

PRIMARY HEALTH CARE AND HEALTH SECTOR REFORMS IN UGANDA

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Abstract

The health system in Uganda has undergone a number of changes since independence in 1962 and the PHC concept was a timely innovation, and very welcome in Uganda. And also as a response to the global economic decline of the 1970s and 1980s, the World Bank and IMF introduced Structural Adjustment Programmes (SAPs) in some developing countries and accordingly a package of reforms was proposed to address problems in the health sector, and these were called health sector reforms (HSR). Both PHC and HSR have faced similar and dissimilar challenges.

Introduction

The Primary Health Care Concept (PHC) concept was introduced at the 1978 Alma Ata conference in an attempt to address the inappropriateness of the health structures inherited by developing countries to tackle their predominant health problems. There was a need to broaden the concept of health (health beyond disease and health care) and also of understanding of the wider causes of ill-health (poverty, literacy, sanitation etc.). There was further a desire to incorporate a greater involvement of communities in decision-making and also shift development thinking towards social ends (human development rather than just economic).

Five main themes of Primary Health Care were considered and adopted at the Alma Ata conference, and these were: importance of equity as component of Health (PHC = Equity = Wider Development); community participation in decision-making; multi-sectoral approach to health problems; adoption and use of appropriate technology; and emphasis on health promotional activities.

PHC in Uganda

The health system in Uganda has undergone a number of changes since independence in 1962. In the period preceding independence, the health system development in Uganda was characterised by establishment of an extensive network of health units and hospitals, with home-hygiene and preventive programmes run by a network of health inspectors complementing this health care infrastructure. During that time, the health facilities were designed around provision of curative care with a doctor as the kingpin. A hospital was established in each district. Ugandans enjoyed free and relatively easily accessible health care, but this system relied strongly on extensive investment in the health sector by the government for support and sustainability.

With the economic decline and bad governance that followed during the Idi Amin era, coupled with the global recession of the 1970's, the health system became

unsustainable and services deteriorated. Most public health programmes collapsed and health facilities faced staff and drug shortages. Under the table payments became

prominent, and there was a resurgence of use of traditional medicine.

So the PHC concept was a timely innovation, and very welcome in Uganda. It was subsequently adopted by Uganda after the Alma Ata conference as the focus of its health system development. This was a major paradigm shift, with the focus therefore changing from provision of hospital-based care to more community oriented health services.

From 1980 to 1983 was a period in which policy makers and health workers were sensitised about PHC. About the same time, a debate on whether to implement comprehensive PHC or selective PHC took place. Selective PHC was the preferred strategy. So the introduction of vertical programmes/projects took place defeating the idea of horizontal holistic implementation of PHC programmes.

The Control of Diarrhoeal Diseases (CDD) programme was introduced around 1983, and about the same time, UNICEF introduced a programme emphasising Growth monitoring, Oral rehydration therapy, Breast feeding, Immunisation, Food security, Family planning, and Female education. In 1986, the Expanded Programme on Immunisation (EPI) was relaunched; the Maternal and Child Health (MCH) programme; Family Planning and the AIDS control programmes were also introduced. Over the period 1989 to 1993 a further expansion of vertical programmes/projects took place, and by 2000, there were 57 programmes in the health sector.

So right from the onset, implementation of PHC in Uganda was fragmented and uncoordinated. Some of these vertical programmes had substantial and considerable external/donor funding and in many cases were not really under Government control.

Health Sector Reforms

As a response to the global economic decline of the 1970s and 1980s, the World Bank and IMF introduced Structural Adjustment Programmes (SAPs) in some developing countries. These programmes entailed complete overhaul of economic policies and the allocation of resources to the

social sectors was to be cut. One of the conditions contained in these adjustment programmes was the condition that user-fees be charged for social services. The philosophy was that social services are not universal human rights as commonly claimed. Further arguments by economists were that public goods/services benefit society as a whole whereas private goods/services benefit the individual concerned (Atkin et. al 1987); so public goods like immunisation benefit society as a whole and the state should finance them while on the other hand private goods like anti-malarials benefit individuals and should therefore be paid for by the affected individuals. In a nutshell, preventive services should be financed by the state and curative services by individuals.

In the 1980s and early 1990s, there were scarce resources for health in the poor countries, with for instance health expenditure for most Sub-Sahara African countries in 1990 estimated to be less than US \$ 20 per capita. Further, there was inefficient use of these scarce public resources, which were largely spent on inappropriate and cost-ineffective services with characteristic poor input mix; emphasis on tertiary rather than primary care; and poor value for money in procurement. Lastly, there was poor utilisation of services – both supply (unmotivated and poorly trained staff, inadequate supplies and drugs etc) and demand side issues (access, poor quality services).

Accordingly a package of reforms was proposed to address problems in the health sector, and these were called health sector reforms. The World Bank/IMF defined these reforms as fundamental, sustained, and purposive changes aimed at defining priorities, refining policies and reforming the institutions through which those policies are implemented.

The package contained four strategies; namely broadening health financing which included charging users of public facilities, providing health insurance or other risk coverage and establishing community pre-payment schemes; decentralisation of health services; privatisation and broadening the provider mix with emphasis on effective use of non-governmental resources and targeting improvements in human resource management (Atkin et. al 1987). A number of African countries adopted these reforms and these included Kenya, Ghana, Uganda, Cameroon and Zimbabwe.

Health Sector Reforms in Uganda

Uganda started implementing these reforms in 1987 in the form of broad decentralisation including the health sector; broadening health financing by the introduction of user charges and later community pre-payment schemes; working with Private Not For Profit and Private Healthcare Providers and also encouraging the autonomy of public hospitals; planning and resource allocation systems (bottom-up intentions vs. top-down practice); and lastly human resources management systems under which there

was retrenchment, pay reform, transparent remuneration structures, and decentralised human resource management.

Primary Health Care and Health Sector Reforms

As mentioned above, the Primary Health Care (PHC) concept was introduced at the 1978 Alma Ata conference and was subsequently adopted by Uganda as the focus of health system development. Its implementation, however, was hampered in the early 1980's by continued bad governance and civil strife. By 1986, the health system was in a shambles. With the failure of the public system to provide for the health care needs of the population, private providers had easily entered the health care market with associated inequities and inequalities of all sorts, with a resultant lack of recognisable PHC activities.

Uganda therefore did not perform to expectation in implementing the PHC objectives, goals and strategies agreed on in Alma Ata in 1978. With the advent of the NRM government in 1986, a process of reconstruction and rapid development was started. The government had an opportunity to start planning for the country on a new platform. In 1986, the Expanded Programme on Immunisation (EPI) was relaunched; the Maternal and Child Health (MCH) programme, Family Planning and the AIDS control programmes were also introduced. The early 1990's were further characterized by the implementation of the health sector reforms. Central to these were decentralization, and the Structural Adjustment Programmes that urged government to reduce its responsibility for paying for social services, such as health, that produce few benefits to the society as a whole. This was aimed to free resources so that more could be spent on the 'poor'.

The decentralization process on the other hand had started in 1986 with power decentralization through 'resistance councils', and was reinforced as a government policy for effective service delivery in the 1995 constitution. The Local Government Act, which put into effect the provisions of the constitution, was passed in 1997 and substantially devolved powers previously exercised by the central government to the district local authorities. The Ministry of Local Government was made the key intermediary between Local Authorities and the Central Government.

The decentralised system is based on the district as a unit, under which are lower local governments and administrative units. The care delivery health system was designed along this decentralised public system, with a corresponding health unit level for each level of local government or administrative unit. There was a resultant multi-layered health care system from Health Centre I – IV as lower level units, with a district hospital for each district. Above this were the regional and national referral hospitals. Responsibility for clinical care was built up this system. However, management of the delivery of the Primary

Health Care services was the responsibility of the District Medical Officer, who reported to the Ministry of Health.

Conclusion

The major objective of PHC was Health for All by the Year 2000 emphasising the concept of equity. That of the HSR was the better functioning of health systems, emphasising efficiency and it was actually more of a health care systems reform. For PHC, the main players were WHO, UNICEF and for HSR, the main players were the World Bank and IMF. There was however some considerable overlap between the contents of PHC and HSR.

Both PHC and HSR faced similar and dissimilar challenges. First of all, there has been lack of information for appropriate decision making mainly caused by a weak HMIS and a weak culture of using evidence for decision making. Secondly, PHC and HSR have been hampered by institutional issues (failure of delivery systems or the behaviour of people) and scarce resources. There have also been the problems of specifying priorities, objectives, monitoring outputs and outcomes, and tracking use of resources.

A three-year health plan was launched in 1993, and from 1994 to 1999, preparations for a new health policy took place. Eventually a National Health Policy was released in September 1999 as the main vehicle for establishing and implementing PHC in Uganda. As a guiding principle, the policy reiterates the role of PHC as the basic philosophy and strategy for national health development. A 5 year Health Sector Strategic Plan was also subsequently formulated and released in 2000 as the main mechanism for implementing the NHP, and by extension PHC. This plan embodies the concept of PHC and all the Health Sector Reforms and so will hopefully begin to deliver on the objectives, goals and strategies agreed upon in Alma Ata in 1978.

References

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