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Strengthening Public-Private Partnership in Decentralized Health Service Delivery Systems The Case of Uganda

By A. Nuwagaba and D. Mwesigwa

Background

Since the late 1980s, it became increasingly clear that most governments in developing countries particularly Sub-Saharan Africa were not able to provide 'free' public health care. The problem emanated from internal crises and contradictions as well as external shocks. The former included political turmoil and civil strife culminating into the 'dearth' of the public institutional structure and the latter took the form of declining terms of trade, balance of payments crisis, which resulted in persistent macroeconomic disequilibria.

It is because of the above crises that most governments in Sub Saharan Africa undertook reforms in the health sector in particular and other sectors of their economies in general. The government of Uganda followed suit by adopting a policy stance to emphasize the need for increased involvement of the private sector in the health care delivery system in Uganda. The National Health Policy (NHP) and the Health sector strategic Plan (2001-2005) underscores the importance of the private sector in the delivery of health services in Uganda.

Although there exists substantial information on the private sector's role in health delivery in Uganda, there is still a paucity of data regarding:

Performance of the Private Health Providers in terms of efficiency and effectiveness;
Nature of partnership (both latent and manifest) between the Public Health Providers and the Public sector; and
Areas and means of maximizing Public Health Providers contribution to health care delivery.

It is understood that strengthening the partnership between Private and Public health sector will be influenced by both supply and demand factors. The former includes inter alia; coverage and range of services provided while the latter includes among others the quality of services.

The Research Problem

The problem under investigation related to the apparent poor quality services provided by the public health sector and the responses that emerged thereafter. The response to these poor quality services has seen the emergence of private health providers who have come to fill this quality void. There is evidence that the public sector can cooperate with the private sector to enhance access to health services. This can be in the form of personnel in both sectors, sharing equipment and information. However, it is not clear how the *private-public partnership* can be executed to the benefit of health services consumers. There is also a paucity of data on how the partnership between private and public sectors can contribute towards poverty alleviation among the local communities. This study was geared toward investigating mechanisms for strengthening the public-private partnership in health service delivery systems and subsequently devising means of contributing to poverty alleviation.

These Policy Briefs are a product of the MDP multi country research project, which was funded by the Government of the Netherlands and coordinated by the Municipal Development Partnership for Eastern and Southern Africa. They are intended to inform, contribute and provoke dialogue on strategies for enhancing local government capacity for effective service delivery and poverty reduction in Sub-Saharan Africa. The views expressed here are those of the researchers and should not be attributed to the MDP secretariat.

Research Objectives

The specific objectives that guided the research process were meant to:

- Establish the nature of services provided by the private and public sectors;
- Establish the current areas of cooperation between the private and public health sectors;
- Assess the level of quality of health services offered by the private and public health providers;
- Establish the benefits that have accrued from the partnership between private and public sectors;
- Assess the viability of the private and public health providers as key players in health care services and subsequently contributing to poverty alleviation; and
- Establish the most effective means of closing the health service delivery gaps between private and public health providers.

Research Methodology

The study adopted a case study based participatory action research approach designed to collect data on all variables related to the role of private health practice and the framing of the public-private partnership in health service delivery. The major sources of information comprised both secondary and primary sources. The former included a review of existing studies in the field of private and public health care practices. The aim was to provide a qualitative database regarding the performance of both private and public health practice in Uganda. The review of the existing studies identified the gaps, which formed the basis of the research issues investigated by this study. The primary sources of data included; private health providers, clients of private health facilities, focus group discussions with households and exit poll interviews with clients who sought care from private as well as public facilities. Observations of various private and public health care facilities were undertaken using an observation checklist. Key informant interviews were also conducted with members of health care organizations, local governments at various levels (LC V and LC IIII) and other relevant policy makers.

The major sampling technique, which was used in this study, is purposive sampling. It comprised of selection of respondents who were able to divulge information regarding the issues in both private and public health service delivery. This mainly focused on the selection of key informants as well as focus group participants. The former mainly included; the Private Practitioners and health service providers while the latter comprised of health service consumers.

Research Findings

The study found that the impetus to establish private health facilities was mainly economic. As such, clinics have been located in what owners perceive to be 'strategic' locations where not only demand for services is available, but also where people will be able to pay. Most rural areas are poverty stricken hence, they have few private facilities. Whereas the spirit of decentralization is to bring services closer to the people, the private sector services in health have always been income sensitive;

The government was found to delegate funds to the Private For No Profit (PNFP) facilities. These are essentially religious based institutions that own both small and large health units. However, it was found that these institutions are still a preserve of the few, as the majority of the poor cannot afford the cost of the services. This situation may already have exacerbated the situation of the impoverished households in rural communities;

The study also revealed that quality of services is a major incentive for seeking treatment in private health facilities. In both urban and rural areas, clients will do everything possible including sale of their assets such as land so as to access treatment. This situation was found to be a potential source of further impoverishment of households;

Whilst there is evidence of improved quality of services among Private For Profit facilities in urban areas, however, the research findings show that Private For Profit facilities in rural areas were still providing poor quality services. This was largely due to market forces. Most people in rural areas are not able to pay for the high quality health services, which has in-turn not attracted good facilities. Hence, the rural folk seem to be 'comfortable' with the level of quality they can afford, rather than the quality of care in real terms;

The research results also show that while the perception of quality in private clinics was favourable, it is limited to a few parameters such as availability of drugs, client care and little time of waiting. Indeed, these aspects are crucial but could easily overshadow other critical aspects of quality in real terms. These include; qualifications of staff and inadequate dosage of drugs. This is where the public-private partnership in terms of enforcement of regulations through support supervision comes in;

Government also employed most private health practitioners. While health workers in most parts of the World are dually employed, they are also obliged to ensure that they fulfill their obligations where they officially belong, without any conflict of interest. In Uganda's case, the research results show that the health practitioners seem not only unrespectful of this moral obligation but they were found to engage in what respondents called misappropriation of drugs and other consumables necessary for treatment of patients in their care in government facilities;

Public health officials supervise most private practitioners. The supervision is carried out annually and mainly focuses on; status of drugs, i.e. whether expired, quality of staff and general facility aesthetics. It is this supervision that determines the annual renewal of operating licenses. However, the research findings show that this supervision was complicated by the illegal facilities, some of which tended to be concealed by the community including the local community leadership in various areas. The issue is easily understood given the level of poverty in communities. The people argued that they 'prefer such illegal and dilapidated structures to non';

Most private clinics make referrals to public facilities. The problem is that most referrals are not investigated. The reasons for referral were mainly lack of equipment like X-rays and operating theatre among private practitioners; and

Finally, private health practitioners revealed that it could be possible and ultimately cheaper to share facilities with the public sector. The facilities identified for sharing included; operating theatre, X-rays, ultra sound scanners and ambulances. This would enable the public sector to fully tap its enormous potential by accommodating the lower income strata. What is important is the working-out of the cost breakdown and the procedure for sharing the proceeds.

Recommendations

There is need to study the impact of the delegated funds on the quality and utilization of facilities that receive these funds. Currently, there is not enough information on the actual impact of the delegated funds on the utilization of the health facilities;

There is need to identify the specific areas of the private sector from where the partnership can be developed. Currently, there is a gray area as to where the government can begin to support the private health providers;

The plight of rural areas can adequately be addressed by both supply and demand side initiatives. The former would include explicit policy guideline probably biased in favour of rural areas in the form of subsidies and other incentives that can attract Private For Profit service provision to rural areas. Similarly, initiatives focusing on poverty eradication strategies should come in to improve household incomes. This will enhance household effective demand for health care services;

There is need for maintenance of the quality of service delivery through strengthening support supervision of Private Health Facilities. This should be done to ensure that the local households are not exploited by unscrupulous private health practitioners who may be bent on making profit rather than providing health services;

The legal framework still needs to prioritize the need for developing private-public partnership in areas such as contracting of Private For Profit Health providers, sharing of facilities and capacity building with regard to the aspect of financial feasibility and sustainability of the health sector; and

Lastly, there is urgent need for policy formulation on Public-Private Partnership. This should be based on comprehensive and accurate data on the private sector such as size, services offered and qualifications of practitioners. This will help to formulate clear guidelines for operationalizing the partnership in a decentralized governance framework.

About MDP

The Municipal Development Partnership for Sub Saharan Africa was launched in 1991 as a multi year partnership between municipal governments and associated institutions and bilateral and multilateral donors. The Partnership was designed to be an alternative model of development assistance, operating regionally and nationally, dedicated to building local institutional effectiveness in Sub Saharan Africa. The Partnership is organized in two units both of which share the same objectives and methodologies. The Eastern and Southern Africa unit covers 25 countries and is based in Harare, Zimbabwe. The Western and Central Africa unit covers 22 countries and is based in Cotonou Benin.

About the Authors

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