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, very well welcomed in Uganda. And also as a response to the global economic decline of the 1980s and 1990s, 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 out. These adjustments were aimed at defining priorities, refining policies and reforming the institutions through which those policies are implemented.

Introduction

The Primary Health Care Concept (PHC) concept was introduced at the 1978 Alma Ata conference in an attempt to address the inappropriate location of the health structures inherited by developing countries to tackle their predominant health problems. PHC was seen as a way of making health care available at affordable prices to a large majority of the population. This was a major paradigm shift, with the focus therefore changing from provision of hospital-based care to more community oriented health services.

Between 1980 and 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 defying the idea of horizontal holistic implementation of PHC programmes.

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 was a concern about access to health care in the poor countries, for instance health expenditure for most Sub-Saharan 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 characteristics poor input mix; emphasis on tertiary rather than primary care; and poor value for money in procurement. Lastly, there was an inequity of services – both supply (surplus 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, Cameron 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 retraining, 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 1980s by continued bad governance and civil strife. By 1989, 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 IMF/Fund programme in 1980, a process of reorganisation 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 launched; 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.

References
