Leaving no-one behind: Rethinking private sector engagement for Universal Health Coverage in Uganda

By Mayora Chrispus

Today, December 12, 2016 is Universal Health Coverage (UHC) day. This year's UHC day is celebrated with a call to "Act with Ambition". While the UHC ideology is not entirely new, it has however been explicitly included in the new Sustainable Development Goals (SGDs) agenda, specifically SDG3. For Uganda, the theme for the Health Sector Development Plan (HSDP 2016-2020) is to "to accelerate movement towards Universal Health Coverage". While it seems clear the focus, the 'how' this can be realized has continued to be a subject of discourse among policy makers, academia, researchers, implementing agencies and funders. It is important to ensure that all stakeholders including citizens – the ultimate beneficiaries – are included in this discourse particularly around rethinking better frameworks for delivering health services to all.

This discussion must extend to redefining roles and responsibilities of actors, and rethink the 'traditional' approach to health service provision as largely a mandate of the state. Two issues emerge from this redefinition; namely, (1) how to empower citizens or communities to actively participate in producing or even financing their own health, and (2) a stronger engagement with non-state actors as complementary rather than competitive actors. For this article, we focus on the later. The non-state actors or simply the private sector includes private and private-not-for profit, and Non-Government Organizations For starters, in terms of health service delivery (infra) structure, in 2015, about 58% of hospital level facilities in Uganda were non-government owned and operated. For lower level facilities that include private clinics and drug shops, the proportion is even higher. This trend will likely continue over the coming years. Over 50% of health service provision in Uganda happens through the private sector.

The rapid expansion and proliferation of the private sector in health in Uganda owes itself partly to inefficiencies in the public sector delivery system. As population continues to grow and a middle class emerges from improvements in income, the demand for health services and of good quality is certainly bound to increase. This will likely provide ground for the private actors to expand even more both in size and role. Working closely with non-state actors is no longer an option, but a necessity. The focus should now be on what models could be adopted to best utilize this rapidly growing sector to ensure the engagement works in the best interest of the population particularly the poor and vulnerable communities.

The framework for engagement should take due consideration of the current structure and incentives that influence private sector behaviour in health service delivery. Three issues – with a bearing on Universal Health Care – must be reflected on; 1) Private facilities are more in urban than in rural areas, yet majority of population lives in the rural area. This poses an equity and access challenge, 2) the private sector is traditionally driven by profit which raises concerns about the cost and financial burden of access to health care, and 3) the private sector often focuses on services that generate high return on investment, which raises issues of how services of public health importance (such as public health education) should be delivered for the greater good of society. Both the state and non-state actors must act with an ambition of ensuring expanded coverage for high quality and affordable health services.

An already existing model to partnership in Uganda – the provision of subsidies to PNFPs and some PFPs – should be the starting point and this needs to be streamlined and even scaled up to cover more facilities. A criteria for selection for beneficiary facilities should take into account for example location in a hard-to-reach area with limited access to a public facility. This must be followed by a strong monitoring and supervision mechanism to ensure the subsidy translates into reduced cost of services. The second model could be for the state to contribute to infrastructure development and deployment of personnel at private facilities to reduce cost of service provision and hence lower access costs. Thirdly, the state could fully contract out certain services to the private sector and only focus on financing. This could be through a performance or results-based financing approach, so that in areas where public facilities are inexistent, an already existing private player may be contracted by government to provide those services. Most importantly however, is to recognise the challenges that come with private sector engagement, and thus provide for a certain degree of regulation to ensure that health care – a public good – is delivered to all. Further, it is important to recognise certain aspects of health service delivery where private sector capacity may be limited, making it apparent for government to come in.

Ultimately, none of the sectors – public or private – can fix the constraints of health service delivery in Uganda, but rather both must complement each other and harness each other's capacities, if Uganda is to achieve Universal Health Coverage.

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