

BETWEEN A ROCK AND A HARD PLACE

The commitment of CHSs to PHC

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WHAT IS THIS ABOUT?

- It is a case for church health services
 - Hospitals and lower level units
 - The great historic investment of Christian churches
 - Today needed as ever
 - Today under great and increasing stress
 - With visible cracks at their seams getting larger and deeper day after day
 - Caught in between their “genetic” commitment to serve the poor
 - And the increasing and increasingly pressing needs of the poor
 - Scaling up access to just about everything
 - Maintaining the commitment to a holistic integrated package of health care (PHC)
 - And starved of resources that - perhaps more abundant now than before at global level - are for them much more elusive than it would be desirable/acceptable given what is asked of them
 - Caught in between a rock and a hard place

WHAT IS THIS ABOUT?

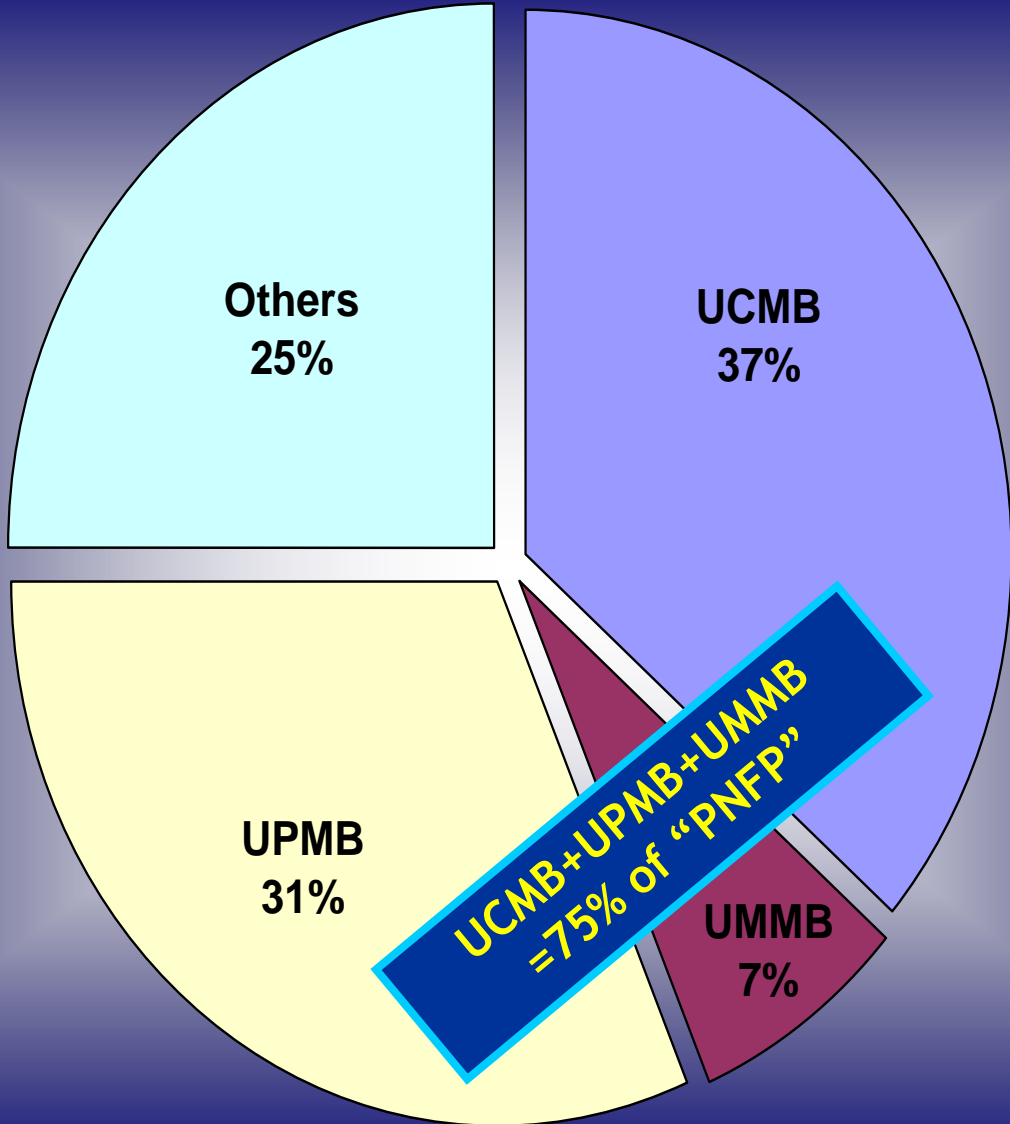
- ◎ I will speak out of experience
 - Some 20 years at the front-line
 - More than half of those as medical director of a large catholic hospital in the most rural and under developed district of the Country
 - Other 10 years in the rear-guard
 - At the health office of the Bishops Conference
 - ◎ UCMB
 - Some of the data I will present are the fruit of an effort started 10 years ago
 - Regularly analysed so that they could tell us what is happening
- ◎ But I know that the conclusions I am reaching are valid for all CHSs
 - If not you tell me

INFRASTRUCTURE

Level	Gov.t	PNFP	PFP	Total
Hospitals	56	44	4	104
HC4	143	8	3	154
HC3	650	147*	12	809
HC2	845	362	262	1469
Total	1694	558	282	2536
HT Schools	8	19		27

INFRASTRUCTURE

	Beds	%
Govt (Incl National and RR Hospitals)	9,448	52%
PNFP	7,882	43%
Institutional	175	1%
Private	712	4%
Total	18,217	100%



OUTLINE

- ◉ Alma Ata 30 years later
- ◉ The growing commitment of CHS to PHC
- ◉ The era of SWAp
 - ◉ The experience of CHS in Uganda till 2004
- ◉ The era to total budget support at Paris Declaration
 - And of Global initiatives
- ◉ Putting it together
- ◉ CHS in Uganda today
- ◉ Conclusion

ALMA ATA DECLARATION

- ◎ Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination”
 - (Alma Ata Declaration 1978, para.VI)

CHS AND ALMA ATA

- ◎ For many Church Health Services (CHSs) Alma Ata in 1978 was the crowning of an ongoing experience
 - The Christian Medical Commission contribution to Alma Ata
- ◎ For others it was a call to “change business”
 - From curative centred approach to a more comprehensive approach
 - From isolation from communities to opening up to the surrounding environment
 - From autocratic management to participated management
- ◎ The redaction of most institutional charters dates from this period

CHS AND ALMA ATA

- ◎ What we see in these charters are
 - A clear commitment to serve the poor
 - A commitment to a package of comprehensive care
 - Continuum of care till the end of the disease episode
 - Attention to the various different determinants of disease
 - Effort to integrate promotion, prevention, cure, rehabilitation
 - The translation of PHC concept in the aspects that concern the health care delivery system

CHS AND ALMA ATA

- ◎ We have very little evidence in Uganda of what happened immediately later
 - Anecdotal evidence from 3 or 4 hospitals in Northern Uganda that took up responsibility for the health of a population
 - Their health zone
 - With implicit and informal agreement of the local health authority
 - And without government support
 - A complete change of perspective
 - From feeling responsible for those (sick) who make it to my door
 - To feeling responsible for the people living in my assigned zone

CHS AND ALMA ATA

- ◎ To give you a few examples
 - Soliciting moneys from donors to buy vaccines for the people long before EPI
 - Buying anti TB drugs that the national program was unable to provide
 - To avoid the loss of confidence of the large number of people affected by TB that were regularly supplied by the hospital network of community health workers right in their communities

CHS AND ALMA ATA

- ◎ This spontaneous alignment (ante litteram) with Government policy bore fruit in the middle of the nineties
 - At that time a deep crisis of the Church Health Services is seen by Government as a crisis of a national asset
 - Deserving Government attention and support
 - As consequence subsidies in the form of conditional grants (that existed in the colonial period) were re-introduced in 1998
 - Accompanied by a loose agreement which unfortunately did not have a long life

THE ERA OF SWAP

- ◎ This fortunate change of government policy occurred at the time when SWAPs appeared on the scene of health care
 - The concept of a sector wide approach
 - Where the sector has different actors
 - Where CHS (or PNFP facilities) are recognised as allied of Government
 - Opened the door to a very fruitful collaboration with positive returns for all concerned stakeholders
 - Government
 - People
 - CHS

THE EXPERIENCE OF CHSS TO 04

- ◎ The loose agreement
 - I.e. the Memorandum of understanding
- ◎ stated few but clear things:
 - Mutual commitment to PHC
 - Will to collaborate in the service of a population
 - Will of Government to avail resources
 - Will of the CHS to provide services and account for both inputs and outputs
- Making reference to a more specific service level agreement
 - In most cases a simple work-plan

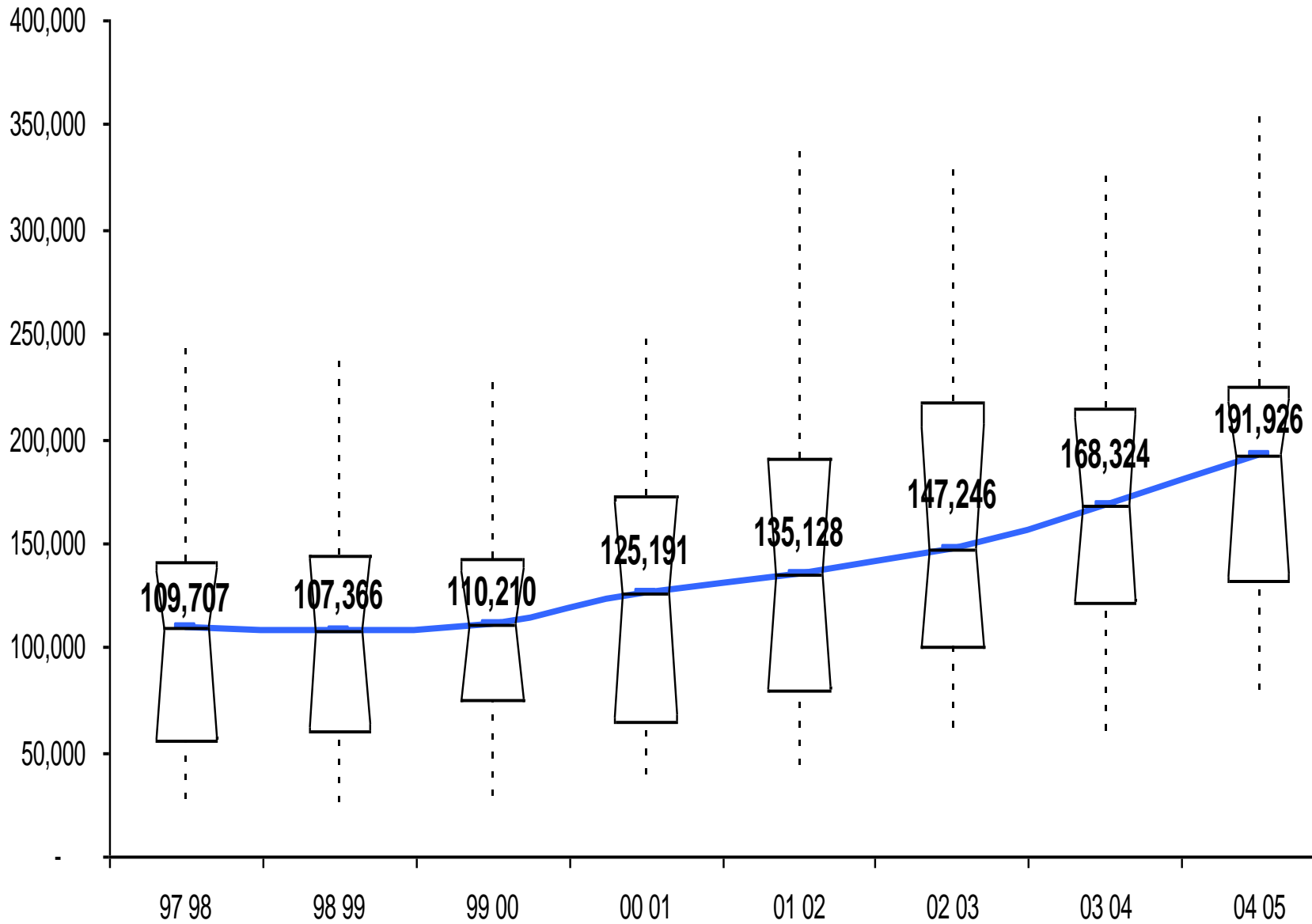
THE EXPERIENCE OF CHSS TO 04

- ◎ This latter was more specific on the type and quantity of services the CHS was expected to produce
 - At which conditions
 - In embryo this was the beginning of a more defined contractual approach
 - In which the element of the established relation of trust and collaboration prevailed over the more quantitative specification of commercial contracts
 - A decent and satisfactory middle ground
 - In the first years three objectives
 - Increase access
 - Increase community interventions
 - Increase staff remuneration

THE EXPERIENCE OF CHSS TO 04

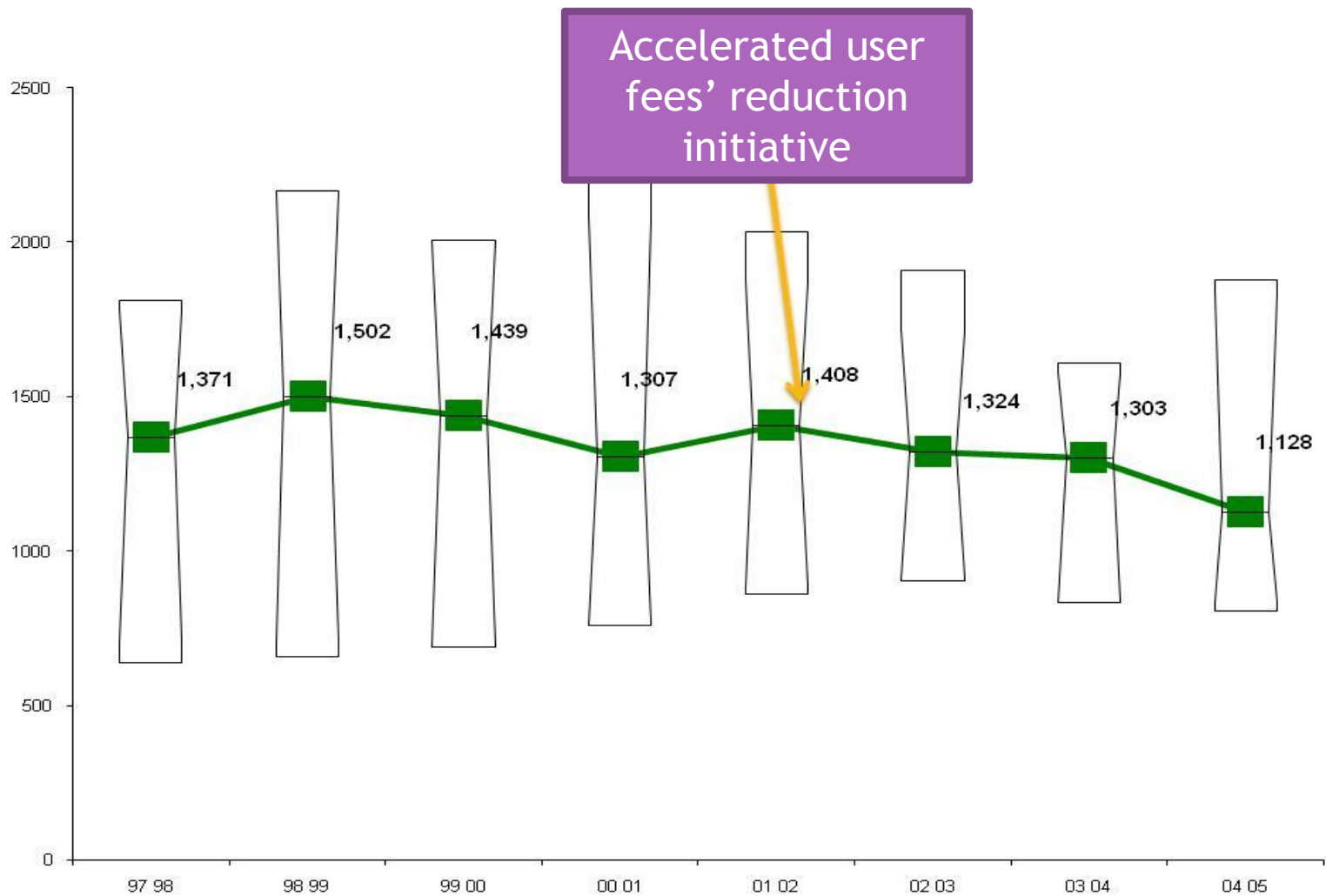
- ◎ Unfortunately things did not develop further
- ◎ In 2001 Uganda public sector went for total abolition of user fees
 - This led to some short lived improvement of access of Government services for people
 - CHSs were allowed to continue charging
 - But this did not go down very well with the political establishment
 - The hitherto good collaboration suffered its first set back
 - This did not hindered anyway the continuous growth of performance indicators of CHSs
 - Indicators of Faithfulness to the Mission

ACCESS



EQUITY

Equity in catholic hospitals - Average fees paid per standard unit of output



PRODUCTIVITY OF STAFF

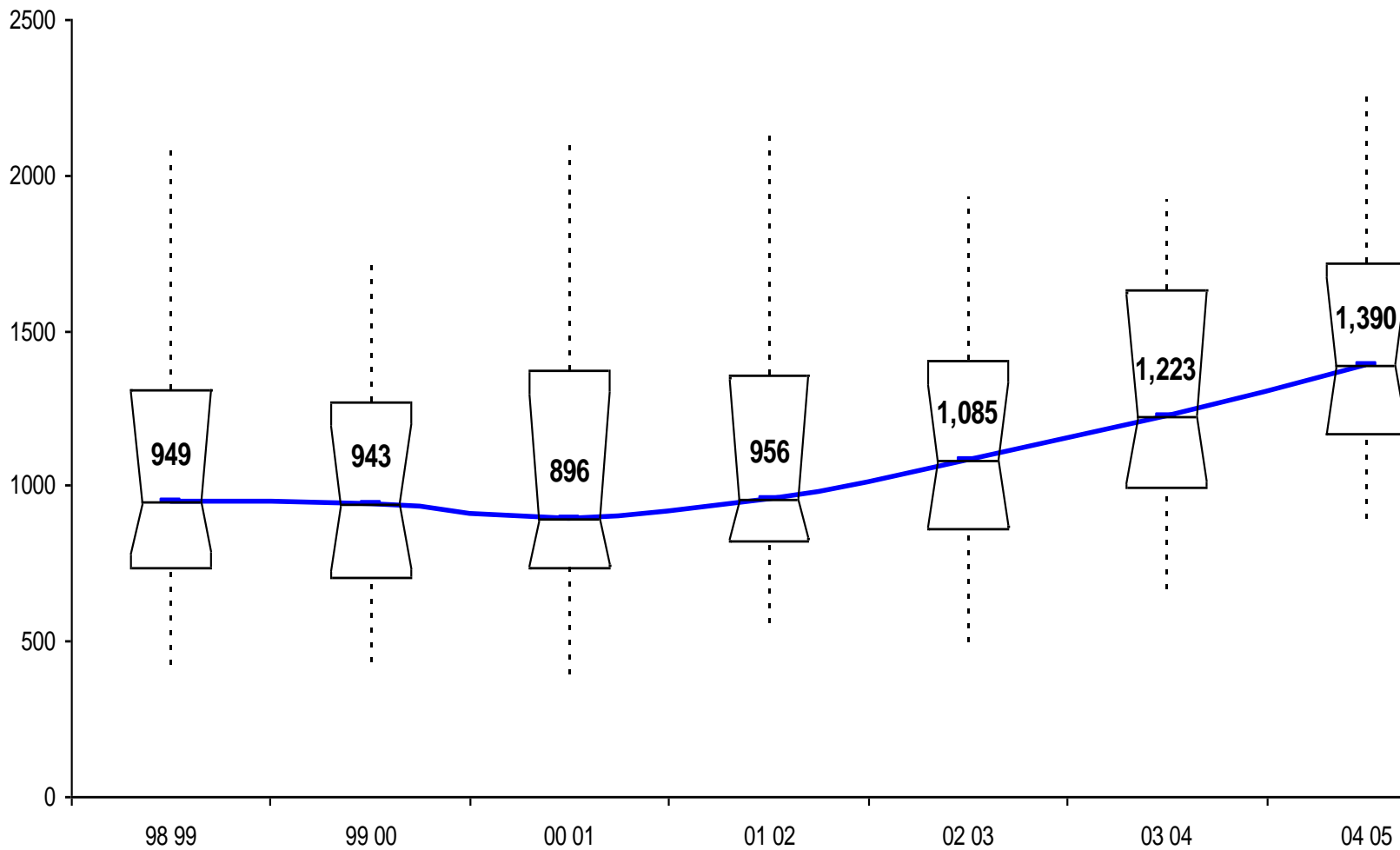
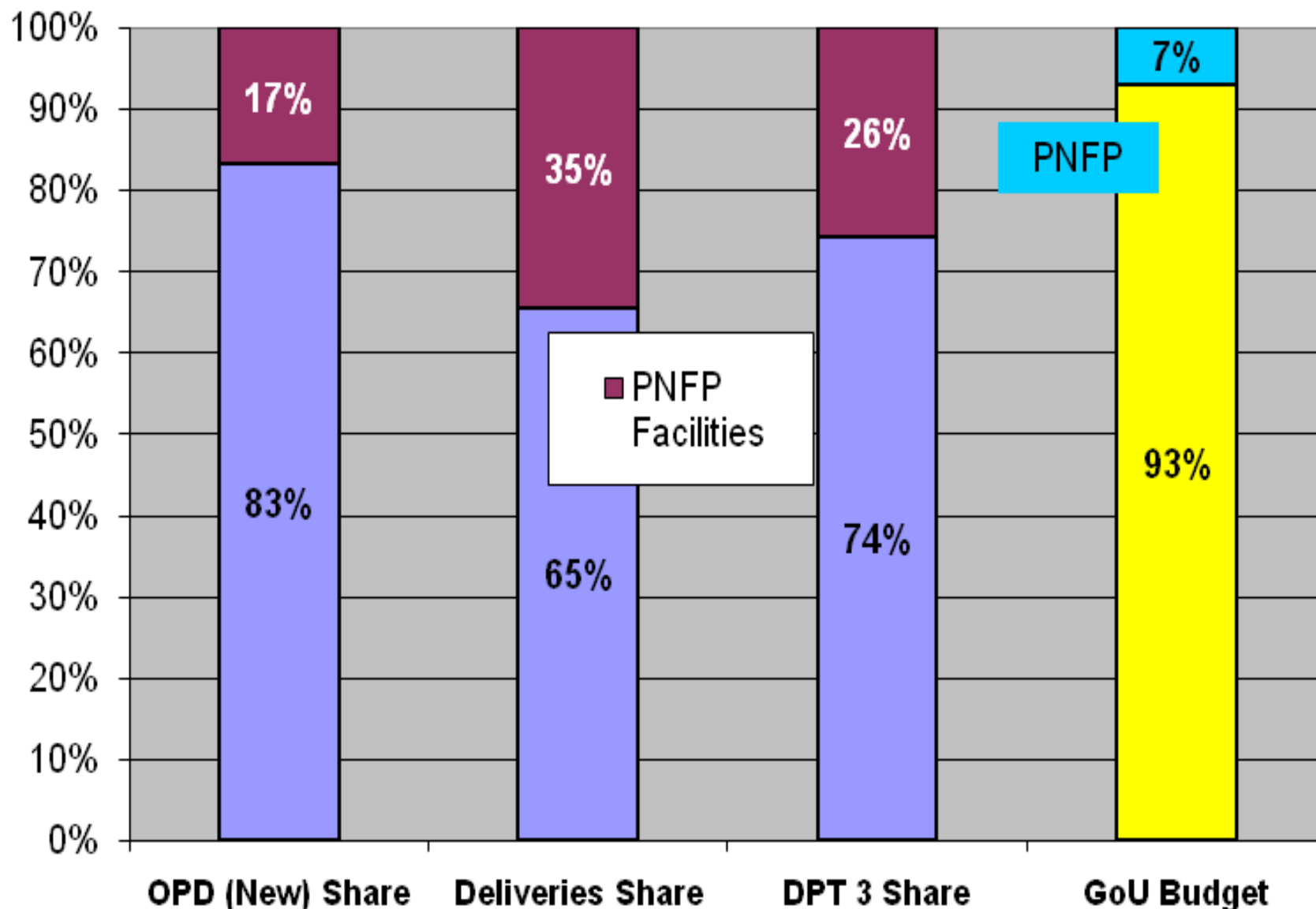


Figure 3: PNFP Contribution to National Health Sector
Key indicators of the PEAP



Source: PNFP Projection are made based on sample of 65% of Hospitals (n=27) and 33% of LLUs (n=185)

National data are derived from AHSPR 2004/2005 and MoH Resource Centre

PARIS DECLARATION AND GI

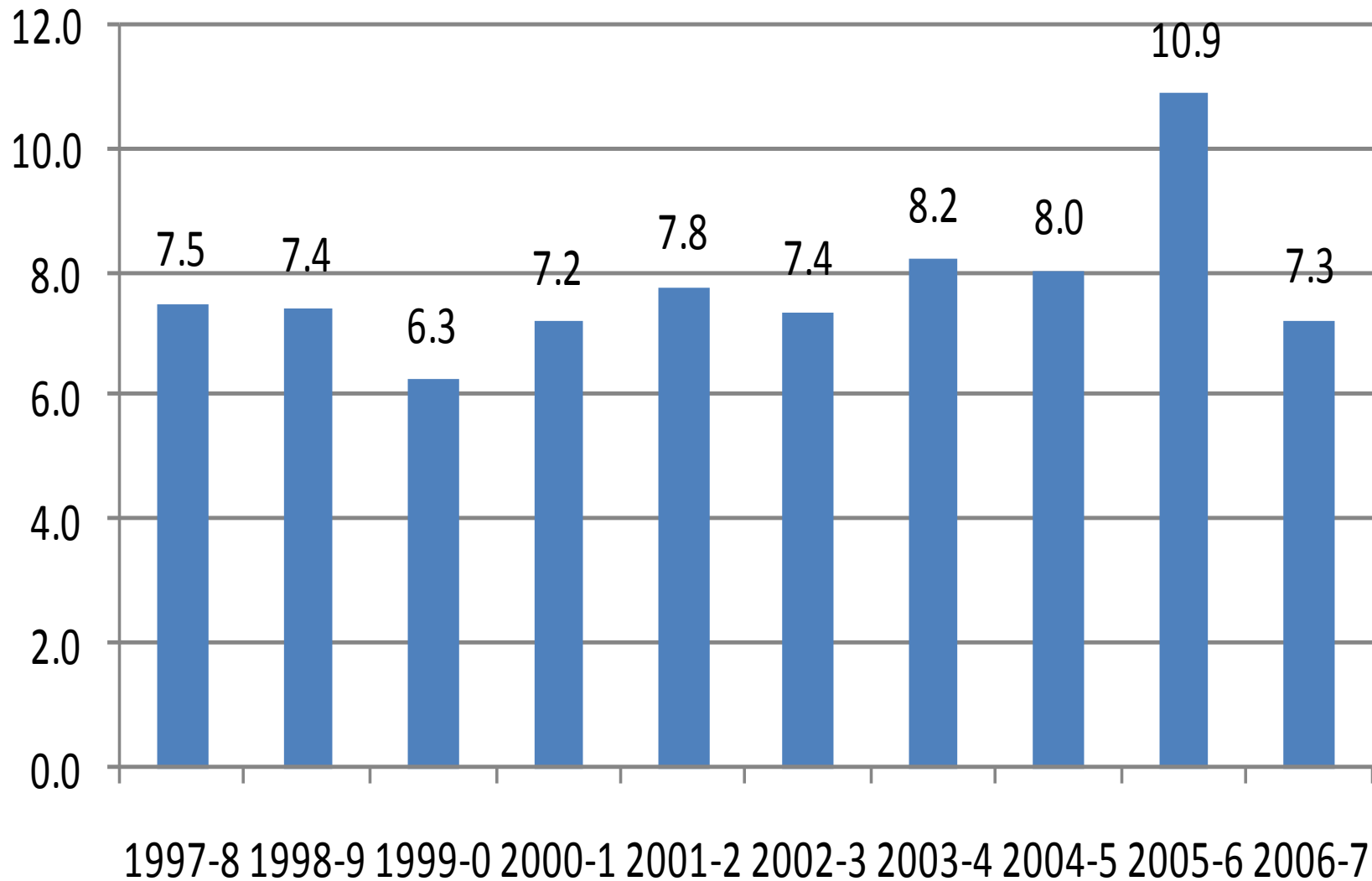
- ◎ Towards 2004 two new global trends appeared on the scene
 - The movement of Donors towards total budget support
 - Result of the Paris Declaration on Aid Effectiveness
 - The coming to maturity of new forms of financing for support to global health threats
 - Namely AIDS, TB, Malaria
 - Global Fund and Pefpar

PARIS DECLARATION AND GI

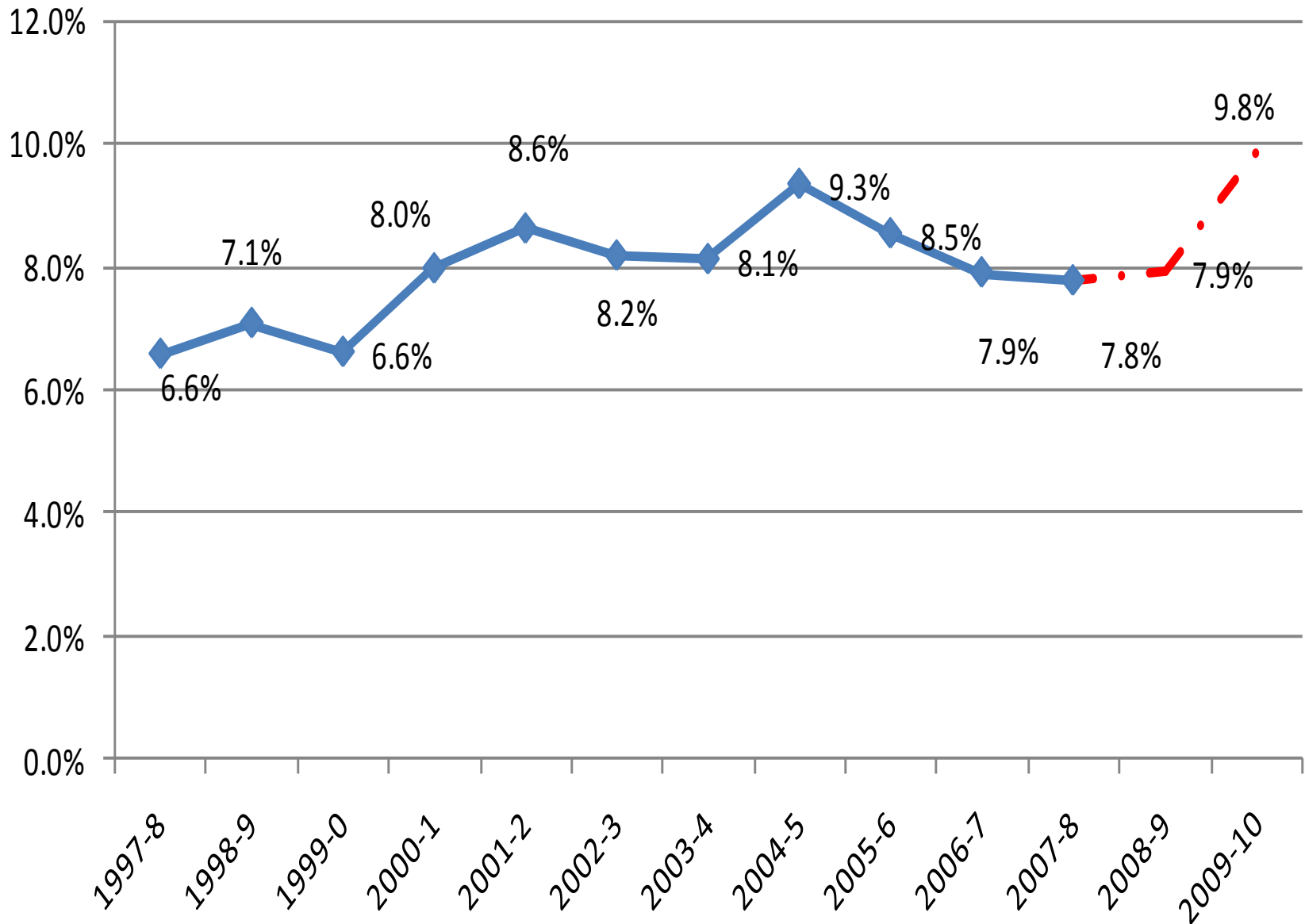
- ◎ While in SWAp donor money is (was) linked to support to a sector
- ◎ With the Paris Declaration on Aid Effectiveness
 - More and more donor money is going into government budget and is “freed” from conditionalities linking it to social services
 - Immediate result is the stalling of health budget
 - The shrinking of grants to CHS
 - Magnification of the role of the Finance Ministries
 - Decreased transparency of the budget process

Public Health Expenditure in Uganda

US \$ per capita



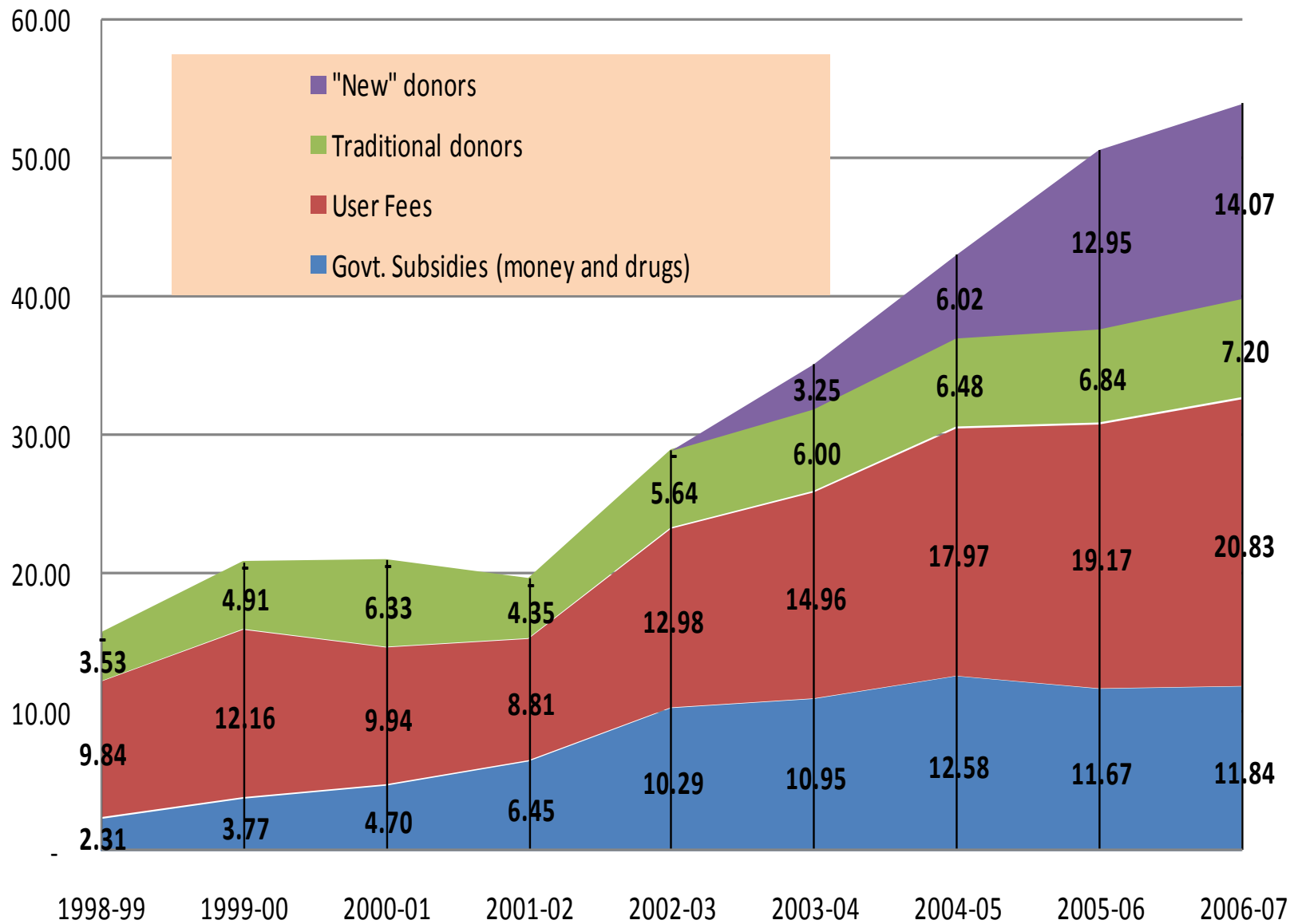
Health/Overall Budget - %



PARIS DECLARATION AND GI

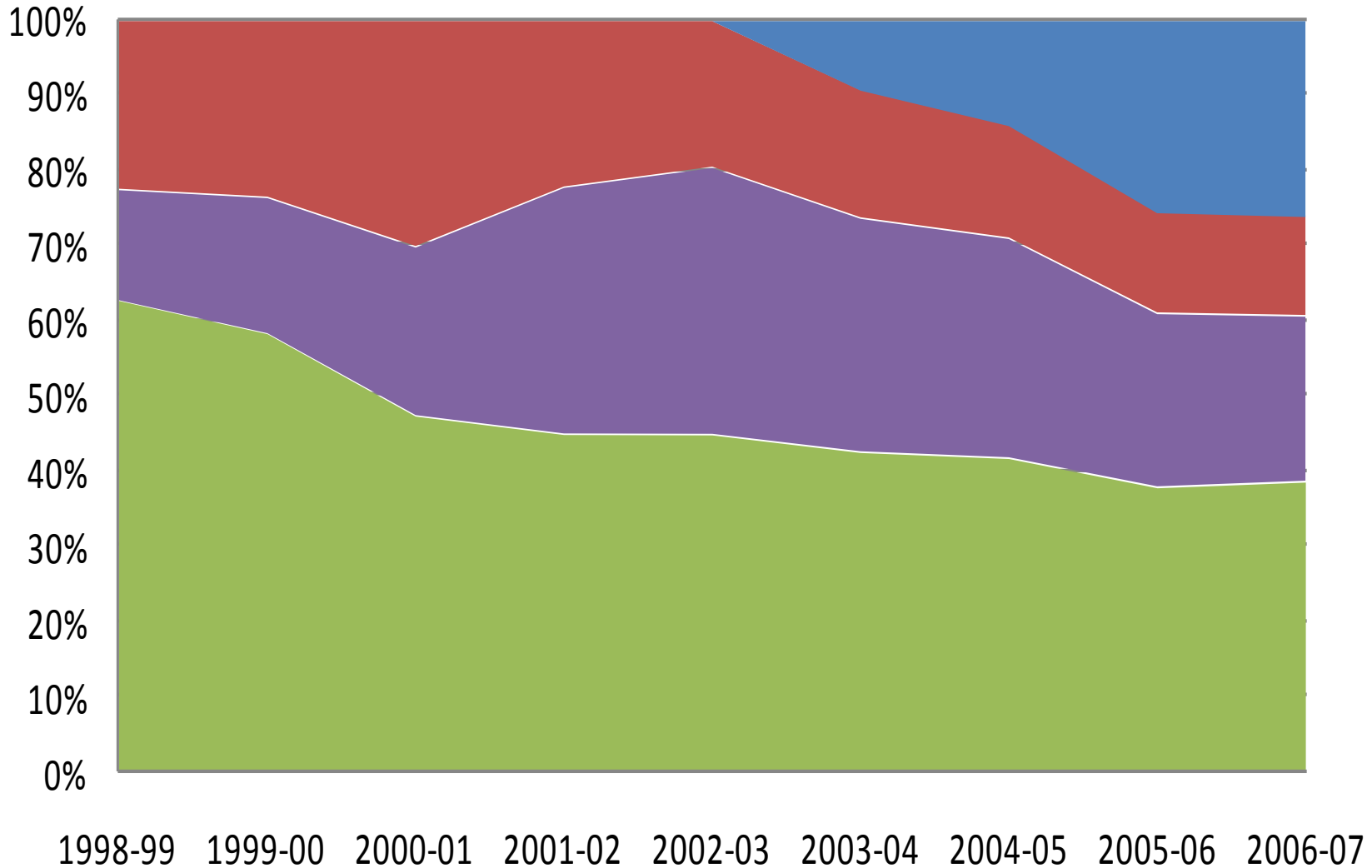
- ◎ Result of the Global Initiatives
 - Increasing amount of moneys going for health are tagged to very selective interventions
 - There is a huge disproportion between moneys available for all diseases
 - And moneys available for the 3 diseases targeted
- ◎ The resource envelop of the Ministry of Health last year was almost exactly 50-50
 - 50% for all diseases
 - 50% for the 3 selected diseases
 - Mostly off budget
 - As such disliked by Finance, who takes its revenge

Financing of UCMB Hospitals (27 - cumulative)

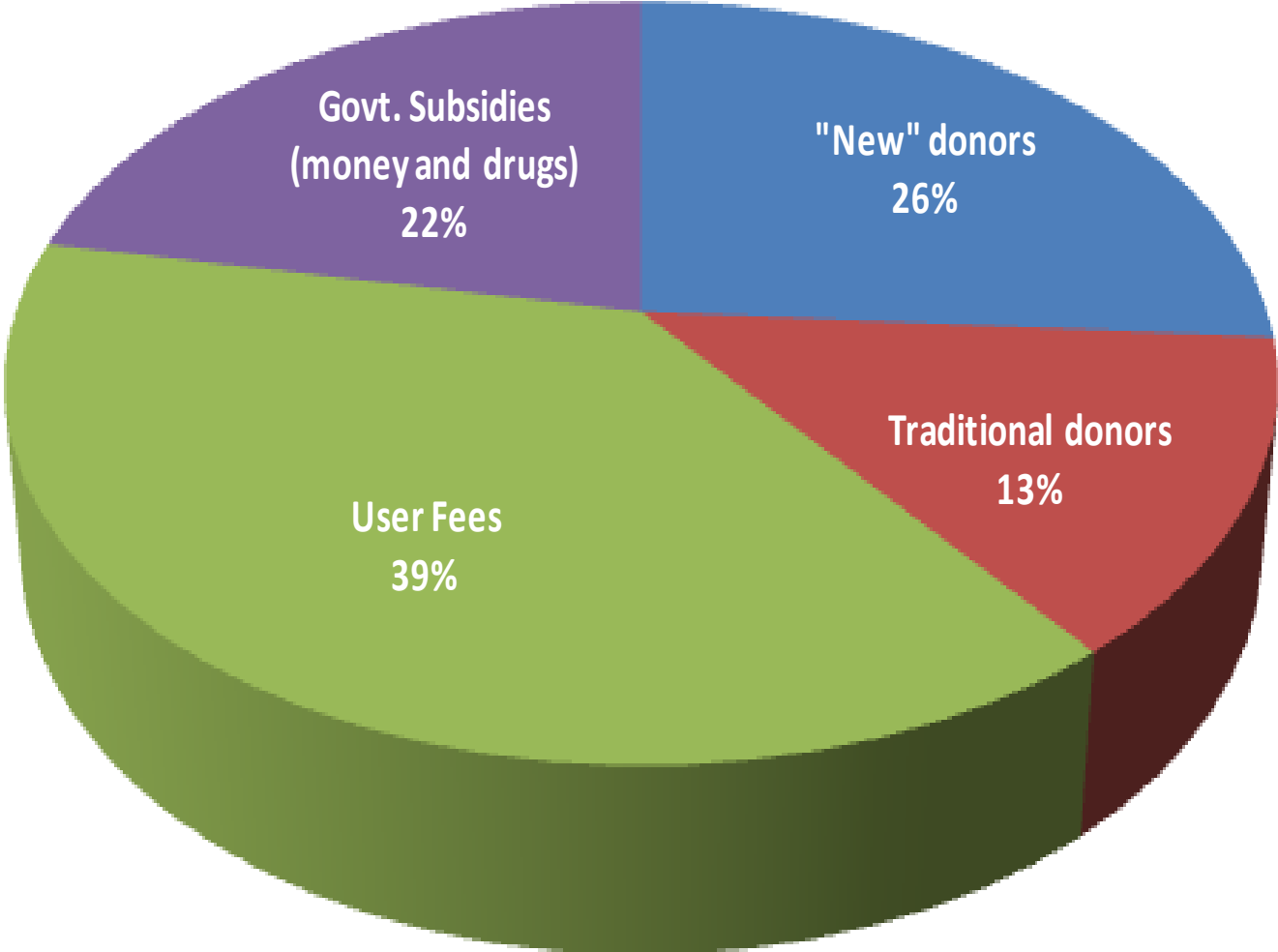


Financing of UCMB Hospitals - rates by source

User Fees Govt. Subsidies (money and drugs) Traditional donors "New" donors



Financing of UCMB Hospitals 06-07



PUTTING IT TOGETHER

- ◎ Government support is decreasing
 - Quite obviously collaboration with CHSs is not very high in the agenda of Government today
 - It may even get worse
 - Budget support gives Government resources that have, de facto, allowed choices that are heavily damaging for CHS
 - Unilateral increase of staff salary
 - 40% three years ago and another further increase being considered for this coming year
- ◎ Donor support is increasing
 - But ONLY for few elements of the package of care provided
- ◎ As consequence user fees had to go up

CHS IN UGANDA TODAY

- ◎ The net result is a set of downward trends that raise a lot of concern when not outright alarm
 - Access going down
 - Equity is decreasing
 - Efficiency going down
 - Productivity going down
 - Cost going up
- ◎ After almost 10 years of very positive trends
 - We spoke of increased Faithfulness to the Mission
 - Do not forget that beneath the positive trends are the increased preventive and promotive activities that characterised that “happy days” of the good collaboration

Figure 6 - PNFH Hospitals - Access
Standard units of output

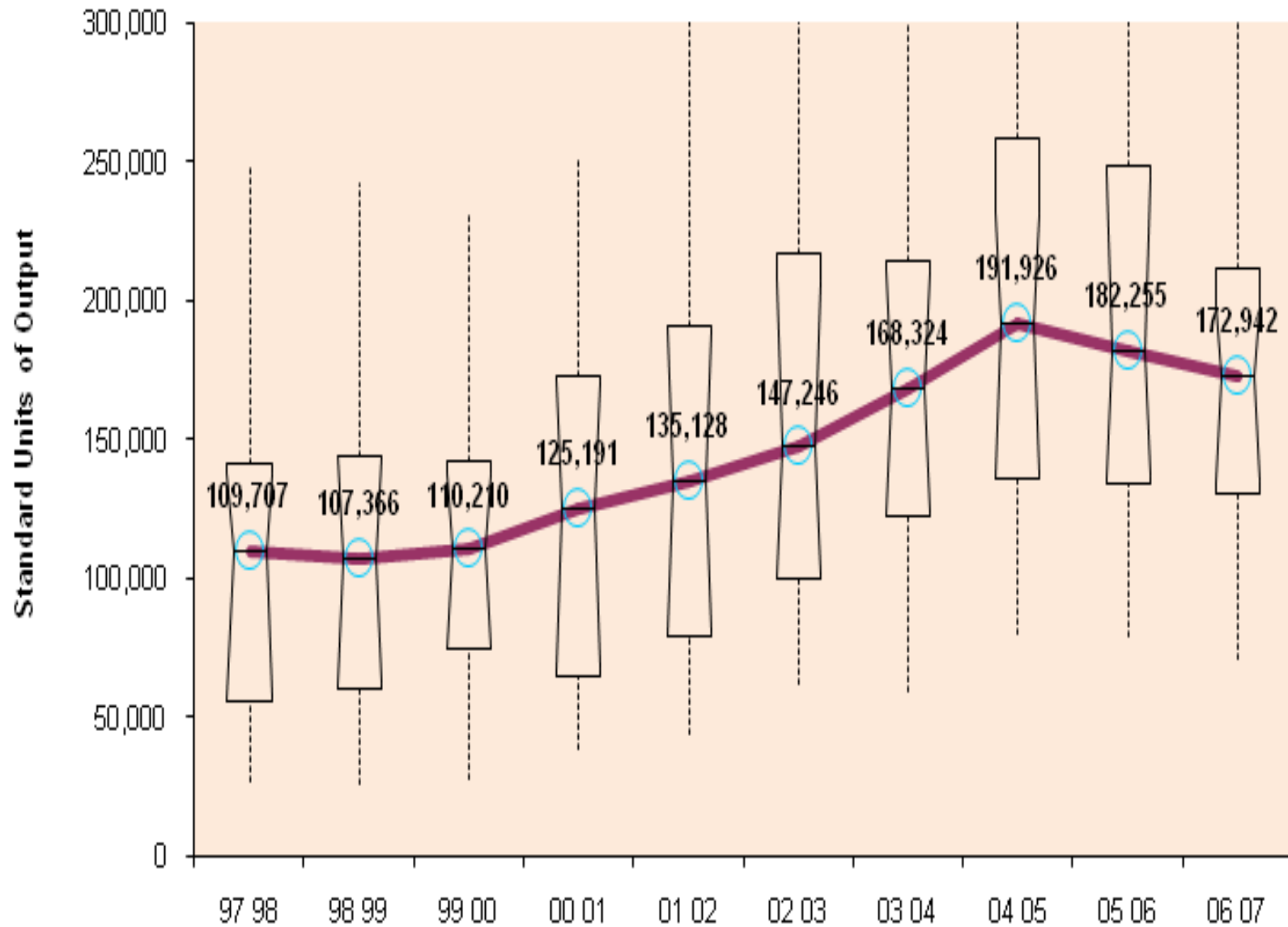


Figure 7 - PNFH Hospitals - Equity
Charges to patients per unit of output

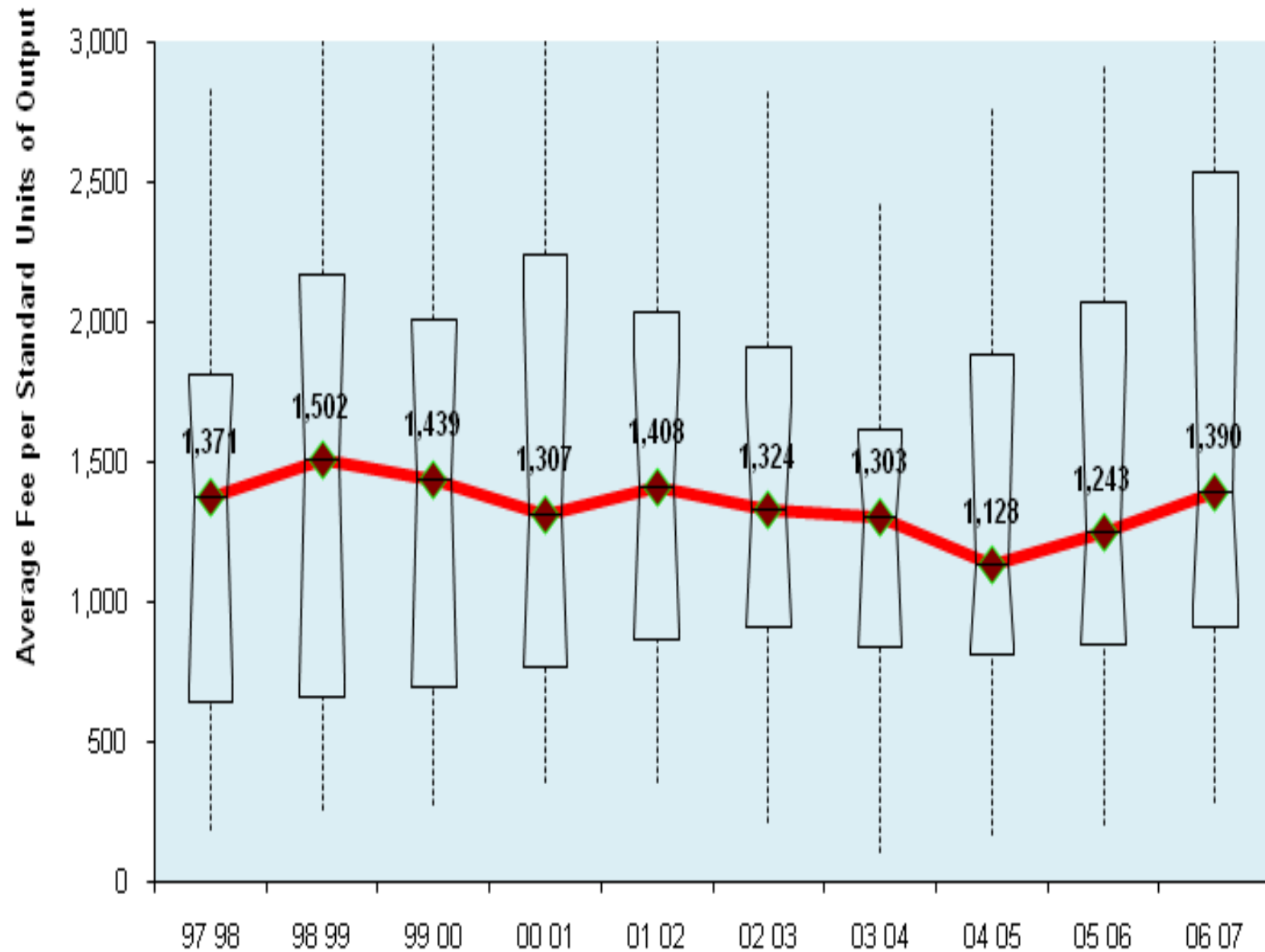


Figure 8 - PNFP Hospitals - Efficiency
Cost per unit of output

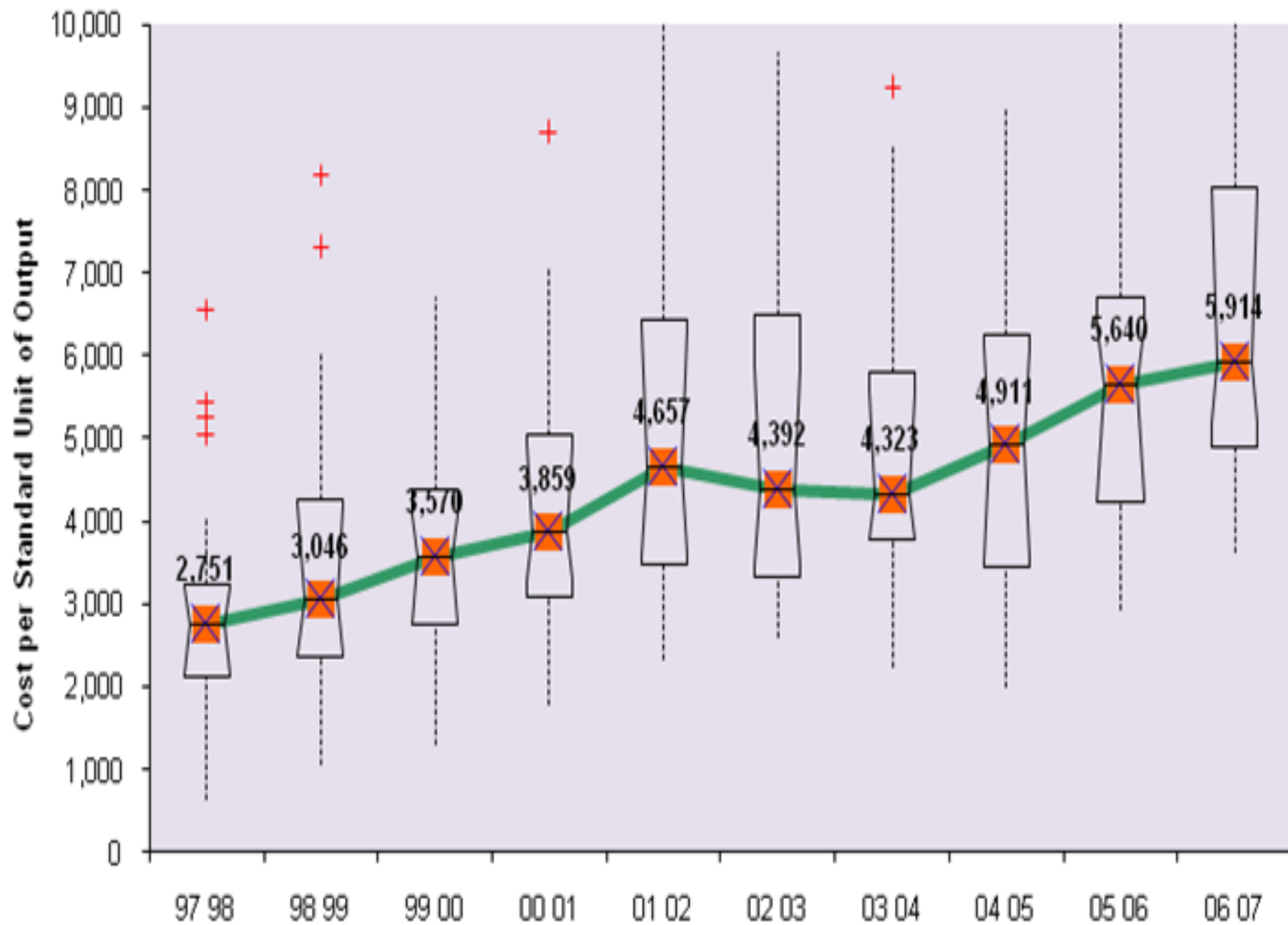
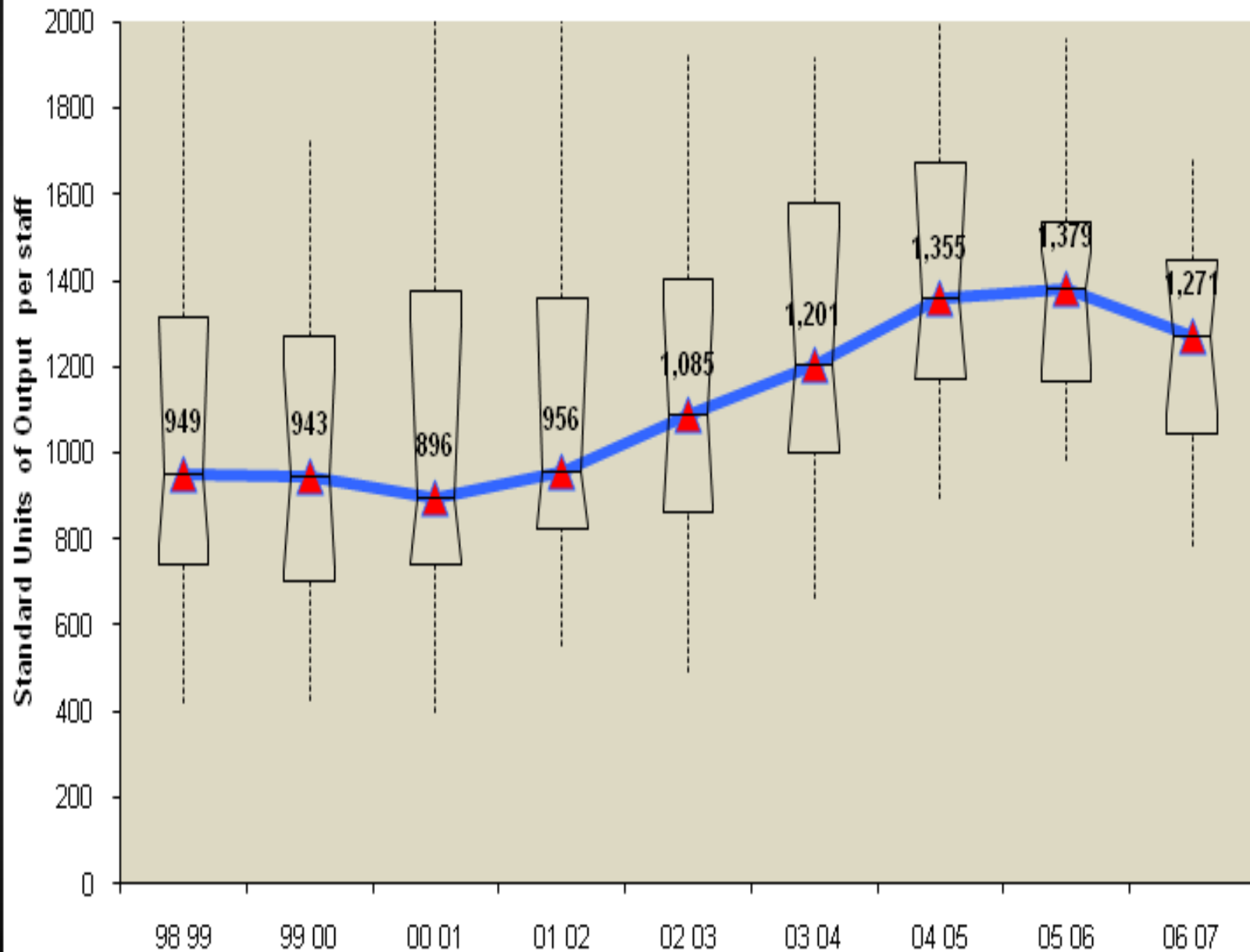


Figure 9 - PNFH Hospitals - Productivity of Staff
Units of output per staff



PUTTING IT TOGETHER

- ◎ The severity of the crisis is at the same time caused and magnified by the HR crisis
 - Dr Mwenda said that “we have cared and served the people and perhaps forgotten to care for the carers”
 - In fact many of our staff are leaving us
 - In higher numbers and proportion than ever
 - With them goes the organizational culture we so much cherish
 - That makes the difference!!!

Table 2: OBSERVED ATTRITION RATES IN THE PNFP HEALTH SECTOR

HOSPITALS	2003/04	2004/05	2005/06	2006/07
Medical Officers	28%	21%	30%	38%
Clinical Officers	22%	21%	36%	26%
Enrolled Nurses	16%	17%	26%	24%
Enrolled Midwives	15%	10%	34%	26%
Registered Midwives	9%	11%	27%	15%
Registered Nurses	5%	14%	11%	15%
Cumulative EN+EMW			29%	25%
LOWER LEVEL HEALTH UNITS	2003/04	2004/05	2005/06	2006/07
Clinical Officers			30%	34%
Enrolled Nurses			45%	36%
Enrolled Midwives			46%	44%
Cumulative EN+EMW			46%	40%

CONCLUSION

- ◎ CHSs are in severe distress
 - Governments have not heartedly embraced partnerships
 - Whenever given the slightest justification tend to move away from sharing resources
 - Even when they have received them with the understanding that they should finance the health system in its entirety
 - And not exclusively the public health system
 - Resources provided by the “new donors” are only nominally additional
 - As matter of fact they are hardly so for CHSs
 - What is additional are only the objectives with their “scaled up” targets

CONCLUSION

- ◎ HR is the real limiting factor to effective scaling up of all interventions
 - Those targeted by the GF and Pefpar as well as all the others
 - The situation is worsening at all levels in Sub-Saharan Africa
 - But it is definitely worse in CHSs
- ◎ We have not yet started seeing the effects of the legitimacy that health workers migration has found in the global agenda

CONCLUSION

- ◎ Being between a rock and a hard place is not very comfortable
 - You can stand it for a while but eventually all your efforts will become vain
- ◎ If this presentation has managed to convey a sense of urgency for the “discomfort” of CHSs
 - I have obtained what I wanted
- ◎ CHSs badly need bold advocates in the community of the people who fight the battle against AIDS, TB and Malaria
 - Do we have them?