Medicus Mundi Schweiz
Gesundheit für alle

**MMS Bulletin #107**
*"Im öffentlichen Interesse..."*

## *Private not-for-profit health service providers in Uganda*

# Improving opportunities through strategic positioning and co-operation

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*In the middle of the nineties it became clear that quite a number of providers in the private not-for-profit health sector in Uganda were unable to cope with the increasing cost of service production and that major crisis were occurring or soon to be expected. This article accounts for the steps taken in order to make the Government of Uganda aware of the ongoing crisis and sparking off a closer collaboration that the Government would obtain, in few years, important reforms leading to a demonstrable and desirable convergence of mutual benefits: for the people, for Government herself, for the private not-for-profit (PFNP) health sector.*

Most private not-for-profit health providers in Uganda are religious based. It is reckoned that they account for a sizeable proportion of the health services delivered in the country.(1) They have a long history in Uganda and have as prime concern the provision of services to the poor. Many mission statements and institution's constitutions specifically mention this aim. Along the last century this sector has found ways and means to continue operating and expanding, especially in rural environment, while providing services (thanks to the solidarity of sister Churches and denominations) at subsidised price for the people. They are co-ordinated through umbrella organisations.(2)

During the era of socio-political upheaval and economic recession between the seventies and eighties, the private not-for-profit sector continued operating, securing the provision of essential health services to the people, showing a remarkable resilience, thanks to the development of "coping mechanisms" (3) (underpayment of personnel, heavy reliance on unqualified staff, maximisation of personnel working time, disregard for the depreciation cost of the capital assets and their major maintenance) aiming at cost containment on one side, and on the other side having recourse to increasing support from external charities. Emergency cost containment measures cannot be sustained for long without causing problems with difficult solutions afterwards; over-reliance on external funding is subject to "donors' fatigue": in the middle of the nineties both approaches showed their limitations.

The attempt of restoring the physical and human capital of the post emergency period occurred right at the time when new standards of service were introduced, the effects of the AIDS crisis became apparent and the inputs from private charities started decreasing. With cost of service production on the increase and support from abroad decreasing, the only possible option for balancing the accounts remained a heavier dependence on user fees. This caused a rapid decrease of utilisation, especially by women and children, with a progressive efficiency loss.

In the middle of the nineties it became clear that quite a number of providers in the private not-for-profit health sector were unable to cope with the increasing cost of service production (4) and that major crisis were occurring or soon to be expected. A further spread of the crisis, given the size of the sector, would have had major negative effects countrywide. One issue of particular concern for the PNFP sector was the decreased access for the most vulnerable groups (women and children) and, obviously, for the poor.

All this occurred right at the moment when the country emerged from the sequels of the era of socio, political and economic crisis of the seventies and eighties. The new Constitution was approved in 1995 and it sparked an era of reform. The re-thinking of the health sector - and of the policies governing it - had started soon after the beginning of the National Resistance Movement (NRM) era. Already in 1986 the Health Policy Review Commission had advocated for a more visible and recognised role of the private sector (at the time almost exclusively constituted by the mission hospitals and health centres (5); this was echoed five years later by a "Ministry of Health White Paper" – the precursor of the National Health policy of 1999. The statements of these important documents had created great expectations in the private not-for-profit health sector, but very little happened. In the middle of the nineties the situation had become so acute for the "mission" hospitals and health centres that "doing something" became a must.

This article accounts for the steps taken in order to make the Government of Uganda aware of the ongoing crisis and sparking off a closer collaboration that the Government would obtain, in few years, important reforms leading to a demonstrable and desirable convergence of mutual benefits: for the people, for Government herself, for the PNFP health sector. To complete the picture this paper will mention also the most recent events: starting from 2004, what is still considered by many a success story in the relationship between public and private health sector, has undergone a very rapid involution. In this case the critical factors at play will be brought to the fore, along with the author's interpretation of facts.

# Strategic positioning

In February 1996 the Catholic and Protestant Medical Bureaux, responding to the increasing calls of distress, received from their (by then) (3,4) hospitals (6), decided to gather the managers of these institutions to chart a way forward to address the crisis. The looming crisis had been precipitated by Government's decision to increase the remuneration package of its own workers (7) and lifting the civil service's recruitment ban. The only option left to the

private not-for-profit to avoid an exodus of staff towards the better paid civil service would have been a similar increase of remuneration levels. This would have caused a further increase of fees, magnifying the already registered and worrying levels of exclusion. On the other hand, the PNFP sector represented a sizeable quota of the health infrastructure and service provision: a crisis of this sector could not be overlooked by Government.

At that meeting the PNFP re-committed themselves to the service of the rural poor, re-defining their name (8), stating their goals and objectives, the rationale of their operations, their predicament and their will to engage in a constructive dialogue with Government. In other words they configured themselves explicitly in the public service arena, carving out for themselves a clear niche between the two poles equating government ownership of facilities with public and social orientation on one side and, on the other side, private ownership of facilities with a profit and market orientation. It is worth of notice that the presentation of this report/memorandum to the Minister of Health did not trigger any immediate reaction, leave alone any kind of support. At the end of the meeting there was a widely shared awareness that the network was composed of public and socially oriented entities owned by private organisations (under the juridical point of view), that had found a new way to explain that their charges were not meant for profit, had understood that being a "parallel" sub-system was leading them towards a progressive marginalisation, had recognised that only a collaboration with Government would allow them to pursue their social mission, had become aware that their demise would constitute a disaster for the country… Because of these reasons they were determined to do something to change the state of affairs.

The report/memorandum ended with clearly stated commitments of the PNFP hospitals; noteworthy are the commitments to the pursuance of closer links and active collaboration with the district health authority and to better documentation and publication/sharing of data on the use of resources and outputs. It can indeed be said that this moment of awareness and identification of their strategic position triggered initiatives that could be summarised in three main points: closer collaboration with the local health authorities, investment in the development of capacity of information management and use of it for advocacy at central and district level.

# Collaboration

At that time quite a number of hospitals had already developed an informal – although often enough very effective - relationship with their respective districts, especially those located in poorest districts of the country. This occurred outside all form of specific policy guidance. The policy documents of that time only advocated for participation of all actors in health care to the district health planning, without going much further. A bolder step was undertaken by a few of the hospitals in this group, which asked their respective districts to recognise the existing collaboration in a formal way, banking on the newly acquired legal and political personality of decentralised districts under the new Constitution. The first Memorandum of Understanding between a private not-for-profit hospital and a District was elaborated in Karamoja (the least developed area of the country), in the middle of 1996. Interestingly enough

this Memorandum of Understanding, while assigning to the hospital supervisory and public health functions in one of the District's Counties (9), did not allocate any financial resource to it. It only expressed the wish to do so should additional resources be made available to the District by Central Government. This sufficed to create an important precedent that did not go un-noticed by the newly appointed Minister of Health. Before the end of 1996 the new Minister had established a Task Force composed of various actors in the public sector and the Bureaux, charged to prepare a rational justification for the possibility of allocating public funds to private institutions.

With this task accomplished to the satisfaction of the Cabinet of Ministers in January 1997, the first of such allocations occurred in the following financial year 1997/98: it was a very limited amount of money benefiting hospitals in very poor environment, which had an established tradition of collaboration with their respective districts. Despite its limited relevance from the financial point of view, this move of Government sent a clear signal: collaboration was possible; it could go beyond the informal arrangement; it could be accompanied by transfer of public funds to private institutions; it required a revision of the national health policy, whereby the notion of health system is extended from government owned facilities to all providers accepting to operate within the frame of the policy. The new Health Policy, providing the general frame of the strengthened public-private collaboration, was published in 1999. Among others, it states "It is a Policy Objective to make the private sector a major partner in Uganda national health development by encouraging and supporting its participation in all aspects of the National Health Programme". Little, or timid, as this may appear, it had instead a catalysing effect for many hospitals and their respective districts. From then on the number of private not-for-profit hospitals abandoning their isolation and "prudent" attitude increased and by Financial Year 1999/2000 all were able to benefit, albeit at different levels of support, from Government subsidies. This commitment was "captured" by a very simple Memorandum of Understanding where the objectives of the collaboration were outlined (although not quantified): decrease of user fees, increase of remuneration of staff, undertaking of public health interventions. Subsidies were extended, two years later, also to smaller health units and health training schools.

# Development of information management and organisational capacity

The other commitment taken by the private not-for-profit hospitals in their meeting of 1996 concerned the availability, use and sharing of information concerning use of resources (financial, material, personnel) and the resulting outputs and outcomes (activities, coverage etc...). One of the most common complaints moved towards the PNFP health sector was its "secrecy". In reality the alleged reluctance in sharing and publishing information had a much more practical reason: information systems – of all types – were absolutely inadequate. There was indeed very little information to share. It simply did not exist or, if it existed, it was so fragmented and unreliable that it would have portrayed a wrong picture in any case. It has to be noted that the hospitals that caused the policy change were also those having the most

developed financial and activity records. The Bureaux, and UCMB in particular, realising the strategic importance of information availability and analysis for both management purposes and advocacy, decided for a sustained effort aiming at improving the transparency and accountability of the network.

The results of this effort are well documented and recognised also as best practice. The development of this capacity became particularly useful when, in 2001, the President, during his presidential election campaign, declared that user fees in Government health units would be scrapped because they represented too serious a barrier to access for the poor. Until then user fees had been a controversial but approved practice in both public and private health units. As consequence, Government policy of supporting the private not-for-profit health network came under close scrutiny and criticism of Parliament and some sectors of Government. It has to be noted that Government subsidies represented only a proportion of the income (10) of the PNFP network: in the "best year" of the partnership, this proportion reached a maximum of 36% of the year's revenues. The capacity of UCMB to collect, analyse and communicate critical information, protected the partnership from negative consequences; unfortunately the effects of this "protection" did not last long (see next paragraphs). The building of information management capacity carried with it also the need of ensuring the necessary capacity of decision making, internal and external accountability. For this UCMB developed specific training programmes of organisational development addressing both managers and board members. Along with these training programmes several manuals and guidelines addressing various managerial and governance issues were developed. (11)

On the whole, the established collaboration with government created a conducive environment and built the necessary momentum for an extensive internal reform of the private not-for-profit health units, their management procedures and their governance. Regardless of the future of the public-private partnership in health, this by-product of the collaboration represents a step forward in the organisational sustainability of PNFP facilities. One of the aspects of the developed capacity is the possibility of using information for advocacy. This capacity is not yet fully developed in facilities themselves, but the umbrella organisations have definitely shown that they are able to advocate for the units affiliated to them. An example of this capacity has been the possibility for the PNFP facilities to demonstrate the effect of the support received on levels of user fees charged to users and on performance in general. It has been possible in fact to demonstrate that the established partnership and the support extended by Government to the PNFP sector has been convenient: convenient for Government who, with a small fraction of its budget has been able to extend access to health services to the population; convenient for people who have benefitted of health services of decent quality at lower fees than before; convenient for the private not-for-profit network, which has been able to reverse the negative trends of performance observed in the nineties and gain efficiency, while continuing to pursue its mission of social concern.

# The favourable environment: SWAp

This account would be incomplete if it failed to mention that all that has been reported occurred at a time when a wide consensus was reached, both internationally and at national level, about the need of developing systems rather than implementing health programmes: this approach is generally known as SWAp (12). The fact that many donors had accepted to provide support to the Government budget (through un-earmarked or sector earmarked grants) as long as Government accepted to run its business (and particular plan and manage its budget) in a transparent way, has undoubtedly been a key enabling factor for the establishment of the partnership.

In fact the partnership sparks off and develops under the frame of poverty eradication and sectoral implementation plans with clear objectives, costs and targets, and a widely participated monitoring and evaluation framework. In addition, at the outset of the SWAp one thing was clear: the Ministry of Health had to consider itself as steward of the health status of the population and guiding centre for the health sector in its entirety. Budget allocative decisions had to be driven by the concept that public money had to purchase public goods for the people and make the best out of its value. Hence considerations of efficiency (and effectiveness) had to be made when allocative decisions were taken. It could be said that at the beginning of the collaboration this overall conceptual frame was, if not clear to all and not always consistently pursued and respected, at least mentioned and to some extent remembered one budget after the other. It must also be said that the private not-for-profit sector was at the outset suspicious of many donors' "conversion" to the total or sector budget support: they saw it as a potential threat to the other important source of revenue of the PNFP sector (donor's support). This fear was allayed – at the time – by the openness of the processes established: participation of the PNFP representatives in the Health Policy Advisory Committee, its technical working groups and Joint Review Missions; access and exchange of critical information in various stages of the health sector budget and report formulation (13); joint monitoring of progress etc. All seemed to be set for a promising further development of the collaboration. As matter of fact the PNFP sector's representatives managed to obtain from the Ministry of Health the establishment of a Task Force to work on a further definition of the Public-Private-Partnership for Health. This task force worked for over one year and was able to widely consult all the stakeholders, including districts health and political authorities. Eventually the draft Policy for Partnership was presented and adopted by the IX Joint Review Mission in November 2003. Among other things, this policy envisaged the possibility of introducing a more defined contractual relationship, able to safeguard the interest of both collaborating partners and protecting them from asymmetric expectations. The next step was supposed to be the approval of the Cabinet of Ministers. This approval never came. What instead happened in the following year could be defined a real "cold shower".

# An unexpected development

Since 2001 the Ministry of Finance had been voicing its concerns for the effects of high volumes of financial aid on macroeconomic stability (14) and announcing corrective measures aimed at stabilising the local currency exchange rates and interest rates. What this measures

(Fiscal Consolidation Strategy) meant for the health sector budget started becoming apparent in 2004. In the same year the Health Workers' Union threatened Government that it would stage a massive strike if the demand for a substantial increase of salary would go unmet. Government, in view of the forthcoming elections, thought better to yield to the pressing demands of a trade union composed almost exclusively of civil servants: this resulted in the award of substantial salary increases (around 40% on average) for health public servants, with the immediate expansion of the wage budget. In addition, in the same year and in the following, a wave of massive recruitment in civil service of health workers occurred.

On the other hand, the macroeconomic stability concern of the Ministry of Finance led to the freezing of the health budget, which at this point left very little room, if any, for the necessary expansion of the non-wage component of the budget, leave alone for a balancing increase of the allocation to the private not-for-profit sector (15). Public expenditure for health has been stagnating (in real terms it has decreased) since 2001, with the remarkable and volatile exception of year 2005/6 when Global Initiatives money (largely imports of antiretroviral drugs and other AIDS related inputs) "artificially" pushed per capita expenditure upward in the very short term (creating important problems of sustainability afterwards). The PNFP sector accounted, in that year, for about 10,000 employees, against 20,000 civil servants. It was expected, and indeed it happened, that the net result of this decision of Government was a massive exodus of workers from the PNFP to the public sector.

Attrition rates for nursing staff (this cadre is the real backbone of the health system) in the private not-for-profit sector have in fact reached in the last two years staggering levels (Table) (16).

**Table: Observed attrition rates in the PNFP Health Sector**

| | 2003/04 | 2004/05 | 2005/06 | 2006/07 |
|---|---|---|---|---|
| **Hospitals** | | | | |
| Medical Officers | 28% | 21% | 30% | 38% |
| Clinical Officers | 22% | 21% | 36% | 26% |
| Enrolled Nurses | 16% | 17% | 26% | 24% |
| Enrolled Midwives | 15% | 10% | 34% | 26% |
| Registered Midwives | 9% | 11% | 27% | 15% |
| Registered Nurses | 5% | 14% | 11% | 15% |
| **Lower Level Health Units** | | | | |

| | | |
|---|---|---|
| Clinical Officers | 30% | 34% |
| Enrolled Nurses | 45% | 36% |
| Enrolled Midwives | 46% | 44% |

Due to the persisting constraints in the health budget since 2004 – and its heavily skewed structure towards wage –, the Ministry of Health has been unable to accommodate even the slightest increase of grant allocations to the PNFP health sector. Under the compounded pressure of the increased cost of service production, stagnating (when not altogether reducing) public subsidies and loss of staff (usually the most experienced), the hitherto very good performance indicators the PNFP sector have started showing undesired and worrying trends, whose effects have now started affecting the whole health sector. For four years in a row this situation has been denounced as inappropriate – to say the least – by the representatives of the PNFP health sector. The arguments of these latter have been, to some extent, echoed by representatives of the Donors (17) who contribute to a sizeable proportion of the Government Budget and hence share in the responsibility of the effects of Government decisions. The undertakings of the last two Joint Review Missions of the Health Sector (18) have reflected the concerns voiced by the PNFP sector, too. Also the Ministry of Health has tried to argue for increased allocations to the PNFP providers. All of this has obtained no effect. It is legitimate therefore to ask if the processes occurring at sector level – that started with SWAp – can still have influence on Government decision making for sectors. It would seem it is not so.

What does have effect, then? It is difficult – and probably impossible - to establish it with certainty. It is nonetheless possible to enounce a hypothesis that may suggest the opportunity of making an in depth analysis.

# Global Initiatives and the Paris Declaration

Two different processes (at first glance of opposing extremes), have effects on the health sector: Global Initiatives with their "vertical approach" and the development of aid harmonisation linked to the Paris Declaration on Aid Effectiveness.

As matter of fact, since the appearance of Global Initiatives, we have witnessed a progressive emphasis on the need of obtaining short term programmatic results in the fight against specific, albeit important, diseases. This is happening, despite all statements - and reassurance to the contrary - at the expenses of "system building" (19) and allocations to typical system component of health expenditure: the "frozen" allocations to the PNFP sector is an example of this.

In the same way, since the Paris Declaration on Aid effectiveness, emphasis has moved from building of "sectoral sub-systems" to the building of the "Country systems": the overwhelming influence of macroeconomic stability concerns with its monitoring processes and discussions on Government allocative decisions is evident (20). These discussions occur at a level far removed, now, from sectoral actors, whose voice (be it that of ministry technocrats, development partners in the health sector or, like the case of PNFP, providers in the sector) does not seem to reach "those who matter".

# Conclusion

A lasting partnership has some unavoidable demands and conditions: it must be based on mutual trust and confidence that the way chartered and agreed will not suddenly change. It must also obtain balanced gains: both actors undertaking the partnership must draw an advantage from it while the public – the final beneficiary – must reap the end benefits (i.e. the partnership has to serve the "public interest"). It is exactly what the first 6 years of public-private partnership for health have produced in Uganda. The private not-for-profit health sector, with its rationale of operation largely dominated by social concern, has been able to obtain, with limited support from Government, remarkable gains of access, equity, efficiency and quality. This happened at a moment when health sector budgets had been expanding, within the frame of the understanding reached under the SWAp approach. Unfortunately, at the first sign of budget stagnation, the Ministry of Health (or Government in general) decided to sacrifice the partnership's demands and listen to the demands of a powerful lobby, arguably claiming to serve the public interest.

This unfortunate contingency has occurred at a moment of weakness of the health SWAp, determined by the influence, on the health scenario, of processes linked to two new currents of thought in development assistance: the appearance of Global Initiatives with their "vertical approach" on one side, and the development of processes linked to the Paris Declaration on Aid Effectiveness on the other. The first has weakened the SWAp by imposing priorities through the sheer volume of strictly earmarked financial aid; the second has weakened SWAp by emphasising the macro level of budget planning, management and effects monitoring, diluting the intensity and effectiveness of sectoral dialogue, planning, budget management and monitoring.

The partnership between public and private not-for-profit health actors has been a "victim" of these new developments. Only time will tell whether we have seen the end of public-private partnership for health in Uganda or not. In the meantime, the first evidence that public interest has not been adequately served has just appeared: the performance of the health sector has started showing signs of deterioration.

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**Notes**

1. The first health facilities were established towards the end of the 19th Century.
2. The Catholic, Protestant, Muslim Medical Bureaux and the Uganda Community Based Health Care Association are the main co-ordinating agencies of the PNFP health sector operating through health facilities. The Catholic and Protestant Medical Bureaux were established in the mid 1950s.
3. The coping mechanisms developed by the sector were: underpayment of personnel, heavy reliance on unqualified staff, maximisation of personnel working time, disregard for the depreciation cost of the capital assets and their major maintenance.
4. The UCMB estimated that, on average, the cost of producing one unit of output had been increasing, in those years, at a rate of +20% per year.
5. The distinction between private not for profit and the private for profit started becoming relevant only after the liberalisation of health care provision, in the late eighties. Before that time so called private clinics were a rarity and were concentrated almost exclusively in big urban centres.

6. At the time the Bureaus were able to reach only the larger institutions i.e. hospitals. Things have changed in these years and the Bureaus are now able to reach, through their peripheral co-ordinating structures, also smaller health centres.
7. The recent downward trend in the relationship between public and PNFP health sector has ironically been caused by the same unilateral decision of Government to award substantial pay raises to its own health employees, without prior consultation with its main partner the PNFP and without the identification of compensating/balancing measures.
8. From that moment on the network started being recognised and mentioned as Private-not-for-profit (PNFP), a definition and acronym hitherto unknown in Uganda.
9. This function had hitherto, for several years, been exercised without either support or formal recognition. The cost of this informal "public function" were borne by the hospital administration with its network of charitable support, thus testifying the "public" orientation of this - and others - PNFP hospital. The experience gained and the methodology followed in this context formed the basis of the Health sub-district policy adopted some years later by the Ministry of Health. In this policy, the function of supervision and support to Lower Level Units, and ultimate responsibility for public health measures and interventions is assigned to any hospital or up-graded health centre in the County, regardless of its institutional setting (government or PNFP).
10. Income and revenues in the PNFP sector basically coincide. Few units close their financial year with little more that a very limited positive balance that is ploughed back in the following year's exercise. Some do incur losses. None, at the moment, is in position to finance depreciation of their physical assets.
11. Areas of specific focus are the management of financial resources, human resources, information and organisational governance.
12. SWAp or Sector Wide Approach: A SWAp is a process in which funding for the sector – whether internal or from donors – supports a single policy and expenditure programme, under government leadership, and adopting common approaches across the sector. It is generally accompanied by efforts to strengthen government procedures for disbursement and accountability. A SWAp should ideally involve broad stakeholder consultation in the design of a coherent sector programme at micro, meso and macro levels, and strong co-ordination among donors and between donors and government.
13. The Annual Health Sector Performance report, to date, always contains a specific section dedicated to the performance of the PNFP health sector. The methodology of performance assessment introduced by this latter, has been adopted by the Ministry of Health to assess performance of its larger hospitals.
14. In a nutshell: the large amount of inflows of foreign currency to finance the fiscal deficit (the gap between projected - and eventually actual - government budget expenditure and internal revenues from various taxation – in Uganda this gap is currently around 50%) force the central bank to purchase local currency through emission of treasury bonds and/or sale of foreign currency. The consequence is 1. an increased interest rate for borrowers on one side and 2. an appreciation of the local currency against foreign currencies. Both have – or are said to have - depressing effects on economic growth by,

respectively, crowding out the production sector from the necessary access to credit and making export of local products less competitive on the regional and international market.

15. Government spending occurs under three main item lines: wage, non-wage and development. Allocations to the PNFP health sector occur under the second of these items, although its use for top-up and facilitation allowances to staff is somehow "tolerated". The legal framework allowing Government to give wage subvention has not been developed yet.
16. The fact that attrition rates in the last financial year are less severe than in the previous year is simply due to the fact that Government has been unable to recruit at the envisaged speed. The extensive recruitment by government will resume in 2008.
17. Excerpt from the speech of the Development Partners' Representative at the closure of the XII JRM in October 2006: "Thirty percent of Uganda's health workers are employed by the private, not-for-profit facilities. They provide efficient services and make an essential contribution to the delivery of health services in Uganda. Over the last two years, these facilities have lost a number of their staff to government facilities due to the salary increase which applied only to government health workers. Failure to address the salary gap now will threaten the contribution made by these providers, and undermine progress across the sector."
18. Both the XI and XII Joint Review Missions' undertakings reflected the concern for the salary imbalance between health civil servants and PNFP health workers – with its systemic consequences - asking Government to enact the necessary measures apt at re-balancing the situation. Agreed undertakings are solemn commitments of Government, whose fulfilment should determine in its turn the commitment of donor partners to put money in the budget's basket.
19. In reality, it would seem the surge of fund flows under project mode has "crowded out" general budget money from the resource envelope for health. It is a legitimate inference that, in reality cannot be demonstrated. On the other hand, it is not possible to demonstrate that Global Initiatives moneys are additional to Government budget (as demanded by the Statutes of most Global Initiatives).
20. The health indicators of MDG – impact indicators - are used to monitor the effects of aid on the Country systems, rather than more "sector system" indicators of output and outcome. Impact indicators do not change dramatically, even in the mid-term. Hence they are not adequate to capture damages to the health system. They are also difficult to attribute, for good or for bad, to the health sector. A wrong sectoral policy can have pernicious effects on the health system and very few, if any, short to mid-term consequences on MDG indicators. In the long-terms, dysfunctions of the health system will probably have consequences also on impact indicators. Tables

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