **1.6 Limitations of the Study**

The major limitation was lack of adequate and recent data. Since the research depended mainly on secondary data, most recent material was not available. This would have been solved if primary data was collected to validate the secondary data. Secondly, over reliance on secondary data tended to give biased views. Since much of the secondary information was written by World Bank, WHO, donors and the GoU it was not critical on the issues on the ground. This bias was minimised by analysing different literature by different authors. Lastly, due to time and data constraints, not all HSRs were discussed. The study focused on main ones which were believed to have had a significant impact on health care delivery and utilization.

### **1.7 Organization of the Thesis**

This thesis is organized into six chapters. Chapter one discusses the background to the study, problem statement, objectives and hypothesis, research concept operationalisation and analytical framework and the limitations of the study. Chapter two deals with the theoretical framework of the study. It begins with the debate about goods/services delivery, and then critically examines the origin(s) of HSRs adopted in developing countries, the rationale for their adoption, major theories and models through which HSRs have been carried out. Chapter three looks at HSRs in Uganda. In chapter four, the thesis discusses effectiveness of HSRs in ensuring improved health care delivery. This chapter examines the achievements of HSRs by assessing the reform results. Chapter five discusses the challenges of HSRs in Uganda. The final chapter (six) summarises the research findings and draws some conclusions and policy implications.



## **CHAPTER 2: THEORETICAL FRAMEWORK**

### **2.1 Introduction**

This chapter forms the theoretical framework of the study. It is divided into four sections. Section one examines the debate about public- merit-private goods and their provision as well as delivery. Section two discusses the origin(s) and scope of the HSRs adopted in developing countries. It also brings out the rationale behind the HSRs. Section three discusses two main theories that have influenced HSRs while section four examines health care reform models in Africa, their propositions/assumptions, weaknesses and strengths.

### **2.2 Debate about Public-Merit-Private Goods Provision and Delivery**

A debate has emerged about appropriate definitions, provision and delivery mode of public and merit goods. This is partly because these goods have been characterised differently either basing on technical (Helmsing,1997:4), economic (Mills et al.,2001:7) and political nature/factors.

From the technical nature, public goods are those specific goods whose consumption is non-rival, where exclusion of free riders is technically difficult and benefits are collective (Batley,1996:726;Helmsing,1997:5). They also have indivisible supply. Examples include health, education, water, sanitation and security. On the other hand, merit goods are “those goods generally not distributed by means of price system but based on need (or merit), because people although having perfect knowledge would buy the wrong amount” (Awortwi,2003:27). They are vital to public, can be provided in a free market but would almost be under-provided. Education and health are considered as examples. The only difference between public and merit goods is that the latter are often privately provided (Awortwi:2003). On the other hand, private goods are the opposite of public goods.

Political categorisation of goods has rather a radical approach. Regardless of all factors, many governments have defined certain goods as public. Certain health care services for instance for, the poor, pregnant women, children and elderly have been “decreed” as public goods/services. With regard to provision, most scholars argue that the public ought to provide public and merit goods while the private goods be privately provided.

However, there is no economic law that public institutions should provide public goods (Soeters,1997:25). Private provision is possible for public goods.

Taken as a single package, health care is both a public and merit good which many health care experts have argued should be provided by the public (but can be delivered privately). However, health care is not a single package with homogeneous services or goods. When horizontally unbundled, there are various categories of health care services. Some are (pure) public in nature (like national health management support, health training etc). Others are mixed public-private in nature (like preventive and curative services for communicable diseases) while the rest are private in nature (like care for injuries and noncommunicable diseases) (World Bank,1994:135).

Musgrove (1996) categorised health activities into three domains: (i) Public goods (ii) Low-cost private intervention and (iii) High-cost private intervention. Health care can also be categorized into economic characteristics (see table 1).

Table 1: Economic categorisation of health care services and their mode of provision

Nature of good/services	Public good/services	Merit good /service	Private good/service
Example of good/service	-Immunization -Antenatal -Vector/disease control -Environmental sanitation -Health education campaigns -Scientific information -Community training	-Respiratory track infection treatment -Diarrhoea	-Cancer treatment -Injury treatment -Plastic surgery
Cost of provision	High	Low	High
Mode of provision	Public	Public-Private	Private
Mode of delivery	Public-Private	Public-Private	Private

*Source: Author's own construct*

This economic categorisation (in terms of degree of externality, excludability and rivalry, degree of informational asymmetry) of services in each of these domains differs

considerably. Musgrove suggested that governments should finance services which fall into the first domain of public goods (Mills et al.,2001:7). Services with externalities should be paid through general taxes (Soeters,1997). For the second domain, government needs to regulate insurance to ensure efficient and equitable access to the services (World Bank, 1993:5; Mills et al.,2001:7). However, the health insurance markets in developing countries especially in Africa can not adequately function. For example, Soeters (1997:17) argues that health insurance markets fail because of: adverse selection that arises when individuals face different risks, consumer and provider moral hazards and high diseconomies of scale to small firms arising from higher average administrative costs per capita. Moreover, there are non-existences of some health insurance markets (Soeters,1997:17) like those of AIDS/HIV. Even if health markets exist, the rural poor people may not be in position to access them. They may thus be useful to only a few urban rich. Hence excluding over 85% of the developing countries' population which lives in rural areas. Even in urban areas where health markets may exist, the (real) poor who live in "illegal" settlements and who constitute a big percentage of the urban population, and are in a dire need of health services are in most cases excluded. For the third domain, regulation will need to be supplemented by government financing by targeting for the poor (Mills et al.,2001:7; World Bank,1993;1994).

However, the economic categorisation of health services is not without problems. First, it does not adequately explain how the poor in the third domain can be subsidized. Second, the categorisation tends to be universal but the nature and extent of market failure will depend upon many factors. For instance the country's epidemiological profile, professional ethics, the organization and development of the business sector, and the level of education among the populace (Mills et al.,2001:9). Others will include historical factors, technology, institutional and political factors (Helmsing,1997:5) that change over time and vary from one country to another. Third, even when this approach is adopted, more context-specific interpretation may be problematic.

This ideological debate about health care services and their appropriate mode of provision and delivery has been at the heart of all HSR theories and models. They have greatly influenced policy design and implementation.

### **2.3 The Origin, Nature and Scope of Health Sector Reforms**

As the economic conditions worsened in developing countries, the health sector was greatly affected. Government financial spending declined, health infrastructure was dilapidated and the whole health sector bureaucracies were overcentralised and become corrupt. Overcentralisation led to lack of autonomy by LGs and lack of clear organizational goals, all which led to reduced motivation for health care workers and health care delivery, culminating into high mortality and morbidity (Mills et al.,2001:2; Soeters,1997:I;World Bank,1993:7).

To avert the already bad situation from getting worse, there was a need for a “fundamental” reform in the health sector. According to Madeo et al.(2000:1), HSRs are a “sustained process of fundamental change in policy and institutional arrangements, guided by governments, designed to improve the functioning and performance of the health sector and ultimately the health status of the population”. Mills et al.(2001:3) also defined them as “sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector”. Casells (1995) has observed that “there is no consistency or universal package of measures that constitute health sector reform”, though most reformers would probably state their overall goals as improving health sector efficiency, equality (Madeo et al., 2000), equity and sustainability

Synthesis of the elements of HSRs include: (i) restructuring of public sector organizations into forms of decentralization and bureaucratic commercialization. This process ensures that publicly owned facilities are restructured to enable them run along the lines of private sector mechanism (hospital ‘autonomy’). (ii) Changing the way in which resources are allocated and paid to both organizations and individuals (with the aim of creating a clearer link between performance and rewards). (iii) Encouraging greater plurality and competition in the provision of health care through policy measures such as liberalizing



the private sector, and contracting with or subsidizing private health providers. (iv) Seeking increased financing for health care from non-tax revenue sources such as user fees, social health insurance and private health insurance. (v) Increasing the role of the consumer in the system through enhancing the power and scope of consumer choice and making health providers more accountable to CBOs such as hospital boards (Mills et al., 2001:4; Soeters, 1997:73).

## **2.4 Theories of Health Sector Reforms**

There are various theories to explain the ideological context in which HSRs have been carried.

### *2.4.1 Neo-liberal economic theory*

According to McGregor (2001:83), Neoliberalism is made up of two notions - "neo" meaning new and "liberal" meaning free from government intervention. Liberalism stems from the work of Adam Smith who, in the mid 1770s, advocated for a minimal role of government in economic matters so that trade could flourish. The mind set of liberal economics was to replace Keynesian economics of the 1930s that advocated for government intervention. In the 1970s, liberalism or the cry for deregulation, privatization and deletion of government intervention in the market economy, resurfaced with a vengeance; hence, the name renewed liberalism or neoliberalism (McGregor, 2001).

The major theoretical assumption of neoliberal economic theory is that invisible hand of the free market leads to a better allocation and utilization of scarce resources. The states (governments) are inefficient while private markets are more cost-effective and consumer-friendly. Thus for economic growth to be realized, the state should play a very minimal role. According to McGregor (2001), there are three main principle of neoliberal economic theory as far as health care is concerned. These are individualism, free market via privatisation and deregulation, and decentralisation. Thus, the neoliberal agenda for health care reforms calls for cost-cutting for efficiency, decentralisation to the local or regional levels, setting up health care as a private good for sale rather than a public good

consumer sovereignty, privatisation, deregulation, competition, reduction of the public sector size to minimise costs among others.

To neoliberals, the minimalist role of the state is to make sure that the rules of the market are followed and the market functions effectively. The state should intervene only when market failures arise. According to Soeters (1997:16) and the World Bank (1993:5), there are five main problems associated with health care provision in a free market. First, patients are not fully informed about the health care products (asymmetry of information). Second, private markets tend to under-provide public goods and those services with positive externalities from which the society benefits at large. Third, private insurance markets tend to exclude high-risk patients (adverse selection), and health care costs tend to escalate if patients are fully insured (moral hazard). Fourth, private insurance markets are rare (especially) in Africa. Fifth, the poor cannot afford health care.

So, the government would be justified to intervene in the health care market for four reasons. First, to provide health care for everybody (equity objective). Second, to protect patients against unqualified or excessively profit-making practitioners. Third, to provide public goods and services which the market would under-provide and lastly, to control the costs (Soeters,1997:21; World Bank, 1993:5). According to neoliberals this state intervention should not kill competition that is ideal for proper resource allocation and utilisation. It ought to be noted that the neo-liberal economic theory seems to have overshadowed current HSRs in most developing countries. This is manifested in the reforms driven by (IMF and World Bank) ideological vehicles of the neo-liberal philosophy.

#### *2.4.2 The New Public Management (NPM) Approach*

In most contexts, the HSR agenda is inextricably tied up with a parallel strand of reform currently being extensively discussed throughout the public sector-namely, "New Public Management" (Mills et al.,2001:4;Russels et al.,1999:767). The NPM has arisen as an attack on the Weber's theory of bureaucracy which concentrated on "doing things right, rather than doing the right things" (Awortwi,2003:29). Awortwi (2003) argues that the

overliance of Weber's bureaucratic theory on rules and regulations had instead promoted inertia and rigidity. At the same time the theory has further been accused of re-tapeism, mechanistic and insensitive to the changes in organization, which many argue were responsible for inefficiencies and are "counterproductive to the accomplishment of public goals" (Awortwi,2003:31) which are dynamic.

He further argues that "the NPM approach looks at re-engineering the public sector from within" (Awortwi,2003:51). To him, NPM hinges on two main premises: First, that public services will be more effective when they are more organised according to the principles of market economics; second, that the management of the market-style public services will be more efficient if it resembles management practice in the private sector. Thus NPM aims at increasing efficiency, effectiveness and competitive ability through public sector reorganisation.

According to Smith (2000:80), the NPM has the following forms/components: contracting out, consumerism, community planning, community leadership, pluralist collectivism and participation. Regarding the health sector, under the NPM framework, the government is to provide an enabling environment for households to improve their health (World Bank, 1993:14; 1994:2) by pursuing economic growth policies that benefit the poor. Other elements of enabling environment on the macro-level also include better legislation, support of the private health commercial sectors, community participation, decentralization among others. On the other hand, Russell et al.(1999:769), argue that the major policies in health sector from the NPM agenda are "user fees, decentralization to health districts, autonomous hospital boards, contracting out (in), deregulation, enablement and the regulation of the private sector".

The enabling environment discourse moves government from "a concern to do, towards a concern to ensure that things are done" (Mills et al.,2001:5) efficiently. While the state may play a key role in development, this role is not necessarily one of direct service, but rather policy-making, purchasing and regulating (Mills et al., 2001:6; Awortwi:2003,81).

Government sets the rules of the game, build and support institutions and provide a level-ground for other actors to deliver services effectively.

However, a critique has emerged against the NPM. For example Desai et al. (1998) argue that NPM leads to fixation on procedure and technocracy thus de-democratizing. Secondly, it claims to support participation but instead mitigates against it. It leads to fragmentation of the state by bringing in various actors like private sector, civil society which leads to co-ordination problems. It deflects interests away from substance (what is or should be delivered) to process (how services should be delivered) through the purchaser-provider split (Baily et al.,1999:162). Furthermore, it focuses on output thus leading to short termism which is anti-strategic planning.

Though, NPM purports to promote accountability it instead makes it fuzzy and difficult for citizens to know whom they can complain to or confront because of the presence of many actors who may be offering the service. The citizens or consumers/clients may not know who to approach –either the purchaser or the provider. NPM destroys the culture of CBOs / NGOs from socially caring activities to business orientation. And some of these CBOs and NGOs may be co-opted by the government, loose their focus and sooner than later become part of the corrupt, unresponsive and inefficient government machinery/bureaucracy (Desai et al.,1998).

Russell et al., argue that “NPM reforms put much demands on government which are not only technically complex but require political leadership, major institutional reforms and shifts in organizational culture” (Russell et al.,1999:776).The absence of these prerequisites has ensured that none of the case study countries had undertaken far-reaching NPM reforms in the health sector by 1996.

## **2.5 Health Care Reform Models in Africa**

According to Soeters (1997:29), there are two models that have been applied in HSRs in Africa: The Primary Health Care model (PHC) and the World Bank Approach (WBA).

### *2.5.1 The Primary Health Care (PHC) Model*

This was endorsed by most African countries in the Alma Ata Declaration (of 12<sup>th</sup> September 1978) as a health reform proposal. The major principles of the Alma- Ata Declaration were: government responsibility for their people's health, community participation, equitable distribution of available resources and the emphasis on prevention (Soeters,1997:29; WHO,2004). The main goal identified in the Declaration was equity. The Declaration advocated for the provision of health care at a cost that the community and the country can afford in the spirit of self-reliance. It also called for more resources to be availed to the health sectors especially from the international health organizations and countries should reduce their extravagant (non-essential) spending.

The PHC model made a strong ethical judgement in support of equity and caring for the poor whom the governments were not adequately caring for, thus advocating for the provision of "Health for All" (HFA). The Declaration made it clear that the role of government in health care provision was to be a leading one like "formulation of policies, strategies and plans of actions for launch and sustain PHC as part of national health system..." (WHO,2004:2). But governments have to work hand in hand with different actors like health professionals and development workers, international institutions (e.g. WHO, UNICEF, NGOs) donors, funding agencies in the areas of technical and financial support etc. Soeters argues that PHC model advocated for deconcentration form of decentralization where the public health institutions would work directly with the community. According to him, it appears that the PHC model does not discuss the market model as the tool for distributing scarce resources, instead it sees the private commercial sector as obstacles particularly in the pharmaceutical industry (Soeters,1997:30).

### *2.5.2 The 1987 Bamako Initiative framework*

The Bamako Initiative was a "series of policy reforms formulated in a response to the rapid deterioration of public health systems in developing countries during the 1970s and 1980s (UNICEF,1995:4). UNICEF notes that the Bamako Initiative aimed at:

"ensuring access to affordable essential health care for the majority of the population while containing costs"..., ..."restoring consumer confidence in the public health system by improving the quality of services and delegating greater decision-making power" and

“to foster better health by promoting behavioural change at the household” (UNICEF, 1995:5).

The Bamako Initiative called upon all governments to create an enabling environment for HSRs by adopting policies embracing the following eight principles: First, national commitment to the development of universally accessible essential health services. Second, essential drugs policies compatible with and complementary to, the rational development of primary health care. Third, substantial decentralization to the district level of the health ministry’s decision making for the management of PHC. Fourth, decentralized management of community resources with funds collected at local facilities remaining under community control. Fifth, community financing of health services usually in the form of payment for consultation, treatment or drugs, which remains consistent throughout the different levels of the health care system. Sixth, substantial government financial support for PHC, preserving and where possible, increasing the proportion of the national budget dedicated to the national basic health services. Seventh, measures to ensure that the poorest people benefit from PHC, through fee exemptions or subsidies, for which criteria should be established in consultation with the community and lastly clearly define intermediate objectives and agreement on indicators to measure them (UNICEF,1995:6-7).

Based on these principles of the Bamako Initiative, governments of 33 developing countries (28 in SSA and five outside Africa -Cambodia, Myanmar, Peru, Viet Nam, and Yemen) committed themselves by 1994 with ambitious plan of carrying out health care reforms and provide HFA by the year 2000.

### *2.5.3 The World Bank Approach (WBA)*

The WBA is enshrined in the *World Development Report 1993- ‘Investing in Health’*. This report stressed that Alma Ata’s HFA goal was relevant. However, Soeter (1997:31) notes that the underlying approaches and economic principles recommended in the WBA were distinctly different from the PHC model in the following aspects: (i) The World Bank did not mention anymore the word PHC, although some PHC elements such as essential drugs remained the same. (ii)The World Bank promoted private financing of tertiary health care, public financing of public health and essential clinical services

packages and encourages competition between suppliers. (iii) Principles such as consumer satisfaction, market forces and technical efficiency considerations replaced principles such as community participation, inter-sectoral co-operation and appropriate technology. (iv) The World Bank presented health reforms proposals less as a doctrine in comparison with PHC model and offered different reform approaches for low-income, middle-income and former socialist countries.

The report asserted that fairness in access to health was paramount and identified equity, efficiency and sustainability as main goals (Soeter, 1997:31). This therefore, required health reforms to respond to negative economic performance as well as broad restructuring of economic and social policies so that the health sector becomes “healthy”. In this approach, user-fees and insurance schemes were endorsed as vital revenue sources to generate resources for financing health care. It also advocated for the provision of health services to the poorest people (through subsidies) since the resources to provide HFA were unavailable (World Bank, 1993:6).

Soeter (1997:32) argues that the WBA focused at achieving “efficiency by better essential drugs policies, improved incentives for health workers, decentralization and by supporting NGOs and the private commercial sectors” and “sustainability by increased government spending on health, cost-recovery and through more effective and donor assistance”. It was the responsibility of the governments to make moral choices among the desired level of equity, quality and cost and about the optimum mix of health reform interventions. This approach further re-echoed the concept of enabling other actors in the health sector by governments.

## **2.6 Conclusion**

This chapter focused on three major issues : (i) The debate of public-merit-private goods and their appropriate mode of provision and delivery. (ii) The origin and scope of HSRs. (iii) Theories and models of health care reform in SSA. From these the following conclusions can be drawn:

First, the categorisation of health services as public, merit or private has been more often political than economic or technical. Political decisions have in most cases ruled the mode of health care services provision and delivery. However, international interference by IMF, World Bank and major donors has reversed events. In most cases many developing countries have been “persuaded” to abandon public delivery in favour of private delivery. This has been exemplified in various HSRs theories and models applied. Second, the origin of HSRs had roots from the economic hardships that led to deterioration in health care, the PHC model and the Bamako Initiative as well the World Bank Approach. Third, the private sector has various ways of delivery health care services like contracting out, open competition and franchising. Fourth, the HSR theories and models call for a wide range of radical and ambitious reforms in Uganda, most of which are broad and inter-related. What are these ambitious and broad HSRs? Why have they been adopted in Uganda? What impact have they had? The next chapters provide answers to these questions in relation to health care delivery and utilisation.



## **CHAPTER 3: HEALTH SECTOR REFORMS IN UGANDA**

### **3.1 Introduction**

Chapter two provided the theoretical framework for analysing HSRs in Uganda. This chapter focuses on major HSRs. It is divided into two main sections. Section one looks at the historical perspective of the health care development in Uganda since the colonial time. It examines the trends which the health sector has undergone. Section two discusses specific HSRs adopted in Uganda to “resurrect” the collapsing health sector to achieve efficient and effective health care delivery and utilization.

### **3.2 Health Care Development in Uganda during 1960s and 70s**

At the time of independence and through the 1960s, Uganda had one of the most vibrant economies in SSA with one of the best health care delivery systems in Africa (Mugisha, 1994:33; World Bank, 1999:73; Dodge, 1987:101). Most of the health indicators were comparable with those of best performers. For example, Infant Mortality Rate (IMR) had fallen from 200/1000 live births in 1948 to less than 100 (1973-1979). This was because: (i) health care development was given high priority as substantial expenditure (18% of all development expenditure) was earmarked for both education and health care during the 1966-71 plan, with health receiving slightly more than half of the total (Scheyer et al., 1985). (ii) Improvement of rural health units and training of health workers was the target (Mugisha, 1994:34). (iii) Health care services were provided freely by the government. (iv) The missionary bureaus offered health services at “affordable” costs through a wide range of dispensaries, hospitals and maternity posts in many communities. But health care was more of curative nature than preventive. For instance 70 to 80% of expenditure on health services was directed towards curative as opposed to preventive services (Mugisha, 1994:34) and still the entire health structure was centrally planned, funded, coordinated and monitored.

However, the decade (1971-79) of misrule by Idi Amin led to worst economic, political and social crisis in Uganda. During this turbulent, brutal and dictatorial regime, Amin launched a “war” to “Ugandanise” the economy and chase away all foreigners especially

the Asians who were in much control of the Ugandan economy. This economic war had devastating effects not only on the health sector but on all sectors of the whole country. Exports earnings dwindled seriously as social and economic investment dried up, inflation skyrocketed and the country was isolated on the international scene (Bariyo,2003:11). Due to economic hardships, human rights violations and brutal leadership, there was an exodus of skilled manpower (Corkery,2000:242) of whom 700 were physicians (MoH, 1992:6). Between 1967-68 and 1979 the number of doctors dropped from 978 to 574, pharmacists from 116 to 15, dentists from 42 to 24 (Whyte,1991:130; Dodge,1987:102).

The economy was left in the hands of the illiterate, ill-trained personnel most of whom had political short cuts to the military regime (Dodge,1987:102). By the end of 1979 most of the health infrastructure was destroyed and insufficient funding was directed to the health sector. The government's priority was in defence unlike health sector<sup>2</sup>. In comparison with other East African countries, Uganda had a miserable health expenditure during this period. For instance, the average health expenditure as a percent of total government expenditure between 1972 and 1979 was 6.1% for Uganda, 7.0% for Tanzania and 7.8% for Kenya (Mugisha,1994:39).

As one would expect, health units greatly suffered from staff shortages as the whole health system was manned by a handful of unmotivated and unqualified staff with little or no administrative and clinical supervision. The general breakdown of law and order in the country during this period made it impossible to enforce statutory controls laid down in the various Acts governing health (Whyte,1991:130). Thus inefficiencies, poor quality care and lack of logistical support were the order of the day (Mugisha,1994:35). In fact, the health sector like other sectors was in total disarray leading to accumulated impact on morbidity and mortality patterns as characterized by preventable diseases. For instance, this period witnessed the re-emergence of epidemic diseases particularly cholera, malaria, measles and sleeping sickness in many parts of the country (Mugisha,1994:33; Dodge,

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<sup>2</sup> Moreover, the entire calendar year 1974 President Amin never appointed a minister of Health after the resignation of Dr. Geza at the end of 1973

1987:108). Paradoxically, the available data show that IMR and Child mortality rates had reduced from 118/1000 and 209 at end of 1972 to 96.7/1000 and 96.5 respectively for the period 1973-77. It is important to note that such a decline in mortality rates may have been an effect of the sound health care system that had been firmly built in 1960s. Therefore, it is hard to attribute such success to brutal, undemocratic and unresponsive regime. What may be attributed to the regime was the increased IMR to 115/1000 and Child Mortality rate to 97.0 for the period 1978-1982 (Mugisha,1994:79, Dodge, 1987:108). Furthermore, for the first time in it's history, Uganda experienced informal health markets. Private clinics, pharmacies, medical laboratories and drug shops mushroomed all over the country (World Bank,1991; Whyte,1991:130) as people struggled to make ends meet during the collapsing *magendo* economy<sup>3</sup>.

In all, the "old golden days" when health services were excellent, accessible, affordable and effective were gone. What remained in place were the relics of the excellent health system that existed in the previous decades. By the time the ruling regime was overthrown, it had sowed enough seeds for its destruction as the health sector was in dead waters.

### 3.3 The Period Between 1980-85

This period was also marked by political and economic upheavals. The economy declined, export earnings as well as standards of living for the majority of the population continuously declined. As a result the World Bank recommended the adoption and implementation of SAPs to assist the economy recover from macro-economic disequilibria. Interestingly, a few policy reforms were adopted but later alone abandoned (Bariyo,2003:22). It is imperative to note that the health sector infrastructure that had survived the reign of terror<sup>4</sup> was greatly damaged and most health workers freed for their lives especially from war-ravaged areas.

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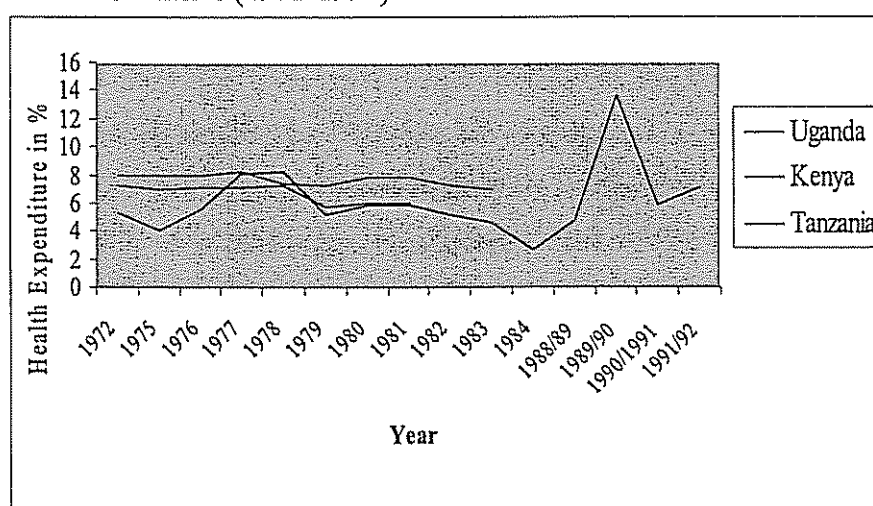
<sup>3</sup> *Magendo economy* referred to a market characterized by smuggling, illegal trade, hoarding and speculation

<sup>4</sup> *Reign of terror in Ugandan history* refers to the Idi Amin Regime (1971-1979)

Furthermore, remuneration for health workers was poor and irregular (most medical professionals could spend up to three months without receiving salaries from the CG) thus leading to reduced morale. As a survival strategy most health workers resorted to moonlighting. The reason was that it was risky for health workers to devote their whole time to government health units where they were paid “bachelor’s or killing” wages. Indeed “trends towards part-time practices by government health workers worsened in the 1980s when unqualified personnel started operating clinics and laboratory services” (Whyte, 1991:130). Thus patients had to queue for long hours waiting for health care services at a few existing and operating government health units.

In comparison with other East African countries, Uganda had a low health expenditure as a percent of total government expenditure in this period. The available data (See figure 2) show that from 1980-1984 Uganda’s health expenditure was 5.3% compared to Kenya with 7.5% (1980-83) and Tanzania with 6.0% (1980-1981) (Mugisha,1994:39). In 1984, Uganda had the worst ever expenditure in health (2.6%). As years went by, the total expenditure steadily declined not until 1988/89 when it began increasing.

Figure 2: Health Expenditure as a Percentage of Total Government Expenditure for East African Countries (1972-1992)



Source: Mugisha (1994:39).

During this period however, some attempts were made to revitalize the health care system. A National Expanded Programme of Immunization (NEPI) was launched in 1983,

manpower training and planning as well as rehabilitation of 100 health centres were undertaken (Dodge, 1987:104). In terms of drug provision, the only viable channel was through the Essential Drugs Programme (EDP). Having been initiated by UNICEF in 1981 and funded by DANIDA in 1985 through Danish Red Cross, EDP was vital in providing drug kits to both government and non-government health units. Less contribution in drug provision was from Central Medical Stores and Joint Medical Stores which supplied supplementary drugs to government and non-governmental health units respectively, as private firms purchased drugs from Uganda Pharmaceutical Ltd. or imported them from abroad (Whyte,1991:131). Despite attempts to avail drugs to various health units, drug shortages especially at government health units were a common phenomenon. This could have been due to drug-leakage at government health units (Hutchinson et al.,1999; Lindelow et al.,2003; Whyte,1991). With little success these attempts were short lived due to inadequate skilled health personnel, lack of political will and insecurity that was ranging in many parts of the country as the programmes launched were "...dependent upon political stability and improvement in overall security" (Dodge, 1987:101).

### **3.4 The State of the Health Sector Inherited by the NRM Government**

On capturing power in 1986, the NRM under the leadership of Museveni inherited a shattered economy. The economy was said to have declined in all the sectors. Economically, it had huge macro-economic disequilibria in all sectors. The social and economic infrastructure was destroyed and the new government had a great task of rebuilding the economy and restoring confidence in a rather traumatized population.

In her article *"Medicines and Self-help: the privatization of health care in Eastern Uganda*, Whyte (1991) explains clearly how "unhealthy" the health sector was, prior to privatization. It was characterized by; mushrooming of unregulated health care units (moreover manned by ill-trained or unqualified personnel) in all corners of the country and medicine leakage was rampant. Furthermore, there were poorly remunerated and unmotivated health workers (who usually absented themselves from government units while moonlighting) and inadequate government financing as well as misuse of health

facilities. For instance one nurse had turned her staff quarters into a bar selling *enguli* (home made gin) while government vehicles, motorcycles and bicycles had been personalized or “owned” by the in-charge to run their own personal errands (Whyte,1991:133).

Furthermore, medicine vending was the order of the day and the presence of “bush” doctor-usually self-taught skyrocketed (Whyte,1991:137). While all these were happening, the poor had their fair share of the problems. They had to “patiently” queue in long lines (amidst insults from rude health workers) at a few existing and operating government health units or just kept at home without seeking medical treatment. Others turned to traditional healers as the last resort. But who should be blamed for this? Should it be health workers who were devising various “survival” strategies? Or the new government that was healing from deep wounds inflicted on it by recurring wars?

Indeed, fundamental reforms were inevitable to “resurrect” the health sector in particular and the whole economy in general. It was at this point that the World Bank and IMF for the second time intervened through SAPs. Although the Ugandan government was hesitant to adopt them (Bariyo,2003:22), later SAP adoption was inevitable for a country’s recovery. In the same way Odaga (2004:2) argues that “owing to economic difficulties, coupled by the mystical faith in the “free-market” paradigm after the mid 1980s concerns started to shift from equity, to efficiency and sustainability. The neoliberal economic paradigm led to a move away from Health For All to health sector reforms”. As such by 1999 over 100 SAP policy options had been adopted.

### **3.5 Health Sector Reforms in Uganda**

Like most developing countries, Uganda embraced HSRs in the late 1980s but were more pronounced in the 1990s and 2000s. A lot of debate surrounds the impetus for their origin. Many scholars have argued that they were embraced as a conditionality of the World Bank and IMF. In order to get more assistance, they argue, Uganda adopted HSRs

as recommended by the World Bank's two famous publications<sup>5</sup>. On the other hand, others argue that HSRs were adopted following the earlier commitments and the international pledges Uganda had made. These pledges were made when Uganda became a signatory to the Alma Ata Declaration and the Bamako Initiative. Wherever the impetus came from, the adoption of HSRs with far reaching consequences on health status of Ugandans became inevitable.

### *3.5.1 Specific Health Sector Reforms adopted*

The major HSRs that were adopted include; civil service reform (demobilization and retrenchment), decentralization and introduction of user fee/cost-sharing (as a cost recovery technique). Others were introduction of Health Management Information System (HMIS), development of essential packages services, privatization, contracting out, partnerships, National Health Plan (NHP), Health Sector Strategic Plan (HSSP) among others. As earlier mentioned, healthcare reforms were adopted with ultimate goals of increased efficiency, effectiveness, equity and sustainability in health care delivery and utilization.

#### *Civil service reforms (demobilization and retrenchment)*

Civil service reform was part of the wider public sector reform. The civil service reform program in Uganda came out of 225 recommendations made by 1989 Public Sector Review and Reorganization Commission (PSRRC) that were accepted by the government in 1991. Among other recommendations cost reduction, retrenchment, improved efficiency and accountability were given priority (Bariyo,2003:28; Corkery,2000:244).

In order to cut its expenditure, increase efficiency, deliver timely, high quality and appropriate services, support national development as well as facilitate the growth of a wealth-creating private sector, Uganda undertook an ambitious policy of downsizing its public sector labour force. The major reform component included decentralization of powers, introduction of results-oriented management (ROM) and capacity building. The

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<sup>5</sup> World Bank, *World Development Report (1993), Investing in Health* and *The 1994 Better Health in Africa, Experiences and Lessons Learned*

main focus of the first phase of the reform programme was the creation of competent, accountable and affordable civil service. The second five-year period of the reform programme focused on macro-economic stabilization, encouraging growth of a vibrant private sector, improving service delivery and poverty eradication. All of these impacted on the health services and their personnel (Corkery,2000:244).

### *Cost-sharing*

Stemming from the recommendation of the WBA and the Bamako Initiative, health users, “even though poor households-they may be, had to pay modest charges (fees) and communities were to finance health centres to generate sufficient incomes to cover recurrent and non-salary costs of basic health units” (UNICEF,1995:5). Cost recovery in one form of user fees in Ugandan government health units was adopted in 1993, though it was never passed by parliament as law. Health care services were to be paid for by all users. Because of unclear guidelines, implementation, administration, use and monitoring it had more negative than positive effects.

The issue of cost-sharing later became a political question. In the run up to elections, the incumbent President (seeking re-election) criticized those who had introduced it “badly” without his “knowledge” and had negatively affected the poor people. Thus, in February 2001 the President directed for the scrapping off cost-sharing in all government health units country wide (Lindelow et al.,2003:224). Paradoxically, referral hospitals maintained the option to charge a fee to those who wished to receive quicker and better services (Lindelow et al.,2003).

### *Re-organization of the Ministry of Health (MoH)*

As a way of strengthening institutional capacity, the MoH has been reformed. New departments (like inspectorate-medical audit), legal boards and institutions have been created while others have been merged to avoid duplication of service delivery. The responsibility and duties of each department and personnel have been “clearly” streamlined so as to avoid overlap and coordination problems. Furthermore, new bodies like Health Service Commission, Autonomous Institutions (National Medical Stores,



National Drug Authority and Uganda AIDS Commission) and professional bodies (like Medical and Dental Practitioners Council, Nurses and Midwives Council, Allied Health Professionals Council and Pharmacists Council) have been created to regulate the practice of health professionals by enforcing standards of performance, ethical practice and professional qualifications. At the same time, various institutions have been transferred from the MoH to other bodies or ministries (MoH,2000). For example, Murchison Bay Hospital to the Ministry of Internal Affairs, National Sleeping Sickness Programme to District Authorities and Basic Training Institutions to Ministry of Education and Sports.

#### *Co-production/Partnerships*

Right from the Alma Ata Declaration (1978), Bamako Initiation (1987) through the WBA approach (1993), important roles have been acknowledged that the private sector plays or ought to play in health care delivery. In Uganda, the days when the government was the sole purchaser and provider of health services are gone. The government has created enabling an environment and worked hand in hand with the private sector, civil society, NGOs, CBOs, among others to provide health care. For example, The AIDS Support Organisation (TASO), Aids Information Centre (AIC) have been formed particularly to supplement government's efforts against HIV/AIDS. Others include Uganda Red Cross Society, Care International, and Health Alliance. The government has in most cases financially "enabled" these organizations to perform<sup>6</sup>.

#### *Health Management Information System (HMIS)*

Until 1993, Uganda had a centralized Health Information System (HIS) focusing on morbidity and mortality reporting data, flowing only from individual health units to the district and national level. Unlike HIS, under the HMIS information is collected and used for decision-making and improving operational health service performance. All the health units (including non-government) collect, process and report routine data relevant both to national and health programme objectives and the needs of health units and health

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<sup>6</sup> For example the government funds 5% of TASO's total annual budget and sometimes pays some medical staff in NGO health facilities

workers. The system is integrated by having one data source and set of forms in the health units so that all existing health programmes and general administration information are brought together. The health units write monthly reports to the District Health Team which in turn compiles district report. Such information is vital to the district for the “formulation, monitoring, and evaluation of annual plans; monitoring and improvement of health unit service delivery in coordination with support supervision visits; and reporting of selected information to the District Health Committee for planning, monitoring and evaluating progress towards district and national objectives” (Gladwin et al.,2003:216). Later, reports from different districts are used by the ministry to compile national reports.

#### *Privatization and contracting out*

According to Turshen (1999:47-48) privatization in SSA countries as recommended by the World Bank took four forms ;(i) Cost recovery. (ii) Self-financing through third party insurance. (iii)Investment in private voluntary sector and (iv)Decentralization. Similarly privatization involves the transfer of functions to NGOs (voluntary, private for profit, for-not profits (Mills et al.,1990:22; World Bank,1999:77). In Uganda, privatization in health sector took the form of cost recovery (through user fees), and partnerships with private sector (contracting out). The private sector and NGOs have been involved in the provision of health care services or auxiliary services like health unit cleaning services, supply of food stuffs to patients and some drugs as well as construction and maintenance of health infrastructure through tendering basis.

### **3.6 Health Care Decentralization**

Health care decentralization in Uganda dates as far back as independence-1962. Towards independence, the World Bank published a report “*The Economic Development of Uganda*” of which health decentralization was a major recommendation. The report noted:

“We have reasons to believe that, as Uganda moves toward independence, there will in any case be a tendency to greater decentralization. With increasing responsibility being vested in the hands of local authorities for the administration of dispensaries and public health legislation, and possibly even regional health boards for the management of

district hospitals, health education... would endorse the wisdom of decentralization” (Davis, 1962:116).

Finally, it recommended that:

“Ministry of Health relinquishes much of its administrative responsibilities for health services, becoming to a greater degree an advisory organization...retains in full its inspectorial duties...” (Davis,1962:116).

However, the history of current (democratic) decentralization dates as far back as 1986 when the NRM captured power and started putting their vision of empowering the people in decision making into action (Hutchison et al.,1999:73). This was exemplified by the political system that was introduced. Resistance councils (later local councils) were formed from the village level to the district level, where all people participated in matters that affected their local areas.

Latter alone, a new constitution was promulgated in 1995 and the LG Act was enacted in 1997 (Hutchison et al.,1999:73). The LG Act spells out clearly (at least in principle) the responsibility, obligations and duties of each layer of government and the personnel involved at each layer. Decentralization in Uganda took different forms of decongestion, deconcentration, delegation, devolution, and privatization. However, it appears that devolution overshadowed other forms, and that is why this research gives it due consideration. Furthermore, health decentralization in Uganda had an “inspiration” from the Alma Ata Declaration, the Bamako Initiative and the WBA because these models called for community participation and decentralization of health care service delivery to the district level.

### ***3.6.1 Rationale for Health decentralization***

According to the World Bank, there are six major reasons for health decentralization in Uganda: (i)improve management efficiency and effectiveness,(ii)increase local representation and community responsibility,(iii)strengthen financial performance through increased revenue generation and rational expenditure decisions, (iv)produce

public goods and services more efficiently, (v)improve integration and (vi)ensure access to primary health care services (World Bank,1999:78-80).

### *3.6.2 The structure<sup>7</sup> of decentralized health care*

Within a decentralized health care delivery, different layers and actors have different responsibilities, duties and obligation to play. For instance:

*Ministry of Health:* Under the new Constitution and the 1997 LG Act, its core functions are: (i)policy formulation, standards setting and quality assurance, (ii)resource mobilization, (iii)capacity development and technical support, (iv)provision of national co-coordinated services, e.g. epidemic control, (v)co-ordination of health services, (vi)monitoring and evaluation of the overall sector performance and (vi)training.

*Districts:* The health responsibilities of district are (i) implementation of National Health policies, (ii) planning and management of district health services,(iii)provision of disease prevention, health promotion, curative and rehabilitation services, with emphasis on the Minimum Health Care Package and related national priorities, (iv)vector control, (v)health education, (vii)ensuring provision of safe water and environment (viii)health data collection, management, interpretation, dissemination and utilization,(ix) recruitment and management of personnel for District Health services, (x) passing by-laws related to health and (xi)planning, budgeting, additional resource mobilization and allocation for health Services.

With in the decentralized health framework, the 1999 National Health Policy (NHP) has been developed. The NHP derives guidance directly from the National Health Sector Reform Programme and the National Poverty Eradication programme. It is reorganised that “poverty is the main underlying cause of poor health situation in the country” (MoH, 1999:20) and “for development to be sustainable, health and economic growth must be mutually reinforcing. Health is an essential prerequisite as well as an outcome of sound development policies. Without good health, individuals, families, communities and nations cannot hope to achieve their social and economic goals” (MoH,2000:30). It is

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<sup>7</sup> See Appendix A

important to note that the Alma Ata Declaration provided significant input and guidance into this policy.

The 1999 NHP and the health component of the Poverty Eradication Action Plan (PEAP) have been implemented through Health Sector Strategic Plan (HSSP). The principal aims of HSSP are to: (i) improve access of the population to the Uganda National Minimum Health Care Package (UNMHCP), special attention is placed on increasing effective access for the poor, the difficult to reach and the otherwise disadvantaged, (ii) improve the quality of delivery of the package and (iii) reduce inequalities between various segments of the population in accessing quality services. HSPP pays particular attention to (i) training, recruitment, rational deployment, motivation and retention of qualified staff across the country, (ii) rehabilitation and improvement in the performance of existing facilities while providing new facilities to identified underserved populations and (iii) social mobilisation for community empowerment and participation in the management and monitoring of health services.

### **3.7 Conclusion**

Health care development in Uganda experienced ups and downs since independence up to 90s. These ups and downs can be linked to three major factors (i) the policies under taken by different regimes, (ii) the 1970's and 80's economic crisis that hit most developing countries and led to deterioration of health status, (iii) and a mystical faith in the "free market" or an ideological shift towards the "free market". Amidst deteriorating health conditions, Uganda carried out fundamental HSRs (on the advise of IMF, World Bank and donors) to reverse the health situation. The major reforms included: civil service reforms, HMIS, decentralisation, cost-sharing, privatisation and partnerships among others. These reforms have been ambitious with broad and (at times) unrealistic objectives. Ever since their adoption, some benefits/achievements (as discussed in chapter 4) have been registered. However, they have also generated or exacerbated various problem/challenges (as discussed in chapter 5) which have affected health care delivery and utilisation.



## **CHAPTER 4: BENEFITS/ACHIEVEMENTS IN HEALTH SECTOR REFORM**

### **4.1 Introduction**

This chapter assesses the effectiveness of major HSRs adopted in Uganda to improve health care delivery and utilization. Using the analytical framework explained in chapter one, the results of HSRs in terms of output and outcomes indicators give a sense to which health care delivery and utilization have been affected. This chapter is divided into three main sections. Section one discusses the current state of health care in Uganda while section two discusses the nature and categories of health care providers. Section three goes into a deeper discussion of the benefits/achievements of HSRs in Uganda. The ultimate aim of this chapter is to evaluate whether the quality of health care has improved, declined or stagnated after HSRs.

### **4.2 The Current State of Health in Uganda**

Uganda is a rural based agrarian economy with over 85% of its 26 million people living in the countryside. For the financial year 2003/2004 it had a per capita income of about US\$250 with Gross Domestic Product (GDP) of 12.1 trillion growing at a rate of 6% (MFPED,2004:4,6). Poverty levels reduced from 56%(1992), 44% (1996/97) to 34% (1999/2000). However, poverty increased slightly to 38% in 2002/2003 (MFPED,2004:28). Currently IMR stands at 88/1000 and MMR at 505/100,000. The ratio of health workers to the population stands at 1:18,700 for doctors and 1:3,065 for nurses and Midwives. Life expectancy (2000) was 43 years, total fertility rate 6.9 while population per hospital bed was 870 (MOH, 2003:5).

Despite the hard won economic growth and economic stability in the last two decades, the living conditions of the vast majority are worrying. Some social indicators-like poverty levels, income equality, rural safe drinking coverage, health workers/population ratios are still poor though they are said to have improved. Malaria and other preventable diseases still account for about 75% of life lost due to premature deaths (MoH,2003). Though the government is making deliberate efforts to “go” rural in terms of health care facilities, the urban bias still dominates (Hutchinson et al.,1999:16).

Great improvement could be done to the socio-economic situation of the poor, especially through increased and targeted public expenditure on health care to rural areas where the poor people who can not afford to pay for health care services live. However, the national budget is limited and the priority is given to other sectors like the defense and military. The small budget allocated to the health sector is insufficient to sustain it for proper functioning. For instance, public expenditure on health (as % of GDP) in 2000 was 1.5 compared to military expenditure (as % of GDP) in 2001 that was 2.1(HDR, 2004). That is why health workers in government health facilities are “poorly” paid leading to rampant strikes thus affecting health care delivery quality.

#### 4.3 Categories of Health Care Providers in Uganda

There are three categories of health care providers in Uganda; the government, private commercial (for- profit) and private-for-not- profit (charitable, NGOs). Since 1972, the number of public, non-governmental and private units has increased almost 400 percent (see table 2) (Hutchinson et al.,1999:7). It is important to note that health units shown in table 2 do not include medical laboratories, pharmacies and nursing homes where the private sector and NGOs take a lead.

Table 2: Number of private and government health units countrywide

	Year		
	1970	1984	1996
National Population	9,535,100	.....	19,500,00
Hospital	62	79	98
Health Centres	46	106	223
Dispensaries/maternity units	65	93	124
Maternity units	20	41	376
Dispensaries	103	77	603
Sub-dispensaries	110	367	57
Aid posts	0	161	33
<b>Total</b>	<b>406</b>	<b>924</b>	<b>1,505</b>
Population/health unit	23,485	.....	12,957

Sources: Hutchison et al. (1999:8), Dodge(1987:106)



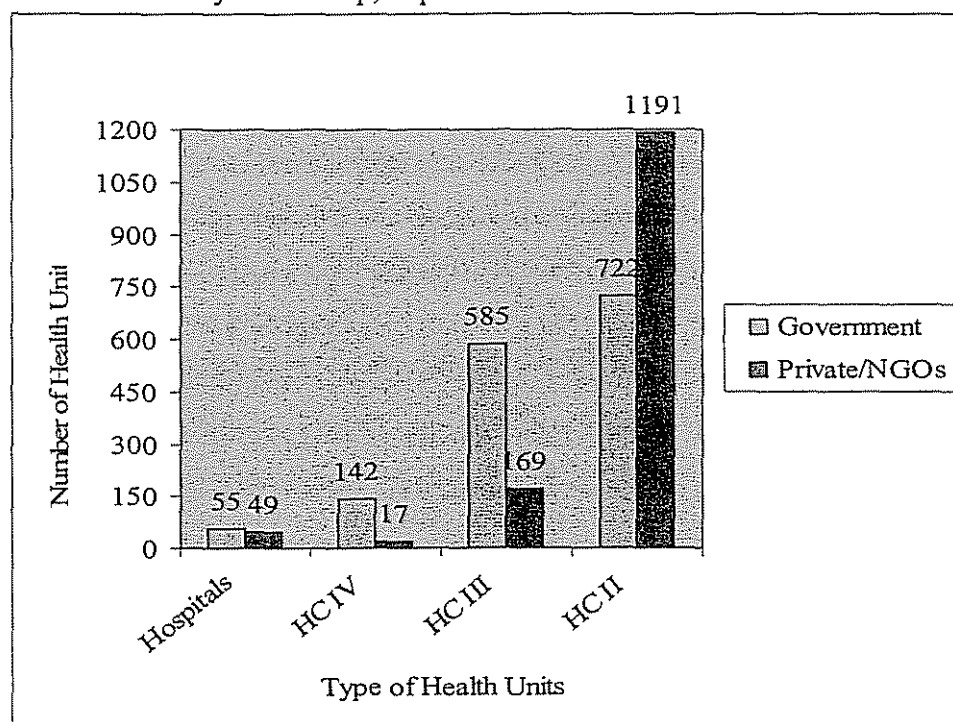
Table 3: Distribution of Health Facilities in Uganda, 1995-96

Health Facilities	Government	NGO/Private
Hospitals	55 (4%)	43(3%)
Health Centres	158(10%)	65(4%)
Dispensaries and below	872(58%)	312(21%)
<b>Total</b>	<b>1,085(72%)</b>	<b>420(28%)</b>

Source: Hutchison et al.(1999:9).

By September 2001, the number of health units had increased to 2,930 (see figure 3). Of these, the government accounted for 1,504(51.3%) while private/NGOs accounted for 1,426(48.7%).

Figure 3: Health Units by Ownership, September 2001



Source: MoH < [www.health.go.ug](http://www.health.go.ug) >

These figures show a tremendous increase in the share of private/NGO from 420 (28%) in 1994-95 (see table 3) to 1,426 (48.7%) in September 2001 (see figure 3). However, the number of health units currently is higher than this for two reasons: First, the government has embarked on the programme of building more health units country wide and secondly, there are many documented private health units in the country.

#### **4.4 Benefits of Healthcare Reforms in Uganda**

Health care reforms have benefited health users and providers.

##### ***4.4.1 Health unit infrastructure***

To improve health care quality and quantity, the government launched a programme of building health units at all local levels. These are Health Centre twos (HC2s), Health Centre threes (HC3s), Health Centre fours (HC4s) where health workers have been posted to bring health care services closer to the population. For example, since the inception of HSSP in 2000, the government has built 400 new HC2, upgraded 180 HC2s to HC3 status (including maternity services) and is upgrading 150 HC4s to provide emergency obstetric and surgical services (MFPED,2004:32). About 48% of these health units in rural areas are provided with power (hydro, solar or thermal) and more are yet to benefit through the Energy for Rural Transformation (ERT) Health component<sup>8</sup>. Furthermore, an ambulance vehicle has been availed to at least every HC4 to reduce transportation costs. In order to increase admissions at health facilities a number of beds has increased leading to a reduction in patient/bed ratio.

##### ***4.4.2 Public-private mix: the role of private providers in healthcare delivery***

With the upsurge of HIV/AIDS pandemic in Uganda, local NGOs have played a greater role in offering health care and other related services to the AIDS/HIV patients and their families. The most significant ones are TASO and AIC. These health NGOs offer services like Voluntary, counselling and Testing (VCT), medical care/treatment of opportunistic diseases like Tuberculosis for HIV/AIDS patients as well as food supplements (most especially TASO) and offer material and monetary support to HIV/AIDS orphans. For instance, since its inception TASO has served over 90,000 clients, assisted 1865 children in education and other programmes, and provided nutritional support to 28,140 beneficiaries<sup>9</sup>. At the same time, donors and International NGOs have also contributed a great share in health care service delivery. With concerted efforts (from the government, NGOs and private commercial sector) HIV/AIDS

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<sup>8</sup> see *The New Vision*, 18<sup>th</sup> July 20004, 'Sh 10b earmarked for health units'

<sup>9</sup> see <[www.tasouganda.org/output/php](http://www.tasouganda.org/output/php)>

prevalence has drastically reduced from 18.5% (1995) to 14.7%(1997) to 9.5%(1998), 8.3% (1999), 6.1%(2000) (MoH, 2004).

These NGOs have a great advantage of offering health services at subsidized or free cost to the rural areas where most poor people live since they are rural based with various outreach programmes and mobile clinics. They also have a well dedicated professional staff. Thus, NGOs in this case become the viable channel through which the poor can access health care services. The government has further enabled most NGO health facilities by paying salaries to some of their health workers (Lindelow et al., 2003:18). However, most private health providers concentrate more on curative care where cost recovery is easier than preventive care.

#### ***4.4.3 Traditional (herbal) medicine and healing***

Another major component of the health care reform in Uganda is the recognition given to traditional medicine and traditional medical practitioners. When the western medical care system was introduced in Uganda, there were deliberate attempts to do away with traditional medicine that was labelled witchcraft and sorcery. However, now efforts have been made to integrate traditional medicine into the main stream health care system. Such efforts have seen the establishment of a modern traditional medicine laboratory in Kampala to test traditional/herbal medicine. Furthermore, an association of traditional herbal medicine and traditional healers has been formed and encouraged by the government. Traditional herbal medicine practitioners have an advantage of availing herbal medicine at reasonable prices to the poor people who are unable to afford high health care costs at government or private health facilities. This has partly helped in preventing, controlling and treating some illnesses.

In the same vein, traditional birth attendants (TBAs) have been incorporated into main stream health care as important partners. They have been trained, registered and given kits to offer health services in communities. Though with hurdles, they are increasingly becoming more convenient and reliable health providers. As a result of their great contribution to reproductive health care services, the number of births under the care of

health providers has increased from 25% (1985-90) (World Bank,1994) to 38% (2000-2001).

#### ***4.4.4 Accessibility to (public) health facilities- distance to health units***

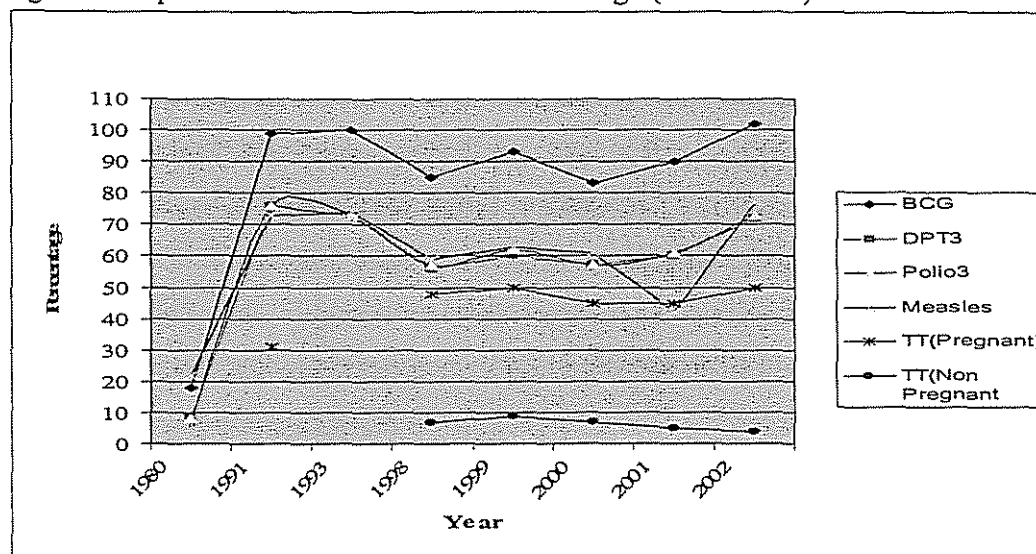
The expansion of health unit infrastructure in Uganda has had a substantial impact on geographical access of the population to health services. Indeed Hutchinson et al.(1999:7) note that by 1993, 49% (currently its 48%) of the population live within 5 kilometers, about one hour's walking to a health unit providing both curative and preventive health services unlike in 1980s when there was only 27%, with additional 43% beyond 10 kilometers. However, significant regional differences exist. For example, far few households in northern districts (like Moroto, 9%) live within 5 kilometers of a health unit relative to the more densely populated regions of central and eastern Uganda (Hutchinson et al.,1999:7).

However, there is hope that with the current system of establishing health units at various local levels, the number of people living within 5km from health unit will tremendously increase. For instance, by the end of 2001, at least 74% of Ugandans were able to find at least a health centre within a walking distance. With reduced distances to health units morbidity and preventable deaths will greatly reduce (MFPED,2000:64).

#### ***4.4.5 Quality of health care services offered and service mix***

Even though there are numerous health units in the country, many do not offer basic primary health care. Only 69% of all health units (private commercial, NGOs and government) provide immunizations, family planning and antenatal care. But nevertheless, the few existing ones have been effective in providing vital health care services like immunization against the major six killer diseases and other services like family planning and antenatal care. For instance, countrywide immunization rates for antigens such as BCG, Measles, Polio and DPT3 for children under one year have been increasing since 2000. There has been an upward trend for all antigens except for *tetanus toxoid* for non-pregnant women, which slightly kept on reducing as shown in figure 4.

Figure 4: Reported routine Immunisation Coverage (1980-2002)



Sources: UBOS: <[www.ubos.org/abstract%20022003.pdf](http://www.ubos.org/abstract%20022003.pdf)>; Uganda National Population and Housing Census (2002: 23); World Bank (1994)

The national immunization rate coverage has increased from 41% in 1999/2000 to 84% in 2003/2004 (Yates, 2004: 50). Regarding maternal health care services, an improvement has been recorded. The number of women who deliver with assistance of health workers increased from 25% (1985-90) (World Bank 1994) to 39% (1995-2001).<sup>10</sup> Concerning Family Planning the percentage of women using contraceptives has increased from 3-5% (1986) to 15% (1999)<sup>11</sup> and to (23%) for the period 1995-2001 (HDR, 2004) at the same time condom use increased although Uganda is one of a few countries in SSA with a low condom per capita.

The availability of health care workers plus the amount of “productive” time spent at health facilities greatly affect the quality of services offered. Though absenteeism is still reported among health care workers it has greatly reduced. Indeed Lindelow et al. (2003: 14), document that over “92% of the staff in the health facilities studied reported to work full time”. This therefore implies that health facilities are open for long hours unlike it was 1980s and early 1990s.

<sup>10</sup> See *The New Vision*, 9<sup>th</sup> September 2004 ‘Pregnant women shun (government) hospitals

<sup>11</sup> see <[www.sti.ch/pdfs/swaps150.pdf](http://www.sti.ch/pdfs/swaps150.pdf)>

#### 4.4.6 Drug/medicine availability for the “haves”

Availability of drug is probably the most important indicator to assess the performance of any health facility. Patients (with adequate funds) find it easy to get health care services from private providers unlike in the past when they could wait for many hours. According to Lindelow et al.(2003:34), there are various reasons (see table 4) given by clients for choosing a specific health units.

Table 4: Reasons for visiting different health units

Reason/ownership	Government	Private for-profit (private commercial)	Private not-for-profit (NGOs)
Proximity	48.6	30.2	39.2
Good treatment and service	<b>32.1</b>	<b>48.5</b>	<b>38.9</b>
Good health workers	<b>5.3</b>	<b>13.4</b>	<b>11.7</b>
Less expensive	12.7	5.5	7.3
Others	1.3	2.5	2.9

*NB. Numbers may not sum to 100 percent because of rounding. Source: Lindelow et al. (2003:34).*

For instance, 87.4% (48.5% private commercial and 38.9% NGOs) of clients prefer visiting private health care providers while 32.1% prefer government health units because of good services (like quick service, no need for making appointments, availability of drugs) offered at private units. Similarly, Whyte (1991:138) found that client preferred private health providers because of the perceived superior health care services.

Secondly, the behavior of the health care providers, from the user's perspective determines the quality of services (Green,1994:56;Whyte,1991:138). Because of good and courteous health workers, 13.4% visited private commercial providers, 11.7 % NGOs and 5.3% government health units. Soeters (1997:90) found out that polite behaviour and respect for patients in Zambia were among major factors that induced patients to seek more health care from private health care providers than from government health units. The same scenario in the Kenyan health care system was documented by Bedi et al.(2003:17). Lastly, clients visited regularly government health units unlike private providers because of two main reasons: proximity and inexpensiveness. However, these two factors can not compensate for the poor quality of services offered. That is why in

most cases, “rich” patients travel relatively long distances to private health units for superior services.

#### 4.4.7 Training and training institutions

The number of private and public medical training institutions has increased. By September 2001, there were 41 training institutions (30 governments and 11 NGOs/private)<sup>12</sup>. This among others has led to a slight increase in health workers-population ratio. However, this ratio is still low (see table 5) like in other SSA countries.

Table 5: Number of private and government staff country wide

Year	1970	1996	2002
Population	9,535,100	19,500,000	24,700,00
<b>Staffing</b>			
Doctors	1,171	964	1,320
Nurses	3,877	4,059	
Midwives	1,793	2,624	
Medical assistant	435	664	
<b>Staffing ratio</b>			
Overall population/staff	7,276	8,311	
Population/ doctor	8,143	20,228	18,700
Population/nurse	2,459	4,804	3,063 <sup>13</sup>
Population/midwives	5,318	7,431	
Population/medical assistant	21,920	29,367	
Population/health staff	1,310	2,346	

Source: Hutchinson et al.(1999:8), MoH (2003:6)

In order to uplift health care among the children through HSSP, an Integrated Management of Childhood illness (IMCI) programme has been launched. This has been accompanied by health worker’s training. For instance in 2001, about 1,040 health providers at the district level received in-service training in IMCI and CDD, while 44 supervisors in 24 district benefited from IMCI/CDD supervision-skill training (MoH, 2001:27).

<sup>12</sup> see <[www.health.go.ug/health\\_units.html](http://www.health.go.ug/health_units.html)>

<sup>13</sup> Nurses and Midwives are combined

#### ***4.4.8 Community participation and “empowerment”***

The management of health units has been boosted by local communities. Through HUMCs, the local communities have played a great role in the management of health units through physical labour and money contributions, planning, budgeting and monitoring the functions and activities of the health units (Hutchison et al., 1999:103; Lindelow et al., 2003:11). They also supervise the health units, take care of regular maintenance and construction. Generally, they are responsible for oversight of personnel, inspection and decision regarding expenditures to improve the quality of care. They have served as a link between communities and the health unit that serves them as they mobilize extensively for activities like public health education, immunization and transportation of the sick to health units. These HUMCs are made up of nine members with Health Unit In-charge as a secretary (MoH, 2003). Other members are elected by the community or sometimes become involved simply because of their official positions for example as local level official. In other developing countries like Senegal participation has also been enhanced by creation of health units committees whose members are elected by the community

#### ***4.4.9 Cost-sharing***

A lot of controversy surrounds the issue of cost sharing in Uganda. Many authors have maintained that cost-sharing in general never affected negatively health care delivery and utilization among many Ugandans. Instead it increased availability, access and affordability of health care facilities and their use in both direct and indirect ways. This was because: (i) the facilities had improved since locally generated resources were available, (ii) health care staff were more accountable to the patients who paid for the services, (iii) more health care staff had been employed using the locally generated funds, (iv) Ugandans had become more responsible for their own health because of financial implication of seeking care thus checking consumer moral hazard and promote allocative efficiency<sup>14</sup> (v) people were more willing to pay and get better services, hence health care utilization had improved (vi) increased community participation inline with the Alma Ata

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<sup>14</sup> *Allocative efficiency judges whether an activity is worth doing and assesses which activities to undertake in order to secure the best outcomes while technical efficiency asks question " given that an activity is worth doing what is the least cost way of providing it? (Soeters, 1997:55-56)*



and Bamako Initiative approaches (Deininger, 2001:1) and (vii) reduced on financing burden faced by the central and local governments.

According to Deininger (2001:1), three conclusions can be drawn as far as impact of imposition of user fees is concerned; First, access to health services had become less dependent on income, rather than more dependant. Thus fears that the introduction of such fees would lead to a systematic exclusion of the poor health services did not seem to materialize. This was because: (i) fees were set at the local level, implementation had been sufficiently flexible to avoid imposition of economic hardships on the poor, (ii) user fees had been ploughed back and resulted in improvement of the quality of service delivery that more than compensated for the cost of gaining access to them, (iii) fees were set at levels that were too low to make an impact on either use or the quality of health service provision.

Secondly, quality of service provision had a major impact on the use of health care facilities and on observed outcomes; (i) quality of health services as measured by variables such as the presence of a doctor, availability of critical medical supplies (including drugs), the distance to the clinic and the number of days the clinics are open, are more important determinants of health facilities' use (ii) providing high-quality services reversed the tendency to seek medical care for those who fell sick, mothers' use of post-natal care, and child vaccinations (iii) having a doctor in the nearest clinic reduced the number of days lost to sickness for those who fell sick, and contributed to lower levels of malnutrition among children and (iv) introduction of user fees seemed to have been accomplished in a way that did not negatively affect the poor, and was associated with an improvement in service quality. Specifically, a US\$1 increase in the fee for initial consultation was associated with an increase of the opening time of clinics by more than one day per week and made it more likely that communities retained those doctors that were already present (Deininger, 2001:2-3). To some extent cost-sharing improved health care delivery and utilisation, but it negatively affected more the poor than the rich as examined in chapter 5.

#### ***4.4.10 Epidemic, disaster preparedness and quick response***

The LGs' involvement in health care provision has increased their awareness to disease outbreak. For instance in 2000/2001 disease outbreaks like *Ebola* fever in Mbarara, Masidi and Gulu districts, *cholera* in Arua and Bundibugyo district, Measles in Kapchorwa and Pallisa districts were successfully controlled (MoH,2001:42-44), thanks to the massive involvement of the LGs.

The local governments have also been involved in health campaigns like immunization. For instance, due to massive immunization campaigns in 2003, the incidence of measles among children has fallen by over 85%<sup>15</sup>. Secondly, they have been active in health care education and sensitization programme. Spearheaded by LGs' political will and commitment, Uganda has been able to reduce the number of districts with Guinea worm disease from 16 in 1986 to 3 in 1999<sup>16</sup>.

Through the LGs, a project aimed at controlling malaria that is responsible for about 38.5% premature mortality deaths in Uganda has been launched. This project that aims at giving insecticide treated misquotes nets while targeting pregnant mothers and children has scored success since its launch. Thus, the rate of malaria occurrence among children and pregnant mothers has drastically reduced. In addition to this project, two quarterly newsletters (Surveillance Bulletins) and a weekly Newsletter were launched in 2001 to provide feedback to the district and health units about the status of Integrated Disease Surveillance (MoH,2001:43).

#### **4.5 Conclusion**

Given the scale, nature and the complexity of HSRs in Uganda, it's very difficult in this research to draw iron conclusions. But the improved output and outcome indicators should be regarded as essential precursors of improved health care delivery and utilisation. For instance, improved accessibility to health units, variety of health care services offered and drug availability (for the haves), reduced mortalities, increased

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<sup>15</sup> *The New Vision*, July 26,2004, 'Measles has dropped by 85%, says WHO'

<sup>16</sup> see <[www.stich/pdf/swap150.pdf](http://www.stich/pdf/swap150.pdf)>

immunisation rates as well as community participation through HUMCs are all steps in the right directions. These improvement indicators clearly show that a number of achievements have and continue to emerge from difficult periods of 1970s, 80 and early 90s. At the same time, these achievements need proper nurturing against the challenges that face the health sector.



## **CHAPTER 5: CHALLENGES/PROBLEMS OF HEALTH SECTOR REFORMS**

### **5.1 Introduction**

Chapter four discussed the benefits/achievements that have been realised as a result of HSRs. This chapter goes further to discuss the challenges. It is important to recall that most advocates of reforms have under estimated these challenges while arguing that they are justifiable sacrifices and would be corrected automatically. This chapter is divided into two sections. Section one discusses specific challenges of HSRs while section two examines the new role that the government ought to play given the ever increasing numbers of health care providers.

### **5.2 Problems/Challenges of Reformed Health Care**

Many challenges in varying magnitudes have emerged as a result of the implementation of HSRS in Uganda. These include:

#### ***5.2.1 Consumer/client exploitation***

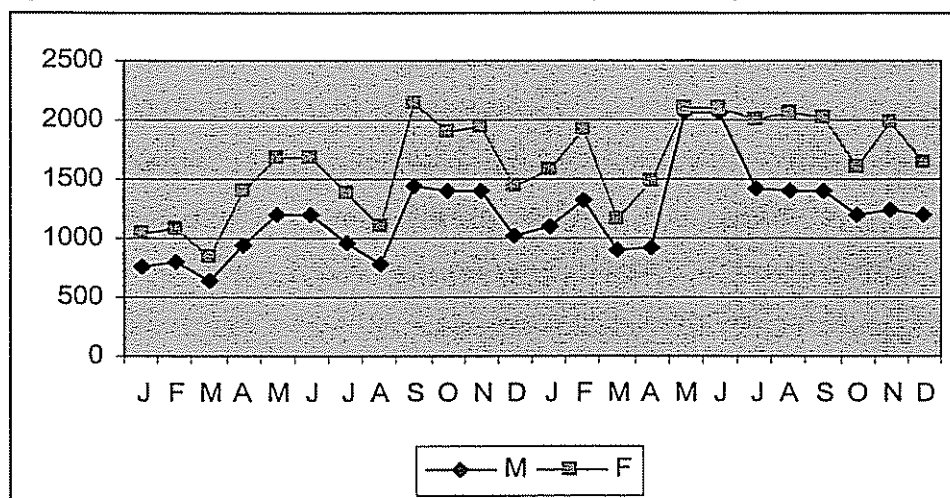
Studies done in Uganda indicate that the medical costs of obtaining health care from the private commercial and NGO units are greater than from the government health units (Lindelov et al.,2003; MFPED,2000:65). Although private commercial and NGO health care units offer “perceived” better quality services they usually charge higher medical costs. Turshen (1999:52) argues that private health practitioners usually prescribe more diagnostic tests and drugs than necessary because they have personal investments in health care facilities and would want to make profits out of them.

Eventually, high medical costs exclude the poor people from seeking health care services from private providers and turn to public health delivery system where services are not good. The poor now resort to traditional healers and TBAs whose fees are charged according to ability to pay, treatment is provided on credit, providers locally available and are usually courteous. High medical costs also lead poor people to take fewer tablets/injections or partial treatment than recommended dose (MFPED,2000:66; Asiimwe,2000). Some patients out rightly default paying their medical bills. Various

private health providers have different mechanisms of compelling clients to pay their medical bills. For instance, an NGO hospital in Kampala established a “retainee ward” for patients who fail to pay their medical bills (Asiimwe 2000). They are only released after paying. Other health providers confiscate clients’ personal property in case one fails to foot medical bills. The poor have devised a wide range of survival strategies. They have resorted to self-medication, herbal/native medicine or traditional healers. In worst cases the poor have “decided” not to seek medical care. For instance, at least 55% of the poor in Uganda never seek health care when ill or injured (Hulme,2004:95-99). All this has led to more health problems.

When it comes to cost exclusion from access to health units, women and children are hardest hit (Kwagala et al.,2000; MFPED,2000:65) that is why when user-fees were “abolished” in Uganda, the number of women OPD at public lower lever units in 2001/2002 was higher than that of their male counterparts because of women’s peculiar reproductive health care needs (see graph 5).

Figure 5: Women at Public Lower Level Units (2001-2002)



Source: Batarigaya (2003:8)

### 5.2.2 Drug over prescription

Inappropriate drug administration has become a great problem among all developing countries that have adopted HSRs (Lloyd-Sherlock, 2000). Similarly, Lindelow et al.

(2003), note that private commercial health providers over-prescribe and give excessive drugs to their clients/patients for three major reasons: First, they are always driven by “profit motive”, so they maximise sales at high prices (Lindelov et al.,2003:39) because their profitability clearly depends on drug sales (Whyte 1991:136). Second, to minimize personnel costs, they usually employ ill-trained staff who are not conversant with drug prescription. Third, pressure from clients with poor knowledge about health and health care e.g. “the demand for injectable drugs when oral preparations or no drugs at all would be appropriate” (Lindelov et al.,2003:40).

However, it is interesting to note that also in government health units drug over-prescription is rampant (Lindelov et al.,2003). This may be because the government lacks adequate trained health professional to offer “right” medical treatment and depends on ill-trained staff, who may be willing to work in rural areas. Second, most health workers in government health units are private health care providers. Hence, they over-prescribe drugs to patients well knowing that they will end up buying medicines (and other health services) from their own health units or at times direct patient to their own health units where they can get “cheap” health care.

According to medical research, over-prescription and under-dosage have led to occurrence of drug resistant disease. MoH (2001:15) findings indicate that malaria resistance to *Chloroquine* ranges from 2% in Rukungiri (south west) to 23% in Arua (north west) to 45% in Moroto (north east) and 65% in Kampala (central). Malaria which was treated by *chloroquine* or *quinine* is now treated by more powerful and costly drugs like *Artemam/Artemether* or a combination of *Chloroquine* and *Sulphamathaxazole-Pyrimethamine* as the first line treatment (MoH,2001:12), thus burdening the poor (Kwagala et al.,2000:172) with extra costs. Such findings are in agreement with what Bedi et al.(2003:18) found out in Kenya.

### ***5.2.3 Self-prescription and self-medication***

This practice emerged with the breakdown of health services especially in 1980s and has since persisted. Earlier studies in Uganda had speculated that self-prescription and self-

medication would disappear with improvement in health care delivery and utilization (MFPED,2000:66). Self prescription and self-medication have a number of side-effects on patients. First, it puts the patient's life in trouble and may results into death especially where the overdose is administered. Second, it makes diseases drug resistant in case of under dose or wrong dosage (Kwagala et al.,2000:174) thus making patient sick all the time. Despite various health repercussions many people still practice self-prescription and self-medication. This number is high in rural areas where the population can not easily access viable health care.

It is important to note that this practice has now been fuelled by health sector liberalization which has "demystified" the medical knowledge, led to emergence of quack doctors, mushrooming of unregulated drug shops and clinics country wide. Self-prescription and medication was also documented in Brazil, El Salvador, Chile, Mexico, Argentina and Colombia (Lloyd-Sherlock, 2000:8), Kenya, Zambia (Bedi et al.,2003:17) where HSRs have been adopted since early 1980s.

#### ***5.2.4 Emergence of "Informal" health care providers and medicine vendors***

With the liberalization of the health sector, many people have joined health care delivery "business". This has seen the emergency of quack doctors, nurses, and midwives opening up health units to offer health care services. Some even operate mobile clinics in buses that ply various routes from the capital<sup>17</sup>. In rural areas, where the government has not been able to reach, such practices command a substantial percent of patronage. It is common in the Ugandan daily newspapers<sup>18</sup> to read about health workers whose illegal operations have led to loss of life. For instance, by assisting young (students) girls to carry out abortions.

Informal health care provision has thrived in Uganda basically for three reasons. First, there is inadequate regulation and monitoring as Asiimwe (2000:6) notes:

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<sup>17</sup> *The New Vision*, 1<sup>st</sup> September 2004, 'Mukula (State Minister for Health) orders arrest of bus owners (who allow unlicensed drug sellers to operate in their buses)'

<sup>18</sup> *The New Vision*, 15<sup>th</sup> June 2003 'A "Doctor" arrested for attempted abortion'



*“the regulatory framework for private health facilities in Uganda is made up of various bodies with rules and regulations that are not harmonized. With each body dealing separately with specific categories of providers, common standards are difficult to implement”.*

Second, due to corruption among the legislators/licencing officers, many informal health service providers have survived through offering bribes. Thirdly, inability of LGs to extend services to the rural areas where they are in a great need. It is hoped that with the establishment of health units at every parish, under the HSSP the size of informal sector may decline gradually.

#### **5.2.5 The Physical structure of health units**

Most of the private health units especially in rural areas are in deplorable state. They have inadequate facilities to keep drugs .They sell and administer expired drugs to their patients, thus a threat to lives<sup>19</sup>. At times the medicines are mixed with other merchandise. In most cases private clinics and nursing homes are situated in inappropriate locations. They usually operate in small rooms usually divided using curtains, mats or cardboards hence undermining the patients’ privacy since other patients seated inside the partitioned small room are likely to hear what the health provider is discussing with another patient. It is common to enter a private health unit (which admits patients) and see patients sharing the same bed<sup>20</sup> with their fellow patients or with their attendants or sleeping on the floor without adequate beddings. The smallness of most clinics and nursing home can easily increase the spread of contiguous diseases such as flue, measles, *Ebola* or tuberculosis thereby compromising the quality of care at the facility (Asiimwe:2000).

#### **5.2.6 Health care workers’ “survival strategies”**

McPake (2002:32) documents a number of survival strategies used by public health workers in Uganda. First, shifting labour from government health units to private commercial units. They frequently absentee themselves or arrive late at public health units and leave early to attend to patients at their own private health units (Lindelov et

<sup>19</sup> *The Monitor* 22<sup>nd</sup> Feb. 2000 ‘Expired drugs on an Increase in Uganda’

<sup>20</sup> *Lack of adequate beds and over crowdedness is more pronounced in private than public health facilities*

al.,2003). This is in agreement with the World Bank's findings where staff absenteeism was 35% among health workers in Ugandan public facilities. Second, drug leakages<sup>21</sup> have hampered the government's efforts to ensure that her health units are fully stocked. Other studies done in other developing countries document cases of drug leakages. For instance, "In Tanzania, poorly trained health personnel steal government medical supplies and sell them illegally to patients, who are told that these same items are out of stock in public facilities" (Turshen,1999:50). Third, creation of "ghost" patients so as to avoid drug and patient usage audit mismatches. Fourth, misappropriation of funds. Fifth, under table charging and sixth operation of private health units and home treatment. The survival strategies employed by public health care workers, have put public interests at risk.

#### ***5.2.7 Human resource capacity constraint and human "exports"***

As shown in table 5, the ratio of trained medical personnel is low like in many developing countries. Despite these low ratios, public service reforms adopted have necessitated a ban on recruitment of additional staff. That is why by 1998 only 34% of the approved public health service posts were filled (Brown,2003:21), leaving 66% posts vacant. Studies by Lindelow et al.(2003), Olowu et al.(2001), Hutchinson et al.(1999), Nsibambi (1998) clearly indicate that lack of adequate human resource is a major challenge to decentralization. It even becomes worse when the few existing personnel refuse to work in rural areas despite various incentives provided to attract them. With the "abolition" of cost-sharing in government health units, the rural health units which used locally generated funds to employ more health workers or "top-up" the health workers salaries were hit most (Lindelow et al.,2003:39). Paradoxically, a country which lacks frontline health workers like the nurses is the one that plans to "export" them to developed countries like United Kingdom (UK) to earn foreign currency.

#### ***5.2.8 Inadequate funding and drug shortages***

Although public health care funding is said to have increased in recent past, it is still low. For instance, the per capita health expenditure in 2002 was US\$12 against US\$30

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<sup>21</sup> *The New Vision*, April 27,200, 'Hospital dispenser arrested'

recommended (MoH,2003:6). Because of inadequate funding, at times government health care units run out of vaccine or medical stocks. Of the health facilities studied by Lindelow et al.,(2003: 22), “approximately 40% of government facilities reported to have run out of some or all vaccine for the major six killer immunisable diseases in the fiscal year 1999/2000” and restocking of some units took up to 5 months. Furthermore, 40% of government units reported occasional acquisition of their own drugs and medical consumables (like bandages, cotton wool, syringes and gloves). When it comes to acquisition of their own consumables, the prices are always inflated by the buying officers or suppliers.

#### ***5.2.9 Loss of morale among government health workers***

Despite having “higher” salaries in comparison with those employed by private providers, government health workers still complain of poor remunerations. They have for the “last ten years been struggling with the government through strikes and demonstrations” to have their salaries raised<sup>22</sup>. Consequently, some health workers have quit public service and established their own health units or left the country for greener pastures. For instance, health workers recently left Mbarara University Teaching (Regional Referral) Hospital to Rwanda for better pay, as nurses and midwives have headed for Europe. This “exodus” of health workers is compounding a problem of insufficient well-trained personnel in civil service. In her study of privatization of health services in Africa, Turshen (1999:54) noted the same situation of health workers leaving the countries of Ghana, Malawi and Sudan for greener pastures abroad.

#### ***5.2.10 Problems of decentralized health care system***

Much as neo-liberal thinkers argue that health decentralization is beneficial (as earlier discussed). Studies done in Uganda and in other developing countries have shown problems of this system. Hutchinson et al.(1999:81) argue that health decentralization in Uganda, at times has led to misallocation of funds into “non-priority” areas by LGs as they have become powerful, most especially “where wrong people are in control”.<sup>23</sup> Such

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<sup>22</sup> *The New Vision*, 21, June 2004, ‘Medics thank Museveni for pay hike’

<sup>23</sup> *People who do not support Museveni’s NRM policies, especially multipartists*

LGs have deviated from the national priority areas, thus generating conflicts between them and the CG/MoH. Second, health decentralization has led to a tendency to create mini-CGs at the district hence creating more local bureaucracy (with powerful local bureaucrats and politicians) while leaving the peripheral areas under or unserved. Third, health decentralization has made it impossible to transfer human personnel from LGs where they are in plenty to where they are scarce. This is because each district has its own independent Service Commission that recruits personnel. Besides being corrupt, Service Commissions have been accused of being “in-ward looking” by recruitment personnel who are locals. This has affected the quality of personnel as well as the quality of services offered. Fourth, decentralization tends to enhance inequalities among LGs.

#### *5.2.11 Community participation, a “hoax”?*

Much as community participation in Uganda’s health care system has been positive (as earlier discussed), it has not been without serious problems. Hutchinson et al.(1999:103), argue that many newly appointed community health leaders have a poor understanding of health system and priorities. Local politicians have used HUMCs to consolidate their local powers. Accusations of nepotism, misuses of health units’ revenues, violence among members are usually cited against HUMCs. At the same time local elite capture has been rampant. It is interesting to note that a large percent of people who serve on local HUMCs are males and the rich leaving out the poor, women and the youths.

Furthermore, many local people are unaware of how HUMC members are chosen. There is lack of transparency in the selection of committee members and activities. Self-serving behaviour of committee members has been a concern to many. Since HUMC members are not paid salaries, they have devised ways of paying themselves. For instance, they award themselves tenders/contracts to build health units, supply inputs (food, firewood, etc) and other services. In most cases this has resulted into shoddy work, hence affecting health care delivery and utilization. Lastly, conflicts have been documented between HUMCs at different levels (Hutchison et al.,1999).

### **5.2.12 Cost-sharing**

Studies done in developing countries have shown that the imposition of user fees had profound negative effects on health care delivery and utilization among the poor. This is because “elasticity of demand for health care is higher for the poor as compared to the rich and the imposition of user charges reduces access to medical care for low-income groups in the population” (Bedi et al., 2003:1). In Swaziland, in 1984 when fees were introduced in public health facilities 30-40% of the patients who had used them switched to private providers especially traditional healers whose costs were affordable. This eventually led to an overall drop in use of 17.4% (Tueshen,1999:49). Similarly, a 52% decrease in outpatient visits at the government health centres was recorded in Kenya in 1989 after the introduction of fees as was a case in Zambia (Bedi et al.,2003:6; Soeters,1997:127; Turshen,1999:48) and Peru (Gertler et al.,1987:85).

The Ugandan experience was neither an exception. Since the introduction of cost-sharing access and attendance of public health units reduced (MFPED,2000:65). Thus, the practice deprived the poor access to and use of health care units. When cost-sharing was later “abolished” in February 2001, there was a 40% increase in new outpatient attendance in government health units and not for profit (NGOs) between 2000/2001 and 2001/2002 (Bataringaya,2003:6). Although cost-sharing was officially abolished, the practice shows the contrary. Illegal payments take place in government health units and this has a great potential of barring the poor from accessing care from government health units.

### **5.3 The New Role of the Government**

After scanning through the reforms adopted and the new role that the dynamic private commercial and NGO sectors are playing in the health care delivery, it leaves one to question the new role of the central and local governments. Some have argued that the state has become completely powerless and weakened thus structurally withdrawing from the public health care delivery. In some cases the private commercial and NGO sectors are said to have become a substitute of the government. The new important roles of the government should be: First, enablement (political, economic/financial and institutional)

of other actors. Second, regulation through setting clearly and fairly the rules of the game that will generate, support and sustain competition among various actors. Third, timely monitoring of all health care deliverers.

#### **5.4 Conclusion**

This chapter has shown that there are many problems/challenges facing the current health sector that for long have not been given due attention. These included: consumer/client exploitation, drug over-prescription, self-prescription and self-medication, informal provision, inadequate funding and drug shortages as well as human resources constraint. The presence of these problems/challenges calls for quick action from health care users, providers and deliverers otherwise the modest achievements will be lost and the quality of health care will reverse to that of pre-reform era.

## **CHAPTER 6: LESSONS, CONCLUSION AND RECOMMENDATIONS**

### **6.1 Introduction**

The main aim of this chapter is to draw lessons and recommend alternative policy interventions to the health care system in Uganda. It is divided into three sections. Section one examines the lessons learnt while section two gives a summary and conclusion of the whole debate as discussed in the previous chapters. Lastly, section three suggests recommendations.

### **6.2 Lessons Learnt**

First, monetary reward is not the single source of motivation to health workers. That is why, despite receiving relatively higher wages, public health workers are unmotivated and offer inferior services compared to those of their counterparts in private practice. Second, the health sector has experienced enormous investments from the government, donors, private commercial and NGOs sectors. Third, HSRs have had differential impacts on different groups of the community, fourth, user fees are regressive among the poor such that any increase in user fees leads to a fall in their demand for health care. Fifth, HSRs have conflicting objectives (e.g. equity Vs cost-recovery) which are hard to reconcile. Sixth many actors who have come on board as a result of HSRs require a systematic and comprehensive regulatory and monitoring framework. Lastly, external influence has characterized most of the HSRs adopted in most developing countries as exemplified by policy shifts to suit the tastes of donors.

### **6.3 Summary and Conclusion**

As already indicated, the study has shown the direction to which the HSRs have taken the health care delivery and utilization. In some cases, the quality of health care has improved while in other cases it has either stagnated or declined. For instance, cost-sharing that was aimed at improving quality health care delivery and utilization never resulted in improved health care, sufficient local resource mobilisation etc anticipated. Furthermore, it is very hard to single out which of the policies adopted has had significant impact on health care delivery and utilisation than the other. This is because changes in

health indicators are a result of a combination of various reforms. It is also difficult to attribute all the changes in the health sector to only HSRs. They could have come as a result of other social, economic and political factors like favourable political and economic environment.

Decentralizing health care may not improve the quality of service, responsiveness to local needs and efficiency; First, if LGs have very limited managerial capacity and still dependant on the centre for almost (if not) all their resources. Second, if health budgets are arbitrarily raided to finance the costs of the local administration. Third, if the rules of the game are not clear about the responsibility between the CG and LG health officials and other health care providers. Fourth, if the government doesn't step in to regulate and control the activities of the private sector and actions of health workers. Lastly, if the poor people are not given a voice in decision making regarding the health matters that concern their lives

With respect to different providers, it was evident that each of the providers (government, private commercial or NGOs) had strengths as well as weaknesses. Unfortunately, the neoliberal thinkers tend to favour the non-state actors in health care delivery and push for various policies they consider as "Magic-tablets/injections" and panacea to the "illnesses" of developing countries' health systems. However, none of the above health providers should be considered as a better evil to substitute a worst case. It is therefore, safe to argue that it does not matter whoever provides a service, whether the government or non state as long as the service delivery and its use are sustainable, accessible, affordable, efficient and effective. The most important thing is to consolidate and strengthen achievements made while tackling the failures.

## **6.4 Recommendations**

### **6.4.1 Human resource**

Human resource question needs to be tackled urgently. Since the health policy has shifted from curative to preventive care there should be a shift in training to tailor-made programmes to PHC workers, TBAs and other workers. The health worker recruitment



ban that has been in existence for long needs to be lifted so the health worker-population ratio improves. Harmonization of health worker pay-roll is needed to avoid remuneration differentials that affect health care quality and more incentives are needed to attract health workers to rural areas. Furthermore, the design and implementation of HSRs should be in line with the existing capacities. The tendency to do too much at once is not helpful. Thus there is a need to identify entry points on which reforms programmes can be built. Lastly, better communication of reforms to various actors is vital. Clear communication is only not for political viability but also for community participation

#### ***6.4.2 Regulation, monitoring and disciplining***

- ❖ The government should be efficient in health care regulatory and supervisory roles.
- ❖ Harmonization of the regulatory framework is vital since there are many uncoordinated bodies performing this function
- ❖ Proper mechanism of disciplining the private and public health workers must be in place to avoid patient exploitation, and treatment standards should be set and enforced so that patients are not exploited instead they should be sensitized about good medical practices

#### ***6.4.3 Community Participation and enablement***

- ❖ Community participation should be genuine and all-inclusive –non-state actors should be enabled to actively participate in health care issues
- ❖ The government should encourage and enable the non-state actors to offer preventive services as well (like through financial and logistical assistance)

#### ***6.4.4 Funding and further research***

- ❖ More responsibility should be accompanied by more funding; Health care decentralization should not be seen as away of reducing financial and managerial burden from the centre to LGs. Instead, LGs should be given adequate resources to carry on the new assignments
- ❖ There is a need for “targeted” health care expenditure especially to the poorest quintiles of the population



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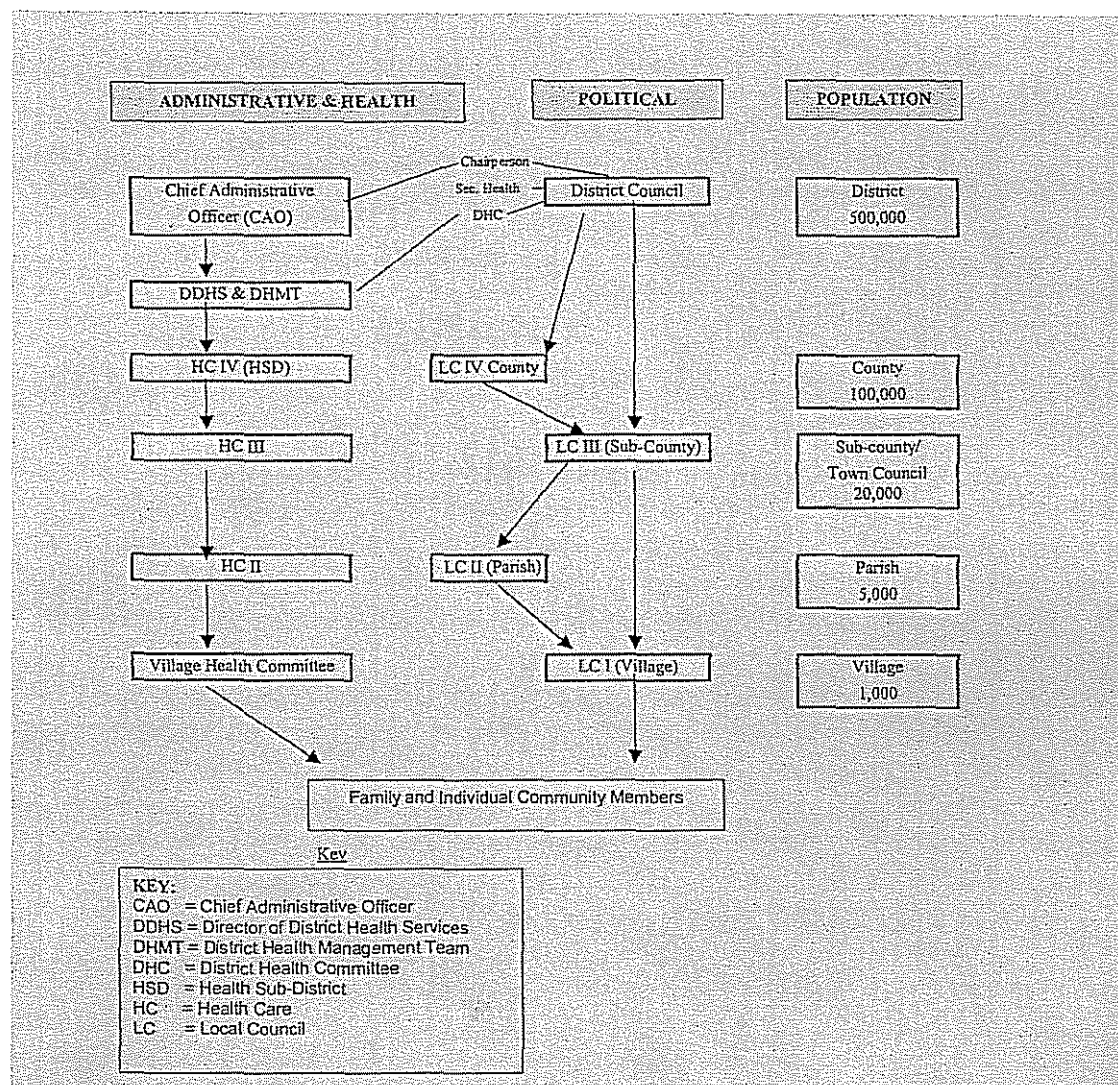
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# Appendix: A Uganda's Decentralized district structure for health delivery



Source: Ministry of Health (2000)

