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

A life thread under threat

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Outline of presentation

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

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

- Same goals and objectives
- Similar principles

Prof. Henry Mintzberge;
“Health is not a business, health is a Calling”;
Kampala, June 27th 2007
The PNFP in Uganda

**Leadership & governance:**
- policy-making
- allocation of resources
- regulation & coordination

**Organisation and delivery of health care services:**
- public – private, for profit – not for profit

**Guiding by values and principles:**
- effectiveness ↔ efficiency
- participation, accountability, trust
- social justice and equity
- sustainability

**Outcomes:**
- universal access
- quality of care

**Goals:**
- improved health
- responsiveness
- social & financial protection

**Organisation of resources:**
- human resources
- financing
- Medical supplies & technologies
- Monitoring & evaluation / information

**Interaction with context**

**Interaction with population**

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Two major categories of PNFP

- Facility based PNFP:
  - Largely faith based
  - Have a sizeable capital investment in place; i.e. Health Facilities
  - 75% are organized under national umbrella organizations: the 4 medical bureaus
Non facility based PNFPs:
- Do not directly own or operate health facilities
- Support/undertake health development activities in partnership with government
- Include international, national and local NGOs/CBOs
PNFP Coordination structures

- Facility based PNFP mainly coordinated by the religious medical bureaus:
  - Uganda Catholic Medical Bureau (1956)
  - Uganda Protestant Medical Bureau (1957)
  - Uganda Muslim Medical Bureau (1998)
  - Uganda Orthodox medical bureau (2009)

- Non Facility based PNFP:
  - Ad hoc coordination structures
  - Disease specific coordination
  - Uganda health NGO network?
Trend of growth of Catholic, Protestant and Muslim founded health facilities in Uganda

- Catholic + Muslim + Protestant HFs
- Catholic HFs
- Protestant HFs
- Muslim HFs

Period of conflicts in Uganda
- Museveni takes over power 1986 to date
- Second Obote and Okello rules (1980-1986)
- Military rule by Idi Amin 1972-1978
- Uganda gained independence, 1962
- First PPPH 1955/56

Cumulative for RCC
Cumulative for Muslims
Cumulative for Protestant
Cumulative PNFP

Sam Orach - based on data from UCMB, UPMB and UMMB, May 2009
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PNFP Contribution to the Health System

- Government funds
  - Donor funds
  - User fees

- Coordination of PNFP sector by medical bureaus
- Collaborate with government structures in policy-making

Leadership & governance

Organisation of resources:
- Human resources
- Medical supplies & technologies
- Information system

Organisation and delivery of health care services

30% of all health facilities (deprived areas)

Interaction with context

Outcomes:
- Universal access
- Quality of care

Goals:
- Improved health
- Responsiveness
- Social & financial protection

Interaction with population

Guiding by values and principle:
- Effectiveness ↔ efficiency
- Participation, accountability, trust
- Social justice and equity
- Sustainability

- Strong community participation
- Appreciation by population

Own supply system, well-functioning

Web-based system

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PNFP Contribution to the Health Sector

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

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

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

Strengthening patients safety practices as a way of improving efficiency in resource utilisation

Trying to improve HR retention
  - Improving HR management
  - Use of HR MIS to improve HR management
  - Training / scholarship
  - Non-monetary benefits

Advocacy for harmonisation of HR management and Terms and Conditions of employment with government
The strains on the PNFP subsector

Leadership & governance
- increasing financial constraints
- Attrition

Organisation and delivery of health care services
Guiding by values and principles:
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Outcomes:
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Interaction with context
Interaction with population

Many resources for total HS are skewed to government
Separate reporting to donors

- role Med Bureaus no authority on operational level (facilities)
- religious owners weak in political advocacy

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Challenges / weaknesses of the PNFP (i)

- Medical bureaus have no direct authority on diocesan health departments and facilities
  - Require a lot of carrot-and-sticks
- Increasing financial constrain amidst increasing demand and
  - Increasing unit cost of service output
- Resources received for the nation mainly used to “strengthen” government system
- Local ownership / governance structure over rely on medical bureaus
- Vertical programs weakening management and governance at facility levels
- Contribution and organisation of the FB-PNFP is increasingly viewed negatively by sections of government
  - Reducing popularity of government facilities
Challenges / weaknesses of the PNFP (ii)

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

- Large resource base
  - F...
Internal challenges / weaknesses of the government system

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

- Uganda is a good example of how:
  - PNFP can complement the National Health System
  - Multiplicity of players is important especially in states of instabilities

- But the good work of the PNFP is now its undoing
  - The effort to redeem government facility is leading to negative attitude towards PNFP
    - Reduction of budget support

- The government system can not be strengthened by simply weakening the PNFP

- Govt policies to reduce support to PNFP is counterproductive to the nation