

# Political analysis of rapid change in Uganda's health financing policy and consequences on service delivery for malaria control

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## SUMMARY

The aim of this study was to assess the political and social dynamics resulting from the rapid change in user-fee reforms in Uganda and the effects on service delivery for malaria control. Using political mapping and political risk analysis techniques, the study analysed qualitative and quantitative data obtained from secondary data sources and key actors in the policy arena. The results have shown that the feasibility of user-fees in Uganda was undermined by the absence of strong central government leadership and strategies to manage the politics of the reforms. The resultant rapid change in policy adversely affected the recurrent expenditures of health units that previously relied heavily on cost sharing, which led to a chronic shortage of malaria drugs and undermined the ability of health facilities to hire and motivate staff. The study results demonstrate that in order to contribute positively to healthcare delivery goals for malaria control in endemic countries, user-fees require full ownership and strong political leadership by the central government. Decentralization, when merely used as a strategy to navigate the political risks associated with user-fees, is unlikely to succeed without a centrally coordinated and managed process of policy formulation and acceptance involving wider consultations and political management of interest groups. Copyright © 2004 John Wiley & Sons, Ltd.

KEY WORDS: health care reform; user-fee; decentralization; malaria; Uganda

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## INTRODUCTION

Over the past decade, many developing countries, including Uganda, have undertaken health-financing reforms in order to revitalize their public healthcare systems, which had been severely weakened by years of macro-economic instability. The thrust of the reforms has focused on the decentralization of healthcare systems and the introduction of community financing mechanisms. Attempts during the 1990s, however, at financing reform through user-fees have swum against a tide of resistance from citizens in many developing countries (Beattie *et al.*, 1997). In Uganda, user-fee reforms have had an unusually chequered history spanning a period of eight decades. First proposed in 1921 by Governor Robert Coryndon, and subsequently rejected by the Buganda Kingdom, user-fees were again proposed in 1939 by Lord Hailely; the directors of medical services again rejected the proposal. In 1959, a Commission appointed by Sir John Croot, then Minister of Health of the Uganda Protectorate Government recommended some payment for the medical services but the whole report was eventually rejected (Uganda: Ministry of Health, 1987).<sup>†</sup> In 1986, another enquiry into the social services affirmed that Ministry of Health (MOH) should continue to provide free medical services, but only a year later, another Government Review Commission recommended the introduction of user-charges.<sup>‡</sup> The Uganda Parliament, however, in 1990 threw out the bill seeking to entrench user-fees (*The Parliamentary Hansards Nos. 12, 13, 14, 1990*), after which the Government opted to implement the policy under the Decentralization Act of 1993.<sup>¶</sup> The policy, however, was abruptly reversed in March 2001, when in the heat of presidential elections, President Museveni ordered its immediate abolition and a return to a system of free public healthcare for all.

This article analyses the political and social dynamics resulting in the rapid change in user-fee healthcare financing reforms (herein after referred to as 'the reforms') in Uganda, and the effect on service delivery for malaria control. The importance of the study derives from the critical role that effective and sustainable healthcare financing plays in making services available to clients in malaria endemic countries, and the potentially disruptive effect of rapid policy change on services delivery.

<sup>†</sup>The Buganda Kingdom rejected the fees on the ground that 'payment would deter people from seeking medical treatment because many of them were very poor'. The objection by the East African Directors of Medical Services was that 'free medical treatment was the chief benefit that the Africans got from paying tax'.

<sup>‡</sup>The Commission recommended the introduction of user-charges—observing that 'with the present system of free medical services to people, even if the national budget for health is increased, government will continue to find it very difficult to meet its obligations of providing adequate free medical services' (Uganda: Ministry of Health, 1987).

<sup>¶</sup>Opponents of user fees argued that since people were already paying for government health services through general taxation, user fees constituted a double payment; and that since the majority of people were poor, introduction of user-fees would increase the barriers to access health care.

Insufficient attention has been given to understanding the political processes and challenges surrounding the implementation of new health financing policies. In addition, there is insufficient analysis of the political strategies endemic countries have adopted to deal with the political challenges associated with community financing reforms and the effects of these on disease control efforts. It was hoped that the study would make a contribution to the knowledge on the financing reform of political processes and change management, and to strategies for malaria control—in a context where endemic countries have few options but to explore alternative health-financing strategies such as user fees.

*Origin context and content of policy reform efforts*

*Political context.* After three decades of political turmoil, Uganda is in many ways a country trying to rebuild a post war society. Due to the political instability and social disruption during the 1970s and 1980s, Uganda found itself unable to sustain its health services (Uganda: Ministry of Health, 1990). When the National Resistance Movement (NRM) came to power in January 1986 after a protracted guerrilla war which overthrew the civilian dictatorship of Independence Prime Minister Milton Obote, President Museveni's priority was to restore stability to the country and rebuild political, economic and social infrastructures. At the local level, Uganda has a decentralized system of governance, and the implementation of this system has resulted in a number of major political developments. Districts are mandated to formulate and implement their own development plans, and to approve, execute and control their own budgets. A referendum on the political system held in June 2000 upheld the current 'no-party system' of government, where political parties are not allowed to operate.

*Economic environment.* Uganda has over the past two decades emerged from the economic ruins of the 1980s, to make a remarkable turnaround. Since the initiation of the reforms, the country's Gross Domestic Product (GDP) has been growing an average annual rate of more than 5%, outperforming most countries in sub-Saharan Africa. By 1999, Uganda's GDP was Ushs.3.454 trillion (about US\$ 2.3 billion) (Uganda: Ministry of Finance, Planning and Economic Development, 2000). The strong economic growth performance in recent years has led to an overall reduction in poverty levels from 55.6% in 1992/3 to 44% in 1997 (Uganda: Ministry of Finance, Planning and Economic Development, 2000). However, Uganda's economic growth 'has not been broad-based enough to address the problem of mass poverty in the country' (Uganda: Ministry of Planning and Economic Development, 1997). Per capita income of US\$ 300 a year is only now approaching the levels (inflation adjusted) of 1971, the year Idi Amin came to power. About one-third of the country's 20 million population remains in absolute poverty, which is defined as an income of less than a dollar a day (Uganda: Ministry of Finance, Planning and Economic Development, 2001).

*Health context.* The country suffers heavily from both infectious and non-communicable diseases. Malaria is one of the main causes of premature deaths, accounting for 29%–50% of all outpatient visits at health facilities, 20% of hospital admissions, and up to 14% of inpatient deaths (MOH, 2001). Uganda's main malaria control programme strategies include early diagnosis and treatment at peripheral health units and implementation of affordable and sustainable preventive measures.

As shown in Box 1 below, the health status in Uganda is very poor.

**Box 1. Key health indicators**

- Infant mortality rate 2000: 88 per 1000
- Under-5 mortality rate 152 per 1000
- Maternal mortality rate 504 per 100 000
- Life expectancy in decline (due to HIV/AIDS) from 46 in 1980 to 43 in 2002
- Total fertility rate 6.9 (2000)
- HIV prevalence 6.2%
- Fully immunized children: 47%
- Acute malnutrition 5%
- Contraceptive prevalence rate 15% (all methods), 9% (modern methods)
- Access to safe water 34% (43% urban, 30% rural);
- Access to sanitation—urban 63%, rural 28%
- Deliveries by trained attendants 38%
- Population per doctor (thousands) 18.7
- Population per nurse (thousands) 3
- Population with physical access to health service 49%

*Source:* Uganda: Ministry of Finance, Planning and Economic Development, 1999.

The focal point of the primary level of care is a sub-county health centre, which provides a daily 24 h service and is responsible for promotive, preventive and curative services.<sup>§</sup> However, most illnesses are treated at home.

The Government is the main provider of health services through the Ministries of Health and Local Government.<sup>||</sup> Health expenditure accounts for around 6% of GDP. Recurrent health spending is over US\$ 12 per head, although public expenditure accounts for only around US\$ 5 of this. Out-of-pocket expenditure accounts for around 70% of total expenditure, 75% of which is spent on drugs.<sup>††</sup> By the

<sup>§</sup>The case management of malaria is dependent upon this infrastructure being in place with a good referral system.

<sup>||</sup>This is through a significant contribution from Non-Governmental Organizations and private practitioners (estimated to be more than 30%).

<sup>††</sup>Under decentralization, financial resources in the form of block grants and non-wage funds are channelled to districts. The health sector is funded by two main grants, namely, Poverty Action Fund grants, and Non-Poverty Action Fund grants. Poverty Action Funds (PAF) caters for programmes that directly relate to poverty such as Primary Health Care (PHC) activities.

Table 1. Health seeking behaviour by income quartile/rural residence, 1993/4

Urban	Rural			
	Lowest	Highest	Lowest	Highest
Type of treatment sought	Lowest	Highest	Lowest	Highest
Quartile	Quartile	Quartile	Quartile	Quartile
No medical attention and no medicine used	16%	1%	17%	2%
Home treatment	34%	19%	36%	23%
Outpatient government facility	17%	19%	4%	8%
Outpatient private facility	25%	45%	39%	62%
Private doctor	2%	9%	0%	0%
Pharmacy	1%	3%	3%	2%
Traditional doctor	4%	1%	0%	0%
Inpatient government facility	1%	0%	0%	0%
Inpatient private facility	0%	1%	0%	2%
Other	0%	2%	0%	0%
Total	100%	100%	100%	100%

Source: 1996 Health Services Inventory, Health Planning Department.

time the reforms were initiated, the proportion of foreign donor contributions had increased significantly, reaching a total of 61% in 1987. By the year 2000, donors provided around a third of recurrent spending and around 90% of capital expenditure (Uganda: Ministry of Health: Health Planning Department, 2001).

#### *Reform content, objectives and strategies*

As the origin and context of reform efforts in Uganda have shown, Uganda's health sector exhibits a number of systemic problems typical of many countries in the developing world. These include inadequate financing of health services, low coverage, inequitable distribution of services and excessive dependence on donor funding. Policy proposals for health sector financing as supported by the World Bank are similar across Africa, responding to a common challenge of declining public resources for health care. User fees in Uganda were based on the World Bank's 1987 policy study, *Financing Health Services in Developing Countries* (Akin *et al.*, 1987).

The overall goal of user fee reforms was to improve the quality of care in the health facilities, in order to enhance equity, efficiency and sustainability of the health system. Fees were proposed for curative services in all public facilities, from the lowest health care facilities (dispensary) to the regional and referral hospitals. In order to safeguard the poor, exemption mechanisms were built within the fee structure based on the absolute inability to pay. The reforms were implemented through Health Unit Management Committees (HUMCs), which were intended to increase the ownership and involvement of communities in management of reforms (Jitta *et al.*, 1996).

## METHODOLOGY

The study was designed as an evaluation of a policy process and its outcomes, in order to generate new insights into political and social dynamics, and to provide a practical feedback to those responsible for healthcare management in Uganda. The study documented and analysed the early development and actual implementation of a financing policy, and assessed the strategies adopted and their short and medium-term effects on service delivery for malaria control. However, by additionally documenting the policy's development and operation, a study of this nature must assess the reasons for successful or unsuccessful performance.

Based on a simple analytical model of policy analysis, the study examined, among other things, the historical and political processes around the adoption and implementation of the policy, the actors influencing implementation, and how the aborted reforms affected service delivery with a focus on malaria control. The population studied was composed of health services users in two selected districts, key local government officials and decision-makers, and health staff. In addition, national-level officials and decision-makers, including senior MOH headquarter staff, key political advisors and decision-makers, Members of Parliament (MPs) and representatives of the donor community were interviewed. Data were collected using both primary and secondary approaches, namely, focus group discussions (with community members), and key informant interviews. In all, a total of eight focus group discussions, composed of 8–10 people, were conducted amongst adult men and women community health services users. In addition to these, 28 key informant (KI) interviews were held with the rest of the actors mentioned above.

A retrospective analysis of data relating to the evolution, and adoption and implementation of the policy over time was also carried out. Two districts, Moyo in the less developed northern part of the country, and Mbale in the more developed eastern region, constituted the environment of the field study. These were selected taking into account socio-economic differences as well as MOH categorizations of the districts' performance in implementing the reforms. Following the unavailability of key decision-makers to conduct a team analysis, the research team instead conducted the analysis with interviews of key stakeholders. The general analytical strategy combined elements of contextual analysis involving patterns matching, in-depth text analysis, and (non-computer assisted) political mapping and political-risk analysis techniques.

In determining the positions and power of different stakeholders, the research team adopted a method of assessment similar to a stakeholder analysis. The major players involved in the policy were identified, including an evaluation of each player's position and power. Using political mapping techniques, the data were displayed to show the positions of players on a continuum from high support through to high opposition. The team then assessed the policy's consequences for major players, identified the main interests of each player, and evaluated linkages among the players.

This approach to policy analysis borrowed heavily from Reich (1996) and was carried out together with an assessment of the epidemiological, economic, organizational and financial factors that affect healthcare finance reform.

## RESULTS

*Perceptions of community members, local government officials and district health service personnel*

The users of public health services strongly opposed user fees as implemented by the Uganda government, citing the inability to pay for healthcare. Many felt that the quality of services did not improve to a level that justified the fees, mostly in the area of availability of essential drugs for malaria treatment. Health service users were therefore pleased with the reversal of the policy. A focus group participant in the Moyo District recounted a common experience:

*'Without money, health workers would tell you to go back and look for it before you could get any treatment. But often, even after paying the official fee (about \$ 0.3), we would still not get the drugs we needed.'*

Local government officials in some places supported the reforms, while in others they were less supportive. Local political leaders who had accepted cost sharing felt that user fees had offered a useful supplement towards the running of health services, in a situation in which the central government is increasingly unable to adequately fund public healthcare. In places where local political leaders opposed the policy, they felt that user fees had hindered access to services by the poor and had not improved the quality of care to any significant level. In most places, user fees were implemented with little guidance or supervision from the district headquarters and there was a widespread perception among district political leaders that the Central Government actually owned and directed the reforms. A Vice-Chairman of Moyo District Local Government Council expressed a recurrent concern:

*'The policy started from the top government level and the best word here is that it was discarded down to the lower levels. The policy was introduced and abolished by the same central government; on both occasions, local governments were not consulted.'*

District health service personnel, however, strongly supported user fees. To them, cost sharing had helped generate additional funds leading to an improvement of the health facility and services in a context where government funding is grossly inadequate and takes a long time to reach the facility level. Most of the health personnel in the districts therefore perceived the central government's decision to scrap the policy as misconceived and as part of pre-election re-positioning by politicians, rather than a genuine effort to reverse a bad policy. Healthcare personnel opposed the government's view that most people could not afford to pay for healthcare. A leader of a national health workers' association reflected a prevalent opinion:

*'In Africa, contribution by the direct beneficiaries or their relatives to healthcare is not new. On a daily basis people visit shrines and witch-doctors where they pay a lot of money or its equivalent without complaining. Besides, many of the health service users' social lives do not exclude daily drinking of alcohol and other*

*forms of entertainment, which, when put in monetary terms far exceeds the fees previously charged in health units.'*

*Perceptions of the donors, MOH technocrats and national political leaders*

The concern of the representatives of the health sector's leading donors is that the government's national spending on health is very low. They are particularly concerned that the country has not yet attained the minimum international health standards in the past two decades. The reversal of the policy would have significant financial consequences throughout the health system, including the financing of the Health Sector Strategic Plan. A leading donor representative shared a common view among the donor community:

*'The MOH has a clear vision of what they want to do and where to go, but they need to concentrate on service delivery and this requires money. We want to see radical measures responding to these difficulties and, in our opinion, user-fees, if implemented with commitment from the central government, constitute one means of Uganda adjusting to a context of declining resources and mounting development challenges.'*

MOH officials, however, were of the view that the donors 'pushed through' user fee reforms largely as a condition for their financial assistance, but without taking due consideration of the political opposition to the reforms on the ground. DFID introduced pre-payment schemes by the government as a condition for continued sector funding in 1993. Officials contended that the government and the MOH only considered the donors' requirements, otherwise the policy was unsuitable for the country. The view of Dr S.A. Okuonzi, Head of MOH Planning Unit (at the time of the study), was typical of many senior MOH officials' feelings about the policy after its abolition:

*'No country in the world relies on user fees to sustain their health financing. Nobody goes with money in his pocket and then gets a health service in exchange for that money. For us, we could not develop user fees as a main factor of funding in our country.'*

Most legislators felt that cost sharing was unacceptable as long as the country lacked a strong social welfare policy that the vast majority of the country's poor could use as a backup. Many of the legislators hold that health is a 'fundamental human right' which the state must guarantee, and that the government should first deal with the country's longstanding problem of official corruption and waste of public resources before introducing user-fees. One leading legislator put it this way:

*'Government should first tackle official corruption. There are enough resources currently being wasted, which, if put to proper use, would have ensured free medical care for all. The country has a very high defence expenditure ratio but when it comes to health, the Ministry of Finance claims that there is no money. Without a*

*social welfare system of any kind, free healthcare is the only way our people can be helped.'*

Even as government adopted the policy, the Head of State President Museveni himself consistently argued against cost sharing in public health services, saying that since Uganda is not yet economically developed, user fees would increase the barriers to health care access. The National Political Commissar and former Minister of Health at the time of the reforms, Dr C. Kiyonga, justified the reversal of the policy in this way:

*'The majority of the people were not going to health centres because they could not afford to pay; yet these are the people we want to help. We have been discussing this (abolition of the policy) for two years in Cabinet and it has now matured.'*

Most stakeholders in the political opposition, however, agreed that the abrupt decision to scrap cost sharing was ultimately sparked off by Dr Besigye, a leading presidential aspirant in the country's 2001 national elections. After Dr Besigye and his *Reform Agenda* party campaigned on the ticket of 'reform', which promised to reform the government's politics and the social services, President Museveni abruptly abolished the policy.

#### *Service provision for malaria control*

The abrupt change of policy, coupled with the government's inability to provide adequate sector funding, accelerated the decline in the quality of services that were already poor in many respects. This was mainly shown in the scarcity of drugs, long queues at many health units and discourteous service provider behaviour. Many health units, overwhelmed by the multitude of people who thronged service centres after the fees were abolished, were found to have resorted to under-dose prescription of malaria drugs.

The quality of services further deteriorated due to the loss of morale by health workers and the inability of health units to meet the recurrent expenditures. Many health workers were reported to have started subsidizing their public obligations with private practice, a practice commonly referred to in Uganda as 'survival strategies.' There were also reports of some health workers resorting to illegal charging for the 'free' government health services, and this was referred to as 'informal fees'. These practices had tended to reduce after fees were introduced. A focus group participant in the Moyo District, painted the situation in a typical public health unit after the abolition of cost sharing in the following way:

*'Nowadays, health units only prescribe medicine, and this comes only after waiting for hours. After this, they advise you to go to private clinics to buy the prescribed malaria drugs. In order to stand a chance of getting malaria drugs at a government facility, you have to visit the facility on Monday, because starting Tuesday, the stocks have run out and you have to again wait until the following Monday. The problem for us is that malaria does not wait the same way.'*

*Analysis of the key players, their positions, capacities and role in policy change*

*Community users of public health services.* Citizens who use the community health services are the core actors in Uganda's user fee policy implementation process. Their ability to vote out of power a sitting government ultimately and decisively determined the fate of user fees reforms in Uganda. When the central government abandoned its role in directing and overseeing the evolution and implementation of the policy, and instead left it to local governments to raise additional revenue, the cost-sharing implementation process was characterized by several grave anomalies that hurt community service users. Rural communities, who make up the overwhelming majority of health users (over 80%) in Uganda, constitute a formidable political constituency which, when mobilized by opposition groups during Uganda's 2001 presidential elections, led to the reversal of the reforms. Given their interests, the decisive power of the ballot they wield, and their ability and willingness to use it when mobilized, the community health service users, we classified them as high-power players, intensely opposed to the cost sharing policy as implemented in Uganda.

*District local governments and their representatives.* Support for cost sharing by the district political leaders was divided. The performance of cost sharing influenced the positions of the district political leadership in the respective districts. But overall, it was the lack of local governments' ownership and leadership of the reforms that was conspicuous. Although substantial political powers were decentralized to the districts, local councils were found to be still heavily dependent on the central government not only for development support funding, but also for effective policy leadership. Due to these constraints, local councils were not influential in the process of introducing or reversing the policy reforms. The success of user fee reform implementation, however, heavily depended on the action of local councils, since this shapes the perceptions of the community members.

Nevertheless, considering their lack of active involvement in adopting or reversing the policy or in overseeing its implementation, we considered district councils and their representatives in the local governments, medium power and moderate support players, with the potential to move to high support in the future.

*District healthcare personnel.* The staff of the health services in the districts are among the key actors in the user fee reform implementation process in Uganda. Besides the fact that several elements of the reforms directly affect their conditions and welfare, achievements and improvements in the health sector are also crucially dependent on their performance at all levels. This, in turn, is closely linked to their general employment and working conditions. Most health workers in the districts are highly responsive to financial reward, and supported the reforms mainly because of the attendant financial incentives. The absence of effective central and local government control and regulation of user-fees in the districts, however, ensured that health workers pursued revenue maximization goals often at the cost of

implementing the required exemptions for the poor, and effecting meaningful quality improvements in health units.

As far as their power is concerned, district health workers did not, to any significant extent, participate in the key decision-making processes concerning the reforms. Health workers are not very strongly organized in Uganda, as unionization is still weak. However, they play an important role in the reform implementation, since they have substantial power to control quality, access and cost decisions in the healthcare delivery system, which, in turn, affects the acceptability of the policy by service users. Nevertheless, as players in Uganda's healthcare reform process, we considered health workers to be medium-power, and highly supportive of the reforms.

*International development partners (the multilateral donors).* With both the central and local governments relinquishing the supervision of the reform implementation to the lower-level health units, the donors remained among the key advocates of the reforms, together with the staff of the district health services.

Members of the Health Development Partners Group (HDPG) comprise DANIDA, DFID, DGIC, Belgian Embassy, European Commission, Ireland Aid, Italian Co-operation, SIDA, UNAIDS, UNFPA, UNICEF, WHO and the World Bank.

As the key financiers of the country's health sector, the donors wield formidable political power to influence the health policy process, and their willingness to use such resources cannot be doubted. Yet, from the results of the study, it became clear that Uganda's donors were also concerned that cost sharing, as implemented in most districts with little central and local government supervision, might have hindered widespread access to health services by needy users. This manifestation of position and power does not necessarily indicate that Uganda's development partners are strongly opposed to the abolition of cost-sharing in public health services but, instead, indicate that they are not prepared to support policies that would undermine the effective implementation of the Health Sector Strategic Plan (HSSP), to which they are major signatories. Based on this analysis, and as far as the user-fee policy in Uganda is concerned, we classified donors as highly supportive, high-power players.

*Uganda Ministry of Health.* The Ministry of Health is one of the most key institutional actors in Uganda's public health sector. Although most of Uganda's health services are widely decentralized, the management of the health sector reform programme remains with the MOH, which is headed by a political Cabinet Minister. However, the lack of active involvement by the MOH in overseeing the reform implementation greatly constrained the effectiveness of the policy. There was only a limited willingness among MOH technocrats to take the leadership position on reforms that lacked a firm national legal standing, and with which the political leadership was unwilling to identify itself. As a result, the MOH did not guide or monitor the reforms as necessary, and had no clear political strategies to manage opposition to the reforms.

Although the MOH has much of the necessary internal structure, administrative machinery and capacity to effectively execute health sector mandates or to meet

long-term health sector reform objectives, like most government bureaucracies of its functional definition, Uganda's MOH tends to suffer from a lack of autonomy from the political executive actors. Its position on reforms of this nature tends to reflect and shift with the official position of the nation's political leaders. As a bureaucracy mainly charged with executing central government mandates, its autonomy and ability to question the vacillations of the political leadership on user fee reforms were clearly limited. We classified MOH as a low-power actor in medium support of user fee reforms.

*The National Legislature (Parliament).* As the supreme policy making body that is charged with oversight functions, the Uganda Legislature is a critical actor in the policy process, and has plenty of resources at its disposal to shape public perception and reception of the reforms. Most of Uganda's MPs at the time of the study were found to be wary of the reform proposals, mainly out of fear of a backlash from their constituents. Although Parliament threw out the bill to entrench the reforms in 1990, central government nevertheless went on to implement the reforms. Records from the *Parliamentary Hansards* showed that since 1993 almost no legislator had raised the issue until the policy was eventually abolished in 2001. Although the Ugandan Parliament enjoys considerable statutory powers over the executive branch, the President still wields much influence over individual legislators and has the largest 'caucus' in Parliament. Parliament has opposition legislators but they constitute a small minority. Based on our analysis of the Ugandan Parliament's interest and behaviour towards the reforms since 1990, we classified Parliament as a moderately opposed, medium-power player.

*Political organizations: The President (President Museveni and the NRM).* There was not much contrasting interest between the Head of State and the Movement, of which he is Chairman. This analysis therefore considered the President and the NRM as one player. Although President Museveni has consistently urged against cost sharing in public health services, results have clearly showed that he took a long time to either fully endorse the reforms or to do away with them altogether. He only took action after opposition groups had mobilized against the policy. Both the president and the ruling NRM faced serious challenges and risked political suicide were they to continue user fee reforms at this time.

The power and resources available to the President and the ruling NRM, and their inclination to shape public perception of the reforms to which they fully subscribed, were, however, indisputable. Although there was significant opposition, for example when the NRM first embarked on the implementation of the first wave of the Structural Adjustment Programmes (SAPs), the government went ahead to fully implement the programmes, drawing on its massive resources to use the media to shape public perception. Stakeholders interviewed agreed that the user-fee reforms, if supported by the Head of State, could have benefited from similar political resources. Although the President allowed local governments to implement user fees, this was more to comply with donor conditions. The President was lukewarm towards the policy and, unlike the way he followed the mainstream SAPs, he neither served as a user fee reforms advocate nor prevailed on the executive bureaucracy to

effectively oversee their implementation. Based on this analysis, we classified the President and the NRM as a high-power, moderately opposed player.

*Political organizations: Colonel Dr Warren Kiiza-Besigye and the 'Reform Agenda' group.* The Reform Agenda's mobilization against the reforms precipitated its eventual scrapping by the President in order to stem mass desertion of most of the rural voters to the opposition. During the March 2001 presidential elections, the Reform Agenda and like-minded opposition groups demonstrated a capability to mobilize resources at short notice, and the ability to access the media and the rural populations to shape the public perception of health reform. However, such groups can only effectively do this during election time and under strong leadership. We considered the Reform Agenda and similar political opposition groups highly opposed to cost sharing, medium-power actors with the capacity to move to a high-power position during times of national elections.

*Other players.* Given the participatory philosophy inherent in the decentralization policy and the relative freedom of speech prevalent in the country, the study found numerous other actors at several levels with relative capacity to shape policy. These include the NGOs and the media, which have grown tremendously over the last decade. Nearly all the country's districts now have Frequency Modulation radio stations that focus their discussions around political and economic events, and they exert considerable influence on the health reform process. Though influential on the national scene and have previously expressed scepticism about the policy (especially the media), we found many of these players to be essentially non-mobilized. Most of them preferred to wait and see what effect the policy dynamics would have on health service delivery before they would take established positions, if any.

Based on this study, Table 2 shows the major players in Uganda user fee reform process in 2001.

#### *User fee policy reversal and malaria control in the districts*

A better and sustainable healthcare financing system is key to the endemic countries' ability to take effective and sustainable action against malaria. In a context where malaria is the leading cause of morbidity and mortality (accounting for 29%–50% of all outpatient visits at health facilities), and where over 90% of the population live in highly endemic areas with perennial transmission, implementation politics and the politics of reversing financing policies, as described, affects malaria control programmes more than anything else.

The main goal of Uganda's malaria control programme is to reduce morbidity and mortality from malaria based on prompt effective case management (curative services), effective vector control measures, sound environmental policies to reduce the breeding of mosquitoes, and health education to enable communities contain malaria.

The scrapping of cost sharing in public health services affected environmental management. Whereas district teams continued with health education outreaches with minimal interruption in some places, in others health education outreaches

Table 2. Summary of key players, positions, power, and intensity of position

Player	Position	Power	Intensity of position
1. Health service users	Rural service users are highly opposed to cost sharing—as implemented in Uganda's public health services. Urban groups are moderately supportive of the policy	High—have the power of the ballot which they can use effectively during national elections	High—quite willing to use the power of the ballot, especially when mobilized by elite political groups
2. District Local Councils and their Representatives	Moderately support cost sharing—but largely depending on the extent to which it enables them raise substantial revenue to alleviate the costs of decentralized services	Medium—closer to the communities and can therefore effectively mobilize for or against the policy. However they are heavily dependent on the central government for development support funding, and policy leadership	Low—less inclined to use their resources in the policy debate
3. Health service Personnel and their Associations	Highly supportive of cost sharing mainly for monetary gains	Medium—firmly control quality and cost decisions, thus can easily influence the positioning of health service users. But not very strongly organized in a country where the degree of unionization is low	Medium—professional organizations can, mainly through workshops, shape policy debate but have limited resources to effectively do so
4. Uganda Ministry of Health	Moderately opposed to cost sharing in line with the position of the executive	Low—MoH is not adequately funded and has limited independence and resources to shape policy debate	Medium—willing to use its resources in the policy debate but largely depends on the level of political and strategic support from the executive
5. Donors	Highly supportive of cost sharing as a means of alleviating the widening funding gap	High—have vast resources at disposal, including financial, to shape the policy debate	High—Uganda's donors have proved quite willing to use their resources in the policy debate
6. The President (Museveni) and the Executive	Moderately opposed to cost sharing but largely for political expediency	High—have plenty of resources to use in the policy debate	Medium—less willing to use such resources
7. Parliament	Moderately opposed to the policy, mainly for constituency politics	High—considerable resources arising from legislative and oversight mandates	Medium—less inclined to deploying such resources
8. Opposition groups	Highly opposed to cost sharing	Medium—can access the media but their financial resources are limited	High—quite willing to mobilize communities against the policy for political gain
9. Other (media and NGOs)	Non-mobilized—tending to adopt a wait-and-see strategy	Medium—has a measure of resources to mobilize communities including through the ubiquitous FM radio stations	Low—not yet inclined to using any resources to shape policy debate

were greatly curtailed. The scrapping of user fees has tended to make basic healthcare more accessible to the poor, and improve equity in healthcare provision. However, the increased use of health services which is not matched with requisite resources on the ground has put even greater pressure on the system under strain. This has led to further deterioration in the quality of services provided in district hospitals and peripheral health units, and led to health seeking behaviours that are detrimental to malaria control.

Making basic healthcare more accessible to the poor and improving equity in healthcare provision are important for the success of the malaria control objectives. This can greatly facilitate early diagnosis and prompt treatment of malaria cases, education and sensitization of people about effective preventive tools. It can also serve to reduce health-seeking (and non-seeking) behaviours that are detrimental to effective malaria control. However, the lack of availability of anti-malarial drugs, as widely reported in all the study areas, means that many patients cannot receive adequate or any treatment at all for malaria when they most need it.

The widely reported practice of health personnel, after the scrapping the policy, to advise malaria patients who come to the health units mid-week, to return the following week when the new stocks of drugs are expected to be delivered to the facility, can only defeat the opportunity of early diagnosis and prompt treatment of malaria-related illness with anti-malarials. Effective case management of malaria illnesses is undermined when patients get under-dose treatment or no treatment at all.

There is a problem of extended delays and waiting at health facilities due to the increased number of patients, which was not matched by a commensurable expansion of existing facilities. The loss of morale by health workers meant that many of the health workers are increasingly preoccupied with survival activities in private outlets and in charging 'informal fees'. Such activities are likely to have an increasingly negative effect on public confidence in the 'free' government services and on the treatment and general management of malaria at peripheral health units.

## DISCUSSION

The study has shown that:

- The feasibility of user fees in Uganda was greatly compromised by politics, and the absence of strategies to manage the politics of the reforms.
- The resultant rapid change in policy adversely affected malaria control efforts by reducing recurrent expenditures of health units.
- The decline in the recurrent expenditures of health units led to a chronic shortage of malaria drugs and the inability of health units to hire and motivate staff.

The interpretation of the study results highlights a number of elements important to the feasibility of user fee reforms in Uganda and similar environments.

### *Element 1: User-fee reform ownership and leadership*

The study results indicated that in the context of political transition, user fee reforms require full ownership and leadership by the central government. In Uganda, the

national government, in order to avoid political capital risks associated with the reforms, chose not to be closely associated with them, and instead attempted to diffuse ownership of the reforms to the local governments. This, however, only lowered the probability of achieving successful implementation of the reforms. The lack of strong political leadership and support for reforms undermined the ability of the national reform group to effectively advocate for and implement the reforms and deal with the political dimensions of the reform process. The consequent weak implementation process alienated health services users who felt the high and immediate costs of the poorly implemented reforms. Popular discontent with the reforms played into the hands of the political opposition groups who were only eager to make political capital out of a poor implementation process.

Political and strategic support and resources must be provided to the reform group to enable the reforms to stand any chance of success. In situations of lack of political leadership and ownership of user fee policy reforms, their prospects are greatly handicapped.

### *Element 2: Decentralization as a political risk management strategy*

Decentralization can help diffuse ownership of politically problematic policies like user fees thus spreading the costs and risks associated with the reforms. However, as the results of this study have shown, decentralization used mainly as a political strategy of 'wait-and-see' or as a means of spreading the risks of unpopular reforms, is unlikely to be affective. This is more evident in contexts where user fees find a decentralization process that is in its infancy and with limited institutional capacity at the local levels. As much as the MOH needed the political and strategic support of the national leaders, local governments needed the guidance, leadership and technical support of the MOH. Without this support, local governments, particularly the district healthcare staff, are unlikely to implement effective reforms. Instead the reforms end up being implemented in ways that hurt the rural poor—and breeding further opposition.

### *Element 3: User-fee reforms and interest groups*

Resistance to user fee reforms is common and will often come into play unless the reform's owners mobilize political support and design effective strategies to manage it. In Uganda, results have shown that user fees have been resisted since 1921—which was a time when the economic outlook of the country was basically sound.

Health policy decisions are mediated events, expressing the views of the powerful electorate, professional groups and political pressure groups. Even where there is broad consensus that the public healthcare system suffers from multiple problems and needs serious improvement, as was the case in Uganda, the support of various actors in the policy arena cannot be taken for granted. There is a need to analyse the political dimensions of health policy and to plan the management of the political environment. In particular, health service users, though highly dispersed in the decentralized districts, less organized and politically visible than other professional groups, they, however, are increasingly strong politically. They have clear

preferences and are susceptible to political influence by better organized political groups. Their role and behaviour in regard to user fee financing mechanisms must be analysed and accounted for in any implementation plan. The policy process in Uganda did not give adequate consideration to this element of health reform planning.

#### *Element 4: Policy change management and healthcare delivery*

Policy change requires careful management and must be orderly to avoid negative consequences for service delivery, particularly for malaria control. In Uganda, the Head of State scrapped the policy abruptly, while on campaign trail in the heat of presidential elections. This did not allow viable alternative arrangements to be put in place in time, including the reform of financial disbursement and management systems. As a result, the recurrent expenditures of the districts that used to rely heavily on cost sharing were adversely affected as well as the ability of health units to hire and motivate staff and carry out other operations. The consequences for service delivery were significant. As the experience of health units in the wake of scrapping cost sharing policy showed, even small sums of money that are available for immediate use are preferable to promised sums of money from the central budget that may be held up for weeks or even months.

Policy changes that affect provider behaviour or aggravate the scarcity of drugs undermine the communities' confidence and trust in the health system and affect disease control objectives in malaria endemic countries, as drugs are rendered inadequate, not available at the time they are needed or lacking altogether. Availability of easily accessible anti-malarial drugs is often the main reason people in endemic countries such as Uganda seek government healthcare. A healthcare delivery system cannot be complete or make a significant contribution to disease control objectives in a malaria endemic country if drugs are inadequate, not available at the time they are needed or are lacking altogether.

#### *Cross-country comparison of reform experience*

The introduction of user fee reforms in many countries has been politically problematic and cost recovery programmes have been introduced through what Shaw and Griffin refer to as a 'political process' (Shaw and Griffin, 1995). In most instances, initiation of the policy has not been indigenous but has been at the direction of multilateral institutions. The adoption of a user fee policy has been seen by governments as political and something governments should be doing, while the implementation has been considered administrative (Walt and Gilson, 1994).

In Kenya, the introduction of user fees was accompanied by announcements from the Minister of Health and when the first introduction had to be cancelled, the President himself announced the decision (Collins *et al.*, 1996). As was found in Uganda, an analysis of the health care reform process in Kenya during the 30 years leading up to 1995 found that some of the user fee reforms suffered delays and reversals when there was no clear guidance on key policy issues or when there

was lack of political will and skill to manage reforms. Donor influence on the timing of the reforms was also found to have been excessive (Mwabu, 1995).

In Tanzania, formulation of legislation on user charges is a function of the central government (Newbrander and Sacca, 1996). In Ghana, when user fees were first introduced, it was done through an act of Parliament (Hospital Fees Act, 1971). Subsequent revisions of fees were also done through central government decrees (Hospital Fee Regulations of 1983 and 1985).

The results from the analysis of Uganda's health financing reform experience strikes a resemblance to those of a health reform study in the Dominican Republic (Glassman *et al.*, 1999). In both cases the pace and feasibility of health reform proposals were affected by political and institutional factors, including leadership and reform ownership. However, Uganda's healthcare financing reform experience adds new dimensional factors, rarely found in similar studies. These include the decentralization of political risks, political indecisiveness, reform cost management, as well as political strategies of 'wait and see'.

Decentralization of political and administrative responsibilities is a central element of the Government of Uganda, which highlights the intrinsically political character of health reforms. The user fee reform process has been informed throughout by the approach of decentralization as a political risk management strategy. Fearing opposition from the electorate that is used to free public healthcare since independence, the ruling Party (NRM) left the user fee reform programme to operate as a district revenue mobilization strategy, but without a clear political and legislative support base; until such a time, it hoped, the population would embrace the idea of paying for public healthcare.

However, 10 years after the reforms were initiated, the government's strategy of 'wait-and-see' has not worked, as the direction and control of the reforms were neither in the hands of local governments nor in those of the central government. Decentralization has the potential to increase the standard of health services delivery. But it is unlikely to be effective when used merely as a political strategy of 'wait-and-see', or of pushing through unpopular reforms without adequate national level strategies and commitment to the implementation and management of the reforms.

### *Limitations of the study*

The study had a number of limitations. First, owing to the inadequacy of databases in the rural districts at the time of conducting the study, the health units covered lacked specific data on malaria and related issues prior to and after the abolition of the reforms. This limited the analysis on how the reversal of the reforms actually impacted on key programmatic elements of malaria care and control in Uganda.

The scrapping of the user charges, for example, seemed to improve physical and geographical access to healthcare outposts by the community members, as reflected in the increased number of patients at such outposts. The shortage of specific data on malaria and service provision dynamics during the years in question, however, meant that it was difficult to establish accurately whether the increased number of patients at the healthcare outposts translated into care and services that made a difference on malaria control goals of reducing malaria related morbidity and mortality

in the communities. The study had to rely on the perceptions of health service users and providers to be able to gauge the effect of the policy change on service delivery for, among other diseases, malaria.

Second, instead of conducting a team analysis involving stakeholders as planned earlier, the research team did an independent analysis based on interviews with various stakeholders. Although systematic, political data and analyses of this nature involve subjective assessments of players, positions and power (Reich, 1996).

Third, although financing healthcare is a problem to all countries, the implementation of financing reforms will be defined by, among other things, how well existing policies, institutions, structures and systems deal with issues of efficiency, access, cost-containment and responsiveness to popular demand. The relative importance of these issues will vary across the socio-economic spectrum. Much as lessons can be drawn from Uganda's user-fee reform experience, they must be interpreted in the particular environment—political, economic, social and cultural—in which it is to be applied.

## CONCLUSION

Financing healthcare through user fees is politically problematic. This is particularly true in developing countries such as Uganda, which not only have a narrow resource base, but also face challenges of extending coverage of basic services, improving quality of the poor health services, and addressing longstanding inequitable distribution of resources. All this takes place in a context of limited institutional capacity and political transition. Yet, in order for such malaria endemic countries to be able to take effective and sustainable action against the disease, they must have effective and sustainable healthcare financing policies.

Our analysis leads to the conclusion that given the above factors, in a context where health financing policies are undergoing rapid change by way adoption and reversal, the effect on health service provision tends to be mainly negative. This is more so for malaria—the leading cause of morbidity and mortality in the communities.

If user fees are to be an effective and sustainable health financing policy option in Uganda, the reforms must be owned and directed by the central government/MoH. The reforms would also require to undergo a careful process of policy formulation and acceptance, and must involve the participation and political management of all interest groups. This must be complemented by good management systems put in place to guide local-level decision-making and to ensure appropriate policy reform management and use of resources; through training, monitoring, enforcing guidelines, and ensuring complementary improvements in the quality of services and community participation.

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