Plenary session 4: User fee competition presentations

PL 04/5
When user fee is a necessity of life: what role for policy in Uganda?

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Introduction

One evening late in December 2007, I had an interesting discussion with my friend, Alex. He argued that user fee is an "unnecessary evil" and fronted a lot of evidence, drawing from the Ugandan experience, to justify his stand. To this line of reasoning, I had no objection, having read the evidence by more qualified voices that have ably documented the effects of this failed reform. Then, the discussion moved to the "dilemma" faced by the Ugandan health sector, compounded by the macroeconomic stability arguments – a way of economic management that has conscripted the entire country to believe there is only one way of managing the national economy.

As I write this short essay, which I prefer to call a "viewpoint", my mind races to this memorable discussion. Having grown up in a rural village in mid-western Uganda, my childhood memories of the 1980s are full of two main actors on the scene of health care delivery in Uganda: the publicly owned and the church owned health facilities. Most of the literature on user fees concentrates on its impact on government provided (and financed) health services. However, I am aware that there are several actors in health care in Uganda. This is my point of departure in this essay where I examine the role that policy can (and should) play for the private-not-for profit (PNFP) health sub-sector – a key feature of Uganda's healthcare delivery system, for whom user fee is a necessity of life.

The PNFP: what is it?

The term "PNFP" is used to describe the hitherto vaguely referred to as "mission" or "voluntary" health facilities. Simply put, it is a group of large networks of service delivery points spread all across the country that started operating towards the end of the 19th century and has kept developing in the first half of the 20th century, long before the establishment of the national health system. They are both facility and non-facility based. The former are for the largest majority belonging to religious denominations, coordinated by three Medical Bureaux (Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau and Uganda Muslim Medical Bureau). In terms of size, these own 42.3% of the hospitals, 22% of the lower level health facilities and 70.7% of the health training institutions in Uganda, with 85% of these

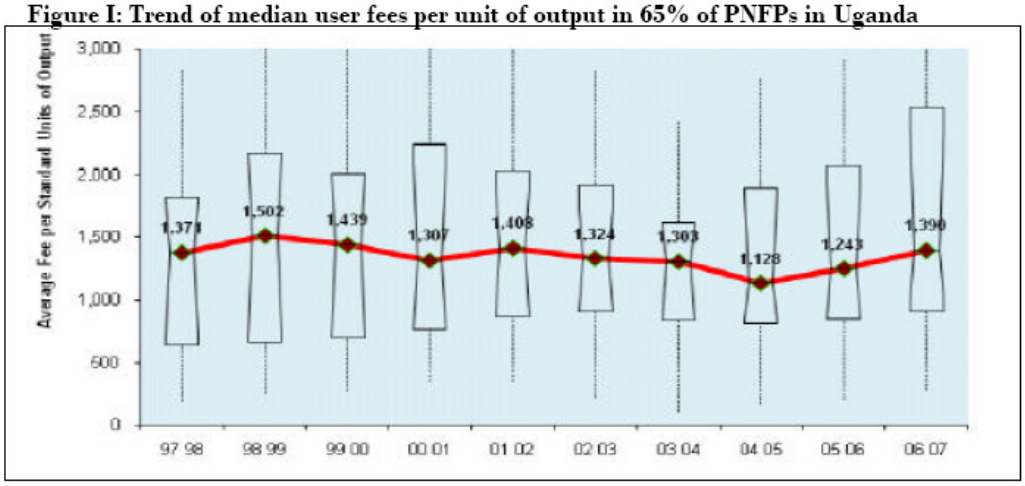
located in the rural areas where the majority poor live. In 2006/7 alone, this sub-sector produced 17% of out-patients, 35% of deliveries and 35% of DPT3 doses of all national health sector outputs.

User fees: a necessity of life for PNFPs in Uganda

From the above, it is evident that establishing these facilities entails sizeable capital investments and efforts. I am also aware that the founders of these facilities desire(d) that they pursue a specific aim and be able to sustain their operations over and beyond the actors that started them. This, in itself, requires PNFPs to operate in faithfulness to the original intent (i.e. treating patients, promoting health, training people, etc. moved by social aims) and, servicing the assets, lest the organization starts shrinking and eventually dies.

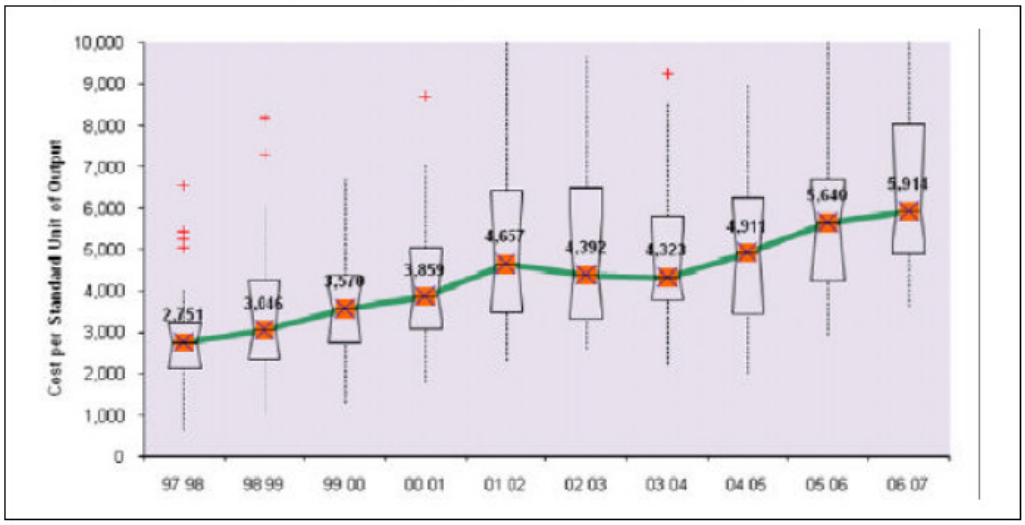
For organizational sustainability, be it in business or social enterprises, the above are *conditio sine qua non*. Cost and price are two key economic concepts that suffice introduction at this juncture. Viewed from the PNFPs' perspective, cost is the value of resources that a health unit uses to produce its services while price is the fee paid by patients to acquire the health units' services. From economic theory, price must always exceed cost, and this intrinsic relationship needs to be respected at all times. Figures I and II below show the status of the relationship in PNFPs in Uganda:

Figure I: Trend of median user fees per unit of output in 65% of PNFPs in Uganda



Source: Giusti D, 2008

Figure II: Trend of cost per unit of output in 65% of PNFPs in Uganda



Source: Giusti D, 2008

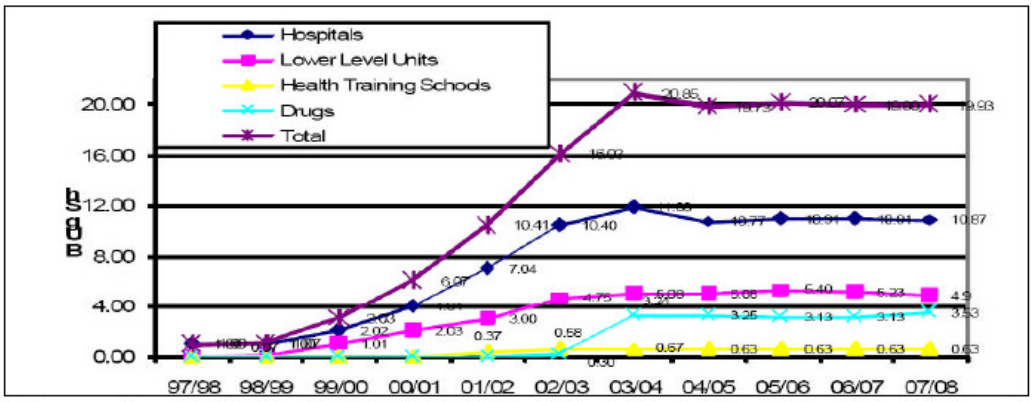
From the above graphics, a steady drop in fee per unit of output over the years is observable, despite the effects of inflation, rising cost of services and reduced government budget support. This is a result of deliberate efforts of the PNFP facilities. The mild upward trend of fees observable in 2004/5 reflects the pressure on the sub-sector of the increased cost of service production and reduced government support (see Fig. III below). Taking recourse to basic health economics, I have no doubt that people are paying now less than they were in 1997/98, even without adjustment for time discount. In the fact, in the face of the macro-economic policy pursued by the country, I have no doubt regarding the PNFPs' pro-poor outlook.

The understanding I have come to over the years is that it if the fundamental economic rule that says that income must exceed expenditure is not respected; the balance sheet will show a net loss of worth of the organization, thereby announcing that it is sick. It is apparent to me that "profit" is a necessity of life, subject to the "non-distribution" constraint (i.e. the profit realized – if any - cannot be distributed to the owners, managers etc but re-invested to develop the organization further). As variously noted (Giusti D et al, 2004), any attempts by the PNFPs to set user fees at levels equal to the cost or above becomes a deterrent to consumption of the good/service they produce.

In light of the above and motivated by altruism, the PNFPs have always tried to find "price substitutes" to finance their operations. These have taken the form of subsidies, grants/donations, and sometimes loans. When these "price substitutes" are either not found or are insufficient, a few options are left to avoid abandoning social goals. Erosion of the "endowment" or increasing user fee charges (with the ensuing negative impact on access, equity, efficiency etc.) are some.

Policy dilemma: imagined or real?

Figure III: Trend of cumulative Government of Uganda allocations to PNFP health facilities



Source: Giusti D, 2008

Figure III above shows that Government of Uganda has 'frozen' allocations to the PNFP. This move, when gauged against the fact that PNFPs are a sizeable component of the system and that they aim at delivering health care out of a concern of equity and social justice, demonstrates – albeit in a subtle way - a public administration with a policy framework that does not value and protect not-for-profit organisations for social benefit.

Uganda has reduced and capped its social expenditure. All this, in the name of macroeconomic stability – as a prime policy interest. Hiding behind theoretical currency overvaluation allegedly arising from donor funds meant to provide basic services for the poor, donor funds have been rejected. In light of the very high infant and child mortality, low and fragmented access to safe water and sanitation, high numbers of orphans and other vulnerable children and, high maternal mortality rates – some among the highest in the world, I find the macro-economic stability argument (especially when viewed as an end in itself, as is oft the case in Uganda) unacceptable.

Economists such as Arthur Louis have argued and even got Nobel Prizes for theorizing that for development to occur, a first increase in inequality is inevitable and then equity can be achieved gradually afterwards. Countries such as China, Japan and Taiwan have proven them wrong, in the long run. As a matter of fact, inequity is not inevitable for growth to occur. This doctrine – the Washington consensus, which Uganda has embraced without any questions, is likely to result into the poor becoming poorer (including inequities in health) as it did in USA in the 1980s, where growth was achieved at the cost of social welfare. In fact, signs are beginning to emerge on the Ugandan horizon – whereas in 1992 the gini coefficient was 0.35, by 2003 it had risen to 0.43. This is evidence of an anti-poor policy.

Conclusion

The stagnating subsidies to the PNFP health sub-sector are threatening equity objectives pursued by the sector. The market economic policy, in the name of macro-economic stability, is not in the best interest of Ugandans given the poor

social welfare in the country. Neither is it for a socially-oriented sector – the PNFP, among others. Whereas the PNFP sector has expressed and demonstrated (in word and actions) a serious intention of continuing to be a permanent feature in the health system of the country, it is increasingly evident that there are signs of an on ongoing crisis that can be averted only if major and bold policy decisions are taken and enacted. Macroe-economic stability is not a *conditio sine qua non* for economic growth and development to take place. Our strategy should be to maximize social benefits to the people. A new generation of economists, with original thinking, putting welfare as first interest is urgently needed to save the "bad condition from getting worse". It is only then that a balance between stability, growth and welfare can be struck. This is the hope for the poor in Uganda. This is my vision for Uganda.

References

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