

**FREE-MARKET ILLUSIONS:  
HEALTH SECTOR REFORMS IN  
UGANDA 1987–2007**

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**We can't solve problems  
by using the same kind  
of thinking we used when  
we created them.**

Albert Einstein (1879 - 1955)

To my parents,  
Ramu Agatre  
and  
Rhoda Ofutaru,  
**in memory**

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## LIST OF PUBLICATIONS

The thesis consists of the following papers, which are referred to by Roman numerals:

### **PAPER I**

Sam Agatre Okuonzi and Joanna Macrae 1995. Whose policy is it anyway? International and national influences on health policy development. *Health Policy and Planning* 10:122-132.

### **PAPER II**

Sam Agatre Okuonzi and Harriet Birungi 2000. Are lessons from the education sector applicable to health sector reforms? The case of Uganda. *International Journal of Health Planning and Management* 15:201-219.

### **PAPER III**

Anders Jeppsson and Sam Agatre Okuonzi 2000 Vertical or holistic decentralization of the health sector? Experiences from Zambia and Uganda. *International Journal of Health Planning and Management* 15:273-289.

### **PAPER IV**

Sam Agatre Okuonzi 2004 Dying for economic growth? Evidence of a flawed economic policy in Uganda. *The Lancet* 364:1632-37.

### **PAPER V**

Sam Agatre Okuonzi 2004 Learning from failed health reform in Uganda. *British Medical Journal* 329:1173-6.

## ABBREVIATIONS

AHSPR	-	Annual Health Sector Performance Review
ANC	-	Ante-Natal Care
ARI	-	Acute Respiratory Infection
BoD/CE	-	Burden of Disease/ Cost-Effectiveness
CDD	-	Control of Diarrhoeal Disease
CO <sub>2</sub>	-	Carbon dioxide
DFID	-	Department for International Development (of the UK)
DHS	-	Demographic Health Survey
DOTS	-	Directly Observed Treatment Strategy
DPT3	-	Diphtheria Pertusis Tetanus vaccine dose number 3
DR Congo	-	Democratic Republic of Congo
FP	-	Family Planning
GDP	-	Gross Domestic Product
GAVI	-	Global Alliance for Vaccines and Immunization
GF/	-	Global Fund: short for Global Fund for the Fight Against Aids
GFATM	-	TB and malaria
GHI	-	Global Health Initiatives
GoU	-	Government of Uganda
GTZ	-	Germany Technical Assistance
HC	-	Health Centre
HMOs	-	Health Management Organizations
HSD	-	Health System Development
HSR	-	Health Sector Reform
IMCI	-	Integrated Management of Childhood Illnesses
IP	-	Inpatient department
MDG	-	Millennium Development Goals
MFPEd	-	Ministry of Finance Planning and Economic Development
MOH	-	Ministry of Health
MUSPH	-	Makerere University School of Public Health
NGO	-	Non Government Organization
NHI	-	National Health Insurance
NHP	-	National Health Policy (of Uganda)
NSSF	-	National Social Security Fund
ORT	-	Oral Rehydration Therapy
OOP	-	Out Of Pocket
OPD	-	Out Patient Department
PEPFAR	-	US President's Emergency Plan for AIDS Relief
PHC	-	Primary Health Care
PFP	-	Private for Profit
PMI	-	(US) President's Malaria Initiative
PNFP	-	Private Not For Profit
PPPPH	-	Public Private Partnership Policy in Health
PPP	-	Public Private Partnership
PRSP	-	Poverty Reduction Strategy Paper
PSP	-	Private Sector Programme
SHI	-	Social Health Insurance
SUO	-	Standard Unit of Output
TB	-	Tuberculosis
TBA <sub>s</sub>	-	Traditional Birth Attendants
TNC <sub>s</sub>	-	Trans National Corporations
UDHS	-	Uganda Demographic and Health Survey
UK	-	United Kingdom
UN	-	United Nations

UNEPI	-	Uganda National Expanded Programme on Immunization
UNICEF	-	United Nations Children's Fund
US/USA	-	United States (of America)
USD	-	United States Dollar
USSR	-	Union of Socialist Soviet Republics
WHO	-	World Health Organization
WTO	-	World Trade Organization



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## ABSTRACT

**Introduction:** By the late 1980s, Uganda's health system had been devastated by two decades of conflict and mismanagement. At the same time, public-funded and run health systems had begun to be viewed as inefficient and undesirable. Uganda's attempt to rehabilitate its destroyed health infrastructure was blocked by donors in favour of reform. Introduced as pre-conditions of aid, market-based health sector reforms (HSRs) were eventually embraced by the government of Uganda as part of the wider globalized free-market policy to provide market solutions to health sector problems. The reforms were driven by ideology; they were untested and not based on evidence.

**Theoretical framework:** The research develops a conceptual framework for critical analysis of HSRs as a policy of the free-market system, and uses policy analysis framework of Hogwood and Gunn, which starts from policy agenda setting and ends with policy maintenance, succession or termination. Where a policy fails or becomes irrelevant, it is succeeded by another policy and terminated. It also employs Raskin et al's transition-and-trend prediction of the future; that uncontrolled free-market capitalism is hungry for markets, resources and investment opportunities with dire consequences of social polarization, terrorism, environmental degradation, climate change and breakdown of welfare, such as health care. Two possible scenario options are predicted: either to reform the free-market policy or develop a new civilization.

**Aim and objectives:** The aim of the study was to explore the implications of market-based health sector reforms in Uganda for the development of sustainable health systems. The objectives were to 1) analyse the genesis, formulation and implementation of HSRs in Uganda; 2) to evaluate the performance of the health sector under HSRs; 3) to evaluate HSRs collectively and individually; and 4) recommend a framework for sustainable health systems.

**Methods:** Four main methods were used in the study: a) Several evaluation studies of HSRs in Uganda were done. Ugandan studies were done in thirteen pilot health reform project districts. Evaluation studies included several separate thematic sub-studies. Most studies employed interviews, focus-group discussions, and structured observation; b) A study was done to compare Uganda's reform with those in other countries under a bi-country study and through a review of multi-country studies; c) Systematic reviews and analyses of various household and health-facility surveys were carried out; and d) A sub-district health systems survey was carried out to assess health system inputs, functions, outcomes and efficiency.

**Results:** Health indicators stagnated or deteriorated during the period under study. Only slight improvements have occurred recently but are associated factors outside the health sector. Of the twenty reforms, only two achieved success: setting up private facilities and community-based distribution of health commodities. Eight failed to achieve individual objectives (user-fees, pricing of health care, defining and implementing an essential health package, hospital autonomy, decentralization, contracting out, sector wide approaches, and restructuring of ministry of health). Seven reforms were not sustainable or feasible (revolving drug funds, prepayment schemes, social-health insurance, income generation for health care, payment incentives, hospital trusts and autonomy or privatization of National Medical Stores). Three reforms were found to undermine health sector objectives, especially that of equity (user-fees, privatization, and decentralization). Factors complicating HSRs include aid, macroeconomic

policy, policy on economic growth, corruption, inadequate internal management capacity, and ad hoc nature of reforms in general.

**Discussion:** The failure of market-based HSRs to achieve collective and individual objectives in Uganda is a trend also documented in other countries. The characteristics of a good health system (such as equity, solidarity, evidence-based decisions, government leadership and control, and regulation) cannot be achieved through privatization and market forces. Moreover, HSRs are linked to a much wider and entrenched socio-economic global system established and driven by free-market capitalism. Health systems crises cannot therefore be addressed independently of the wider global economic order. Either there has to be policy reform within the prevailing framework of the free-market, focussed on addressing perpetual crises as they emerge, or a new world order based on different values has to be defined and the human society has embark on the path of a new civilization. It is envisioned that only when the values upon which the free-market is based (such as materialism, winner-takes-it-all, individualism, and domination of others) are replaced with other values (such as equity, solidarity, mutual existence, and shared responsibility), will there be a suitable environment for sustainable and equitable health systems development.

**Conclusions, lessons and recommendations:** The health system crisis in Uganda is due to free-market policy, introduced through and driven by donor aid and its poor management. It was also due to poor leadership and governance in Uganda. Market-based approaches need close control and regulation to protect social welfare and the environment. To address the crisis caused by HSRs, Uganda requires counter-reforms in the economy, health policy, social services, leadership and governance. But globally, the market has to be controlled in favour of human development, peaceful coexistence and sustainable use of resources. Ultimately, a new civilization in which the market is fully controlled and is not the mechanism for health service delivery needs to be established.

## SUMMARIES AND UPDATES OF PUBLICATIONS

### Paper I

This paper highlights the important role played by donors and donor agents, using the leverage of aid, to influence and determine health policy for Uganda. The paper uses two examples of user-fees and drug policy. User-fees were introduced as one of the conditions for securing a World Bank loan for a health project. Danida used its funding of essential drugs in Uganda as leverage to introduce a drug policy, the National Drug Authority, and to make the National Medical Stores (NMS) autonomous. The paper points out problems of inadequate national capacity and the erosion of national sovereignty in policy process. The reduced sovereignty led to NGOs operating micro-policies of their own, largely unchecked, and thus impairing the development of one national strategic policy direction, which was to be led by the Government. An earlier conclusion of this paper was that policy has to be owned by the country, not just by the government. An emerging qualification of this ownership is that it must be democratic.

### Paper II

Based on a comparative study of the successful enrolment in primary school under the Universal Primary Education (UPE) programme and PHC, paper II assesses key health sector performance under HSRs. The indicators show stagnation or deterioration, in spite of 10 or so years of HSRs. Lessons from education were that political support and stewardship, free access, better funding, and few, direct objectives made UPE successful. The paper discusses and evaluates HSRs, and concludes that they failed both in their individual and collective objectives.

A question has been posed by a reviewer of this paper: Why is there a difference in ownership between UPE and HSRs? This hits at the core of this paper. UPE was internally conceived and developed; and HSR was imposed from outside. UPE was developed by the GoU at a time when privatization of social services had begun to lose appeal at the World Bank and so its funding from the Bank was readily granted. But the 10-year health sector rehabilitation plan that the MOH developed earlier had been rejected by the Bank in favour of the Bank's own pre-packaged market-based HSR. This has never been owned by the population and has remained controversial today. Uganda's own health policy, which is largely unimplemented, shows that the country's intentions were clearly different from the reforms.

### Paper III

The paper compares vertical and holistic forms of decentralization between Zambia and Uganda, respectively. In Zambia, purchaser-provider split was made in the MOH, with part of it becoming "provider" another part remaining "purchaser". Organizational and management changes were made up to the village level. Improvements were made in planning, financial management, prioritization, procurement, monitoring, supervision and donor coordination. In Uganda, all ministries including the MOH were restructured and service delivery was decentralized. Organizational changes were made at central, district, facility and community levels. Changes were made in the functions of local agencies, as in Zambia. But in both countries, these changes did not improve health service delivery. On the contrary, the quality, immunization coverage, equity and access to health care worsened. In addition, there was lack of support for national priority programmes at local levels. The support from the centre to

districts, especially supervision, dropped significantly as a result of reduced funding to the centre. The local level capacity for many activities was grossly inadequate.

The paper concludes that decentralization on its own fails to improve health services. Holistic decentralization is good for integration of the health sector into the overall development and is more likely to be sustainable. But vertical decentralization is good for focusing on health and for giving priority to the health sector. However, it is difficult to be used for integration and sustainability of the health sector. The statement “HSR is more sustainable in Uganda because it is rooted in the wider political structure” requires a qualification. First, with the benefit of hindsight, it is clear that HSRs tied to decentralization were pre-packaged from outside and imposed through aid. But it is true decentralization in Uganda started as a successful homegrown programme. However, the policy has now become so politicized and dysfunctional that a new conclusion can be drawn: even a successful homegrown reform that is mismanaged cannot deliver.

#### **Paper IV**

Focusing on the impact of extreme economic policy measures on the health sector, this paper argues that Uganda is pursuing a market economy which is to be export-oriented and driven by private-sector investment. This, it is argued, requires macro-economic stability. Uganda has thus adopted drastic measures supposedly to maintain macro-economic stability. Public expenditure on social services, especially on health-care has been kept minimal. Hospital funding, for example, has capped since 1990's under is the so-called Medium Term Expenditure Framework (MTEF). Ceilings have been set arbitrarily on all social services without due regard to the continuing deterioration of these services. External aid targeting social services have been rejected supposedly because this will upset macro-economic stability. It is argued that Uganda's economic policy is too drastic and yet not based on evidence. World experience shows that a country can maintain a healthy economic growth, whilst improving social services.

The reason for denying aid for essential services to the poor is not based on evidence and is flawed. The paper includes the warning that unfettered market economy in Uganda is the cause of deterioration of social services. It is recommended that the Government study the example of UK's public intervention in improving welfare, and the focus on health and education pursued by Asian Tiger countries as part of their fast-tracked economic growth. Uganda is advised to consider all interconnected factors, which include speed of economic growth, social welfare, work ethic, tradable and exportable commodities, and social values. Finally a warning is given that an economic model largely supporting investors and multinationals while marginalizing the majority of the local population is a recipe for social and political instability that could lead to violence. Alternative economic strategies to address tensions between economic growth and social welfare involve the empowerment of the local population in economic production leading to sustainable and peaceful economic growth.

#### **Paper V**

This paper argues that HSRs have been implemented in Uganda for almost 20 years but they have failed to achieve their objectives. They were imposed as conditions for aid, not through careful analysis and consultation with stakeholders. The reform packages were similar across countries with widely varied socio-economic and political circumstances. The effects of the reforms have been the reduction of access to health care, increase of inequity, reduction in health status, and no improvements in the quality and efficiency of health services. Those who support these reforms provide partisan and misleading interpretation of the performance of the health

sector under HSRs. They usually use life-expectancy and output indicators, without linking these to the specific health-sector goals and objectives.

The paper concludes that market principles are good for business and economic growth, but not for sustainable human development, including health care. Sustainable HSR must be largely non-market oriented, based on solidarity, and linked to health sector goals and objectives. Health services will only improve with increased funding from internal sources or from external aid that is not conditional on free market policies or other restrictions. Even in a poor country, effort must be made at the outset towards universal coverage with targets and a framework for implementation. Economic policy should be oriented to support welfare and human development. A number of poor countries have been able to achieve universal social welfare – Cuba, Costa Rica, Kerala of India, Mauritius, Seychelles and Sri Lanka, among others. They have also experienced remarkable economic growth.

## SUB-THEMES OF PUBLICATIONS

The five thesis papers assess HSRs and cover a wide range of sub-themes. Most of these had originally been dealt with as single topics, with no or incomplete links to each other, without providing the bigger picture of the free-market economy, and how this affects health systems development. The sub-themes covered by the papers include:

### **Paper I: External influence on health policy**

1. Health financing and especially the role of user-fees in setting the reform agenda
2. The role of aid in leveraging reforms
3. The freedom enjoyed by NGOs to set up parallel policy environment in the absence of effective oversight by the host government
4. The lack of national capacity to understand the nature of market reforms and to respond appropriately
5. The erosion of national sovereignty and the lack of ownership of the reforms

### **Paper II: Inappropriateness of market-based priority setting**

6. The overemphasis on priority-setting and its elaborate tools, but without any significant practical application or usefulness
7. Development is much more than just economic growth; the overemphasis on economic growth at the expense of social development
8. Achievements of the health sector despite the reform problems

### **Paper III: The failure of ideology-based decentralization**

9. Evaluation of the health sector: the failure of the HSR and the health sector
10. Excessive, politically driven decentralization, largely unrelated to and often working against health sector objectives and HSD

### **Paper IV: The destruction of health services as a result of free-market policies**

11. How free-market principles are driving global capitalism or globalization, whose objectives run counter to health sector objectives
12. The near destruction of hospital services in Uganda under the guise of controlling cost explosion or trying to attain efficiency

### **Paper V: One-size-fits-all reform policy and dishonesty about reform results**

13. The uniformity of market reform around the world, regardless of the local circumstances
14. The highly partisan, selective and often dishonest interpretation of the results of HSRs



## 1.0 INTRODUCTION

### 1.1 Definition and origin

Health Sector Reforms (HSRs) have been applied worldwide over the past three decades. The term “reform” has become increasingly popular, being used to cover incremental and structural changes in policy and institutions. Reforms are concerned with defining priorities, refining policies and changing the institutions through which the policies are implemented (Cassels, 1995). HSRs were inspired by the neo-liberal ideology as a result of political, economic, historical and cultural pressures and changes. The reforms were meant to address genuine health sector problems that had emerged (Eriksson et al, 2001).

Initial efforts for health reform were undertaken in Europe. In Western Europe, where welfare-state countries provided universal health care, funded from tax or social insurance, new issues began to be noticed. The primary pressure was the demographic change, mainly with aging populations. This brought about changes in health care needs and demands. There was the increased burden of chronic illnesses and mental problems. Technologies for diagnosis and treatment also improved greatly, raising expectations for high quality services. There were also increased waiting times for diagnosis and treatment (Abel-Smith, 1994). Specifically the demand for shorter waiting-times was a key driver in United Kingdom to reform their National Health Services (NHS).

In Eastern Europe, especially in the republics of the former Soviet Union, the economies were being restructured from centrally planned to market economies. As a consequence, there was a sharp decline in health sector budgets. In addition, state funding of the health sector was severely skewed towards hospitals and curative care, taking 70% of the entire health care budget (McKee and McPake, 2004). There were also changing patterns of disease, and greater opportunities for better medical interventions from improved technologies. Medical training was highly hospital-centred and the health system provided limited alternative forms of health care outside the hospital. Health planning was bureaucratic and centralized, and most stakeholders especially patients had little opportunity to participate.

In Africa and Asia, following the oil crisis of 1970s and the ensuing macroeconomic instability, there were drastic declines in external aid and thus in health budgets. Health infrastructure started to deteriorate, and supplies were reduced and became unpredictable. Then the HIV/AIDS pandemic started, devastating populations and putting enormous pressure on health systems that were already falling apart. The increase of infectious diseases and public health problems soared with the emergence and re-emergence of TB and other diseases associated with HIV/AIDS. As public health facilities deteriorated, private sector provision of health care increased in proportion (Bloom and Standing, 2001) especially in Asia.

All these pressures on health systems around the world were to be “cured” by free-market reforms. A central theme of HSRs is to reduce public spending to improve the efficiency of health services. “Efficiency” is the subject of the neo-liberal economic theory. The theory is that competition and financial rewards (incentives) tied to performance are superior in improving productivity, efficiency and quality, relative to a comprehensive state-owned and funded health care provision. Thus, concepts of purchaser-provider split, internal or quasi markets, managed competition, and performance-linked remuneration were at the core of these reforms.

HSRs led the African Inter-Country Meeting in 1995 to re-define HSR as

*a sustained process of fundamental change in policy and institutional arrangements, based on scientific evidence, guided by the government, and designed to improve the functioning and performance of the health sector and ultimately the health status of the population (WHO, 1997).*

The group emphasized “evidence-based”. But this ideal definition defers significantly from the HSRs in use and in practice, which is the orientation of health care systems to be market-based, because of the blind belief that markets are efficient and are the best mechanism for managing society, including health systems (Helms, 1993).

## 1.2 The problem

Twenty years ago, Uganda came out of a war that left a great deal of the health care infrastructure destroyed and the health system dysfunctional. The government of Uganda (GoU) made an elaborate ten-year plan to rehabilitate the destroyed health infrastructure. But donors advised GoU that no major rehabilitation of the health infrastructure be carried out. The donors, who were supposedly assisting Uganda, had determined that what Uganda needed was a “major reform of the tertiary sector” – the hospital sector (World Bank, 1994).

A key reform measure was to orient health services to Primary Health Care (PHC), which was interpreted to mean preventive and promotional services, leaving out curative care for individuals to buy from the private-sector (World Bank, 1993;1994). The vast majority of poor people requiring hospital care would be left to fend for themselves because hospitals “required costly investments” which the government could presumably not afford (GoU 2004). This meant that the public financing of hospitals would be capped or even reduced, and that public hospitals would possibly be privatized.

As time went by, more contents of what came to be known as Health Sector Reforms (HSRs) were revealed. A number of reform rationales were particularly at odds with the reality on the ground. For example, the reason to introduce user-fees in public facilities was given as “the willingness of the poor to pay for health services” (Akin et al 1985), and because about 70% of all health financing in the country was out of pocket (Hutchison, 1998). Some reform measures seemed plausible and potentially useful; for example, the essential health package concept.

The GoU unquestioningly embraced all these reforms. When the National Resistance Movement (NRM) took over power Uganda in 1986, it inherited a severely fractured but still somewhat working health system. But there was a high possibility at that point for a quick turnaround in the decline in health services through the NRM’s ten-point programme, which embraced economic as well as social development (Paper I). But in a dramatic change of policy within a few years of assuming office, the NRM, embraced the free-market policy. This was perhaps a necessary change in line with the prevailing global economic order. Over time however, the NRM government pursued an aggressive economic growth policy paying less attention to social services (Paper IV). Health services and especially hospitals were the most affected. The government developed an extreme doctrine out the free-market policy, where top politicians often openly said “Seek ye the kingdom of economic growth and everything shall be given unto you” (Matsiko, 2007).

And yet, in 1960s, Uganda had one of the best net-work of public rural hospitals and health centres in sub-Saharan Africa, supported by health inspectors and health visitors (Paper I). Health care was available, predictable and free (i.e. funded entirely from taxes), and easily accessible through a good network of roads and railways. Health inspectors promoted home and personal hygiene, mosquito spraying to control malaria, and a programme of immunization

for children. They ensured each homestead had a latrine. Health visitors (nurses or midwives) advised expectant mothers about birth risks and families about the health of young children. Safe water sources were provided in most areas. Food storage and reserves were encouraged to mitigate famines and food shortages. Nutrition centres were established around the country to cater for acute childhood malnutrition, which was rampant. These measures ensured that within 30 years (1940 – 1970), infant mortality was reduced by two-thirds, from ~300 per 1000 to 120 per 1000.

But prior to the market reforms, Uganda's health system had been devastated by civil conflict, mismanagement and economic crises. At the same time, the health-system models that had been used in Uganda became inappropriate. These included high-tech, hospital-based, PHC and market-based models. Most poor countries had similar experiences. The word "reform" gives the impression of changing something fundamentally for the better. But health sector reforms became synonymous with market orientation of health systems. Often it was doubtful whether indeed some health sector problems such as inequity could ever be addressed by market interventions.

Market principles and approaches are ordinarily used for generating private wealth. But they were stretched to apply to health care and other social services. Donors used aid to introduce HSRs, but largely denied the use of aid for straightforward interventions such as rehabilitation of health care infrastructure, buying drugs and equipment, and paying health workers. Instead much funding and effort was devoted to suspicious sounding reforms such as autonomy, privatization, and contracting (Papers II and IV). HSRs were unquestioningly embraced by political and finance ministry leaders who believed that market-based reforms were the best way of improving the economy, including the national health system. The reforms were ideologically defined and driven as a policy. They were introduced as untested interventions, not based on evidence. And there was great doubt and resistance among the medical professional community, and the general public about the viability and usefulness of HSRs, particularly about free-market interventions solving health sector problems and hence improving health services (Paper I). Therefore, the reforms required evaluation and analysis.

### **1.3 Research question**

What are the implications of market-based health sector reforms for sustainable and equitable health systems development in Uganda?

### **1.4 Role of the researcher / author**

I was head of the health policy analysis unit and policy advisor to the MoH from 1998 - 2003. My analytical curiosity was heightened when I started teaching health policy and health economics to master degree students at Makerere University (and later Uganda Christian and Uganda Martyrs Universities) from 1997. Research carried out or commissioned by my unit was meant to help me advise the government. But over time, the inconsistencies and contradictions between health policies preferred by donors on one hand and by MoH based on the realities on the ground on other hand became overwhelming. I became the punching bag between donors and the government. I was also head of health sector reform project under which all HSRs were introduced, formulated and implemented from 1995 - 2000. I commissioned, supervised or carried out over 50 feasibility and evaluative studies on HSRs. The five thesis publications derive from these studies. I wrote most research reports and the accompanying policy briefs. I

also remained responsible for presenting research findings and defending policy recommendations arising from the research in the MoH and the GoU at large.

## **1.5 Study aims and objectives**

The aim of the study was to explore the implications of market-based health sector reforms in Uganda for the development of sustainable and equitable health systems.

The study objectives were:

1. To analyse the genesis, formulation and implementation of market based HSRs in Uganda.
2. To evaluate the performance of the health sector over the period in which HSRs were introduced and implemented in Uganda
3. To evaluate the health sector reforms collectively and individually, and
4. To recommend a framework for a sustainable health system.

## **1.6 Thesis cover**

The thesis cover links the five papers with the same theme of health reforms. It also serves to update the papers and to draw collective conclusions and lessons which no single on its own would be able to achieve. Based on the conclusions and lessons the cover also provides a chapter on recommendations. The thesis cover is not a stand-alone paper but part of the whole thesis and should be read together with the five papers.

The cover sets out to achieve the following specific objectives:

1. to create one coherent picture of health sector reforms in Uganda as part of global health reforms and as part of the global market economy
2. to provide the results of the discussion and analysis done in especially papers IV and V  
It does not repeat the findings which are already in the five papers. But it summarises them to gain an overall picture
3. to present an updated literature review, which provides literature background to the subject of health sector reforms as well as findings from literature search to answer specific questions as a methodology
4. to describe in detail the methodologies used in all the studies on which the five papers are based
5. to draw collective and overall conclusions and lessons from the different papers, and to
6. to make recommendations based on the conclusions and lessons for achieving sustainable and equitable health system in Uganda

## 2.0 THEORY AND ANALYTIC FRAMEWORK

### 2.1 Policy analysis

The thesis is based on two theoretical approaches: theory of policy analysis and projection of future global trends and scenarios.

In policy analysis, HSRs are seen collectively as a policy. Policy has been defined as a set of interrelated decisions taken by political actors or groups of actors concerning social goals and the means of achieving them (Walt, 1994). Hogwood and Gunn (1984) argue that “policy” is a course of action pursued by political actors. Anderson (1975) defines policy as a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of social concern. By policy analysis one seeks to find out how policies are made, who the actors are, and whether a policy has achieved its objectives, and should be maintained or replaced. A useful policy analysis framework is both descriptive (how policies are made) and prescriptive (how policies should be made) (Hogwood and Gunn, 1984).

Policy analysis approach employed in the HSR study has several purposes as below. This is illustrated in figure 1.

**Policy Content:** The approach aims to assess the origins, intentions and operation of specific policies and areas. Such studies of policies help to inform policy-makers.

**Policy Process:** The concern here is with how policies are actually made in terms of the actions taken by various actors at each stage. This can consist of individual case studies or attempts to devise generalizable but largely descriptive propositions about the nature of public policy-making. This thesis has done both: several studies were carried out and generalized conclusions were drawn from the findings.

**Policy outputs:** Studies of outputs from policy typically seek to establish the determinants of the pattern of distribution of expenditure or other indicators of policy outputs. Such studies often involve statistical analysis with a number of variables relating to economic, social, and political characteristics. This has been achieved through these studies.

**Policy evaluation:** Evaluation studies seek to assess specific policies in terms of the extent to which their outcomes have achieved the objectives of the policy. Evaluation studies can be descriptive to improve our understanding of the factors which shape policy, as well as providing information which can be used in future policy-making. Much of the HSR is actually a policy evaluation study.

**Information for policy-making:** This refers to the collection and analysis of data with the specific purpose of aiding a policy decision or advising on the implications of alternative policies. Such analysis differs from ‘content’ studies in that it is explicitly designed to contribute to policy-making. Many of these HSR studies were originally done to aid policy making.

**Process advocacy:** The analyst is here concerned not simply to understand the policy-making process but to change it – usually in terms of somehow making it more ‘rational’. This often involves putting a high value upon particular approaches, procedures, and techniques. The emphasis is less upon what any particular policy should be than with how policies ought to be made.

**Policy Advocacy:** This involves the use of analysis in making an argument for a particular policy. It may be worth distinguishing between (a) the analyst as political actor and (b) the political actor as analyst. Both roles are controversial. Academic analysts who involve themselves in the policy process to the extent of becoming ‘policy advocates’ may do so at the

expense of scholarly standards of objectivity and detachment. When, on the other hand, political actors such as ministers and senior civil servants set themselves up as analysts, both the quality of the resulting analysis and its motivation are often questioned. To a great extent, I worked as a policy advocate. Later, while teaching policy at the university, I looked at the whole study more objectively and thus became an academic analyst.

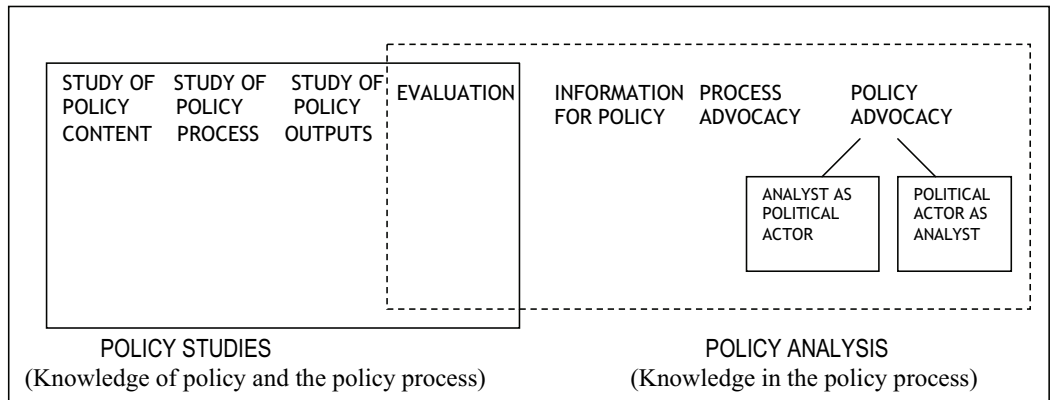


Figure1: Framework for public policy analysis

Source: Hogwood and Gunn, 1984.

**The Analysis of Analysis:** Appraisal of assumptions, methodology, and validity of policy analysis is important. The extent to which ‘facts’ and ‘values’ can be separated in analysis is of vital importance. Policy analysis can be descriptive and prescriptive. In this thesis, it is both.

**The characteristics of policy analysis:** Policy analysis is usually applied rather than pure. Policy studies are problem-oriented. The analysis is usually inter-disciplinary as well as multi-disciplinary. To deal with real many-sided problems (such as health), it must develop an integrated or interdisciplinary approach. Policy analysis is politically sensitive. Typically, there is concern with developing indicators of social conditions and problems, better forecasts, hierarchies of objectives, improved definitions and appraisal of options. There is therefore an overlap between policy analysis and policy planning. This thesis has attempted to give complete characterization to HSR policy analysis.

## 2.2 Transition and trend analysis

In transition-and-trend scenario analysis (Raskin et al, 2002) it is suggested that the world changes from one era to another over time. So far it has gone through three major eras: stone-age, early civilization and now, modern era. Each successive era takes a shorter time. The stone-age lasted 100,000 years, early civilization about 10,000 years, and modern era 1,000 years. It is predicted that a new planetary phase has begun and will last only 100 years. Thus, there is a logarithmic acceleration of change and complexity. The movement from one era to another is called a transition, which happens in distinct three phases. First there is a take-off, then acceleration of transition and thirdly stabilization, when transition gradually ceases and gives

way to a non-changing period. It is suggested that the planetary era has begun, with globalization and increasing technology reaching a planetary scale (see figure 2)

The transition is being driven by capitalism, a perpetual revolution in technology, culture and desire spawned by an explosion of population, and production and economic complexity. Globalized capitalism is hungry for new markets, resources and investment opportunities. The self-expanding and colonizing industrial system entered a planetary phase (involving the whole planet earth) over the past 50 years. It started to take off into a new rapidly changing phase from 1980-2005 with significant features hitherto not seen. These include climate changes, the ozone hole, the earth summit, the information revolution, the collapse of the USSR, the hegemony of capitalism, globalization, the creation of the World Trade Organization, and the increasing influence of Transnational Corporations and NGOs.

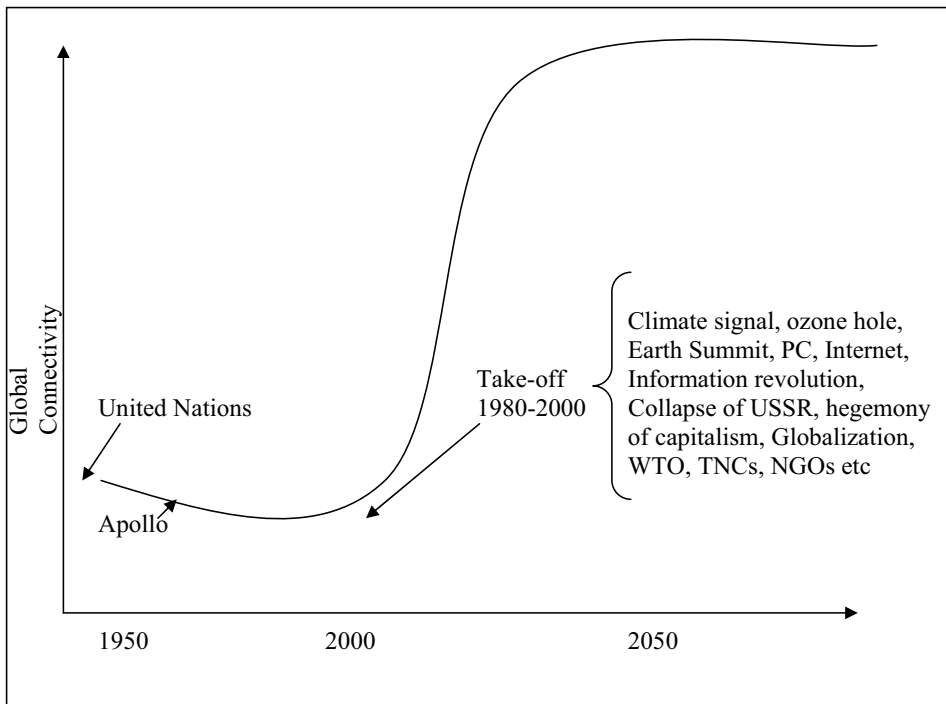


Figure 2: Planetary transition

Source: Raskin et al. 2002

The changes have created three archetypal social philosophies on the future of the world: evolutionary, catastrophic and transformational futures. Evolutionists are optimistic about prosperity, stability and environmental health. Catastrophists fear deepening social, economic and environmental tensions, with dire consequences for the world's future. Transformationists share these fears but believe an opportunity can be seized to forge a better civilization for

humanity. These represent incremental adjustment, cataclysms, and structural shift and renewal. These scenarios are in relation to five areas of development: population, economy, environment, equity, technology and conflict. Figure 3 illustrates the trend and change implications of each type of scenario that could happen.

Based on these outlooks, three possible global scenarios are projected – the conventional world, barbarization and great transition:

1) A possible scenario is incremental adjustment of the current conventional world. This means that the status quo is more-or-less maintained. “Conventional world” assumes that the

Scenarios	Population	Economy	Environment	Equity	Technology	Conflict
<b>Conventional Worlds</b>						
Market Forces	↗	↗	↘	↘	↗	↗
Policy Reform	↗	↗	↗	↗	↗	↘
<b>Barbarization</b>						
Breakdown	↪	↪	↪	↪	↘	↗
Fortress World	↪	↪	↪	↘	↗	↗
<b>Great Transitions</b>						
Eco-Communalism	↪	↪	↗	↪	↗	↪
New Sustainability Paradigm	↪	↪	↗	↗	↗	↘

Figure 3: Scenario structure with illustrative patterns

Source: Raskin et al. 2002

global systems in the twenty-first century evolve without major surprises, sharp discontinuity or fundamental transformation in basic human civilization. The current dominant forces and values driving globalization will shape the future. Incremental market policy and adjustments are thought to cope with social, economic and environmental problems as they arise. But the market-driven development is now judged to be unsustainable. It is being built to overcome market barriers, create and enable institutional frameworks to integrate the world into a global economic system. But there is now increasing frequency of crises as a result of this system: rising food and energy prices, market crashes, terrorism, etc. Thus, the path to this scenario is possible, but undesirable.

2) Through cataclysms a possible situation of “Barbarization” is foreseen. The problems not solved by the “conventional world” cascade into self-amplifying crises that overwhelm institutions, with civilization descending into anarchy. “Barbarization” scenario inevitably leads to a global conflict. The warning bells are being sounded – breakdown of health systems, social polarization, terrorism, environmental degradation, climate change – but go unheeded. As a multi-dimensional crisis unfolds, anarchy may result. Conflict may result into a “Fortress World” where powerful regional and international actors engineer an organized response to



protect their own interests and create lasting alliances. The poor are kept away by a police force and the rich live in favoured enclaves in rich and poor nations. This is a situation that many have begun to see and are trying to avoid. It is possible that sufficient global effort can be mobilized just to avoid this scenario.

If mankind makes a serious effort through a structural shift, addressing economic, social and governance issues, the current problems created in the world as a result of global capitalism, including health system crises, could be overcome. This is global policy reform. However, this may still not provide a sustainable solution to development, including health systems, without major changes in values and lifestyles.

3) But through global renewal, it is also possible to create a new civilization. Called the “Great transition”, this envisions profound historical transformations in the fundamental values and principles of organizing society. New values will emphasize quality of life, material sufficiency, human solidarity and global equity, and affinity with nature and environmental sustainability.

Thus, health system crises around the world are but just one of the drivers or potential drivers of global change. Other drivers of change include population explosion with dire consequences on food availability; trans-national enterprises taking over national governments and economies; increasing social inequality and economic inequity; globalised information technology fostering a consumer culture; technology revolution giving a high potential to improve human livelihood, but may raise ethical and environmental issues; the environment is degraded by toxic substances, loss of species, and degradation of ecosystems; a trend in governance towards individual rights, private sector, civil society and diversity in culture.

## **2.3 Analytic framework**

The theoretical framework to explain the HSR policy pathway is based on four approaches. First is the analysis of the market and market-based systems. Here the origin, the evolution and the factors that are driving the market-based model of development are discussed. Second is the analysis of the health systems, especially the evolution of hospitals and health financing. The “marriage” of health system development to the free-market is analysed. Third is policy analysis where HSRs are seen collectively as a policy. Because of the external influence (of inhibition) of donor aid on national policy processes, the national stages did not take place (Paper I). This also explains the lack of ownership of aid-driven policies by recipient countries. Thus, a meaningful analysis of HSRs as a policy can only focus on five elements of the elements: issue definition; setting objectives and priorities; implementation, monitoring and control; evaluation and review; and maintenance, succession or termination. It is suggested that when a policy fails to deliver, it is terminated and replaced.

Fourth is the transition-and-trend scenario analysis. Here it is suggested that the world changes from one era to another over time. The planetary era has begun, with globalization and increasing technology reaching a planetary scale. But in this analytic framework, only the most desirable changes, policy reform and great transition are analyzed. They represent a definite departure from the current systems which sustain continuing social and health system failures and crises. Figure 4 below combines the analyses of health systems, the market, policy and trend-and-scenario into one theoretical framework. The discussion, conclusions, lessons and way forward of the thesis are based on this framework.

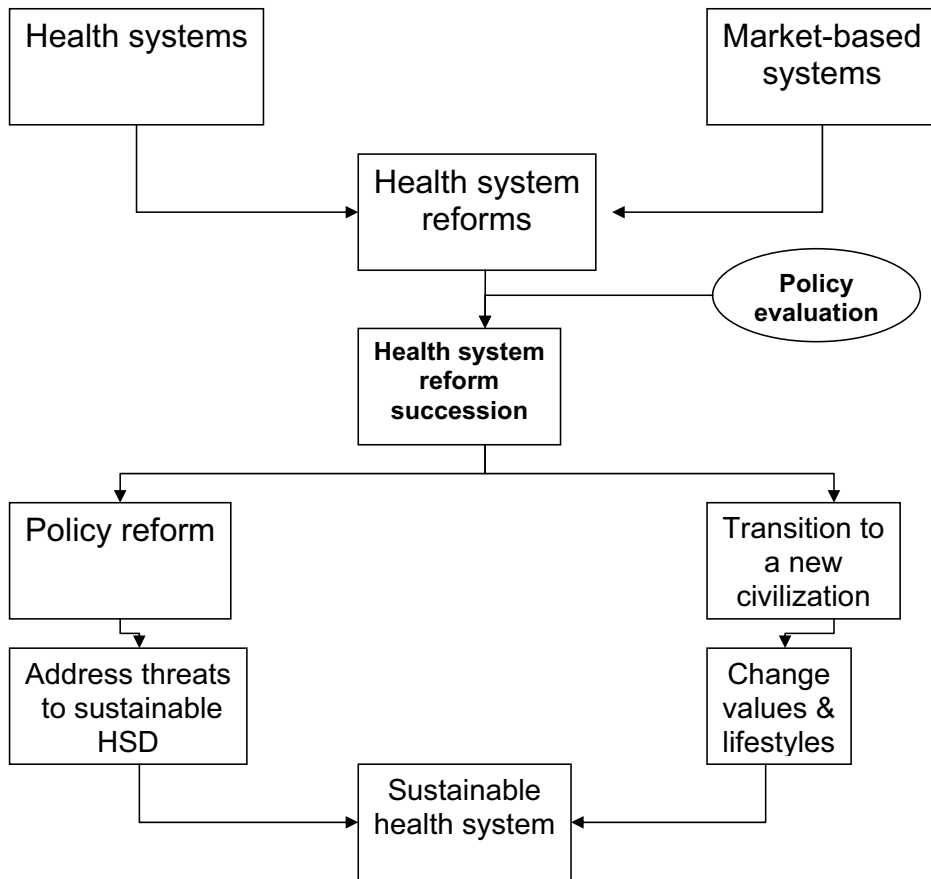


Figure 4: Analytic framework  
 Source: author's compilation

In the top boxes are health systems and market-based systems respectively. These systems have evolved along different paths, with different characteristics and values. Health systems evolved to help the sick and achieve equity. The market evolved as a mechanism for exchanging commodities and for generating wealth. But increasingly, as a deliberate and distinct policy, market mechanisms are used to organize social services and life in general, including health services. Thus, in the box in the second level the health system and market are mixed. The resultant cocktail is the subject of evaluation in this study. But several analysts (eg Raskin et al, 2002) have concluded that market-based systems are responsible for inequity, social crises and failure of social systems. They predict that for sustainable global development and living, including sustainable health systems, market-based systems are untenable. Thus, in the box at the third level, they predict the need to succeed the market-based policy as a normal and necessary step of replacing policy (Hogwood and Gunn, 1984). There are two key pathways to

the succession of the market-based policy: reform of the system or transition to a new civilization. Reform of the market-based system is to leave the system intact but address the threats such as inequity, social unrest and conflict, population explosion and food shortages. It is predicted that this may lead to an uneasy form of sustainable life, including an uneasy sustainable health system (see box at the bottom). It may also not be as much resisted as introducing a new system. A second key pathway to succeed the market system to a sustainable, equitable and peaceful world however is the transition to a new civilization altogether with new values and principles on which to organize society. This civilization will emphasize quality of life, material sufficiency, solidarity, global equity and environmental sustainability. It is envisaged that only under such conditions will it be possible to have sustainable and equitable health systems, represented in the box at the bottom of the diagram.

## 3.0 LITERATURE REVIEW

### 3.1 Uganda: the context of reform

Uganda is a landlocked country located in East Africa astride the equator. It is bordered by the Sudan, Kenya, Tanzania, Rwanda and DR Congo (figure 1). It shares Lake Victoria, the largest inland fresh water lake in Africa, with Kenya and Tanzania. It is elevated to an altitude of 1000-1500 metres above sea-level and covers an area of 240,000 sq km. It lies in the equatorial belt with temperatures between 20 to 30 degrees Celsius. Rainfall is regular throughout the year, with peaks in April-May and October-November. However, this pattern appears to be changing. The country is generally fertile and suitable for agriculture except in North-East, where it is semi-arid. Vegetation varies between rainforest and savannah land to semi-desert vegetation of shrubs.

#### *High population growth and poverty*

Uganda's population is projected to be about 31 million in 2007 (table 1). The country has a high population growth rate of 3.2% per year. Infant and maternal mortality rates are relatively high and have persisted at about the same level over the past 30 years. However, in the most recent population surveys some slight reduction in mortality has been achieved (GoU, 2006(a); 2006(b)). Other health indicators have not changed much. Total fertility is still high at 6.7 children per woman. Contraceptive rate is only 23.7%, supervised births are at 41%, and full immunization is at 46%. Stunting in children under-five years of age is quite high, at 32%. Nevertheless, Uganda has done well in reducing and managing HIV/AIDS, where HIV prevalence has reduced from about 30% in 1991 to only 6.4% in 2007. It has also dramatically improved access to ARVs for AIDS patients with financial support from donors.

Other human development indices show that human poverty index has remained at 36%, but life expectancy has increased from about 47 years in 1990's to 54 years. The proportion of expenditure on health as a percentage of the GDP is 2.2%. But expenditure on education as a proportion of the public sector budget rose from 1.5% in 1991 to 5.2% in 2007. The majority of the people are peasant farmers. About 90% of the population lives in rural areas. Modern agriculture for export has begun to emerge in many places. The major foreign exchange earners are coffee, tea and tobacco; and increasingly newly commercialized products, such as vanilla, fish and flowers.



Figure 5: Map of Uganda

### ***Colonial history: roots of instability***

The British colonialists found what has now become Uganda a conglomeration of different ethnic groups living separately and often at war with each other. Some ethnic groups had become organized as kingdoms with a strong central authority. These included Buganda, Bunyoro, Ankole and Tooro. Others were organized along clan relations without a strong central control. The British established indirect rule over the kingdoms through the kings, and appointed chiefs to administer the non-kingdom areas. Eventually, the British carved out Uganda as its territory and declared it a protectorate. However, dissent against the British sparked off by the Omukama (king) Kabalega of Bunyoro spread to Buganda, the dominant kingdom that time, and to other parts. Thus, by 1950s, there was a well-organized resistance against the British colonial rule.

### ***Post-colonial political instability***

On October 9, 1962, Uganda got its independence from Britain. The Kabaka (king) of Buganda became president and Milton Obote from another ethnic group became prime-minister. Political and tribal rivalry within the newly established post-independence government led Obote in 1966 to change the constitution and abolish kingdoms. He became president and declared Uganda a republic (Jorgensen 1991). Buganda wanted its kingdom restored and began to agitate for reform. Subsequently an attempt was made to assassinate Obote in 1969. In 1970, there were sufficient rivalries, plots and counterplots within the establishment to cause change of government - which happened in 1971. In a swift, coordinated chain of events, Idi Amin, the head of Ugandan Army, overthrew the government. He was initially a welcome change to curb the growing restlessness, especially in the Buganda region. But as he began to consolidate power and became aware of the rising insurgency from members of the previous government who had grouped in neighbouring countries, he became increasingly ruthless. He abolished the constitution and ruled by decree, and eventually declared himself life-president. From 1971 to

1979, Uganda experienced the worst dictatorship, and political and economic mismanagement. The economy declined and social services sharply deteriorated.

Table 1. Uganda: selected development indicators

Indicator	Value
Population	31 millions
Population Growth Rate	3.2 %
Urban Population	12.8 %
Infant Mortality Rate	76 /1 000
Child Mortality Rate	137 /1 000
Maternal Mortality Rate	435 /100 000
Total Fertility Rate	6.7 children/ woman
Full immunization	46 %
Stunted Children	32 %
HIV Prevalence Rate	6.4 %
Literacy Rate	69 %
Human Development Index	0.502
Income inequality	0.43
Gender Related Development Index	0.498
Human Poverty Index	36 %
Government expenditure on education	5.2 % of GDP
Government expenditure on health	2.2 % of GDP

*Source: Uganda Bureau of Statistics: Fact sheet 2007*

In 1979, through a concerted effort of the government of Tanzania and Ugandans in exile, Amin's military junta was overthrown. A government of national unity was established, but there were serious internal wrangles among groups that had deposed Idi Amin. Within two years, Uganda changed presidents three times. Eventually, elections were held with the support of Tanzania, which paved the way for Obote to return as president for a second time. But the elections were widely contested and largely viewed as having been rigged (Jorgensen 1991). One group that had been part of the effort to remove Idi Amin had organized under the banner of a party and had lost in the elections. This group, led by Yoweri Museveni, the current president, returned to the bush to wage a guerilla war against Obote's government.

As Obote tried to re-organize the economy, insurgency by the guerillas severely destabilized his government. Within five years, Obote's government was overthrown for a second time by his own generals through a tribal rivalry. The generals tried to persuade Yoweri Museveni to join them in forming a government of national unity, but the latter regarded the generals as part of the old establishment. Thus, the National Resistance Army (NRA) led by Museveni over-ran this new, partially formed, and unconsolidated government within a matter of months.

The NRM government was a multi-ideological alliance of freedom fighters. They thought that parties and religious beliefs divided people, and so peaceful change of government should be organized through a "no-party system" (Odonga-Ori, 1998). Individuals should compete for political posts on personal merit rather than through political parties. The no-party experiment took about ten years before it was found to be unsuitable. The NRM behaved like a party and anybody with dissenting views was regarded as opposition, even an enemy. It thus lost its multi-ideological stance. With pressure from donors and internal opposition, a multi-party system of governance was re-introduced in Uganda in 2001 and NRM has become a fully-

fledged party. It is now the ruling party, having won elections in 2001 and 2006. The NRM government has been innovative, achieving considerable successes in economic recovery and the fight against AIDS.

### *Western medicine*

Modern-type health care was first introduced in Uganda in 1889 by the Imperial British East Africa Company (IBEAC), a trading concern. IBEAC brought doctors to look after its staff and Indians who were needed for the construction of the rail-road from Mombasa to Kampala. Africans received medical care only in emergencies. But successive epidemics forced IBEAC to treat Africans generally. These medical services were subsequently taken over by the colonial office (Owor, 1987). It was missionaries who started medical services devoted mainly to Africans. Dr Albert Cook arrived in Uganda in 1897 and opened the first hospital in Mengo, in Kampala. In 1917 he became the first person to teach Africans modern medicine. The three-year diploma course led to the qualification of "Native Medicine Assistant". His wife, Sister Timpson, also started teaching African midwives. Later, other missionaries brought more medical workers, building more hospitals and starting schools for nurses and midwives.

During the period, the country experienced successive epidemics of plague, sleeping sickness and small pox. Also, Dr Cook's analysis of patients at Mengo Hospital showed that 80% of patients had syphilis (Owor, 1987). These problems forced the colonial administration to establish a medical department in 1902. By 1909, three health centres had been established at Mulago, Mityana and Masaka for the treatment of venereal diseases. Mulago hospital was completed in 1913 and dedicated to the treatment of venereal diseases. It became a general hospital in 1923. Other hospitals and dispensaries were gradually established in provincial and district headquarters throughout the country.

The rapid succession of epidemics of small pox, plague and syphilis shortly after the arrival of Europeans and Indians in large enough numbers is not surprising. Recent studies of human evolution and development show that Africans remained free from these diseases which originated from animals which were subsequently transmitted to humans who got in close contact through domesticating the animals (Diamond, 1997). Agriculture, including the domestication of wild animals started in Middle East and Asia. Genetic and archaeological evidence show that some early Asians migrated to Europe and gave rise to the European race. These Euroasians picked up germs from animals, which caused them illness and mutated. But over hundreds of years, humans developed immunity and were able to resist infections from these germs. Africans remained non immune to several diseases until Europeans brought the diseases with them when they colonised Africa. Initially, the diseases had devastating impact on African populations, until they gained immunity against the diseases.

Smallpox originated from cattle and is related to cowpox. Plague also originated from animals – rats, transmitted to humans by fleas. Syphilis has its origins from animals. The indigenous epidemic to Uganda was sleeping sickness which is transmitted from wild and domestic animals to humans by the tse-tse fly. Epidemics are diseases of crowds. In Africa, there were no crowds until relatively recently. But "crowds" first developed in areas where agriculture started. In a crowd, there is a high possibility of exposure to infectious diseases and ease of transmission of disease from one person to another. Plague, which is carried by ticks found on rats, would be possible only at a certain population density. Syphilis also has its origins in animals. The indigenous epidemic to Uganda was sleeping sickness.

The colonial government encouraged local administrations to participate in the running of health services. This role of local authorities was later strengthened by Local Administration Acts of 1964 and 1967 (Owor, 1987). Traditional medicine predates the colonial era and it continued to thrive throughout the country. However, the colonial government viewed traditional medicine with suspicion. As a result, the government legislated that traditional healers would only practice in their own communities. Today, traditional medicine has become officially established alongside western medicine in most countries. WHO has now recognized traditional medicine as an integral part of the national health system. After the Second World War, international cooperation in health became a global concern under the newly established United Nations (UN). UN agencies, WHO and UNICEF, began to sponsor health programmes in public health, which became the building blocks of the health system in Uganda.

#### *Post-independence health sector development/mismanagement*

The MOH was created in 1961 out of the colonial department of the Ministry of Social Services. By 1961 there were 27 hospitals and 1,288 staff for a population of 7 million. After independence another 22 new rural hospitals were built throughout Uganda, bringing the total number of hospitals to 49. During the period from early 1960's to early 1970's, Uganda had one of the most outstanding networks of health services on the continent. But the 1970's ushered in political upheavals culminating into 2 decades of devastating wars. The exodus of trained personnel, the decline of the economy, rising inflation, mismanagement, neglect, and the physical destruction of health facilities reduced the previously good services to an appalling state (Owor, 1987).

The public outcry about the deterioration of health services led the government to institute a commission of inquiry in 1977, but by 1985 the recommendations had not been implemented. Understandably, the country was in period of turmoil - both political and economic(Owor, 1987). Meanwhile, NGOs and churches continued to provide health services, contributing at least 40% of services in the national health system. The private sector was small in 1960's especially when the national health system was working well. As the health system deteriorated, private health providers increased in number and scope of services. The general breakdown in law and order in the country made it impossible to enforce statutory controls over private practice. This led to an explosion of illegal private clinics with indiscriminate peddling of drugs by unqualified persons.

#### *Primary Health Care*

During early 1980's, the concept of PHC was introduced in Uganda as a major strategy for health improvement. It was defined as an essential, affordable and acceptable health care based on intermediate technology and implemented through an inter-sectoral approach, with community participation (WHO, 1978). The National PHC Action Plan was completed in 1982, but remained unimplemented because there were no clear modalities for its implementation, and its budget was unaffordable. Within three years, PHC was dismissed by most health officials as impracticable and they sought more consultation. This dilemma was faced by most low-income countries. The impasse was partially resolved by Walsh and Warren (1979) and later taken up by UNICEF under the selective PHC. UNICEF subsequently developed the famous GOBIFFF (Growth monitoring, Oral re-hydration, Breastfeeding, Immunization, Family Planning, Female education and Food Supplementation) formula. This selective approach was rejected by WHO, who insisted on PHC in its comprehensive state. But for programme managers, this was a distant academic debate. Uganda embarked on selective PHC.



NGOs, initially providing emergency and relief assistance, eventually joined the health sector in large numbers to champion selective PHC. But NGOs operated their own micro-policies, especially in the absence of a national policy and overall guidance. Thus, in 1987, the government appointed a “Health Policy Review Commission” to review the situation and propose a health policy for the country. By 1991, no health policy had been made, but a plan – the “National Health Plan 1990-2000” - was completed. It had ten key policy measures some of which were later to become key components of the NHP. The plan had the following policy measures: commitment to comprehensive PHC, community participation, decentralization of health care, inter-sectoral collaboration, coordination of NGOs and donors, collaboration with NGOs, promotion and regulation of private practice, integration of traditional medicine, re-organization of health care system into four levels, and promotion of alternative methods of health financing (Okuonzi, Owor et al, 2002).

#### *The advent of AIDS*

Before the plan and policy could be completed, there were increasing concerns about the emergence of HIV/AIDS and the sorry-state of health care infrastructure (Paper I). Two projects funded by a World Bank loan were set up to address these concerns. While remarkable achievements were made with regard to controlling AIDS, the infrastructure rehabilitation targeted only a few facilities, which were partially done. In 1992, the MOH completed its ten-year plan. But its publication prompted a major outcry from donors. The point of contention was that the budget of the plan exceeded by fourfold the available resources.

With the benefit of hindsight, it has become evident that resources were not the main issue because donors eventually spent much more on health sector programmes than had been envisaged in the budget (Okuonzi, 2004 ). The real bone of contention was that no further expansion or rehabilitation of existing health care infrastructure would be funded by donor funds. This was in line with the new donor vision shaped by market reforms that were seen as the panacea for health systems in crisis. Therefore, the concern about the direction the plan had taken – greater government involvement in the provision of health care - prompted donors to get involved in health policy and planning, and to use aid as a leverage to get their way.

In addition, Uganda’s health system became highly decentralized. Decentralization in the health sector was defined as “bringing health services nearer the people” (Okuonzi and Lubanga, 1997 ). It entailed the MOH ceasing to be operational and assuming the roles of policy, strategic planning, technical guidance and supervision. The MOH was re-structured accordingly. Health planning was to be carried out and approved by districts. Health funds would be transferred directly from the treasury to districts and urban councils. Local authorities would become responsible for the management of health personnel, including hiring and firing. Local authorities would manage district hospitals and funds for service delivery. The decentralized administrative levels corresponding to the health system are presented in figure 6.

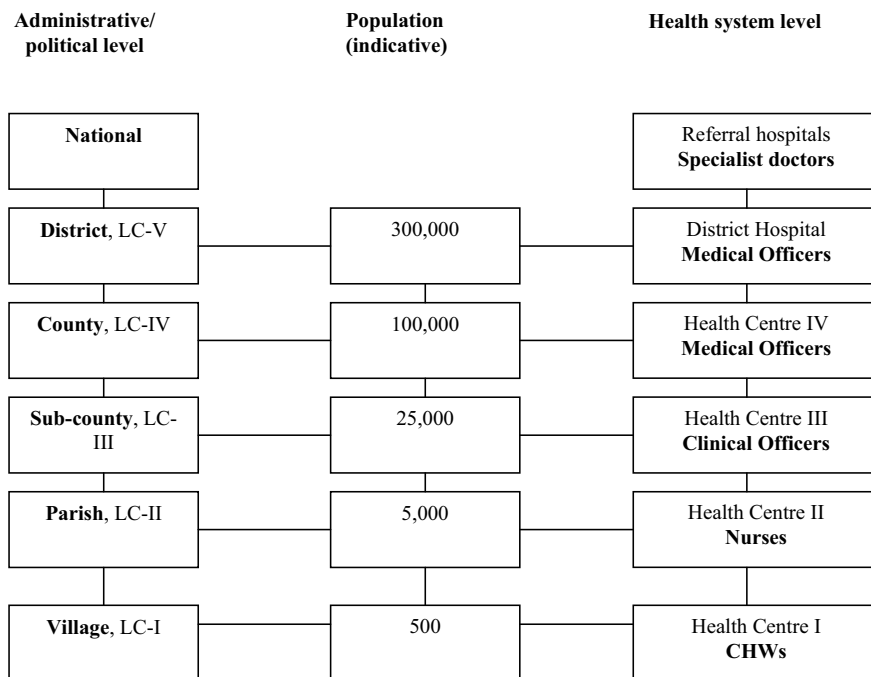


Figure 6: Uganda’s administrative and corresponding health system levels

Source: author’s compilation

***The emergence of the World Bank as health sector leader***

By 1992, with the assistance of World Bank advisors, a three-year plan frame had been made (GoU, 1993). This provided the blue-print for subsequent reform programmes. The plan frame laid down six policy measures: no further expansion of health care; restore functional capacity of existing facilities; orientation of services to PHC; a basic-package approach should be used; to respond swiftly in managing AIDS, while mitigating its social and economic consequences; and promoting user-fees as a way of financing health care. In 1990’s, the World Bank had begun to play a leading role in the health sector. In 1994, after three years of negotiations, the bank and the government agreed to implement a wide range of health sector reforms. This resulted in the health sector reform programme led by the World Bank.

***First Health Project***

The World Bank made its first appearance in Uganda’s health sector in 1988 with the approval of USD 42.5 million for the First Health Project (FHP). The FHP was conceived as an “emergency project” to rehabilitate the badly devastated health infrastructure following a twenty-year period of civil wars and social instability. FHP had three objectives (GoU, 1998). One objective was to rehabilitate Mulago national referral hospital, the national blood bank, 8 rural hospitals and 30 health centres. A new hospital was to be constructed in Rakai district, a famous area where AIDS in Uganda was first identified locally as the “slim” disease. Another objective to

promote health education through mass media and training; and community-based distribution of drugs, counselling HIV/AIDS affected people, including assisting the families and promoting household hygiene. The last objective was to strengthen planning, budgeting, financing and partnership with CBOs and NGOs. A number of short-term achievements were made. These included preparation of the national health plan, establishment of a health education programme and the rehabilitation of 8 hospitals and 27 health centres (GoU, 1996).

Major challenges included the failure of the government to provide counterpart funding due to the low revenue base, which was worsened by the collapse of coffee prices; the continued under-funding of the health sector; demoralized and inadequate health workers; the badly structured MOH (along vertical programmes); and the lack of institutional framework to deal with NGOs and other civil society organizations. At the end of FHP in 1996, a number of lessons had been learned. Sustainability of health infrastructure and services emerged as the major issue for the health sector, which could not be addressed by a short-term and highly confined project such as FHP. There was dire need for institutional building across the health sector.

#### *District Health Services Pilot and Demonstration Project (DHSP)*

At the close of FHP, it was agreed that a follow-up project would be necessary to address the wider issues of the health sector and some critical issues such as health financing and sustainability. In particular, a World Bank appraisal (World Bank, 1995) noted the lack of capacity (in terms of human resource numbers and skills, infrastructure, systems and institutions) and the need to ensure a reliable delivery of basic health-care. Thus, a new project, DHSP, to cost USD 75.1 million, was conceived effectively as a vehicle for market reforms of the health sector.

### **3.2 Evolution of health systems**

Health-care has a long history of evolution, which is quite distinct from the evolution and development of the free-market ideology (Abel-Smith, 1994). Traditional medicine and spiritual care have been with mankind for thousands of years. But the modern, organized health-care system for the public is about 200 years old. The development of the modern health-system started with the development and management of hospitals. Hospitals first emerged in India, Arabian Kingdom and in southern Europe. In Europe, they became part of monasteries and convents. Abel-Smith (1994) identifies six reasons for the creation and emergence of hospitals: 1) to provide residential treatment for the public; in Europe these were owned and run by religious institutions; 2) to serve the sick who had no families and support; 3) to serve soldiers and sailors who were often sent abroad to colonies to fight for the expansion of empires; 4) to manage epidemics, especially smallpox, cholera and typhoid; 5) to treat venereal diseases which started in Sweden, and 6) to treat leprosy which started in Norway.

In Europe, where hospitals had been entrusted to and run by the Catholic Church, they were eventually transferred to public authorities. The reasons for the transfer were mismanagement of the hospitals, misappropriation of hospital funds, anti-clericalism and lack of funds. In some countries, churches continued to run hospitals (Abel-Smith, 1994). From 1870's, hospitals were developed as a function and responsibility of local authorities in Sweden. In Britain, King Henry VIII suspended monasteries and transferred hospitals to public institutions and they began to be funded by charitable institutions. Public hospitals of this nature were supplemented by

numerous, small and private hospitals for those who could afford them (Palmer and Colton, 1995).

There is a close association between the poor on the one hand, and the development of hospitals and health systems on the other. In Britain, the poor law (and social assistance in other countries) enabled the poor to be catered for with respect to hospital services. For 350 years in Norway, salaried doctors paid by the government were employed to look after the poor. This practice spread to Poland, Sweden, Switzerland, UK and Russia. Midwifery developed as a separate profession, and midwives were also paid salaries to look after the poor. Home-nursing developed as a charitable movement to help the poor in 1859 in Britain. Later, nursing homes were subsidized by local authorities and eventually taken over as a key function of the local authorities (Abel-Smith 1994).

### **3.3 Evolution of health financing**

Thus far, hospitals and outreach services were funded by public authorities, charitable organizations, and the church. But modern methods of financing of health-care began to develop with voluntary health insurance. Voluntary sickness insurance developed as a movement in Europe, New Zealand, Australia, and later in South America. But in 1883, voluntary health insurance evolved into compulsory insurance for civil servants and miners. Chancellor Bismarck of Germany eventually introduced a law to establish compulsory insurance to create loyalty to the employer and state. This was in response to growing restlessness in the country about a possible socialist revolution (Palmer and Colton, 1995). The compulsory health insurance was gradually adopted in other countries around the world.

#### *Evolution of universal coverage*

But compulsory health insurance excluded a lot of people from health care, including fishermen and farmers. Many countries sought different ways to extend insurance coverage to the whole population. They did this either by reducing the premium to make it affordable by all, or by subsidizing using trust funds or tax funds. Eventually most high income countries adopted universal health care, starting with Russia (1938), Britain (1941), Scandinavia (1960's), Canada (1970), Italy (1980), South Korea and Taiwan (1990-94), Singapore and Malaysia in 1990's (Abel-Smith, 1994).

Various mechanisms were used to cover the poor, the aged, children and the disabled. One way was to cover them under the able-bodied, who were insured. The other way was to establish a specific social security scheme, which supported health-care and other benefits such as pension. A third way was to provide direct assistance in health-care by local authorities. The only high-income country without universal health-care coverage to date is the USA. There are 47 million people without any insurance or access to health-care in USA. The main reason is the prevalent negative and racist attitude to the poor, and the association of poverty with blacks and recent immigrants. In addition, there are no strong union movements in USA, and the medical profession wields much political influence (Halvorson, 1993).

#### *Crisis in health financing*

Most of the low-income countries were colonies and inherited or adopted the universal model of health-care from their European colonizers. However, from 1960 -1980, pressure began to be applied on health expenditure for increased demands created by knowledge, technology, aging populations and disease patterns. The pressure to spend on health-care reached a "crescendo"

around early 1990's when a "cost-explosion" was reached (World Bank 1993). In poor countries, the pressure was generated by the oil-crisis 1970's that led to a slump in the world economy. This reduced economic growth, and so donor countries reduced the amount of aid they gave to the poor countries. The poor countries themselves experienced high interest rates, which led to a high cost of debt servicing.

They also sold less of their produce to the outside world, lowering the level of foreign exchange. Consequently, the currencies of the poor countries lost value, making it even more costly to service their debts. With less aid coming in, and difficulties in balance of payment deficits, they had to reduce spending on health. This led to the widespread collapse or near collapse of health systems in most poor countries in 1980s to 1990s. Most have not yet recovered.

#### ***Response to financial crises***

By late 1970's, it had become clear that the third-world needed a different kind of health system. Under WHO and Unicef, third-world countries defined a new health system that became known as PHC. But within a few years of launching PHC, it became clear that the strategy was not implementable or fundable in its original form. So "selective PHC" was devised, where only a few affordable elements and cost-effective interventions would be implemented, giving rise to disease specific or vertical programmes that are now prevalent in third-world countries.

But the introduction of PHC did not halt the downward spiral of health services in the third world. By year 2000 it had become clear that PHC had largely failed due to lack of funding. It was partly because of the difficulty with PHC that HSRs were started. Through the reforms, the health system was meant to fund itself, largely through health-insurance schemes or user-fees, which did not happen. Thus, health financing remains the most intractable challenge for the health sector today. This challenge has led to the development of the MDGs as a compact between nations. This global health compact is to be funded through scaled-up aid to poor countries on a long-term basis.

### **3.4 Health system under the free-market**

#### ***Belief in market superiority***

The rise and spread of market solutions are rooted in the belief that market-based systems are superior to other types of systems (Amin, 2000). In particular, it is claimed that market-based systems are superior to government-run systems. The collapse of the former USSR and Eastern Europe are cited as evidence for the weakness and inferiority of government- or public-run systems. The emergence of USA as the only superpower in technology, economy and military might, is given as evidence for the superiority of the market, on whose principles the USA runs all its affairs. Heavily influenced by the US government, the World Bank and IMF - the two most influenced global financial institutions - have placed a particularly extreme version of the market philosophy at the heart of their policies.

In the early 1990s, the US treasury heralded the triumph of capitalism. Together with IMF and WB, the US Treasury formulated the Washington Consensus Policies founded on the principles of the market (Stiglitz, 2002; Sachs, 2005). The policies were projected as the true and only way for economic growth and development. They consisted of four policies: privatization, liberalization of trade, macro-stability and investment. Nothing else mattered. The consensus model was idolized to the extent of ignoring the context and process of implementation. In

many countries in South America and Africa as well as Russia, the timing, order, dynamics and pace of the reforms, which should have been considered, were ignored. Other important development factors such as land reform, taxation policy, financial regulations were not emphasized (Sachs, 2005). In countries such as Russia, the consensus policies have largely failed. But East Asian Tiger countries, which opposed these policies, or implemented them in their own terms, have experienced remarkable economic growth and social development over the past 20 years.

### *The market philosophy*

The underlying philosophy of market principles is libertarianism. This espouses individual freedom as supreme; there should be no restraint on it. The free market is regarded as the most beneficial means of production and distributing goods and services (Gilson, 1988). The market is a just and neutral mechanism. Above all, the free market protects and guarantees the freedom of the individual. Private property is outside government's control and taxation is a form of robbery. Social justice is seen as being caused by the actions or inactions of individuals. These actions or inactions by individuals create large differences in socio-economic situations of such individuals. These differences should not only be accepted but expected, because it is in the nature of human beings under the forces of the impartial market forces for differences to arise among individuals. The government's interventions are unjustified and unacceptable because they interfere with individual rights and freedoms (Gilson, 1988). The individual is viewed as autonomous, and he makes decisions based on self-interest and pursuit of his welfare. The individual is seen as maximizing his utility (satisfaction) from consumption decisions that he takes, a phenomenon called utilitarianism.

### *Assumptions of a perfect market*

But the principles drawn from the market economics are based on a hypothetical perfect market, built on numerous impractical assumptions. The hypothesis is that the perfect market is in equilibrium, where demand and supply of goods and services are equal at prevailing price. Under such conditions, there are a large number of small-sized buyers and sellers in competition. There are no barriers to enter the market, and there are no monopolies. There are no external benefits and costs (or externalities) in the process of exchange to people other than the buyer and seller. And the consumers are all well-informed.

In a rebuttal of the economics theory, as it is supposed to apply to health and health-care, Rice (1998) shows that no perfect market exists because no single assumption holds true in health-care. Since the assumptions do not hold, the market-based health-care model is a myth. Rice examines fifteen assumptions of a perfect, competitive market from which the principles of market-based policies are derived, and found that none of them holds true.

Assumption 1: *There are no negative externalities of consumption.* This means that when two people transact business, the transaction does not affect anybody else negatively or positively. The assumption totally collapses if one considers that goods or services consumed are affected by, relate to, are compared with, and affect the bundle of goods and services of other people. Happiness, for example, is relative to other people's states of happiness or sadness. Employers can affect the welfare of employees.

Assumption 2: *There are no positive externalities of consumption.* This is an extension of the first assumption focusing on the positive aspects a transaction between two people, one buying and the other selling. But people do have concerns for the welfare of others, and there is a common sense of social justice everywhere in the world on the right or moral things to do.

Assumption 3: *Consumer tastes are pre-determined.* This means that in a transaction, consumers know exactly what they want to buy, which is supposed to have been pre-determined. This is again not true because consumer tastes are malleable through exposure to different experiences and knowledge, environments and opportunities.

Assumption 4: *A person is the best judge of his or her own welfare.* This assumption is in fact based on another assumption that everybody at all times has the capacity to make the choice of consumption in his/her best interest. But this is not necessarily true because people do not have full information on the consequences of their consumption decisions, they do not know the consequences, and people are not always rational. People who have cognitive dissonance (for example, through addiction to drugs) may rationalize risky behaviour. Drug addicts, gamblers, sex-workers, those who commit suicide, and those knowingly involved in very risky behaviour do not make consumption decisions in their best interest.

Assumption 5: *Consumers have sufficient information to make good choices.* As already alluded to above, this is simply not true in real life. People do not have that kind of information, and much less so in health-care.

Assumption 6: *Consumers know, with certainty, the results of their consumption.* Again as mentioned above this is not true. Nobody has the capacity for this kind of certainty.

Assumption 7: *Individuals are rational.* This is true up to a certain point. But the problem of cognitive dissonance and similar situations often make individuals behave irrationally.

Assumption 8: *Individuals reveal their preferences through their actions.* Drug addicts, gamblers and sex-workers do not necessarily prefer these consumption behaviours, but have been caught or trapped into such behaviour by circumstances. In addition, there is a great deal of inter-dependence of people’s utilities. People are influenced by others to take certain actions when in fact their preferences are different.

Assumption 9: *Social welfare is based solely on individual utilities, which in turn are based solely on the goods and services consumed.* But total welfare is not simply the sum of the welfare of individuals. Society distributes income and welfare. An individual’s welfare is relative to that of another individual. The welfare of individuals is affected by, and affects, the welfare of other individuals. This has profound health policy implication for solidarity and universal coverage health care through a national health insurance.

Table 2: Assumptions for a perfect market and health policy implications

Assumptions		Policy Implications	
		If assumptions hold true	If assumptions do not hold true
1.	No externalities	Health care is private matter; people should buy it from the market	Public goods should be funded by public funds or through solidarity.
2.	Consumer tastes are predetermined	People determine the care they get when they fall sick.	People are guided and educated about health care.
3.	Consumers have sufficient information	-do-	-do-
4.	Consumers know the results of their consumption	People know the effect of health-care and do not need to be guided	Nobody knows the full effect of health care. People need to be guided and advised.

5.	Individuals are rational	Health workers should do what patients order them to do	Health workers should assess what patients say and examine them to make the correct diagnosis
6.	Individuals reveal preferences in action	Individual behaviour should form the basic criteria for deciding the type of health care.	Individuals' actions and preferences should be assessed comprehensively in determining health-care requirements for the individual and for the public.
7.	Welfare is based on individual's ability.	Patients should be given treatment, which they ask and will be psychologically satisfied even though it does not help them.	Individuals' psychological satisfaction is secondary to the correct overall health care.
8.	Supply and demand are independent	Patients and clients should be left on their own to determine whether they need health care.	Individuals can be educated and advised to seek for health care.
9.	No monopoly exists	All health care should be provided by competition between many providers.	Sometimes it is more efficient to have monopolistic health care provider due to the advantage of the economy of scale
10.	Firms maximize profit	Services exchanged for money should be charged above the cost of production	Other factors, like equity and inability to pay, may require subsidy of services.
11.	Production is independent from wealth distribution	Invest in "productive" sectors not in consumption such as health and education.	Investment in health and education increase productivity.
12.	Health distribution is approved by society	Distribution of health care by the market is the best as it is impartial and does not cause discord in the society, even though some people miss out.	Health care requires to be accessed by all, so other methods (other than the market) need to be used to "distribute" it.

*Source: author's compilation*

Assumption 10: *Supply and demand are independently determined.* A common phenomenon in health-care is the physician-induced health-care demand. This example shows the linkage and interrelationship that can exist between supply and demand of goods and services.

Assumption 11: *Firms do not have the power of monopoly.* Monopoly occurs when only one firm sells a particular good or service in the market. Power of monopoly is where the firm can change the price without losing the market. This not only happens in real life, but is sometimes preferred by society. It might be more efficient for one firm (monopoly) to produce and sell goods and services than for this to be done by many firms. But such a monopoly firm needs to be regulated on the price and quantity of goods or services produced.

Assumption 12: *Firms maximize profits.* This is not always true. The owners of a firm (called principals) may not have the same goals as the managers of the firm (called agents). Principals tend to maximize profit, but agents have other goals to pursue. Therefore, overall, firms will not always maximize profit.

Assumption 13: *There are no increasing returns to scale.* In real economic cycles, there are increasing and decreasing returns to scale. If production is moved from many firms to one firm



(monopoly), there may be a situation of increasing returns to scale provided the monopoly firm is regulated on the price and quantity of goods and services produced.

Assumption 14: *Production is independent of the distribution of wealth.* Many studies now demonstrate the relationship between health and productivity. The purpose of the Macroeconomics and Health Study (World Health Organization 2000) was to demonstrate and disseminate this relationship. If production is represented by the formula

$$Q = f(L, K)$$

where Q = output, f = technology L = labour and K = capital, it becomes evident that the poor health of the people providing labour will affect the overall output.

Assumption 15: *The distribution of wealth is approved of by society.* The assumption is that health is redistributed through money-transfer payments to reach a final competitive equilibrium in accordance with society's desires. This excludes the notion of equity and fairness which are key in resource distribution in any country. The assumption is based on utilitarian model and is based on cash-transfers. But redistribution is mostly in goods and services. In addition, people provide charity which is not a function of a competitive perfect-market. This assumption has profound policy implications - whether to provide health services rather than cash, or to focus on people's health not their utility, or to provide universal health care coverage through a national health insurance or similar mechanism.

The failure of these assumptions to hold true in real life is acknowledged as "market failure" in economic theory. But the acknowledgement is not nearly enough to deter market economists, ideologues and enthusiasts from holding market principles sacrosanct. Commonly, the reasons given for the failure of health-care markets include: uncertainty and asymmetrical information about health services and goods; the advantages of producing health-care on large of scale; there are natural monopolies (hospitals) in health-care; there usually exist professional barriers and regulations to entry into the health care market; there are external costs and benefits; and markets have no regard for the ability to pay or for people who have low income but great needs. Table 2 summarizes the assumptions and policy implications.

Hsiao (1995) argues that the uncritical belief in the market as the best mechanism for restructuring economic and social sectors has been wrongly pushed on to low-income countries. According to him, economic theory only applies to the market for producing and distributing private goods and services. He concludes that markets in the health sector are massively plagued by market failure and that markets in the health sector are intrinsically complicated. Market competition in the health sector engenders high transaction and administrative costs. Market principles must be severely bent in the health sector for them to work, and even then at an unacceptably high cost of administration. Thus, there is no efficient and simple free-market solution to the financing and provision of health services.

### 3.5 The evolution of the market system

Today the structure of the international development is built around the free-market concept. The vision of market-based development is the globally integrated free-market, with no trade barriers, using market-enabling institutions to spread wealth and the Western-model of development. The global hope is to enable all economies to grow, increase overall wealth, and reduce poverty, improve international equity and reduce conflict (Raskin et al, 2002). But there are inherent contradictions in this model. Untrammelled free-market globalization has severe consequences on the environment through uncontrolled use of resources and opulent or reckless

lifestyles. Concerns of human impact on the atmosphere, land and water include toxic substances, loss of species and degradation of ecosystems. There are also changes in the climate arising from carbon dioxide emissions as an industrial waste. This undermines global climate stability, further risking ecological, economic and human health impacts. Increases in wealth inequity have given rise to social polarization, terrorism and conflicts.

The evolution of the market-based economic model of today has been chronicled by Shutt (1998). He argues that the current economic-model based on the market is unsustainable and could spiral into cataclysm. The problem with the model starts with redundant and excessive capital in the West. Capitalism is fairly new in relative terms in human history, having begun only about 200 years ago. Before that wealth was distributed through a system of customary rights and obligations in a stratified social ladder – a system called *feudalism*. But technological breakthrough with the steam power multiplied manifold the potentials and possibilities of manufacturing, mining, agriculture and transport. With so much production, capital accumulated very fast. New rules were needed to manage the large capital; customary rules became inapplicable and irrelevant. New rules created property rights and were rationalized by philosophers and other intellectuals.

#### ***Rationalization of the market economy***

Economic misadventures were also rationalized by the church. At first religion played a significant role as an obstacle to untrammelled and exploitative nature of venture economy based on market-forces (Shutt, 1998). The church, for example, resisted the lending of money at interest as immoral. But the growing power of emerging merchants gave rise to an ideological rationalization of the values associated with moneyed wealth. And the Calvinist religion, a splinter Christian faction, and the philosopher Locke later rationalized private property rights in eighteenth century. This Christian rationale of private property made founding fathers of the USA endorse the ownership of slaves and the industrial magnates in England to rationalize the displacement and degradation of millions of people to take advantage of the new technology allowing large-scale agriculture. The moneyed class rationalized, through different doctrines, the centrality of property rights and protection of wealth. The continuing accumulation of capital was not without perils. The resulting destitution and the cyclic economic disasters that followed plunged Europe into social unrest. In France, this led to Napoleonic wars in 1815. Britain averted similar rebellion by savagely repressive laws.

Detractors of the free-market, notably Marx and Engels in their *Communist Manifesto*, warned that such a system was unsustainable. But its supporters, most notably Adam Smith, in his *Wealth of Nations*, asserted that morally questionable consequences (such as economic exploitation and slavery) were a necessary price to be paid for “enhancing the prosperity of society as a whole” (Shutt, 1998). These events prompted the classical economists Malthus and Ricardo to rationalize and conclude about the inevitability of and the need to accept such cyclic disasters and suffering as part of the “invisible hand” of the free-market. Thus, the ruling class plus the elite did nothing to avert the suffering of the masses. Such conspiracy and lack of action, which is being repeated today with new globalized capitalism, led to an inevitable consequence – worldwide wars.

#### ***Results and lessons of economic exploitation***

The growth of capitalism led to and was interrupted by the two world wars. In 1945, the West entered a new period of economic dispensation. Two lessons had been learned from the wars: that the state should ensure economic security for everyone; and international cooperation would be institutionalized to curb the effect of morbid nationalism like that of Adolf Hitler

(Shutt, 1998). Although the West was tilted to market orthodoxy, it was not fully applied. The state played a leading role in wealth creation and distribution. Employment was a key goal under the Keynesian economic doctrine. There was substantial growth of the economy in this period. But the period – called the boom period – lasted for thirty years, from 1945 to 1975. Then the oil-crisis started and there was a slump in economic growth. Markets became saturated and inflation rates soared. The control of inflation became the number one economic policy. Inflation was identified as the main cause of economic recession.

Thus, in 1970s there was a return to market orthodoxy. The policies that evolved were aimed at keeping price stability and balancing budgets. Formerly, under the economic boom period, economist Keynes had propagated the use of control of prices and wages in the control of inflation (Shutt, 1998). But in the new economic dispensation, inflation was to be controlled by the control of money supply. This became the monetarist economic policy pioneered by Milton Friedman. But this approach has not, since 1970s, led to a rebounded economic growth. The global economy has been growing at only 2.5-3% at best, whereas in the 1950s and 1960s it grew at around 5% per annum.

Shutt (1998) identifies the redundant, overvalued capital in the west as the root cause of reckless and uncontrolled market-globalization, which he argues is destructive. To deal with this huge capital, the West, through its governments and corporations, began to expand outlets throughout the world for investment. The public sectors of the OECD countries took debt out of the capital to finance their own budget in the face of inadequate revenue generation by the governments. Since 1970s, these countries have not recorded a budget surplus. US, France and Canada, in particular, have been in perpetual budget deficit. On average, an OECD country has a budget deficit of USD700bn in 2000s compared to only USD100bn in 1970s. In addition to investment through expanded outlets, the West privatized state-owned assets and government services. Other ways of coping with the excessive capital accumulation included, mergers and acquisitions, and high risk venture investments such as bonds.

Using international financial institutions, these same policies were prescribed to other countries as a condition for getting aid. Typically, the prescribed policies are: decontrol prices, remove import barriers, remove barriers to capital movement, liberalize the financial sector, privatize state-own assets, balance your national budget, and introduce high interest rates to control inflation. With few exceptions (such as China, Poland and Czech Republic) most countries did not succeed in improving their economies. Those that did succeed (e.g. East-Asian Tiger nations) did not follow all the policy prescriptions, defying many.

Easterly (2002) argues that for over 50 years since the World War II, the rich countries have applied all angles and interventions of the market economies to enable poor countries become rich, and have failed. The central problem seems to be the failure to sustain a high enough economic growth to support the value of existing capital at levels demanded by the capital market. The net result of this market capitalism is that it has increased public/private debt; reduced public services; increased deprivation even in rich countries (25% of the British population was deprived in 2002 compared to only 10% in 1970); increased fraud, corruption, organized crime, loss of state and corporate accountability, all because of deregulation and liberalization; increased conflict and terrorism; and increased unemployment.

### ***New rationalization of the free market***

After the world wars, the free-market model was pushed to the periphery. But academics and intellectuals began to rationalize it again by 1950. Most notable is Friedrich von Hayek who published his essay "*The Intellectuals and Socialism*" in 1949 (Alkire and Ritchie, 2007) in which he tells his readers "to have courage to be utopian" by embracing the free-market ideals. Hayek's publication of *The Return to Serfdom* established him as a high-profile theorist. He and his colleagues used mass communication methods of dissemination of their ideas. These included teachers, news-media, novelists, films and entrepreneurs. They recruited financiers, formed think-tanks and intellectual community through networking. Notable among these are Mont Pelerin Society, the University of Chicago Economics Faculty, the Institute of Economic Affairs in the UK formed in 1955, and American Enterprises Institute formed in 1943. The intellectual community outlined "fundamental principles" and chose "battle issues" to tackle, which included workers' unions, inflation and privatization. They were supported and financed by corporate firms to polemicize for the market ideology and carry out technical and empirical studies.

The now widening network of free-market enthusiasts began to invest in talent: recruiting, training, supporting and rewarding brilliant young people. By 1970s their influence to revive the free-market and neo-classical economics had begun to have effect. Under President Jimmy Carter, USA carried out deregulation of the economy. In 1974, Hayek was awarded the Nobel prize in economics and Milton Friedman one of the bright early recruits in the network got a Nobel prize in 1976 (Alkire and Ritchie, 2007). These high profile awards signalled rapid changes towards free-market ideology under Ronald Reagan and Margaret Thatcher in 1980's. The ultimate signal to intervene massively in the global economy was the global oil-crisis, a disaster Hayek said he had predicted. Other opportunities of introducing the free-market policies included strategies, such as supporting dictators like Pinochet in Chile, because dictators created "a positive and necessary situation ...to allow historic vices of statism to be corrected..." (Alkire and Ritchie, 2007). It was argued that an authoritarian regime would allow such reforms to take place. Thus, the return to free-market economics is not accidental, but was strategically plotted and planned. Some of the strategies were and continue to be immoral and evil.

### ***The eminent collapse of globalized capitalism***

But the market economy appears to be collapsing under its own weight. Some (eg Shutt, 1998; Amin, 2000; Raskin et al, 2002; Stiglitz, 2002; Bello, 2004) have predicted that the market capitalist system will run its course over a few more decades and give rise to another economic and political order. The signs of this eminent collapse now occur more frequently. These signs include: trade cycle and market crashes (the collapse of Northern Rock bank in the UK and of housing mortgage market in the US are recent examples); rising inflation and public debts; rising food prices and food riots; huge surplus capital; increasing knowledge-based economy which will not need huge capital; weakening of states vis-a-vis powerful multinationals; erosion of legality; and lessening prospects for economic growth recovery.

The current global financial crisis sparked off by the US mortgage market crunch appears to confirm that the free-market capitalist system has begun to disintegrate. Current efforts to prop up the system by bailouts are superficial and do not address the structural flaws. The root cause of the current wave of crises can be traced to October 12, 1977 when the US President Jimmy Carter signed the "anti-redlining" law which, with good intent, allowed people in poor neighbourhoods to get cheap loans for housing mortgages (Butler, 2008). Western countries

were being flooded with cheap credit from the floating capital. After September 11, 2001 attacks on the US by Al Qaeda terrorists the Federal Reserve took the US interest rate down from 6.25% to just 1%, to improve on the falling investment confidence. Crotty (2008) argues that the flaw in the New Financial Architecture (NFA) is deep both in the institutions and the practices. NFA is a global integrated system of giant bank conglomerates. Based on the free-market, the financial institutions under NFA are hardly regulated at all. Without regulations, perverse incentives driven by greed, has generated excessive risk-taking. In addition, the mortgage-based securities to the short-lived boom were non-transparent and overpriced. As NFA is interconnected and integrated, the high risk accumulated over time can be transmitted around the world easily and rapidly – as is happening now.

Analysts have reached the following conclusions, that: true free markets do not exist, but are supported by the state in the West, acting in the interest of the multinationals; contrary to the optimism created by market economic system and globalization, there has not been an appreciable general rise in prosperity: instead poverty has spread around the world; unacceptable social consequences of market-based capitalism are set to worsen with the erosion of the power of the state; crippling economic policies have made more people worse off, while making the West and multinationals better off. In establishing a new and fair economic order, we must address the problems of capital surplus, public-sector deficits, and the huge gaps in living standards between the rich and the poor.

### *The future of unreformed market system*

Although free-market capitalism has accelerated rapidly under the current phase of globalization, it is predicted not to be sustainable. In a study to forecast the future (Raskin et al, 2002) it is predicted that under the market-driven development model, populations will grow almost uncontrolled. Incomes and overall economic outputs will increase significantly, but food requirements will also increase, which will leave over a billion people still hungry by year 2050. Poor countries will grow but the difference in wealth between poor and rich countries will widen. This will be a major cause for restlessness and war. The demand for water and energy will greatly increase and may become a cause for conflict. CO<sub>2</sub> emissions will increase over the next 50 years causing further damage to climate stability. Forest cover will become further degraded. There will be more social instability from inequity and deprivation of some groups. The future envisaged is that of moving from one crisis to another, in environment, social and security and other aspects. But in the long run, the economic system will not be sustainable. Its logical destinies are conflict (wars) or “Fortress World”, where the rich 20% of the world and rich 20% of the poor countries will link up and barricade themselves against the rising anger and desperation of the rest. The privileged will control the disenfranchised through a police state, militarism and segregation.

It is predicted that the current market frenzy, foot-loose market-driven globalization, cannot last. It may lead to economic boom in the foreseeable future. But its effects of environmental degradation, social polarization, increasing cost of living, the collapse of fisheries, stress on international food aid and water shortages, etc. will eventually lead to a global crisis (Raskin, et al. 2002). Attempts may be made to put in place rules to control the market frenzy, but the rules will be eroded by persistent poverty and social polarization. Gradually, widespread social revolt against global corporations will become inevitable. The current conspiracy and consensus on the market superiority will be questioned and will unravel. Responsible organizations, alliances and leaders will lobby governments to re-organize the economic system. There will emerge a giant coalition of individuals and organizations to respond to the world’s crisis.

The coalition will include enlightened groups, NGOs, corporations and individuals in all countries. In such widespread crisis, leadership at governmental and international levels will emerge to establish order, bring on board giant corporations, clean up the environment, improve equity and address poverty. Thus, the “wake-up” to sustainable development will begin. Ceilings will be imposed, with global agreements on CO<sub>2</sub> emissions, ocean fishing, wood trade, etc. International taxes will be charged to finance international health. Innovations and generous donations will finance poverty reduction and sustainable livelihoods.

A new drive to expand greatly information technology to all parts of the world will be inevitable as will be investing in the welfare of the poor and in the environment (Raskin et al, 2002). Only then will disparities among human societies reduce and improvement made in the environment and ecological stability. However, the basic incentives and values that drive markets will persist. The lure of materialism and opulence, driven by greed, will prevail in a good section of the globe’s population. Thus, there will inevitably be tensions between sustainable development and market-based economic growth.

### ***Market systems can be reformed***

As long as such values exist in society, and the market is placed above human life, divisions will always be with us. But in a scenario where there is a fundamental change in values, from materialistic lifestyle to less materialistic, sufficient and sustainable lifestyle, peace and stability can be achieved. This lifestyle is based on a satisfying the new art-of-living, which is culturally rich and pluralistic, of high quality within the context of global unity (Raskin et al, 2002). It calls for equal participation in governance and management of human and global affairs. This is not far-fetched. Value-based organizations (VBOs) could create giant networks and alliances advocating for a change of values.

They could monitor governments to ensure that they are accountable and responsible. They could promote the reduction of prices and increase opportunities for employment in poor countries by making corporations and governments change their policies. Intense lobbying and education could make entire products be re-engineered with nanotechnology to save on energy and materials currently used in production. The corporate and government leadership could begin to adapt a more responsible attitude to the environment, social welfare and poverty. But to reach this situation, it is predicted that two factors would be critical: a crisis arising from the market frenzy, and the global realization that there is need for a change in values and lifestyle.

Human societies have evolved through interactions with one another and through changes in lifestyle (Diamond 1997). So this would not be new or even the last in the evolution of human society. Human societal organization evolved from family to clan, tribe, and kingdom, empire and now global. It is becoming planetary. In the course of this long process of evolution, there were conflicts, wars and other forms of violence. Entire peoples were often annihilated; others subjugated by and integrated into dominant groups. Others are being exploited through unfair economic systems (Raskin et al, 2002). Fortunately mankind is equipped with enough knowledge and experience to reform the market system. If ultimate drivers are aligned with proximate drivers of change, the desired peaceful, healthier and equitable global society should be possible. Figure 7 shows the links between proximate and ultimate drivers of change.

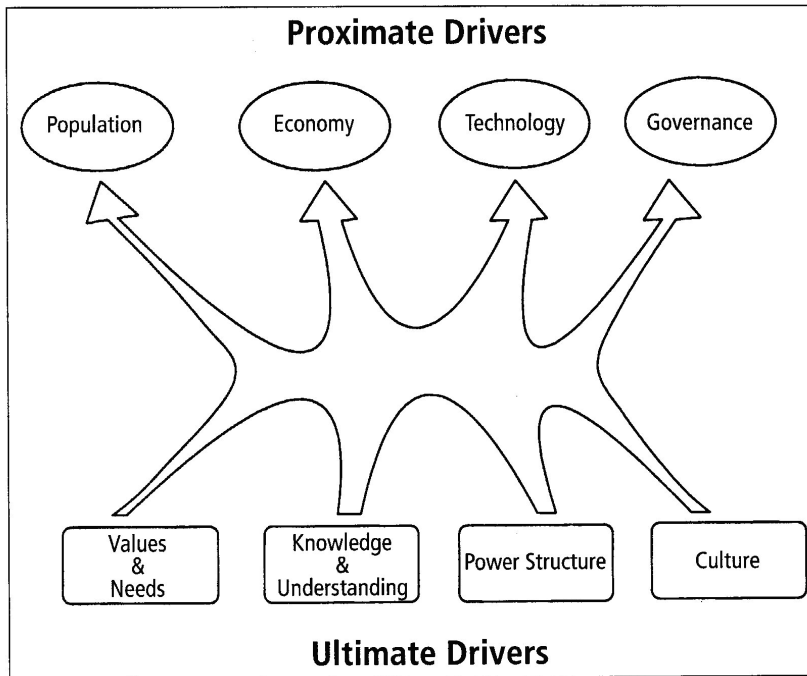


Figure 7: Proximate and ultimate drivers of change  
 Source: Raskin et al, 2002

### 3.6 Health sector reforms around the world

#### *Reasons for reform*

A variety of reasons are officially given by the countries undertaking HSRs (Karlberg and Adamiak, 2002). *First*, they give economic difficulties, which range from the global economic crisis in 1980's-90's to specific problems, such as the slump in world prices of copper and coffee in Zambia and Ethiopia, respectively. Economic difficulties also arise from countries emerging from conflict, such as Mozambique, Angola and Uganda. *Second*, countries cite the escalating costs of health care. This is mostly cited by rich nations where the cost of new and better technology is higher and the level of expectations from health-care is rapidly rising. *Third*, changing medical and health care technology, and methods of management are cited. For example hospitals had to be merged, in Sweden and others were closed down when it became difficult and costly to operate numerous small specialist hospitals in 1960s.

*Fourth*, increasing expectations of better quality and effective services are given as another reason for reforms. This arises from better-informed patients and clients, more rights legislated or guaranteed in policy, and better technology, especially in the richer countries. *Fifth*, a common reason and trend in both poor and rich countries is the changing pattern of disease. In rich countries, diseases have shifted from infectious to non-communicable, and in poor countries, there is a double disease burden where both categories of diseases are prevalent. Previously the major problems were infectious diseases in poor countries. But with increasing

life-expectancy and changing life-styles, even in poor countries where the proportion of non-communicable diseases has reached significant levels, there is need for reform of national health systems.

*Sixth*, demographic changes are given as a major reason. Populations are getting older, i.e. the proportion of elderly people in the population is increasing. This brings with it changes in needs and demands on the health systems, and in turn the need for a change in the way the the health system is organized and managed. Finally, ideological and political reasons are given by different countries. In particular, there is a trend to regard the state as a poor provider and manager of health services. Market mechanisms are seen as superior in health and other types of service delivery.

### ***Reform aims and objectives***

Although the reasons vary in different countries, the aims and objectives of the HSRs in the countries undertaking them are strikingly similar (Papers II and IV). The main aim is to improve health service delivery. But specifically the following are often mentioned: to improve health, to respond to the population's expectations, to provide financial protection to citizens, to raise resources for health service delivery, to improve equity, to use resources efficiently in order to improve the quality of care, and to make health-care systems effective. Often five or fewer of these objectives are given for HSR in different combinations (Walt 1994; World Health Organization 1997 ; Eriksson, et al. 2002).

### ***Process of reform***

Two distinct processes used by different countries to initiate and implement HSRs can be discerned. One is an internal political process. Here, a political group that is in power, usually in an established democracy, believes in the ideological values of market reforms and sets HSRs in motion. Technocrats remain to work out the details. It usually turns out that the details are the models of reforms used everywhere, which diffuses around the world. This diffusion of ideas occurs through pressure created by experts and consultants through advocacy. The models also get to be associated with legitimate, progressive and successful organizations (Eriksson, et al. 2002). These organizational models become institutional standards and every country tends to adopt them. They are not adopted because they are proven to be efficient, but because they are perceived to be good and legitimate structures, processes or ideologies.

The other process is one that is usually initiated and driven or directed by external agents, usually donor agents, using aid as leverage. This happens in poor countries, usually with limited or disorganized internal capacity, either because they are emerging from conflict or some economic/ social crisis. Depending on how functional and firm a poor country is on internal values, there may or may not be any internal control of the reform direction. For example, Uganda and Burkina Faso's HSRs have largely been driven by international donor agencies, especially the World Bank, with little internal control (Haddad et al, 2006; Bodart et al, 2001). But in Vietnam's HSR, although also leveraged and implemented through an aid funding, there was sufficient control and maintenance of the socialized health system framework. This appears to have stemmed from the socialized health system that had been firmly established and is functional in Vietnam, and because of the strong belief in the values of equity and solidarity in Vietnam.



### *Content of HSRs*

Eriksson et al (2002) identify at least twelve distinct reforms have been commonly adopted and implemented in the health sector by different countries. The content, intensity and extent of the reforms tend to depend on types of approaches in the implementation of the reforms. These are whether 1) the reforms are managerial, without too much political direction and participation; 2) they are political in order to improve accountability and local democracy, or as a way of providing collective goods that are not effectively provided by the private sector or through the market system; 3) they are part of holistic economic reforms, affecting all sectors; or 4) the reforms are focused on the health sector alone.

Commonest of the reforms seems to be decentralization. The other reforms include contracting; public-private partnership (PPP); priority-setting, commonly using an essential or minimal health package; hospital autonomy as a single reform or part of wider hospital restructuring; health insurance with various methods of co-payments and reimbursements; human resource reforms, mainly retrenchment and various incentive mechanisms, provider-payment reforms; purchaser/provider split; mergers; and financing reforms, which include user-fees (compare with the reforms in Uganda set out in Paper III).

### *The result of reforms*

The result of HSRs follows a similar pattern, whether in high or low-income countries. Initially, there is usually a strong enthusiasm about HSRs in all countries. But the positive attitude is typically not matched with the actual results of the reforms. The ultimate benchmarks to assess the results of the HSR should be the health sector objectives – equity, efficiency, quality and financial protection. A review of HSRs in over 20 countries, shows no clear achievement of any of the health sector objectives (Papers IV and V). The same findings and trends were also noted in WHO,1997; WHO, 2000; Raskin et al, 2002; Meredith, 2005; Hancock, 2006). Instead, HSRs have had the following effects: a) they have solved management problems, but without significantly improving the health sector objectives, b) created new problems, with or without solving the old problems, and c) worsened the old problems. Table 3 summarizes the review of selected countries and table 4 provides an overview of HRS evaluation across different countries.

Table 3: Health sector reform results in selected countries

Country	Key problems identified for reform	State of problem after HSR	New Problems created	Effect of HSR on state of HS objectives
Burkina Faso	Inequity Access problems	Not changed	Project-based HS fragmentation	Nil; have remained as bad as before
Kyrgyzstan	Inadequate funds. No private sector participation	Increased funding through SHI Private sector involved	Increase in inequity	Nil; same or worse
Sweden	Soaring costs. Services for the	Partial cost containment	Increase in waiting time	Not evident; all objectives

	elderly	established	and inequity	already had high scores.
Uganda	Access problems Inadequate funds Inefficiency	Same Same Same	Fragmentation by projects and NGOs	Nil; largely as before
UK	Waiting time (WT) Soaring costs	WT better for only some Cost somewhat contained	Increasing inequity	Not evident; inequity is worse.
Vietnam	Inadequate funds No private sector participation.	Increased funding through SHI Private sector involved	Increasing inequity	Increased inequity, no effect on others.

*Source: GoU 1998; Eriksson et al, 2002; Haddad, Nougara et al 2006*

### ***Some beneficial health care reforms***

Despite the clamour for market solutions, there are numerous examples of successful non-market health-care solutions leading to better health services in many countries. These reforms have often been ignored and even suppressed by market-oriented donors, such as the World Bank. It has therefore not been possible to get wide publicity and financial support to spread these good innovations around the world. Some of the reforms are small-scale and need to be scaled-up, and so require considerable funding.

*First*, identifying good initiatives using low-cost interventions, but producing remarkable health outcomes, was done as far back as 1980s (Abel-Smith, 1994). The Rockefeller Foundation selected five outlier countries that seemed to have had much higher life expectancy for their level of the economy. These were China, Costa-Rica, Cuba, Kerala state of India and Sri Lanka. The study identified that these countries emphasized nutrition, land reform, universal coverage of primary education including females, a good degree of income equality, priority given to health ad community participation, and universally accessible and well-developed rural health care.

*Second*, Chile is another country that has done well in reducing infant mortality through two phases of health reforms (Jimenez and Romero, 2007). The first phase focused on poverty reduction, PHC, environmental and demographic factors. The second phase focused on specific risks to children: parental risks, acute respiratory disease, congenital heart disease, and vaccine preventable infections. Chile with per capita income of less than USD5000 reduced its infant mortality to 8.9 per 1000 in the year 2000, matching the rates of wealthier countries. The strategy targeted public investment in social services.

Table 4: Overview of evaluation of HSRs across countries

Reason for reform	Reform measure	Results	New problem created	Source of information
Inequity: Uganda,	Project based reforms	No significant health system	Health system fragmentation	GoU 1998; (Haddad,

Burkina Faso		improvement		Nougara and Fournier 2006)
Inadequate funds for health services: Kyrgyzstan	SHI; user-fee policy	Increased health sector funding	Increased inequity	Eriksson <i>et al</i> , 2001
Soaring health costs: Sweden;	Variety of market measures	Partial cost containment	Increased waiting time; increased inequity	Eriksson <i>et al</i> 2001
No or little private sector participation: Uganda and Kyrgyzstan	Facilitate greater private sector involvement	Achieved	Increased inequity	GoU, 1998; Eriksson <i>et al</i> , 2001

*Source: author's compilation*

*Third*, Ugandans had been battling against unpopular and regressive health user-fee policy for over ten years (Deinenger and Mpuga, 2004). In 2000, the government took a firm stand and abolished user-fees and marginally increased health funding to compensate for the revenues lost by the abolition. The impact of the abolition of user-fees on welfare was that health-care utilization increased dramatically and the aggregate benefits from the abolition of user-fees were significant.

*Fourth*, the Netherlands enacted a health-care system in 2006 to achieve universal insurance (Naik, 2007). This was done to address the common problems of incomplete coverage, risk-based fragmentation of the population, selection of less at-risk people for coverage leaving out those at high risk, such as the elderly, as well as people disabled and/or with chronic diseases. The law requires that all adults purchase insurance and all insurers offer a policy to anyone who applies, regardless of age or status of health. Individuals who cannot afford health plan premiums are subsidized by taxes. The government compensates insurers for providing coverage to high risk patients such as the elderly and those with chronic diseases.

*Fifth*, a number of beneficial reforms have arisen out of research ( Savigny, Kasale et al, 2008). Tanzania Essential Health Interventions Project (TEHIP), through investing in improved district level planning and priority-setting together with modest investments in health services and careful and honest evaluation, demonstrated considerable returns inform of reduction in infant and child-mortality to the strengthening of district health management.

*Sixth*, the Thai Universal Coverage Scheme was set up through research in financial protection and coverage, designing a new universal coverage, and setting up a monitoring and evaluation system (Hughes and Leethongdee 2007). At every step of the process, multiple studies were undertaken to help inform decision-making. Recent studies suggest that the scheme has increased financial access for the poor and provided much improved financial protection. A similar reform is being carried out in Mexico under the “Comprehensive health system reform”.

*Seventh*, a multi-country evaluation study of IMCI has highlighted that clinical training and interventions alone are unlikely to lead to positive impact (Bryce, Victora, et al 2004). It has underlined the importance of working through communities to extend service coverage as well as to enhance public accountability of service providers to the community.

*Eighth*, in Ghana, antenatal care (ANC) was typically chaotic, inefficient and of limited benefit to mothers. The cases of malaria in pregnancy were high, accounting for 10% of admissions of the pregnant women and 9% of maternal deaths. Most health facilities practice “factory assembly-line” approach, with separate unlinked services to the ANC. But in Tema General Hospital, a new system was introduced to improve the quality and effectiveness of ANC services, especially of integrating malaria in pregnancy (MIP) (Deganus 2007). The system employs individualized and comprehensive system of continued care. MIP strategies and DOTs for anti-malarial treatment and prevention are used. Information and education are given to the patient. Promotion of ITNs has been adopted under this new health care system. The promotion of partner (husband) involvement in ANC services has also been incorporated. The results over from 2002 to 2006 have been remarkable. There has been significant and consistent increase in utilization of ANC, delivery and post-natal services. Stillbirths and maternal mortality have markedly declined. There is also job satisfaction among health workers and client satisfaction with the services. Male involvement in ANC has tripled.

*Ninth*, performance-based financing has become increasingly popular form of contracting in low-income Asian countries. The evidence from these countries shows that it can improve health service delivery. In Rwanda, this approach has yielded remarkable results (Soeters et al. 2006). Performance-based financing requires an independent well-equipped fund-holder organization, separating purchasing, provision and regulatory roles of local authorities from the role of contract management (negotiation, disbursement and monitoring). Local authorities are asked to respect the autonomous management of health facilities competing for public subsidies. A survey showed that the performance of health facilities had significantly improved, and there was remarkable consumer satisfaction with the new system.

*Tenth*, in Malawi a multi-pronged strategy is being used to tackle malaria and human resource crisis (Okuonzi, Ali and Birungi, 2007). The problem-oriented approach based on evidence is used. Tailored responses to specific problems were found to be effective in addressing management problems. The government subsidized insecticide-treated mosquito nets (ITNs) and anti-malarial drugs as a way of reaching more vulnerable populations with these life-saving products. The malaria policy and guidelines were simplified for use by end-users. Directly observed treatment (DOT) was used to ensure compliance with the treatment regime. A gestational wheel was designed locally to help health workers estimate the age of gestation in order to determine the course of prophylactic dosages of anti-malarial drugs, which had previously been problematic. The combined use of private- and public-sector outlets for the distribution of the life-saving products was effective. Free mass retreatment of mosquito nets with insecticides was highly publicized and ensured that most of the nets were treated and effective in repelling or killing mosquitoes.

These innovations stem from a policy where the national leadership, backed by donor-partners, has put malaria control as the number one priority of the health sector. Consequently, about 70% of pregnant mothers sleep under the ITNs, and 80% of them now take a second dose of the anti-malarial drug, up from 37% before the new strategy. Indications are that there is a declining

prevalence of malaria. Placental malaria has decreased by 10%, malaria anaemia is down by 35% and low-birth weight, usually due to malaria, reduced by 13%.

Malawi's human resource crisis includes difficulties with staff retention, and net staff loss from the public-sector to the private-sector and abroad. Health staff shortage is thus a major problem. A strategic human-resource plan supported with financing from DFID, GTZ and Norwegian Church Aid has a staff retention programme. Started in 2005, this programme aims to retain and attract staff into public sector facilities by topping up salaries and providing non-monetary incentives (water, electricity and housing). Hardship allowance is also provided to those staff working in difficult areas, and to nursing tutors.

The conclusion from these beneficial reforms is that they were generally initiated or driven internally. They were based on evidence or linked to locally done situation analyses. They were not tied to ideologically defined solutions, and they employed both market and government interventions – whichever was appropriate. They did not allow market solutions to obstruct the wider goal of equity and social justice.

### ***The health system of the United States***

Countries around the world often see USA as a market-driven success. This, it is assumed, includes the US health-care system, which is the market-based prototype. It is what is supposed to inspire other countries about how well a market-based system efficiently operates without government interference, but only with the guidance of the market's "invisible hands". But the US health-care system is probably the worst among high-income countries. Health-care expenditure in the USA has now reached an all time high of USD 6,697 per capita, twice that in any other developed country (McCarthy, 2007). Moreover, 47 million US inhabitants do not have health insurance or reliable access to health-care. Furthermore, by any measures such as infant mortality and life expectancy, US citizens are less healthy than people living in other developed countries that spend far less on health care.

Today, the US health system, which is 100 percent market-driven, is much more problematic than systems that are less market-oriented. The system creates the highest health-care expenditure for the worst comparable health-care outcomes. It is highly inequitable. Because of unquestioning faith in the invincibility of the market, it is not regulated. As a result, the insurance system has segmented the population into risk classes or categories. Health-care has been left to the innovation and management of investors and entrepreneurs, who have taken full advantage of it. They have innovated methods for getting the highest possible profit, and have no energy or regard left over for the distributive ethic of health-care, which is cardinal in health service (McCarthy, 2007).

In addition, the fee-for-service (FFS) is inherently complex and costly to manage. There are perverse incentives within the system that create waste and unnecessary procedures. Up to 30% of medical procedures in the US are unnecessary (Halvorson, 1993). Purchasers of health-care (both government and private sector) are unsure of and do not demand record quality or efficiency. The entire American health system lacks national control. It has become highly fragmented into numerous different organizations (White, 2007). The system needs non-market reform. Put another way, it needs the "visible hands" of the government. Costs have to be controlled, which requires government intervention. It is difficult to raise capital to set up health institutions such as HMOs that are unattractive to investors. This also requires the government.

There is a general lack of cohesion and sense of direction in the American health system, calling for further government intervention. The government is also a critical factor in ensuring equity, which is weak and getting worse in the US. And yet health-care systems are in fact about equity. The system requires to be “reformed”, and to get away from its extreme market orientation. The US health system, besides being relatively inefficient, is fast becoming unaffordable through health insurance. The system presently works in such a way that it fails to cater for people who are sicker, more at-risk and more in need. It is geared to individual profit, with individuals preferring to work alone rather than in teams. There are virtually no mechanisms for rewarding, demanding, monitoring and accounting for quality. Problems in the US health system are managed on *ad hoc* basis without addressing the bigger and whole health-care system (Halvorson, 1993).

The US National Association of Community Health Centres, The George Washington University and the Robert Graham Centre, 2008 have, in a joint report, summarized the US health sector situation succinctly as follows:

The US health care system is in a tailspin and in need of systemic reform. Rising numbers of people are uninsured or even underinsured, forced to delay care at the risk of imperilling health. Health care disparities continue to widen between the haves and have-nots. And tragically the US is rated dead last among 19 other industrialized nations when it comes to premature deaths that could have been prevented by timely access to care. Access remains the most pressing challenge to our health care system, where the landscape continues to fragment with costly and diminishing health care choices for consumers...

### ***The Nordic experience***

But the Nordic (or Scandinavian) experience is totally different. It is distinguished by the relatively short-time it took to attain human development and poverty eradication. This is based on the cardinal principles of universalism and equality of opportunity and outcomes, regardless of social class, income and gender differences (Lundberg, Yngwe *et al*, 2008). Internationally, Nordic countries have some of the lowest poverty rates, a direct outcome of welfare state redistributive system. These countries are distinguished for their low poverty rates among vulnerable groups such as families with many children, single parents and the elderly. Low poverty rates and compressed income distribution are beneficial to health and are curvilinearly associated. The key factor is the control and conscious directing of resources, both material and intangible, to conditions of life. Social spending and coverage by social insurance were found to be linked to significant overall improvement of life expectancy from a study of 17 OECD-countries from 1900 – 2000.

The strategy to reduce poverty in Nordic countries was relatively short and it was phased. According to Diderichsen *et al*, 2001, there are a number of points of entry and interventions to achieve universalism and equity, a strategy that Nordic countries followed:

- a) Modifying social stratification (eg creating parity between females and males)
- b) Modifying exposure, risk levels and distribution (eg control of alcohol consumption, employment provided by the government)
- c) Modifying susceptibility (eg encourage and promote breast feeding, vaccination, and screening for diseases)
- d) Modifying the consequences of diseases (subsidized insurance, labour market laws to ensure the disabled are employed, sickness insurance, access to quality and effective health care)

e) Modifying social context (promote social participation, cohesion and capital)

The Nordic experience may not work every where, but it provides important lessons to poor and rich countries. For the rich countries, the lesson is that universalism is the cornerstone for social and human development and sustainable poverty reduction. Another lesson is that life cycle perspective of social interventions is critical. That is, interventions should be made at every stage of human life, throughout the life. Lessons for poor countries include:

- It is critical to have or create the ability to coordinate, plan and implement policies.
- Local actors (local authorities and NGOs) need to be empowered to provide services
- An educated or literate population is easier to deal with when applying social interventions
- Economic growth should be converted into health or welfare promoting investments such as water, sanitation and education
- Universalism should be planned at the onset; it is not the product of economic growth or better wealth
- Inter-sectoral collaboration on health promoting interventions is critical
- Trade and free-market policies should not trample on and dislodge beneficial social policies and programs
- Universalism requires ambitious design of social programmes, without having to wait for economic growth to lift a country to a certain targeted level of the economic status
- Poverty can be eliminated even by low income countries if social spending is well directed and managed according a well thought out social policy

### 3.7 Update of key issues and reforms

#### *The quagmire of aid (from Papers I and II)*

International aid is a tool with which donors manipulate and influence policies in poor countries. The thesis papers (Papers I and II) show that using aid, donors have destroyed or disorganized social services. Since these papers were published, much more knowledge about international aid has become available, much of it supporting what the papers say, and filling gaps in these papers.

Donors provide aid to poor countries with supposedly good reasons. These are to: 1) contribute to global public goods, 2) provide global health security (against epidemics, for example), 3) provide a show of solidarity, and 4) support their own domestic policy (Schieber *et al*, 2007). But these honourable intentions are often betrayed through the process by which aid is channelled and administered. Aid is often earmarked and spending is not usually in the short-term linkable to any concrete outcomes. Tax-payers in rich donor nations have begun to question the results of aid in poor countries. Hence donor agents are less inclined to fund health systems and provide budget support. They would rather focus on single diseases where spending can be linked to clear and usually numerical outputs, not necessarily linked to the desired outcomes. Studies have increasingly shown astonishing disconnect between country needs and priorities on one hand, and what donor-aid funds on the other.

It has become clear that there are intrinsic problems with aid today (Schieber *et al*, 2007). *First*, no one is in charge of aid globally. There are no mechanisms globally to ensure compliance to aid commitments or on how aid should be administered. Aid is short-lived, volatile, unpredictable, and often misaligned with recipient country needs and priorities. The Global

Health Initiatives (GHIs), for example, use application criteria to determine who gets how much aid, but not on who has the greatest need. *Second*, there are too many aid management instruments. Transaction costs of aid are therefore often high. Often there are no frameworks for measuring the results of aid spending. *Third*, many of the recipient countries are plagued with poor governance (usually corrupt and dictatorial regimes), weak public management, weak institutions, poor policies and low domestic revenues. In addition, at least 50% of donor assistance is usually off-budget and off balance-of-payments. Governments often reduce spending their internally generated revenues in areas favoured by donors, thus undermining the principle of additionality.

*Fourth*, the health sector is complex, whereby recurrent funding is long-term, and hence largely unsuitable for aid funding. There are usually many organizations in the health sector, making agreement and consensus difficult. The private sector predominates in financing and delivery of health-care, but is not often involved in policy formulation. The regulatory framework for health systems is complex and requires a lot of investment. In health care, costly financial protection is essential, and this is unique only to health-care. These unique features of health-care do not match with the characteristics of aid.

Hancock (2006) argues that aid is not assistance, but has become an aloof and mechanistic industry. The industry has increasingly become non-transparent and impenetrable. "Expertise" is bought from donor countries even when it is unsuitable or available in recipient countries. There are increasing cases of arrogant aid workers and leaders with paternalistic attitudes. Britain's Prime Minister Margaret Thatcher is quoted as remarking about Ethiopian peasants that "We have to try to teach them the basics of long-term husbandry."

Aid through the Bretton Woods Institutions has become even more bizarre (Hancock, 2006). To get aid from the World Bank is a long and tortuous process, and yet much of the aid often funds only salaries and equipment. It is easier to get a loan for structural adjustment project, such as privatizing electricity or water supply, than for health services. The International Monetary Fund (IMF) determines which country gets loans from the World Bank, in conformity with the IMF rules. IMF conditions include devaluation of local currency, drastic cuts in public spending, especially education and health, reduction in food and other consumable subsidies, reduction of wages, abolition of price controls, privatization of public utilities, high taxes and high interest rates. Countries that obtain a World Bank loan find it difficult to spend it due to IMF rules. Under the IMF Poverty Reduction and Growth Facility (PRGF), only 28% of ODA receipts was spent during 1999-2005. This is because of the IMF's rulings to keep inflation below 5% (McKinley 2007). And yet IMF's own research suggests that up to 15% of inflation is benign and does not affect economic growth or investment. Such constraints on spending mean that social welfare targets, such as MDGs, cannot be achieved.

Goldsborough (2007) argues that small fiscal deficits are assumed to lead to higher levels of private investment. But in reality investment chances are also influenced by other factors specific to a country, and not necessarily the inflation rate. Also, that medium-term and long-term benefits of public spending are not factored as key drivers of economic growth. Most IMF inspired plans have short-term horizons. Projections of aid are usually conservative, and shortfalls in actual aid available are matched with spending cuts, usually on health and education. Schiebar et al. (2007) recommend that, given such a scenario with aid, a) countries should reject aid which is not aligned with national priorities, b) governance and public sector management should be improved as a precondition for an aid package, c) accountability



mechanisms should be set up for both donor and recipient countries, d) poor countries should begin to raise revenue for social services and wean themselves off aid in a well defined time-frame, e) spending decisions should be unlocked from IMF conditions and based on cost-effectiveness and equity considerations, and f) leadership at the highest national levels needs to be trained in the political economy of aid.

A recent study on the quality of aid identified four criteria for deciding whether aid is bad or good. Bad aid is unlikely to produce any benefits and may even damage existing social welfare (Rodman, 2005). The criteria for bad aid are: 1) tying aid to ideological, bureaucratic, and profit-oriented conditions; 2) aid administration structure that is huge and inefficient, and takes >15% of the total budget; 3) uninformed or ill-prepared and non-participating prospective beneficiaries; 4) the use of project approach in administering aid, in particular, where there is a proliferation of grants or sub-grants within the project. Some effort has been made to address the weaknesses of the current aid management.

The “Paris diagnosis” which underpins the Paris Declaration on Aid Effectiveness represents an unprecedented effort to rein the fragmentation that characterizes development aid today. It proposes a system to make aid work better by supporting country-led development (Fritz and Menacol, 2007). The declaration was signed in 2005 by 61 donors and 56 aid-recipient countries. The Paris framework consists of five components: 1) ownership by aid-recipient countries, where these countries set the agenda 2) alignment between donors and aid recipients, where donors align to recipient country agenda and systems, 3) harmonization among donors, where simple and common arrangements are used, and information is shared 4) managing for results, and 5) mutual accountability.

The British House of Commons identified in a recent report two areas that are critical to make aid effective: a) division of labour among donors, and b) recipient country ownership of programmes and policies that aid funds ((Fritz and Menacol, 2007)). The report notes that the Paris Declaration defines ownership as “partner countries exercising effective leadership over their development policies and strategies, and coordinating their actions”. The report also makes reference to Christian Aid, a charitable NGO based in the UK, which identifies a strong link between ownership and the successful implementation of development policies: “the current development consensus is that countries are more likely to implement a policy if they own it”. According to this report, of the five principles of the Paris Declaration, “ownership” of policy is the “most fundamental”. Democratic ownership of policy involves the key stakeholders in the governance of a country - parliament, civil society, the executive and the public.

For aid to be useful it is also essential that it is effectively used for capacity building. Development implies independence, which in turn implies adequacy or progress in the capacity of countries to solve their own problems. Potter and Brough (2004) argue that aid can be used effectively to build capacity in the health sector of developing countries if the approach is systematized. They suggest a four-level hierarchy of capacity needs to be addressed, with nine elements altogether. The four capacity needs are 1) structure, systems and roles; 2) staff and facilities (taking care of support service, facility, supervisory and workload capacities); 3) skills; and 4) tools (performance capacity). Systematic capacity building entails diagnosis of sectoral shortcomings, designing an appropriate programme and monitoring framework to address the shortcomings, and more effective use of resources. Based on extensive action research in 25 states in India, this approach can be put to practical use anywhere. The approach could provide

the best value for donor money if governments and development partners agreed to implement it.

***Sector-wide Approaches (SWAPs) (from Paper II)***

One way of streamlining aid management and coordination is through Sector-Wide Approaches (SWAPs). SWAPs were conceived to address the multiplicity of actors and funds in the health sector, which usually lead to duplication, confusion and lack of direction in the sector. Early efforts to conceptualize SWAPs started in early 1990's. But a definitive guide based on a conceptual framework was made in mid 1990's (Cassels, 1997). It was conceived as a partnership for a negotiated programme of work, which it was assumed would have a better chance of success than health projects. This meant that health policy and strategies would recast resource management, planning and capacity development differently. The implications were that donors would lose the right to select programmes to fund; the agreement between donors and recipient countries would be based on development objectives, not on conditions; local priorities and systems would be used as a basis for planning, funding and reporting; projects would be realigned; and donors would realign their aid instruments. SWAP was defined to cover the entire health sector including public, private and voluntary sectors.

Paper II notes that SWAP was to be structured in such a way that it would be compatible with decentralization, as local governments would become a sector in their own right. While budget support was the preferred funding method, certain priorities would be ring-fenced or earmarked. Indicators of progress and performance would be agreed for the sector as a whole. It was preferred that some funds would be transferred directly to the people in the spirit of poverty alleviation and decentralization. SWAP was to have the political support and ownership of the country. Corruption and accountability were to be effectively addressed by SWAP mechanisms. While governments of recipient countries would take the lead in SWAPs, donors would now scrutinize national authorities more critically. SWAPs would require clear and agreed policy goals, instruments and priorities. SWAP resource requirements would be projected over short, medium and long terms.

It would be critical to get the balance between the health-care package to be funded and its sustainability (Paper II). The instrument for this balance would be the medium-term expenditure framework (MTEF) (Paper IV). Institutional capacity building would include leadership development; structures, systems and incentives; and establishing management systems. Common management arrangements would be agreed for monitoring and evaluation, financial management and procurement. Agreement with partners would include guidelines, statement of intent by donors (partners), memoranda of understanding (MoUs), code of conduct and practice. The SWAP programme would require joint appraisal, reviews and planning. Planning cycles of the different partners would be harmonized with that of the recipient country. The role of technical assistance (TA) would be clarified and aligned to the agreed programme of work, and staff development would ensure continuity of programme implementation.

In a number of countries that embarked on SWAPs in the early days (Bangladesh, Cambodia, Mozambique, Zambia and South Africa), SWAPs were found to be unstable due to constantly changing groups of actors, many of them fiercely protective of their independence and autonomy (Walt et al. 1999). There were numerous setbacks and crises. But there were also unexpected good spin-offs. SWAPs depended very much on the institutional and systematic issues in donor/recipient contexts. They also depended on the capacity of the recipient

government to develop the health sector on its own and on the capacity to negotiate a realistic programme package with donors.

In Uganda, SWAP was adopted in 1999. The agreed programme of work was the Health Sector Strategic Plan (HSSP) and its structures included Health Policy Advisory Committee (HPAC), Health Sector Review Committee (HSRC), Joint Supervision, the National Health assembly, and Health Sector Working Groups. MoUs were signed to use the government budget as the basis of donor funding (Murindwa 2001; Örtendahl 2007). According to an early assessment (Murindwa 2001) SWAP made some achievements in Uganda. It raised the health sector profile in the national politics and helped mobilize more resources. It increased funding to PHC by fourfold. It helped to increase immunization coverage (DPT3) by two times (41% to 73% from 1999 to 2003) and increased OPD attendance by two times from 1999 to 2004. But this situation was dramatically reversed since 2005 (Örtendahl 2007). GoU's budget increments from own revenue have ended. The health budget as a proportion of the national budget has declined from over 10% in 1990's to 8.3% in 2006. The ministry of finance attributes the decline of the health budget to increased project funding, the poor quality of budget prepared by the MoH and more funds now being channelled to the energy sector, the current number one priority for the government. Annual project funding increased dramatically through the Global Health Initiatives (GHIs) - mainly GFATM, PEPFAR and PMI - from USD250 million in 2004 to USD500 million in 2006, bringing per capita expenditure on health from USD9 to USD15.

The current decline in SWAP's performance is attributed to four factors (Örtendahl 2007). *First* is the weakness in the health sector leadership, especially the long period of leadership vacuum at the MoH after the Director General left the MoH. In addition, the current new team at the MoH is inexperienced. There is also dire interference by the State House whereby presidential advisors/ ruling-party activists have been posted to manage the MoH. *Second*, GHIs have destabilized the health sector greatly. GAVI's lack of clarity and transparency led to huge sums of money being channelled by health ministers to the State House, a scandal in which the three health ministers were arrested and are now in court. Uganda's GFATM programme was rocked by a mega-scandal where millions of dollars were embezzled and by gross mismanagement. This has paralyzed policy-makers, implementing agencies, and relations with the MoH for over two years now.

PEPFAR has fragmented HIV prevention by insisting on abstinence-only methods, when the success of Uganda's HIV prevention has been ABC (Abstinence, Being faithful, and Condom use). US President's Malaria Initiative (PMI) has started a new malaria control programme outside the MoH and the government system. The programme has so much money that it would overwhelm the counter-funding by GoU and all sustainability strategies. It has disrupted the national malaria programme completely. Such huge projects have directly clashed with SWAP and HSSP principles. The GHIs have re-introduced duplication, administration burden, and the burden for coordination of many parallel efforts and systems, the very reasons why SWAP was introduced.

*Third*, it has been argued that dependence on external aid causes macro-economic instability because aid unduly appreciates the value of the Uganda shilling making exports difficult and more expensive. It drives up interest rates and hence discourages investment and so reduces GDP growth. It causes inflation of staff and material costs, for which aid competes against the local currency. In addition, dependence on aid reduces the demand for internal resources and hence reduces tax revenue.

*Fourth*, donor countries like to flag-show the projects they fund. Through SWAP, flag-showing tends to disappear as achievements are seen as collective effort. But for donors who like to show-off their contribution and achievement, this is an unwelcome trend, which they want to stop. The key lesson is that SWAP does not suit everybody's interests, both within the country and in the donor community. So, major compromises have to be made for SWAP to work. A balance has to be struck between the project-approach and budget support, as the two approaches will most likely continue. An agreement for SWAP needs to be extended to non-SWAP partners on integrating projects. New discussions to reform SWAPs have been held based on the Paris Declaration on Aid Effectiveness.

The new initiatives that were recommended include: The Global Fund's Country Coordinating Mechanism (CCM) to be the SWAP arrangement based on a common fund. TAs should be integrated into government's staffing structure of the MOH and other ministries. Aid partnerships should be rationalized to reduce transaction and administration costs. Guidelines for managing partnerships should be simplified and made easy to implement. SWAP arrangements and plans should support macro-economic balance, and the balance between projects and the budget-support. There should be an agreed strategy to share and use effectively non-financial resources such as staff and materials. Finally, SWAP should be informed by an overarching national planning framework.

But a reformed and highly compromised SWAP is unlikely to meet the original purpose for which it was established – that is, to prevent health sector fragmentation, duplication of roles, and high cost of management (Paper II). From the start, some (eg Hancock, 2006) doubted the viability of partnership with donors to develop national health systems.

#### ***The abolition of user-fees (from Papers IV and V)***

User-fees were finally abolished in Uganda's health sector in 2001. The political cost of user-fees had risen sharply. A survey had only recently concluded that the greatest problem people had was with accessing health-care, and the biggest obstacle was identified to be user-fees (GoU, 1999). A household survey also reported that 51% population living within walkable distance from health facilities did not use the facilities due to user-fees. With presidential and parliamentary elections due soon, user-fees became a major issue in 2000. When an analysis was made on the benefits of user-fees, they were found to be negligible.

User-fees contributed only 3.6% of public sector health revenue. The cost-recovery of health facilities was 3-5%, with only two hospitals raising over 10% of total revenue from user-fees (GoU, 1999). The abolition of user-fees led to a dramatic increase in health facility attendance estimated to be over 100%. Donors demonized the abolition of user-fees, arguing that it was causing a crisis in the payment of staff and in drug supplies. But the "crisis" of patients overwhelming the health-care system was not caused by the abolition of user-fees. It was due to the paucity of the overall health financing, as the contribution from user fees was so small.

A study compared household funding data for Uganda for 1999/2000 and 2002/03, i.e. before and after the abolition of user-fees in public sector health services (Deininger and Mpuga, 2004). The policy to abolish user-fees was found to have improved the use of health-care, and reduced the probability of sickness in a way that was particularly beneficial to the poor. The study noted concerns about the poor quality of health-care, but demonstrated that aggregate benefits of no user-fees were significantly larger than those with user-fees in place. Another study to assess

possible changes in the quality of health in public health facilities was also carried out following the abolition of user-fees in Uganda (Nabyonga, Karamagi et al, 2007). It showed that both technical and consumer assessed quality of health-care was maintained at the same low levels even after the abolition of user-fees. This indicates that, in the context of Uganda, user-fees had negligible role in improving the quality of health care.

The user-fee policy continues to be controversial. Some think that at least a moderate level of cost recovery is justifiable to put social services on a sound footing. That, the potential negative consequences of a modest user-fee is a small price to pay. But others argue equally strongly that user-fees discriminate against the poor. In theory, both outcomes are possible. But the practical implication for policy is that the empirical evidence in any given setting to determine whether or not to levy user fees will be critical.

***Private sector and public-private partnership ( from Papers IV and V)***

The role and influence of the private sector in the health sector has multiplied many fold in recent years. In Uganda during the 1960s, the health system was fashioned on the UK's National Health System: public funded and provided (Paper I). The private sector was small, serving white expatriates and Indian traders. During the 1970s and 1980s, the health system collapsed due to economic decline following political mismanagement and prolonged civil conflict. This brought about the emergence of informal private sector (unregistered and unrecognized by the State). In the 1980's and 1990's, the Government began to acknowledge the increasing and important role played by the church health sector, and later by the private-for-profit providers.

Paper I notes new laws that were enacted in 1995 to promote and regulate the private sector. Most health professionals were permitted to operate private practice. Previously, only doctors and midwives were allowed to practice. Those employed in government services were not prohibited from operating private practice. Recently, a public-private partnership policy in health (PPPPH) was completed. It recognizes that the private sector consists of private-not-for-profit (PNFP), traditional and complimentary practitioners (TCP), and private-for-profit (PFP). However, except for PNFPs, no formal partnership has yet been developed between the state (public) and the private sector.

A study (Konde-Lule, Okuonzi et al 2006) showed that the informal health sector (i.e. those not recognized by the state) made up 77% of "health facilities" in the community. But only 7% of the population had ever visited these informal facilities; 56% preferred formal facilities, and 42% preferred self-treatment. In practice, the theoretical demarcations between sectors are dismantled through a dynamic interaction between formal and informal health-care systems, and public and private sectors. Of all referrals, 60% is between public and private sectors. The two sectors also share services (such as x-rays) in 20% of cases, and personnel in 8% of cases.

This study was an effort to justify a greater partnership between private and public sectors. But the global study involving China, India, Laos, Vietnam, Zambia and Uganda concluded that the concept of public-private partnership needed to be further refined (Sunderwall and Forsberg, 2006). It emerged that partnerships have three dimensions: co-existence, competition, and collaboration. But true partnership with a shared vision does not exist in the real world. Rather, partners aspire to work together while pursuing different visions. The public sector is always grappling with funding, efficiency and political pressures. The private sector has to meet the challenges of profitability, legal framework and personnel. The study also found that partnership is not always a desired intervention, with the two sectors intrinsically suspicious of

each other. The study has thrown light on what has been labelled as “partnership”, when in fact it is privatization. The public sector, having failed to provide services to the whole population as often planned, unintentionally creates a “market” for health-care. This opportunity is seized by entrepreneurs, many coming from the public-sector, itself. PPPH has become a mainstream development agenda in developing countries.

In Europe where partnerships have worked there are certain prerequisites in place (Nikolic and Maikish, 2006). These are: functional regulatory systems, available skills to manage partnership, enough time has been given to nurture the partnership, in-built business and management functions, well-defined consultations, and clear channels of communications with all stakeholders. Most of these pre-requisites lack in Uganda and other African settings and require cultivation.

### ***Health insurance and health financing (from Papers II, IV and V)***

The initial excitement about user-fees gave way to disillusionment and frustration (Paper II). The miserable generation of revenue from user-fees, and its negative impact on equity, ruled out user-fees as a viable financing method of health services where the majority are too poor to afford the basic requirements. The projected health expenditure of Uganda’s outstrips the current health expenditure four-fold. Without another source of funding, it would require the Government’s budget to grow at 6% per annum (Paper I).

It has been argued that the best way to assess how much a country should spend on health should be through international comparisons of national incomes and health spending (Musgrove, 1996). Thus, in a country below the GDP of 500USD per head, no additional expenditure can in fact make a significant difference in health gains. Such health gains are possible between GDP of 500-2000USD per head. Above 2000USD, child-health gains nearly reach their peak, and adult life expectancy continues to increase. These gains are mainly through education and environmental improvements. Above a GDP of USD 500, even life expectancy reaches the peak. By this logic, the cost of supply health-care based on need would be too high for the corresponding income and a minimal defined package of health care would be advisable. For Uganda, the package is around USD 28 per head (or USD 40 including anti-retroviral therapy (ART). This is not affordable. One group of advocates has called for increased donor funding of the “basic” package and to address MDGs. A typical example of such advisory is Jeffery Sachs, advisor to the UN Secretary General (Sachs, 2005).

But Uganda’s economists in its finance ministry argue that increased donor funding of health under the guise of MDGs is flawed (Browbridge, 2004). It necessitates increased internal public expenditure. This shifts resources away from export industry and private investment. Also, there are usually absorptive and spending problems with aid. In addition, donor funds distort public budget allocation patterns, cohesion and stability. They argue that MDGs would require a budget equivalent to 13.6% of Uganda’s entire GDP, which is arguably not possible. Instead, it is advised that Uganda should concentrate on economic growth. In ten years, it is estimated that the country’s revenue will have increased by 150%, which will enable the government to spend about 15% of its budget on health. Then, MDGs or similar social targets will begin to be addressed; and this has become policy for Uganda.

With such an economic policy, government funding of health and related services will be greatly limited and social targets such as MDGs will remain a mirage. There have been efforts to identify other viable sources of health financing. Social Health Insurance (SHI) has become a

popular possible financing option for Uganda. A feasibility assessment was done in 2000 (Berman et al, 2001). Feasibility was defined in three dimensions: financial and affordability, capacity and experience, and knowledge of users and funders. A key objective of the SHI is to mobilize funds through contributions of co-payment and co-insurance. SHI is distinguished from National Health Insurance (NHI) and tax-funded systems by being restricted to only those who are eligible, making benefits correspond with benefit packages, separating the funds from general tax, maintaining its own solvency, and by the fact that contribution rates and benefits are only altered by legislation. SHI has the advantages of being stable, good for risk pooling as well as mutual support. It can ensure efficiency and quality in health-care, and can free resources for other services. It can also provide an orderly transition to NHI.

However, it is often limited to formal employees, creates funding deficits, requires supporting public funding, and may create unnecessary demands (Berman et al. 2001). In Africa, the National Hospital Insurance Fund (NHIF) of Kenya has been relatively successful. But success elsewhere in Africa in SHI has been greatly limited. In Uganda, the feasibility study recommended 8-10% contribution rate, and an intense preparation and investment in a) the mechanisms for collection of funds, b) management and regulation, c) improved health care provision, and d) accreditation and quality control.

#### ***Macroeconomics and health (from Papers IV and V)***

Macroeconomics has recently become the single most important factor determining how health care can be financed and reformed (Paper IV; WHO, 2001). Macroeconomics stability refers to the national budget balance against domestic debt burden (internal balance) versus balance of payment against debt-service burden (external balance) (Ekman and Gerdtham, 2006). Macroeconomic stability became a key feature of the IMF/World Bank programming model, which was imposed on countries as a condition for loans. The macroeconomic stability model has three components: fiscal, monetary and financial policies. Fiscal policy deals with taxation and expenditure, and monetary policy deals with the government's regulation of money supply and interest rate. And financial policy deals with mobilization of savings and resources for investment and employment, and also addresses social problems (Vernengo, 2006).

The macroeconomic stability model preferred by the World Bank and IMF stems from orthodox or mainstream economics. It opposes the Keynesian neo-classical economic theory which was applied in 1950's and 1960's in the golden age of capitalism (Epstein and Grabel, 2007). The Keynesian approach was that the state was the general agent of economic growth. The state mobilizes savings, directs investment and employment creation, creates and directs credit, and provides financing for investment. But using orthodox or neo-classical economics, the IMF, World Bank and the US Treasury put together a new policy called the Washington Consensus (Stiglitz, 2002; Sachs, 2005).

The basis of this consensus policy was that state regulation of the economy is counter-productive. The economy should be controlled by price and competition, that is, through market mechanisms. It was argued that state regulation lowers interest rate and increases inflation, making people save abroad, and increases consumption. When consumption increases, prices increase, resulting into more inflation. When inflation is high, there is low saving, and banks have only a small pool of money. Therefore, there is reduced investment, employment and economic growth. Domestic markets are fragmented and dominated by politically connected borrowers. As a result, genuine borrowers get disenfranchised and consequently entrepreneurship, employment creation and economic growth suffer.

Under the Washington Consensus, it is claimed that domestic financial systems should be liberalized to increase investment and efficiency of the economic system (Stiglitz, 2002; Sachs 2005). Efficiency can be attained through the discouragement of corruption, enforcement of market discipline, and innovation of different financial instruments, such as capital markets. Indeed, this policy did help in integrating global markets and enabling governments to borrow from financial capital markets. But most of the envisaged benefits did not materialize. There were negative effects on the poor and many cases of capital flight. The real interest rates were often high, not low. There was slow credit creation. Credit and capital became cyclical, and long-term capital was not available. There was always insufficient capital for small and medium enterprises (SMEs).

However, recent studies and analyses (Vernengo, 2006; Epstein and Gabel, 2007; Filho, 2007; Weeks and Patel, 2007 ) show various ways in which these macroeconomic policies of the Washington Consensus have been damaging to the poor. The net effect of the policies has been to starve the poor of basic social services. But a variety of interventions have been proposed to achieve macroeconomic stability, while at the same time addressing equity and unemployment, and keeping inflation low and achieving economic growth. Under fiscal policy, it is suggested that in order to achieve a pro-poor macroeconomic stability, one needs to identify the desired outcomes, specify the macro-variables, and differentiate between excessive and non-excessive economic fluctuations. Commonly, the macro-variables are: a) the rate of economic growth, b) distribution of income, and c) investment and expenditure. Under the monetary policy, it is suggested to target credit for investment in pro-poor sectors and control capital flow into the country, since uncontrolled capital inflows destabilize the economy.

Under the financial policy, pro-poor interventions suggested include depositing insurance to enhance confidence in the economy; directing credit allocations and subsidized-lending to the poor; establishing and implementing lending-targets, ceilings and tax incentives; establishing specialized lending-institutions and development banks; establishing credit-guarantee schemes to reduce premiums on long-term investments; introducing variable asset-based reserves for stocks, bonds and mortgages; improving and easing lending through information and business services by linking formal and informal financial institutions; providing technical support to micro-credit institutions to serve borrowers better; and introducing employment-oriented financial policies.

Without pro-poor macroeconomic policies, it would be impossible to achieve MDGs (Vernengo, 2006). The necessary domestic resources would not be mobilized and allocated effectively to pro-poor sectors and activities. Also, external aid would not be adequately mobilized under the orthodox macroeconomic framework, which discourages aid inflows because it is deemed to increase inflation. Under the auspices of WHO, a Commission for Macroeconomics and Health (CMH) was created which made two key recommendations. First, in order to achieve MDGs, aid must be significantly scaled up. Second, low income countries should mobilize higher levels of resources for health and related services through increased domestic budgets (WHO, 2001).

The report also urges poor countries to determine an essential package of interventions as a priority based on their efficiency, ability to target the highest burdens of diseases, ability to provide the highest possible social benefits at the lowest cost, and ability to address the needs of the poor. It was calculated that a minimum basic package would cost about \$30-40 per head. The report lays out an agenda for action, urging countries to form national committees on macro-



economics in health and to formulate national strategies. It also urges donors to commit funds, estimated at US\$38 billion, by 2015 globally. Other action points include defining effective funding mechanisms, funding global public goods (surveillance, data collection and dissemination), and developing drugs for neglected diseases.

The GoU has carried out a consultancy to chart the way forward to develop a strategy for macro-economics and health. The Government currently prefers tax revenue generation to getting more aid through grants. But its current tax revenue is only 12% of GDP, below the critical 15% (Ekman and Gerdtham, 2006). While aid is feasible over medium term to long term, in the short term the government is urged to mobilize funds from projects to fund its health budget. One way in which it was thought funding would be increased to social sectors was through the debt cancellation of the highly indebted poor countries (HIPC), of which Uganda was one. But after the debt cancellation, resources to health sector did not increase significantly. At the same time, the debt problem has not been solved since new loans have been taken. In addition, the domestic loan in Uganda is now larger than the external debt. The report recommends a rigorous analysis based on evidence of what works and what does not, and why. Based on available information, the key issues to address are water, sanitation, education, family planning, evidence-based policy development and systematic use of impact evaluations.

### ***Decentralization of health services (from Paper III)***

Decentralization is said to be important for proper implementation of PHC (WHO, 1978) planning, community participation and for HSRs (Paper III and Okuonzi S and Lubanga F 1997). In Uganda, decentralization has been defined as the transfer of authority or power for planning, management and decision-making, and for resources, responsibility and accountability from the central government to local governments. Decentralization in Uganda is holistic, i.e. it covers all sectors of the economy. The health sector is just one of the sectors. Uganda planned and implemented an elaborate decentralization. Local and community structures were put in place, and real authority and roles were devolved to lower level units.

The reasons for decentralization in Uganda included community participation, local self-reliance, promotion of accountability, overcoming administrative constraints, promoting coordination at the implementation level, and promoting market surrogates for efficiency. Although many responsibilities are decentralized in Uganda in theory, only planning, some resource allocation, limited policy-making, and service delivery are practiced by local authorities. In designing decentralization, the critical issues are the capacity to raise revenue, institutional capacity and the use of incentives.

Mills *et al.* (1990) differentiate between political and managerial decentralization. In the former, the aim is to achieve collective services for the public, and emphasizes accountability, which is good for local democracy. But the latter's aim is to improve services and efficiency through market mechanism. Although Uganda combined both features in the design, it appears that decentralization in the country has turned out to be political, more focused on local democracy than on efficiency and improvement of services. Major management problems in the health sector have thus remained unabated. Other problems have even increased with decentralization. Decentralization overwhelmingly changed the organizational landscape of health care delivery. But access to health care has remained difficult (Saito, 2004).

Decentralization was meant to bring services nearer to the people (Saito 2004). In addition to reduced access to health services, the quality of health care has worsened. Drugs have become

less available, patients wait long to be seen by health workers, and the attitude of health workers has remained unfriendly and rude. There are more unqualified staff working in rural health units than before and are preferred by local authorities because of their low salaries. With poor health worker motivation, the overall perception by the population of health-care delivery in Uganda is said to be “worse than before” (Saito, 2004). Corruption appears to have been decentralized and increased. There is widespread practice of bribery, under-table payments, and “leakage” of drugs. Not only have the local authorities failed to control corruption, but they are also involved in it themselves (Saito, 2004). There are too many local units and not adequate funding to meet overhead costs. In less than 10 years, the number of districts has increased from 33 to the current 80. Other lower level units have multiplied in the same proportion. The bulk of the funding to the local governments (85%) is from the centre, of which most (70%) is earmarked or conditional.

Bossert (2000) argues that decentralization can improve or worsen health system development, depending upon how it is done. Lessons from the Philippines indicate that decentralization was planned in such a way that quality and other HSD objectives were kept in mind as a main focus. In particular, health workers were reassured, made confident and secure in their jobs and benefits. Simple changes in management practice, such as stopping an allowance (in the case of Uganda, immunization allowance), can cause enormous damage to health-service delivery. In Uganda, the decline of national immunization coverage in early 2000’s was attributed to the abolition of immunization allowances. Operational funds, drugs, supplies and infrastructure should also be catered for if the quality of health-care is to improve. In the case of Uganda, all factors associated with quality worsened with deepening decentralization.

Other factors must also have contributed, but decentralization as a major vehicle of reform for “bringing services to the people” did not help in any significant way to curb the deterioration of health-service delivery (Paper III; Saito, 2004). It is clear that a review of the health-sector decentralization is needed. The choice of level of authority, the choice of authority, the tasks to be decentralized, and how to achieve HSD objectives within the decentralized framework need to be comprehensively reviewed.

The poor performance of the health sector under the decentralization regime in Uganda can be attributed to four main factors (Saito, 2004). First, it turned out to be a political rather than managerial decentralization. Local governments increased exponentially in number and hence became less viable to operate. District status was granted to many small communities merely to reward them for their political support or to solicit support for the ruling party. Second, there is a huge discrepancy between the responsibilities given to districts and the resources they have at their disposal to perform those responsibilities. Third, due to the weakening of local governments by continuously subdividing the country into more and smaller districts, capacity building of institutions has largely failed. Finally, there has not been any viable incentive structure and mechanisms to enable an effective service delivery to be carried out.

### ***Pharmaceutical sector reforms (from Paper I)***

The National Drug Policy (NDP) clearly establishes the guidelines for the Ugandan drug supply system, and stipulates that the NMS is one of a variety of institutional entities responsible for drug supply being charged specifically with the quantification, procurement, storage and distribution of essential drugs to the government health care system (Paper I). The NDP seeks to assure the attainment of a good standard of health for the population of Uganda, by ensuring the availability, accessibility and affordability at all times of high quality essential drugs, and by

promoting their rational use. A principal tenet of the NDP is that essential drugs should be accessible to all patients who need them. This has the dual implication that essential drug supply must be assured at all times, at all levels of the health care system, and that all patients can afford essential drugs regardless of their socio-economic or health status.

Though National Medical Stores Act calls for the NMS to be an efficient and effective supplier of medicines and medical supplies, this objective needs to be achieved in a manner that fosters distributive equity (Paper I). The two objectives – distributive equity and efficiency – can be promoted and to a certain degree achieved simultaneously, but where a trade-off must be made between the two, concerns for distributive equity must prevail over the need for efficiency. As the demands on the country's healthcare system continue to grow, so too will the demands for the provision of essential medicines and medical supplies. How effectively the national health care system responds to these demands will in a significant way depend upon how effective and efficient the NMS will be in satisfying its mission.

However, NMS is only one of several institutions responsible for ensuring that the demand for drugs and medical supplies is adequately satisfied (MCDI and SCL, 2006). Uganda's drug supply system is comprised of a number of supporting entities that have significant roles to play in the efficient procurement, storage and distribution of pharmaceutical products to the public health sector in all reaches of the country. Among the entities that comprise the drug supply system, the MoH together with the NDA is charged with planning and forecasting of the national essential medicine need as defined by the minimal health care package. The NDA is also charged with the efficient regulation, registration and quality assurance assessment of the nation's drug supply. The MoH, together with the Ministry of Finance are responsible for funding the drug supply (through the essential medicines Credit Line and the Primary health Care (PHC) grant funds) to meet the public sector need and finally, since the enactment of the Local Government Act, the districts, and more specifically the District Director of Health Services (DDHS), are responsible for quantifying the local drug supply needs and communicating these requirements to the NMS to ensure the timely delivery of medicines, and through the use of the Credit Line and PHC Grants to finance the procurement of these drugs. Together, the GoU, through the MOH, MFPED, NDA and DDHS are responsible for working with the National Medical Stores to ensure the efficient procurement, storage and distribution of quality medicines and supplies to support the country's growing public health needs.

Reforms that have impacted on the drug supply system in Uganda are as follows (MCDI and SCL, 2006):

1991: Public sector liberalization and privatization introduced by Government of Uganda: In an effort to improve efficiency and public sector service delivery effectiveness throughout the country, the Government of Uganda began evaluating the prospects for liberalization and privatization as part of their public sector reform strategy. Initially, discussions regarding privatization covered a broad range of industries and government held enterprises and considered varying levels of privatization from complete divestiture to outsourcing specific functions within existing public sector organizations. The government's formal policy and statutes on liberalization and privatization were introduced under the Public Enterprise Reform and Divestiture Act (PERD) of 1993. This Act coincided with the preliminary efforts to liberalize and privatize the national drug supply system – a process that included the creation of the NMS as a class II parastatal.

1993: National Drug Policy and Authority Act is enacted: The National Drug Policy and Authority Act (NDPAA) committed the Government of Uganda to ensuring that essential, safe, efficacious and cost-effective drugs were made available to the entire population of Uganda as an integral element of its overall commitment to meeting the health needs of its population. The NDPAA established the National Drug Authority to promote rational drug use based on an Essential Drug List of Uganda that is consistent with the National Health Policy enacted in 2000. The NDPAA further identifies the NDA as being responsible for establishing the Essential Drug List for Uganda (UDLU) and for overseeing the estimation of drug needs for the country.

1993: National Medical Stores Act is enacted: NMS was established in 1993 at the same time as the NDPAA to ensure equitable access by the population of Uganda to high quality, efficacious and cost effective essential drugs. The NMS was charged with procuring these essential drugs primarily for public sector health institutions. In keeping with the Public Enterprise Reform and Divestiture Act (PERD) of 1993, the NMS was created as a Class II parastatal or a semi-autonomous, not-for-profit organization, designed to operate on sound commercial principles, while above all maintaining equity of access to medicines. In order to safeguard its distributive equity role and ensure that it had a sufficient market to enable it to break-even, the NMS was given a monopoly to supply all public health institutions.

The specific objectives of the NMS corporation included: (1) efficient and economic procurement of medicines and other medical supplies of good quality primarily to the public health services; (2) secure, safe and efficient storage, administration, distribution and supply of goods in question in accordance with the National Drug Policy and Authority; (3) establishment and maintenance of systems to ensure the quality of goods supplied; and (4) estimation of current and future needs as a basis for procurement, planning and budgeting by the corporation itself and the Ministries concerned.

As a corporate body, the NMS was authorized to generate income through cost recovery, which was to be used to create and maintain an operating reserve and to improve the corporation's services and facilities. Cost recovery is achieved through the sale of 3<sup>rd</sup> party programme products or through the sale of drugs and medical supplies to the private sector. The term cost recovery is also understood to imply any profits generated by the NMS from the delivery of drugs to the districts financed under the Credit Line budget. Such profits, to the extent that they occur, are the result of being able to deliver the drugs and medical supplies at a cost under the agreed to sale prices. The NMS can also generate potential cost recovery revenues if it fills orders financed under the PHC Grant. Cost recovery in this context does not mean that NMS drugs are sold to patients as would occur under a standard revolving drug fund arrangement. In the Ugandan case, the "sale" takes place to the districts that are in turn using grant revenues provided by the Central Government to "pay" the NMS. The cost recovery provision does not therefore contravene the NMS's mandate to ensure access to affordable drugs, at least from the standpoint of the patients. Through this act the NMS was also given an advisory role to the NDA and MOH related to matters of estimation of drug needs and distribution and use of medicines in public service.

1995: Constitution of Uganda: The Constitution of Uganda enacted in 1995 committed the government to a policy of decentralization through devolution of previous centrally controlled powers and functions to the district level. A more formal delineation of the decentralization policy was subsequently articulated in the Local Government Act of 1997.

1997: Local Government Act and Decentralization: With introduction of this Act, districts began to assume responsibility for the provision of their own healthcare services and responsibility for drug procurement. This procurement was to be financed through two funding sources from the Central Government: A Credit Line budget allocated to the MOH for each District and ring-fenced for essential drugs procurement from the NMS, and at a later date a PHC Grant, 50% of which is in principle earmarked for drug procurement (both essential drugs and non-essential specialty drugs) procured either from the NMS or other sources.

2001: Study to improve logistics management: By 2001 the supply chain that had been established for public sector drug distribution and the distribution of 3<sup>rd</sup> party programme supplies (e.g. reproductive health supplies) was considered to be performing inadequately and inefficiently, particularly as it related to meeting the needs of populations residing in the rural areas of the country. Among the more obvious problems that were identified at this stage were those associated with drug supply logistics. It was recognized more specifically that inadequate logistics were negatively impacting healthcare programme outcomes and causing inefficiencies associated with the time and expense of getting drugs from the centralized drop point within a district to the HSDs.

2002: Introduction of the Pull System: The logistics study of 2001 noted a significant build up of expired products in many of the district stores. This problem was attributed to the existing “push” system of drug delivery where kits and various medical products were delivered by the NMS based on gross estimates of need rather than on the demand of the health facilities themselves. The Study recommended a change to the current “pull” system whereby the Districts quantify and plan for their own needs and procure supplies using the Credit Line funds which were allocated by the MOH based on district population and other demographic factors.

2002: Memorandum of Understanding between MoH and NMS is signed: To ensure that NMS procured and distribute drugs and supplies in support of the National Health Plan and the National Drug Policy, the MoH engaged the NMS's services as a corporate entity through a document known as the Memorandum of Understanding. This document obligated each party to certain activities – including the obligation that NMS would serve as the distribution arm for the MoH and its expanding number of third party health care programmes.

2000: Liberalization of the drug supply market: Uganda's drug supply system began to be liberalized during the early part of this decade. Liberalization brought an increasing level of competition for the NMS; it was no longer the sole source of essential medicines for public sector health facilities. Liberalization was introduced in part as a response to supply deficiencies by the NMS and the consequent stocking-out of needed drugs and medical supplies at government health facilities. Since the liberalization of the pharmaceutical sector began, a series of middlemen suppliers or wholesalers have emerged. These suppliers sell their pharmaceuticals products in geographically restricted markets around the country directly to the Districts, and one offer the national coverage or distribution services that the NMS offers. In some situations, these same wholesalers supply both the districts and the NMS and compete with NMS for sales to the districts.

2003: Assessing the costs of distribution of drugs: In light of the emerging supply deficiencies associated with the NMS and in particular the difficulties the districts and Health Sub-Districts (HSDs) were having with the NMS in fulfilling their drug supply orders in a complete, regular

and timely manner, the Ministry of Health asked the Logistics Management Project to conduct a further study to determine how to improve delivery of drugs to the HSD level.

Among the issues assessed was the monopoly status of the NMS vis-à-vis supplying the district stores, the exclusive use of credit line funds for procurement from the NMS, and inadequacies in the communications infrastructure and procedures between the NMS and the districts and HSDs. Each of these issues was seen as having a potential impact on drug and medical supplies accessibility and on the efficiency of the system.

The study revealed that district-based delivery costs were excessive relative to what should be achievable. The study concluded, however, that the solution would not be in turning the district distribution function over to the NMS. Estimates from the study suggested that distribution costs would be 82% higher if the NMS took over responsibility for delivery to the HSDs relative to the prevailing district-based delivery approach. The logistics study also noted that drug supply functions such as inventory control, order-processing, warehousing and transportation were being managed sub-optimally at both the district and HSD levels. It further suggested that an absence of accurate consumption and morbidity data was making it difficult to forecast and plan for drug requirements.

2003: PPDPA Act and Regulations introduced: The Public Procurement and Disposal of Public Assets Act (PPDPA) of 2002/03 was enacted to guide public enterprises in the procurement and disposal of public assets. As a Class II Public Enterprise, the NMS falls under the statutory purview of the PPDPA. By placing restrictions on the manner in which the NMS must procure products – restrictions that do not apply to the NMS’s private sector competitors – the PPDPA has created an unfair competitive advantage for the NMS’s competitors, and undermined the NMS’s ability to generate cost recovery revenues.

The impact of the PPDPA can be seen from a comparison between the revenue position of the NMS and the JMS. While NMS sales have stagnated in the past several years (after experiencing a substantial growth due to the introduction of the Credit Line budget, which has guaranteed business for the NMS, and boosted sales to over Ushs.11 bn per year), JMS sales grew from Ush.10.8 bn in 2000 to Ushs.25.3 bn in 2005. Anecdotal evidence indicates that consumers perceive that the JMS is more strategic and efficient in management than the NMS. The reality is, however, that the JMS is not constrained by public procurement rules, and is free from political pressure and public sector obligations. All its customers pay promptly while most NMS customers who are public sector institutions, have, at one time or another, defaulted in paying their debts.

2004: Euro Health Group Technical Review initiated to “fix NMS”: The inefficiencies within Uganda’s drug supply system have been evident for some time as noted by the various studies that have been conducted and the attention that has been given to improving the National Medical Stores through its restructuring and through offers of technical assistance. The technical review was structured to look specifically at how to improve the performance of the NMS. The Technical Review identified a number of operational problems within NMS that could be addressed with technical assistance or some degree of structural reform. Although it is clear that the NMS is a central entity within the national drug supply system and that it suffered from deficiencies which necessitated remediation, it is also clear that the NMS is only one of a considerable number of entities engaged in drug supply. As such it is now understood that overall drug supply systems performance enhancement vis-à-vis achieving the goal of equitable

access with efficiency requires a broader analysis that considers the interplay between the NMS and these other key entities. This broader analysis was the focus of this study.

2005: Rapid expansion of third party programmes: As a result of strong policies dedicated to health system reform and poverty reduction, Uganda has garnered the attention of numerous international aid agencies and NGOs. This has resulted in generous contributions of pharmaceutical products and medical supplies to assist in achievement of its National Health Plan. While the contributions offer tremendous benefits to the Ugandan people, they have also complicated the drug supply process for the NMS, undermining to a degree its effectiveness, and introducing new forms of inefficiency.

Since the vast majority of donations are programme specific and are procured without the prior knowledge of the NMS, there has been little opportunity for the NMS either to negotiate with the donor for items needed to fill requirements gaps or to adjust its own orders so as to avoid duplication and reallocate its resources towards the procurement of other items. The NMS has been the recipient of significant quantities of duplicate items – items which the NMS is often required to distribute on a priority basis to the districts even if it means that the duplicate products it has procured sit on its shelves.

The financial position of the NMS has also been undermined by the fact that it has been unable to recover the full costs of storing and distributing third-party programme products. Storage fees (overhead) agreements agreed to by the Ministry of Health and the donors have been inadequate to cover the true cost to the NMS. The impact of these agreements has grown as the volume of third party drug supply has increased both in absolute terms and as a share of the total value of the NMS's trading stock. In 2005, for example, the value of third party stock holding exceeded the value of NMS trading stock by a margin of nearly 3:1. The burden placed on NMS by third party programmes has undermined its ability to effectively satisfy its mandate to procure and distribute essential medicines efficiently throughout the country.

2005-07: District proliferation – from 48 to more than 80 districts: Not only is the NMS responsible for the procurement, storage and management of the public sector drug supply, it must also orchestrate distribution to Uganda's growing number of districts. As districts are added, the NMS must add a delivery point. During the past couple of years the number of new districts created has increased significantly and the Government continues to add more. Districts are being added before there is the human resource capacity to quantify, procure and manage drugs and medical supplies. This not only constrains NMS from the point of the work it must do and the places it must deliver, it compromises efficiencies because of inadequate infrastructure at the district level.

2005: World Bank commissioned NMS study: The study was to assess the potential for enhancing efficiency of NMS through privatization. But the study found that the attainment of the goals and objectives of the National Drug Policy was not self-evident. In particular, it was clear that the objectives of distributive equity were not completely convergent with those of economic efficiency and that a certain trade-off was required in the efficiency domain in order to maximize the possibility and ultimately the reality of achieving the overarching distributive equity objective. In addition, it is inevitable that a certain level of inefficiency above and beyond that required by the trade-off for distributive equity would also be inevitable at least in the short to medium term as the health sector in Uganda develops. Even where feasible avenues for improving efficiency were identified and where the resources had been allocated to enhance

systems performance in a way that was consistent with attaining these efficiency improvements, it was likely that time would be required to actually realize the efficiency gains. These “persistent” or longer term sources of inefficiency plus the base level inefficiency that was due to the trade-off for distributive equity represent the cost of achieving the goals and objectives of the National Drug Policy. And since this cost was not a cost that could be borne by either the private sector or the donor or NGO community, it was to be the responsibility of the government to finance them. The study concluded that it was an incontrovertible reality that the national drug supply system should in a very fundamental way remain a publicly financed and publicly provided system.

The study made the following key recommendations:

1. The NMS should remain under 100% government ownership. Under no circumstance should the objective of the NMS be to maximize profits. This would simply be inconsistent with the distributive equity objective of the National Drug Policy and the National Health Policy.
2. The GoU should refocus its National Drug Policy largely on the supply of essential drugs, while allowing private drug suppliers to compete for the non-essential or specialty drug supply market.
3. The donor community will need to step up in the short to medium-term to support the effort of fully developing the capacity of the NDA or MOH to undertake accurate procurement planning.
4. The donor community and in particular those organizations that are funding 3<sup>rd</sup> Party national health programmes will also need to step up their commitment to coordinating their input supply with the national drug supply system (the NMS, NDA, MOH and Districts). This analysis confirms what previous analyses have made clear: there is considerable inefficiency, duplication, and resource wastage occurring as a result of inadequate coordination between the 3<sup>rd</sup> party programmes, their MOH managers and donors, and the NMS and NDA.



## 4.0 MATERIALS AND METHODS

### 4.1 Study methods for Paper 1

This paper originates from a study done from 1989- 91 to develop a medium-term post conflict health policy and strategic plan. One phase of Uganda's civil war had ended in 1986 and a new regime was consolidating itself. A ten-year plan had been elaborated by the MOH to rehabilitate the infrastructure that had been destroyed and looted during the war. This plan had been rejected by the key donors and advisors of the government (World Bank, WHO and Unicef) because the budget exceeded available and foreseeable resources fourfold. And the plan did not have a strategy for financing. Thus, the World Bank, which was just coming on the health-sector stage, joined WHO, Unicef and GoU to agree on a) priorities, b) financing strategy, and c) appropriate reforms to be carried out in the health sector.

#### *Study team*

It was decided that a study be done to address these three issues. A study team was appointed and was led by a World Bank consultant. Experts were sourced from Unicef, WHO, MOH, and MFPED. Altogether there were 6 investigators. I was on the team representing the MOH and also the main report writer. I also remained responsible for defending and implementing the recommendations of the study. I was the writing author of the paper.

#### *Study sites*

The study was done in five districts selected in each geopolitical region of the country. The selection was based on convenience, mainly the ease of access and security concerns. In each district one hospital and three health centres (government or NGO) were selected based on the same criteria. Other sites of study were the district medical office, district administration, and district-based NGOs. At the centre, the National Medical Stores, Danida and five national NGOs were selected for the study. Also, three active and functional national programs were studied: CDD, water and sanitation programme, and UNEPI.

#### *Approaches of the study*

A preliminary meeting of the researchers and key stakeholders was held. In this meeting four main areas of study were agreed upon: pharmaceutical supply, infrastructure, PHC programmes, and health financing. An observation checklist was drawn to find out the status of equipment, staffing, buildings. Questionnaires were developed to gather views about the past and current states of the health system, and the future direction, from three key categories of respondents: national politicians (ministers and members of parliament); MOH decision-makers (the permanent secretary, directors, commissioners and programme managers); the district health team; and heads of health facilities. Key informant interviews were also held with NMS managers, Danida and the essential drug programme, national NGOs, and managers of national health programmes and of mission health services. Consensus meetings were organised to discuss preliminary findings and also agree on contentious issues.

#### *Method for the user-fee study*

This was a descriptive, cross-sectional study based on review of hospital records and interview of management teams and patients. Eight hospitals were selected based on their regional

representation. Hospital records were reviewed from the year 1989 – 1994 to assess the trends. Data was collected on a number of variables from each hospital. These included:

- Extent of user-fee reduction and the targeted population.
- Exemption mechanisms
- Outpatients utilization
- Inpatients utilization
- Expenditure on drugs and sundries
- Total expenditure
- Income from user fees
- Total income
- Delegated funds to each PNFP hospital
- Government funding per standard unit of output (SUO)
- Expenditure per SUO

Data was analyzed to see the implications of each hospital fee structure and practices on sustainability and equity. The main income and expenditure items were also analyzed in the same way. A standard unit of output (SUO) also called ‘outpatient equivalent’ was used after converting the various hospital outputs – inpatients, deliveries, antenatal care contacts and vaccinations - into outpatient equivalents. The formula that we used was introduced by a World Bank consultant was

$$\text{SUO-op} = (15 \times \text{No. IP}) + (\text{No. OP}) + (5 \times \text{No. Deliveries}) \\ + (0.2 \times \text{No. immunizations}) + (0.5 \times \text{ANC visits})$$

which equated the cost of treating one inpatient to the cost for treating 15 outpatients, 1 delivery to 5 outpatients, 0.2 vaccinations to 1 outpatient and 0.5 antenatal care visits to 1 outpatient. The same method was used to determine how much expenditure on drugs etc, was spent on a single outpatient equivalent for comparison between hospitals.

#### *Method used for the pharmaceutical management assessment study*

The purpose of this study was to evaluate the performance of the drug supply system and recommend strategies for improving the drug sector’s ability to fulfill the policy mandate set by Government to assure an equitable distribution of drugs in as efficient a manner as possible. The performance assessment was framed by the organizational and functional assessment. The NMS and other supporting entities within the national drug supply system were evaluated relative to their defined roles and responsibilities, taking into consideration their position within the overall institutional structure responsible for drug supply. Where performance weaknesses are identified, consideration is given to the impact that organizational design may have on achieving the desired functions, and where relevant, recommendations for restructuring the institutional framework are posited as part of the mix of strategies presented for enhancing system performance.

The method was based on the guiding principles of national health policy. Performance was assessed against explicitly defined objectives and verifiable performance criteria derived from a variety of disciplines. The performance indicators included:

*Equity of access*, which included both a

Coverage or supply-side aspect (i.e. ensuring that required drugs are available at all levels of the public health care system, which is synonymous with effectiveness of the drug supply system); and

Financing or demand-side aspect (i.e. ensuring that the cost of drugs are affordable for the entire population and most particularly for targeted or vulnerable groups, and that government subsidization is well targeted to reinforce this objective);

*Economic efficiency*, which has a

cost-minimization aspect subject to a given level of production (or production output target);

market-failure-alleviation aspect which redresses problems associated with externalities (cases where individual illnesses or treatments impact on the welfare of other individuals), economies of scale or economies of scope which require a size or scope of production that are not economically viable without subsidization, incomplete markets (goods or services that are unwilling to supply given uncertainty, adverse selection, moral hazard, rent seeking, shirking, corruption, and/or high transformation or coordination costs), and/or inadequate information; and/or,

consumer satisfaction or demand aspect which focuses on ensuring tht supply conforms to the preferences (expressed needs) of consumers (in this case either patients or their care providers);

*quality*, or the extent to which the systems and/or procedures adhere to normative standards or protocols that define either minimum acceptable levels of performance or desired benchmarks;

*reliability*, or the likelihood that the system and/or procedures will ensure that the desired quantity of goods and services re supplied at the time required;

*accountability*, or the likelihood that the entities producing or supplying the goods or services in question do so in a manner that is consistent with production objectives and in a way that can be effectively monitored and evaluated; and,

*Adaptability and sustainability*, or the likelihood that the production or supply process is flexible enough to respond effectively, and efficiently to changing endogenous or exogenous factors impacting on production both in the short run as well as the long run in anticipated and unanticipated ways. These production-impacting factors include:

contextual factors such as national commitment to goals, the political environment, administrative and financial decentralization policies and practice, macro-economic conditions or performance, donor involvement and the extent to which it is collaborative, complementary and reinforcing of government policies and objectives, and the extent of private sector market penetration;

programme or project-related factors such as planning capacity and community participation;

design factors such as whether the programme or system is designed in a vertical (stand-alone) or integrated manner, whether appropriate technologies are incorporated or not, whether human capital development is incorporated or assumed (available from the open market), whether socio-cultural, ethnic and/or gender factors are accounted for;

characteristics of the implementing organization such as whether it is integrated with other entities within the sector (intra-sectoral integration), the type of governance and leadership structure and systems it employs, its management capacity, the adequacy of its information systems the extent to which this information is the basis for decision-making, and the extent to which there are effective management systems in place to minimize the presence or impact of strategic behaviours that undermine productivity such as shirking, corruption etc; and/or,

financing factors such as the capacity to budget and manage the finances of the organization or production process, the type and extent of government subsidization, the extent to which there is a foreign exchange constraint, the extent to which financing is diversified to include cost recovery, and the cost structure of the organization or production process.

In light of the decentralized design of the government of Uganda, and the fact that much of the responsibility for equitable, efficient and effective drug supply was at the sub-national level, a meaningful performance review of these systems and procedures required a particular focus on the district level. The purpose of the district-level assessment was, therefore, to identify key service factors critical to district drug supply that have a bearing on the performance of the NMS and to propose strategies and/or interventions that will enhance the overall drug supply system's equity of access and economic efficiency. More specifically, the objectives of the district assessment were to:

1. Assess the role of NMS in the district drug supply system
2. Validate district motivations to procure from alternate sources (i.e. price, service, quality, availability, etc.) instead of the NMS
3. Better understand the conditions that lead districts to procure drugs elsewhere (i.e. from vendors other than the NMS)
4. Determine the level of accountability that the districts have in the equitable (affordable) and efficient procurement of medicines
5. Assess the adequacy of district level quantification methods for assessing drug and medical supply requirements
6. Identify factors that lead to procurement ineffectiveness or inefficiencies (whether staffing, communications, transportation, sourcing, financing, conflicting legal regime, etc.)
7. Explore options for increasing the effectiveness and efficiency of district procurement from the NMS
8. survey districts about their level of satisfaction with the NMS compared to alternative available (i.e. private sector) supply sources.

A cross-sectional survey was carried out using both qualitative and quantitative methods of data collection:

#### *Qualitative data*

This was based on the following methods:

*Key informant interviews:* Survey of key district health and administrative officials using the KI guide as instrument. The key informants were: the Chief Administrative Officer, the DDHS, the officer in-charge of District Medical Stores, the accountant attached to the DDHS' office, the Medical Officers in-charge of two urban local authorities.

*FGDs:* Views expressed by district officials responsible for the procurement of drugs from the NMS, the JMS or other private suppliers were also gathered.

#### **Quantitative data**

Quantitative data collection was based on the following methods:

*Semi-structured questionnaire:* Questions were administered to key informants in the district.

*Observation:* The following were observed: patient attendance registers, patient load, availability of drugs, drug-procurement procedures and constraints.

#### **Method for the study of the National Medical Stores**

*Review of district reports/documents:* Documents and reports on health services in general and on drugs in particular were obtained and reviewed. This included district budgets and plans for the last two financials years. Whenever possible, both hard and soft copies of documents were obtained from the districts.

*Sampling Procedure:* In order to ensure a representative cross section of districts, four districts were chosen, based on the following criteria: region, performance and distance from NMS. The team traversed the country in all geographic directions and surveyed the following districts (see table 5).

Table 5: Selection criteria for the study districts

<i>District</i>	<i>Region</i>	<i>Performance</i>	<i>Distance</i>
Bushenyi	West	Good	Medium
Kapchorwa	East	Poor	Medium
Arua	North	Fair	Far
<b>Mpigi</b>	Central	Good	Near

In each district, two local authorities were randomly selected by the DDHS for the study. Though the study design foresaw data collection in eight sub-districts, in the end, only seven were included. All the DDHS and CAOs of the four study districts were interviewed. The overall number of health service points involved in the study was 17 (i.e. 7 local authorities (including where Kapchorwa and Gombe district hospitals are located), 1 regional hospital (Arua Regional Hospital) an autonomous (mission) hospital, 4 DDHSs and 4 CAOs.

The study variables that were explored included:

1. Drug quantification and procurement capacity;
2. Reasons for recourse to use other sources of drugs
3. NMS market share in the district
4. Supplier preferences by districts and the reasons for these preferences.

5. The role of service delivery promoters in enhancing the NMS market viability at the district level.
6. Management of funds.
7. Satisfaction with NMS compliance with orders compared to other suppliers.
8. District management of drug stocks including planning, projection, stock outs, expiry, etc.
9. Comparing NMS and other suppliers in terms of price, discount, timeliness of delivery/response and compliance and satisfaction with the order of drugs.
10. Perceptions concerning the advantages and disadvantages of “pull” versus “push” drug supply systems.
11. Acceptance of the NMS as the exclusive district supplier
12. The impact of decentralization on district resource management (financial, human, material, time and information resources) and the availability of a functional district-level transport system; and
13. Existence of effective communication, including communication technologies, feedback mechanisms, possibilities for negotiation or flexibility by parties.

## 4.2 Study methods for Paper II

By the time the mid-term review (MTR) of the HSR programme (also called DHSP) was due in 1998, UPE had already been in existence for two years and achieved a remarkable 80% enrolment of school age children, up from about 50%. Also, studies and surveys were showing a stagnation and even deterioration of health and other socio-economic indicators. This became an issue for the MTR and in particular it was thought that lessons could be learned by the health sector about the “successful” UPE and education sector reforms.

### *Study team*

Funded by the World Bank, the Economic Policy Research Centre (EPRC) based at Makerere University commissioned a study to understand why PHC was not producing good results as UPE, and what lessons the health sector could learn from UPE. An independent principal investigator was hired by EPRC and I was the co-principal investigator as I was the manager of the HSR programme. The principal investigators were supported by other researchers and assistants. I was charged with not only writing the report but also implementing the recommendations, including preparing policy briefs to the ministers to adopt into policy. I was the writing author of the report and the paper.

### *HSR evaluation studies*

The evaluation of HSRs focused on: a) assessment of district capacity to deliver the essential health care package; b) assessment of new ways of delivering the health care package (the reforms); c) assessment of the implementation and impact MOH restructuring in support of decentralization. Different methods were used. Reforms were assessed under separate, single studies. I was the overall coordinator who issued terms of reference, commissioned and supervised the studies, and compiled various studies into one report.

The evaluation studies were as follows:

Evaluation study 1: To assess the delivery of the essential health package (EHP) in 13 project districts. This study was split into a number of sub-studies, covering key aspects of the EHP:

*Sub-study a)* Assess the understanding and application of the concept of package of essential health services.

*Method:* The national health policy, national strategic plan and annual district work plans and reports were reviewed to determine if EHP was applied and implemented.

*Sub-study b)* Assess the implementation of plans based on the essential health services package by each district.

*Method:* District work plans, budget allocations and actual expenditures were reviewed to establish the nature of health services delivered relative to the defined district essential health package.

*Sub-study c)* Assess the coverage and access by gender to the essential health services package per district.

*Method:* The latest demographic and health survey (DHS) and household integrated survey reports and district specific community assessment surveys were reviewed. Three project districts were sampled and within those districts 380 communities were sampled for in depth study.

*Sub-study d)* DHSP's financial contribution to the implementation of the defined essential health package desegregated by districts.

*Method:* Financial expenditure records and reports were reviewed.

*Sub-study e)* Assess whether quality standards were developed and implemented MOH with DHSP support, and were complied with by districts and MoH.

*Methods:* i) QA reports and financial expenditure reports were reviewed; ii) A list of quality standards was compared with what was observed; iii) The health staff were interviewed; iv) Exit interviews of patients and clients was done to assess satisfaction as well as their views on how the quality of health care could be improved.

*Sub-study f)* Assess morbidity trends in the 13 pilot districts implementing the EHP

*Method:* Morbidity data collected through routine HMIS was reviewed against recent population surveys.

**Evaluation study 2:** Assess the extent to which financial resources were mobilized for the delivery of the EHP.

The study consisted of the following sub-studies:

*Sub study a)* Estimating the level and trends of total public funding (both internal revenue and external aid) of the health sector.

*Methods:* i) National Health Accounts study was done. The method used had been developed by World Bank consultants; ii) Financial and expenditure data collected or submitted by districts were reviewed.

*Sub-study b)* Assess the availability and use of fee-for-service guidelines in government health units, and revenue from fees as proportion of total health expenditure desegregated by districts.

*Method:* HIMS information and financial reports on the collection, use and accounting of user-fees were reviewed.

*Sub-study c):* Estimate revenue raised from pre-payment schemes supported by DHSP as a proportion of public expenditure on health care.

*Method:* Financial data on pre-payment schemes was reviewed.

*Sub-study d):* Estimate the number of corporate bodies or firms with insurance schemes and the number of people covered by insurance by the schemes

*Methods:* i) A list of firms and insurance schemes was obtained from the Investment Authority and Insurance Commission; ii) Questionnaires were administered to the firms.

*Sub-study e):* Estimate how much the government spend on medical cases referred abroad and what nature of cases these are.

*Methods:* i) Interviews were done with MoH on expenditure on referral cases abroad and documentation on the nature of cases; ii) Review of MOH records on referral abroad was done.

Evaluation study 3: Evaluate specific policy reforms piloted to promote efficiency and cost-effectiveness in the health sector. This consisted of the following sub-studies:

*Sub-study a)* Assess the application of the contracting method of health care delivery

*Method:* Comparison of service-contract details (of services contracted out as well as the benefits from the contacts) with actual reports and observations, and with services that were not contracted out, was done.

*Sub-study b)* Assessment of partnership with NGOs and the private sector as a proportion of district public health expenditure

*Method:* Analysis of district financial and audit reports and of the National Health Accounts was done.

*Sub-study c)* Determine whether district authorities developed and implemented staff motivation schemes.

*Methods:* i) Review district reports to identify such schemes was done; ii) Districts were sampled and in-depth interviews and observation was carried out on the identified schemes; iii) Districts that did not implement such schemes were studied by observation and interviews to find out why not.

*Sub-study d)* Assess the viability and sustainability of drug revolving funds

*Methods:* i) Review of drug revolving fund reports was carried out; ii) Projections of possible breakthroughs in self-financing were made; iii) Interviews and focus group discussions carried out.

*Sub-study e)* Assess districts' ability to develop and operate a system of community-based commodity sales of drugs, bed-nets, etc.

*Methods:* i) Questionnaires, and ii) KI interviews were used.

*Sub-study f)* Assess whether private health units were established in under-served areas supported by the project.

*Methods:* i) We reviewed reports on project support to private health units in under-served areas; ii) We obtained a list of newly established private health facilities in the project from the medical registrar; iii) The facilities were visited and studied through a questionnaire and interview of KIs.

Evaluation study 4: Assess district capacity building to support decentralization policy.

This study comprised of the following sub-studies:

*Sub-study a)* Decentralization of the health budget.

*Methods:* i) Health budget and expenditure data at the Ministry of Finance and MOH were reviewed, ii) District financial reports and activity reports were also reviewed and compared with the period before decentralization, iii) Views were gathered from districts and the centre through interviews and questionnaire. The study focused on:

- Allocation of decentralized funds for health services by districts.
- Actual expenditures of the decentralized fund
- Proportion of decentralized donor-external health resources

*Sub-study b)* Assessment of staffing levels and institutions for decentralized operations

*Method:* Analysis of actual staffing and institutional set up against the prescribed standards in the decentralization policy. This involved interviews and observation on the ground.

*Sub-study c)* Assess whether budgeting, financial management, health information system, planning and supervision at the district level had been strengthened



*Methods:* i) Financial and annual reports were reviewed; ii) comparison of actual indicators against expected indicators under decentralization was done. The following were in particular assessed:

- District staff trained in financial management
- Whether financial management systems were functional
- The accuracy and comprehensiveness of quarterly financial statements
- Whether financial audits were done and what issues were identified by the audit
- Whether the HIMS was functional and used for planning and management
- Whether reporting on health services by districts was comprehensive
- Review of district progress reports
- Whether district health management committee and other structures were functional

Evaluation Study 5: Assess the restoration of the functional capacity and improvement of the efficiency of existing government health facilities.

*Methods* i) Reports on different aspects were reviewed. Most of these were routine reports and others reports were from specially commissioned studies; ii) Verification of facts and figures was carried in the field to check the accuracy of the reports, or where there were doubts, or conflicting facts. The studies covered the assessment of:

- physical rehabilitation and re-equipment of health facilities
- compliance with quality standards of rehabilitation and equipment
- compliance with minimum staffing standards
- drug needs quantification desegregated by district
- whether demand-driven drug procurement system was established and functional
- whether legislation on greater autonomy of hospitals and health training institutions was established and implemented
- whether policy on how to improve the effectiveness of training was established and implemented

Evaluation study 6: Assessment of the extent to which a greater role of NGOs, the private sector and communities had been achieved.

*Methods:* i) Supervision reports submitted by districts were reviewed; ii) Records on NGOs and private firms were obtained from the Registrar's office and reviewed; iii) Memoranda of understanding were analyzed against financial and audit reports; and iv) Reports of studies on contracting out services to NGOs were reviewed and the analysis was integrated with the reviews of other reports and data. This study focused on the following variables:

- Supervision of government health facilities by NGOs
- Participation and recognition of NGOs in district health service delivery
- Financial support to NGOs per district as percentage of district public expenditure
- Total support to the private-for-profit sector, as percentage of the total district health expenditure
- Lessons on contracting of health services to NGOs
- Whether annual reviews of NGOs and CBOs are carried out

Evaluation study 7: Assessment of the capacity of the MoH for policy, planning, research, training, setting of standards and supervision

*Method* i) The following were reviewed and analyzed:

- MOH structure in relation to the constitutional provisions
- Policies and policy documents

- The National Strategic Health Plan and how it relates to the health policy
- Health service standards, plans and reports.
- Current laws and regulations against the old ones, and studies to find out if there is compliance.
- National joint supervision reports by GoU and donors; against other independent reports on progress in the health sector

*Method ii)* Through KI interviews and physical attendance in 6 project districts the process of health policy-making and planning was studied. The key variables were:

- Reduction of the size of MOH
- Consistency of MOH's new roles with decentralization
- Capacity of MOH to analyze and set policy agenda
- Health policies address key health sector issues and problems
- The use of the National Strategic Health Plan to guide district planning
- Availability of health care and service standards are available, and in use
- Availability of updated laws and regulations governing the health sector, and a mechanism for ensuring compliance
- Proportion of annual work plans (both central and districts) prepared in time for the new financial year

#### *Review of primary school reforms*

Reports and documents on UPE were reviewed for the 3 pilot districts under DHSP: Masindi, Mukono and Soroti. The following variables were studied:

- Enrollment of school-going age total and sex
- Physical structure
- Scholastic materials
- Classroom condition: spacing, ventilation, safety etc
- Availability and cleanliness of water source
- Availability and adequacy of toilets
- Hygiene of students
- Availability/access to health service
- Student performance in national exams.

#### *Review of health policy and regulation*

The study of the effect of policy and regulation on the health sector in Uganda was done through document review and key informant interview of policy-makers and other stakeholders. Themes covered in the interviews with policy makers included:

- How public policy affects the private and public sectors: specifically looking at overall economic framework, regulation/laws, effectiveness of policy/law implementation
- How policies are made: normative process, actual process, who makes decisions, what causes the difference between normative and actual process?
- Problems impeding the health sector reform
- How does the private sector contribute to or solve these problems?
- The desired role of the private sector
- Actions that have been identified and are being supported to increase private sector contribution to health sector performance
- Implementation and evaluation of policies and regulation
- Perceived and actual policy implementation

The target groups for the interviews were:

Policy-makers: Decision-makers and advisors were limited to: Permanent Secretary, Directors, Commissioners, Assistant Commissioners, and Technical Advisors in the ministries of Health, Finance, Local Government, Justice and Labour Gender and Social Development. These ministries were selected upon realizing that policies affecting the private sector for health include those made in other ministries which were listed above.

Donor s: These include all categories of donors plus their agencies and collaborators

District Authorities: These included district, sub-district and urban authorities

Non-Government Organizations: These included local and international NGOs, including community based organizations and civil society organizations.

### 4.3 Study methods for Paper III

This paper was based on a study to compare decentralization in Uganda with that in Zambia, to learn from the Zambian experience. The Zambian health-sector decentralization was said to have been successful and was becoming a model for other African countries to learn from. Uganda had embarked on holistic or political decentralization but the health sector's decentralization had not been well defined and was not operating well. The work was divided between the two authors: Jeppson mainly worked on Zambia and I on Uganda. My overall task was to design a workable health-sector decentralization in the context of Uganda's overall decentralization policy. The study was based on four approaches:

#### *Approaches*

a) Systemic literature review: This was done on decentralization concepts, principles and issues in general, and about decentralization in developing countries. We categorised the literature papers as follows: i) papers on principles and theory; ii) decentralization in developing countries, especially Africa; iii) decentralization in Zambia; and iv) decentralization in Uganda.

b) Joint tours: An 8-member team travelled to Zambia and another Zambian team of six travelled to Uganda three months later. Zambian MOH officials were equally anxious about some of the drastic changes that had been made in the health sector and wanted to learn about its model of political decentralization, which had become a model for other countries to emulate. The Ugandan team to Zambia included the two authors of the paper (my advisor and myself). The team developed questionnaires to interview six categories of respondents: government officials (from MOH, MOF, national/referral hospitals); managers of lower level health facilities; district health, administrative and political leaders; and leaders of NGOs and private sector health institutions. An observation checklist was drawn to record the following: type and level of decentralization; level of re-organization; health facility management arrangements and functions; new roles of the MOH; Collaboration with NGOs and the private sector; lower level health facility and interface with the community; planning and budgeting at different levels; financial management arrangements; user-fee implementation; health care package selection and sizes at different levels of care; staffing at different levels; donor coordination at different levels. Similar interviews and observations were done for Uganda.

c) The Ugandan Study: Four methods were employed to carry out the study. First, available literature about decentralization and health systems in general, and in the context of Uganda in particular, were reviewed. Second, existing data from the routine health information system was reviewed since special surveys were not required in the study. Third, key officials at national, district, sub county and health unit levels were interviewed both informally and using semi-

structured questionnaires. Fourth, focus-group discussions were held with district, sub county, community and health unit leaders and officials.

Six districts were selected on the criteria of distance (from MOH headquarters), region and phase of decentralization. Districts were selected from all regions except northern region. The northern region was not studied owing to financial limitation and insecurity. Four districts were in the first phase of decentralization to which recurrent funds started to be transferred in July 1993. One district was in the second phase where financial decentralization started in July 1994. And one district was in the third phase where financial decentralization had not yet started but was due to start in July 1995.

Each district visit started with a courtesy call on political (elected) leaders. In some districts (Tororo, Masaka and Kiboga) elected political and appointed leaders formed discussion groups. In the other districts, leaders were seen separately. Except for Mbarara and Kasese districts, at least three government health units were visited in each district including a hospital, a health centre and a dispensary. Discussions were held with four key officials of MOH and MOLG, and the Director of the Mulago National Referral Hospital. The total number of respondents was 101.

Tables 6, 7 and 8 summarize the distribution of districts, number and type of respondents/participants, and number and type of health units.

Table 6: The selected districts, number of health units and respondents

DISTRICT	REGION	HEALTH UNITS	RESPONDENTS/PARTICIPANTS
Kasese	West	2	5
Kiboga	Central	5	30
Masaka	South	3	21
Mbarara	West	1	3
Mpigi	South	4	20
Tororo	East	5	22
Total	-----	20	101

Table 7: Types of respondents/participants in the study

DISTRICT	POLITICAL LEADERS	ADMINISTRATORS	HEALTH WORKERS	COMMUNITY LEADERS	TOTAL
Kasese	0	0	5	0	3
Kiboga	3	1	10	16	30
Masaka	2	2	8	9	21
Mbarara	0	0	3	0	3
Mpigi	1	2	7	10	20
Tororo	2	2	12	6	22
Total	8	7	45	41	101

Table 8: Types of health units visited

DISTRICT	HOSPITAL	HEALTH CENTRE	OTHERS	COMMUNITY PROJECT
Kasese	Kilembe	Kilembe	-	
Kiboga	Kiboga	Bukomero	Ntwetwe DMU	Ntwetwe

			Kyanamuyonjo DMU Gayaza SD	Maternity Kyanamuyonjo Integrated Bukomero Inpatient Ward
Masaka	Masaka	Kinoni Kalungu	-	-
Mbarara	Itojo	-	-	-
Mpigi	Entebbe Grade B	Wakiso	Ngando DMU	Ngando Inpatients Ward
Tororo	Busolwe Tororo	Masafu Nagongera	Busia Disp.	Masafu Operating Theatre

DMU = Dispensary and Maternity Unit

Disp = Dispensary

SD = Subdispensary

d) **Consultation and consensus meetings:** These meetings were held to discuss and agree on the findings, recommendations and the way forward.

#### 4.4 Study Methods for Papers IV and V

These papers arose from a study that was conducted to find out why despite years of HSRs, infant and maternal mortality increased rather than decreased. This was according to UDHS 2000/01, in which it was found that mortality of infants and mothers had increased between 1995 and 2000. Concerned about this trend, the government through MFPED formed a multi-sectoral mortality task-force. Concerns had been raised about funding ceilings set up by the MFPED which restricted funding to social sectors. This was said to be a measure for stabilising macro-economic drivers, especially inflation. Also, a new policy on aid was that for any amount of health aid brought into the country, the equivalent would be offset from the national budget allocation for the health sector – in effect leaving with health sector with the same level of funding, but less and less funding per capita since the population was growing at 3% per annum.. Another policy on aid was that health aid could be rejected if it was determined that this would upset macroeconomic stability. But no evidence of how the upsetting would be caused was given. Nor was there a transparent process of how it would be determined that a certain amount of external aid would cause macroeconomic upset. I was appointed principal investigator and writing author for the study. Five approaches were used in the study:

##### a) *Sub-national health systems assessment*

WHO in its 2000 World Health Report had proposed a framework for assessing the health system performance that has been extensively modified. The framework provides a systematic approach to analyzing different aspects of health system performance from inputs through to functions, achievements in intermediate goals such as coverage and provider performance, to overall health system goals and efficiency. The methodology relies on using information from different sources for issues that impact on the overall performance of a health system. A tool developed by WHO to guide the assessment of health system performance was used.

The four components on which the assessment was based were:

- a) Health system inputs/resources
- b) Health system functions
- c) Health system outcomes/goals

d) Health system efficiency

In the assessment, the following available data sets were used:

- i) The Uganda Demographic and Health Survey (UDHS) of 2001/02. The Demographic and Health Survey provides data on demographic patterns, utilization of health services, morbidity and mortality of populations.
- ii) The Uganda National Household Survey (UNHS) of 1997, 2000 and 2003. The National Household Surveys provide data on illness patterns, health-seeking behaviour, expenditure on health by different social economic categories, age groups, gender and vulnerable groups e.g. orphans.
- iii) The Ministry of Health Statistical Abstract of 2002. The Ministry of Health Abstract provides data on access to health services, availability of beds and human resource by districts and, utilization of health services.
- iv) Uganda National Health Accounts data for 1998/99-2000/01. The National Health Accounts provides data on health expenditures at the different levels of service delivery.
- v) The Population and Housing Census of 2000, which provided population figures by district and by sub-county.

**b) Study to develop a mortality reduction M&E framework**

A framework for monitoring the reduction of infant and maternal mortality was developed. The study involved:

- 1) Review of relevant documents
- 2) Interview of stakeholders
- 3) Reviewing sector specific reports
- 4) Preparing and discussion of a synthesis report by stakeholders.
- 5) Assessing M&E approaches currently used for their strengths and weaknesses in addressing mortality.
- 6) Identifying specific indicators for mortality reduction

The key elements to assess as M&E and feedback are summarized in the table 9.

Table 9: Key elements for M&E and for feedback

Elements	M&E	Feedback
Identification of the key causes of mortality	Reduction of the causes over time. Indicators: Mortality Rates	Identification & inclusion of new or other causes of mortality.
Poverty reduction policy is oriented to focus on mortality reduction	Economic policy is pro-poor Growth ahs human face. Social sectors mainstream mortality reduction. Gender equality Women Empowerment	Identify and include other issues or why sector goals are not being achieved, and how this should be addressed.
Economic growth Rate of real poverty reduction Social welfare	Rate of economic growth Income equity Access to social services Quality of social services	Identify and include other factors that may be hampering progress.

	Gender equality	
Mortality reduction	Infant mortality Maternal mortality Gender equality	Assess pace of change versus strategies & resources. Include better strategies.

Source: author's compilation

**c) Systematic review of literature, reports and related materials on mortality**

The materials reviewed were categorised to cover: i) general concepts, issues and knowledge about infant and maternal mortality; ii) general and specific issues about health and economic policies in Uganda; iii) official reports of major surveys and studies; namely: UDHS 1995, UDHS 2000/01, Populations Census and Housing Census 1992, and Household Surveys 1995 – 2002; iv) all policies that had a major bearing on mortality of infants and mothers. "Major bearing" was derived from the determinants of health and agreed on by the task force. The policies were on such health determinants as nutrition, health, agriculture, education, transport, the economy, water and sanitation, land, gender and women empowerment; v) reports on the implementation of various programmes such as young child and mother nutrition, UPE, EPI, reproductive health, child welfare and rights, gender equality, and gender equality and women empowerment; vi) reports from international organizations about health, the economy and mortality. These included the World Bank inspired PRSP/PEAP, various reports by WHO, Unicef and other international organizations. Review methods are summarized in table 10.

Table 10: Methods of systematic review of literature on mortality

Key Tasks	Method	Outputs
1. Identify Causes	Literature review Comparative analysis	Causes in general Causes in Uganda Causes by level
2. Identify interventions	Literature review Comparative analysis Evaluation of Uganda's policies	Critical interventions Lessons from successful, unsuccessful countries and from Uganda.
3. Review existing policies	Evaluation against policy objectives related to mortality	Key policies affecting mortality Gaps and weaknesses in policies Recommendations
4. Identify household and community challenges	Review of reports Evaluation against key problems	Problems and issues identified Existing strategies to address these effectiveness & weaknesses identified
5. Formulate a strategy	Based on outputs in 1-4, deduce strategies	Strategic issues identified Strategic actions identified Strategic plan in log frame with M&E indicators developed.

Source: author's compilation

d) *Routine task-force meetings*

These meetings were to discuss and agree on the report format, key issues and their interpretation.

e) *Consensus meetings:*

Meetings of stakeholders were held to agree on recommendations and a way forward with respect to addressing the escalating mortality.

## **4.5 Ethical considerations**

The thesis studies were done over a period spanning more than 15 years. In the earlier years, ethical committees/procedures were not readily available. Today, such studies would all have to be approved by the National Council for Science and Technology. For the study on paper II, approval was obtained from Makerere Institute of Social Research and Economic Policy Research Centre ethics committees. For studies on Papers I, II, IV and V, approval was done by a research committee of the MOH. Permission to carry out the studies was granted by the Permanent Secretaries of MOH and MFPED (Papers I & III and IV & V respectively). In addition, permission to carry out the study in the selected districts was sought from District Local Councils, the Chief Administrative Officers and District Health Officers, (formerly called District Medical Officers or DMOs). Written informed consent was obtained from each respondent and confidentiality was ensured throughout data collection, entry, analysis and dissemination.



## 5.0 RESULTS

### 5.1 Uganda: A context of instability and poverty

Uganda is a poor country that has been unstable politically and socially. Table 11 summarizes the country context in which the reforms were done.

Table 11: Uganda country context

Variables	Findings	Sources of information
Socio-economic status	Poor country with GDP per capita of 250 USD	Papers II & IV
Political and social stability	45 years of total or partial instability	Papers I & IV
Status of health system	Infrastructure completely or partially destroyed by 1986; only 4% of facilities can handle emergency	Papers I, II, IV
Health system models	Hospital-based, PHC-based and market-based: None has been found satisfactory	Paper IV
Health sector objectives	Little progress made; some indicators are at the same level, others have worsened.	Paper II

*Source: author's compilation*

### 5.2 Overall evaluation of health sector reform

The overall evaluation of HSR in Uganda was based on two sets of indicators, those that assess health care and status (Table 12) and those that assess specific reform objectives (Table 13). Under health-care and status, except for some improvement in access to safe water and sanitation, all other indicators show a worsening trend during or after the reforms. The recently published Demographic and Health Survey (2006) shows that mortality rates (IMR, MMR and CMR) have been significantly reduced. The rates are now officially taken as 76/1000, 435/100,000 and 137/1000 respectively. Thus, while some reduction has been achieved, maternal and childhood mortality rates are still high.

Table 12. Health care and status trend in Uganda over 20 years

Indicator	Before reforms 1985 – 1995	After reforms 1996 – 2005	Trend
IMR/1000	81	89	Deterioration
MMR/100,000	506	505	Persistently high
CMR/1000	147	151	Deterioration
Child nutrition (%)	6.2	7 – 8	Deterioration
Access to EMOC (%)	---	14	Probably worsened
Access to facility-based delivery (%)	38	38	Persistently low
Life expectancy (in years)	51	47	Deteriorated

Access to safe water (%)	34	51	Improved
Access to sanitation (%)	39	54	Improved

Sources: Paper IV

Table 13: Performance of specific reform objectives

Reform objectives	Expected result	Actual result	Evidence
Equity	Increased physical and economic access	Physical access improved, but not economic access	At least 40% sick people are discouraged by costs from seeking health care
Efficiency	Increased output DALYs /input (resources)	No evidence of improved efficiency	Recent studies show significant resource increase in health sector, but not reflected in better outcomes
Quality	Increased technical and client perceived quality	No improvement or even worsening of both types of quality	MOH's own reports point out major issues of quality (GoU, 2006b)
Health status	Remarkable improvement	Deterioration, stagnation or marginal improvement	UDHS 1995, 2000, 2006.
Sustainability	Dependence on external funding of health care will significantly reduce	Dependence has remained same or even increased, with even the private sector depending on donor aid	Global Health Initiatives have double funding to Uganda since 2004, but Government health budget has stagnated or even reduced in real terms

Source: Report of study for Paper II

The HSR reform objectives have not been achieved (Table 10). In addition, HSRs are associated with some issues in the health sector that have worsened or complicated the performance of the sector. These include aid, through which the reforms were imposed or enforced; macroeconomic policies, to which the health sector has to conform; the primacy of economic growth over human development; the deepening and widening of corruption due to the erosion of legality associated with free-market economics; the weakening and disorganization of the national health system and capacity by parallel arrangements like projects, international health initiatives (e.g GFATM, GAVI etc) and SWAP; and the fact that HSRs have in effect increased dependence on aid and technical assistance, and hence pushed the country further away from independence and sustainability (Table 14).

Table 14: Issues associated with health sector reforms

Issues	Findings	Sources of Information
Aid	Interruptive & destructive to health systems	Papers I, II
Macro-economics and health	Macro-economic stability achieved through under-spending on health	Paper IV

Economic development	Government policy position is that economic growth should be achieved first, before social services can be improved	Paper II
Corruption	Levels of corruption have deepened and widened. The massive embezzlement of GF and GAVI funds	Paper II
Capacity	Weakened and disorganized national capacity to build and sustain HSD. Key factors are aid and SWAP.	Paper II and IV
Sustainability	HSD and financing not sustainable in foreseeable future: 60-80% of health sector funding is from donor aid	Paper II

Source: author's compilation

### 5.3 Individual reforms implemented under DHSP

The overall objective of DHSP was to demonstrate on a pilot basis the feasibility of delivering an **essential health package** (EHP) through improvements in policy, institutional organization and financial management. The specific objectives were to pilot new policies (reforms), strengthen district level planning and management, and restructure the MOH. The project was divided into two main components, pilot and capacity building. Under the pilot component, the following ways were tested for delivering an essential health-care package (EHP). The results below were obtained from the final evaluation of DHSP, which was the basis for papers IV and V.

Under new financing mechanisms to be introduced, **user-fee** was the main strategy promoted under this project.

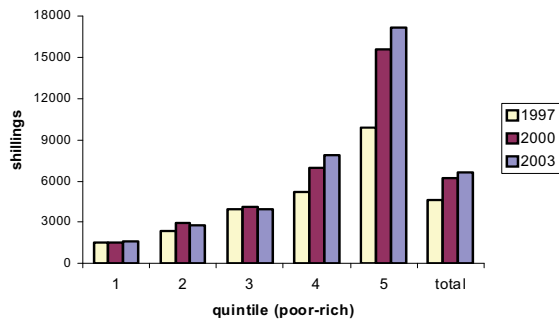


Figure 8: Out of pocket expenditure by quintile (1997 -2003).

Source: Report of study for paper IV

**User-fees**

The user-fee bill had previously been rejected by the Parliament (Paper I). But a loophole was found in the Local Government Act of 1997 which allowed local authorities to charge fees at their discretion for services they provided. Under the project, numerous studies were completed and a user-fee policy was finally drafted. It had been proposed by the project to **price services**, but this was eventually left for the health unit management committees to decide. The committees preferred flat user-fee rates to graduated fees. Graduated prices were found to be difficult to calculate, understand and manage. Experience has shown that health systems, which rely less on out-of-pocket payments (OOP) as a way of paying for health-care, generally protect the poor better from catastrophic spending.

User-fees as a deterrent to seeking care: Figure 8 gives the percentage of people who did not seek care, mentioning user-fees in health facilities as a deterrent. There is a decreasing trend over the surveys as a result of local resistance to user-fees and their eventual abolition in 2001.

Generally, there were no significant changes over the three surveys, although a slight increase is noted between 2000 and 2003 in the poorest quintile, and quintile 4 shows an increasing trend (Figure 9).

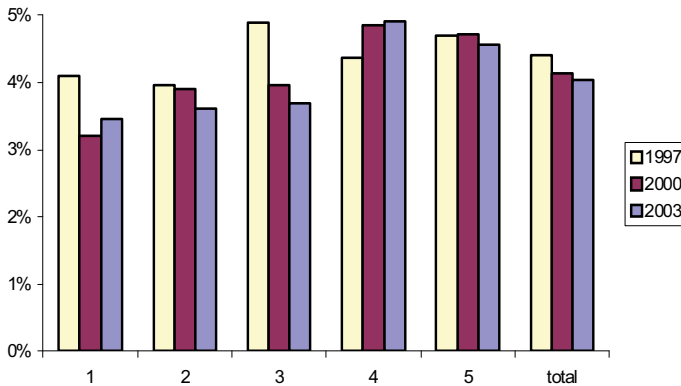


Figure 9: Out-of-pocket expenditure on health as a share of total household expenditure by quintiles (1997-2003).

*Source: Report of study for Paper IV*

Hospitals and drugs constitute the bulk of out-of-pocket spending across all income groups and across all surveys (Figure 10).

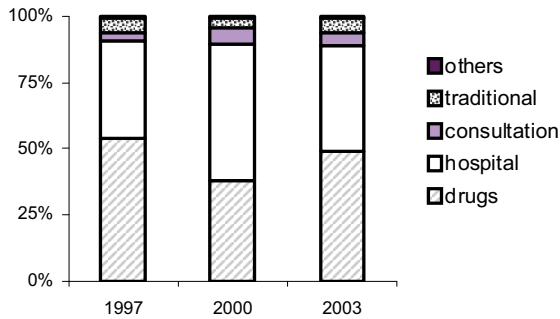


Figure 10. Components of OOP health expenditure.  
 Source: Report of study for Paper IV:

**Catastrophic health expenditure:** This is defined as out-of-pocket health expenditures that is equal to or exceeds 40% of household non-subsistence spending. This results into reduction of expenditures on other basic commodities.

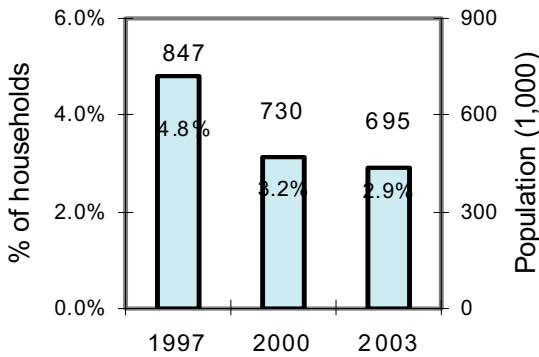


Figure 11. Percentage of households facing catastrophic expenditures.

Source: Report of study for Paper IV

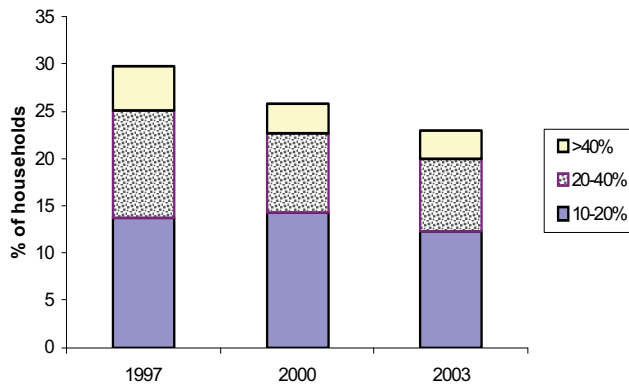


Figure 12: Percentage of households incurring high levels of spending (1997 -2003).

Source: Report of study for Paper IV

The proportion of households facing catastrophic expenditure is low for all the surveys and shows a decreasing trend (Figure 11). The lowest reduction was recorded between the 1997 and 2000 surveys. The proportion of households incurring catastrophically high health spending (over 40% of disposable income) fell from 5 to 3% between 1997 and 2003 (Figure 12). The proportion of households at risk of catastrophic spending (those already spending between 20-40% of disposable income) also decreased from 11 to 8% over the same period, signifying that the government had not provided adequate financial risk protection prior to the abolition of user-fees.

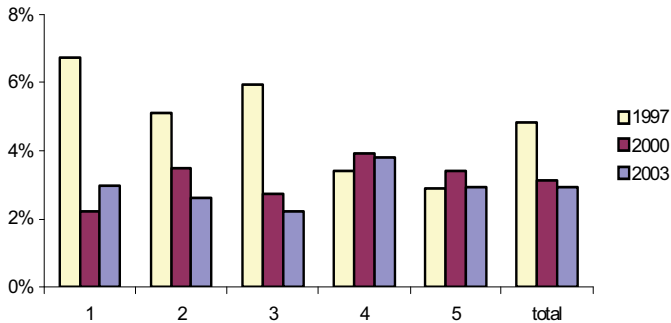


Figure 13. The proportion of households with catastrophic spending by quintile.

*Source: Report of study for Paper IV*

Catastrophic spending occurs in all income groups, although for all groups together, catastrophic spending was significantly reduced between 1997 and 2000 (Figure 13). It fell again after the withdrawal of fees for the 4 richest quintiles from 2000 to 2003, although it increased for the poorest quintile after the withdrawal of fees. There are two possible explanations. After the reform of user fee, utilization of health services in both public and private facilities increased significantly for the poorest quintile. Even though the consultation in public facilities is free, patients may have to pay for tests, hospitalisation and some medicines when they are not available in public facilities and transport costs. Public health system, which is free, may not offer most of the services that predispose the poor to catastrophic expenditures. The capacity to pay for these services among the poor has reduced, as shown by the increase in the proportion of people living below the poverty line from 35% in 1999/2000 to 38% in 2000/2003. There may be under the table payments.

Causes of catastrophic payments: Not surprisingly, the use of health facilities inevitably increases the risk of incurring catastrophic expenditures in countries where comprehensive risk protection mechanisms are limited. This is the case in Uganda where OOP share of total health expenditure is high (>40% in 2003). People using public facilities are at less risk than those using private facilities, but the former does not fully protect people from catastrophic spending, since, as mentioned before, patients still have to pay for various items. Households with elderly members are at greater risk of incurring catastrophic spending, as are poor households, holding all other factors constant including the use of facilities (Figure 14).

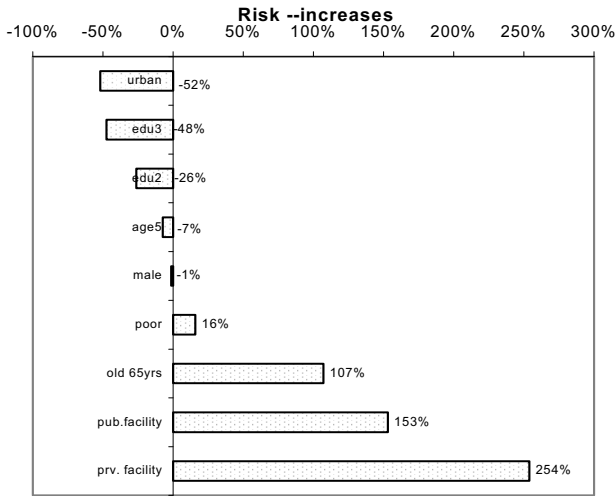


Figure 14: Risk to incur catastrophic expenditure.  
 Source: Report of study for Paper IV

**Impoverishment:** Households are pushed into poverty as a result of seeking health-care. The percentage of households impoverished by OOP expenditure on health is generally low and shows a decline overtime time (Figure 15). There were fewer households impoverished as a result of health spending in 2003 compared with 2000. This resulted from the abolition of cost sharing in all public facilities, a policy decision taken in March 2001.

Note that the percentages started falling before the abolition of user-fees. The decrease in

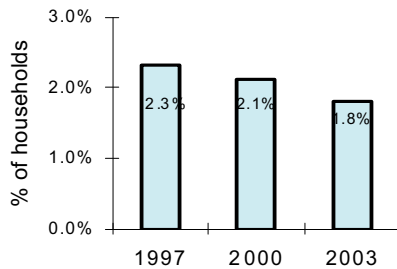


Figure 15: Percentage of households impoverished as a result of seeking care.  
 Source: Report of study for Paper IV

poverty could have contributed to the improvements seen between 1997 and 2000 (from 44 to 35% of the population living below the poverty line in 2000).



**Revolving funds (Paper II)**

It had also been proposed that funds should be generated through **revolving drug funds**. But it became logistically difficult to create a fund at the district level since there were many sources of pharmaceuticals and the procurement system for each source was different. It was eventually concluded that revolving drug funds were not possible until the management of drugs from the different sources was harmonized.

**Prepayment schemes (Paper II)**

Other health financing mechanisms piloted were **prepayment schemes** linked to hospital services, and **income generation** ventures. The prepayment schemes were small-scale and proved to be successful. They were supported by donors who financed the operational costs and the reinsurance. The schemes were in communities that had reliable and regular harvests of cash-crops, which enabled households to make their contributions. In one scheme, the communities already had sickness societies upon which this scheme was built. The schemes were neither sustained over time nor scaled-up. Income generation activities were tried but were not found to be sustainable or useful for addressing entrenched poverty and ill-health faced by most of the communities.

**Health insurance (Paper II)**

An evaluation study under DHSP to assess **health insurance** feasibility in Uganda proposed compulsory mutual funds for large firms and for civil servants. It also proposed voluntary health insurance for the rural population and for those in informal employment. The study recommended medi-save programmes for those who could save money on prepaid health-care plans (Berman et al. 2001). But these proposals required major changes in the laws governing employment and salaries. This has, up to now, been a contentious issue, with civil servants arguing that their salaries are too small to raise the insurance premium. Estimates of potential enrollees for social health insurance (SHI) in Uganda presented in Table 15.

Table 15 Estimates of potential enrollees for SHI in Uganda

	Estimated number of potential enrollees	Average monthly salary (Uganda Shillings)
<b>Most reliable estimates</b>		
- Civil servants	67712	122783
- Teachers	116194	90571
- Total public sector	183906	102431
<b>Less reliable</b>		
- Private sector employees making regular payments to NSSF	80000	168589
- Private sector employees registered by Uganda Revenue Authority as taxpayers	120000	139991

*Source: Report of study for Paper II*

After a systematic assessment of potential enrollees and their incomes and other related data, it is estimated that just over 300,000 workers could potentially be reached with SHI. Another 100,000

could be included by the Uganda Revenue Authority as having regular taxable income, and making a contribution of 4% of income to the SHI. Table 16 presents projections of revenue from groups of workers.

Table16: Estimates of expected monthly revenue for SHI in Uganda

	Number of contributors	Total monthly revenue base (Ug Shs)	Expected monthly revenue at 4% (Ug Shs)
Civil servants	67,712	8,313,882,496	332,555,300
Teachers	116,194	10,532,806,774	420,952,271
<b>Total public sector</b>	<b>183,906</b>	<b>18,837,689, 270</b>	<b>753,507,571</b>
Private sector	220,000	30,798,000,000	1,231,920,000
Total	403,906	49,635,689,270	1,985,427,571

*Source: Report of study for Paper II*

The total annual revenue from SHI would be about Ugsh 24 billion (compare with the total annual public sector health budget of Ugsh 300 billion). And yet there is no guarantee that the government would not reduce (instead of maintaining or even increasing) the health budget. The principle of additionality of the budget (to meet the MDGs) has been broken by the government, in the case of GFATM, thanks to the macro-economic policy. There is inadequate institutional capacity, which requires investment and time to build. Above all, SHI requires changes in attitude, knowledge and expectations. All these require time and investment on the part of the government. SHI is only a means to an end, which is the equitable and sustainable health-care system. SHI is a long-term contract and requires long-term commitment. This has so far not been demonstrated by the government. In SHI, people show perverse behaviour: providers demand more payment; payers want to pay the minimum premium, and employees want more pay for less work. Getting the right design and structure of the SHI is critical. But without initial investment by the government to get the SHI structure right and operational, it is highly unlikely to succeed.

### *Encouraging private health insurance (Paper II)*

The project sought to encourage **health insurance for private firms**. Not only did a study under the project find private insurance feasible, but an on-going practice. However, this did not address the fate of the vast majority who had no health insurance or access to basic health care.

### *Health trusts (Paper II)*

Health trusts were first to be tried in Mulago Hospital. Health trust funds were to go hand-in-hand with the creation of 12 hospitals as autonomous entities. But the policy and law to carry out this reform got embroiled in politics.

### *Hospital autonomy (Paper II)*

Studies (eg Ssengooba et al. 2002) have shown that there is little evidence in Uganda or elsewhere that autonomy improves hospital performance. A study of mission (autonomous) and government hospitals (non-autonomous) did not show any significant difference in patient load (Table 17) or quality of health care (Table 19), but mission (autonomous) hospitals appear to be more efficient in staff use mainly a result of motivational incentives (Table 18). The efficiency, however, is not reflected in the total expenditure or bed-use. Instead, **hospital autonomy** and

**trust funds** were seen as limiting access to public hospitals for the majority who have nowhere to go for hospitals services.

Table 17: Hospital workload over two years 1998 – 2000

	Rukungiri district		Masaka district		Luwero district	
	Kambuga Public	Kisiizi Mission	Masaka Public	Kitovu Mission	Nakaseke Public	Kiwoko Mission
Maternal patient load	15,192	24,560	38,152	20,374	15,408	24,931
Child patient load	40,356	65,352	33,856	59,174	54,326	33,288
Adult patient load	63,967	43,163	84,497	48,701	57,130	49,351
Diagnostics	19,691	19,033	19,533	30,494	4,567	16,878

*Source: Sengooba et al, 2002*

Table 18: Average annual workload per health worker

Districts	Public/ Not autonomous	Mission/ Autonomous
Luwero	1,480	1,510
Masaka	857	1,211
<b>Rukungiri</b>	1,808	2,500

*Source: Sengooba et al, 2002*

Table 19: Perceived average quality scores in 1998

	Public hospitals	Mission hospitals
Availability of drugs	1.25	1.57
Attitudes of providers	1.50	1.50
Technical skills	1.64	1.45
Privacy	1.66	1.67
Total	1.61	1.62

*Source: Sengooba et al, 2002*

### ***Greater autonomy or privatization of National Medical Stores (Paper I)***

National Medical Stores (NMS) is 100% state-owned. It was established to ensure efficient and economical procurement of pharmaceuticals, and to provide secure, safe and efficient storage, administration, distribution and supply. It was also to ensure quality of medicines, and to estimate current and future medical supply needs of the country. But in line with free-market principles, the NMS was to be restructured to become autonomous or privatized. Numerous studies were carried out, the latest being that commissioned under the Privatization and Utility Sector Reform Project, funded through a World Bank loan (Medical Care Development International (MCDI) and Serefac Consultants Limited (SCL), 2006).

But recommendations that NMS be made autonomous or privatized have met with three main snags: it is the only institution in the country 1) with adequate capacity to handle donor / NGO drugs that are donated, which constitute a sizable proportion of pharmaceuticals in the country; 2) that has capacity to provide drugs to the under-funded district local governments on loan; and 3) that can stock unprofitable drugs such as vaccines and certain obstetric drugs (eg oxytocin). Thus, NMS has continued to be funded by the government through grants. It has been realized that the much-desired self-financing status of NMS cannot be attained without it breaking even in financial terms. To do so, it has to abandon its “public goods” role of stocking and distributing unprofitable but essential pharmaceuticals, such as rabies vaccine.

### *Contracting (Paper II)*

**Contracting** as a management strategy was promoted by the project. This was done successfully for health-care and non-health-care services to the private sector, NGOs and missions. The idea was that services would be more available and efficient. While contracting in itself was found to be a good thing, the experience in Uganda was that it did not make services more available for the population, and there was no evidence that contracting of services was more efficient or cheaper as has often been claimed (GoU 1998, a study report for Paper II).

### *Payment incentives (Paper II)*

Payment incentives for health workers were a key reform to be introduced. A study commissioned under DHSP was done in Kabale district to identify and recommend ways of motivating health staff through payment incentives (Kabwiga 1996). The study found that the staff salary was below their monthly expenditure. Most of the incentives were not met because of a public sector system that had been weakened and disorganized by free-market reforms and under-funding (Paper I). Table 20 provides a summary of the state of incentive mechanisms in Kabale hospital.

Table 20: Status of incentive staff mechanisms in Kabale hospital (Kibwiga, 1996, a study report for paperII)

Mechanisms	Yes	No	Total no of staff
Night allowance	0	41	41
Safari allowance	0	41	41
Transfer facilitation	11	8	19
Salary	41	0	41
Lunch allowance	29	12	41
Further training	3	38	41
Uniform	9	30	39
Residential accommodation	24	17	41
Medical treatment	0	41	41
Leave	3	38	41
Transport	36	5	41
Confirmed in service	3	12	15
Promoted in service	0	15	15
Informed about policy	0	41	41
Involved in planning	0	41	41

Involved in meetings	0	41	41
Supervised	9	1	10

*Source: Report of study for Paper II*

The staff took off part of their official work-time to earn a living through trading and farming. It was recommended that health workers get at least a living wage to deter them from taking off work-time to make ends meet. In addition, performance-based rewarding, co-ownership of motorcycles and bicycles (to acknowledge and incentivise the staff, who were using these transport equipment for private purposes already anyway), and improved staff appointments and promotions were recommended. A bonus-scheme to reward good performers was tried but was stopped because the rewards were corruptly changed to pay workers by seniority rather than by performance.

### *Community based commodity distribution (Paper II)*

**Community-based mosquito-net distribution** was stopped due to the doubt cast by a World Bank mission team about the cost-effectiveness of such a scheme (GoU 1998 and Paper I). But today, widespread distribution of nets throughout communities is acknowledged as one of the most effective ways of tackling malaria (Cohen and Dupas 2007; Okuonzi et al. 2007).

### *Eliminating barriers to health care market (Paper II)*

To **eliminate legal barriers to health care market**, a study (for Paper II) was done to identify such barriers and recommend how barriers could be eliminated. The barriers were identified as centralized and bureaucratic registration and licensing, long and mandatory pre-certification period before private practice, not allowing stock-piling of drugs in private clinics, restriction of ownership of private practices only to professionals, no incentives to attract private practitioners to undeserved areas, and substantial critical capital required to start a private practice. The study made the following recommendations: 1) Licensing should be every 3-5 years, not annually; 2) Decentralize registration and licensing of private practice; 3) Rescind laws preventing stock-piling drugs in private clinics; 4) Government to provide soft loans to private practitioners; 5) Selected public health services should be licensed; 6) Formalize the relationship between the government and the private sector; 7) Government to increase grants to non-profit private health care providers (the mission health facilities); and 8) Enforce laws and regulations

Many of these recommendations had begun to be incorporated into the law and policy by early 2000's, but the process has stalled. However, the formalization of the public-private partnership has been achieved. Also, government grants to non-profit private health facilities have increased, but still fall short of what is required to make the facilities operate effectively. However, soft loans to the private sector and the enforcement of laws were not achieved, because they required better funding and management of the health sector.

### *Promoting the private health sector (Papers II and IV)*

Learning to **work closely with private sector health-care providers** included: private-sector participation in district health planning, direct support to private organizations, training health workers without discriminating between public and private sectors, creating a **private-sector liaison office** in the MOH, and allowing competent private-sector staff with good performance to supervise government facilities. These initiatives were successful to a considerable extent, and became adopted as policy, but the practice has not been sustained.

A private sector programme study (PSP) was carried out to assess its potential to improve health and health-care outcomes (Konde-Lule et al. 2006). This was done against the background that the private sector might offer the best chance for improving health outcomes, which had declined or stagnated. The study found that 45% of the population goes to mission (subsidized) health facilities, 42% to public (free or greatly subsidized), and only 13% to private facilities. The poor and those with very serious illnesses were more likely to go to public health facilities and be hospitalized (Figure 16).

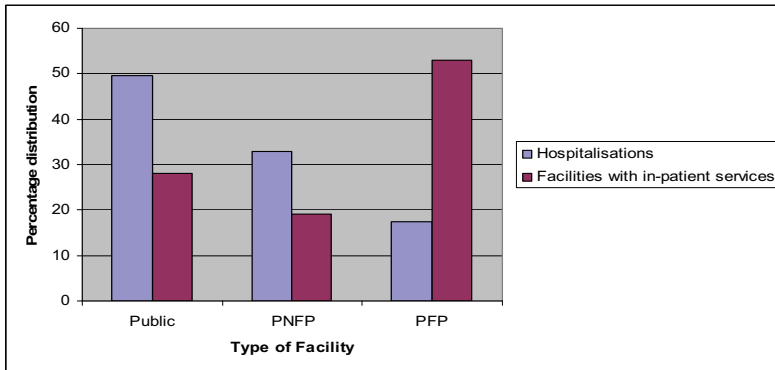


Figure 16: Comparison of reported hospitalisations by type of facility

Source: Konde et al, 2006

The key reasons for choosing health care providers were different for different categories. Public facilities were chosen for perceived better technical skills (45%) and low cost (29%), while mission and private facilities were selected for convenience of location (56 and 59%, respectively). The main reason for doing nothing about a health problem (Figure 17) besides the perception of its being a minor problem is lack of money. It seems evident that there is nothing inherently unique about the private sector that will dramatically improve health outcomes without the improvement of public-sector services in a country where the majority live on less than two dollars a day.

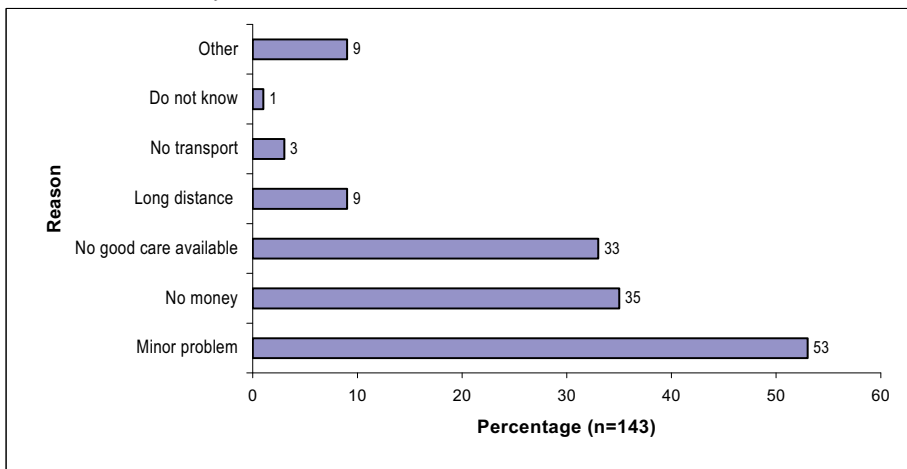


Figure 17: Reasons why household members did nothing about health problems

Konde et al, 2006

**Defining and using the essential health package ( Papers II and IV)**

To **define the essential package of health services**, the burden of disease/cost-effectiveness (BOD/CE) study was commissioned. The idea was to calculate disease-burden for the ten most common diseases and to identify interventions which would best reduce the burden. In theory, these interventions would constitute the essential health-care package. But there were serious methodological problems. Information was not adequate or reliable for such a task. It was difficult to classify some disease conditions, such as anaemia, which cut across many illnesses. After defining the EHP, “cost-effective interventions” – those with the lowest price per life year saved – as a package were found to be largely meaningless in practice (Table 21). For interventions to be effective in public or clinical practice several (usually preventive, curative and promotive) are combined. Health professionals argued that the whole process was time-consuming, complicated and costly, and did not provide any new knowledge. The most “cost-effective interventions” were not the ones that could maximize the attainment of health sector objectives. There was a general lack of confidence and credibility in this mechanical approach to priority-setting (Paper II; GoU 1998 ).

Table 21: Cost-effectiveness of health care interventions for ten common diseases: Selected interventions

Diseases	Interventions	Cost-effectiveness in US\$ per discounted life year saved
AIDS	Sensitization of high risk groups	23,057
AIDS	Sensitization of trained TBAs	107,658
AIDS	Sensitization of religious leaders	155,350
AIDS	Training of community peer educators	638,378
AIDS	Drama shows	9,350
AIDS	Condom supply outreach	3,023
AIDS	Counseling AIDS patients	391,785
AIDS	Case management/treat complications	1,276,791
	Hospital IP (diarrhea, pneumonia, oral candidiasis and skin rash)	
ARI	Health education in the community	69,378
ARI	Immunization against measles in a Health Centre	49,360
ARI	Immunization against measles at an outreach	25,060
ARI	ARI case management Health Centre	1,563
Acute Diarrhoea Disease	Improved latrine construction.	125,823
Acute Diarrhoeal Disease	Water source protection.	5,194
Acute Diarrhoea Disease	Health education schools	3,177
Acute Diarrhoea Disease	Case tracing through home visiting	178,645
Acute Diarrhoea Disease	ORT communication strategic in the community	4,333
Acute Diarrhoea Disease	Diarrhoea case management. HC/ OPD	2,622
Acute Diarrhoea Disease	Severe diarrhoea case management hospital	2,257
Malaria	Train a microscopist	4,101
Malaria	Health education in the community	42,095
Malaria	Provision of impregnated mosquito nets	157,678

Malaria	Chemoprophylaxis in hospital	8,919
Malaria	Treatment of uncomplicated cases at health centre OPD	696
Malaria	Management of severe malaria at IP hospital	39,261
Maternal Complications	Management of chloroquine resistant malaria cases at hospital IP	3,893
Maternal Complications	Training of TBAs	31,483
Maternal Complications	Train Nursing Aides, at hospital	89,055
Maternal Complications	Antenatal Care health centres	197,303
Maternal Complications	Family planning with Lofeminal, Health centre	147,915
Maternal Complications	Family planning with Depo provera, Health center	145,191
Maternal Complications	Treatment of puerperal sepsis, hospital IP	112,097
Maternal Complications	Caesarian section, hospital IP	18,347
Maternal Complications	Safe delivery at health centre	374
Maternal Complications	Safe delivery, at hospital	116,874
Measles	Health education schools	41,428
Measles	Immunization measles in a Health Centre	2,417
Measles	Immunization measles at an outreach	107
Measles	Case management at hospital as IP	99,230
Malnutrition	Education on malnutrition	24,326
Malnutrition	Establish school gardens	82,019
Malnutrition	Vitamin A supplementation during measles immunization outreach	5,865
Malnutrition	Vitamin A supplementation at health centre	335,658
Malnutrition	Conduction of growth monitoring and health education activities	22,487
Malnutrition	Case management at health centre level	7,739
Prenatal Causes	Health education in ANC	34,190
Prenatal Causes	Safe delivery health centre	82,662
Prenatal Causes	Neonatal tetanus treatment	122,159
Sleeping Sickness	Health education at outreach	28,994
Sleeping Sickness	Sleeping sickness care tracing in the community	92,549
Sleeping Sickness	Provision of tsetse fly traps	11,049
Sleeping Sickness	Treatment of sleeping sickness cases presenting in the early stages at hospital	22,863
Sleeping Sickness	Treatment of sleeping sickness cases presenting in the early stages at hospital	139,732
Tuberculosis	Health education at outreach	
Tuberculosis	Immunization health centre	107,392
Tuberculosis	Immunization outreach	31,894
Tuberculosis	Treatment of new smear (-)ve or (+)ve TB cases with long course treatment	3,581
Tuberculosis	Treatment of new smear (-)ve or (+) TB cases with short course treatment	5,359
Tuberculosis	Treatment of new smear (+)ve TB cases with short course using treatment	5,662
Trauma/Injuries	Health education on trauma/injuries outreach.	13,553
Trauma/Injuries	Treatment bruises and minor cuts at health centre OPD	523



Trauma/Injuries	Surgical toilet of wounds hospital OPD	420
Trauma/Injuries	Treatment of injuries, e.g. gunshot wound fractures, hospital IP	3,407

*Source: Report of study for Paper II*

In the end, a combination of consensus by stakeholders, the identified “cost-effective” interventions and the size of the resource envelope guided the definition of the EHP. A contentious issue was the inclusion of private resources in the EHP, over which the government had no power over how such resources would be allocated – except perhaps by advising individuals owning such funds. But an individual would rather spend his money on treating malaria than on immunization, however “cost-effective” immunization may be. Thus, the EHP finally agreed upon was no different from what had always been known. As the current financial envelope is still inadequate to meet the EHP, the implication that it is not the basic package that is contentious; it is how to secure more funds to finance the package that is the issue. Thus, while a number of reform initiatives were potentially beneficial and innovative, they were overshadowed by unnecessary market and private-sector orientation. The emphasis on this orientation went beyond and out of context of the reality on the ground. A lot of effort and resources were wasted on fruitless interventions, when more obvious needs, such as drugs, staff remuneration and motivation, medical equipment, and service delivery systems remained ignored, unfunded or under-funded. Table 22 summarizes all the different reforms carried between 1987 and 2007.

Table 22: Individual reforms carried out under DHSP

Reforms	Anticipated Results	Actual Results	Source of information
User fees	Sustainable financing of health services	Only 3-5% cost recovery rate. Removal of fees increased service utilization by 100% User-fees abolished	Paper I
Pricing of health services	All services to be priced so people pay according to service received	Found to be impractical; flat fee preferred	Paper II
Revolving drug funds	A drug fund to be maintained through sale of drugs	Drug fund not sustained; most people could not afford the market price of drugs	Paper II
Pre-payment schemes	Schemes to be piloted, and scaled-up countrywide; to become a key strategy for health financing	Two schemes done. Small scale, highly funded by donor aid and collapsed when donor support stopped	Paper II
Social health insurance	To become the main method of financing and sustaining health services	Feasible for a small well-off minority. Government funding will be greatly required for the rest.	Paper IV & V
Private insurance	All employees of private firms to get health insurance	Most employees of big firms are insured. But not the smaller firms	Paper IV & V
Income generation	Provide seed money to poor families to raise incomes so they can pay for health care	The poor had far more needs than just health care. Income was not enough or sustainable	Papers II
Payment incentives	To pay workers by	A study was done and	Paper II

to health workers	performance and reward good performers	incentive scheme tried in one hospital. Scheme was mismanaged. It could also not be sustained	
Eliminate barriers to health care market	Open up health-care market for entrepreneurs to make services available and better	Market opened for health workers other than doctors and midwives. Market still restricted by other factors. Not regarded lucrative sector	Paper II
Make public hospitals autonomous	Hospitals to be run like business firms, to generate income and sustain themselves with little or no support from Government	Politically contentious; hospitals not able to generate adequate funds unless privatized. Access would be reduced for the majority poor	Paper II & IV
Create health trusts	Autonomous hospitals to operate on money held in trust, with little government funding or involvement	Initial trust fund difficult to get. Sustaining the fund without revenue generation or grants from government was not possible	Paper II
Work closely with the private sector	Recognize the role of the private sector and pay private sector organizations to provide services because they are better at that	Closer collaboration established. Contracting of private providers to provide services has increased. NGOs used more than private firms. Major problems have been found with involvement of NGOs	Paper IV & V
Establish a public private partnership	Build a health system based on PPP	PPP has been achieved mainly with non-profit and church-based organizations. But conditions for good PPP are not available in Uganda. Its benefits not seen in many countries	Paper IV & V
Establish contracting as a method of health service delivery	Value for money of health care delivered	Contracting rules manipulated by the private sector (NGOs, especially under the Global Fund), and government had little capacity to manage contracting regulation	Paper IV & V
Community-based distribution of health commodities	Communities to distribute condoms, bed-nets, medicines, FP pills etc	Tried with considerable success	Paper II
Define EHP using BoD/ CE analysis	Using burden of disease, identify interventions that can reduce the burden most and finance only these	There were methodological problems and the "cost-effective" interventions could be effectively deal with diseases that require different approaches.	Paper II

Decentralize health services	Local governments to be fully responsible for health care planning, management and financing.	Funding at local level was low (3-20%); much of the funding was from the centre, earmarked by donors. decentralized services deteriorated	Paper III
SWAP	All donor funds and programmes to be harmonized	Some donors joined SWAP, others did not. Global initiatives with big money disrupted the whole arrangement	Paper II
Restructure the MOH in support of decentralization	MOH was down-sized and its role was to be limited to strategic planning, policy and technical guidance	MOH continues to provide services through national programmes and is still highly compartmentalized by (donor) source of funding	Paper II
Make NMS autonomous	NMS to operate like a private firm; self sustaining and without the control of the government	NMS also distributes in drugs which are not profitable but essential. Most customers of NMS are government units. NMS is under capitalized. Its various funding sources disorganize its operations	Paper I

Source: Reports of studies for all papers

## 5.4 Key findings from literature

The review of literature was on market-based economic systems, health reforms and systems, and health indicators in Uganda and around the world:

### *Modern health system in Uganda*

1. A good and working system established in Uganda in the early 1960s was undermined by political and social instability, and by mismanagement (Owor, 1987).

### *PHC*

2. The failure of the PHC-approach, especially its financing, its infeasibility and impracticality led to other ways of improving health services which led to introduction of HSRs (Okuonzi, Owor et al 2002).

### *AIDS*

3. HIV and AIDS pandemic took a disproportionately large attention, resources and effort of the health sector, leaving little to the rest for the rest of the services (Ortendahl 2007).

### *Health system evolution*

4. Health systems evolved specifically to cater for the poor, marginalized; special groups such as soldiers, the elderly, children and women; and for public health problems such as epidemics (Abel-Smith, 1994).

*Financing*

5. Health services were originally financed by the church, then taken over by Governments and later complimented by solidarity arrangements in form of social or national health insurance (Abel-Smith ,1994).

*The free- market policy*

6. The free-market policy is regarded as superior and this is said to be evidenced by the triumph of the USA, which operates a free-market economy over USSR, which operated a planned economy. The World Bank, IMF and US government then developed the Washington Consensus to promote free-market principles in the global economy. But market principles fail almost entirely to apply to health, especially for equitable and sustainable health services. Classical market economics had led to economic exploitation and the world wars. The world under the League of Nations and the United Nations had resolved that economic and social security of all individuals would be the responsibility of governments. But in 1950s, multinational corporations begun to sponsor and promote free-market policy again until it became the prevailing system in 1970s to-date. The system reduces the role of government and encourages health care to be rationed by market forces. But the whole global economic system under the free market is unsustainable and is projected to fail sooner than later (Stiglitz, 2002; Sachs, 2005).

*HSRs around the world*

7. HSRs were introduced as a political ideology in rich countries and as conditions of donor aid in poor countries. The reasons included hard economic circumstances, rising health care costs, changing technology, rising expectations in quality and outcomes of care, changing disease patterns, and aging populations. No country has demonstrated any significant achievement of health sector objectives by market based reforms (Eriksson, Diwan et al, 2002)

*Beneficial nonmarket reforms*

8. Nonmarket reforms have benefitted a number of countries. Significant government investment in social welfare in China, Chile, Costa Rica, Sri Lanka and Tanzania ( Abel-Smith, 1994). Some countries such as Chile had to tackle poverty, environment and demography first, then focus on specific risks such as child and maternal mortality (Jimenez and Romero, 2007). User-fees were abolished in Uganda, Zambia and now other countries too (Deinenger and Mpuga, 2004). Universal coverage was promoted by law in Netherlands (Naik, 2007) and by trial, research and monitoring in Thailand (Hughes and Leethongdee, 2007). Community involvement was found beneficial in IMCI programmes in several countries (Bryce, Victora et al, 2004). In Ghana, the total-quality-management approach turned around antenatal care and especially treatment and prevention of malaria in pregnancy (Deganus, 2007). In Rwanda, performance-based funding was implemented with remarkable success (Soeters et al, 2006). In Malawi problem-based approaches were used in tackling malaria and human resource crisis with excellent results (Okuonzi et al 2007). All these successes were based on evidence and not inspired by ideology.

*Donor aid*

9. Aid can cause and has caused health sector fragmentation through donor inspired programmes and choices. For aid to be effective some criteria need to be used whereby

recipient governments take lead in policy and setting priorities (Fritz and Menacol, 2007).

*Factors complicating HSD*

10. Factors complicating health system development include foreign aid, macro-economic policy, policy of predominantly focusing on economic growth, corruption, inadequate internal management capacity, and ad hoc nature of the reforms.

## 6.0 DISCUSSION

### 6.1 The failure of free-market policy

The results show that HSRs have by their own objectives collectively and individually failed. The wider economic and social policies based on the free-market have not produced the desired results either. Of the twenty reforms carried out in the health sector over the past twenty years in Uganda, only two reforms – encouraging the establishment of private health facilities and community-based distribution of health commodities – were successful. The rest failed to be established or produced undesirable results, or their good results could not be sustained or up-scaled. This is consistent with the trend in other countries (WHO, 2000). Countries set up free-market policies to address economic difficulties, escalating health care prices, rising expectations from health services, and the changing demographic and disease patterns. But over 30 years down the road of HSRs, these have remained or even escalated (Eriksson et al. 2001). Thus, the continued faith of countries – both poor and rich – in the free-market is perplexing.

### 6.2 Results of HSRs in general

In the USA, the market approach has always been used. The reasons are historical, cultural and ideological. Abel-Smith (1994) bluntly says that racist exclusion of black Americans from welfare was at the heart of America's rejection of a solidarity-based welfare system and preference to market-based distribution of welfare. And yet the American health system that is market-driven and often used by others (for example, by European countries) as a benchmark to reform their own systems is remarkably inefficient (Eriksson et al, 2002).

In Europe, better public health and cost-containment - the key reform objectives - have not been achieved through market-style reforms in countries such as Sweden and the UK which have undertaken reforms in earnest. On the contrary, the most efficient and consumer-friendly health-care system in the European Union was declared at the end of 2006 to be that in France (Ionescu, 2007). The French health care system is solidarity-based, largely public-funded and non-market-based. All attempts at reforming the French system to become market-oriented have so far been resisted. However, the new French President, Nicolas Sarkozy, has vowed to "reform" the system by introducing a non-refundable tax. He is faced with an outstanding health care budget deficit of Euros 6billion at the end of 2006. But with mounting opposition to this tax from various groups, he is less inclined to go into fully-fledged market reforms.

The outcome of market-reforms in Eastern Europe is worse than elsewhere in Europe. It is characteristic of the outcome in Africa and Asia. The original attempt to orient health systems in poor countries to primary health care (PHC) dramatically changed. Both economic crises and reforms, and health sector reforms, weakened health and other social sectors. As a result, inequality of access to health care increased. In Africa all the major problems, which HSRs were introduced to address, persisted or even increased. In addition to the key health problems not being effectively addressed, African health systems continued to be weak, under-funded, and under-utilized (WHO 1997).

Four specific concerns were expressed about HSRs in Africa:

*First*, some of the individual reforms were clearly undermining or in conflict with health sector objectives. Health sector objectives in general are to improve equity in health and health-care, increase efficiency in resource use, improve quality, provide financial protection against

catastrophic expenditure (WHO 2000), mobilize resources, and accord greater satisfaction to consumers and providers of health care (WHO 1997 ). Some of the reforms go directly against equity and the protection against catastrophic expenditure. An example is the health financing policy of user-fees.

*Second*, a number of reforms were introduced as isolated solutions, whether they were user-fees, health insurance or decentralization. The reforms were often unconnected and not linked to the overall working of the national health system.

*Third*, adequate monitoring of the impact of reform was not in place, resulting in lack of information and evidence for decision-making.

*Fourth*, the HSRs were often forced on poor countries as a condition for international aid, and not introduced as a result of careful situation analysis. The reform packages are usually pre-packaged, with remarkable similarity across countries as far apart as Uganda, Bolivia and Russia (Eriksson, et al. 2002).

### 6.3 Characteristics of a good health care system

A framework for a good health system can be derived from three sources (see figure 23): a) observation and analysis of health system development (especially noting solidarity, charity and compassion as important elements), b) WHO framework (WHO, 2007), which provides most of the other elements but lacks in information about certain inputs (eg institutions, infrastructure), pillars and management, c) some good market principles (eg financing innovations, citizen control and payment incentives).

Table 23: Derivation of the framework for a good health system

Sources of information	Elements of a health system	References
WHO	Service delivery, health workforce, health information, medical products, leadership/governance, safety, access, coverage and quality	WHO, 2007; WHO 2000
Market principles	Payment, funding, efficiency, citizen control, organization	Helms 1993
History of HSD	Solidarity, charity, compassion, resource generation, government guidance, evidence based	Abel-Smith, 1994

*Source: author's compilation*

From the above sources, it can be concluded that despite the market-orientation of health systems today, the nature of health care has always been consistent and distinct. The *first* observable characteristic of a good health-care system to which societies aspire, is one that includes the poor. In fact, the health system was not evolved for those who could afford. It was developed for the poor, disabled, elderly, children and expectant mothers. This is as true today

as it was 200 years ago. *Second*, the health system has a major element of charity, where the rich assist the poor. The rich pay hospital services for the poor. In modern times, the rich still pay for the health-care of the poor. An example is the Global Fund to fight AIDS, TB and Malaria funded by Bill Gates for the purchase of antiretroviral drugs. *Third*, there is a major element of compassion, and the involvement of religion. Suffering and illness evoke emotions of sympathy. This drives some people to act and help. This is unique in health-care, or it is not as profound in other social services as in health-care. *Fourth*, is the element of solidarity. People may be divided on political, ethnic and racial grounds. But in health-care and other social concerns, there tends to be solidarity to help one another. The concept of risk pooling and sharing is the centre piece of health insurance.

*Fifth*, the health system does not emerge spontaneously. It is planned, designed, directed and steered by the Government. The role of the government in a good health-care system is therefore eminent. *Sixth*, there is the element of legislation. To reach the poor and powerless, and to make things work, legislation is an inevitable mechanism in health system development and operation. *Finally*, the rich always want the best and they can afford it. And health services for all will always be available for the population who can afford. The private-sector providers can be mobilized and integrated to enhance the overall health system. This has been demonstrated in the history of health system. These good health-care characteristics can be summarized as being equitable, efficient in resource use, government controlled and directed, regulated by laws and rules, based on solidarity, provided with compassion, with elements of charity and based on the practice of public-private partnership.

From the various country cases, different policy thrusts of interventions have helped improve the sector performance. Where health systems seem to be working close to what is desired – a health system that is internally sustainable and able to meet the needs and expectations of the population – certain factors are constant. These factors can best be described using the five-by-five schematic diagram in figure 18. It has seven elements, each with 5 key contents. The elements are inputs, pillars; management functions, stewardship and outcomes (expected results):

Under *inputs* are adequate human resources, appropriate and functional institutions, appropriate and adequate infrastructure, adequate funds, and reliable and quality medicines and supplies. The *pillars* include evidence-based solutions, guidance by the government, solidarity, compassion and charity. Under *management* functions are oversight (political oversight supported by a monitoring system and vibrant civil society), partnership with stakeholders, accountability to the population being served, monitoring and evaluation, and incentives to health workers to facilitate better performance.

*Stewardship* is the conscious steering of the health system towards desired outcomes. Stewardship has five controls: 1) financing: raising of funds in adequate and sustainable amounts; 2) payment methods: paying of health workers in such a way as to provide incentives for them to work hard and usually include performance-based payment, bonus for good performance and rewards; 3) organization: structuring the sector in such a way that it is internally coherent and compatible with the rest of the national economy and social systems; 4) regulation: the establishment of laws to regulate the behaviour of individuals (both providers and consumers of health services) and of organizations so as to attain the desired health sector goals; and 5) citizen control: this is where citizens are empowered by information knowledge and institutions to influence the direction and functioning of the health system to suit their needs and expectations. Under *values* are equity, access, coverage, quality, and safety. There provide a radar to steer health services.



Under *service delivery* are preventive, curative, rehabilitative, promotive and advocacy services. Advocacy services deals with encouraging efforts to put on determinants of health such as education, child protection, water and sanitation, nutrition etc. Under *outcomes* are five expected results of a good health system: 1) equity: there should be no avoidable differences in access and health status between societies and individuals; 2) efficiency: the use of resources should maximize the production of health care outputs and health outcomes; 3) health improvement: the system should lead to an appreciable improvement in the health status of the population: 4) responsiveness: this deals with how the health system fulfils the client’s or patient’s expectations, needs and wants. They are divided into client-oriented responsiveness and respect for the individual. Client-based domains to which the health system responds are access and support, promptness of attention, quality of services, and choice of health institution and provider. In respecting the individual, the health system should provide and guarantee dignity, confidentiality, clarity of communication, and involvement in decisions about the service; and 5) protection from social and economic risks. Figure 18 is a proposed framework for a good health system.

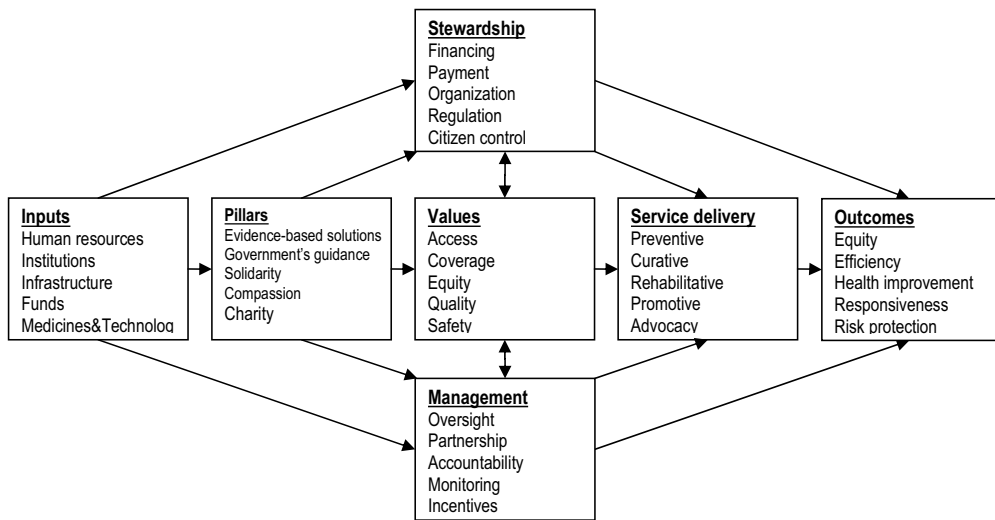


Figure 18: The framework for a good health system  
Source: author’s compilation

## 6.4 HSR policy genesis and implementation

### Policy genesis

This thesis focuses primarily on the evaluation and succession of HSRs as policy, but this is the end-tail of the analysis. It is essential to discuss first the genesis, policy development and policy implementation. In Uganda, HSRs were initiated and propelled by five factors (Paper I), most of which are common to other developing countries. *First*, Uganda in mid 1980’s was coming out of civil war, which had left much of the health infrastructure devastated. There was a dire need for major health infrastructure rehabilitation. *Second*, there had been economic decline for 10 years during and following the political mismanagement of the country under dictator Idi Amin. Uganda’s economy had been contracting, not expanding.

*Third*, the contracting economy was worsened by the global economic crisis arising from the increase in oil prices in 1970s. With the advantage of hindsight, this appears to have been the major factor behind Uganda's accelerated economic decline in 1970's. Even peaceful and politically stable countries, such as Tanzania and Kenya, eventually suffered similar degrees of economic decline in 1990s. *Fourth*, there was widespread dissatisfaction with PHC as a vehicle for health-care delivery among both politicians and health-care professionals. Even ordinary people, already disillusioned with the deteriorating health services, did not view PHC as a positive strategy. Instead, many people mistakenly associated the worsening health services with the introduction of PHC. *Finally*, the World Bank had asserted its strong views through the publication of the World Development Report 1993, and subsequently assumed the leadership of the health sector. WHO, which was championing PHC and viewed as failing, was "pushed aside" to leave way for the World Bank which seemed to have revolutionary ideas that struck deep cords in politicians and ministries of finance in low income countries.

The usual process of policy discussion, issues-definition and forecasting of policy which should normally take place internally in a country among different interest groups (Hogwood and Gunn, 1984) did not happen. Some discussions initiated by the media and civil society were held, but these were peripheral and did not affect the content of HSR agreed between the GoU and the World Bank and other donors (Paper 1). The GoU wanted funding and the donors had a duty to promote their domestic policies through aid. Many HSR policies were extensions of domestic policies of donor countries and business interests supporting multi-national corporations of the donor countries. For the World Bank, the clear aim was to remove all barriers to a free-market global economy and ensure that all systems, including health systems, conformed to and became compatible with free-market principles.

### ***Policy development***

Health policy development in Uganda was ambivalent (Paper 1). It was driven by national political leaders on the one hand who wanted a genuine health sector development based on the usual agreed health-sector objectives. On the other hand, it was controlled by donors, led by the World Bank, which ignored most of the policy proposals made by Ugandan politicians and health professionals. A typical example is the "Three-Year Health Plan Frame 1993-1996" developed by World Bank consultants posted to the Ugandan MOH. Subsequent policies developed by MOH were shelved and they largely remained unimplemented.

Only selected elements of the health policy (generally those market-oriented initiatives) were funded by the Bank and other donors under the Bank's Poverty Reduction Strategy Papers (PRSP) (Paper II). Similar parallel policies were thus developed every year under different names and funded through the Ministry of Finance. The Ministry virtually became an extension of the Bank in the country, acting as its agent. Broad policy frameworks were set by the Ministry of Finance and all sectoral policies had to fit within this framework. Thus, while health policy was progressive, its implementation was subjected to market-based economic policy framework known as the Medium Term Expenditure Framework (MTEF). This framework set arbitrarily low and unrealistic ceilings for health and other social services. In the end, donors triumphed. Only donor-selected policies (the HSRs) were funded and implemented.

Table 24: How the National Health Policy did not fulfil implementation preconditions

Conditions	Comments
External factors do not impose crippling constraints	Crippling constraints in form of unrealistic budget ceilings, restriction to market reforms and other management restrictions.
There is adequate time and resources	NHP was devoted far less resources than was optimal. Most resources targeted donor determined priorities, in most cases market-based interventions.
Required combination of resources is available	Mostly impossible; usually there was lack of human skills, infrastructure and drug supplies, even when other supplies such as vaccines were available.
Theory of cause and effect is valid	There is some cause-effect relationship in the NHP, but no demonstrable link between market-based HSRs and health system performance
Cause-effect relationship is direct	True for NHP, but not HSRs.
There is an understanding and agreement on policy	True for NHP, not for HSRs.
Dependency relationship is minimal	For most of the past 20 years, the health sector has depended on donor aid for 50 to 90% of its funding. So this condition was not met.
Tasks are fully specified in the correct sequence	In real life this is usually difficult to achieve. It is even more difficult in a dependency relationship.
There is perfect communication and coordination	There was no transparent communication on the HSRs, which became the <i>de facto</i> national health policy, displacing NHP.
Those in authority can demand and obtain perfect compliance	In real life this is not usually fully achieved, but it becomes even less achievable under dependency and non-transparent arrangements involving donors.

*Source: author's compilation*

### ***Policy implementation***

Implementation of the HSRs, which in Uganda doubled as the whole public-sector health service, was done through projects and NGOs. The HSRs were geared to activities with clear and immediate outputs for accountability to donors. These projects or programmes typically avoided funding health care infrastructure, health personnel, institutional development or long-term plans. The implementation of HSRs also fragmented the health system. In many cases, with the increasing participation of numerous NGOs funded by donors, the system became uncontrollable by both donors and the government. The mismanagement of Uganda's Global Fund programme exemplifies how donor rigidity and the involvement of too many NGOs with varying and conflicting interests made the programme spiral out of control (Okunzi, 2005).

The implementation of HSRs thus disrupted and obscured the implementation of the HSD that was envisaged in the health policies of the government. The necessary conditions to have a genuine HSD implemented in Uganda and other poor countries were not achievable with a strong HSR agenda in place. Hogwood and Gunn (1984) laid down ten conditions for perfect implementation of policy. The genuine HSD in Uganda articulated in the National Health Policy (NHP) did not fulfil most of the conditions for implementation, which are summarized in the Table 24.

## 6.5 HSR policy evaluation

In evaluating the HSRs, it is taken that the reforms were meant to add, supplement or even replace HSD as originally conceived under the NHP. However, if the concepts underpinning the health policy are disaggregated, three categories of health policy objectives are discerned. It is important to distinguish them. They are health, health-care and health sector reform objectives. Health-care deals with prevention and treatment of disease as well as repair and rehabilitation of health. Health is a state of physical, mental and social well-being. HSR is the orientation of the health system to be compatible and in harmony with the free-market.

Table 25: Categories of health policy objectives

Category	Proximate objectives	Ultimate objectives
Health overall	Health care objectives	Reduce mortality
	HSR objectives	Reduce fertility
	HS HIV/AIDS objectives	Reduce HIV/AIDS
	HS inequity objectives	Reduce inequity
Health Care	Physical access	Access to all
	Human skills targets	Good quality
	Quality targets	Efficient use of resources
	Efficiency targets	Financial protection
	Equity targets	Equity
HSR	Budget ceilings	Efficiency
	Proportion of public sector health financing	Private sector dominated
	Funds controlled by local authorities	Minimal public expenditure decentralized

*Source: author's compilation*

It is also important to distinguish between proximate and ultimate objectives ( see Table 25). It is usually taken that the ultimate objectives are those of the "health", which, it is assumed, all other efforts including those outside the health sector, contribute to. But health services are not just about health status, which is clearly important. It is also about health-care that is increasingly seen as an ultimate goal in its own right. Health-care is not just a mechanism for good health. The permanency of health-care, even in situations of the highest possible health status, means that it is an ultimate objective in its own right. Therefore health-care objectives are not just proximate objectives of the overall health objectives.

Table 26 identifies different types of objectives from the NHP and the PEAP in Uganda.

Although the presence of health-care in society is essential because it does help individuals, as has been articulated by others (Mckeown, 1965; WHO, 1986; Abel-Smith, 1994), health care by itself makes only a limited contribution to the health status of a nation. The ultimate goals for health status are the cumulative result of the overall development of a country. Attributions to different sectors may be difficult and contentious. Thus, the health sector evaluation is left with health-care as its main domain of evaluation.

Table 26: Evaluation of Uganda's health care by objective

Objectives	Assessment	Sources
Access to care	Good for preventive services; unpredictable and low, stagnating or declining for curative care	Paper II
Quality of care	Generally low; combined lack of or unavailable combination of the right inputs is common	Paper II
Efficiency	Improved in some aspects, but increased wastage and mismanagement of resources in the public sector programmes have reduced efficiency levels further	Papers II and IV
Financial protection	No target was set; not assessed in reports. But with increasing economic and social disparity, this is bound to increase even when user-fees are banned. Effective services are only available for a fee in the private sector.	Paper IV
Equity	Considerable inequity arising from the fact that NGO hospitals which are more effective charge a fee; public sector facilities which largely provide no services are freely accessible.	Paper IV

*Source: author's compilation*

Although there have been minor reductions in mortality in recent surveys, mortality of children and mothers in Uganda has remained high - higher than for countries of similar economies and circumstances. But no significant improvements have been made in any of the health-care objectives. In fact, a number of health-care objectives have fallen short of previous achievements. Table 26 summarizes health-care evaluation.

Overall, therefore, health-care performance has been particularly poor. This trend is also seen in other poor countries (WHO, 2000). The slight improvement in mortality reduction in Uganda is attributed to improvement in the economy. But this improvement is incremental and unpredictable, as it has been over the past twenty years. Sustainable reduction in mortality can only occur with increased social spending, which runs against HSR policy. Market-based objectives are diametrically opposed to the ideal HSD objectives. HSR objectives address

efficiency, and minimization of expenditure and private investment in health care. HSD objectives deal with improved access and equity through greater resources (more and efficient public spending). Some non-market based reforms have been implemented in Uganda and other countries. However, while the initiative had the potential of being beneficial, they have typically remained on a small scale and are often unattractive to donors.

In evaluating of the global HSRs, it is interesting to note that, in no country - poor or rich - can it be demonstrated clearly that HSRs or market mechanisms, have improved the performance of health systems. But there is a linking relationship between four factors: aid, market reforms, politics and HSD. Aid, market reforms and HSD are linked in the case of poor countries where aid leverages market mechanisms to address HSD. In the rich countries, politics and ideology leverage market mechanisms to address HSD. This is presented as the Square of HSR (figure 19).

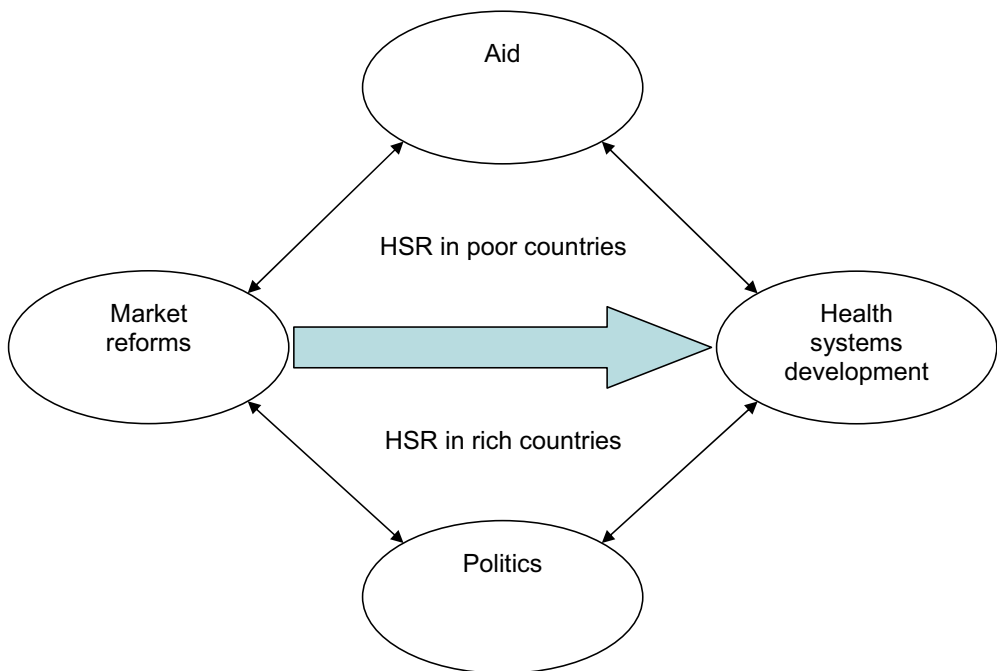


Figure 19. The square of HSR  
 Source: author's compilation

Two groups of poor countries have applied market-based HSRs with dramatically different results. One group comprises of countries with largely collapsed or non-functional health systems (such as Burkina Faso, Uganda and Zambia). These countries have ended up with worse states of HSD objectives, and with health sector fragmentation. The other group of poor countries includes Vietnam and Kyrgyzstan. These countries already have working health-systems and all they need is to improve the system in the context of the changing global political and economic environments. But they want to retain their socialized health-system structure. What distinguishes these two groups of countries is the extent to which they have retained

sovereignty over the health system. The more functional a system is, the more sovereignty the country has been able to exercise.

The other factors differentiating these two groups of poor countries are the levels of capacity and accountability to the people. The stronger the poor countries exercise sovereignty and capacity, and account to their own people, the better. The weaker countries have had their sovereignty seriously eroded by the dependence on donors and with weak democratic systems, have no accountability to their populations. Instead they usually account to please donors in order to get more aid. This further fragments national health systems. Therefore, it seems evident that to get a balanced HSR that is genuinely geared to real HSD, the three factors must be strongly in place. Figure 20 presents pre-requisites for a balanced HSD.

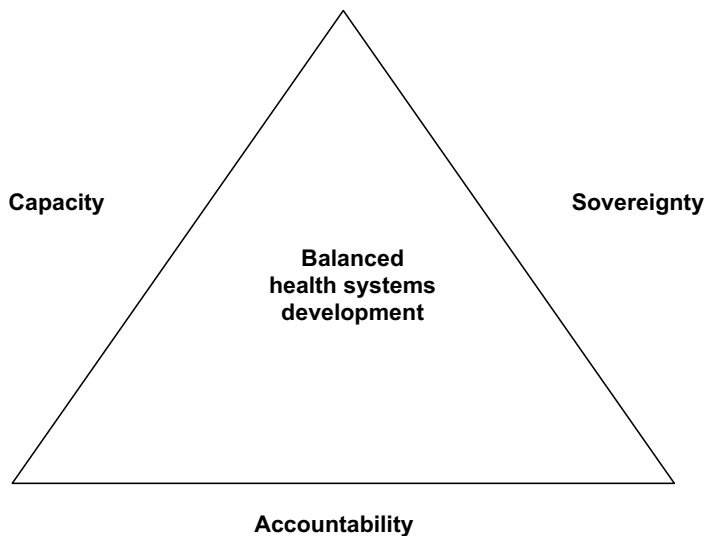


Figure 20: Pre-requisites for a balanced health systems development

*Source: author's compilation*

## 6.6 HSR policy succession

Policy succession occurs when a policy has failed or has achieved its purpose and is no longer needed, or when there is need for change of direction (Hogwood and Gunn 1984). There is now a widespread acknowledgement of the increasing health problems, and the role of HSRs and globalization in creating and perpetuating the problems. As well as the breakdown of health systems in poor countries, there are non-responsive or deteriorating health systems in richer countries. There are also international health concerns of HIV/AIDS, emerging and re-emerging diseases; health problems during conflicts and disasters; human resource shortages; the damaging impact of aid on health services; inadequate and unsustainable financing mechanisms; and a multitude of health-sector actors independent of one another and having different views, principles and interests (Amorim et al, 2007).

In a review of safe motherhood initiatives over the past twenty years, Freedman *et al* (2007) conclude that it is now time to shift focus on the challenges of effective implementation. They note that political commitment along with forging coalitions across sectors, programmes, professions and countries and to tap the local knowledge, will be critical. But they are cautious because “courage [will be] needed to confront what is wrong in health systems that do not function for people, especially those who are poorest, despite huge infusions of development aid”. And crucially they advocate for transformation in the health system. This advocacy for transformation will inevitably confront hardened mindsets and world perspectives shaped by free-market values. But to begin to question such fixed positions and values against the backdrop of glaring public health failures will be a step in the right direction.

There is an increasing realization that there is need to end the ideologically driven, market-dominated HSRs. Such HSRs are to be replaced with policies based on the lessons learned over the past twenty years. There is need to rethink, and to put the best of government-based and market-based approaches together to find a better policy. New actors in the new health system will have to be the giant corporations, which need to be reigned in as they continue to wield more powers in the affairs of the world. The UN institutions need to harmonize their action, but eventually the entire UN system will require to be overhaul in order to function well and to become useful (Bello, 2004). The importance of international health security has recently been highlighted (WHO, 2007a), and will require a new type of funding mechanism. Aid from ODA is becoming increasingly untenable as a method of funding HSD. International tax for health security and for the environment will become inevitable as suggested by WHO. Innovations and best experiences in sustainable livelihoods will have to be adapted and scaled-up for implementation by countries.

The succession of HSR policy requires two steps for the long-term strategy. *First*, there is need to reform the current policies to address emerging problems especially of inequity, deepening health crises and social unrest. *Second*, there is a need eventually to have a change in values in our lifestyles and to adopt a culture that will sustain the world’s resources. This will take a much longer time scale, but a beginning has to be made. The immediate succession policy for the health sector is to address the emerging and prevalent problems. The efforts will need to be geared to international or cross-country problems.

Global instruments (laws and covenants) should be enhanced. Global institutions should be reformed (Bello, 2004). Also, the character of aid should be improved through an international agreement on what is good or bad aid. More effort has to be put in tackling development, trade and governance so that these address quality-of-life issues. At the national level, countries need to carry out rigorous situation analyses, and identify health system problems and solutions. Solutions come from options that have been known to lead to good results before, best practices, and what has previously worked in other countries. Some good initiatives are on a small scale in many countries, and these will need to be scaled-up.



## 7.0 CONCLUSIONS AND LESSONS

### 7.1 Conclusions

#### *General conclusion*

From the foregoing discussion emerge three key reasons why the health system in Uganda collapsed. These are: 1) the free market policies (Papers IV and V); 2) aid as a factor for distorting priorities, fragmentation of the health system, creating a dependency syndrome and inhibiting initiative, and introducing unnecessary procedures and structures (Paper I and Örtendahl,2007); 3) poor leadership, management and bad politics that destroyed a decentralized system that had started well (Papers IV and V; Örtendahl,2007).

While there is mounting evidence of the unsuitability of the free-market policy for developing or organizing health systems, and as the cause of health system failures and crises in Uganda and around the world, many leaders continue to have faith in the market as the solution for health system development. It is not possible to achieve health-sector objectives using HSRs or the free-market. HSRs based on the free market were not democratically developed or owned by the developing countries. Democratic policy ownership has emerged as a fundamental factor in the success of implementing policies and programmes (Amorim, Douste-Blazy, et al, 2007; Fritz and Menacol, 2007)). While free-market principles in the health sector have also diffused to developed countries, these countries can cope with free-market economic and social crises through democracy. This is not possible for many developing countries, especially in Africa.

But regardless of where a policy originates from, when it fails or becomes irrelevant to the problems it is supposed to solve, it should be succeeded or replaced with another (Hogwood and Gunn, 1984). Thus, market-based HSR policy needs to be replaced with a HSR policy where fundamental changes in the health system are based on evidence and guided by the government through democratic ownership (WHO, 1997; WHO, 2000; Lundberg, Yngwe et al, 2008). For sustainable health systems development, enduring efforts have to be made through policy reform, consisting structural shifts in the organization and management of society. But health systems cannot be built in isolation. Indeed the change in health systems cannot be a sufficient reason for re-organizing society. However, the breakdown of health systems and ensuing crises are not the only crises arising from the global free-market policies. Other crises – price increases, market crashes, energy, water and food shortages, social polarization resulting into the creation of terrorists etc – are also the result of the free-market policies (Bello, 2004; Raskin, Bamuri, et al 2002; Shutt, 1998). Hence, there is need for a wider reform of the global societal organization and relations.

#### *Specific conclusions*

A number of specific conclusions can be drawn from Uganda's experience, and from market-based HSRs around the world. These are:

*One*, market-based HSRs have either destroyed health systems or added negligible value to health systems around the world. In Uganda and other poor countries they have destroyed or fragmented health systems, and in some cases reversed progress that had been made in health and health-care objectives (Paper II, IV, and V). In rich countries, there is no clear evidence of the value added by market-based approaches (Eriksson, Lönnroth, et al. 2002).

*Two*, market-based principles may be good and superior for making profits and creating private wealth, but they are disastrous for social services such as health-care. Markets have no superiority at all in most aspects of health services. The assumptions on which market principles are supposed to operate (assumptions of a perfect market) do not hold true (Hsaio, 1995; Rice, 1998; Sachs, 2005).

*Three*, for a balanced economic and human development, which includes better health and health care, the market needs to be directed, controlled and regulated by the Government. In the wider scheme, the market needs to be regulated by the government (Paper II). In particular, to avert an impending crisis of over-use of global resources through globalized capitalism, which will lead to social conflict arising from deepening inequity, governments and international institutions urgently need to intervene in two specific areas: 1) save the environment, and 2) reduce widening inequity (Bello, 2004; Raskin, Bamuri, et al 2002; Shutt, 1998).

*Four*, the failure of market-based HSRs in Uganda and other countries - both poor and rich - is not the result of "the devil in the details" (McKee and McPake, 2004), or of how badly the reforms were done, but the problem of the "big picture" - the whole market-approach to health-sector reform (Hsaio, 1995; Rice, 1998; Sachs, 2005). The market-approach is simply unworkable for organizing health and other social services, especially for the poor.

*Five*, external aid has proven to be disruptive and even destructive to socio-economic development in poor countries (Paper I; Rodman, 2005; Hancock, 2006). As a general rule, it is important for countries to wean themselves off external aid as quickly as possible (Schieber, Flesher, et al, 2007). But aid can be useful if the quality of aid is good and it is well-managed. Aid should be aligned to the recipient country's socio-economic development framework (Fritz and Menacol, 2007). It should not just support a market-oriented, detached and parallel macro-economic policy. The governance and management of aid has to be improved both within the recipient country and by the donors. Accountability mechanisms need to be strengthened for both recipient countries and donors.

Spending decisions should be unlocked from IMF, World Bank and other donor conditions (Rodman, 2005). Recipient countries should raise their own revenue for health services and plan to wean themselves off aid funds. Leaders at all levels should be educated about the political economy of aid. In addition, for aid to be accepted and judged as useful, it should not be tied to ideological, bureaucratic and profit-oriented conditions; aid-administrative structure should not be large and costly; beneficiaries of aid should be prepared to implement aid-funded programmes, and participate fully in all stages of programme design; and project approach to the use of aid, especially where aid is proliferated into small grants, should be avoided.

*Six*, user-fees for health services were imposed as a principle of the market, allegedly based on research findings from Philippines and Malaysia in 1980's (Akin et al. 1985) which contributed to the World Bank policy that supported user-fees for health services. After more than twenty years and over 100 large-scale studies on user-fees around the world, it is now abundantly clear that user-fees have had very negative effects on the utilization and development of health services, especially in poor countries (Paper IV; Bodart, Servais et al 2001; Deineger and Mpuga 2004; Nabyonga, Karamagi et al, 2008). There is now a trend of reversing the policy on user-fees. It is important to spread the message about the pernicious nature of user-fees for social services

and to destroy the false creed that even the poor are willing to pay for health care, and are not deterred by user-fees.

*Seven*, the importance of inflation and other macro-economic variables in poor countries are overstated (Weeks and McKinley, 2007; Paper IV) and are often assigned without due consideration to the consequences they could have on human welfare. It is perfectly possible to design a system where both economic and social development can be achieved. Progressive fiscal and monetary policies can be harmonized within a pro-poor national development framework. Fiscal policy should be expansionary and focused on financing wide-ranging public investments; exchange rates should be managed in order to maintain short-term price and currency stability and foster long-term competitiveness and diversification of the economy. The monetary policy should accommodate fiscal expansion, instead of restricting it through targeting of unreasonably low inflation rates and correspondingly high real interest rates.

*Eight*, reckless and uncontrolled decentralization driven by politics and ideology can destroy health and social service systems, as has happened in Uganda and Zambia (Paper III; Saito 2004). But well planned decentralization can also improve participation, and provide better oversight and accountability for services.

*Nine*, neither the private-sector nor the public-private partnerships are a panacea for health sector development (Nickolic and Maikish, 2006). Both have been promoted merely as part of market ideology. The impact of the private-sector and the PPP on health systems development is mixed (Sunderwall and Forsberg, 2006). They can only work well in particular contexts, where certain prerequisites are in place. These include a) functional legal systems b) management institutions and skills, c) adequate time to nurture partnership, and d) in-built business and management functions. Such prerequisites are absent in most African and low-income countries.

*Ten*, the development of a SHI is tied to long-term plans for sustainable health financing (Paper II; Berman, Hsiao et al, 2001). This is in turn linked to, and will be determined by, the macro-economic policy. Once the bigger socio-economic development strategy is enabling, SHI becomes feasible. Thus, sustainable financing strategy for health-care, and eventually of universal coverage of health-care, becomes feasible. For Uganda, the macro-economic policy needs to be reviewed and harmonized with economic and social development (Ekman and Gerdtham 2006). Then SHI development process may start with the development of mechanisms and institutions for a) collecting and managing funds; b) management and regulation c) health-care provision, d) accreditation and quality control.

*Eleven*, if Uganda, and indeed any other poor country, is ever going to get the HSD and the bigger socio-economic development right, it must have the three pre-requisites: a) adequate internal capacity (knowledge, skills, infrastructure etc.), b) accountability to the people of the country, and c) sovereignty (freedom from external forces to make decisions concerning the welfare of the country and in particular to own policies) (Paper I; Schieber, Flesher, et al 2007).

*Twelve*, good health care systems around the world have unique and consistent characteristics (WHO 2000; WHO 2007 b). These characteristics have not been developed through market-based approaches (Paper IV). The characteristics are: oriented to serve the poor, while the well-off cater for themselves; oriented to reducing access gaps between the rich and the poor; charity, where the rich show genuine concern for the sick, poor and unfortunate and provide help; compassion, where those who provide health-care have a strong ethic of compassion or are

regulated to have a strong ethic of fairness and courtesy; solidarity, where people pool risks and resources, and where the well-off cross-subsidize the poor; centrally-designed and directed system of health care; are not allowed to evolve spontaneously or directed and fragmented by market forces; a strong and functional legislation to control the delivery of health care and constrain the undesirable behaviour of health care providers, funders, users and evaluators; and partnership between public and private sectors, including the civil society in the overall context of equity and other health-sector objectives (Abel-Smith, 1994).

*Thirteen*, health systems all over the world are experiencing crises (Paper V). The degree of crises varies, being more severe in poor countries with fragile health systems attempting to introduce market-based HSRs. The crises are also severe in former socialist countries which have embraced market reforms wholesale, such as Russia. However, the crises are moderate where health systems are centrally managed, based on solidarity and directed by the government (e.g. Sweden and UK). Where crises are moderate, only minor market changes have been made to try and improve otherwise well functioning systems. But the evidence of the value of these market changes is hard to see. These widespread crises signal the point where market-based approaches for HSD need to be replaced with another policy. Neither the pure government-approach, nor the market-driven approaches are perfect. But we are now better equipped to design much improved health systems based on evidence, best-practices, and on what actually works.

*Fourteen*, health system crises around the world are part of the wider crises in the global economy and social stability (Paper V). In particular, global resources are fast being consumed at unsustainable rate through globalized capitalism. In the process of expanding markets for the large capitals in the West, social safety networks around the world are breaking down and inequity is increasing causing social stability and terrorism. Therefore, the wider socio-economic situation of the world has reached a point where it needs to be replaced. Emerging problems from these crises require urgent action. But ultimately, the world needs to adopt new values and lifestyles that can enable us live in a sustainable way and in peace.

## 7.2 Lessons

### *Lessons in general*

Uganda has learned its lessons the hard way. The decision to embrace such a massive, long-term and unproven policy of free-market health sector reform has become disastrous. The GoU's relegation of its roles of providing health service to NGOs, donors and UN organizations has made things even worse. This underlines the basic fact that development should be internally initiated and driven. The health sector has deteriorated beyond the level where it would need only remedial actions and policies such as SHI. It needs a total overhaul. It is critical and urgent to significantly bring up public spending on health, reorganize the health system and make decentralization functionally viable. Uganda needs to reorganize the way aid is accepted, overseen, and used. Partnership with donors is good but in the case of Uganda, the partnership under SWAp is a false one; donors and other external actors still determine policy. The partnership is based on a dependency relationship: GoU being almost fully dependant on it's partners for technical and financial support. This dependency comes about because GoU has, through the free-market macro-economic policy, restricted allocation from its internal revenues to the health sector. Thus, in effect GoU has relegated its role of planning and financing health services to donors and other partners. Lack of assertion and bad aid-conditions have kept GoU in a subordinate position to donors and other external actors.

***Specific lessons***

Specific lessons from Uganda's experiment with market reforms in general and with HSRs in particular are:

- 1) The single-minded pursuit of economic growth without due regard to social development has led to disintegration of health and other social services in Uganda (Papers IV and V). Economic pursuit is a good thing, but it should not be at the expense of, or regardless of, social goals. Economic growth is a means to development, not an end in itself.
- 2) The blind faith in the market as a vehicle to prosperity and as a way to manage society is disastrous (Shutt 1998; Stiglitz 2002; Sachs 2005). It has led to disintegration of social services, deepened inequity, and it has thrown wide open the doors for increased corruption through reckless deregulation of the civil service.
- 3) The macro-economic stability of fixed low inflation budget and balance-of-payment deficits is not sacrosanct (Paper IV; Vernengo 2006; Filho 2007; Weeks and McKinley 2007). Desired pro-poor fiscal and monetary policies that allow economic growth are possible. Under fiscal policy, the desired outcomes, macro variables, and boundaries between excessive and non-excessive economic fluctuations need to be set. The macro-variables are a) rate of economic growth, b) distribution of income, c) investment, and d) public expenditure.
- 4) Under monetary policy, investment in pro-poor sectors (health and education) is critical (Paper IV; Filho 2007). Also, capital flow into the country needs to be controlled, since uncontrolled capital flow can destabilize the economy. Specific pro-poor financial policy interventions need to be introduced. These include subsidized lending to the poor, reduced premiums on long-term lending through the establishment of credit guarantee schemes; establishment of variable asset-based reserves for stocks, bonds and mortgages; facilitation of micro-credit institutions; and introduction of employment-oriented financial policies.
- 5) While it can be useful if well intended and managed, aid has become an encumbrance to socio-economic development, including democracy in Uganda (Paper I; Ortendahl 2007). Huge and constant aid to Uganda has led to a culture of dependency, corruption and impunity. It is a big disincentive to innovation of indigenous solutions to social and economic problems of the country. It has distorted the allocation of resources, paradoxically "starving" the health sector where most of the aid is supposedly coming to. The aid in the sector is for donor favoured programmes, such as AIDS and immunization, leaving the mainstream health system development under-funded. Uganda has to free itself from aid as soon as possible. However, the country should find ways to increase the generation of internal revenue and allocate more to social sectors. Rules should be set for aid to be accepted and rejected, and for its effective use.
- 6) Decentralization is not an end in itself (Paper III; Saito 2004). It is supposed to improve social services and accountability. Uganda is fast becoming a museum of a runaway decentralization, which was derailed by politics and market orthodoxy. Decentralization should be redesigned together with macro-economic policy and the new health system. Education and health services will remain key services to be provided by decentralized units.
- 7) The current promotion of private-sector involvement in health-care and of public-private partnership needs to be supported by the wider and simultaneous development of skills

- and knowledge in management, legal and regulatory systems, quality assurance and a business-like culture (Paper III; Nikolic and Maikish 2006).
- 8) The development of the SHI for Uganda is intricately linked to public sector spending, health-sector reorganization (including decentralization), and macro-economic policy. Unless these policies are designed together with a focus of improving the welfare of the population (specifically to reducing equity and improving access to services), none of the policies designed without the other will be effective (Papers III, IV and V)
  - 9) A number of donor and poor countries have now understood the negative impact of market-based HSRs and market reforms supporting globalized capitalism. Together, they have signed an agreement to increase aid to fund health and education, and to use the funds effectively. The donor countries and organizations include Norway, Germany, Italy, France, Netherlands, European Union and WHO. The poor countries include Burundi, Nepal, Zambia, Ethiopia, Kenya, Mozambique, Cambodia, Brazil, Indonesia, Senegal, South Africa and Thailand (Amorim et al. 2007; WHO 2007). Uganda should join hands with these countries, taking advantage of the lessons it has learned to design a better health system and use aid-funding in an effective way.
  - 10) Past experience has shown that there are numerous actors in the health sector with a wide range of objectives, many conflicting (Paper I). And these actors are fiercely independent. They usually congregate under a loose coordination arrangement called Sector-wide Approaches (SWAPs). In principle, the government is supposed to lead the process of coordination and policy-making. In reality, the government is subordinate to these actors. In developing new policies and designing organizational structures, the government should keep these actors at bay and only consult them where necessary. Otherwise, governments of poor countries will never get a clear way forward in determining their own destinies (Papers I and II).
  - 11) No genuine development in general or HSD in particular is possible unless a nation exercises sufficient sovereignty, capacity to take charge, and accountability to its people through true democracy (Paper I; Sen 1999).

## 8.0 RECOMMENDATIONS

### 8.1 General principles

The recommendations below consist of general principles, socio-economic changes for sustainable health system in Uganda, and global reforms towards justice, peace and sustainability of resources and environment. It is through these changes that sustainable and equitable health systems can come about.

The collapse and devastation of Uganda's health system is intertwined with a wide range of social and economic crises in the country and in the world. The root cause is the unfettered global capitalist globalization. Health system and other social sector crises cannot be effectively or fully resolved without tackling the root cause. However, it has to be recognized that the momentum of unfettered market globalization is too immense to be stopped in the short-term, without reigning in global forces. But its effects could be contained.

Practical steps can be taken to address the crises at national and global levels. Thus, general principles underpinning the recommendations given below are:

- a) Improvement in the health system cannot be made successfully in isolation, rather it should be part of a wider social reform
- b) Economic growth without human development in terms of appreciable improvements in health, education, nutrition etc should be abandoned
- c) People's empowerment through health, education and general wellbeing should be used as an engine for economic growth
- d) Policies, regulation and incentives should be created to ensure economic growth improves human welfare, and this wellbeing is channelled and harnessed to feed into economic growth.
- e) Leadership that is pro-poor, and for sustainable environment, stability and peaceful co-existence, should be promoted nationally and worldwide.

### 8.2 Uganda: Reforms for a sustainable health system

#### *A) Economic policy reform*

The current economic policy in Uganda can only bring about cyclic crises in form of social polarization, instability, environmental degradation and conflict. Foreign capital mainly from multi-national corporations is what drives the economy and the economic growth. While foreign firms employ a number of local people, this has not stopped the rise of unemployment. Moreover, employment terms under foreign-funded businesses are usually deplorable –very low wages and harsh terms that contravene labour laws. Under conditions where the vast majority is unemployed or underemployed and underpaid, domestic production is below optimal, incomes are low, purchasing power (spending) is low, and the demand for services like education and health is low.

Unemployment in an environment subjected to capacity constraints will generate a poverty trap (GoU, 2004). The limited capacity of an economy to absorb labour will result in high and increasing levels of unemployment with depressing socio-economic and growth implications.

High and rising levels of unemployment will cause a large portion of the population to be subjected to low income levels and poverty, thereby limiting their access to a range of economic and social services and which further diminishes their chances to be absorbed into the economy. The problem is further exacerbated by those who have become discouraged and have lost faith in the ability of the system to generate jobs, resulting in them remaining unemployed "by choice".

In addition, low income and poverty-stricken groups have little financial maneuverability and make little to no contribution to savings, which in itself hampers investment, output growth and employment. While adverse socio-economic conditions contribute to the creation of only a limited amount of job opportunities, a high level of relatively unskilled labour supply further exacerbates the unemployment problem. Unemployment and poverty thereby becomes a self-fulfilling prophecy - unemployment creates a poverty trap which requires innovative intervention targeted at eliminating the significant structural impediments (GoU, 2004).

Uganda's accelerated growth is diverging from its employment and development performance. There is a significant and sustained decrease in the employment rate as measured by the ratio of the total number of employed people, formal and informal sectors, to the economically active population. The declining trend in this ratio implies that the labour market has not sufficiently absorbed new job-market entrants, causing growth in the economically active population to outstrip the amount of new jobs created, resulting in increased unemployment. The most disconcerting about the overall employment rate is that even though GDP growth rates have recently been on the increase, the trend of employment rate is still declining. This negative relationship between GDP growth and the employment rate suggests that the employment problem is not only a cyclical problem, but is structural in nature.

Accelerated economic growth that Uganda aspires to is not necessarily sustainable or does it always translate into accelerated employment. Bohlmann, Du Toit et al, 2007 argue that demand-side fiscal and monetary policy interventions aiming at accelerating gross domestic output will be effective in an economic environment without structural constraints impeding the capacity of the economy to absorb everyone willing and able to work. It will also serve to attract sufficient investment capital. In an environment unfettered by structural constraints, this course of action will achieve the goal of higher economic growth without putting pressure on the balance of payments, the exchange rate and domestic inflation.

Figure 21 shows that a supply-side based strategy, such as the lowering of taxes and/or interest rates will cause increased demand/spending assuming little or no capacity constraints, which will translate into higher domestic production and subsequent higher shared income for the owners of domestic production factors (labour, capital and land). However, in a scenario where the economy is faced with structural supply-side constraints, domestic production will fail to meet increased demand. In this case, accelerated growth represented by increased domestic expenditure on gross domestic product will not cause an equivalent increase in employment and hence fail to have everyone share in the higher income generated in the economy. The lack of domestic production to meet the increased domestic demand will merely be supplemented by increased imports, which, in turn will impact negatively on the balance of payments, the local currency exchange rate and domestic inflation.



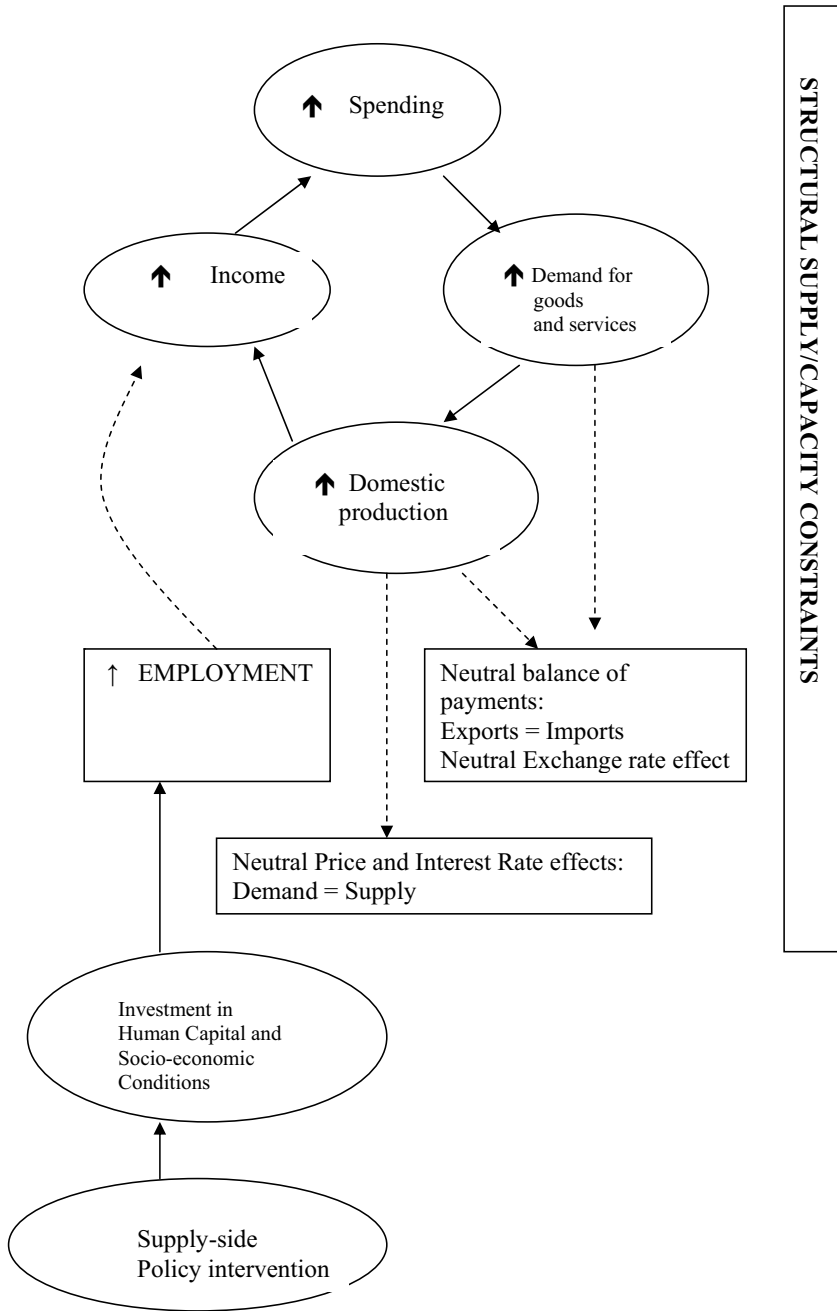


Figure 21: New paradigm: supply-side driven growth strategy  
 Source: Bohlmann, Du Toit et al 2007

A new paradigm: a shared economic initiative

Thus, a new economic paradigm is required for Uganda. This is an initiative that is led by the government but should involve the full cooperation of businesses, civil society and donors (Bohlmann, Du Toit et al, 2007). It consists of five key strategies:

- Shared responsibility between the government, businesses, civil society and donors to act in complementation on poverty reduction and appreciable improvement of the welfare of the population
- Mobilize and empower all employable persons 18- 60 years
- Target family and household as a unit for employment benefits
- Define social-economic employment benefit-packages to consist of nominal wages, social wages and in-kind compensation, infrastructure and social services
- Define socio-service package that the community must be entitled to. This is to be provided by the government, businesses and civil society, in a combination and proportions that will depend on the where the community is and who is the dominant actor on the ground.

Reform of macroeconomic policy

Pro-poor macroeconomic stability is possible (Epstein and Grabel, 2007). Reforms of fiscal, monetary and financial policies require harmonization, consistency and focus on two moving targets: economic growth and people's welfare.

**Fiscal policy reform:** The country should agree on what is excessive and non-excessive economic fluctuation. Fluctuation in the economy is what has led governments to maintain a low inflation to prepare a good environment for foreign investment and to cut down social spending putting severe constraints on social welfare. But some fluctuation is inevitable and with this the economy can be steered back on the growth course. So, micro-variables such as rate of growth, investment, public-spending and income distribution can be balanced in such a way that both economic growth and appreciable poverty reduction occur.

**Monetary policy reform:** The country should target credit for investment in pro-poor sectors. The flow of capital into the country should be controlled. Uncontrolled capital flow into the country can actually distort national priorities and override any pro-poor plans and strategies. In the end it can destabilize the whole economy.

**Financial policy reform:** A deliberate investment regime in pro-poor sectors is required. It has to be supported by the government depositing insurance to enhance confidence in the economy. Credit and subsidized lending should be made available to the poor. Lending targets, ceilings and tax incentives need to be set to facilitate lending to the poor. Specialized lending institutions and development banks should be set up and facilitated to function for the purpose they were created. Such facilitation may include providing information and business services and linking formal and informal financial institutions. It also includes providing technical support to micro-credit institutions to serve borrowers better.

Other interventions include depositing insurance to enhance confidence in the economy; directing credit allocations and subsidized-lending to the poor; establishing and implementing lending-targets, ceilings and tax incentives; establishing specialized lending-institutions and development banks; establishing credit-guarantee schemes to reduce premiums on long-term investments; introducing variable asset-based reserves for stocks, bonds and mortgages; improving and easing lending through information and business services by linking formal and

informal financial institutions; providing technical support to micro-credit institutions to serve borrowers better; and introducing employment-oriented financial policies.

#### Reform of aid policy

Aid is still expected to play an important role in the foreseeable future. So a number of strategies of using aid better and to effectively and genuinely support pro-poor agenda are recommended, adopted from recommendations of research on aid (Fritz and Menacol, 2007) :

**Aid governance:** The governance and management of aid in Uganda should be restructured. It should be governed by a board consisting economists, social welfare experts, health experts and educationists. It should include civil society as well as the private sector. The board should be charged with: a) accepting or rejecting aid according to agreed criteria fashioned on the Paris Declaration on Aid Effectiveness; b) appraising the pro-poor orientation of aid project and its overall social and economic benefits versus its costs and damages; c) evaluating aid funded projects and programmes. The board should set up accountability mechanisms in consultation with donors.

**Criteria to accept or reject aid:** Criteria to accept or reject aid should be set. In particular, the amount of aid coming to the country should not be subjected to arbitrary ceilings set under the macro-stability policy. Social welfare factors need to be factored in.

**Weaning Uganda off aid-dependency:** The government should identify the sectors that need aid and those that do not. It should then set ceilings and targets to reduce aid over a period initially of say, ten years. In general, the desired trend should be that of aid levels coming down as the economy grows. Only under certain conditions, such as disasters and crises, should aid be increased. It is always much better to plan with your own resources. This will provide a better view on how to forge a head with our national development.

**Unlock aid decisions from IMF:** The most unhelpful advice on aid regarding social development and poverty reduction is usually given by IMF. The board on aid should act as the final national decision forum for matters concerning aid. Political interference and interests may persist. But a political strategy for the social reform will require the participation and promotion of politicians with a different set values and development outlook from those who are currently in power. More of the political strategy is discussed under C) below.

### **B) Health policy reform**

The current rush in Uganda to set up a SHI scheme is untimely and ill-advised. The country is simply not yet ready for such a huge transition. SHI entails a total reorientation of the national system with new institutions and capacities. This requires carefully planned and executed preparation – and time. Currently, public dismay and mistrust of the health system in Uganda is high, as is clearly evident from the media and population surveys. A national SHI scheme, though a good move, should not be the first thing to be done to address the health system crisis. The first thing is to restore the functioning of the health system and to regain public confidence and trust in the health system. Then a SHI scheme covering at least 50% of the population should start, based on the confidence and trust in the system. Plans should be made upfront to swiftly bring everybody on board under the scheme. The coverage must be large to give it a national character and where the division of the health system into tiers does not occur.

The health policy reform should address the following critical areas of the Ugandan health system:

- Human resources
- Equipment supplies

- Financing
- Payment system
- Organization and decentralization
- Performance improvement

#### Human resources

A key constraint to the good functioning of Uganda's health system is inadequate, poorly paid, unmotivated and ill-trained health staff. Ultimately, the plan should be build a human resource to provide equitable, efficient and quality health care. But in the short-term, the following strategies could be adapted to set the country in the right course:

**Task-shifting:** This entails identifying cadres of staff who can undergo short courses to carry out duties that were usually done by staff at a higher level (WHO(c), 2007). Such duties should be relatively simple but with huge social benefit ratio to the population. These potentially include prescription by nurses, dispensing by nurses, diagnosis by nurses, and simple surgical operations and Caesarean sections by clinical officers and nurses.

**Salary and benefit enhancement:** A salary and benefit enhancement programme should be set up to attract and retain good staff in health service, including in difficult areas. If this is not possible through the government budget appropriation, then this is an area where short-term and phased external aid is required. A similar programme has been implemented in Malawi with considerable success (Okuonzi, Ali et al, 2007).

**Sharing of health staff:** The health staff is inadequate and will remain so in the foreseeable future. As an interim measure, some sharing of staff will be necessary. Arrangements need to be made to share staff between hospitals and outlying health centres. Better staffed hospitals and health centres should be supported give supervisory, technical and back-up support to outlying and understaffed health units.

**Human resource for health (HRH) strategic plan:** Several HRH plans have been made in past but not implemented. It will be imperative for a new strategic (long-term) plan to be developed based on the current needs, knowledge and technology skills requirements.

#### Equipment, drugs and supplies:

Another cause of poor health care services in the country is the lack of medical equipment, drugs and other supplies. Four problems are related to the "lack" of equipment: a) none availability of equipment, b) incompleteness of equipment for use, c) un-serviced otherwise usable equipment, d) staff are unable to use equipment (GoU, 1998). Therefore as a way forward:

- Existing equipment need to assessed to find out the extent to which the four problems contribute to the health care crisis
- Organize short-term trainings on the use of existing equipment
- Establish a program to service equipment that require servicing throughout the country, including replacing missing parts and repairing
- Redistribute equipment where a health unit or district has more than is needed
- Based on equipment needs assessment a procurement program should be drawn to re equip all health facilities
- Work with manufacturers and suppliers to set up service and repair workshops in the country
- Review and update policy and standards on quality, safety, cost-effectiveness, and scientific soundness of equipment and technology

- Review and update policy on procurement, supply, storage and distribution of equipment

On drugs and supplies the following are recommended (MCDI and SCL 2006):

- The NMS should remain under 100% government ownership. Under no circumstance should the objective of the NMS be to maximize profits. This would simply be inconsistent with the distributive equity objective of the National Drug Policy and the National Health Policy.
- The National Drug Policy should largely focus on the supply of essential drugs, while allowing private drug suppliers to compete for the non-essential or specialty drug supply market.
- Short to medium-term to support should be given to the effort of fully developing the capacity of the NDA and MOH to undertake accurate procurement planning.
- Third party national health programmes need to coordinate their input supply with the national drug supply system (the NMS, NDA, MOH and Districts). This analysis confirms what previous analyses have made clear: there is considerable inefficiency, duplication, and resource wastage occurring as a result of inadequate coordination between the third party programmes, their MOH managers, donors, NMS and NDA.

#### Health financing:

While the health sector budget is still far short of the optimal level of 15% of government budget, funds in the sector are not currently used efficiently. There is need to systematically reassess the use of available funds in the sector so as to improve the use of funds, and to strategise for more health budget allocation. The following steps are suggested:

- Assess all health sector funding, government, NGOs, and off-budget
- Renegotiate all off-budget funds to be aligned with Uganda's priorities and to be equitably distributed countrywide
- Identify areas /systems where wastage occurs most in MOH and districts. And find cost-saving strategies to prevent such wastages
- Increase government spending in line with agreed priorities and overall long-term plan. The increase in government spending will be for two purposes: a) to improve services by providing the necessary inputs and b) to invest in infrastructure to expand services in readiness for a SHI.
- As people gain confidence in different health units, micro prepayment schemes can be introduced slowly by health units in consultation with district and other local authorities.
- The national SHI scheme can then come at a later stage to help gradually raise revenue so as to create a sustainable health-care system. This is in the long term

#### Payment of health facilities and workers

The way health workers are paid (in form of salary) has been a source of inefficiency and abuse. Under a new programme to enhance health worker pay, a different pay system must be worked out. It should be based on outputs and results. It could include a basic salary and a bonus based on results produced. Likewise, payment or funding of health facilities has to change. It should also be related to outputs and results. The annual number of clients and patients seen is a good starting point. But the sizes of populations being served, the proportion of the population the facility is serving etc, will all be important.

### Performance improvement

There are simple practical performance and quality improvement steps that have worked and can be employed on a national scale. These require: a) documentation of best practices in performance and quality improvement approaches; b) root cause analysis, solution finding and implementation; and c) packaging best practices in a nation-wide context.

### Reorganization of the health system

Under the current political and administrative decentralization, it is almost impossible to run a health system tied to local governments. This is because the local governments so created are not viable in authority, capacity and resources to run relatively independent district health systems. The recommended strategy is for the health system in Uganda to be divided into health regions. It is possible with such a health care region to mobilize adequate resources – human, financial and material - to run a self-sustaining health care system. In such a region that consists of several districts, it is recommended that:

- Unified health programmes for all the districts in the region be established
- At least one hospital is designated as a referral hospital where difficult cases requiring highly specialized skills can be handled. Such a hospital would also provide back-up support to lower level health facilities and services
- A regional medical store and equipment workshop be set up
- A regional health council or committee consisting of all District Council Chairmen, Chief Administrative Officers, District Health Officers and Superintendents of hospitals be established. One district council chairmen would be elected as chairman of the regional health council, and the chairmanship would rotate annually.
- A joint regional health plan for some joint programmes with clear financial support be made and implemented
- The Sub-district health system be maintained and strengthened, especially to cater for maternal health where a doctor's or a senior midwife is required.

### Regulation

There has been a near total breakdown in law and order in the health sector. It is important to begin a process leading to the observance of and enforcement of law and order. The following steps will lead the way:

- Identify all laws in the health sector and find out why they are not enforced or observed
- Pick out the most critical health system and public-behaviour related laws that need support for enforcement. Mobilize human, material resources for enforcing the laws. The number of laws being enforced should be increased over time to cover all existing laws in the country.
- Laws should be reviewed to assess whether a) they can be reduced and perhaps merged, b) they can be updated, and c) they can address new health issues.
- Mobilise resources as part of the overall policy reform to address the breakdown of law and order in the health sector

### Social Health Insurance

When the critical elements of the health system have been put in place, it is expected that the functioning of the system will be set in motion (Berman, Hsio, et al. 2001). This process should be allowed to unfold over a period of 5 – 10 years effective from the onset of implementation of

the policy reform. The SHI scheme would be the second phase of the health policy reform. Meanwhile, the following are recommended during the transition:

- a) A programme with targets towards universal health service coverage and quality improvements should be established through this policy reform
- b) Social services revitalization programme (addressing education, child welfare, water and sanitation, food security and maternal health) is established and progressing well.
- c) Investment, capacity building and preparation in the following areas related to a future SHI scheme:
  - Design mechanisms for collecting funds
  - Identify and design methods for paying health facilities and health workers
  - Create a management and regulation regime for the SHI scheme
  - Design mechanisms of accreditation of health facilities for inclusion under a SHI scheme
  - Design and establish quality and performance improvement mechanisms

### ***C) Social Services Reform***

Without an effective social service provision, health will not improve. Social services cover what are called health determinants or prerequisites (Abel Smith, 1994). As a beginning only few critical services could be embarked on and others would be added as the economy and the social systems improve. The critical social services / benefit packages are:

- Primary school completion and quality enhancement programme
- Child welfare and protection
- Food security and nutrition
- Water and sanitation
- Maternal health

The following strategies are recommended to deliver the services/ benefit packages:

- a) Improving basic salary and other benefits for workers through a review and amendment of laws governing salary and workers benefits
- b) Incentives and regulations to firms to provide better benefit packages for their workers
- c) Mobilizing an effective workforce for employment through employment oriented policies and regulations
- d) Pension benefits ( which usually support disadvantaged homes with very old people and very young children) should be increased through a concerted effort of budget reform and social policy reform
- e) Programme to provide food or cash support to very poor families should be piloted and scaled-up

The funding to finance these services and reforms could come from the following sources: 1) government to provide better social sector funding, now that the false constraint of macro-stability being tied to an arbitrarily low social spending has been disproved and addressed in a different way; 2) firms and businesses will be compelled by law to pay a reasonable salary and other benefits that can meet demands of the household; and 3) civil society organizations who will mobilize funds through charity and donations to support the indigent.

### ***D) Leadership for pro-poor socio-economic reform***

A national leadership to steer the country towards pro-poor development (as opposed to economic growth that merely benefits foreigners and multi-nationals) will be critical. Three possible ways by which such a leadership can come about are a) persons who are convinced about the misery of the majority poor and the hopelessness brought about by the current economic growth policy in Uganda should aspire to national leadership and influence policy in the pro-poor direction. This is possible as many people are getting restless with the current policies and their disastrous results; b) mobilize a large number of likeminded political and civil leaders against the current free-market policies that are damaging social services, causing social polarity and instability; and c) mobilize and lobby Uganda's development partners to put pressure on the government to adopt serious pro-poor socio-economic policy reforms, and scale down its free-market model of "development".

## **8.3 Towards global sustainable health systems**

National efforts to build sustainable, equitable and effective health systems will be severely constrained by the current unjust world economic order. So, national efforts alone will not be sufficient to bring about sustainable health systems. Uganda and other poor countries can only hope to achieve sustainable and equitable health systems through wide ranging socio-economic reforms globally. And these reforms will require international efforts. By nature, global reforms are long-term and can be contentious. But world leaders who are genuinely concerned about the current injustice and unfairness brought about by the free-market policies could firmly turn around the situation within a decade by first controlling the harmful effects of the global free-market economic policies and secondly by basing the new global economic order on different values. The world has come a long way from where every nation or ethnic group was at war with its neighbours, to the current situation where some semblance of coexistence is possible between different peoples. A global leadership that can turn the current situation around can be mobilized by coalescing likeminded individuals and groups (through networks) to ascend to positions of leadership.

Three key approaches can be used: a) changing global governance, b) actions to support global policy reforms, and c) working towards a new civilization.

### ***A) Global governance***

Currently, the global economic system is built around and to serve the floating capital from the rich western countries (Shutt, 1998; Amin, 2000). The Breton Wood institutions as agencies of the west are used to impose structural economic adjustments on poor countries, mainly to open up their markets to enable the floating capital to be absorbed. And yet there is no effective political management of such a global system. In particular, the poor countries are not effectively represented in the current institutions that attempt to govern the world politically. Instead, the world is being run as a huge market, where communities are subordinated to the demands of the market. A prerequisite of the market is that states should be weakened or even destroyed so that they do not interfere with capital globalization. This has dire consequences for a sustainable and equitable health system, because such a health system can only come about through state leadership and assertion.



Thus, the following should be done:

1. The current efforts to reform the UN system as a true global forum for global governance should be enhanced. This will entail the creation of a global parliament where decisions are taken by representatives of the world in a democratic way.
2. IMF should be reformed to issue real currency to replace the US dollar as this tends to facilitate one country – USA – to dominate the world economically. In other words, the Fund should act as the world's central bank
3. The World Bank should be reformed to collect surpluses from Japan and Germany (the only rich countries that currently have surpluses) to lend to the third world. This would be called development fund.
4. A genuine World Trade Organization should be created based on true free-trade rules that applies equally to all countries
5. Environment and sustainable resource use issues should be key global concerns. Global tax to manage and prevent environmental crisis should be decided on by the global forum and instituted to all countries equitably and in a phased manner.

### ***B) Policy reform actions***

The free-market capitalism which constrains efforts to build equitable health systems, as discussed above was predicted by many to implode sooner rather than later because of the flaws in the entire system. The solution is to create new institutions or reform the old ones, and institute better regulated practices.

Nine key actions to support global policy reforms will include ( Shutt, 1998; Amin, 2000):

1. The third world must organize itself urgently to break away from the five monopolies enjoyed by the rich west – monopolies that have made global justice impossible. These are the monopolies for financial systems, technology, culture, media and military power. Unless these monopolies are broken it will not be possible to stop the western world from asserting its will on the rest of the world. The Third World forums are a useful beginning to nurture these ideas and bring them into real actions. The breakaway from these monopolies means that more countries will be able to express themselves in the affairs of the world and will not be mere recipients of harsh policies such as market-based HSRs.
2. The European left is sympathetic about social justice and so it should be mobilized and lobbied to work with the left of the Third World to push for reform in global governance and for dismantling of unfettered free-market economy, which has severe implications for health and other social services.
3. Lobbying through networks and justice-conscious leaders to reconstruct the UN as the locus for global political and economic negotiation.
4. Mechanisms to limit the return on capital by major private-sector companies must be established. This will need the involvement of the public in influencing prices and investment strategies.
5. Private investors will tend to find rates of return deemed to be compatible with financial stability to be too low to compensate them for the risk of loss. So, the government will need to guarantee them against loss or break the enterprise into small viable companies independent of external shareholders.
6. Enterprises underwritten by the taxpayer must be accountable and subject to public approval of their policies.

7. The value added of return on capital, which is usually inflated, will need to be greatly reduced. Instead, the bulk of this “value” can be applied to a) reduce public deficits and debts; b) reduce prices for consumers; c) provide adequate and equitable salary; and d) provide adequate social benefits and services, including health services.
8. Any compensation to existing private owners for transfer of assets to collective ownership must be below the market value so that the huge overhang of surplus capital, which is destabilising markets, can be reduced.
9. Accountability through a new democracy in the world will be necessary. All party manifestos will require wide public consultation, and will not be left only for party officials to decide. Mechanisms will be needed to ensure that the public can access economic and investment policies and agreements. Where the state provides protection to a corporation, such a corporation will have to be subjected to government supervision. The media will need to be given access to corporation’s policies and reports.

### ***C) Towards a new civilization: fundamental changes in values***

Global policy reforms without fundamental changes in social values will not bring about sustainable development, peace, and social stability (Raskin, Bamuri *et al*, 2002). A new civilization is needed. It will require a shift of values from profit maximization, market competition, and market allocation to social stability and environmental sustainability, output based performance and employment, integration, harmony, and coexistence. There has to be a shift away from materialism, winner-takes-it-all, individualism and domination - which are the values of the current dying civilization. It will require the control over the market by the state. Trade flows will have to be regulated. New rules based on new values will have to be adopted using democratic global institutions. New values for a new civilization will include equity, mutual coexistence, solidarity, shared responsibility, among others. Trade will be allowed only where such rules are acceptable to participating nations. Official policies on trade will promote output and employment. Peripheral economies will need to be integrated into the mainstream global economy, where the same rules apply to all nations.

All these will require value-based organizations (VBOs) through networks and alliances, and the reformed and democratic global institutions to advocate for these changes. VBOs can target governments to be transformed in such a way that they are responsible and accountable to the people. They can campaign to reduce prices, and increase opportunities for employment by making governments and corporations change their policies. They can also campaign to promote the creation of a global welfare system where equitable and sustainable health systems can become a reality.

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