

HEALTH CARE IN UGANDA: CHALLENGE AND CHANGE

Executive Summary

The two studies presented in this monograph represent a body of research of health system and health policy issues that Dr. David O. Okello and his colleagues¹ at the Clinical Epidemiology Unit of Makerere University in Kampala have undertaken in the past several years. The research was supported by grants from the Carnegie Corporation of New York, through the International Health Policy Program of the World Bank, to advise the Government of Uganda on the state of the health care system, and policies needed to restructure and restore high quality health care to its populace. After two decades of political unrest and social chaos, the infrastructure of the Ugandan health care system had seriously deteriorated. The government's scarce resources for health were concentrated in hospitals in towns, leaving more remote and rural health centers depleted. Morale of health care personnel was low due to low salaries, and supervision had broken down at all levels. Consumers utilized nongovernmental organization (NGO) health facilities more than government facilities, believing they rendered higher quality services.

The first study was commissioned to identify problems of the system, assess differences between government and NGO facilities, and determine measures needed to rebuild the system. "The Challenge to Restoring Basic Health Care in Uganda"² reported results of a study of both government and NGO health facilities conducted between June 1992 and December 1993. Based on survey findings and interviews, the investigators offered policy recommendations to the government for systemic change. Communications between the investigators and the government were continuous, and modifications were begun. Government health care management was decentralized, regulations were reviewed, salaries were improved, and user fees were tested.

Government policy toward the private health sector changed, allowing it to grow and fill gaps caused by limited government resources. The second study, "Aspects of the Private For-Profit Health Sector in Uganda: An Appraisal of Scope and Impact,"³ explored private for-profit medical clinics to assess the scope and impact of their services and understand their appeal to consumers. This study became a catalyst for policy discussion and debate within government on the relationship of government to the private health sector, as regulator or partner, a very positive step toward initiating change. It also led to a third study to investigate the influence of the donor community on Ugandan health care policy and services, the results of which were to be released after the completion of this monograph.

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²Okello, D.O., Lubanga, R., Guwatudde, D., and A. Sebina-Zziwa. The Challenge to Restoring Basic Health Care in Uganda. *Social Science and Medicine* 1998; 46(1): 13-21.

³Okello, D.O., Konde-Lule, J., Lubanga, R.G.N., Arube-Wani, J.W., and Lwanga, J.B. Aspects of the private for-profit health sector in Uganda: an appraisal of scope and impact. Health Policy and Development Group, Uganda, 1997.

These studies were conducted by members of the Clinical Epidemiology Unit of Makerere University in Kampala, Uganda, in close collaboration with non-INCLEN researchers at the University, all of whom are listed in the footnotes below.

Introduction

Uganda is in a process of recovery and rehabilitation following several years of civil strife that depleted the national economy, leaving the health care system in serious disrepair. The new government, which assumed power in 1986, sought new approaches and policies to upgrade health facilities. The first study examined the challenges facing government in restoring basic health care in the country. The government was repairing and rehabilitating health unit buildings, but inadequate staffing and supplies (especially pharmaceuticals) were still serious problems, especially in facilities at the lower levels of care. People rejected use of the small health units and flocked to large urban hospitals, where trained staff still existed. Governmental clinics at lower levels were so poorly staffed by under-trained personnel that no amount of renovation would draw consumers to them. The second study focused on the emerging private for-profit sector of health care. The private sector had grown precipitously, with encouragement from the government, which was unable on its own to satisfy the demand for health care services. Consumers wanted high quality care, which was not available in the lower levels of governmental facilities. People chose NGOs and other private health providers, opting to pay for services that they perceived to be of higher quality than the free services of governmental facilities. The Ugandan Ministry of Health (MOH) decided to integrate the private for-profit providers into its overall strategy for providing health care. To do so, the MOH sought additional information about the private sector regarding its size, practices and potential and so commissioned this second study.

The First Study: The Challenge to Restoring Basic Health Care in Uganda

Political and social turmoil in Uganda for the two decades after Idi Amin's rise to power in the early 'seventies contributed to the deterioration of the health care system. Prior to that time, patients in the rural areas could be seen at an aid post, dispensary or health center for primary care, whence they would be referred to larger units for advanced care. As uncertainty enveloped the country, the quality of health services declined and public confidence in governmental health providers waned. Governmental facilities tended to be poorly maintained with fewer medications and supplies. Consumers and providers perceived that governmental resources were concentrated in hospitals, thereby motivating consumers to overuse hospital services, while bypassing more appropriate lower level health services.

In 1983 the Ugandan government, as part of health sector reform, adopted a policy of Primary Health Care, advocating access for all households to essential health care through community-based and lower levels of service. The revised health delivery system was based on four levels of services: primary, consisting of health centers and lower service units; secondary, provided by a network of district and rural hospitals; tertiary, through the general referral hospitals located in the regional capitals; and quaternary health care, found at the two national hospitals, Mulago and Butabika.

Both government and NGOs delivered services in smaller health units as well as hospitals. Most of the 39 districts in Uganda had at least one hospital supported by several lower level health care units, but no standards existed to explain how sites were selected for health care units. Capacity of units varied greatly from district to district. Population density also varied, with only 27% of Ugandan citizens living within 5 km of a health unit (*Uganda Government, 1992*). The aid posts and dispensaries of the older system were upgraded to health centers, and their functions broadened to incorporate health education and prevention programs focused on immunization, environmental sanitation, better child feeding practices, and early diagnosis and treatment of minor ailments. Beginning in 1986 new health care resources had been devoted to capital improvements of hospitals and health centers and to single-focus vertical programs such as diarrheal disease control. While rehabilitating facilities was favorably received, the government found itself unable to adequately fund operating expenses (*Barton and Wamai, 1994*).

The survey for this study conducted between June 1992 and December 1993 assessed existing programs and determined patterns of distribution and utilization of resources, to offer policy recommendations for improving efficiency. Health sector reform initiatives were instituted as a result of the study, such as decentralization and review of regulations and user fees, to customize local health care to local needs and ease the government's financial burdens (*Okuonzi and Macrae, 1995; Gilson et al., 1995; Uganda Government, 1995; Macrae et al., 1996*).

Objective

Focusing on issues of resource allocation, unit costs and consumer satisfaction, the first study addressed the general standard of care and services, examining the distribution and utilization of resources within the health care system. The specific objective was to compare similar health facilities with different managers -- governmental and nongovernmental -- in order to shape policy at the district level and inform the debate on decentralization of the health care system.

Methodology

A survey was conducted between June 1992 and December 1993 of both governmental and NGO health facilities selected from each of the five regions of the country. Two districts from each region, a total of ten, were randomly selected for inclusion in the study. Within each district one governmental unit and one NGO unit were chosen from each of three different levels of care: hospital, health center and dispensary (or dispensary/maternity). A district medical office was included as well, totaling seven units from each district studied. Ultimately, the study comprised 81 health units: ten district medical offices, 20 hospitals (eight district and 12 rural), 22 health centers, nine dispensary/maternity units (DMUs) and 20 dispensaries. Health unit personnel completed questionnaires regarding resource utilization, costs and financing, using such variables as patient throughput, average length of stay, bed occupancy rates, attendance rates at various health unit programs, and use of drugs and medical supplies. Capacity, staffing levels, revenues and expenditures were considered in comparing responses of various units. To answer these questionnaires, information was extracted from records of the above units for the period between July 1991 and June 1992.

Secondly, 480 patients were surveyed between March and December 1993 regarding consumer perceptions of availability and quality of resources and services, and resulting consumer utilization of governmental and NGO facilities. Trained interviewers administered the survey to randomly chosen outpatients as they exited one of the units included in the sample. In addition, 13 focus groups of patient attendants were held, ranging in size between 6 and 32 persons per group. Unstructured interviews were also carried out with some unit managers and members of unit health management committees. These interviews addressed the quality and usage of available services and resources.

Results

Significant variation in the capacity and utilization of health facilities existed with no apparent plan to match demand to supply. Hospitals had as few as 70 or as many as 200 beds. While most health centers had between 12 and 20 beds, one NGO health center had 150 beds. Hospitals generally had high to maximum occupancy rates, while other health units lagged far behind. District hospitals had occupancy rates exceeding 100%, while rural hospital occupancy rates varied from 54 to 119%. Health center occupancy rates were 24 to 56%. Dispensaries had occupancy rates between 17 and 29%, and DMUs between 18 and 36%. In some remote northern areas, lower level health units had occupancy rates as low as 0.2%. Overall figures for bed occupancy showed underuse of inpatient services at the primary level and overcrowding at the hospital level of care, especially in urban areas.

Longer stays contributed to a higher proportion of filled beds in hospitals. While length of stay averaged 18 days in district hospitals, the average for rural hospitals ranged from 6 to 15 days. Length of stay for rural NGO hospitals was higher than for rural governmental hospitals, and the rural NGO hospitals had significantly more beds than rural governmental hospitals. At lower level units the lengths of stay were significantly shorter for both NGO and governmental facilities, frequently less than a week. Differences in the types of cases handled by various types of facilities accounted for variation in the length of stay. For example, normal deliveries of babies occurred in DMUs. Persons with more complex cases or accidents went to hospitals.

NGO facilities admitted more inpatients than governmental units. However, NGO inpatients were more often placed at lower level units such as dispensaries. Ratios of outpatients to inpatients in lower governmental units were higher than for comparable NGO units, perhaps due to admissions policies or more sufficient resources of NGO units compared to governmental units.

Consumers voiced concerns about the adequacy of resources of all primary health care units, and often traveled great distances for hospital care. Bypassing nearby lower level units in either rural or urban locales, 62% of hospital users traveled between 1 and 60 km to get to a hospital, averaging 12.9 km per trip. Of those responding, only 15% of hospital visitors had actually been referred to the hospital. When asked why they had traveled so far to avoid lower level units, respondents listed the following reasons: insufficient skilled medical personnel; inadequate diagnostic facilities and clinical support services; insufficient transfer facilities when complications arose; unworkable referral system.

In fact, patient perceptions about personnel were verified by the study. Staff at higher level units was found to be more skilled than in lower levels of care. At lower level units ward maids or dressers comprised 40% of the work force and performed many of the essential tasks of the unit. Sometimes called nursing assistants or nursing aides, ward maids or dressers were usually school dropouts who had received on-the-job training in simple nursing procedures such as dressing of wounds. Trained nurses were rarely found at this level.

Consumers overall rated NGO facilities higher than governmental facilities in terms of amount and quality of staff, hours of service, and availability of drugs. Of the 480 participants in the survey, 283 (59%), preferred NGO to governmental facilities. Hours of service were longer at NGO facilities. NGO facilities employed fewer workers per bed than did governmental facilities, but staff were perceived as more motivated. NGO personnel received higher salaries, with more skilled persons such as doctors and nurses earning double what their colleagues earned in government facilities. Furthermore, NGO facilities also provided their staff with a variety of in-kind benefits, including free medical care, better housing and material items like food, clothing, and bar soap. Government workers received free health care and some received better housing, but without the material extras given to NGO employees. Often their paychecks were months overdue, so government health care workers would work other jobs as well to meet personal budget needs. As a result of these problems, staffing patterns were irregular at governmental facilities and hours of service shorter.

Higher consumer ratings for NGOs were also due to greater availability of medications. “More drugs” topped the list of improvements requested by consumers. In absolute terms as well as per patient, NGO facilities used more drugs than governmental facilities. Governmental facilities obtain their drugs through the Essential Drug Management Program, which stresses primary care.

The proportion of patients who reported receiving all of the drugs prescribed for them varied by level of care and type of provider, governmental or NGO. The proportion of patients who reported receiving all of their prescription drugs was 49% in governmental hospitals, 79% in governmental health centers, and 93% in DMUs. In NGO facilities patients reported receiving all prescribed drugs 92% of the time in hospitals, 94% in health centers, and 90% in DMUs. Furthermore, governmental facilities distributed generic drugs, while some NGOs received donations from abroad that tended to be brand name drugs, adding to the NGO consumer-approval rating.

Maintenance of equipment and buildings was poor everywhere. Nevertheless, NGOs budgeted more for maintenance than did governmental organizations, especially at the DMU level. Furthermore, governmental facilities tended to suffer from long-term neglect, needing major repairs or renovation.

User fees were also problematic in the minds of consumers. NGOs were very explicit about fees, collecting them after services were rendered. Governmental facilities attempted to collect user fees as a registration procedure before any services were delivered, and refused to give refunds, even when no services were completed. Under-the-table collections by government workers of all levels were commonplace. Relatives of managers and staff of health units were known to be exempt from fees, yet no clearly articulated exemption policies existed.

Accountability was loose. With drug shortages and facilities in disrepair, consumers did not believe that user fees were improving the quality of services they received and most consumers refused to pay them. As a result, very few governmental facilities succeeded in collecting user fees, and many did not bother to try. Total user fees collected by governmental units contributed less than 0.2% of hospital operating costs, and up to 8% of lower unit operating costs.

NGO collections of user fees covered between 31 and 46% of recurrent costs. The success of the NGOs in collecting such a large portion of their budgets from user fees and the government's comparable lack of success motivated the investigators to recommend further study so that government might learn from the NGO example. In addition, the investigators recommended study of the quality of health care and establishment of standards of care by which one could measure areas of institutional strength and weakness. Another recommendation was the review of personnel policies and procedures, to devise more realistic pay scales and staffing patterns that provide a living wage and enable regular staffing of facilities. Since districts varied significantly in their distribution of population and health facilities, decentralization of the health care system was advocated, so that decisions regarding health care could be informed by local conditions and needs.

In fact, contact between the MOH and the investigators was ongoing throughout the research process, and changes in the health care system were observed. Management of health services was decentralized. Health regulations were under review. User fee schemes were also reviewed and tested in many districts. Salaries of civil servants improved considerably. The private health sector grew rapidly, and the impact of that growth became the subject for the second study.

The Second Study: An Appraisal of the Scope and Impact of the Private For-Profit Health Sector

As Uganda's recovery from the political strife of the 'seventies progressed, the public demand for health care services grew precipitously. When governmental and NGO facilities were unable to keep up with that demand, the government began encouraging development of the private sector, including private health care. However, government made little or no attempt to ensure quality of private health services or to coordinate the public and private sectors. In fact, as in most developing countries, little information was collected or available on private health care providers, especially in urban areas (*Munishi et al., 1994; and Yesudian and March, 1994*). The National Five Year Health Investment Plan 1997-2001 in 1997 included an initiative to integrate the private for-profit domain into the national health system (*Uganda Government, 1997*). In order to synthesize the governmental and the private sectors, the government needed data about the size, composition, services, personnel, patient load, consumer approval rating, and potential resources of the private sector. Existing laws and regulations pertaining to private clinics required review in light of their past and future impact on the development of the private sector.

The government commissioned this second study to focus on the private health sector, as a follow-up to the first study on the efficiency and effectiveness of health care delivery systems. Researchers at the Clinical Epidemiology Unit at Makerere University were again asked to lead

the study. MOH figures showed that private health clinics treated more than 50% of outpatients in the country, and that nearly all Kampala residents had used private health clinics. Since most private clinics were found in urban settings, the new study focused on three large towns: Kampala, Jinja and Mbarara. Each of these towns had a large government hospital plus multiple smaller health units well-dispersed so that most residents had easy access.

Objectives

With an overriding goal of improving and expanding health care in Uganda, the MOH sought detailed information about the private sector in order to design policies that would cultivate a public-private partnership. This study had the following objectives:

- assessment of existing regulations governing private health care and their impact on the development of the private sector;
- defining the scope of operations of private practice;
- delineating the quality and deployment of personnel providing private services;
- assessment of the clientele, including demographic and socioeconomic data and patient load; and
- understanding consumers' perceptions of the quality of care and their reasoning in choosing where to obtain services.

Methodology

Data were collected between November 1995 and January 1997. The first step was to assess laws and regulations governing operations of private medical practice and the second, to conduct a series of unstructured interviews with health officials and professional organizations. The interviews were to elicit information on legal issues affecting operations of private practice, such as weaknesses in the law, entry barriers, pertinence, linkages and coordination, supervision, enforcement, and consumer protection. Numerous statutes, position papers and promotional materials were included in the review.

Three techniques were used to define the operations of private clinics: structured interviews with clinic managers, inspection visits, and exit interviews with consumers. Interviews with clinic managers and inspection visits sought to determine number and types of personnel employed, numbers and types of clients, range of services, equipment available, investigation techniques, medications, physical plant, medical waste management and disposal procedures. Client information on socioeconomic characteristics, perceptions of quality of clinic services, and reasons for selecting a particular clinic was gathered through exit interviews.

Eighty-nine clinics were included in the study: 60 from Kampala, 16 from Jinja and 13 from Mbarara. Many private clinics were unregistered with the MOH and, therefore, hard to identify and locate. Consequently, the study focused on registered modern clinics drawn from a listing maintained by a registrar of clinics in each of the three towns chosen for the study. In Kampala, a city of a million people, 30% of approximately 400 private registered clinics were studied. Jinja town numbers 70,000 inhabitants, and 62% of its clinics were studied. Mbarara, a much smaller town with rural surroundings, had 13 (87%) of its 15 registered clinics surveyed.

Focus groups were conducted with community leaders and individuals in the communities who had some experience with private clinics. Discussions centered on perceived quality of care and variables considered in selecting medical care providers. Quality of care was determined by patient/provider communication, treatment outcomes, availability of medications, diagnostic equipment, staffing, and staff demeanor towards patients (solicitousness and attentiveness). Focus group participants were recruited primarily from persons who had visited clinics in the month prior to the discussion, with a few participants having visited up to six months previously. Their ages ranged from 20 to 65, with most between 25 and 40. Both men and women were included, particularly those who made household decisions to seek medical care. They represented low- and middle-income levels. Persons from high-income level residential areas were unavailable due to time constraints of long work hours and commute times. Groups averaged eight persons but varied in size from six to 20. Twenty-four discussions were held altogether, 12 in Kampala and six each in Jinja and Mbarara. Discussions were recorded, transcribed and analyzed for major themes and sub-themes.

Results

Laws and regulations are the government's best means of enforcing standards on the burgeoning private sector. The Ugandan parliament legislated several provisions to ensure high quality health care, five of which have particular relevance to private providers. The 1993 National Drug Policy and Authority Statute and National Medical Stores Statute were passed to institute control over pharmaceutical supplies, regulating import, manufacture, export, storage, distribution and quality at the national and district levels. Laws restricted private clinics to those drugs carried by the National Formulary, and prohibited stockpiling and retailing of drugs, creating medical and financial constraints for most clinics.

In 1996 three bills were passed regulating medical practitioners: the Uganda Medical and Dental Practitioners Bill, the Uganda Nurses and Midwives Bill, and the Allied Health Professionals Bill. The three bills instituted Councils to establish and maintain educational standards and professional ethics, with registration and licensure of all health professionals and disciplinary powers for noncompliance. The bills gave recognition to some health professionals previously prohibited from private practice, who could now operate openly. Provisions were also included requiring regular reporting of diseases and conditions treated by private practitioners. However, the legislation provided no resources, and government lacked the means of enforcement or incentives to improve quality of health care in the private sector. Private practitioners did not participate in framing the laws or programs on either local or national levels. Standards of operations were unclear, as were those for reporting procedures, physical plant and equipment, and quality control.

Private clinics were found to have an average of six rooms. In Jinja and Mbarara, where there were fewer clinics and a smaller population, competition for prime space in the commercial centers was less. Accordingly, clinics were more spacious than in Kampala, and many had inpatient facilities. Clinics situated in better sections of town tended to have better physical facilities -- more space, better lighting and ventilation, clean tap water and flush toilets. Clinics in slum areas were generally of poorer quality, reflected in space, ventilation, water and plumbing. Most clinics had basic diagnostic equipment needed for outpatient care, such as

thermometer, sphygmomanometer and stethoscope; 75% had microscopes, and 50% IV equipment. Specialized equipment was found in clinics owned by specialists. Most clinics had to direct patients to referral hospitals for non-routine care.

Private clinics offered longer hours, including evenings, weekends and holidays, when governmental facilities tended to be closed. Generally, services included outpatient care for common medical problems such as malaria, acute respiratory infections, diarrhea, hypertension and maternity care. In addition, 57% performed simple surgical procedures such as draining abscesses, dressing wounds and surgical toilet. Less than 12% offered preventive services, i.e. immunization, family planning or antenatal care. 62% had diagnostic laboratory services, while 36% contracted out those services, mostly to privately owned labs. Generally, the range of services was independent of the degrees of specialization of personnel.

Clinic owners tended to be sole proprietors (58%), while 28% were partnerships and 9% company-owned. NGOs accounted for 5% of clinics studied. NGO clinics tended to be larger than other private clinics. The person in charge of a clinic was most often a doctor: 36% were generalists and 30% were specialists. Medical clinical officers (paramedics with diplomas), other paramedical staff, or nurses managed the remaining 34%. Some doctors registered multiple clinics under their names, visiting each briefly and leaving junior staff persons to carry out clinic operations.

Employees were nearly equally divided between full-time and part-time work. Doctors constituted 26% of all clinic employees, 73% of whom were part-time workers, usually with other positions in government facilities as well. Enrolled nurses and midwives comprised 21%, laboratory technicians 11%, medical clinical officers 8%, registered nurses and midwives 7%. Unlike government units, where nursing aides comprised a large percentage of all employees, only 4% of private clinic employees were nursing aides. All nursing aides were full-time workers.

Ninety-five per cent of clinics maintained stockpiles of drugs to dispense to their patients. Although more recent laws have forbidden stockpiling, clinic managers justified the stockpiling because the drugs provided added income to cover clinic expenses. Consumers in focus groups listed availability of drugs as the major reason for frequenting private clinics.

The number of patients seen daily fluctuated according to the number of hours a doctor was present at a clinic. Patient load was higher during hours when a doctor was on-site. Clinics not served by doctors had very low volume, generally less than 5 patients per day. Those run by a group of practitioners had a higher daily average of patients. Overall, private clinics were reported to have lower patient volume than governmental clinics. The patient load of governmental clinics was so high that doctors could spend very little time with individual patients. Private clinics were preferred over governmental clinics, because the comparatively moderate volume of patients allowed doctors to spend more time with patients, which focus group participants stated they appreciated.

Records were maintained for each patient in nearly all private clinics, but no records were kept of referrals and no standard format for referrals existed. Eighty-three percent of private clinics

did not report conditions treated to authorities, although they were required to do so by law -- laws that were obviously not enforced.

Waste management and disposal have serious public health implications, since infection can be transmitted by soiled refuse discarded after treating ill persons (*WHO, 1993; Sharma et al., 1994*). None of the clinics in the study had formulated waste management and disposal policies, and personnel were not trained in proper procedures. Most waste was openly burned or thrown in municipal bins. Liquid wastes were usually deposited into the sewer system. No guidelines were identified for pretreatment of materials, so rag pickers, scavengers and animals often handled or had access to solid and liquid wastes, as well as sharp objects and needles thrown into open bins. Local authorities had no concise regulations for waste disposal and management.

Private clinic operators complained about their relationship with governmental authorities. They felt unsupported and undermined, particularly, as one clinic manager related, by denunciations on radio by senior government officials. Patients referred to governmental facilities reported that they felt that they were mistreated for having gone to a private clinic initially. Governmental practitioners gave no feedback to referring doctors from private clinics. The MOH did not collect reports from private clinics, and private practitioners had no contact with the MOH. While the government had regulations for drugs and for medical personnel, private clinic operators felt that standards were not articulated or enforced for other aspects of either public or private clinic operations, such as physical plant or quality control. Ultimately, the growth and operations of unregistered clinics run by unqualified persons went unchecked. Private practitioners could not participate in training programs the government provided for its employees, even if they were willing to pay for them. No ambulance service existed, which would be especially helpful for transfer of patients in emergencies. High rents in Kampala prevented many clinics from operating in highly trafficked locations. Taxes were cumbersome, too many taxes paid at different times.

Consumers in exit interviews and focus groups gave the same reasons for choosing private clinics. The frustration of long periods in line at governmental clinics, only to find that no drugs were available, persuaded 91% of consumers to go to private clinics. Consumers continually complained of the discourteous personnel and the frequent unavailability of drugs in governmental facilities (*Okello et al., 1994*). Availability of non-emergency services at private clinics after work, on weekends and on holidays also drew consumers to them. Posted fee structures and the availability of services on credit also attracted consumers. Consumers also favored private clinics over public ones because they felt they received better attention, respect and care from personnel in private facilities.

Conclusion

After the earlier attempts at renovation of health facilities failed to attract significant numbers of patients back to the health units, the Ugandan government began to re-think its policies in health. Budgetary constraints were severe. In the economy as a whole – not just in health care – the government was now emphasizing the need to allow private markets to flourish and grow, to relieve government of some burdens and roles. Findings of the first years of research showed the system's inequities and significant consumer preference for NGO health care services. In

response to the rapid growth of the private health sector, the Ugandan MOH developed a strategy to incorporate the private health sector into the National Five Year Health Investment Plan 1997-2001 (*Uganda Government, 1997*). The research team was asked by the Ugandan government to investigate the role of the private health sector in transforming the health care system of Uganda in recent years, to assess its current impact and future potential. Conditions in Uganda were dramatically changed: the growth of the private medical clinics proved to be greater than anyone had realized. Many people were using private clinics daily for basic health care and paying for it, despite the availability of free care at government clinics. A coherent policy toward private health care was needed to establish guidelines that ensure quality, guarantee health care for the poor, protect all consumers against fraudulent practices, and support professional associations in regulating member practices. The Ugandan government sought to permit growth while promoting high quality health care. The second study generated considerable debate on the changing role of government, and the government issued policy documents giving the private sector a more prominent role in some areas of health care. Although the government has not yet reallocated resources as a result of the growth of the private sector, stimulation of policy discussions through these studies is a major achievement and a hoped-for precursor to change.

The significant growth of private medical clinics noted in this study suggests the need for further research on what is happening in other parts of the private medical sector in Uganda. For example, what is the quality of private pharmacies, laboratory services, hospitals and nursing homes? Is the private sector keeping abreast of advancements in medicine? Consumers are entitled to high quality care, and further work is needed to define attributes of technical quality that can be measured and achieved with available resources in all clinics, public and private. Finally, the influence of the donor community is important in the private sector; its role, impact and participation should be examined.⁴

⁴ It should be noted that since completion of the second study, David Okello and colleagues have finished a study of the role of the donor community in the Ugandan health system and begun to examine issues of the technical quality of health care delivered in the private sector.

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