

Is there a case for contracting health services delivery to PNFPs in Uganda

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Introduction

The draft Public-Private-Partnership for Health (PPPH) Policy for Uganda recognizes three categories of private sector in health as partners to the public sector are the Private Not For Profit health providers (PNFP), the Private Health Practitioners (PHP) and Traditional and Complimentary Medicine Practitioners (TCMP). It is the facility-based PNFPs, that are discussed in this paper. The year 1955 and 1956 saw the beginning of Uganda Protestant Medical Bureau (UPMB) and Uganda Catholic Medical Bureau (UCMB) respectively. Their emergence followed the Colonial Government's recognition of the sub-sector's provision of services to the mainly rural poor and the need to provide them subsidy. The bureaus therefore emerged as channels for provision of such government subsidy. The term "PNFP" instead came into use in Uganda in the late 1990's initially referring to health facilities in three networks of UCMB, UPMB and UMMB. PNFP does not refer to a formal structure. Together the three bureaus now represent 78% the facility-based PNFPs¹, the rest belonging to other humanitarian organisations, community-based health care organisations and other NGOs.

For close to ten years now, as part of the wider public-private-partnership for health (PPPH), the government of Uganda gives budget support to the facility-based PNFPs. However the questions that keep coming up from different people are "Is there a reason for using PNFPs to provide services on behalf of government or to complement government efforts? If so, what approach should be used to obtain health delivery through PNFPs?"

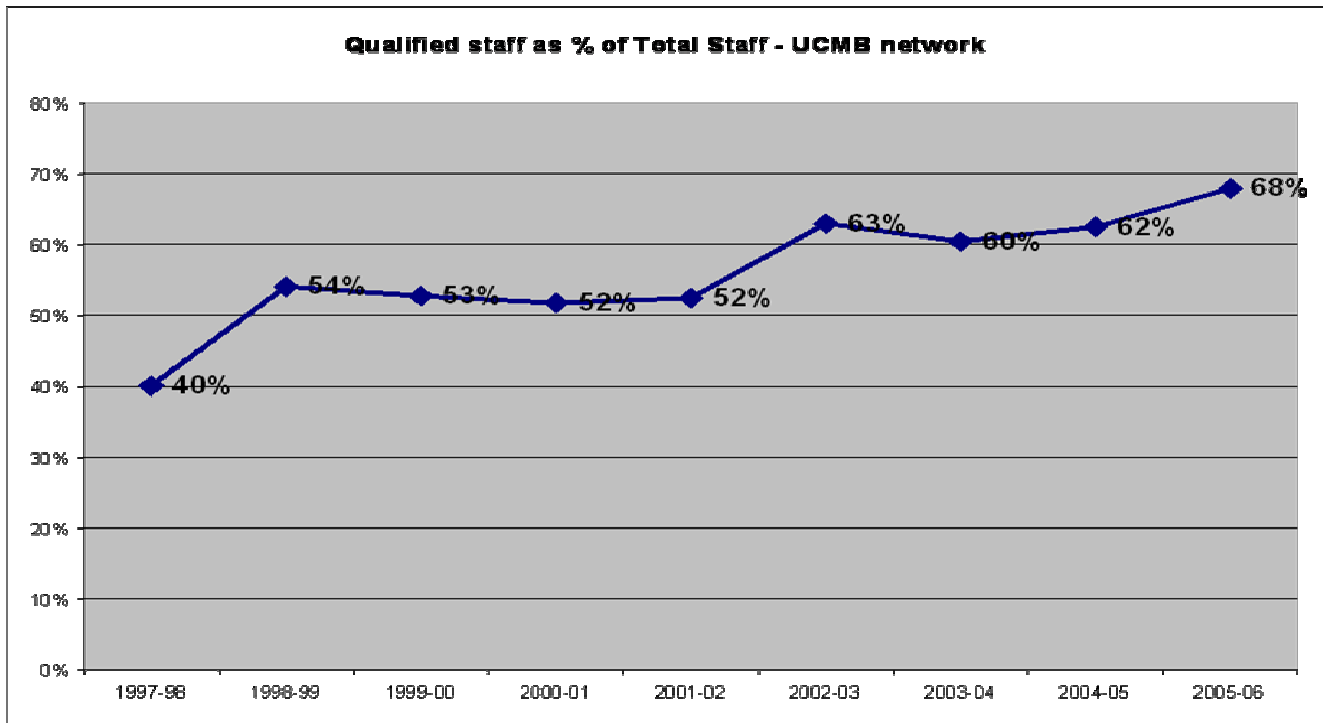
The size of the PNFP

The three networks together have 44 (42.3%) of the 104 hospitals in Uganda, 558 (22%) of the 2536 lower level health facilities and 19 (70.7%) of the 27 Nurses and Midwives training schools. Majority of them are rural. About 10,000 (30%)² of the combined public and PNFP workforce are in the PNFP. Quality of PNFP health workers has improved over the years. In 2005/06 68% of them were qualified (with nursing assistants excluded).

¹ Health Facilities Inventory 2002 (excluding Private Health Practitioners facilities)

² MoH; Health Sector Strategic Plan II (2005/06 – 2009/10)

Figure 1: Trend in quality (proportion qualified) of staff in PNFP facilities



What does “Not-for-profit” mean?

People have questioned why PNFP facilities are actually called so when they often have unspent balances of money / surplus / “profit” at the end of the financial year; and why they charge fees for services provided. Questions have been asked why government should therefore provide them budget support.

“Not-for-profit” does not mean the facility must not have surplus or profit otherwise the facilities, even government-owned ones, would soon run down and close. The term means that the facilities are legally and ethically restricted from distribution of “profits” / surplus to “owners”. Surplus is also made by government departments and health facilities and may simply mean that some planned or budgeted for activities not carried out for one reason or the other even though the money for it was there, or expenditures / costs turned out being lower than anticipated in the budget or revenue / income was higher than anticipated. There could be unanticipated income from, for example, gifts. If surplus occurs after all activities have been implemented as planned, PNFP organizations use such money for sustainability of services or improving access or quality of services. The beneficiary of the surplus is thus not the “owner” or institution per se but the user who benefits from the sustained or improved services. If services were not implemented, they are carried forward along with the money to the next year.

Financing of PNFP Budgets

PNFPs have a total cost of service provision to meet. Overall government support finances only about 20 - 35% of the cost of services provided by PNFPs. The facilities have to meet the remaining \approx 65 - 80% of the cost? PNFP Facilities get only Recurrent Non-wage component. Government facilities instead get government financing of both recurrent budget and Wage.

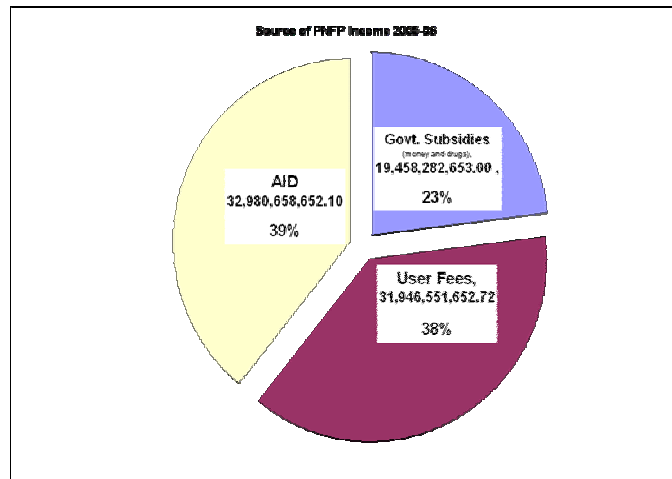


Figure 2: Sources of Finances for PNFP Budget in 2005/06

This total received by government facilities (*PHC Recurrent non-wage + PHC Wage*) is far greater than the budget support to only part of the non-wage recurrent costs of PNFPs of PNFP facilities of equivalent sizes. There is therefore no way PNFP facilities would scrap user charges simply because they receive money from government.

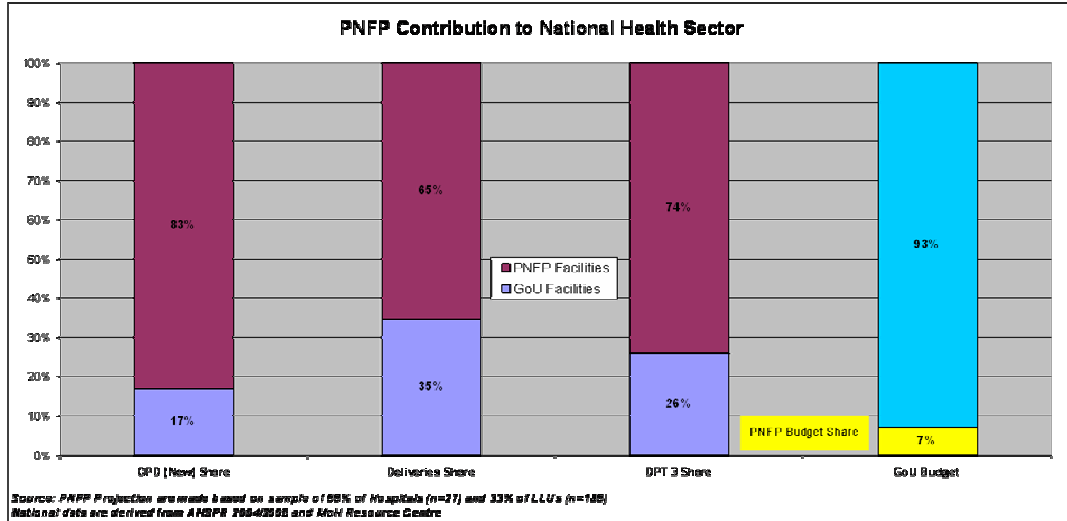
Existing Financial Relationship with government

Government support to PNFP facilities since 1997/08 has been in the form of budget support which has no direct relationship to increasing cost of services or to increasing workload. In fact the total amount budgeted has been constant at Ug. Sh. 17.74 b for the last three years and is projected to remain the same over at least the next three years. This amount is currently only 7% of Government health budget and slightly over 1 billion of this is not transferred to the PNFP facilities. This amount is managed centrally as wage subvention for doctors posted to PNFPs a good number of which positions are not filled. During these coming years per unit cost of service delivery will continue to increase as PNFPs will at the same time be expected to cope with increased service demand (due to, among others, population increase) and pressure to scale up existing services as well as complete the range of services in the Uganda Minimum Health Care Package and improve or sustain quality of the services at the same time.

PNFP Contribution to National Health Sector Outputs

The government grant given to PNFPs is only 7% of the total Government of Uganda health sector budget. The PNFPs on the other hand provide 25 – 35% of the output of the Health Sector Strategic Plan (HSSP II) indicators (17% of Out-patients, 35% of deliveries and 35% of DPT₃ doses).

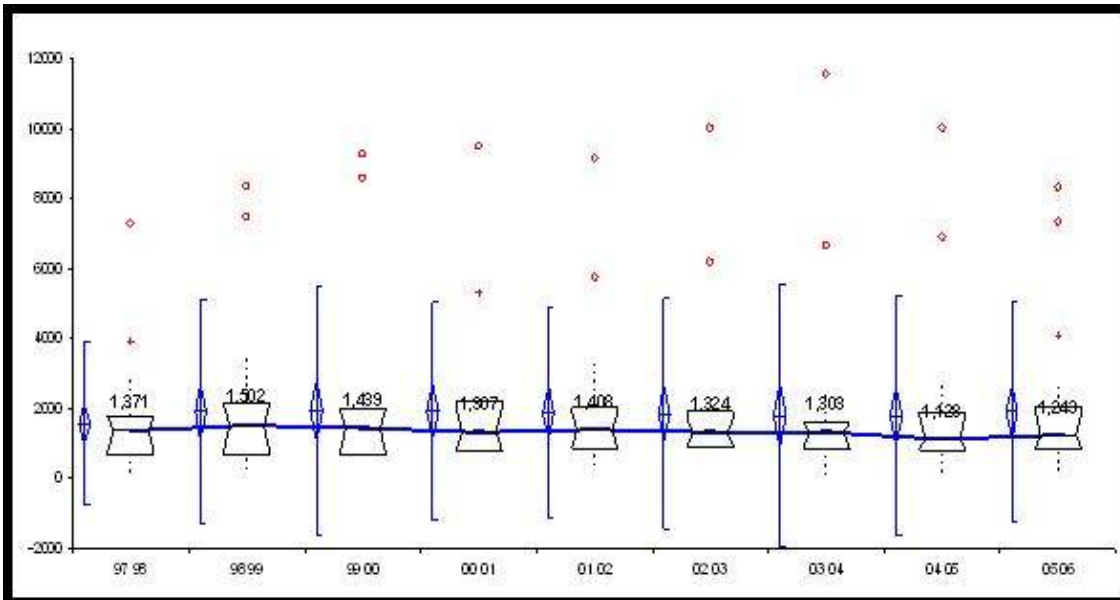
Figure 3: PNFP contribution to the HSSP output compared with proportion of government health budget given to PNFP in Uganda



Increasing PNFP Staff Productivity

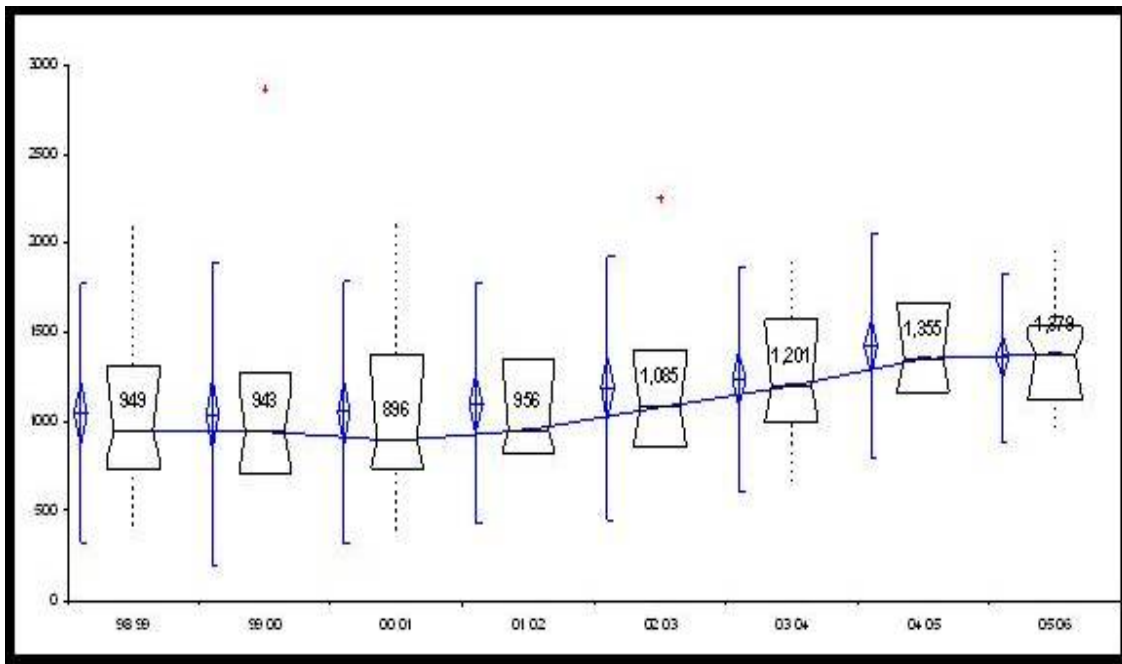
Despite these financial problems PNFPs have made deliberate efforts to make services more affordable and increase utilization. While specific fees vary, overall fee per unit standard unit of output (SUO) has over the years dropped from Sh. 1,502 in 1998/99 to 1,243 in 2005/06.

Figure 4: Trend of fee per SUO in PNFP facilities 1998/99 to 2005/06



This has contributed to the steady rise in utilization reflected in terms of increasing standard units of output.³ Standard Unit of Output (SUO) produced per staff has also steadily increased from 949 in 1998/09 to 1085 in 2002/03 to 1355 in 2004/05 even at a time when staff remuneration is much lower than in government and when budget support is falling.

Figure 5: Trend of staff productivity (SUO per staff) in the PNFP health sub-sector 1998/99 to 2005/06



Meanwhile there is rising recurrent cost / SUO due to extrinsic rather than intrinsic factors. These include the increase cost of human resource. It is also due to introduction of expensive services like antiretroviral therapy and other global initiatives that have spill-over effects on systems costs.

Increasing Range of Services

Nonetheless, because of commitment to provision of services to the population and especially the less privileged, PNFPs have, despite all these constraints, made deliberate efforts to increase the range of services they offer towards completing the service availability within the Uganda minimum health care package. Surveys on completeness of UMHCP implementation in UCMB network have been conducted (2003 , 2006) which show that the completeness (median) risen from 68% (2003) to 75% (2006) in HC LLUs. This should build confidence in terms of availability of needed services in PNFPs. Completeness of implementation of UMHCP in public facilities is currently not known.

³ The SUO is an index that measures multi services (Inpatients, ANC, Deliveries, Immunization, Outpatients) in terms of equivalent of one service e.g. out-patient attendants.

Are there benefits in contracting Civil Society Organization for provision of health services?

There are many positive experiences world-wide including Uganda although most of the experiences are with non-clinical services. There is limited experience with clinical services. Such experiences with clinical services include the support to PNFPs in Uganda, Christian Health Associations in Malawi, Zambia, Tanzania, Ghana although these have taken varying modes.

In Bangladesh contracted NGOs performed much better than the public sector even with the same amount of resources (Loevinsohn 2002)⁴. Managerial autonomy of NGOs to manage implementation was one of the major advantages sited.

In Guatemala there was increased coverage of basic health services due to contracting NGOs.

As described earlier, in Uganda government is getting higher HSSP II output for money given as budget support to PNFP. A Uganda study on contractual approach (*Lundberg, Marek and Pariyo, 2007*) covered Arua, Bushenyi, Jinja, Kyenjojo and Mukono.⁵ The study concluded that amount of money was not the only limiting factor in improving performance. Like the Bangladesh study, they observed that freedom to plan for and spend is more important factor in improving performance. The researchers observed that PNFP facilities allocated budgets more effectively than the MoH facilities. They proposed that removal of restrictions on the use of PHC CG to PNFP (all things being equal) would lead to expanded output.

Is there therefore reason to fund PNFP

It is clear that PNFPs are not competitive but complementary to government and the two share the same objectives. They obtain money only for providing and improving services – not profit. Moreover the PNFPs constitute significant fraction of Uganda's health care system with most of them being rural – complementing government efforts to reach the less accessible. They have also demonstrated clear efforts to complete range of services within the Uganda minimum health care package.

From a business-like point of view, the Principle (government) is getting higher return for money (value for money) money given to PNFPs in terms of HSSP II output indicators, in terms of increasing access in rural areas and in terms of demonstrated efficiency / productivity.

Increased funding with freedom to spend will definitely increase return even more. The main freedom needed is being able to spend on wages. PNFP governance and

⁴ Benjamin Loevinshn MD MPH; Practical issues in contracting for Primary Health Care Delivery: Lessons from two large projects in Bangladesh, Washington DC.

⁵ Mattias Lundberg, Tonia Marek and George Pariyo; Contracting for Primary Health Care in Uganda; 2007.

management structures already provide for the freedom to creatively plan for implementation of the minimum health care package and spend where they think it is likely to bring get higher return.

One advantage PNFs have which partly accounts for higher performance is that the governance structures are closer to management and implementation level thus providing closer supervision and more responsive decision making. The PNFs governance and management structures also recognize the need for complete accountability and have made deliberate efforts to improve this toward internationally acceptable standards.

What approach should be to used in funding PNF

With the current budget support it is difficult even for the government to target specific output whether from PNFs or government institutions themselves. It can be said that the money, however big or little, goes towards “supporting everything and nothing” because no activity output targets are agreed upon for the amount provided.

By contrast, a Contractual Approach purchases agreed targets or outputs. It also provides the required freedom to spend the obtained money for better outputs. In this way it provides motivation for increases performance.

However, whatever contractual approach requires costing mechanism, something that is currently greatly lacking in Uganda.

But if a contractual approach is to be used, then which one would Uganda prefer? There have been advocates for Performance-based Contracts? This has many limitations especially in current situation in Uganda especially in terms of what performance to measure and pay for. A Relational Contract is more broad and flexible. It can be fine-tuned with Service Level Agreements. It may not conflict with the up-coming SHI

However some challenge is seen with the contractual approach especially in terms of what level the contract would be managed under the decentralized system.

Conclusion

The government of Uganda stands to gain more by spending more than currently done on PNF health sub-sector. A contractual approach (rather than the current budget support) that removes restriction on spending will increase value for money. Disease costing will make contractual arrangements transparent and realistic and both parties break even. More discussions are needed on the management of such contracts, should the system be introduced, in the current decentralized governance system.