

**PUBLIC PRIVATE SECTOR PARTNERSHIP IN HEALTH CARE  
SERVICE DELIVERY IN SEMUTO SUB-COUNTY  
NAKASEKE DISTRICT – UGANDA**

**BY**

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## DECLARATION

I Katamba Moses do hereby certify and confirm that this research report is my original work and has never been submitted or presented in any university or Institute of Higher Learning for the award of any academic qualification.

KATAMBA MOSES




Date 28/09/2016

## APPROVAL

This is to certify that I have supervised this research and confirm that it is ready for examination.

MR. MUHWEZI IVAN  
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Date 28/09/2016

## DEDICATION

I dedicate this research report to HASH FAMILY that is Katamba Hashim, Serunjogi Hashram, Nabatanzi Mirembe Hashfat Jamidah, Namwano Racheal, Vickram Martins Rossette and Kampala Shafiq.

I also dedicate it to my father Capt. Serunjogi Sulah, my mother Maimuna Serunjogi, Senga Nabatanzi Jamida, Namakula Aminah and all my colleagues in academic struggle and my supervisor Mr. Muhwezi Ivan.

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## ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APA	American Psychological Association
BOO	Build-Own-Operate
BOOT	Build-Own-Operate-Transfer
BOT	Build-Operate-Transfer
BOT	Build-Operate-Transfer
BTO	Build-Transfer-Operate
CG	Conditional Grant
DBO	Design-Build-Operate
HIV	Human Immune Virus
IDPS	Internally Displaced Persons
MOH	Ministry of Health
NMS	National Medical Stores
NPM	New Public Management
OPD	Out patient department
PFI	Public Finance Initiative
PPF	Private- for- Profit
PHC	Primary Health Care
PNFP	Private-Not-For Profit
PPP	Public-private partnerships
SPSS	Statistical Package for Social Scientists
UBOS	Uganda bureau of statistics
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UPMB	Uganda Protestant Medical Bureau
USA	United States of America
WHO	World Health Organization

## ABSTRACT

The aim of the study was to identify, how can governments reap the potential benefits of public-private partnerships (PPPs) in the provision of health service delivery? Private sector involvement in the provision of public goods is long-standing, often relying on franchises or concessions. More recently, public-private partnerships (PPPs) have risen in prominence, promising innovative solutions and a better allocation of inputs than traditional procurement with separate concessions. However public-private partnerships (PPPs) are not without risks with the outcome depending on the identification of the most efficient bidder, the risk sharing between the public and private sector and the design of the contractual relationship. Furthermore, public-private partnerships (PPPs), particularly when they are used to circumvent budgetary constraints, present risks to government budgets by creating large contingent liabilities. Drawing on a discussion of the economics of public-private partnerships (PPPs) in relation to health service delivery and questionnaire responses, synthetic indicators are used to assess how well-suited policy frameworks are to benefit from public-private partnerships (PPPs).

The results show marked heterogeneity across countries, suggesting there is scope to improve performance and gain expertise by considering other countries' experiences.

## CHAPTER ONE

### INTRODUCTION

#### 1.0 Introduction

This chapter comprises of the background of the study, problem statement, purpose of study, objectives of the study, research questions, research hypothesis, justification of the study, significance of the study and definition of key terms.

Nakaseke district is a newly establish district, its found north of Kampala and it was created in 2005. It was off from the greater Luweero district which borders it in the north east , Wakiso in south, Mityana in south west, Kiboga and Kyankwanzi in west, Nakasongola in north and Masindi in north west.

Nakaseke district has eleven (11) subcounties and four (4) town councils and these include Semuto subcounty which is my area of research, Kapeeka subcounty, Semuto town council, Kasangombe subcounty, Kiwoko town council, Kikamulo subcounty, Kinyogoga subcounty, Butalangu town council, Ngoma town council, Ngoma subcounty, among others. Nakaseke district has the following hospitals: Nakaseke referral hospital which is the biggest hospital, Semuto health centre IV, Kapeeka health centreIV, Ngoma health centre IV and Kiwoko hospital which is a private hospital.

The intention of public private partnership in Semuto subcounty was to improve on the health care service delivery in the above mentioned health centres.

#### 1.1 Background to the Study

Public-private partnerships (PPP) were developed in the UK, where they are more usually known as the Public Finance Initiative (PFI). Public private partnership/Public Finance Initiative (PPP/PFI) is now being promoted across the world as the panacea for public sector capital investment. Uganda is one of the countries where this concept is being actively encouraged by its government. Public-Private Partnership (PPP) refers to public and private sector actors working together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria (Ahmed, 2000).

The Uganda Ministry of Health (MOH) defines the term partnership as the formal relationship between or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources and/or skills for the purpose of achieving these common goals (MOH, 2003).

In Uganda, the Public private partnership (PPP) in health was initiated in 1997 by the Ministry of Health with the support of a parliamentary resolution in July 2000. Within this resolution, the private sector can be broadly categorized into Private- for- Profit (PFP) and Private-not-for-Profit (PNFP) providers. The Private-not-for-Profit (PFP) group contains both formal and informal providers. Informal providers mainly include general merchandise, shops and traditional healers. There are also new non Ugandan systems of care such as the Indian and Chinese medical systems.

Operationally, the benefits of Public private partnership (PPPs) include efficiency gains; output focus; economies generated from integrating the design, building, financing and operation of assets; innovative use of assets; managerial expertise; and better project identification. These benefits can result in some combination of better and more services for the same price, and savings, which can be used for other services or for more investment elsewhere. Strategically, partnership contracts enhance accountability by clarifying responsibilities and focusing on the key deliverables of a service. A department's managerial efficiency can benefit significantly as existing departmental financial, human and management resources can be refocused on strategic functions.

Involvement of the private sector is, in part, linked to the wider belief that public sector bureaucracies are inefficient and unresponsive and that market mechanisms was promote efficiency and ensure cost effective, good quality services (WHO, 2000). Another perspective on this debate is linked to the notion that the public sector must reorient its dual role of financing and provision of services because of its increasing inability on both fronts (Mitchell J., 2001). Under partnerships, public and private sectors can play innovative roles in financing and providing health care services.

Partnership has significant potentialities for achieving efficient and effective high quality health services. It aims to establish a functional integration and sustained operation of a pluralistic health care delivery system by optimizing the equitable use of the available resources and investing in comparative advantages of the partners. It ensures the utilization of the potentials of both the public and private sectors (Barakat, 2003). The need to provide and improve the efficiency of the health system delivery has been gaining attention worldwide (Jamison et al, 2006). Many countries have introduced reforms with the goal of making health care more effective (Mattke et al, 2006).

In 2001, Private-not-for-Profit (PNFP) health sub sector in Uganda was commended as an indispensable subsystem that offered comparable better and acceptable quality of health care than government (Muwanga et al, 2001). They are under three umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). By 2002, the Bureaus together represented 78% of the 490 Private-not-for-Profit (PNFP) health units while the rest fell under other humanitarian organizations and community-based health care organizations (MOH, 2001).

In partnership with government, Semuto Subcounty receives government support from three main sources: Primary Health Care Conditional Grant (PHC CG), Essential Drugs and Personnel through secondment of medical staff (Semuto Subcounty, 2007). Human resource remains the central gist that determines the overall effects of the reforms (Rigoli, 2003). Semuto Subcounty has been a beneficiary of the PPP since 1996/7. Like any other Private-not-for-Profit (PNFP) hospital in Uganda, the level of financial and human resource support and the extent to which such support has impacted on Semuto subcounty's efficiency in delivery of health services to the community remains not well understood. This study was conducted to assess the effect of the financial and human resources support through PPP on efficiency of delivery of health services in Uganda using Semuto Subcounty as a case study.

## **1.2 Statement of the Problem**

The public-private partnership (PPP) in the health sector in Uganda has been going on for a number of years in different districts and Nakaseke district inclusive.



The objective of research was to improve on service delivery in the health sector. Government went ahead to put up different infrastructures (hospitals) in different districts in some cases and later or allowed the private sector to come on board to provide some health services using the same infrastructures.

However, in spite of the good intentions of the Public private partnership (PPP) in the health sectors in Uganda, for the case of Nakaseke district in particular Semuto Subcounty, such objectives have not been fully achieved. As a student doing research, these are the reasons as to why I wanted to find out why things appear the way they are.

### **1.3 Objectives of the Study**

#### **1.3.1 General objective**

The general objective of the study is to establish the Public Private Partnership (PPP) of health care service delivery at Semuto Subcounty Nakaseke district.

#### **1.3.2 Specific objectives**

The study specifically aimed:

- i. To find out how public-private partnership affect delivery of health care services.
- ii. To establish the benefits of public-private sector partnership in health service delivery in Semuto subcounty.
- iii. To find out the challenge of public private partnership in delivery of health care service.
- iv. To find out the solutions to the challenges faced by public private sector partnership in the delivery of health care services.

### **1.4 Research Questions**

- i. How does public private partnership affect delivery of health care services?
- ii. What are the benefits of public private partnership in delivery of health care service?
- iii. What are the challenges of public private partnership in delivery of health care service?
- iv. What are the solutions to the challenges faced by public private sector partnership in the delivery of health care services?

## **1.5 Justification of study**

Public private partnership (PPPs) are mechanisms that blend traditional procurement and full privatisation (Grimsey& Lewis, 2005a). Boardman (2010) notes that Public private partnership (PPPs) combine government control and ownership with access to private sector efficiency and capital. In a Public private partnership (PPP), the private sector is responsible for constructing, partial financing, asset operations, and the service provision. Despite intensive use, it remains unclear whether Public private partnership (PPPs) lead to more efficient use of public resources; however, the 'infrastructure gap' implies that the long-term global prospects for Public private partnership (PPPs) remain strong. Understanding government motivation in the use of Public private partnership (PPPs) and their ability to enhance public sector efficiency is valuable for future Public private partnership (PPP) success.

## **1.6 Scope of the study**

### **1.6.1 Geographical scope**

The study was carried out in Semuto subcounty Nakaseke district Uganda. Nakaseke District is a district in Central Uganda. It is named after Nakaseke, the largest town in the district and the location of the district headquarters. Nakaseke District is bordered by Nakasongola District to the north and northeast, Luweero District to the southeast, Wakiso District to the south, Mityana District to the southwest. Kiboga District and Kyankwanzi District lie to the west and Masindi District lies to the northwest. Nakasongola, the location of the district headquarters, lies approximately 66 kilometres (41 mi), by road, north of Kampala, the capital of Uganda and the largest city in the country. The coordinates of the district are:00 44N, 32 25E.

Nakaseke District is divided into the following administrative units: Kapeeka,Ngoma, Kinyogoga, Wakyaato, Nakaseke Town Council, Kaasangombe, Semuto and Kikamulo. It estimated that 59.2 percent of the Nakaseke District community is literate, which is largely limited to the local Luganda language. A Primary Teachers' Training College has been built in Nakaseke. Nakaseke District has seven health units including a 100-bed public hospital, Nakaseke Hospital, administered by the Uganda Ministry of Health. Nakaseke Hospital is connected to other health units by a radio. There is also a community hospital at Kiwoko, Kiwoko Hospital, administrated by the Church of Uganda where there are five doctors, six medical assistants, 23 midwives and 33 nurses, as of 2010.

### **1.6.2 Content scope**

This study concerned itself with public private sector partnership in health care service delivery with sub themes like Assess the extent to which the financial and human resources support through Public –Private Partnership affect Semuto subcounty’s delivery of health care services. Establish the benefits of public- private sector partnership in health service delivery in Semuto Subcounty Nakaseke district. Establish the good public- private partnership practices in Semuto subcounty Nakaseke district.

### **1.6.3 Time scope**

Research on partnership in Nakaseke district has been from 2000 to 2016. The study was taken a period of 6 months that is from January to June 2016.

### **1.7 Significance of the Study**

Little is known about how the financial and human resource support through the Public private partnership (PPP) has influenced Semuto subcounty’s ability to transform the inputs into health service delivery outputs. Measuring the hospital efficiency in delivery of health services were helped to understand some of the disparities in performance as well as providing some guide in the reallocation of resources in the bid to close the inequity gap in service provision. Furthermore, the findings from this study, may guide health policy makers and planners in developing more effective strategies for efficient allocation of resources in government supported health facilities.

### **1.8 Definition of terms**

**Public–private partnership** (PPP or 3P or P3) is a government service of government and one or more private sector companies. Public- Private Partnership (PPP) involves a contract between a public sector authority and a private party, in which the private party provides a public service or project and assumes substantial financial, technical and operational risk in the project.

A **partnership** is the relationship existing between two or more persons who join to carry on a trade or business. Each person contributes money, property, labor or skill, and expects to share in the profits and losses of the business. Feb 25, 2016

Publics are groups of individual people, and the public (a.k.a. the general public) is the totality of such groupings. This is a different concept to the sociological concept of the public sphere. The

concept of a public has also been defined in political science, psychology, marketing, and advertising. In public relations and communication science, it is one of the more ambiguous concepts in the field.

Private; Capitalized in shares of stock that are held by a relatively small number of owners and are not traded on the open market: a private company; a company that went private; took a company private.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.0 Introduction

This chapter presents ideas and facts that have been contributed by other scholars, theorist and stakeholder that the researcher finds necessary to provide an insight to the proposed study it covers theoretical review, and related literatures. Material was drawn from text books, journals newspapers, websites.

#### 2.1 Theoretical review

##### 2.1.1 Theory of Public Private Partnership

The agency theory is more commonly known as the principal-agent theory. According to Ross (1973), a principal-agent “relationship has arisen between two (or more) parties when one, designated as the agent, acts for, on behalf of, or as representative for the other, designated the principal, in a particular domain of decision problems’ (Ross, 1973).

Under the relationship, the agent is empowered to act for the principal because the principal hires the agent or because there is an implicit contract between the principal and agent. The principal-agent problem lies in the differences of interest and information between the two parties. This means that the agent may not always act in the interests (or best interests) of the principal, and the costs of selecting an agent and monitoring the agent’s performance could be expensive, meaning that the principal may not be able to enforce her was on the agent. (Bowie, 1992) (Petersen, 1999)

The theory argues that principals must perform two basic tasks in choosing and controlling their agents (Palmer, 2009):

- Principals have to select the best agents, such as employees or contractors, and create incentives for them to act as desired
- Information asymmetry leads to adverse selection and moral hazard. Principals have to monitor the behaviour of their agents to ensure that they are acting as agreed. Problems

arise when the parties' goals have conflicts or when it is expensive for the principal to verify what the agent is actually doing.

Public private partnership (PPP) may incur high transaction costs for the government, especially where there is no culture of Public private partnership (PPP) or little knowledge of the approach. In government service provision, production costs determines the total social costs, and because they are internalised, transaction costs are relatively low (Palmer, 2009). However, managerial inefficiency may lead to high production costs; experiences show that large government infrastructure projects have often been over the budget (Palmer, 2009).

Public private partnership (PPP) can lower production costs because competitions reduce managerial inefficiency.

Economies of scale may mean that the private sector could attain lower production costs. But PPP could raise transaction costs because the government has to negotiate with and monitor the private sector partners who have their own interests and agendas.

## **2.2 Brief History of Public Private Partnership**

In New Public Management (NPM), Public private partnership (PPP) is highly regarded with the private sector pays for construction and the government avoids committing funds and engaging in risk-taking to support the venture (Linder, 1999). This facilitates a decentralized government and the leverage of private sector expertise (Abdoulaye, 2006). Public private partnership (PPP) is now used by national governments around the globe to develop and expand a wide range of service, including energy, utility networks, telecommunications, transportation systems, water, sewage, health and education (Rondinelli, 2002).

Private businesses are playing increasingly important roles in managing a wide range of public services through contracts and concessions, Build-Operate-Transfer (BOT) arrangements, public-private joint ventures, and other forms of cooperation with governments.

Public private partnership (PPP) has been used in France to finance public infrastructure since the 17th century, when the French concession model emerged (Grimsey, 2005). The first concession contracts were awarded to the construction and financing of the 'canal de Briare' in 1638. Later, in the 19th century, France used Public private partnership (PPP) extensively to

finance its infrastructure, including railways, water and electricity which were designed, constructed, financed and operated by the private sector, including banks.

While France can justifiably be seen as the pioneer in using Public private partnership (PPP), the evolution of Public private partnership (PPP) has been accelerated in the United Kingdom as the trend on privatization gave way to different mechanisms for private businesses to deliver public services (Grimsey, 2005).

Meanwhile, Public private partnership (PPP) continued to penetrate to other parts of the world. Public private partnership (PPP) in the USA were set out by the federal government in the 1950s and 1960s as a tool to facilitate private investments in infrastructure and economic development (Bult-Spiering, 2006).

They became an instrument during President Carter's administration in the 1978 national urban policy and urban development action grant which encouraged cities to go from private investment subsidies to joint equity venture Public- Private Partnership (PPP) (Bult-Spiering, 2006). Later, the Reagan administration reinforced the direction towards private investment by reducing the size of the administration and its role in local decision making. Under this direction, policies gave priority to private investments. More recently, the Clinton administration promoted Public private partnership (PPP) as a key component of its urban policy. The Clinton administration was an advocate of the Third Way policies, which are consistent with New Public Management (NPM), stressing partnerships as a new way of governance.

### **2.3 Types of Public Private Partnership**

The followings are some common types of Public private partnership (PPP) (Palmer, 2009).

**Service Contract:** The government contracts with a private entity to provide services that the government provided previously.

**Management Contract:** The private entity is responsible for operations and maintenance of the facility under contract.

**Design-Build (DB):** The government contracts with a private partner to design and build a facility or infrastructure according to the requirements set by the government.

After completion, the government assumes responsibility for operation and maintenance.

**Design-Build-Operate (DBO):** The private sector designs and builds a facility. Once the facility is completed, ownership is transferred back to the public sector, while the private sector operates the facility for a specified period of time. This contract model is also referred to as Build-Transfer-Operate (BTO).

**Build-Operate-Transfer (BOT):** This model is by far the most popular model in Public private partnership (PPP). It combines the responsibilities of design-build procurements with the private sector partner providing operations and maintenance of a facility for a period of time.

At the end of that period, the operation is transferred back to the public sector.

**Build-Own-Operate-Transfer (BOOT):** The government grants a franchise to a private partner to finance, design, build and operate a facility for a specific period of time. Ownership is transferred back to the public sector at the end of that period.

**Concession:** The government grants the exclusive rights to operate and maintain a facility to a private entity over a period of time according to the requirements set by the government. The public sector retains ownership of the original asset, while the private operator retains ownership over any improvements made during the concession period.

**Build-Own-Operate (BOO):** The government grants the right to finance, design, build, operate and maintain a facility to a private entity, which retains ownership. The private entity does not need to transfer the facility back to the government.

**Privatisation:** The government transfers an asset to the private sector.

## 2.4 Benefits of Public Private Partnership

Forming Public private partnership (PPP) to assume functions that were previously public sector responsibilities has potential benefits for citizens, governments and the private sector itself. In theory,

Public private partnership (PPP) can increase competition and efficiency in services provision, expand coverage and lower delivery costs (Rondinelli, 2002). Public private partnership (PPP)



can usually respond more flexibly to market signals or market trends and more easily procure new technology than public agencies. Moreover, Public private partnership (PPP) may help governments reduce public expenditures or raise revenues from concessions. Partnerships that displace inefficient state-owned-enterprises can help reduce government subsidies or losses and relieve fiscal pressures. A Public private partnership (PPP) has more flexibility in hiring, work and pay mechanism than government departments, which are subject to civil service laws and not market-driven (Rondinelli, 2002).

On a macro view, Public private partnership (PPP) is often an effective way for governments to mobilize private and foreign investment capital for infrastructure expansion or development. Public private partnership (PPP) can lead to higher national productivity and economic output, ensuring an efficient allocation of resources, facilitating the transition to a market economy and developing the private sector itself (Rondinelli, 2002).

### **2.5 Potential Risk of Public Private Partnership Loss of control by government**

One of the trade-offs for the government when entering into a Public private partnership (PPP) contract is the reduction of control, when compared to the traditional project delivery methods mainly through government departments or non-government organisations (Stainback,2000). The negotiated deal structure between the government and the private partner(s) can be customized to meet the desired level of control over issues such as master plan, architecture, plot ratio, operations and maintenance (Stainback, 2000). To prevent a loss of control, the government will have to establish servicing standards and to ensure that the public interest is protected (Ministry of Municipal Affairs, 1999).

### **2.6 Conditions for effective Public Private Partnership**

According to literature, apart from financial terms, there are sociological aspects that will make effective Public private partnership (PPP).

**Transparency and Trust** - Fear is often the main reason to avoid partnership.

Partners are not likely to come together and co-operate if they do not have any assurance that the outcomes will be favorable to them (Klijn, Erik-Hans and Geert R. Teisman, 2000). The partnership is vulnerable to information asymmetry, misrepresentation and opportunism. Partners

often stick to their own interest and refuse to cooperate as they are worried about being exploited by the other actors.

Therefore, a successful partnership requires actors to be open-minded and that some trust between the partners exists (Klijn, Erik-Hans and Geert R. Teisman, 2000).

According to Carnevale (1995), trust refers to the faith that “the intentions and actions of a person or group to be ethical, fair and non-threatening concerning the rights and interests of others in social exchange relationships” (Carnevale, 1995). While the concept of social trust is diffused and non-specific in nature, there is a strong normative foundation supporting the concept, which is believed to be able to facilitate cooperation among strangers (Ruscio, 1996). For a Public private partnership (PPP) to succeed, stakeholders must trust that the government will engage with businesses and civil society, with the aim of maximizing public interest. In partnerships, it is difficult to restore public trust once it is lost or hurt. A Public private partnership (PPP) will be difficult to proceed when the citizens distrust the government (Fukuyama, 1995) (Uslaner, 2003). Trust and confidence can be undermined when the goals of the partners are ambiguous or when their objectives are in conflict or unrealistic (Rondinelli, 2002).

Experience suggests that if a Public private partnership (PPP) is to succeed, the government must (Rondinelli, 2002):

1. Formulate and enforce clear and transparent regulations to the private sector / partners;
2. Remove unnecessary restrictions that prohibit private enterprises from bidding for the project;
3. Position the government’s role as facilitating and regulating private sector service provision, instead of directly producing and delivering services that conventional governments do.

## **2.7 Good Public Private Partnership Practices**

### **Consideration of community dynamics and history**

According to Davy (2001), consideration of community dynamics and history could help form an effective Public private partnership (PPP). A case in point is oil company Shell. Before winning

the exploration contract for Camisea in Peru in 1994, Shell had done some exploratory work on community history and attitudes in the mid-1980s, which revealed the people's negative attitudes towards resources exploitation because of Shell's prior involvement in the area (Davy, 2001). The study found that previous conflicts between Shell and local indigenous people had led the community to expect conflict in a potential Public private partnership (PPP) and demand that renewed exploration projects be tied to a community development fund. These findings, although negative, enabled Shell to better understand the community's perceptions and concerns, which helped the company to build a constructive partnership with the local government / the community later on.

### **Investment in community liaison capacity**

According to Davy (2001), community liaison capacity is an effective way to create mutual trust between the community, government and private sector. Investing in community liaison capacity helps form partnerships and the basis for realistic expectations (Davy, 2001).

### **Enabling community participation**

The civil society, which often sees the community as "victims" of partnerships, tends to take a backseat or reduce their involvement in partnerships and engagement (Davy, 2001). Under this condition, it is important to enable community participation, i.e. people have a role to play in determining their own development. Various approaches, including tri-sector partnerships (business, civil society and government) can help overcome this self-proclaimed victim mentality. Such partnerships can help community groups acknowledge responsibility for community development, thus enabling them to remove the "victim" concept, and become participants in the partnership formation and implementation process (Davy, 2001).

### **Adopting a Public Private Partnership Policy**

When a government decides to adopt Public private partnership (PPP) for certain service deliveries, it would have potential impact on other existing policies, such as planning, fiscal and development policies. The unique nature of Public private partnership (PPP) means specific policies would need to be formulated to cater to its special needs, such as competitions, bidding and a comprehensive regulatory framework (Ministry of Municipal Affairs, 1999).

## **2.8 Public-Private Partnership and Hospital Service Delivery**

### **Total Funding to Private-not-for-Profit (PNFP) Sub sector in Uganda**

Total funding to the Private-not-for-Profit (PNFP) sub sector amounted to just 0.5 percent of the total health sector budget in 1997/98, and this had grown to 7 percent by the year 2002/03 (Ssengoba et al, 2007). This funding made a considerable contribution to the financial sustainability of the Private-not-for-Profit (PNFP) health units. For example, in the year 2001/02, government funding from the Private-not-for-Profit (PNFP) conditional grant constituted nearly 30 percent of the budgetary requirements of the Private-not-for-Profit (PNFP) health units (Bataringaya & Lochoro, 2002).

Growing financial support from government grants and improvements in management efficiency have enabled many of the Private-not-for-Profit (PNFP) facilities to adjust their user fees downward. At least 81 percent of the Private-not-for-Profit (PNFP) hospitals and a number of lower level units have been able to lower fees, leading to increases in utilization, especially for child in-patient stays and general out-patient consultations (Odaga & Maniple, 2003).

According to Green (1999), a financing system may have negative influences on the way health services are provided. Litvack & Bodart (1993) in Cameroon and Gertler & Molyneaux (1997) in Indonesia found that price increases without compensatory improvements in quality discourage utilization of health services for the poor.

### **Human Resource in Private-not-for-Profit (PNFP) Sub sector inputs**

In Uganda, from 1972 to 1996, the number of doctors dropped from 1171 to 964; with a population ratio more than doubling from 1:9090 up to 1: 20228; though the number of nurses increased slightly from 3877 to 4059, the population ratio again rose from 1: 2745 to 1: 4804. Similarly for mid-wives and medical assistants the population ratio rose from 1: 3917 to 1: 7431 and 1: 24457 to 1: 29367 respectively (Mwesigye et al, 2000)

The total volume of health workers coordinated by the three medical bureaus (Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB) and Uganda Muslim

Medical Bureau (UMMB)) was 11,114 as by June 30th 2007. This is up by 10% from the 10,000 as of November 2004. It is a very minimal rise in about three years and still much lower compared to 28% rise in the Public sector. About 4% of the Private-not-for-Profit (PNFP) staff in Uganda is civil servants, either deployed by the districts or posted by the Ministry of Health. Whereas there has been an increase in the number of staff and in the percentage of qualified staff employed in Private-not-for-Profit (PNFP) health facilities over along period, the size of the workforce has been stagnating.

### **Accessibility to Medicines**

Access to affordable medicines is included amongst the health-related Millennium Development Goals. Medicines are a major health expense for poor households in most developing countries where 50-90 percent of medicines are paid for by the patients themselves, while in many developed countries, 70 percent of medicines are publicly funded through reimbursement plans and other mechanisms (Quick et al, 2002). Moreover it is estimated that less than half of the population in the poorer parts of Africa and Asia have regular access to essential medicines. This remains a major obstacle to good health despite the many achievements in the field of essential medicines since the Declaration of Alma Ata in 1978 (Quick, 2003). Social and cultural constraints disproportionately prevent women, children, ethnic minorities, and other marginalized populations from gaining access to medicines (Ruxin et al, 2005).

Improved public expenditure on or/and medicines supply are expected to translate into higher utilization of health services overall (Nazerali H & Oteba M.O. 2005).

### **Credit line for medicines grant from National Medical Stores (NMS)**

The National Medical Stores (NMS) is a semi-autonomous medical supply agency serving the Public Sector in Uganda. Similarly, faith based organizations running the many Private-not-for-Profit (PNFP) health facilities can benefit from economies of scale through the Joint Medical Stores (Kawasaki, 2001). It should be noted that government spending buys far more medicine per unit of expenditure than households spending, as government can benefit from bulk purchasing efficiencies using the National Medical Stores(NMS) (Gabra and Green ,2000; Euro Health, 2004).

## **2.9 Public- Private Partnership and Hospital Service Delivery Outputs**

Reich (2002) argues that partnerships result into innovative strategies and positive consequences for well-defined public health goals, and they can create powerful mechanisms for addressing difficult problems by leveraging the ideas, resources, and expertise of different partners. Such line of thinking is the same enshrined in the objective of Public- Private Partnership and Hospital (PPPH) in Uganda which is to establish functional integration and to sustain the operation of pluralistic health care delivery system by optimizing the equitable use of available resources and investing in comparative advantage of the partners (MOH, 2006).

In Sub-Saharan Africa, for example, the number of people receiving HIV/AIDS treatment increased more than eight-fold from about 100,000 to 810,000 between 2003 and 2005 and more than doubled in 2005. This massive improvement would not have been possible without key public-private partnerships in the HIV/AIDS sector (UNAIDS, 2006). Other studies have reported increased access and reversal of the decline in utilization of health services immediately after the introduction of government subsidies to Private-not-for-Profit (PNFP) sub sector. There was an upward trend in utilisation of composite Standards units of output (SUO) and this rise in utilisation has continued at an even steeper pace into the present day. This is attributed to the effect of the government subsidy in replacing user fees and allowing the charges to be gradually pushed downwards (Giutsi et al, 2004).

Singapore appears to be getting good value from its adoption of the public private partnership for health in its health care system. Patients enjoy complete freedom of choice between easily accessible private (80%) and public (20%) clinics for outpatient care, and public (80%) and private (20%) hospitals for inpatient care. Singapore doctors enjoy a high reputation, as attested by the steady streams of well-heeled foreign patients (150,000 in 2000) who fly in from the surrounding region for medical treatment. Average length of stay in a public hospital is 5 days. A recent nation-wide survey of patients discharged from all the corporatized public hospitals revealed a high overall patient satisfaction (Meng Kim Lee, 2003).

## **2.10 Hospital Outputs**

### **Immunisation**

Immunisation is a method of primary prevention aimed at preventing communicable diseases in order to reduce on morbidity and mortality due to the diseases being targeted. In Uganda, six childhood immunisable diseases are tuberculosis (T.B), Diphtheria, Whooping cough (Pertusis), Tetanus, poliomyelitis (polio), and measles. Immunisation is one of the government priorities and is well spelt as an approach for primary health care (PHC). It is one of the most important means of mortality and morbidity in children (Jelliffe, 1979), the others being good nutrition and good environmental sanitation.

Each and every year, infants should be fully immunized. The immunization coverage rates are greatly influenced by the socio-economic status of the mothers. An increase in socio-economic status of mothers results in an increase in immunization coverage rates, the level of participation in immunization activities and the number of fully immunized infants while a decrease results in lowered rates (UBOS, 2007). During the period of 1962 to 1970, Uganda established a comprehensive immunization programme, in which a high degree of vaccination coverage of infants and young children was achieved especially for TB and Polio. By 1973 coverage of TB and Polio was about 70 % for children less than 14 year.

A number of factors do affect immunization service delivery to populations. Some are related to the populations themselves while others are related to the health services (Kasule, 1992). In a study conducted by Kasule (1992), it was reported that knowledge, attitudes and practices of a community affected coverage rates and that these were linked up with mismanagement. Other factors influencing immunization included: education, status of parents, husbands consent, and general health education to the community. In one study done in Hoima by Baguma (1988), it was found that despite the mothers having good knowledge of immunization centres, the immunization coverage was low (18.2 %).

### **Antenatal Care (ANC) attendance**

Most women in Semuto Sub- County initiate Antenatal Care late in pregnancy thereby fail to reach the recommended 4 visits. Unplanned/mistimed pregnancy is one of the contributing

factors to delayed Antenatal Care attendance. Makaweri (2000) on frequency and timing of Antenatal Care in Kenya found out that the first visit occurs in the fifth month of pregnancy on average.

Nyane L (2007) conducted a study on factors associated with Antenatal care drop out among pregnant women in Tororo District in Uganda and found out that the level of education, age, parity (number of children previously had), distance and transport, socio-economic status, clients perception on Antenatal Care (ANC) services, knowledge about Antenatal Care, Occupation, decision making, marital status, gender dimensions, timing for Antenatal Care and unplanned/mistimed pregnancy among others are responsible for Antenatal Care drop out. A study done in Mberere District in Kenya found out that mothers living less than 5 km from the health facility utilized Antenatal Care services better than the mothers who were 5 km from the health facility (Mwaniki & Mbugua, 2002).

### **Deliveries**

Munaaba E. (1995) found out that the distance to a health unit was a major factor in determining whether professional care for delivery was sought or not. The difference in attendance of mothers from within a radius of 3 km from a health unit, as compared to utilization of health units by mothers who came from a distance of greater than 3 Km was found to be highly significant. This finding suggested that the catchment area of a health unit for purposes of maternity care, should be revised to 3 Km.

Other factors which influence mothers 'choice of location of child birth in Uganda include ethnocentricity, position adopted at child birth, staffing at health units, health facility equipment. Availability of service is a major factor contributing to choice of location of birth. And the WHO chronicle sums it up thus; As long as they are not sufficient conventional health personnel for total population coverage, as long as funds for health care remain mal-distributed and inadequate, so long will these TBAs continue to be in demand (WHO Chronicle 36 (3) 1982).

Many modern facilities charge a fee (user fee) which fees are in monetary terms and on a cash delivery \_basis'. The expectant mother may opt for the traditional sector where payment in real terms may be less, mode of payment flexible (that is, cash or kind), and allowing for credit



facilities. In Kenya it was estimated that 75 % of all births in areas where the research was conducted occur under the supervision of Traditional Birth Attendants (Nyamawe, 1984)

A survey on utilization of Home and hospital deliveries in Botswana revealed that 77.1% of urban women chose to deliver from hospital or clinic and only 45.2% of the rural women chose hospital or clinic. The proportion of home deliveries was highest in the most remote villages (low availability of modern service) and lowest in low-cost sites in the urban area (Anderson, 1986).

### **Inpatients**

Access and use of hospital in-patient care services can be influenced by several factors. In developing countries, Uganda inclusive, two main aspects of quality that have been documented to influence service utilization significantly are availability of skilled personnel and essential drugs (Hutchinson, 1999; Barnum and Kutzin, 1993). In the government hospital more patients were likely to be admitted due to the free services' rendered. However, due to higher tendency of stock outs of drugs and poor quality services, patients are either discharged earlier or seek for referral or may out right leave the government hospital, implying low costs of provision of inpatient care. On the other hand, the Private-not-for-Profit (PNFP) hospital which charges a fee for service may have fewer admissions, more IPDs and longer stays mainly due to good quality services. This may contribute to the high costs of provision of inpatient care and higher unit costs and hence an impression of poor efficiency (Ongom M, 2006).

### **2.11 Measuring Efficiency**

The discussion on the definition and measurement of the output of health care organizations has been dominated by two schools of thought namely; process approach and outcomes approach. The process approach, asserts that the output of a health care organization consists of services provided by the different units such as the X-rays, laboratory procedures, patient days etc; and the outcomes approach, regards the above processes only as intermediate steps leading to the desired change in patient's health status. According to this approach, therefore, output should be measured in terms of the end result or outcome that is improved health (Mersha, 1989).

Output can be seen from the providers' technical standards and patients' expectation (Brown et al, 2003). Uganda Catholic Medical Bureau (UCMB) (2005) noted that efficiency in health care stimulate people to seek treatment and reduce negative attitudes which increase access and utilization of services. Mills (1990) mentioned that working in an environment where employees are aware that treatment quality is poor is not motivating staff because it affects their morale. Lack of focus on quality results in waste of resources. Focus on delivering quality of services provides opportunities to utilize resources efficiently.

The outcomes approach is highly limited by practical difficulties. First, it is easier to measure and define processes in health care than changes in health status. Second, changes in health outcome can not be entirely attributed to health care. Health is multi-dimensional and affected significantly by a host of other socio-economic factors. Consequently, output is measured as an array of intermediate outputs (health services) that supposedly improve health status (Melbourne, 2004).

## **2.12 Trends of Standard Unit of Output in Private-not-for-Profit (PNFP) Hospitals in Uganda**

MOH (2007) revealed that for the three years running (2004/05, 2005/06 and 2006/07), there was a trend analysis of access and efficiency parameters of a set of 65 Private-not-for-Profit (PNFP) hospitals in Uganda. The components of the Standard Unit of Output (SUO) revealed the following; the outpatient attendance has decreased by 2% from 2005/06; the inpatient attendance has decreased by 10 % from 2005/06; Utilisation of antenatal services has increased by 14 %, immunization increased by 2%; and the overall volume of outputs measured by Standard Unit of Output (SUO) has decreased by 5%. Uganda Catholic Medical Bureau (UCMB)- Uganda Protestant Medical Bureau (UPMB)- Uganda Muslim Medical Bureau (UMMB) (2007) documented that both Private-not-for-Profit (PNFP) hospitals and lower level facilities have steadily registered increases in Standard Unit of Output (SUO) –a proxy for access-which is a composite index of IP, outpatient department (OPD) attendance, Antenatal Care, Immunisation and deliveries. They mention that the slight drop in 2005/06 is undoubtedly a consequence of the reduced support from government.

## 2.13 Conclusion

In New Public Management (NPM), Public- Private Partnership (PPPs) is widely used and is considered complementary to good governance.

Public- Private Partnership (PPP) generally involves a continuity of relations, including relational contracts that are based on trustful negotiation and dialogue and actors involved must be willing to invest material and non-material resources in the partnership. There are various types of Public- Private Partnership (PPP), among them the Build-Operate-Transfer model is widely used, i.e. the private partner is responsible for building, operating and maintaining a facility for a specified period of time, and after that the operation of the facility will be transferred back to the public sector.

Public- Private Partnership (PPP) has been used in France to finance public infrastructure since the 17th century when the French concession model was pioneered. Since then, the practice has been used globally, spanning from Europe, America, Australia, to Asia. Both developed countries and emerging economies are using Public- Private Partnership (PPP) as a tool in provision of services in areas such as healthcare, infrastructure, utilities and transportations.

Forming Public- Private Partnership (PPP) to assume functions that were previously delivered by the public sector has potential benefits for all stakeholders, including citizens, governments and the private sector. Examples of the benefits include increased competition and efficiency in services provision and reduction of public expenditures. However, like other business models or means of governance, Public- Private Partnership (PPP) is not without risks. Potential risks include loss of control by government and pre-development process being placed under a microscope of the media and the administration. One of the underlying problems arises from Public- Private Partnership (PPP) is agency problem the principal (government) have to monitor the behaviour of their agents (the private sector partner) to ensure that they are performing as agreed. When there is conflict between the goals of the principal and agent, it is difficult and expensive for the principal to verify what the agent is actually doing.

Ultimately, Public- Private Partnership (PPP) is a means to deliver public services, which involves the use of public resources such as land. Therefore, policy makers will have to make sure that the public interest is protected in Public- Private Partnership (PPP). This will help the

administration gain trust from the public. The public, on the other hand, has high expectations on the government in Public- Private Partnership (PPP), including aspects such as finance and transparency. Good practices of Public- Private Partnership (PPP) included consideration of community dynamics and history, investment in community liaison capacity, enabling community participation and adopting a Public- Private Partnership (PPP) policy. A government policy on Public- Private Partnership (PPP) will allow government to communicate its position in Public- Private Partnership (PPP) to other interested parties, including potential private partners, interest groups and the public.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

This chapter explains how the research was done. It covers the research design, research population, sample size, sample procedures, research instruments, validity and reliability of research instrument, data analysis, ethical consideration, and limitation.

#### 3.1 Research Design

Both qualitative and quantitative research designs were used. The qualitative technique helped ingathering and evaluating data on respondents' preferences, contextualization, interpretation, attitudes, opinions and behavior while the quantitative research gathered information using a constructed questionnaire and scales.

#### 3.2 Study Population

The study targeted people who work in the public private sector partnership in the health care delivery in Nakaseke district. Group (strata) was selected basing on the level of involvement and knowledge in the public private sector partnership in health care service delivery. The target population for the study was 100 and these included, medical personnel, Directors, Head of department committee, Evaluation committee, contractors/ supplies and beneficiaries.

#### 3.3 Sample Size

The sample of this study is 80 respondents drawn from the above population. According to Roscoe cited by Sekaran (2003), a sample size larger than 30 and less than 500 is appropriate for most studies. Bailey (1992) argues that for the descriptive research, 10 percent of the population is adequate and for research involving smaller population 40 percent may be considered. Each member in the sample size is referred to as a subject sometimes, the term respondent are used in the details of the population, sample size and selection methods.

Solven's formula is used to determine the sample size.

$$n = \frac{n^2}{1 + n(e^2)}$$

n= sample size

N= population size

e= level of significance

e= 0.005

$$e^2 = 0.005^2$$

$$n = \frac{100}{1 + 100(0.0025)}$$

$$n = \frac{100}{1 + 0.25} = \frac{100}{1.25}$$

**n=80**

The sample size was 80

### **3.4 Sampling Procedure**

The following sampling procedures were used by the researcher to select the sample while in the field.

#### **3.4.1 Simple Random Sampling**

In this method a researcher obtained the sample from the population in the way that the sample of the same size was given equal chance of being selected. This method is advantageous because it is free of clarification error and it requires minimum advance knowledge of the population other than frame.

#### **3.4.2 Purposive Sampling**

In this methods, the researcher targeted a specific group of respondents and administrators (commissioners, directors, head of departments contract committee, evaluation committee and

suppliers) since they are believed to be reliable and knowledgeable about the procurement process and performance of the organization and they would be in position to give the researcher detailed information about the topic to be invest

### **3.5 Research Instruments**

In order to ensure reliability of the study findings, several data collection methods were employed. The type of data to be collected dictated the methods to be used, as seen below;

#### **3.5.1 Primary Data Collection Method**

##### **Questionnaire**

Questionnaire is a data collection tool in which written questions are presented that are to be answered by the respondents (peasant farmers) in written form. The researcher gave out questionnaires which were to be answered by the respondents in written form. 40 questionnaires were given out to the respondents. The questionnaires were hand-delivered and collected at a later date. For respondents who could not read and write; assistance was provided by the researcher through direct discussion to answer the questionnaire. Open ended and closed ended questions were used so as to eliminate bias when answering questions

##### **Interview**

This method was specifically used to collect information from the NAADS Coordinator. The researcher was used an interview guide for this purpose. Interview is a flexible method of data collection, it was used to supplement the data collected using questionnaires, and the researcher considered it to be suitable for the study. It also permitted on spot editing which enhanced the accuracy of the data. Agricultural Extension workers were also interviewed in the same manner.

#### **3.5.2 Secondary Data Collection Method**

Secondary data was also collected by reviewing documents. The researcher reviewed journals like magazines, library books, manuals, workshop and seminar papers, official circulars from NGOs, Acts of Parliament, Newspapers, Internet documents and so on

### **3.6 Validity and Reliability of Instruments**

The Interview guide and questionnaires were pre-tested in the area of study to test their validity and reliability. There was need to translate the questionnaires since some of the respondents were illiterates.

Data was collected, edited, sorted, coded and was entered in the computer for processing using APA versions to ensure that data collected is complete and accurate and is actually reliable.

For the purpose of the validity of the instrument the designed questionnaire or the draft of the questionnaire will first be checked by the supervisor or other research experts in order to remove the error from it.

Results from the pilot exercise helped to make suggestions, which were incorporated in the final draft of the tools to improve their validity and reliability.

### **3.7 Data Analysis and Presentation**

The data entry was done using Statistical Package for Social Scientists (SPSS) to generate frequencies and percentages. This made the data collected from the field more organized, meaningful and easier to analyze. The statistics were presented using charts and tables. The data collected was presented in form of a written report (essay), tables and charts which were generated using Ms. Excel.

### **3.8 Consideration to Ethical Standards**

The researcher was given an introductory letter from the university. This letter was for the relevant authorities for the purpose of this research.

The researcher was sought consent from the respondents before distributing the self-administered questionnaire in order to create good relationship such that he can get unbiased information

Under this section, the researcher was made the respondent to have knowledge of the study, its procedures and purpose of the study duration,

Any unforeseen risks or discomforts extent of privacy and confidentiality. This was done by getting letters from the ethical body and consent of the respondents. The researcher was also



borrow ideas and views of other authors and academicians and recognize the respondent by giving them the source of information.

### **3.9 Limitations**

The researcher might a number of problems that could affect the research findings or the stipulated time for the research. Some of these problems included the following.

Financial limitations: To do any research successfully a good amount of money should be used on the different expenses like transport, paying any support staff, printing and other secretarial work among others. Since the study was carried out in Nakaseke, the researcher was had travel to Nakaseke district thus incurring the transport expenses to and fro.

During this study, the researcher expects to have some threats that could reduce the validity of the findings. This included emotional biases of respondents, inefficient time, unplanned change in the daily working and questionnaires retrieval.

There was none availability of some records on personnel employed between 2003/04 and 2011/2012. This might have limited the analysis on some variables for that period. However, given that the data was collected for a long period over 10 years, this did not significantly affect the validity of results since the vast of the records accessed allowed meaningful comparisons.

Data on immunization and ANC was composite and not disaggregated and thus difficult to differentiate between first, second, third etc (ANC and immunisation), new and old re-attendances. However, this did not affect the validity of the results based on the economic model (SUO) applied which takes into consideration use of aggregated data on the outputs.

Although efficiency of health centers may be measured by use of Frontier methods of efficiency measurement such as the linear programming techniques (for instance, data envelope analysis) and econometric techniques (for instance, production and cost functions), in this study, these techniques were not appropriate because the study was focusing on a single health facility.

There are other commonly used ratios as measures of operational efficiency that have not been looked at in this study. These include: bed occupancy rate, turnover ratio, turnover interval and average length of stay. These were not used due to inadequate data availability.

### **3.10 Solutions**

The researcher tried to mobilize resource from different sources, which helped him to overcome the financial problem.

The researcher prioritized his schedule according to deadlines in order to utilize the given time effectively and efficiently.

The researcher tried to explain to the respondents about the research to avoid the biasness among the respondents who eventually gave information without biasness.

## CHAPTER FOUR

### DATA PRESENTATION, DISCUSSION AND ANALYSIS

#### 4.0 Introduction

Between April and August 2016, data on health centers records to ascertain the level of government financial and human resource support and the efficiency on health service delivery at Health centers through PPP were reviewed for the period 2015/2016. Findings in sections 4.1 and 4.2 are relevant to research objective one while section 4.3 is relevant to research objectives.

#### 4.1 Inputs to Health centers under the Public Private Partnership

##### 4.1.1 Sources of Funding for Health centers

The sources of funding for Health centers with corresponding financial support based on review of health center financial records and disbursements from central government for the fiscal years 2015/16 are summarized in Table 1.

**Table 1:** Sources of Funding for Health centers

Source of funding	Frequency	Percentage (%)
Government contributions	57	71.25
User fees	16	20
Donor agencies	05	6.25
Sales	02	2.5
Other incomes	00	00
<b>Total</b>	<b>80</b>	<b>100</b>

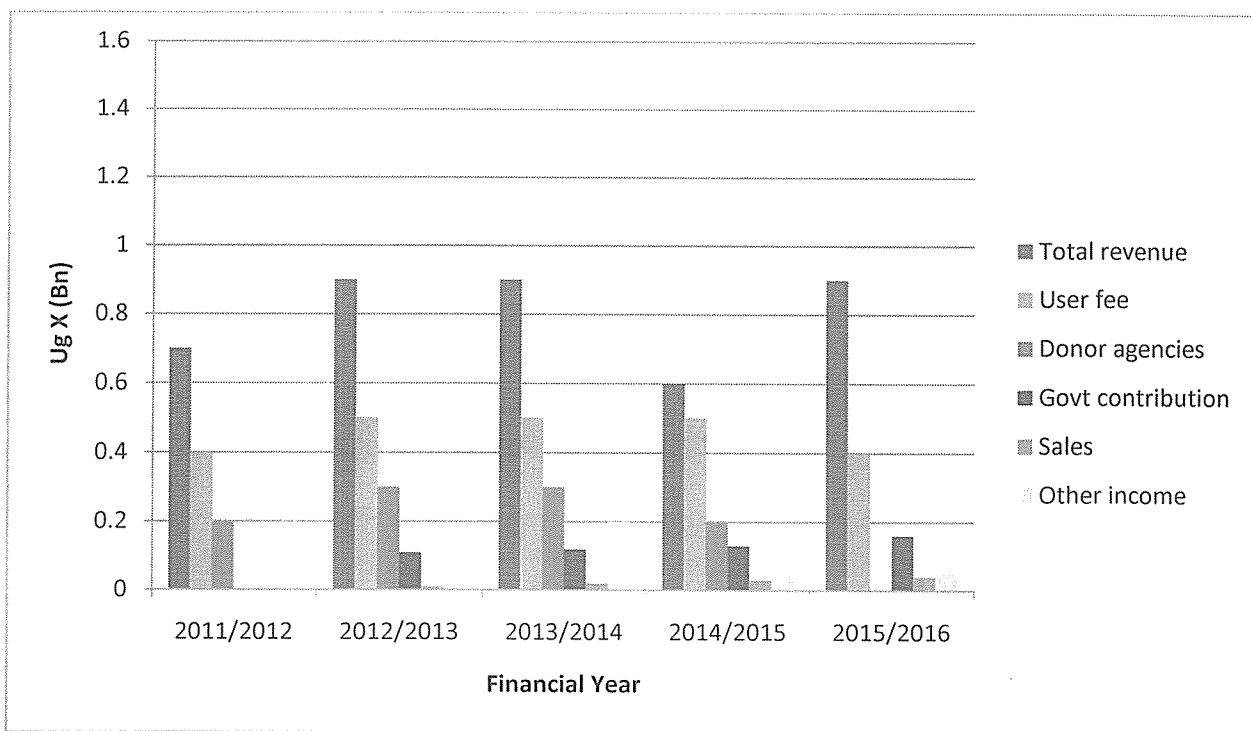
Findings from Table1 reveals that 57 (71.25%) of the respondents said the health centers received funding from government while 16 (20%) said it was from user fees then 05 (6.25%)

said it was from the donor agency, 2 (2.5%) said it was from the sales and 0 said it was from other incomes. This implies the majority the funding from government and the minority was from the sales.

#### 4.1.2 Trends in funding

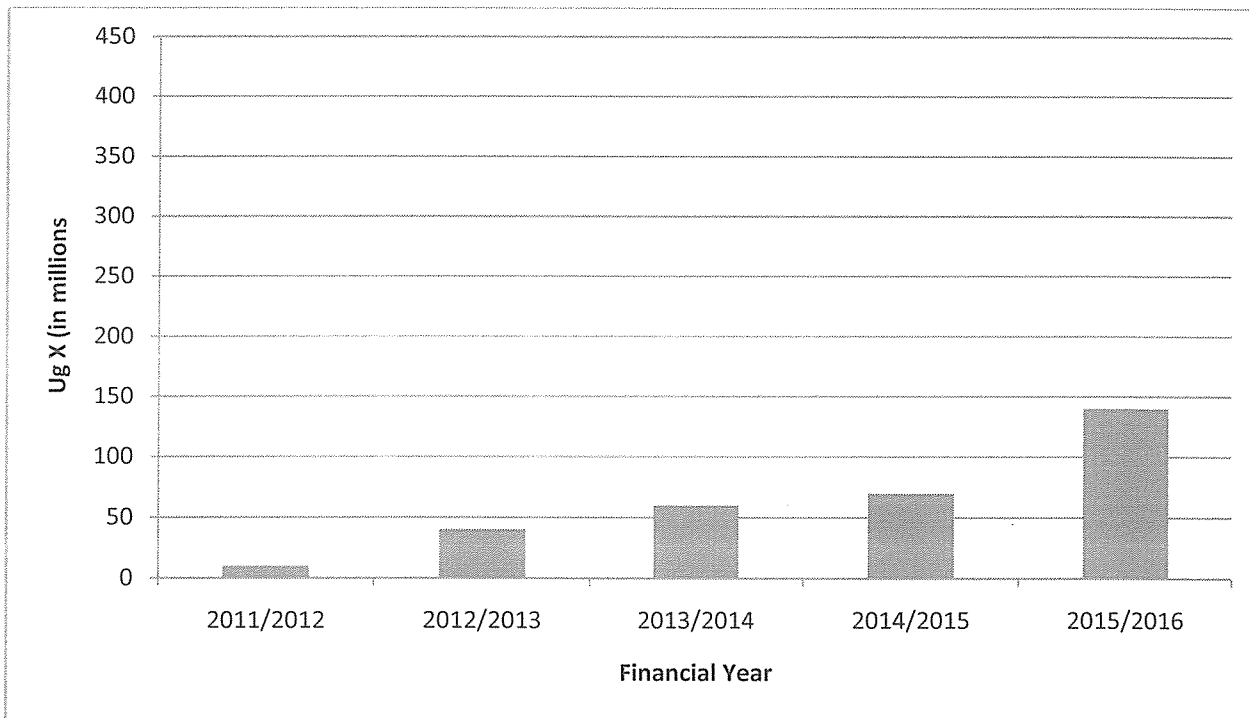
In this study, we documented trends in funding by source over five fiscal year period from 2011/12 to 2015/15. Findings are summarized in Figure 1.

**Figure 1: Trends in funding by source for Health centers 2011/12-2015/16 in billions (bn)**



Findings from Figure 1 revealed an increase in government contribution as well as increase in other sources of funding from the financial Year 2011/2012 up to 2012/13. However, from 2006/7 to 2013/14, a decline in funding from many sources while donor funding increased is observed. Further analysis of government financial support through the PPP scheme was done separately to appreciate the trends over the 5 year period.

**Figure 2: Trends in government financial support to Health centers under PPP**



Findings from Figure 2 reveal a general increase in government financial support to the health centers. However, a decline in government funding was noted in the FY 2011/12 and 2013/14.

#### **4.1.3 Support to Primary Health Care (PHC)**

Further analysis of financial support to primary health care under PPPH to Health centers exhibited an increasing trend from FY 2011/12 to 2015/16 from Ugs\$ 7.17 million to 62.5 million and then declined over the period 2011/12 to 2015/16 as shown in figure 3.

**Figure 3:** PHC support to Health centers, FY 2011/12 to 2015/16

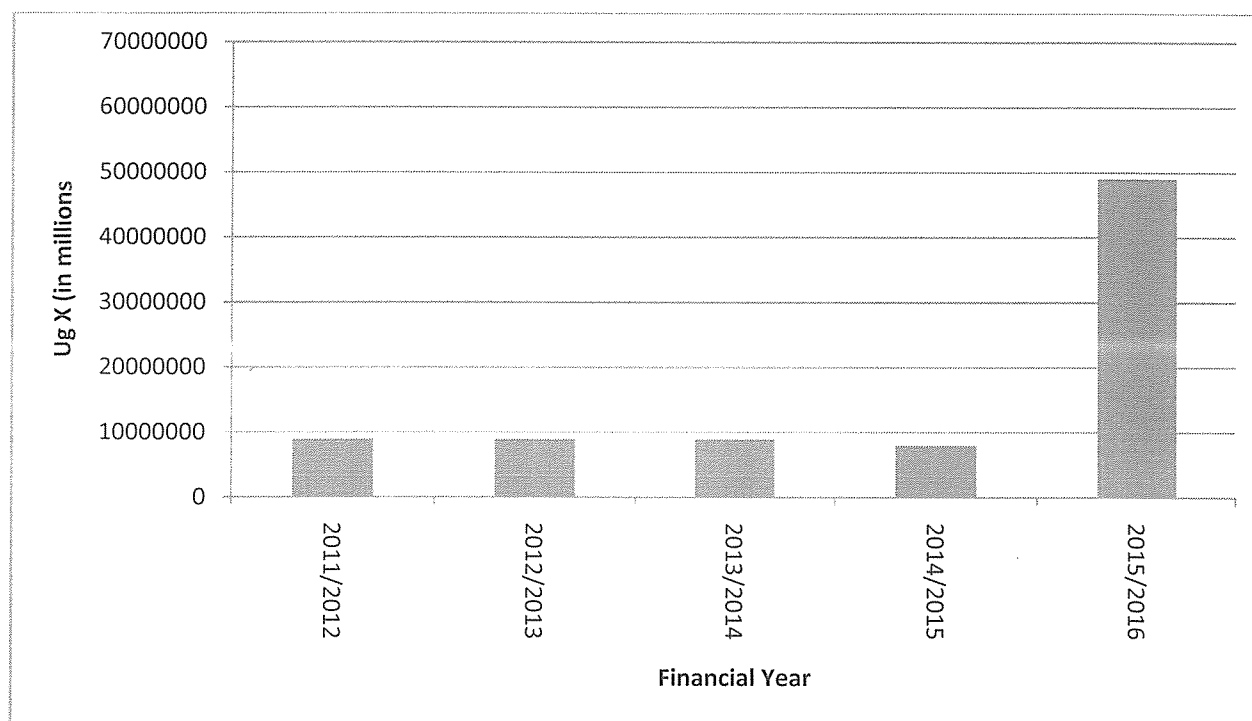


Figure 3 shows that there was an overall increase in PHC funding to Health centers over the period FY 2011/12 to 2014/15 and an increase in support in 2015/16.

#### 4.1.4 Support to HIV/AIDS activities

The Joint Clinical Research Centers (JCRC) mobilized funds from development partners on behalf of government and disbursed the funds to Health centers for HIV/AIDS prevention shown in Table .

**Table 2:** Financial support (in 000) by Joint Clinical Research Centers to Health centers between FY 2011/12 and 2015/16

FY	2011/12	2012/13	2013/14	2014/2015	2015/2016
Ugshs (000)	90,000	110,672	110,672	10,000	54,840

The pattern of financial support to HIV/AIDS in Table 4.2 shows that there was an overall increase in financial support to HIV/AIDS activities over the period 2011/12 to 2015/16. The HIV/AIDS support reveals a sharp increase trend in FY 2015/16.

#### 4.1.5 Support to Human Resources for health

Under public private partnership, government supported human resource development at Health centers through the wage subvention fund to staff who are seconded by government. Findings for the entire staff of Health centers for the FY 2009/10 to 2013/14 are summarized in Table 5.

**Table 3:** Staffing at Health centers in the Financial Year 2015/16

Response	Frequency	Percentage
Doctors	9	11.25
Nurses	41	51.25
Other employees	30	37.5
<b>Total</b>	<b>80</b>	<b>100</b>

Overall, Health centers employed on average 80 staff in a given year. The staff included Doctors who ranged from Specialist Medical Officers, Medical Officers, Pharmacists and Dentists to Residents and Interns. Nurses included Nurses/Midwives of different professional categories ranging from professional enrolled, registered, community nurses/midwives, to nursing assistants. Other employees included paramedics and assistants technicians, administrative staff and other general staff. It is important to note that the majority of the staff were nurses compared to doctors and other employees. The maximum staff level of 80 staff was achieved in FY 2011/12 and 2015/16 while the lowest staffing of 80 was registered in 20013/14.

Further analysis of the staffing was done to determine what proportion of the total staff were employed by government. Table 6 shows the staff who were seconded by government to Health centers under the PPP strategy.

**Figure 4:** showing staff Seconded by Government to Health centers, FY 2011/12 – 2015/16

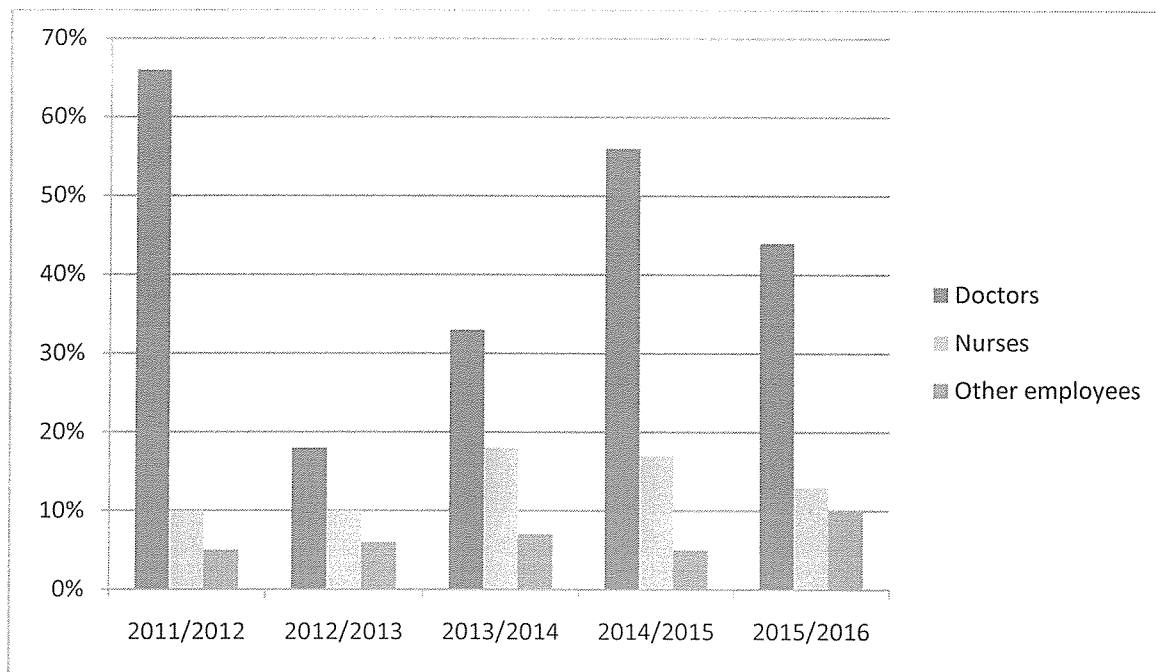


Figure 4 revealed that 9% to 14% of Health centers staff was seconded by government, the majority of whom were doctors followed by nurses and other employees. However, data on Human Resource between 2011/12 to 2015/16 was not available. At any given year, the total number of staff seconded to Health center varied between 17 and 25.

#### 4.1.6 Staff bed ratios

Ideally, an increase in medical staff in a health centers should lead to an increase in staff to bed ratio if the staffing is to have any effect on health centers efficiency. The yearly total staff per bed, doctor per bed and nurse per bed ratios was calculated to assess if the increase in staffing due to government secondment had an influence on staff bed ratios. Table 7 summarises the details.

#### 4.1.7 Support on medicines through Credit line

The Government also provided medicines for use by the Health centers under the credit line for medicines grant that was managed centrally by the Ministry of Health through the Joint Medical Store (JMS) summarized in table 8.



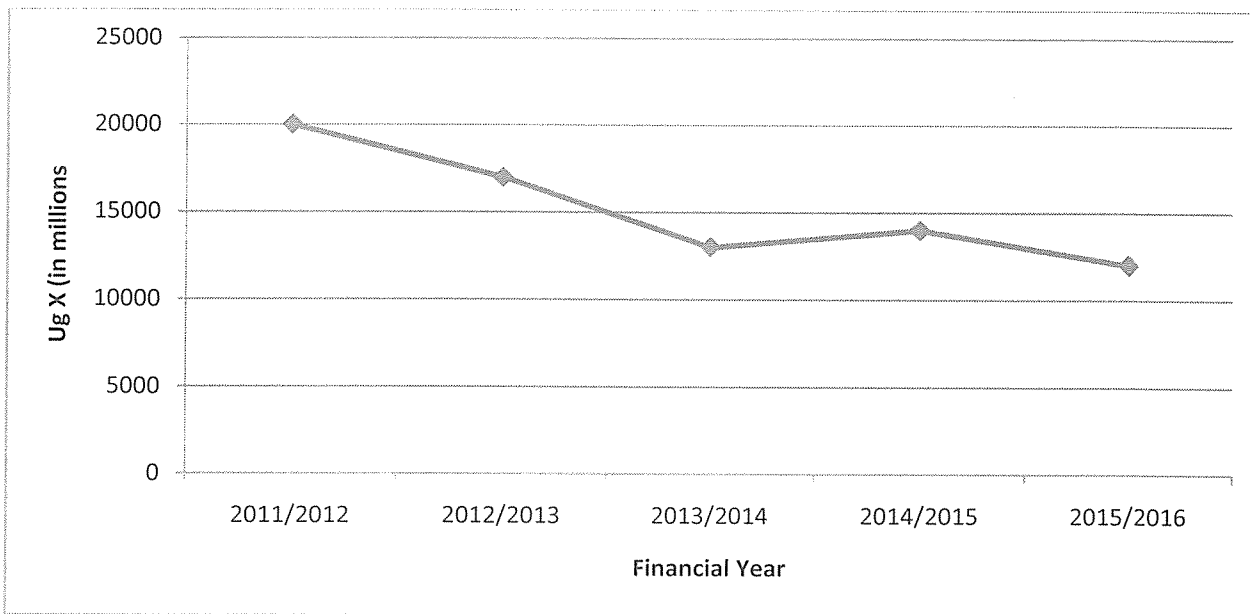
## **4.2 Health centers Service Delivery Outputs**

The study looked at specific outputs at service delivery level to determine the extent to which Health centers utilized the government funding and human resource received over the eleven-year period. This was based on key variables on the SUO and other vital output variables. These included number of children immunized (irrespective of the type of immunization), number of patients seen at OPD (irrespective of old and new cases), mothers who attended ANC (irrespective of new and repeat visits), number of admissions, number of deliveries and surgeries performed (both elective and emergency) during the period under study. Details are presented in the proceeding sections.

### **4.2.1 Immunization for children 0-5 years**

Immunization for children is a proxy for health centers involvement in the provision of PHC activities to the community and thus a key output indicator. In this study, documentation of the trends in immunization of children for the period FY 2003/04 to 2013/14 was done. Details are summarized in Figure 5.

**Figure 5:** Number of children immunized at Health centers over the period 2011/2012 to 2015/16.

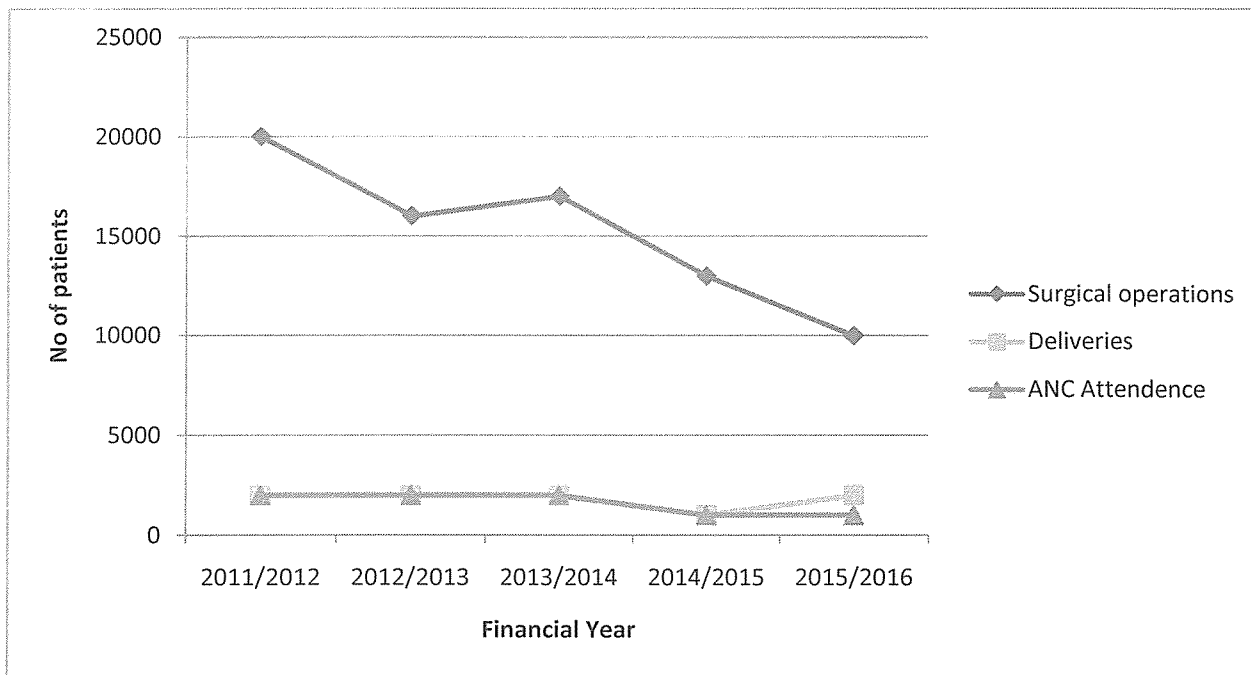


Overall, there was a declining trend for the total number immunized from 20592 immunized children in FY 2011/2012 to 11399 immunized children in FY 2015/16, with a slight increase in 2013/14 and then a decline for rest of the period under study most likely due to changing priorities in budget allocations.

#### **4.2.2 Surgical operations, normal deliveries and ANC attendance at Health centers between FY 1996/7 and 2006/7.**

In this study, we assessed the trends in number of surgical operations, normal deliveries and ANC attendance. These are important indicators in health centers service delivery. Results are presented in Figure 5.

**Figure 6:** Trends of Surgical operations, normal deliveries and ANC attendance at Health centers between FY 2011/12 and 2015/16



ANC attendances over the period of 11 years showed a declining trend. Mothers can prefer to go for re-attendances of ANC in other health facilities nearest to them not necessarily the health facility of first visit. The total number of deliveries and surgical operations revealed a flattened declining and increasing trend for the entire eleven year period of PPP implementation. Total ANC attendances was highest in FY 2011/12 at 20,450 and continued to decline to 6,823 in the FY 2013/14 while total deliveries per year was highest at 1,917 in FY 2015/16 and lowest at 1,243 in FY 2011/12. Surgical operations were highest at 2,036 in FY 2013/14 and lowest at 740 in FY 2012/13.

#### 4.2.3 OPD attendances and Admissions

Similarly, OPD attendance and health centers Admissions is a sign of increased access and use of PHC services by the population and thus a proxy measure of efficiency.

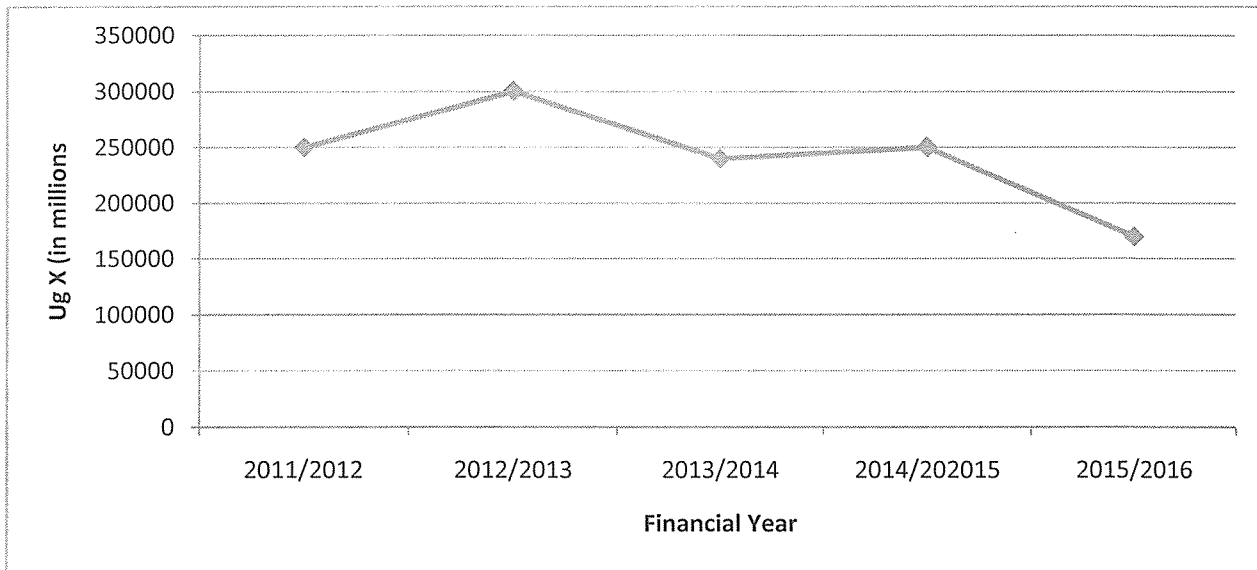
#### 4.3 Standard Unit of Output (SUO)

The SUO is used as a proxy for measurement of the volume of activity of a health centers and adds up 5 main outputs as if they were all outpatients based on their relative cost to the outpatient. This analysis was relevant in achieving objective two. The SUO was calculated using the formula developed by Giusti (2002): Standard Unit of Out put (SUO) = (15\*total admissions)

+ (1\*total OPD attendances) + (5\*total deliveries) + (0.2\*total immunisation) + (0.5\*total ANC attendances). Based on this formula, Giusti (2002) concludes that a health facility is said to be efficient if the SUO exhibits an increasing trend while a decreasing trend is said to reveal inefficiency in health service delivery, as a proxy of access.

Figure 7 shows the trend of the total annual SUO for Health centers from 2011/12 to 2013/14. The trend of total annual SUO revealed a declining trend from 2013/14 to 2015/16 and an increasing trend from 2012/13 to 2013/14. The declining trend of SUO was due to decline in health centers service delivery outputs of Immunisation, OPD attendances and ANC attendance. In addition, Government of Uganda budget support cuts to Health centers could have negatively impacted on the overall performance of the SUO.

**Figure 7:** Standard Unit of Outputs for Health centers between 2011/12-2015/16



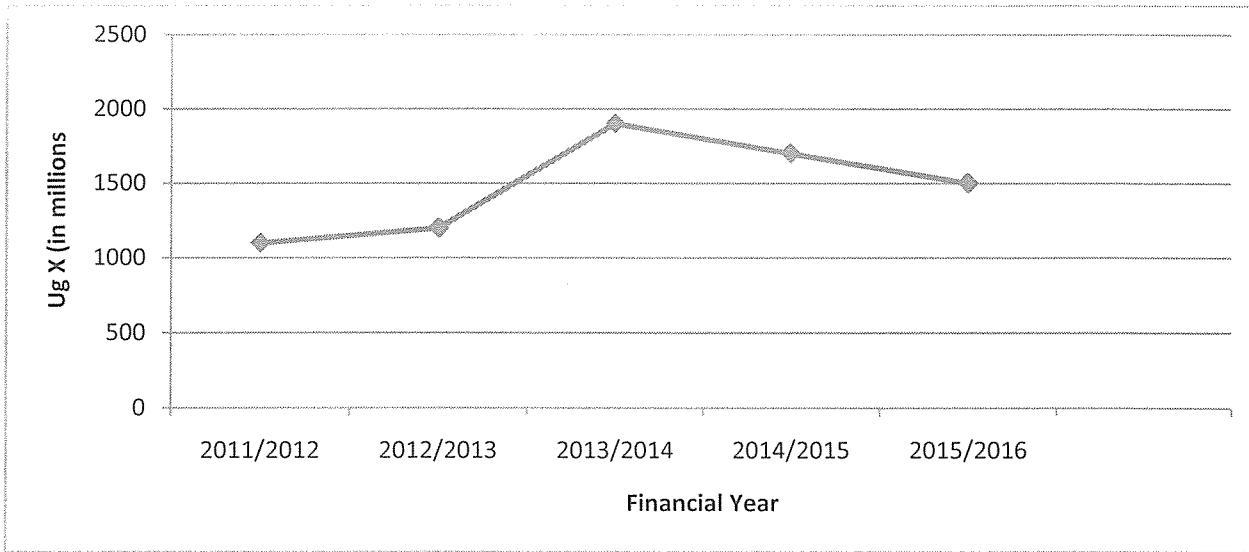
The SUO increased from 252,294 in FY 2011/12 to 307,699 in FY 2012/13 then declined and was at its lowest in 2015/16. It then began to rise peaking at 290,380 in FY 2013/14. The standard unit of output at Health centers was highest at 307,699.8 in FY 2013/14 and lowest at 166,750.2 in FY 2015/2016.

#### 4.3.1: Standard Unit of Output per staff

Standard Unit of Output (SUO) per staff measures staff productivity over time. Gusty (2002) argues that an increase in SUO per staff reveals improved staff productivity while a decline in

SUO per staff reveals a reduction in staff productivity. In this study, the SUO per staff for Health centers was determined as a way of measuring efficiency. The overall trend of the SUO per staff is an increasing one as shown in figure 8

**Figure 8:** SUO per staff for Health centers 2011/12-2015/16



The Standard Unit of Output per staff increased from 1,084.8 in FY 2011/12 to 1,908.6 in FY 2012/13 when the total number of government seconded staff to the health centers increased in the same year and then took on a declining pattern up to 1,489.1 in FY 2013/14 even when the health centers had the highest number of seconded staff from government. The staff, on average, was responsible for 1,389 outputs per year.

#### 4.3.3 Total cost per unit of output (SUO)

Cost per unit of output (SUO) is another efficiency indicator. The total costs considered for Health centers included expenditures on: salaries (local), treatment of staff, training and welfare, canteen and food, drugs and medical supplies, consumable supplies, transport, fees waived, power, donations and bad and doubtful debts. However, other cost centers of the health centers such as nursing training were not included. A health facility reflects efficiency when the cost per standard unit of output declines. As the cost per standard unit of output increases, it is said to be reflecting inefficiency in health service delivery.

#### **4.3.6 User fees per SUO**

Financial access is demonstrated by the average fees paid for SUO. A reduction in fees paid by patients for one SUO makes the more vulnerable more able to afford services than before while a rise in fees paid by patients for one SUO indicates that the more vulnerable are unable to afford health services. In this study, we explored whether user fees per SUO was reducing as a measure of affordability of health services over the period of study.

#### **4.4 Discussions of the findings**

##### **4.4.1 Financial and Human Resource Support through PPP to Health center**

Government financial support through PPP constituted 18.42% of the total budget for Health center over the period under study. This contribution is lower than revenues received from donors and user fees of 26.74% and 47.61% of total budget respectively. This finding is in agreement with UCMB-UPMB-UMMB (2007) which estimated government contribution to PNFP facilities to be at 15% to 36% of the facility total budget.

Trends in government financial support revealed a general increase in government financial support to the health center. However, a decline in government funding was noted in the FY 2008/9 and 2013/14. One of the reasons for this decline included budget cuts from the central government. The above findings therefore imply that any fluctuations in government funding have a direct effect on the budgets of government supported health facilities. Similar findings have been reported in other developing countries where health center budgets are dependent on government support (Cush, 2005).

A higher proportion of Health center doctors compared to nurses and other employees were seconded staff. However, the proportion of 9 to 14 % for seconded staff is still lower compared to 28% rise in staffing of medical staff in the public sector (UCMB, UPMB and UMMB, 2007). The findings in addition agree with Moody (2004) who reveals that health care delivery is labour intensive and thus the workforce determines productivity and quality of services.

#### **4.4.2 Health Center Service Delivery Outputs**

The research observed a decrease in immunization trends with corresponding increment in government financial support but also a reduction in numbers in spite of stepped PHC funding in some instances. This may be attributed to changing priorities in budget allocations over the entire period under study. It is possible that while government funding through PHC increased more allocations could have been made to other activity outputs than immunization for the period where numbers in total immunization reduced. The role of other factors that reduce immunization numbers can not be underestimated. Kasule (1992) argues knowledge, attitudes and practices of a community can affect immunization coverage rates.

#### **4.4.3 Antenatal care (ANC), Deliveries and Surgical Operations**

The overall pattern of Antenatal Care (ANC) revealed a declining trend despite of the increase in government funding. Mothers can prefer to go for re-attendances of ANC in other health facilities nearest to them not necessarily the health facility of first visit. Given that the illiteracy levels in semuto Sub County among women is low (37%) and that the majority of women are dependant on men for financial support, it is possible that the above factors could have played a role in the decline in utilization of ANC. We can not under estimate the role of other factors such low sensitization among communities on importance of ANC and health care provider factors in contributing to the low ANC uptake irrespective of the increased government funding. This is further supported by Nyane (2007) in which Antenatal care drop out among pregnant women may be attributable to the level of education, clients perception on ANC services and knowledge about ANC.

As the financial support to Health center increased the total number of deliveries did not significantly increase. This can partly be explained by the existence of the government owned health centres that have nurses mid wives' offering a similar service within a radius of 5 km. These findings are in agreement with Munaaba (1995) where distance to a health unit was a major factor in determining professional care for delivery. Other factors that could explain such trends include traditional birth attendants, ethnocentricity, position adopted at child birth, staffing at health units (WHO chronicle 36 (3) 1982), Nyamawe (1992) & Anderson (1986).

The increasing trend in number of Surgical Operations per year in some instances could be attributed to the increasing number of government seconded medical doctors. This observation confirms that government secondment of health workers to PNFP health units is an endeavour to work together with the private sector to improve the performance of the health system in general (Lochoro et al, 2006) and thus human resource remains the central gist that determines the overall effects of the reforms (Rigoli, 2003).

#### **4.4.4 Outpatient Department (OPD) and Total Admissions/or Inpatient**

When the OPD utilization and admissions are compared to government support, OPD utilization and number of Admissions steadily increased with increasing government financial support from FY 2008/09 and reduced when government funding was lowered in 2013/14. This observation confirms that the support through PPP had a positive influence on health service delivery and utilization at Health center. Outpatient Attendance in government and PNFP units is a measure of utilization of health services, and is used as a proxy measure for both the quality and quantity of services,(supply side) and the health seeking behaviour of the population (demand side). The initial increase in new OPD attendance was attributed to the reduction of user fees and flattening of fees in PNFP facilities (MOH, 2007).

#### **4.4.5 OPD patient: Doctor ratio and OPD: Nurse ratio**

When the health center employed the highest number of doctors, the workload for doctors was lowest compared to the year when the health center employed the lowest number of doctors. This observation confirms the fact that government secondment increased the number of doctors at Health center which reduced doctor workload and thus likely to increase staff productivity in terms of service delivery. On the other hand, as the number of nurses in Health center reduced the nurses' workload increased and hence likely to have reduced staff productivity.

#### **4.4.6 Inpatient: Doctor ratio and Inpatient: Nurse ratio**

The Inpatient: Doctor ratio was high when Health center had low numbers of doctors and this led to increased workload for doctors in the Inpatient wards. However, in the year when the health center employed the highest number of doctors, the workload for doctors was lowest. Hutchinson( 1999) & Barnum and Kutzin, (1993) found out that in developing countries, Uganda



inclusive, two main aspects of quality that have been documented to influence service utilization significantly are availability of skilled personnel and essential drugs .

The Inpatient: nurse ratio increased as the number of nurses in Health center reduced which increased the nurses' workload in the Inpatient wards and reduced for the rest of the period as the number of nurses employed increased. These findings are in agreement with UCMB- UPMB, UMMB (2007) who found out that there are high levels of attrition in PNFP health centers at 16 % in 2007/08 and human resource gap represented a proportion of 54 % of the total human resource gap in the health sector. Also agree with WHO(2000) who note that Gaps in human resources for health in numbers, skill mix and distributions continue to pose a challenge for effective service delivery in Uganda. In a health center, the inpatient care departments consume the largest share of inputs. Maurizio et al (2003) notes that the way these inputs are organized and managed can be the predominant factor in determining the overall efficiency of a health center.

#### **4.4.7 Standard Unit of Output**

The trend of SUO per year for Health center showed an overall declining pattern despite of increased government funding implying a reduction in access to health services. However, in some instances, the SUO per year increased with increased government funding to the health center which implies increased access to health services by the population for some particular years. The declining trend of SUO can be attributed to the reduction in total admissions or inpatient, OPD attendances, immunisation and ANC attendances observed in the initial years. This finding is in agreement with MOH (2007) who found that over the 2 years of the HSSP II, there has been a worrying trend of reversal with overall declining outputs, including OPD, IP and Primary health Care services like Antenatal Care and immunization. These findings disagree with UCMB-UPMB-UMMB,(2007) who noted that SUO per year from a sample of 27 health centers(65% of PNFP health centers), shows constantly increasing values of SUO and that the slight drop in SUO is undoubtedly a consequence of the reduced support from government to PNFP health units .

#### **4.4.8 SUO per staff (Staff productivity)**

Staff productivity which is measured by Standard Unit of Output (SUO) produced per staff showed an overall rising pattern in comparison with financial and human resource support from government. The upward trend of SUO produced per staff showed efficiency in use of human resource. In some instances staff productivity reduced and this can be attributed to the declining trend in SUO when total admissions, OPD attendances, immunization and ANC were declining in Health center. However, this could also be attributed to staff attrition when total staff reduced with reduced SUO. These findings are in agreement with UCMB, UPMB, UMMB (2007) who reveal that efficiency gains are lost in PNFP health centers due to increasing staff attrition in a study carried out in 65 % of PNFP health centers in Uganda.

The average SUO per staff of 1389 for Health center agrees with findings of MOH (2007) who found out that a staff on average was responsible for 1,395 units of outputs. The findings agree with Giusti et al (2004) who carried out a study on pro-poor health services and found out that SUO per staff remained stable, and in some cases showed a decline.

#### **4.4.9 Unit Cost per standard unit of output**

The total cost per standard unit of output revealed an overall upward trend in comparison with increase in government financial support to Health center implying that the health center lost efficiency gains. A steep rise between FY 2006/07 and 2007/08 can better be explained by the significant reduction in the standard unit of output due to reduction in health center outputs-admissions, Immunisation, ANC and OPD attendances, and increasing costs of service delivery at the health center. This observation is in agreement with the findings of UCMB- UPMB- UMMB (2007) who noted that with increasing cost of human resource; the cost per unit of output (SUO) is increasing even in lower level health facilities as health centers particularly increase salary levels in attempt to retain staffs. However, this finding disagrees with Maurizio et al (2003) who asserted that an increment in expenditure alone does not guarantee efficiency but the way inputs are organized and managed can be the predominant factor in determining the overall efficiency of a health center.

#### 4.4.10 User fee per SUO

The results provide some evidence that the health center has become more pro-poor with an overall trend of declining fees paid per standard unit of output. It should be noted that drop in user fees makes the more vulnerable to afford services than before and hence increased utilization of health center services by the poor. The findings are in agreement with McPake (1993) who noted that although fee reductions were not targeted at the poor, it is known that utilization by the poor is more elastic to fee adjustments. Bennet (2004) showed that substantial fee increases resulted in immediate drops in demand, however, with higher income groups showing a less elasticity in demand over time. Studies done in Uganda (WHO/MOH, 2002) also found out that user charge rates and availability of drugs have a rapid effect on health service utilization. The mild increase of user fees reflects the pressure on the sub-sector of the increased cost of service production and reduced government support (UCMB-UPMB-UMMB, 2007).

## CHAPTER FIVE

### RECOMMENDATION AND CONCLUSION

#### 5.1 Introduction

This chapter therefore presents the summary of findings, conclusions and the recommendations for further research.

#### 5.2 Conclusions

Health center received financial support from government to the tune of UGX 2.2 billion over the eleven years amounting to 18.4 % of the health center budget.

Government seconded staff to the health center accounted for 9-14 % of the staff establishment, which is still low to significantly improve health center efficiency in service delivery.

The main staff seconded by government is medical doctors and nurses with the former accounting for 18% to 66% of the total number of doctors employed in the health center. Seconded nurses only account for 10% - 18 % while other employees account for 5% - 10%.

The health center service delivery outputs that reveal an increasing trend include Admissions while deliveries and surgical operations reveal a flattened increasing trend. Health center service delivery outputs that show a declining trend include Immunizations, ANC and OPD attendances

There is evidence that some health center service delivery outputs increased due to increase in financial and human resource support to the health center and also a reduction in outputs due to reduction in support from the government.

The overall trend of Standard Unit of output for Health center reveals a declining trend implying a reduction in access to health services over the period 2003/04 to 2013/14. The overall rising trend of SUO per staff reveals efficiency in utilization of human resource at Health center.

There is evidence that the health center has become more pro-poor with an overall trend of declining fees paid per standard unit of output. A reduction in user fees per SUO enables the more vulnerable to afford and access services.

### 5.3 Recommendations

Government grants to Health center should not be overlooked in view of the cost of health service delivery. The grants should be maintained and increased where possible to ensure sustainable and increased utilization of health services by the community.

The government of Uganda through the PPP strategy should continue secondment of staff to Health center focusing on seconding more doctors to the health center since they offer specialized services that can improve the health outputs of the health center in critical departments.

Health center should recruit more doctors in addition to those seconded by the government to increase the health outputs of the health center. This improved staff workload and efficient utilization of the human resource at the health center.

Further research into the efficiency of health service delivery at Health center should be carried out taking into account quality of care indicators in addition to the standard unit of output. A study is recommended to assess the quality of service delivery in the periods before and after the PPP in health at Health center in comparison with government health facilities. This was provided valuable information that would guide investments into quality improvement.

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## APPENDICES

### Appendix I: Questionnaire

#### Use both open and closed ended questions

This study is aimed at finding out the public private sector partnership in health care delivery at Semuto subcounty Nakaseke district. As a student studying BPA am kindly requesting you to provide me any information regarding the public private sector partnership in health care delivery. Your information was treated highly confidential.

#### Section A: Demographic questions

1. Age (Tick your appropriate)

21-30

61-70

51-60

41-50

31-40

2. Sex

Male

Female

3. Marital Status

Single

Married

4. Education level

Primary

Secondary

University

None



**Section B**

What is your states experience in PPPs? (answer “c” or “d” go to question 10)

- a) Experienced
- b) Currently Practicing
- c) Plan to implement in the future
- d) Don't plan to implement

Which of the following types of PPP have been used in your state? (Select all that apply)

- a) Pre-Development Agreements
- b) Build-Operate- Transfer
- c) Long term lease agreement
- d) Design -Build-Finance-Operate
- e) Build-Own-Operate
- f) Other (please specify):

What is the primary reason for implementing PPPs in your state?

- a) Financing
- b) Risk transfer
- c) Shortage of work force
- d) Cost and time savings
- e) Other (please specify):

Has the PPP been successful in accomplishing its objectives?

- a) Yes
- b) No

What financial instruments have been used in your state? ( Select all that apply)

- a) Grant anticipation bonds (GARVEEs and GANs)
- b) General obligation bonds
- c) Flexible Matching (including toll credits)
- d) Section 129 Loans
- e) Transportation Infrastructure Finance and Innovation Act (TIFIA) credit
- f) Direct user charges (tolls and transit fares) leveraged to obtain bonds
- g) Equity partnerships and revenue sharing

h) Concessions and long term leases 78

i) Other (please specify):

How would you rate the effectiveness of communication with the private sector?

(Not satisfied = 1 2 3 4 5 = very satisfied)

Was the PPP project completed on schedule and within budget?

On Schedule

i. Yes

ii. No

Within Budget

Yes

i. No

Explain the risk that your state had to consider while entering into a PPP:

Overall, rate your general satisfaction on the PPP process: (not satisfied = 1 2 3 4 5 = very satisfied)

Is there legislation on PPPs in your state?

Yes

No

Bill in process

Comments:

We would greatly appreciate any other suggestions, advice, or lessons learned on the methods and feasibility of PPP projects within your state.

### Appendix II: Time Frame

Month Activities	Jan	Feb	March	April	May	June
Proposal writing						
Submission and approval						
Collection of literature						
Instrument Design						
Pilot test						
Corrections						
Data Collection						
Data analysis and Report writing						
Approval and submission						