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Understanding the role of regulation in improving the contribution of private sector towards health care delivery in Uganda

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Abstract

As the deadline for the Millennium Development Goals (MDGs) draws nearer, the ambition to achieve universal and equitable access to quality health care remains an urgent mission for Low Income Countries (LICs). In that regard, LICs are finding ways of expanding Health Care Delivery (HCD) by addressing challenges existing in the health sector. And one way of achieving this as different scholars assert is by expanding the contribution of Private Sector for profit (PHS). This is because PHS is already providing a wide range of services, with some interventions guaranteeing high outcomes when delivered through PHS because of perceived quality and proximity. The emergence of business in health sector has been accompanied by different market failures such as high price of services, declining quality of services, unfair distribution of services, monopoly tendencies, and failure to meet national interests and these have weakened the World Bank's argument that PHS is efficient in providing health services.

Market failures have stimulated the need for regulation of PHS with the view of improving quality, accessibility, and equitable distribution of health services. Therefore, this study has focused on regulation of PHS with the view of improving HCD in Uganda. The researcher has conducted a qualitative case study of Uganda as a case of government trying to regulate PHS in a country where PHS is expanding rapidly alongside limited government resources to foster regulation. The researcher has relied on secondary data especially scientific articles, reports and textbooks as the main sources of data.

The study has found out that Uganda is using different regulatory mechanisms including self-regulation, legislation, incentive-based regulation, licensing, and market regulation. These are used to influence key variables in the health sector like quality, price and access. Self-regulation through professional bodies is the highly used approach but limited funding to the regulatory bodies continues to affect the enforcement and monitoring of regulations hence leading to low compliancy.

Key words; Regulation, private sector, health care delivery, Uganda

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List of Abbreviations

AHPC; Allied Health Professionals' Council
AIDS; Acquired Immune Deficiency Syndrome
BRT; Better Regulation Taskforce
CBOs; Community Based Organizations
CHWs; Community Health Workers
DHO; District Health Officer
DHTs; District Health Teams
GDP; Gross Domestic Product
GNI; Gross National Income
HCD; Health Care Delivery
HICs; High Income Countries
HIPS; Health Initiatives for the Private Sector
HIV; Human Immune Virus
HUMC; Health Unit Management Committee
IFC; International Financial Cooperation
IHR; International Health Regulations
JMS; Joint Medical Stores
L G A; Local Government Act
LICs; Low Income Countries
MDGs; Millennium Development Goals
MOH; Ministry of Health (Uganda)
NAFOPHANU; National Forum for People Living with HIV AIDs Network
NDP; National Development Plan
NGOs; Non-Governmental Organizations
NPPPPH; National Policy on Public Private Partnerships in Health
PHS; Private Health Sector (for profit)
PPPH; Public Private Partnerships in Health
PHA; Public Health Act
SSA; Sub-Saharan Africa
U.K; United Kingdom
UAPO; Uganda Alliance of Patients' Organizations
UBOS; Uganda Bureau of Statistics
UHCA; Uganda Health Consumers Association
UHF; Uganda Health Federation
UHMG; Uganda Health Marketing Group
UMA; Uganda Manufacturers Association
UMDPC; Uganda Medical and Dental Practitioners' Council
UNDA; Uganda National Drug Authority
UNDP; United Nations Development Program
UNMC; Uganda Nurses and Midwives Council
USAID; United States Agency for International Development
VHTs; Village Health Teams
WHO; World Health Organization

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Chapter 1

1. Introduction

As the deadline for the Millennium Development Goals (MDGs) draws nearer, the ambition to achieve universal and equitable access to quality health care remains an urgent mission to accomplish, especially combating key challenges like maternal mortality, and infant mortality in most Low Income Countries (LICs) (Yoong *et al*., 2010; Hongoro&Kumaranayake, 2000; IFC, 2011; Oxfam, 2009). Moreover, IFC (2011) indicates that Sub-Saharan Africa (SSA) accounts for 11% of the world's population, yet it bears 24% of the global disease burden but only commands less than 1% of global health expenditure which explains why health care in SSA continues to be the poorest. In that regard, LICs are finding ways of expanding Health Care Delivery (HCD) by addressing challenges existing in the health sector. And one way of achieving this as different scholars assert is by expanding the contribution of Private Health Sector for profit (PHS) in HCD (Taylor, 2011; Garcıa-Prado & Gonzalez, 2007; Sekhri & Savedoff, 2006; Peters &Muraleedharan, 2008; Kumaranayake, 1997; IFC, 2011).

PHS is already providing a wide range of services in LICs including health insurance, diagnosis, treatment, immunization, pharmacies, family planning as well as contributing to health care financing by investing in equipment and other services (Kaboru, 2012). Studies indicate that there is a range of skills, capacities, and comparative advantages within the PHS which are needed to ensure high health outcomes (Rockefeller Foundation, 2008; IFC 2011). It is argued that some health interventions can be effectively delivered through PHS as the target groups may prefer PHS because of proximity and perceived quality (ibid.). WHO (2002) indicates that PHS in LICs is comprised of commercial companies, groups of professionals such as doctors, national and international NGOs, individual providers and shopkeepers (Oxfam, 2009). PHS is at different levels including those with well-established pharmacies, hospitals offering high technology services like surgical operations and other advanced services. However, most private service providers operate small clinics and drug shops serving both rural and urban populations as well as people of different income levels (Kaboru, 2012; Konde-Lule*et al*., 2006;Swecare Foundation, 2013).

However, the emergence of business in health sector has been accompanied by market failures that have weakened the argument of World Bank that PHS is efficient in providing

health services (Oxfam, 2009; Hongoro & Kumaranayake, 2000).[1] The main market failures cited by scholars include unfair distribution of services, high prices which rule out the poor, poor quality services, monopoly tendencies, and failure to meet the public interests for instance where a lot of resources are invested in curing the diseases that attract higher pay leaving out the key areas of national interest like primary health care (Busse *et al.,* 2003; Kumaranayake, 1997; Patouillard *et al.,* 2007; Basu *et al*., 2012). PHS in most areas has been characterized by Poor physical infrastructure, shortage of qualified medical workers, poor standards of care, poor equipment, misuse of public resources for instance where pubic workers steal public drugs and sell them in private clinics, taking away qualified workers from public sector, and medical malpractice and negligence (Kumaranayake, 1997; Hongoro & Kumaranayake, 2000). Field studies in Uganda for example indicate that 11% of drugs shops have ever reused disposable syringes and this puts human life at risk (Sandback *et al*., 2011). Basu *et al*. (2012) conclude from their systematic review of literature that studies evaluated do not support the claim that the PHS is usually more efficient and medically effective than the public sector. According to scholars, market failures in health sector have exacerbated the level of social exclusion, impoverishment and marginalization of the poor in LICs (Mackintonsh &Tibandabage, 2002; Kadaï *et al*., 2006; Peters &Muraleedharan, 2008; Oxfam, 2009).

Market failures have stimulated the need for regulation with the view of improving quality, accessibility, equity,and addressing medical malpractice, (Taylor, 2011; Kumaranayake, 1997; Bundred, 2006). There is a need to guide the PHS in order to meet the national goals, as well as restoring reputation of PHS so as to promote social inclusion (Mills *et al*. 2002). Recent studies indicate that World Bank has also begun to reconsider the role of public sector in providing health services, this time not as a provider of services but as a regulator and steward with a view of expanding health care system through public-private engagements (Basu *et al*., 2012; Oxfam, 2009). This view point is shared by different scholars who think that the only way to ensure high health outcomes is by engaging with PHS through calculated regulation (Taylor, 2011; Kumaranayake, 1997). Scholars have henceforth suggested various regulatory mechanisms that can be used to regulate PHS in ensuring better HCD. These include incentive-based regulation, market regulation, licensing and certification, legislation, and self-regulation intending to influence price, quality, distribution and accessibility (Mills *et*

[1] Health sector refers to all organizations, people and actions whose primary intent is to promote, restore or maintain health (Koburo, 2012).

al., 2002;Patouillard *et al*., 2007; Sood *et al*., 2011; Busse *et al.,* 2003; Jacobson, 2001; Mackintonsh &Tibandabage, 2002; Hongaro & Kumaranayake, 2000).

Therefore, this thesis is about regulation of PHS with the view of improving HCD using Uganda as the case study. The study is in response to the ongoing debate on the need to boost the performance of PHS by focusing on addressing key challenges facing PHS through regulation. Different authors have conducted a literature reviews and systematic reviews on the role of PHS in HCD with a particular look at LICs (Basu *et al.,* 2012; Levin and Kaddar, 2011). They found out that the role of PHS has not been sufficiently studied in most of these countries. Their studies reveal that the PHS is playing different roles and functions in different countries according to economic development levels, the governance structure and the general presence of the PHS in the health sector (Levin and Kaddar, 2011). These scholars have identified research gaps in the literature and have recommended them for future research ranging from geographic to thematic gaps. These included the role of regulation towards improving the performance of PHS in LICs, the level of quality of services offered by PHS and effectiveness of regulating PHS. This study has focused on regulation of PHS with the view of improving HCD in Uganda.

The Republic of Uganda is found in East Africa, it's a landlocked country with a population of about 35 million people, with a high population growth rate of 3.2% which raises need for expanded health resources. Uganda is a LIC with the GDP per capita of $551 and the economy is growing at an annual rate of 7% (UBOS, 2013). Percentage of national budget allocation to health sector continues to be lower than recommended and it reduced from 9% in 2010/2011 to 7% in 2012/2013 which poses health challenges (MOH, 2013). Health indicators are still low especially maternal mortality rate of 500 per 100,000 live births and infant mortality rate of 90 per 1000 live births (ibid.). Malaria continues to be the leading cause of death alongside other problems like HIV/AIDS, and TB. There is no minimum capital required to start business in Uganda and this has given birth to a growing PHS (Swecare Foundation, 2013). PHS comprises of more than 4,000 facilities nationwide ranging from lower level units providing outpatient and in-patient services such as drug shops, day care clinics, domiciliary units, nursing homes, pharmacies, and hospitals. Studies show that out of all these only 514 (9.2%) facilities are registered with health authorities (MOH, 2013).

1.1 Research problem

It is important to note that PHS has been involved in HCD in Uganda for quite a number of years and today the contribution of PHS is estimated to be above 50% (Taylor, 2011; Swecare Foundation, 2013; MOH, 2013). Health care business has attracted entrepreneurs from different spectrum ranging from small scale drug shops to large hospitals and pharmaceuticals (MOH, 2012). However it is still evident from the available literature that Uganda faces a lot of health challenges ranging from high maternal mortality rate (500 per 100,000 live births), under five mortality rate of 90 per 1000 live birth, low life expectancy (50 years) and high disease burden which raises debate about the contribution of PHS in addressing national health challenges (WHO, 2012; UBOS, 2013; MOH, 2012). It is also clear that there are many challenges still relating to services offered in PHS. It is argued that presence of PHS has not made much impact on addressing priority needs of the country of providing quality and affordable health services to all citizens as outlined in Health Sector Strategic Plan 2011/ 2012-2014/2015(MOH, 2010). This calls for a study to find out what can be done to step up the contribution of the PHS. The study will therefore focus on regulation of PHS with the view of improving HCD in Uganda. The study will contribute to understanding the role of regulating PHS in improving HCD.

1.2 Relevance

It is important therefore to carry out a study on regulation of PHS in Uganda to be able to understand how proper regulation can improve HCD. This is because most reports suggest PHS as the solution to the overstrained public sector which is not able to provide services to the vast number of people who need help in SSA (IFC, 2011; Rockefeller Foundation, 2008). The researcher chose the area of regulating PHS because the government of Uganda identified engagement with PHS as a key priority in its National Development Plan and this explains why it has been given much attention in Health Sector Strategic Plan 2011/ 2012-2014/2015 (MOH, 2010). There is a general emphasis on the need to expand health care system to be able to extend services to the large masses of people. The researcher chose to study PHS in HCD in Uganda because Uganda fits into the ongoing debate of those countries which are still working hard to achieve health targets as set in the MDGs. Therefore as a country where over 50% of health care services are provided by the PHS (Taylor, 2011; MOH, *et al*., 2012; UBOS, 2013), it is necessary to look at ways of enhancing the contribution of the PHS since it is only through addressing challenges facing the PHS that the battle of attaining MDGs will be won or lost (Oxfam, 2009).

Therefore, this study fits in the ongoing debates as different gaps can be identified in the literature and previous researchers recommend further studies on those gaps. However, this study will only focus on regulation of regulating PHS with a view of improving HCD in Uganda.

1.3 Purpose

The purpose is to study the regulation of Private Health Sector for profit (PHS) with the view of improving Health Care Delivery (HCD) in Uganda.

1.4 Research Questions

1) How is the private health sector regulated in Uganda?

a) Which regulatory mechanisms are used?

b) How is regulation governed?

c) How is quality ensured?

2) Which markets failures are addressed by the current regulation in Uganda?

3) What is the quality of regulation in Uganda in relation to best known practice?

4) How can regulation of private health sector be improved in order to improve HCD in Uganda?

The researcher has chosen to use the above questions as the best questions that can help this study to attain its purpose. The first research question is descriptive and will help in generating facts about regulation in Uganda. These facts include mechanisms used in regulation, actors involved in regulation, the institutional capacity, bodies involved in regulation, how regulation is done at local government levels and measures used to ensure quality in regulation. The second question is analytical and will help the researcher look at how regulation helps to address market failures in health by impacting on different health market variables like price, quality, distribution and competition. The third question makes an assessment of quality of regulation in Uganda in relation to principles of good regulation. Describing facts about regulation in Uganda, understanding how regulation addresses market failures and assessing quality of regulation will help the researcher to answer the forth question concerning how regulation can be improvedin order to improve HCD in Uganda. Therefore all research questions contribute to the research purpose of understanding regulation of PHS with the view of improving HCD in Uganda.

1.5 Theory and analytical framework

The researcher has developed analytical framework from literature review consisting of four aspects. The first part explains the meaning of regulation in a public health perspective as well as discussing rationale for regulation. Aspects discussed here include price, quality, competition, distribution and malpractice as key areas which regulation should address. The second part discusses the mechanisms used to regulate PHS and these include legislation, licensing, incentive-based regulation, self-regulation, and market regulation. The third part discusses governance of health sector and how it relates to regulation and issues discussed under that include institutional capacity, stakeholder involvement, and decentralizing regulation. The forth part discusses principles of good regulation that were developed by Better Regulation Taskforce (BRT) as guidelines to ensure that regulations are fair, affordable, effective, and generate public confidence and are only formulated when it is necessary (BRT, 2003). These principles include proportionality, accountability, consistency, transparency, and targeting. The researcher has chosen to use these principles because they are in line with the literature discussed about what is needed for good regulation practice and as such they will help the researcher assess the quality of regulation in Uganda hence providing avenues for understanding what can be done to improve regulation in Uganda. These principles will be explained further in chapter 3.

1.6 Methodology and Methods

The researcher has conducted a qualitative desk study about regulation of PHS and HCD in Uganda. Uganda is a case of government trying to regulate PHS in a country where PHS is expanding rapidly alongside little government resources to invest in regulating the health sector. The study is abductive in a sense that the researcher has conducted literature review to construct analytical framework which has been used as the tool to interpret findings of the study. This has been a desk study involving mainly use of secondary data. Data has been mainly collected from scientific articles that were searched through Linnaeus University library. More data has been collected from Ministry of Health (MOH) reports, and documents available on the websites of different organizations and institutions like world bank, WHO, Oxfam, USAID as well as data from text books.

1.7 Disposition

The first chapter has given a brief description of the research problem, purpose, theory, and methods used. Chapter 2 is the methodology chapter in which the researcher explains the

research design as well as the methods used to collect data, sources of data both secondary and primary data, as well as data analysis. Chapter 3 presents theory and analytical framework and this will involve literature review. This chapter explains the meaning of regulation, rationale for regulation, different regulatory mechanisms, and principles of good regulation. Chapter 4 is the empirical chapter where the researcher presents findings of the study in a descriptive manner. Chapter 5 presents the analysis of findings using the analytical framework to contribute to the understanding of the problem and also fully answering the research questions. Chapter 6 presents conclusions and recommendations.

1.8 Limitations and delimitations

The study has faced a challenge of insufficient data as record keeping in Uganda is a problem especially in PHS that is not properly regulated by government. The researcher could not get the exact figures about the number of private service providers and some of their activities since MOH indicate that PHS does not report about their activities. However the researcher has used different sources in order to generate more data and improve the quality of the study. The study has depended mainly on secondary data. It is also a limitation that the researcher does not have training in medical related aspects and sometimes some medical terminology could be challenging but this challenged the researcher to read more about the subject. However the researcher has worked hard to finish in time and come up with reliable findings.

The study has had some delimitations to consider for instance the study has been limited to PHS that is participating in Health Care Delivery (HCD) in Uganda. The study has used data for the last three decades. The study has only focused on Private Health sector for profit (PHS). Therefore NGOs, traditional health service providers, and faith-based providers were not studied.

1.9 Ethical considerations

The researcher did not collect field data and as such relied on documented data. Therefore the researcher has tried to use proper referencing to avoid misrepresenting other authors' work. The researcher is a Ugandan and as such high level of objectivity has been observed in order to avoid biases.

Chapter 2

2. Methodology

Under this chapter, the researcher will explain how data was collected, the methods he used, the sources of data and how he worked with the data.

2.1 Ontological and epistemological assumptions

A pragmatic world view has guided this study as the main focus under pragmatism according to Patton (1999) is to find solutions to the problems by looking at what works well (Creswell, 2009). Here the researcher focuses on the problem and therefore uses all approaches available to understand it properly since social science research is problem oriented and can employ pluralistic approaches to acquire knowledge about the problem (ibid). Creswell (2009) notes that pragmatists do not see the world as absolute unity and they believe that truth is what works at a time so the researcher can employ different methods and use both qualitative and quantitative data to be able to come up with proper understanding of the research problem (ibid.).

2.2 Methodological approach

A case study has been conducted as the researcher has only concentrated on regulation of PHS in Uganda. The study has focused on Uganda as a case of government trying to regulate PHS in a country where PHS is expanding rapidly alongside limited government capacity to enforce regulation. Creswell (2009) highlights that case studies are good at providing a deeper understanding of the problem being studied. This has been an abductive study since the researcher has carried out literature review in which the already existing knowledge has been used to construct analytical framework which has been used as a lens through which the empirical data has been interpreted. Meyer and Lunnay (2013) argue that an abductive approach helps the researcher to re-conceptualize a phenomenon and understand the complex dynamics a round that phenomenon as the researcher is able to recognize relations and meanings which are not obvious. This helps to broaden knowledge and stimulate the research process hence helping in generating and introducing new ideas. Therefore the researcher has based on existing knowledge to interpret the empirical data.

This has been a qualitative study much as it has used some quantitative data such as morbidity rates, maternal mortality rates and infant mortality rates as such data has been used to reinforce qualitative data. Collecting both qualitative and quantitative data side by side is recommended by Creswell (2009:14) as such data helps to reinforce each other. Creswell (2009) advises researchers to collect different sets of data from different sources and in that regard the researcher has collected data from various sources and this has been instrumental in capturing all important ideas about the problem and also validating different sources of data. Creswell points out that qualitative research is good at bringing out a holistic approach as researchers are able to develop a bigger picture about the phenomenon being studied. Therefore qualitative research has helped to generate multiple perspectives and factors involved in regulating PHS in Uganda. The researcher has used this approach to get a comprehensive and deeper understanding about regulation of PHS with the view of improving HCD in Uganda.

2.3 Sources of data

Data has been collected from different sources and these include both secondary and primary sources**.**

2.3.1 Secondary data

This study has based on secondary sources as the main way of obtaining data. The main source of secondary data has been scientific articles that were able to pass the criteria of being considered academic sources. These articles were searched through Linnaeus University library search and this introduced the researcher to a large data base from where the researcher identified the articles to use. The researcher considered articles that have been peer reviewed by other researchers and those that are published in internationally recognized journals. The researcher used the key words in the research topic and questions in order to refine and limit search in order to get the articles that are most relevant to the subject. The key words that were used include regulation, private sector, and health care delivery. The researcher tried to read the abstracts and key words of those articles to find those that suite the study. Since the study is looking at regulation of PHS in Uganda, priority was given to articles that carried out their studies in Low or Middle Income Countries or those that contain data about such countries and this was based on world bank criteria of having current per-capita GNI less than 12,275 US dollars (Todaro & Smith, 2011). The researcher made use of scientific articles that conducted field studies as well as those that reviewed documents. In

that case, articles providing full text and pass the above criteria were considered for this study. The researcher also tried to assess the backgrounds of the authors as well as understanding their professional experience by also looking at the institutions they are attached to especially for non-academic sources like reports and other publications. Where possible the researcher tried to understand the funders of their research in order to detect possibilities of bias. All those measures were intended to know what may have influenced their findings and biases that might exist in their findings. More secondary data has been collected from government reports especially Ministry of Health (MOH) and reports published by internationally recognized organizations and institutions like World Bank, WHO, USAID, and Oxfam. These have been chosen on the basis that they are key partners in Uganda´s HCD (MOH, 2012). Text books have also helped to provide additional data for this study especially Todaro and Smith (2011). Creswell (2007:126) explains that collecting data from different sources helps to maximize ideas hence helping to generate different perspectives.

2.3.2 Source criticism

It is important to note that the environment in which we are living influences the way we think as well as the way we act and this has an effect on the findings different authors come up with and as such, the researcher needs to be critical of different sources used (Creswell, 2007). Data collected from official government document can be taken as being authentic and as such can be included as a research material. However, this does not rule out the fact that data from government documents are biased but the researcher believes that it is also interesting to get such documents and be able to see what biases exist in such documents. In this case, the researcher has been cautious when using such documents to be able to strike a balance between what is described in documents and what can be considered credible for use in this study. The same criterion has been used to assess the authenticity of data collected from reports and publications of different organizations. For instance data from World Bank and IFC has been subjected to scrutiny since those institutions are known for supporting privatization and state disengagement in most sectors. The researcher tried to compare such data with the one collected from Oxfam which is a charity organization equally interested in extending health care services to the marginalized groups in LICs. This has helped the researcher to triangulate and be able to increase the reliability of the findings. The researcher has used principles of good regulation developed by Better Regulation Taskforce (BRT) in analyzing quality of regulation in Uganda. BRT was founded in 1997 as a semi-autonomous body that is funded by Cabinet office of UK, and it is responsible for giving technical advice

the UK government concerning formulating and implementing regulations in a way that will benefit the public without frustrating small businesses. The taskforce also works with stakeholders to ensure that regulation is clear, effective and appropriate as well as helping those being regulated on how comply with regulation. BRT is also charged with the role of giving technical assistance to other countries concerning improvement of regulation of private sector (BRT, 2003).The researcher chose to use these principles because they are in line with the literature discussed about what is needed for good regulation practice and as such they will help the researcher assess quality of regulation in Uganda hence providing avenues for pointing out what can be improved in regulation of PHS in Uganda. Being developed by BRT which provides technical advice on policies and regulation in the U.K and other countries, the researcher finds them credible for use in assessing regulation of PHS in Uganda considering the fact that even most health related laws in Uganda were designed during British colonial rule such as Public Health Act(PHA) of 1935 (MOH, 2014).

2.4 Primary data

The researcher has collected some primary data from Uganda Bureau of Statistics (UBOS) which is a state agency that carries out various surveys in Uganda. The researcher has used some of their statistics generated from the surveys conducted in Uganda that is accessible on the agency's website. The researcher has treated such data as primary since the role of UBOS is to collect data and avail it to government and other policy analysts for research and planning purposes.

2.5 Data analysis

Data has been analyzed using thematic analysis in which coding has helped to generate themes, categories and concepts (Creswell, 2009:181). Mikkelsen believes that there is no precise point where data collection ends and data analysis starts and therefore elements of analysis and interpretation will emerge during data collection and according to Mikkelsen this overlapping increases the quality of analysis (Mikkelsen, 2005:181). The researcher has analyzed data according to the analytical framework formulated from reviewing literature and themes in the framework have formed the themes in the analysis. The analytical framework has four parts and these include (1)market failures/rationale for regulation (quality, price, distribution, competition, and malpractice), (2)regulatory mechanisms (legislation, licensing, incentive-based regulation, self-regulation and market regulation), (3)governance in the health

sector (institutional capacity, stakeholder involvement and decentralizing regulation), and (4)principles of good regulation (proportionality, transparency, consistency, accountability, and targeting). These have formed the main themes during the analysis. The analysis chapter has three parts in which the first one looks at how different regulatory mechanisms are being used to address market failures in PHS. Each market failure (rationale for regulation) has been analyzed in relation to all regulatory mechanisms in order to ascertain which market failure is being addressed by which mechanism. This has helped to point out the mechanisms which are more effective in addressing market failures in PHS. The second part of analysis looks at governance aspects since scholars have explained how regulation of PHS is dependent on governance issues such as institutional capacity, how different actors are involved, and how regulation need to be decentralized to lower levels. The researcher has analyzed Uganda's case to see how governance aspect is addressed and the above governance aspects have formed the main themes in analysis. The third part analyzes the quality of regulation in Uganda using principles of good regulation and principles form the main themes in analysis.

Chapter three

3. Theory and analytical framework/literature review

This chapter will begin by explaining the meaning of regulation of health sector according to different scholars. This will make it easy to understand other aspects about regulation like reasons for regulation, mechanisms and principles of regulation. The chapter will then discuss rationale for regulation. These include; ensuring quality of services, fair distribution of services, ensuring affordable prices, regulating competition and regulating malpractice. The researcher then discusses different mechanisms used in regulation of PHS. These include legislation, incentive-based regulation, self-regulation, market regulation, and licensing, certification and accreditation. There follows discussion of governance of the health sector since regulation takes a form of governance especially in policy making, participation, resource allocation and implementation (Taylor, 2011). Aspects under governance that will be discussed include institutional capacity, stakeholder involvement, and decentralizing regulation. The researcher will then discuss principles of good regulation that were developed by BRT as a tool to guide policy makers to ensure that regulations are fair, effective and affordable (BRT, 2003). These principles include proportionality, consistency, transparency, accountability, and targeting. The chapter ends with explanation of how analytical framework will be used. The researcher has tried to be problem oriented in approach and in that case the study has not been limited to one particular theory but instead borrowing ideas from different theories like neoclassical economic theory, institutional theory, human development and capability theory, and neoliberal theory.

3.1 Defining regulation

Kumaranayake (1997) looks at regulation as a deliberate government action to manipulate prices, quantities, distribution, and quality of services. This is done in collaboration with several actors including health care professionals, managers, the Ministry of Health, commercial interests, NGOs, community, and consumer groups. Brennan and Berwick (1996) define health care regulation in Busse *et al*. (2003) as different factors outside the practice or administration of medical practice that influences behavior in delivering health care. Sood *et al.* (2011) look at regulation as command and a control style used by the government to enforce what the government considers to be a desirable practice in health

sector. Hood and Scott (2000) defines a regulator in Bundred (2006:182) as "*an organization that seeks to shape the behavior of another organization where there is an arm's-length relationship between the overseeing organization and that being overseen, and where the overseer has some sort of official mandate or authority for its oversight*".

3.2 Rationale for regulation

This section begins with highlighting on the market failures that exist in health sector. The term market failure is defined in general perspective and later linked to health sector. The researcher then discusses key areas in health care market where market failures exist and those are the areas that form the rationale for regulation. Those key areas include quality, price, distribution, competition, and malpractice.

Market failure refers to "*a market's inability to deliver its theoretical benefits due to existence of market imperfections such as monopoly power, lack of factor mobility, significant externalities and lack of knowledge*"(Todaro and Smith, 2011:128). It is therefore argued that market failures have provided a justification for state intervention in form of regulations in order to direct private sector to socially desirable direction (ibid.). Todaro and Smith (2011) argue for market friendly approaches that aim to safeguard key sectors like health care and education to ensure that vulnerable people are not left at the mercy of markets. They argue that profit motive may induce higher prices and resource allocation may not meet social demands.

The highly liberalized health care market has made citizens susceptible to exploitation, abuse, poor quality and poor accessibility due to market failures that exist in health care market (Mackintonsh &Tibandabage, 2002). Scholars have noted challenges in PHS like poor quality services, high prices, social exclusion due to concentration in urban areas targeting higher income groups, misleading advertisements, unfavorable competition, unqualified staff, inappropriate technology, medical malpractice, poor infrastructure, and poor hygiene in the facilities (Sood *et al.,* 2011; Bundred, 2006; Taylor, 2011; Jacobson, 2001; Sekhri & Savedoff, 2006; Kumaranayake, 1997; Peters & Muraleedharan, 2008). Scholars argue that PHS tend to compromise quality of services, withhold information concerning their activities, and others do not meet the minimum standard required to operate a health care facility which all point to the necessity for regulation (ibid.). Regulation should help to provide information to the public concerning services available in different facilities, attracting business in health

sector, upholding professional ethics and stimulating public trust in the PHS (Garcıa-Prado & Gonzalez, 2007; David & Muraleedharan, 2008).

3.2.1 Ensuring quality

Regulation of private health service providers is needed to ensure quality of the services offered. This is done through offering licenses and certificates in which regulatory bodies approve only those facilities which meet high quality standard (Sood *et al.,* 2011; Busse *et al.,* 2003). Tight control measures are also put on personnel before being recruited in health care system to ensure that they go through examination to be able to prove their competence before being trusted with health care work. Busse *et al*. (2003) argue that a private license may be subjected to periodic renewal and this should be done on confirmation that the person or the facility is meeting the quality required. Scholars have provided a number of ways to ensure quality in private sector including;

> examination of applicants' credentials to determine whether their education, experience, and moral fitness meet statutory or administrative requirements, administration of examinations to test the academic and practical qualifications of medical graduates against preset standards, granting of licenses on the basis of reciprocity or endorsement to applicants from other localities or foreign countries, issuance of regulations establishing professional standards of practice, and investigation of charges of violation of standards established by statute and regulation; suspension or revocation of violators' license (Busse *et al*., 2003:260).

3.2.2 Fair distribution of services

Todaro and Smith (2011) argue that markets are good at ensuring efficiency in production but they also mention that market failures still exist in some sectors like health which necessitates government hand to ensure equitable distribution of services. Scholars have noted that PHS does not consider social aspects because of profit motive and as such regulation is needed to ensure the provision of fair and needs-based access to health care for the whole population, including the poor, rural, elderly, disabled, and other vulnerable groups (Yoong *et al*., 2010; Busse *et al.,* 2003). Incentive-based regulation can help government to induce PHS into operating in areas which are under served by public sector through contracting or direct incentives like tax holiday, free connection of electricity, providing medical equipment and

staff training (Mills *et al*., 2002; Patouillard *et al*., 2007; Sood *et al*., 2011; Kumaranayake, 1997; Jacobson, 2001).

3.2.3 Ensuring affordable prices

Different authors indicate that PHS may be good at ensuring good quality services as well as reaching out to places which are under served by the public sector, but there is still a challenge of profit motive which drives prices so high that majority of the people in LICs are likely to remain socially excluded from their services (Mackintonsh &Tibandabage, 2002; Hongaro & Kumaranayake, 2000; Sood *et al*., 2011; Mills *et al.,* 2002; Patouillard *et al*., 2007; Yoong *et al*., 2010). This necessitates government intervention in order to ensure manageable prices especially for certain health challenges which are deemed a priority in a certain country. This can be done through offering incentives to PHS in order to ensure reductions in the prices of their services. Busse *et al.* (2003) cite an example of Rwanda where government sets standards and prices to be charged by the PHS and such fees are to be pinned on the doors of PHS to reduce the possibilities of consumer exploitation through higher prices. It is noted in different studies that PHS tend to carry out unnecessary treatments in order to extract higher prices from patients basing on studies in India and South Africa (ibid.).

3.2.4 Ensuring fair competition

Competition is seen by different scholars as not only a good regulator of PHS but also an engine of growth through efficiency (Busse *et al*., 2003). Allowing many firms to enter health care market increases the quantity and quality of services. When providers are many in an area, competition will increase and some firms will relocate to new areas hence increasing distribution. Competition will lead to high quality in order to attract more customers (ibid.). Regulation should be able to address provider monopolies, combat scarcity of certain necessary services and reduce wasteful service utilization. Such arrangements are necessary in balancing supply and demand to ensure that resources are directed towards where they are needed most (Jacobson, 2001; Sekhri & Savedoff, 2006).

3.2.5 Regulating malpractice

Regulation of PHS will help to restore the integrity of the sector by addressing different kinds of malpractice which have always been associated with unregulated PHS. These malpractices range from carrying out illegal abortions, swapping of babies, negligence of duty, raping

patients, selling expired drugs, wrong prescriptions and administering wrong treatment (Sandback *et al*., 2011; Kumaranayake, 1997; Mackintonsh &Tibandabage, 2002; Bundred, 2006). Mackintonsh &Tibandabage (2002) believe that building institutional capacity by enhancing professional conduct through professional bodies can help to stump-out such malpractices. This is why scholars believe that much as legislated regulations are expensive to enforce, they should be in place to guard against such malpractices and professional bodies can be empowered to work on such malpractices using the existing legal framework (Kumaranayake, 1997; Mackintonsh &Tibandabage, 2002).

3.3 Regulatory mechanisms used in health sector

Kumaranayake (1997) looks at regulatory mechanisms as those tools and interventions which are used to influence variables such as price, quality, and distribution. There are different regulatory mechanisms that policy makers have used to influence the activities of PHS in different countries. This study will look at legislation, licensing, incentive-based regulation, self-regulation, and market regulation.

3.3.1 Legislation

Legislation is the way of implementing administrative and bureaucratic approaches and it involves government coming up with specific laws governing the activities that take place in the health sector. PHS must adhere to legal requirements or face punishment in form of sanctions and penalties (Busse *et al*., 2003). This involves formulating laws covering different aspects like minimum standards expected in a health facility in terms of qualifications of staff, quality of services offered, structures, code of conduct, as well as malpractice in health sector (Busse *et al*., 2003; Garcıa-Prado & Gonzalez, 2007). These requires a functioning court system and proper appealing mechanisms, as well as dissemination of information to consumers about their rights as patients and procedures of how they can report their complaints about malpractice. These laws should cover quality of services in terms drug manufacturing, storage and distribution. However, Busse *et al*. (2003) concurs with other authors (Garcıa-Prado & Gonzalez, 2007; Peters & Muraleedharan, 2008; Kumaranayake, 1997) that such kind of regulation is hard to administer in terms of being costly especially to get all information regarding the activities of the PHS as well as the court systems taking too long to handle health related cases.

3.3.2 Incentive based regulation

Busse, *et al*. (2003) assert that from 1990s, there has been a shift towards regulatory regimes that are softer, market style and incentives that encourage rather than compel PHS to adhere to the desired behaviors. Many authors believe that incentives have high potential to influence the behaviors in PHS since PHS is always cautious about profitability and can work hard in order to win certain favors that help to improve profitability (Patouillard *et al*., 2007; Mills *et al*., 2002; Kumaranayake, 1997; Garcıa-Prado & Gonzalez, 2007; Busse *et al.,* 2003; Rockefeller Foundation, 2008). These incentives can take form of tax holidays, training and professional development opportunities in needed specialties, franchising, or direct monetary incentives or government contracting PHS to offer services to people in areas which are not properly served by government facilities (Patouillard *et al*., 2007; Kumaranayake, 1997). Busse *et al.* (2003) argue that, with increasing PHS in LICs, there is a need for governments to offer incentives in order to reverse the ongoing trend where PHS are concentrating in urban areas targeting higher income groups which leads to social exclusion (ibid.). However, government should ensure monitoring to follow up on whether incentives are influencing PHS in the desired directions (ibid). Studies show that incentives help to reduce on the administrative costs that are always coupled with legal interventions (ibid.). Incentives have a possibility of inducing PHS to actively participate in uplifting the standard of their facilities as well as giving information which enhances collaboration among actors (Mills *et al*., 2002; Patouillard *et al*., 2007; Garcıa-Prado & Gonzalez, 2007).

Financial incentives in form of provision of access to capital for investment and tax reduction can be a very big incentive to boost quality of private facilities since a lot of capital is needed to invest in modern health equipment (Busse *et al.,* 2003).

3.3.3 Self-Regulation

There is an on-going debate about the need to increase self-regulation with some authors claiming that LICs are faced with resource constraints in form of personnel and financial hence fronting the necessity to stimulate self-regulation (Kumaranayake, 1997; IFC, 2011; Kadaï *et al*., 2006; Garcıa-Prado & Gonzalez, 2007). They believe that stringent measures end up impacting on the prices of the services as well as limiting business in the health sector. Their suggestion is to encourage self-regulation through professional bodies and by strengthening organizational culture of good health practice (Mackintonsh &Tibandabage, 2002). Professional bodies come up with guidelines concerning required standards in terms of behaviors, code of conduct, quality in order to ensure good services. Scholars point out that self-regulation leads to high commitment and ownership of regulations, reduced cost on

the side of government, adjustments can be adopted rapidly since standards set by professional bodies are seen as being appropriate, ease of enforcement and complaints handling (Busse *et al.,* 2003; Kumaranayake, 1997; Jacobson, 2001). Literature shows that professional bodies are properly functioning in High Income Countries (HICs) but there is still a challenge with these bodies in LICs due to limited funds and personnel to carry out the duty of oversight (Kumaranayake, 1997; Garcıa-Prado & Gonzalez, 2007). With reference to developing countries, scholars are skeptical that even with more financial resources allocated to the bodies still they will not function properly if issues of dual practice are not addressed. This is because professional bodies are composed of medical practitioners who themselves operate private facilities which induces enforcement bias (ibid). However, professional bodies are increasingly gaining importance in LICs and MICs with Ghana, Tanzania, South Africa, and Thailand providing good examples (ibid).

3.3.4 Market regulation

This involves an arrangement of establishing ground rules for participants in the HCD especially spelling out requirements for the entry into the health care market. This can also involve determining who is eligible to provide services, influencing those who join medical schools, or start medical schools as well as licensing individuals and facilities to begin operating (Busse *et al*., 2003). Many scholars believe that regulation is necessary to match supply and demand but they maintain that regulation should not frustrate the market but instead should guide PHS towards socially desirable directions (Sood *et al*., 2011; Sekhri & Savedoff, 2006:359; Jacobson, 2001; Busse *et al*., 2003). There is need for regulation to stimulate meaningful competition by opening up markets to increase the number of service providers which will help to keep prices low (ibid.). Luís-Manso & Finger (2007) argues that since regulation can take different forms, economic regulation should be enforced with care in order to avoid causing negative externalities especially where higher taxes are charged from the providers which can lead to higher prices. Competition should be managed to ensure markets are not manipulated which can cause high social impact (ibid.).

Scholars advocate for a balance between consumer oriented approaches and market oriented approaches. Consumer oriented approaches are those that enhance the ability of the consumers to voice their demands and their opinions about the kind of services they want (Peters &Muraleedharan, 2008; Busse *et al*., 2003; Jacobson, 2001). This is dependent on information accessibility and communication channels that exist. Market oriented approaches are those that increase competition among providers and this leads to efficiency and wider

coverage. Under this, contracting of services by government can enhance competition there by increasing professional regulation to meet the required standard and be able to win contracts (Peters & Muraleedharan, 2008; Jacobson, 2001). The reason behind such regulations is that unrestricted expansion of health care system is likely to cause supplier-induced oversupply or wastage of scarce resources (Busse *et al*. 2003, Jacobson 2001).

3.3.5 Licensing, certification and accreditation

Scholars argue that licensing, accreditation, and certification are the most commonly used instruments for regulating the quality of health care (Peters & Muraleedharan, 2008; Hongaro & Kumaranayake, 2000; Busse *et al*., 2003). Licensing helps the government to sieve out those providers that don't meet minimum requirements for operating health facilities. Accreditation and certification involves offering approval to the facilities and personnel who meet the required standard to start operating and according to scholars this should be done following a rational process (quality standard) as this is the basis for the general public to judge the technical quality of individuals and their facilities (Busse *et al*., 2003). In this process of accreditation and certification, regulatory bodies should be able to provide information to PHS on how to improve their services (ibid.).

Busse *et al*. (2003) note that licensing helps government to ensure that minimum standards are met and therefore, licensing is not necessarily a standard measure of quality but just a starting point. However there is a negative tendency in LICs whereby once private health facilities are licensed to operate, the government does not go back to monitor whether the agreed upon standard continues to exist in such facilities and this has led to the deterioration of health services in PHS (Hongoro & Kumaranayake, 2000; Kumaranayake, 1997; Busse *et al*., 2003).

3.4 Governance in the health sector

Under this sub-section, the researcher will discuss governance aspects in the health sector and how they relate to regulation of PHS. WHO (2007) believes that governance is a core aspect of health system since it is likely to influence policy making, defining strategies, coalition building, doing the oversight, monitoring the effects caused by policies, funding, and promoting participation (Taylor, 2011; Rockefeller Foundation, 2008). Governance influences how systems operate, what decisions are made, and what inputs are absorbed which necessitates government to observe high degree of administrative capacity to provide framework for the functioning of PHS to attain common good (ibid.). Governance aspects which will be discussed under this sub-section include institutional capacity, stakeholder

involvement, and decentralizing regulation as these influences the design, enforcement and compliancy to regulations.

3.4.1 Involving all stakeholders in regulation

Regulation of PHS should involve the input of different stakeholders in order to create public trust in the regulation as well as compliance (Mackintonsh &Tibandabage, 2002; Kadaï *et al*., 2006; Kumaranayake, 1997; Rockfeller Foundation, 2008; Bundred, 2006). Actors like professional bodies, health care professionals, NGOs, patient organizations, local leaders in the local governments, health care managers, independent regulatory bodies and commercial interests like insurance companies should be involved (Kumaranayake, 1997). Although many actors are meant to participate in regulation of PHS, scholars argue that most actors are not visible in LICs citing challenges of poor funding, lack of information and weak institutional framework (Sekhri & Savedoff, 2006, Peters & Muraleedharan, 2008). They argue that regulation will not be effective if it does not gain public support through media, civil society as well as citizenry to be able to put pressure on PHS for better services (Rockefeller Foundation, 2008; Bundred, 2006; Garcıa-Prado & Gonzalez, 2007). Effective regulation need to be formulated in consultation of different actors and incorporating in their inputs. This should involve getting information concerning the needs and priorities of different groups and possible out comes to avoid marginalizing the poor or frustrating businesses during the enforcement of the regulation (Bundred, 2006).

3.4.2 Institutional capacity

Most governments in SSA are faced with a challenge of limited funds to invest in monitoring the activities of the PHS as well as setting up functional bodies to do the oversight role (Mackintonsh & Tibandabage, 2002; Hongoro & Kumaranayake, 2000; IFC, 2011; Taylor, 2011). Most governments have laws in place but they are not implemented because of having limited capacity to enforce and follow up on the compliance with those laws (Kumaranayake, 1997). Some legal frameworks in some countries are outdated or inappropriate which make them hard to implement (IFC, 2011; Rockefeller Foundation, 2008). Most stakeholders like civil society, consumer groups and the general public are not empowered enough and they lack information concerning how to demand for better services. Mackintonsh & Tibandabage (2002) advise governments in SSA to concentrate on strengthening institutional norms and values which will help to generate a generally accepted behavior in which patients and health workers are obliged to comply with such institutional

values. There is need for governments through ministries of health to collect information concerning the presence and services of PHS as this facilitates planning (Peters &Muraleedharan, 2008; Busse *et al*., 2003). However, this is still lacking in SSA because of funding (ibid).

3.4.3 Decentralization and regulation

It is argued that many LICs are faced with low institutional capacity which affects design, monitoring and enforcement of regulation at lower at local administrative units (Sekhri & Savedoff, 2006). The financial, labor and medical care markets are often characterized by a high level of inconsistency that makes efficient administration difficult and hinders transparency. Issues concerning differences in level of income and regional imbalances in economic development as well as low revenue collection do not only make it hard for LICs to enforce regulation but also make it so challenging to come up with appropriate regulations that will appeal to all classes of people (ibid.). Busse *et al*. (2003) argue that through incentive-based regulation, government can stimulate good medical practice in remote areas where government services are inadequate and this can reduce the cost of regulation. Regulation at local levels can only be possible through collaboration between different actors like patients' organizations, NGOS, local leaders, and the general public. But this is dependent on the information available to the people are how empowered they are to demand for better services (Bundred, 2006). Bundred (2006) further argues that local governments should be facilitated through funding so that they ensure regulation of health activities at local levels.

3.5 Principles of good regulation

Government regulations impact greatly on people and businesses which makes it necessary that regulations be properly designed to avoid excessive costs, sabotaging business, and to ensure compliancy (Better Regulation Taskforce BRT, 2003; IFC 2011; Bundred, 2006; Rockefeller Foundation, 2008). It is important to ensure that such regulations are necessary, effective, fair, affordable, and generate public confidence (BRT, 2003). To achieve this, there is a need to adhere to five core principles of better regulation. The researcher chose to use these principles because they are in line with the literature discussed about what is needed for good regulation practice and as such they will help the researcher assess quality of regulation in Uganda in relation to best known practice in order establish how to improve regulation in

Uganda. Being developed by BRT which is a semi-autonomous body that provides technical advice on policies and regulation the U.K government and other countries, the researcher finds them credible for use in assessing regulation of PHS in Uganda considering the fact that even most health related laws in Uganda were designed during British colonial rule such as Public Health Act of 1935 (MOH, 2014). Bundred (2006) believes that principles can form a standard tool for measuring and improving regulation, easing enforcement, and providing for negotiation between government and different stakeholders. These principles include proportionality, accountability, consistency, transparency and targeting (BRT, 2003).

3.5.1 Proportionality

Better Regulation Taskforce [BRT] (2003) argues that regulators should only intervene when it is necessary and that regulations should be in line with the risk being posed in order to define risks involved and minimize them. IFC (2011) concurs with this by arguing that some regulations in LICs are inappropriate and outdated. It is therefore important to see that remedies are proportionate to the intensity of the problem to avoid wasting of resources. Kumaranayake (1997) asserts that LICs are faced with financial constraints and as such should concentrate on key aspects that matter most. To achieve proportionality, different policy objectives have to be defined and different alternatives weighed to come up with most effective and cheaper options. This is because disproportional regulation has the potential to put most small business at risk yet reports show that most PHS in Uganda operate on small scale (Swecare Foundation, 2013; MOH, 2012).

3.5.2 Accountability

Accountability principle provides that regulators should be accountable to the public by justifying their decisions and be subjected to public scrutiny (BRT. 2003). Regulation proposals should be availed to all those who will be affected by the regulation, clearly explaining why decisions were made and detailing how regulation will be enforced. Bundred, (2006) explains that government should exhibit high level of accountability when carrying out regulation of health sector. He further argues that such regulation should detail on how health facilities can be accountable to the public. In meeting this principle, regulators and enforcers should clearly define guidelines and standards from which they can be judged, regulators should be accessible and there should be an effective way of handling complaints as well as appealing procedures (ibid.). BRT (2003) points out that regulators should be accountable to the ministry of health, parliament, local councils, as well as the public. Scholars believe that

this collaboration can ensure good health outcomes (Hongoro & Kumaranayake, 2000; Kadaï *et al*., 2006).

3.5.3 Consistency

Government regulations and standards should be implemented fairly and in situations where regulatory bodies are many, they should be consistent with each other (BRT, 2003). New rules should take into account the internationally agreed standards and the already existing regulations either nationally or globally to ensure consistency (ibid.). IFC (2011) argues that regulations in SSA are outdated and that this frustrates businesses by government concentrating on tariffs and licensing leaving out other important aspects like self-regulation.

3.5.4 Transparency

Regulators should be open, regulations should be easy to adopt and the need for regulation should be clearly defined and properly communicated to all parties including the private sector (BRT, 2003). Wide consultations should be made when developing proposals to ensure that views of stakeholders and experts are included. This is intended to come up with regulations that are clear, simple, and guiding which is vital to ensuring compliancy (Bundred, 2006; Kadaï *et al*., 2006, Sekhri1 &Savedoff, 2006:359, Jacobson, 2001). The new regulations where possible should take at least 12 weeks to take effect and such time should be used to inform those being regulated of their obligations, legal framework and best practice (BRT, 2003). The private sector should be given support if possible in order to comply and the consequences of not complying should be made clear to everyone (ibid.).

3.5.5 Targeting

Regulation should focus on the main problem and work to minimize the side effects. Goal based approach may be appropriate so that the enforcers and the private sector are given flexibility in choosing how to meet the defined goals and targets (BRT, 2003). Regulations should be periodically reviewed to establish whether they are still relevant or effective before deciding whether to keep or drop them. Regulators should focus mainly where the problem is posing high risks in order to minimize side effects. This is because excessive regulation of health sector in LICs is likely to frustrate business there by enhancing ill health (Hongoro & Kumaranayake, 2000; Mackintonsh & Tibandabage, 2002; Taylor, 2011).

Table 1 showing analytical framework

Rationale for regulation/market failures to be addressed	Regulatory mechanisms	Governance in the health sector in relation to regulation	Principles of good regulation
✓ Regulating Quality ✓ Ensuring fair distribution ✓ Ensuring affordable prices ✓ Regulating competition ✓ Regulating malpractice	• Legislation • Incentive based regulation • Self-regulation (through professional bodies) • Licensing, certification and accreditation • Market regulation	➢ Institutional capacity ➢ Involvement of different actors ➢ Decentralizing regulation	▪ Proportionality ▪ Consistency ▪ Accountability ▪ Transparency ▪ Targeting

3.5.6 Operationalization of analytical framework

The author has constructed an analytical framework out of reviewing literature and that will be used in analysis of findings. The analytical framework comprises of four parts and all of them will be used. These include rationale for regulation/market failures, regulatory mechanisms, governance, and principles of regulation. Themes under rationale for regulation/market failures that will be used in analysis include regulating quality, regulating price, ensuring fair distribution, regulating competition, and reducing malpractice. Market failure and rationale for regulation have been used together in this framework because market failures form the rationale for regulation as discussed in 3.2 above. The regulatory mechanisms that will be used in analysis include legislation, incentive-based regulation, self-regulation, licensing, and market regulation.

Market failures and regulatory mechanisms will be analyzed concurrently by looking at how regulatory mechanisms are being used to address market failures in PHS. Each market failure/rationale for regulation will be analyzed in relation to all regulatory mechanisms in order to ascertain how it is being addressed and which mechanisms are more effective in addressing it. This is because scholars have pointed out in chapter 3.2 above that regulation should be able to target health market failures. Hence, the researcher will be able to analyze how regulatory mechanisms help to improve the quality of services, the distribution and

access to health services, ensuring affordable prices, stimulating competition or reducing competition in areas where competition is becoming wasteful, and reducing malpractice in PHS. The author will be able to identify regulatory mechanisms that are more effective in Uganda as well as understanding market failures that are not being adequately addressed.

Governance aspects which will be used in analysis include institutional capacity, stakeholder involvement, and how regulation is decentralized. As pointed out in 3.4 above, scholars have explained how regulation of PHS is dependent on health sector governance. WHO (2007) believes that governance influences policy making, enforcement, participation, funding, and coalition building which are key to regulation of PHS (Taylor, 2011; Rockefeller Foundation, 2008).The author will analyze Uganda's case to see how these key governance areas are addressed.

The author will then use five principles of good regulation to analyze the quality of regulation in Uganda. These include proportionality, consistency, consistency, transparency and targeting and they will all be used. This will help the researcher to understand quality of regulation in relation to real practice as suggested by other scholars and BRT. Here the researcher will be able to identify areas which need improvement in order to improve regulatory quality in Uganda.

Therefore, the analysis chapter will comprise three parts; the first part will be analyzing how regulatory mechanisms are being used to address market failures in Uganda. The themes that will be discussed under that part include regulating quality, regulating price, ensuring fair distribution, regulating competition, and reducing malpractice. The second part will be the analysis of governance aspects in relation to regulation and themes that will be discussed under that include institutional capacity, stakeholder involvement, and decentralizing regulation. The third part will be the analysis of quality of regulation in Uganda using principles of good regulation. Themes under that part will include proportionality, consistency, consistency, transparency and targeting.

Chapter 4

4. Findings

This chapter will discuss the findings of the study. It begins with a discussion of how regulation is done in Uganda, by looking at mechanisms used. The researcher then discusses governance of regulation in Uganda by looking at Uganda National Drug Authority (UNDA), other stakeholder involved in regulation and how regulation is decentralized. The researcher will then discuss quality of regulation descriptively by looking at institutional capacity and quality assurance mechanisms and how regulation is enforced in Uganda. This chapter has been structured in relation to the analytical frame work, beginning with mechanisms used to regulate PHS, governance of the health sector, and quality measures in regulation. But these aspects will be discussed descriptively under this chapter. This is meant to improve clarity by looking at the same aspects in the theory, findings as well as analysis. Two aspects of the analytical framework (rationale for regulation and principles of regulation) have not been discussed at this level since they are more analytical and will only be discussed in chapter 5.

4.1 Regulatory mechanisms in Uganda

The government of Uganda has employed a number of mechanisms aimed at influencing different variables such as price, quantity, distribution as well as quality in a view of meeting national goals. These mechanisms do not work in isolation as they tend to complement each other and there are different bodies involved in implementing those regulations. The researcher is going to answer the research question 1(a) about approaches used to regulate PHS in Uganda by discussing different regulatory mechanisms used including self-regulation through professional bodies, legislation, market regulation, incentive based regulation and licensing, certification and accreditation.

4.1.1 Self-regulation/Professional bodies in Uganda

Uganda has various professional bodies mandated under the law to regulate individuals and institutions involved in delivering health services including both private and public sector. These bodies may target both PHS and public sector since the intention to improve professional conduct in both sectors (MOH, 2014). Functions of these bodies include ensuring discipline, ensuring the educational standards, keeping registers, supervising professional practices at all levels, as well as formulating guidelines and requirements for PHS (Birungi*et al*., 2001). They have powers to register PHS that meet the requirements or deregister those

that do not meet the set standard. The roles of these bodies are complementary to each other as they are formed along the professional lines. They include Uganda Nurses and Midwives Council, Uganda Medical and Dental Practitioners Council, Allied Health Professionals' Council and Pharmacy Council (Birungi *et al*., 2001; MOH, 2014).

Table: 2 Professional institutions charged with regulation of health professionals in Uganda

Health Worker Cadre	Accrediting Institution	Legislation
Doctor and Dentists	Medical and Dental Council	Medical and Dental practitioners Act Statute
Nurses and Midwives	Nursing and Midwifery Council	Nursing and Midwifery Act Act No. 2 of 1996
Allied Health Workers	Allied Health Council	Allied Health Practitioners Act Statute No. 10
Pharmacists	Pharmacy Council of Uganda	Bill not yet passed
Traditional Practice	(no legitimate agency)	No attempts yet

Source: MOH, *et al.* (2012).

4.1.1.1 Uganda Nurses and Midwives Council (UNMC)

This is a statutory professional body responsible for regulating the nursing profession in Uganda (UNMC, 2014). UNMC was instituted in 1922 and is currently governed by Uganda Nurses and Midwives Council Act (1996). The council plays a number of functions like regulating the standards of nursing and midwifery in Uganda, supervision and regulation of training of nurses and midwives, giving out certificates to people who have completed their respective courses in the field of nursing and midwifery, regulating the conduct of nurses and midwives and exercise control over them to ensure discipline, supervise the registration and enrollment of nurses and midwives and publication of their names in the gazette, exercise general supervision and control over the two professions as well as advising government on matters relating to the two professions (UNMC, 2014). The council also ensures the compliance with nursing ethics and this has been through developing the Professional Code of Conduct and Ethics for Nurses. The Code of conduct serves as a reminder of the shared obligations and duties of all nurses and it can be purchased from the council at slightly over 1$US. UNMC receives and handles complaints about the conduct of nurses and midwives. UMNC believes that regulation aims at protecting the public from unsafe practices, ensuring quality of nursing services, enhancing the development of the nursing profession and helping to ensure responsibility, accountability, identity and status of the Nurses/Midwifery in the country (UNMC, 2014). The council works in collaboration with other government bodies to

effectively regulate the PHS by ensuring both internal and external regulation. Internal regulation is done by this council whereas external regulation can be under taken by other actors for instance the police are mandated to arrest and prosecute personnel found involving in medical malpractice (ibid.). The licenses for private sector workers are renewed every year and by 31st March of each year, all nurses/midwives working in the PHS are expected to have renewed their licenses. There are procedures for securing a private nursing license as well as renewing the license which involves assessing the qualifications, the facility where the person is going to work from, payment of required fees as well as approval from UNMC and District Health Officer (DHO) after inspecting the premises where the facility is going to operate.

4.1.1.2 Uganda Medical and Dental Practitioners Council (UMDPC)

UMDPC was first set up in 1913, but it has passed through a series of legislations and is currently governed under the Uganda Medical and Dental Practitioners Act 11, of 1996 with a mandate to foster good medical practices, to keep the registers of the qualified medical officers and dental surgeons in the country and to promote high standard of medical education by ensuring that what is taught in medicine and dentistry is acceptable internationally (UMDPC, 2014). UMDPC is mandated to protect the public from malpractice of the professionals by disciplining the naughty ones, offering advice to the government on medical and dental professions as well as sensitizing the masses on professionals matters related to medical ethics (ibid.). UMDPC carries out different functions including registering and licensing qualified medical practitioners in private facilities, ensuring that all PHS units meet the requirements set by the council, conducting regular inspections on PHS, investigating all reported issues of malpractice and taking appropriate action on the culprits, monitoring the compliancy of PHS to the set standards, coordinating the regulation of PHS at national level but also in rural areas as well as participating in activities of East African Medical Council (UMDPC, 2014). UMDPC registers all medical training institutions both private and public in the country and monitors what is taught in those instructions to ensure that they match with the internationally set standard. The council also publishes the list of all training schools, lists of all private health units in the country that have been licensed to offer health services. The council has powers to withdraw licenses from individuals or facilities which do not meet the set standard and there is a guiding procedure for doing that. The inspection of PHS is done comprehensively with a list of different aspects that are monitored ranging from issues of cleanliness of the premises, quality of services, training of the staff, equipment in the facility

among other considerations. Inspection should be done in rural and urban areas with DHOs being delegated to oversee the work of inspection in rural areas. PHS units are then graded according to their performance in relation to different guidelines set and here a recommendation is made by a senior officer on whether the facility should either stop operating or should continue to work.

4.1.1.3 Allied Health Professionals' Council (AHPC)

AHPC was established by an Act of Parliament in 1996, cap 268 as a body corporate with a perpetual succession with powers to sue or be sued (AHPC, 2014). By law, an Allied health professional is any person who attains a qualification in health sciences, and registers with the council. Membership of the council is broad as it encompasses medical clinical officers, orthopedic officers, orthopedic technologists, psychiatric clinical officers, dispensers, medical laboratory technologists, ophthalmic clinical officers, anesthetic officers, public health dental officers, environmental health officers, health inspectors, and health assistants (AHPC, 2014). AHPC plays many functions like exercising general supervision and control over the health professionals, approving courses of study for health professionals, approving, supervising and regulating the training institutes for the different categories of Allied Health Professionals, as well as approving the qualifications awarded by the different institutes to health professionals (AHPC, 2014).

4.1.1.4 Pharmacy Council

The Pharmacy Council aims at protecting the general public from harmful and unethical pharmaceutical actions in the country (MOH, 2014). This is to be done through enforcing and ensuring compliance with standards of pharmacy practice in all districts, regulating the conduct and discipline of all pharmacists, keeping and updating a register of registered pharmacists, ensuring pharmacy training institutions are in line with the set standards, approving all pharmacy practice outlets both public and private, Carrying out continuous pharmacy education and boosting the community's ability to demand for quality pharmaceutical services (ibid.).

4.1.2 Legislation

Uganda has put in place a number of legislated regulations some of them dating back from the colonial times. These regulations have under gone a series of legislations in a way of

reviewing them to address the current health needs. Legislated laws in place provide for the establishment of professional bodies charged with responsibilities of overseeing the activities of professionals in both private and public sector (Birungi *et al.,* 2001). Various laws exist on aspects like operating a private health facility and professional bodies carry out the work of inspecting different interested investors to assess whether they meet the requirements. The Public Health Act (PHA) of 1935 explains the powers and responsibilities of different actors in the management of national health system as well as detailing on various aspects concerning handling of health related crimes (Wamala *et al.,* 2010; Birungi *et al.,* 2001). The Local Government Act (LGA) (1997) also mandates lower administrative units to collaborate with line ministries in implementing different government programs including regulation of PHS. The LGA calls for the formation of a district executive in which one of the five secretaries must be responsible for health services in the district (LGA, 1997). There is also National Food and Drugs Act (CAP 278) that explains issues about drug misuse and food poisoning in which people are allowed to report to the DHO drugs related offences and the DHO can order for the confiscation of such drugs (Wamala *et al*., 2010). MOH (2010) indicates that a number of bills are being revised such as PHA in order to fit in modern times. New bills are being debated including Pharmacy Profession and Practice Bill; Uganda Medicines Control Authority Bill; National Health Insurance Bill and the Traditional and Complimentary Regulatory Bill. The MOH indicates that this process is going slowly for example the review of PHA has been going on since 2000s (ibid). Also, Pharmacy Profession and Practice Bill and the National Policy on PPPH were initiated in 1999 and the process had not been completed by 2010 (MOH, 2010).

4.1.3 Market regulation

The government through various mechanisms has tried to regulate PHS by using professional bodies to restrict entry into the market but also coming up with policies aimed at influencing quality, increasing accessibility and increasing or reducing competition. Through UNDA, the government has managed to reduce wasteful competition or stimulate competition among pharmacies and drug shops in the country. This is done through issuing strict guidelines and requirements before being allowed to operate a pharmacy or a drug shop whether on whole sale or retail level (UNDA, 2013). Licensing a new drug shop or pharmacy puts into consideration the number of other facilities which already exist in the area and the population of the area. UNDA stipulates that no pharmacies for human drugs will be allowed to relocate into central division of Kampala from areas outside the division. Only pharmacies with in that

division can migrate to new places but such places should in a distance of 200 meters from the already existing pharmacies. Even outside Kampala, relocation of a drug shop has to be approved by UNDA and must be inspected to ensure that it meets the minimum stipulated distance from the existing drug shop. UNDA lists down different suburbs, municipalities and towns which are considered to be adequately served and as such no new drug shops or pharmacies are allowed there (UNDA, 2013). By being strict on distance between drug shops and pharmacies, UNDA aims to reduce wasteful competition as well as ensuring location of services to areas which are under served. The government has also influenced health care markets by attracting many foreign investors to come and invest in health sector by establishing hospitals, pharmacies as well as drug manufacturing (MOH, 2012). There are various health projects which the government implements through working with PHS such as family planning, and immunization (MOH, *et al*., 2012). This is because some areas don't have public facilities and in that case government collaborates with PHS to provide subsidized services in such areas. Most of these collaborations are disease based especially when the government realizes that a certain disease has become a challenge in that area (Taylor, 2011). The government has been working on consumer protection through UNDA by scrutinizing the drug related advertisements. Through various forms of consumer awareness, the government has tried to influence market tendencies for instance the government marking drugs which are meant to be given out to people freely through PHS facilities is meant to reduce consumer exploitation. Wamala *et al*., (2009) indicate that Uganda is a member of WHO and as such it has to abide by International Health Regulations (IHR[2005]) that were set as legally binding for all member states with the intention of streamlining the protection of public health without necessarily sabotaging business in the health sector.

4.1.4 Licensing, certification and accreditation

Laws in Uganda indicate that one needs to obtain a license before beginning to operate a health facility or drug shop and it allows different bodies to carry out the duty of scrutinizing to see those who meet the requirements (UMDPC, 2014). This approach is related to market regulation because through licensing, the government restricts entry into the market depending on the health needs in the country. Different professional bodies issue licenses to different professionals as well as licensing their facilities. Most of the licenses offered in Uganda are short term in most cases renewable every year and there are conditions given to PHS before they can renew their licenses. For example UNMC issues out licenses to nurses and midwives for one year and before they are renewed, a decision is based on their

performance and attainment of more training for at least fifty hours. These professional bodies also regulate the activities of training institutions by licensing new institutions taking into consideration the quality issues as well as national health policies. Licensing is one way in which professional bodies generate funds to run their activities since PHS pay money to be registered as well as obtaining certificates (MOH, *et al.,* 2012).

4.1.5 Incentive Based regulation in Uganda

The government offers subsidies to the PHS in form of offering training to private health care workers, offering some medical equipment, giving some contracts to PHS to implement some health policies in certain areas, lobbying foreign resources to help in the expansion of private facilities (Birungi *et al*., 2001). The government sometimes provides direct financial incentives to the PHS especially established hospitals and institutions training health personnel. In rare cases, the government offers loans to private practitioners to be able to expand their facilities. However studies indicate a few instances where government provides direct incentives to PHS (ibid.). The government under MOH in collaboration with International NGOs and donors has been organizing workshops and refresher courses in which private sector workers are also invited to attend (HIPS Annual Report, 2013). This is to orient PHS about modern techniques required in the medical field, sensitizing them about new dangers and epidemics. This is intended to boost their efficiency at work in a way of working towards attaining national health plans. HIPS, a USAID funded project has been involved in incentive-based regulation through helping PHS to secure bank loans, linking the partner clinics to necessary training and mentoring programs usually for free or subsidized costs in order to raise their ability to provide quality services. HIPS provides knowledge about reliable supply chains by collaborating with other actors like Uganda Manufacturers Association (UMA), Uganda Health Marketing Group (UHMG), Joint Medical Stores (JMS) to ensure the continuous supply of essential drugs and medical equipment to partner clinics with a view of reducing stock outs (HIPS Annual Report, 2013).

The above discussion has helped the research to answer the research question 1(a) about approaches used to regulate PHS in Uganda. The discussion shows that self-regulation through professional bodies is widely used and UMDPC as well as UNMC can be seen as working hard to improve the services in PHS. Other forms like legislation, licensing, market regulation, and incentive based regulation are applied to regulate PHS in Uganda.

4.2 Governance and regulation in Uganda

Under this part, the researcher will answer the research question 1(b) about how regulation is governed in Uganda. Governance has been mentioned by different scholars as an important aspect in fostering regulation since it influences policies, participation, funding and monitoring (Rockefeller Foundation, 2008). The researcher under this will discuss Uganda National Drugs Authority (UNDA) which governs drugs and medicines in the country, different stakeholders involved in regulation, as well as decentralization to see how regulation is done at lower levels.

4.2.1 Uganda National Drug Authority (UNDA)

This is a nonprofessional body which also takes part in regulation of activities of PHS in HCD. The UNDA was established as a regulatory body in charge of regulating drugs in the country. This was provided for under National Drug Policy and Authority (NDP/A) Act, Cap. 206 to guarantee the availability at all times of essential, efficacious and cost effective drugs to the people of Uganda as a mechanism to ensure satisfactory health care and safeguarding the appropriate use of drugs (MOH, 2014). The aim of UNDA is to protect the general public especially in terms of ensuring quality, safety and efficacy of human and veterinary medicines and other health care products through the regulation and control of their production, importation, distribution, use, and advertisements (ibid.). Functions of UNDA include ensuring the regulation of pharmacies and drugs in the country by controlling the importation and exportation or sale of pharmaceuticals insisting on quality of drugs, promoting and overseeing the local production of essential drugs, encouraging research and development of herbal medicine, putting in place as well as reviewing professional guidelines, providing information to professional, disseminating information to the public as well as giving advice concerning National drug policy (UNDA, 2014). UNDA carries out registration of drugs and medicines before being supplied in the market, inspecting and licensing all pharmacies and outlets, inspecting foreign pharmaceuticals producing drugs in Uganda, licensing medicine importers, screening and monitoring drug adverts, assessing medicines for quality, safety and efficacy in the country. This done by concentrating on importers, wholesale pharmacies, retailers, drug shops, health clinics, manufacturers and hospital dispensaries (UNDA, 2014).

4.2.2 Other stakeholders in regulation

Regulation of PHS is done by different other actors other than professional bodies which by law are mandated to regulate the health care system. Other actors who play regulatory role in Uganda include the police, media, patient organizations, NGOs, business community especially insurance companies which contract services of the PHS, community leaders among others (Birungi *et al*., 2001). These actors influence the activities of PHS in varying degrees for instance the police have a legal mandate to arrest and prosecute medical workers who are found to be engaged in medical malpractices. The role of police is not to target PHS necessarily but its mandate extends to the public sector as well. The media both newspapers, radios and Television stations influence the activities of PHS by reporting on services offered in different facilities as well as publishing different scandals committed in different facilities. NGOs regulate PHS by using incentives where NGOs and donor organizations offer some contracts to PHS to implement some health related projects like family planning, distribution of condoms, male circumcision, among other projects (HIPS Annual Report, 2013). NGOs which have participated in this collaboration include Marie Stopes International and World Vision (MOH, 2013). Through advocacy, NGOs also try to influence the activities of PHS by working to empower the community into demanding for better services. There are a few patient organizations which have also been involved in advocating for quality services as well as good conduct during delivery of health services. The notable example of patient organization include National Forum for People Living with HIV AIDs Network (NAFOPHANU), Uganda Alliance of Patients' Organizations (UAPO) and Uganda Health Consumers Association (UHCA) all of which work towards empowering patients to get quality services (MOH, *et al*., 2012). Insurance companies and corporate bodies which insure their employees in Private facilities find themselves in one way or the other influencing the level of services in PHS. Community leaders like Local councils, Parish chiefs, sub-county heads and other local leaders are supposed to monitor PHS by checking to see if those practitioners are licensed (ibid.).Donors also participate in the regulation of PHS in Uganda for instance Health Initiatives for the Private Sector (HIPS) a USAID funded project works closely with all partners to ensure that services provided by PHS meet national quality standards (HIPS Annual Report, 2013). HIPS facilitates regular and comprehensive support through supervision of different PHS to ensure that health workers are effectively trained and clinics have regular supplies, equipment and referral networks for proper diagnosis and treatment (ibid.). HIPS has also enhanced the formation and launching various key private sector support mechanisms aimed at boosting and sustaining the PHS. They include the Uganda Health Federation (UHF) which has fostered a unified voice that advocates for the

interests of PHS as well as addressing pertinent issues such as quality standards (HIPS Annual Report, 2013).

4.2.3 Decentralization and health sector regulation in Uganda

The current legislation in Uganda provides for lower administrative units ranging from districts, counties, sub-counties, parishes and villages which are the smallest units (LGA, 1997). The regulation of health activities in the district is coordinated at the district center by the district health team headed by DHO in collaboration with other officers like District Health Inspector, Senior Nursing officer, medical superintendents of the hospitals, and all members of district health management committee (Birungi *et al*., 2001). District authorities have powers to supervise and regulate activities in social sectors like education, health and environment. LGA provides for a district executive in which one of the secretaries must be a for health and children affairs responsible for among others monitoring the performance of health facilities both private and public in the district (ibid.). Studies carried out in Uganda indicate that there are many drug shops operating in rural areas without licenses run by untrained people (Konde-Lule *et al*., 2006; Stanback *et al*., 2011; Awor *et al*., 2012). Therefore decentralization of regulation is in response to trends of people continuing to operate illegal clinics and drug shops (MOH, 2010). Regulatory framework in Uganda indicates that professional bodies as well as MOH are meant to collaborate with districts by delegating some of the regulatory roles to DHOs (Konde-Lule *et al.,* 2006). The DHOs are charged with the duty of supervising the activities of the PHS by carrying out regular visits to different clinics and hospitals to inspect the quality of the services provided. The DHOs are supposed to carry out assessment of all those who intend to open new drug shops and clinics by inspecting their premises, evaluating their qualifications and making necessary recommendations to the UMDPC which is a professional council entrusted with the duty of approving and licensing new clinics and hospitals. The Health Unit Management Committee (HUMC) is meant to ensure community connection with activities taking place in the healthy facilities. This is done by collaborating with community leaders to foster sensitization of the public about services offered in different facilities (MOH, *et al*., 2012).

This part has helped the researcher to answer the research question 1(b) about how regulation is governed in Uganda. The researcher has discussed the role of UNDA as a body which governs drugs and medicines in the country. The study has also shown how regulation in Uganda involves different stakeholders like NGOs, donors, police, local leaders and

business community. This section has also explained how regulation is decentralized up to lower levels.

4.3 Quality of regulation in Uganda

This part gives a descriptive explanation of issues involved in regulation of PHS with the view of ensuring quality in regulation. Aspects concerning quality assurance measure in regulation, institutional capacity, enforcement and compliancy will be discussed in order to answer research question 1(c) about how quality is ensured in regulation of PHS in Uganda.

4.3.1 Quality assurance measures in Uganda

Different measures have been put in place to ensure quality in regulation in a way of fostering quality of HCD in the country. The MOH reserves the mandate to ensure regulation of health services offered by different providers in order to be able to monitor and supervise how different providers are working towards meeting their expectations (Taylor, 2011). MOH works with different organs including professional bodies, UNDA, local governments, NGOs and donor organizations (HIPS Annual Report, 2013). Different legislations have been put in place streamlining the activities of professional councils and other regulatory bodies as well as reviewing some of the old laws in order to make them adaptable to ensuring proper regulation of PHS. Different laws are being amended such as PHA, Consumer Protection Act in order to ensure quality in regulation of PHS (MOH, 2012). Uganda has prioritized decentralization in which the country is increasingly being sub-divided into more districts and sub-counties. The number of district today stands at 112 with each district having health offices and some personnel necessary to coordinate health activities in the area (MOH, 2013). The government believes that decentralization brings services nearer to the people especially administrative services. It is argued that splitting bigger districts into many districts and putting up health offices in each of those districts will improve monitoring of health services as well as easing regulation enforcement (ibid.). Even at district level, health department is more subdivided leading to creation of health sub-districts with a view of monitoring health activities in a small geographical area (ibid.). The collaboration between different actors both in bureaucratic, political wing, civil society and NGOs, is meant to ensure quality regulation. Leaders at all levels are meant to exert pressure on PHS in order to improve quality of services. The government has liberalized health care market as well as attraction of foreign investors and encouragement of local entrepreneurs with the view of increasing the number of

service providers in the country (MOH, 2013). This is meant to increase efficiency in health sector through increased competition in which different providers will work towards maintaining a large market share. The professional bodies have issued tight guidelines for licensing PHS in which emphasis is put on qualifications of the practitioners and standard of the health facility (UMDPC, 2014). By issuing licenses for only one year, professional bodies are able to enhance performance of professionals who have to work hard in order to have their licenses renewed as renewal requires one to have attained more professional training (ibid.). The professional councils promote professionalism by encouraging every member to buy the code of conduct leaflet and also being strict on institutions that train medical workers by supervising the exams they do and ensuring that those who come out of those institutions are of required quality (UNMC, 2014). The MOH in collaboration with Kampala Capital City Authority has embarked on crackdown of all illegal drug shops and clinics that operate in Kampala with an intention of stumping out those who do not meet the standard and sub-standard drug shops have been forced to close in Kampala and a few other major towns MOH promises to continue the campaign to rural areas (MOH, 2014).

4.3.2 Institutional capacity in Uganda

Different authors have argued that there is nearly enough legal framework to enable the MOH to carry out the work of regulating private sector (Taylor, 2011; Birungi *et al*., 2001; Konde-Lule *et al*., 2006; Stanback *et al*., 2011). Different laws like PHA, Consumer Protection Act are being worked on to help in the regulation of PHS (MOH, 2012). The MOH has opened up regional offices of professional bodies and recruited more professional staff to streamline the work of regulating the activities of PHS (MOH, 2013). However the challenge still remains with enforcement of these laws which partly explains why many clinics and drug shops continue to operate illegally (Konde-Lule *et al*., 2006). Governance of health sector in Uganda has created challenges with concentrating powers in the public sector leaving the PHS biased about the regulation (Birungi *et al*., 2001). There are still funding challenges in the MOH as the ministry's share on the national budget continues to be low (only 7%) which makes it hard for the ministry to reserve enough funds for the regulation of PHS which explains why the ministry has always relied on self-regulation and market forces (HIPS Annual Report, 2013). Scholars argue that the creation of new districts necessitates increased government spending to put up health offices and facilitate them with funding and other requirements. However studies indicate that capacities are still very low especially in hard to reach districts where even the public sector is lacking enough staff to fill important positions

to ensure supervisory functions (MOH, *et al.,*2012). The professional councils which are expected to deliver in terms of ensuring high quality standard are themselves not properly facilitated and this explains why their influence has only remained visible in urban areas living rural private sector almost unregulated (ibid.). These councils lack funds necessary for monitoring PHS and as such inspection is only done when issuing licenses (MOH *et al*., 2012). Some leaders in professional councils are part of PHS which makes it hard for them to effectively discharge their duties without playing double standard. Different actors who would add much value to influencing the activities of PHS are either reluctant or not empowered enough to actively participate in influencing the PHS. The level of community participation is low and nonexistent in some remote areas because people do not know the best health practice. Consumers don't have power to influence the prices charged by the PHS. Capacity of both government and civil society is still low with regard to sensitizing the public about the demanding for better services. MOH doesn't have fully compiled data about the presence of PHS, their location and the kind of services they offer which makes the planning of the health sector challenging. Other actors like NGOs and donor organizations try working with PHS but their coverage is low since they only work in a few areas with selected clinics and private hospitals (HIPS Annual Report, 2013).

4.3.3 Regulation enforcement in Uganda

Standback *et al.* (2011) indicate that drug shops in Uganda operate without license and others sell a variety of prescription drugs- including those requiring injection- and also provide care and treatment, even though 30% of drug shop attendants lack any medical qualifications yet the law in place prohibits such practices. There is still some laxity in laws as well as issues of monitoring for instance Standback *et al.* (2011) indicate that unlicensed drug shops and clinics operate openly without any interference from UNDA or health authorities in the area. Professional bodies have tried in enforcing regulation especially by insisting on qualifications before issuing licenses, monitoring the training of health workers, and making necessary recommendations to the government when consulted (UMDPC, 2014). The challenge is that these bodies are less visible in rural districts. The fact that these councils get insufficient funds from MOH and through licensing has rendered them less influential for instance their revenues dropped from UG shilling 95 million to 20 million UG shillings in 2012 due to reduced number of professionals renewing their licenses and this leads to over dependence on MOH for further funding (MOH, *et al*., 2012). The MOH notes that many newly created districts lack staff that possesses management and leadership skills required to perform

government functions including monitoring and supervisory functions (ibid.). For instance the DHOs are supposed to monitor all health services in the district both private and public, enhancing community participation in health planning and management of health service delivery, as well as formulating and passing health related by-laws (LGA, 1997). However scholars indicate that most of these have not been done partly because of limited capacity in terms of resources and expertise (MOH, *et al*., 2012). This explains why some scholars have begun to question the theorized benefits of decentralization as proposed by World Bank to be ensuring high service delivery. Uganda's case indicate that the number of districts has raised from 34 in 1990 to 112 in 2010 with some districts lacking enough staff and facilities (MOH, *et al.,* 2012). It is important to note that these challenges of enforcement are not unique to Uganda only, for instance a study in Kenya and Ghana by Sood *et al.* (2011) indicates that much as 90% of health facilities had ever been inspected in 2 years, only 35% in Ghana and 10% in Kenya mentioned they had ever heard of a case in which a facility had ever been punished for malpractice.

This part has helped the researcher to answer research question 1 (c) about how quality is ensured in regulation in Uganda. The study has discussed different laws which have been enacted to streamline the work of regulation, how decentralization has been emphasized with hope that it can improve quality of regulation, and incentives which are meant to increase compliancy.

Chapter 5

5. Analysis

Under this chapter, the researcher has used analytical framework that has been explained in chapter 3 to interpret findings and fully answer the research questions. The researcher has looked at how different regulatory mechanisms suggested by different scholars are being used to address key areas that form the rationale for regulation of PHS. Each aspect that forms the rationale for regulation has been analyzed in relation to all regulatory mechanisms in order to ascertain which market failure is being addressed by which mechanism. The researcher has analyzed how different mechanisms used are able to influence quality, price, distribution, competition and addressing malpractice in PHS. Discussion in chapter 3.4 explains how regulation of PHS is dependent on governance issues such as institutional capacity, involvement of all stakeholders, and how regulation is decentralized. The researcher has analyzed Uganda's case to see how these key governance areas are addressed. The researcher has used five principles of good regulation to analyze the quality of regulation in Uganda. These include proportionality, accountability, consistency, transparency and targeting.

5.1 Analysis of how regulatory mechanisms address market failures

As pointed out in chapter 3, regulation is meant to target health market failures which are linked to quality, price, distribution, competition and malpractice (Busse *et al.,* 2003). These approaches include self-regulation, incentive-based regulation, market regulation, licensing and legislation. Therefore, analyzing how regulation addresses these key areas will help the researcher to answer the third research question about which market failures are addressed by regulation in Uganda. The researcher has analyzed regulatory mechanisms in relation to market failures because these mechanisms are meant to address such market failures. Here the researcher will establish which mechanisms are more effective in addressing different market failures as each health market variable will be analyzed to see which mechanisms are being used to address market failures relating to that variable.

5.1.1 Quality of services

Findings of the study indicate that Uganda is highly using self-regulation through professional bodies to regulate PHS in order to raise the quality of services. These professional bodies monitor quality through licensing new professionals, certification and accreditation as well as

constant monitoring of activities of PHS. These bodies also monitor the quality of training institutions. However, these bodies have not ensured the expected quality because of limited funding from the government which has forced these bodies to rely on license fees as source of funding. This leads to understaffing and lack of branches outside main towns (MOH, 2013). MOH indicates that funding for these bodies is still low and that this has hindered their work of monitoring quality especially in rural areas (ibid.).

Incentive-based regulation has improved quality of services where it used especially through contracting, giving out pre-packaged drugs, use of vouchers, training of private practitioners and providing them with equipment and subsidized drugs (HIPS Annual Report, 2013). However these initiatives are still in selected facilities and mostly used by NGOs and donor agencies. Legislation has not showed much result with regard to quality since level of enforcement is low. The crackdown of low quality clinics and drug shops has only worked in main towns. Regulating competition doesn't reflect on quality because consumers lack knowledge of good medical practices and as such they can't put pressure PHS for quality services (MOH, *et al*., 2012).

5.1.2 Distribution of services

Legislation has helped UNDA to work towards ensuring fair distribution of drug shops and pharmacies by restricting the new entrants in the market in areas which are considered fully served. Publishing towns and areas where no new pharmacies and drug shops are allowed has helped to extend services to areas which are still underserved (UNDA, 2013). Market regulation especially opening up markets in the health sector has attracted many private practitioners to extended services to areas where government is not able to reach. Incentive-based regulation has improved access and distribution of services especially where vouchers and prepackaged drugs are used. However, incentive-based regulation is still narrow based considering the fact that most initiatives are either brought up by NGOs or donor agencies with government concentrating on the public sector (Birungi *et al*., 2001). Busse *et al*. (2003) highlight a number of incentives like offering training and professional development opportunities, low cost loans, tax incentives, concessions, Social marketing programs, and management training. These initiatives are still underdeveloped in Uganda yet studies show that countries which have adopted a wide range of incentives have improved distribution and quality of services. For instance elimination of duties on commercial importation of contraceptives and elimination of price control measures in Ghana has increased the accessibility of health services through regular supplies and lower prices (ibid.).

5.1.3 Regulating prices

Incentive-based regulation has tried to regulate prices especially where government and NGOs give out vouchers, or supply prepackaged drugs as well as contracting services of the PHS in order to give customers subsidized services (MOH, 2013). However, it should be understood that these measure are not countrywide but rather project based targeting a certain disease or implementing some health project. For instance Marie Stopes Uganda has been contracting PHS to provide subsidized reproductive health services (ibid.). There is no legislation in the country concerning prices according to the data that this study has come across since the government is running a liberal economy where market forces determine prices. Much as prices may be influenced by the fact that government allows many actors to enter into health care market, this does not directly influence prices partly because of high demand for health services and perceived high quality in the PHS (Birungi *et al*., 2001). This explains why different scholars argue that regulation in Uganda is not consumer-based but market based considering the fact that it does not regulate prices yet many people cannot afford higher prices (ibid.). Health indicators may worsen if prices remain unregulated.

5.1.4 Regulating competition

Scholars believe that competition should be regulated either to increase the availability of services, or to enhance quality of services as providers struggle to attain a large market share (Busse *et al*., 2003). Regulating competition is meant to help in balancing supply and demand but also helping to direct resources to areas which are of public interest like maternal and child health (ibid.). There have been attempts to regulate competition in Uganda especially by UNDA, by being strict on distance from one drug shop to another for instance in Kampala, a pharmacy should at least be located 200 meters from the one another which is meant to ensure fair distribution but also reduce wasteful competition (UNDA, 2013). UNDA earmarked most of the suburbs in Kampala and surrounding as being fully served and therefore new drug shops are not allowed in such places. This has paved way for relocation of some drug shops in underserved areas. Increasing competition by allowing foreign investors especially in the pharmacy sector has helped in the ensuring regular supply of essential drugs and equipment, but positive outcome from increasing number of clinics is still questioned by scholars who think that the large number of providers has failed to guarantee quality (Birungi *et al*., 2001).

5.1.5 Regulating malpractice

Professional bodies and other stakeholders like patient organizations, police and the general public have tried to regulate malpractice in the PHS. UMDPC provides guidelines to follow when reporting malpractice and how the complaint can be handled (UMDPC, 2014). Much as these guidelines are available on the body's web site, many people lack knowledge about laws and what entails medical malpractice. This explains why issues like forced treatment, and reuse of syringes have continued to happen unreported. UMDPC is under stuffed hence not able to handle complaints raised relating medical malpractice (MOH, *et al*., 2012). However these bodies are trying to regulate malpractice as different cases have been reported and handled and in extreme cases, licenses of culprits have been withdrawn and this is a positive trend towards stamping out malpractice in the PHS (UMDPC, 2014). It has to be recalled that resources are not enough to fully monitor and follow up on all issues of malpractice.

Under this part, the researcher has succeeded in answering the third research question which asks the health market failures which are addressed by regulation. The study has found out that different approaches used to regulate PHS are influencing health market variables like quality, access, distribution, price and competition to address market failure within those aspects. Whereas professional bodies and incentive-based regulation have tried to influence quality of services, more efforts are needed especially to influence price since many people cannot afford high prices. Market regulation has not stimulated enough competition to bring down the prices as well as raising quality since people are not aware of what makes good quality services. Incentive-based regulation and legislation are helping on increasing distribution especially where vouchers and prepackaged drugs are distributed through PHS.

5.2 Analysis of governance issues related to regulation

As earlier noted in chapter 3.4 above, governance forms a big aspect of regulation since governance is likely to influence policies, monitoring, participation, enforcement and funding (Taylor 2011, Rockefeller Foundation, 2008). The researcher has analyzed governance aspects like institutional capacity, decentralizing regulation, and stakeholder involvement in the process of regulation in relation to how these aspects have been discussed in chapter 3.4.

5.2.1 Institutional capacity

Whereas different laws are in place streamlining how PHS should be regulated in Uganda, there has been a reported challenge of implementation and compliance which can be

explained in line with low institutional capacity. The funding of health sector in general is far lower than the recommended (only 7% of the national budget) (MOH, 2013). MOH allocates little funds to regulation and monitoring. Reports indicate that creation of new districts has not been accompanied by increments in funding and this has complicated service delivery (MOH, *et al*., 2012). The low speed at which regulation laws are being debated in parliament also frustrates the initiatives to regulation for instance the PHA has been on floor of parliament for over 10 years. Birungi *et al*. (2001) indicates that government has tried to initiate some level of collaboration with the PHS but this requires developing a proper framework for engagement. Walt (1996) argues in Birungi *et al.* (2001) that Public Private Partnership in Health (PPPH) requires the government to comprehensively address various policy issues concerning legislation, monitoring, and enforcement to be able to harness the fruits of PPPH. The increasing number of PHS both licensed and unlicensed has created challenges for planning and implementation of meaningful engagement (Stanback *et al*., 2011; Birungi *et al.,* 2001). The continuous isolation of PHS in national health planning and planning at the district level as well as poor communication channels between policy makers and PHS has made engagement challenging. Studies show that although planning process seems participatory, the outcomes of those plans are not representative of different actors especially PHS (MOH, *et al.,* 2012). This is worsened by low levels of subsidies, low incentives to induce the PHS and limited capacity to effectively regulate PHS towards desirable directions which has left the PHS fairly out national policies. It is also argued that most initiatives of MOH usually target public sector as well as religious based private sector giving less attention to PHS which biases PHS into thinking that government asks them too high standard which is not reflected in Public Sector. For instance the law which prohibits any medical personnel from operating a private clinic until the person obtains three years of experience yet public sector recruits interns to manage wards of over 200 patients (Birungi *et al.* 2001). Scholars have also maintained that PHS in Uganda is highly segmented with most of it operating illegal facilities which make it hard for them to benefit from PPPH (Standback *et al.,* 2011; Konde-Lule *et al*., 2006; Taylor, 2011). With number of PHS estimated to be more than 4000 facilities in the country, Statistics show that only 514 (9.2%) facilities are registered with health authorities which further indicates limited capacity (MOH, 2013).

5.2.2 Decentralizing regulation

Studies indicate that capacities at local government level are very low especially in newly created districts (MOH, *et al*., 2012). Whereas government has created many new districts

with the view of increasing service delivery, this has been frustrated by limited funding of districts and inadequate staff to carry out regulation of PHS (ibid.). The VHTs, HUMCs and CHWs are inactive in some areas. The fact that people are not sensitized about good health services reduces their ability to demand for better services from PHS. Whereas regulation has made positive impact in urban areas, rural areas have continued to be served by poorly trained practitioners who put human lives at risk (Standback *et al.,* 2011; Awor *et al*., 2012). There have been attempts to set up regional offices for professional bodies but funding has not been enough to help them recruit enough staff.

5.2.3 Involving key stakeholders

Uganda has tried to make the regulation framework inclusive by allowing different actors to participate in the process (MOH, 2010). Different workshops and conferences are being organized by the MOH in which different actors like PHS, civil society and public sector are invited to participate. However it can also be seen that participation is still concentrated at national level involving well-established PHS. By living out the majority of the PHS who operate at lower levels in most of these initiatives, the government is losing out on the point of implementation and compliance since these small clinics are the ones serving majority of Ugandans who cannot afford high prices charged in the established private facilities (Birungi *et al*., 2001). Birungi *et al*. (2001) indicate that most initiatives of PPPH left out most of the important stakeholders like PHS especially those based in rural areas. Scholars maintain that any attempts to boost HCD should concentrate on improving the capacity of the lower level providers since they are closer to poor people (Hongoro & Kumaranayake, 2000). Scholars indicate that the era of having a commanding state is gone and that what we have now is governance through partnership (Kadaï *et al.,* 2006:897).The level of community participation is low and nonexistent in some remote areas. It can also be noted that consumers lack power to influence the prices charged by the PHS. This shows that capacity of different actors especially the government and civil society is still low with regard to sensitizing the public about demanding for better services. MOH has not compiled data about the presence of PHS, their location and the kind of services they offer which makes the planning of the health sector challenging. Other actors like NGOs and donor organizations try to work with PHS but their coverage is low since they only work in a few areas with selected clinics and private hospitals (HIPS Annual Report, 2013).

The analysis of governance of regulation in Uganda has helped the researcher to point out some strengths and challenges. The above discussion indicates that regulation is

participatory especially involving NGOs, donors, police, and PHS. Decentralization is also a good approach to help in monitoring HCD at lower levels. However, some challenges are worth mentioning. These include; poor institutional capacity due to limited funding, lack of independence of professional bodies since members are part of PHS, low level of engagement with PHS, the PHS is too large and fragmented, low reporting of PHS about their activities, lack of adequate knowledge on the side of consumers to influence private sector, and lack of offices at the local levels by regulatory bodies. Understanding these facts helps to know which areas need improvement.

5.3 Analyzing quality of regulation in Uganda using principles of good regulation

Under this, the researcher will assess the quality of regulation in Uganda in relation to principles of good regulation. Bundred (2006) believes that principles can form a standard tool for measuring and improving regulation, easing enforcement, and providing for negotiation between government and different stakeholders. The principles that will be considered here include proportionality, accountability, consistency, transparency and targeting. This will help the researcher to answer the third research question concerning quality of regulation in Uganda in relation to best known practice. This will help the researcher to understand where regulation needs to be improved with view of improving HCD since these principles were developed by BRT to guide regulation in UK and other countries to ensure that regulations are fair, effective and enforceable.

5.3.1 Proportionality

BRT (2003) argues that regulators should only intervene when it is necessary and regulations should be responding to the risk being posed. In Uganda's case, it can be seen that there are many market failures which have been highlighted by different scholars ranging from decreasing quality of care in private sector, concentration in urban areas targeting the high income customers, health malpractice, inappropriate technology and the rate at which unlicensed drug shops and clinics are opening (MOH, *et al*., 2012; Standback *et al.,* 2011; Konde-Lule *et al*., 2006; Taylor, 2011; Birungi *et al.,* 2001). This implies that regulations in Uganda are a response to the need to improve HCD. According to data obtained from MOH and other researchers, Uganda's regulations can be considered proportional to the perceived dangers of unregulated PHS considering the fact that the country is struggling to meet the MDGs by 2015. However, Uganda's problemscome at implementation stage where the level of enforcement has continued to be low even when there are obvious risks like untrained

workers (Konde-Lule *et al.,* 2006). In this case, regulation enforcement is less proportional to the risks posed on human life. Scholars believe that the problem of LICs is not necessarily lack of legislated laws of regulating PHS but rather lack of enough resources and capacity to enforce the legislations already in place (Mills, *et al*., 2002; Hongoro & Kumaranayake, 2000; Bundred, 2006). However, some scholars who have conducted their field studies in Uganda believe that enforcing a strict regulation in Uganda may cause more harm than good considering the fact that small clinics and drug shops are more adaptable to consumers' demands especially accessibility and lower prices hence filling the gap caused by inadequate public facilities (Konde-Lule *et al*., 2006; Standback *et al.,* 2011; Awor *et al*., 2012). These scholars argue that instead of condemning unlicensed and informal providers, the government should train them, help them to access regular supplies of essential drugs and equipment like syringes since they are already meeting the demands of many poor people. Other scholars who have conducted studies aimed at improving capacities of PHS in LICs have made similar recommendations especially putting emphasis on offering training, use of vouchers, pre-packaging of drugs, franchising, accreditation and contracting-out and regular monitoring (Patouillard *et al.,* 2007; Hongoro & Kumaranayake, 2000; Busse *et al*., 2003). This is because disproportional regulation has the potential to put most small business at risk yet scholars argue that most PHS in Uganda operate at health Centre level (MOH, 2013).

5.3.2 Accountability

This principle demands that regulators should be accountable to the public by coming out clearly to justify their decisions and actions (BRT, 2003). In Uganda, there are attempts by different regulatory agencies to be accountable to the public but this is at different levels for different bodies. UNDA has tried to carry out mass sensitization of the public about dangers of buying drugs from unlicensed drug shops in order to justify its policy of cracking down on some of the illegal drug outlets (UNDA, 2013). UNDA has tried to explain the reasons for its strictness on licensing new drug shops and pharmacies especially empathizing qualifications and distance from another drug shop or pharmacy. UNDA aims to ensure fair distribution of services by restricting business in areas which are already properly served (ibid.). Pharmacy council has also tried to foster accountability to the public by publishing its annual performance reports highlighting on different aspects concerning measures being taken to improve their profession (MOH, *et al*., 2012). Much as UMDPC provides guidelines to the public about how to report malpractice, this information is not known to the public which leaves a big gap between regulators and the people they intend to protect. Therefore in terms

of accountability, the regulators in Uganda are not yet fully accessible since they do not periodically report their progress to local councils, MOH, and parliament. Much as VHTs and CHWs are meant to provide health information to the public, reports indicate that in most districts these structures are inactive (MOH, *et al.,* 2012). As noted earlier in chapter 3.4, regulation can only be effective if there is involvement of all stakeholders and proper accountability to the PHS, civil society, general public, parliament, as well as local leaders (Kadaï *et al*., 2006; Busse *et al.,* 2003; Awor *et al*., 2012). Limited accountability on the side of regulators has made PHS to be biased about the whole process thinking that regulation is only targeting them and that government behaves as if everything in public sector is fine and all services in PHS are poor (Birungi *et al.* 2001).

5.3.3 Consistency

This principle calls for harmonization of regulation so that implementing bodies are consistent with each other as well as not violating international agreed standards or other national, regional or international laws (BRT, 2003). The government of Uganda has tried to ensure consistency in its regulations especially by working hard to operationalize different statutes in order to provide a legal framework in which regulation should take place (MOH, 2013). However, the speed at which laws are amended or debated is low for instance PHA has been on floor of parliament for over 10 years (MOH, *et al*., 2012). Wamala *et al.,* (2009) indicate that Uganda is a member of WHO and as such it has to abide by IHR of 2005 that were set as legally binding for all member states with the intention of streamlining the protection of public health without necessarily sabotaging business in the health sector. Uganda has been trying to ensure stability of regulations since most regulations have been in place for quite long time and the process of amending new regulations is always slow to allow PHS to adjust towards the requirements of new regulations. The only side of inconsistency and unfairness lies with too much strictness put on PHS compared to public sector (Birungi *et al*., 2001). Scholars cite inconsistencies like emphasis on one three years working experience for one to operate a small private clinic yet government hires interns to manage public hospitals which sounds as if regulation only aims to improve quality in the PHS leaving the public sector unregulated (ibid.). There is need for more consistency in designing policies that strike a balance between market forces and national health plans of providing quality services to all Ugandans (MOH, 2013). Whereas there are some inconsistencies cited in the regulation for instance leaving some informal providers and unlicensed health workers to continue operating, some scholars think that such inconsistences and reservations are reasonable since

the government has no capacity to fully provide services or commit many resourcesto regulating the PHS (Konde-Lule *et al*., 2006).

5.3.4 Transparency

This principle calls for proper communication to all the concerned parties about the need for regulation as well as having more consultations to get the input of different actors (BRT, 2003). Regulation in Uganda accommodates the inputs of different actors including PHS, civil society, NGOs, government, local leaders, patients' organizations, and general community (MOH, 2013). Even at local levels, community participation is encouraged through CHWs. However, studies indicate that this arrangement is still weak with some districts have no CHWs and HUMCs to sensitize people about what is going on in the health sector (MOH, *et al.,* 2012). It is further indicated that even the information in the suggestion boxes is not taken seriously (ibid.). Studies indicate lack of transparency from the side of regulatory bodies as some of them have been documented for not even publishing the lists of professionals who are licensed (MOH, *et al.,* 2012). The UMDPC and UNMC have lists of training institutions which are licensed on their official websites but this is not the best channel of communication since many people in Uganda do not have access to internet (UBOS, 2013). This principle also asks governments to give necessary support to the PHS in order to comply with the new regulations which is still lacking in Uganda especially looking at low levels of PPPH (MOH, 2013). Much as government has always invited different actors to take part in designing policies in the health sector, the outcomes of those policies barely reflect interests of PHS and this complicates compliancy (MOH, *et al.,* 2012; Birungi *et al.,* 2001). As noted earlier in chapter 3.4, regulation needs support from key stakeholders including those who will be affected directly to be effectively implemented (Bundred, 2006; Kadaï *et al*., 2006). Thus, Burger *et al*. (2012) argue that PHS can only be part of sustainable solution of ensuring access to quality health care if their ability is enhanced to improve the quality and quantity of the services they provide. And in doing this, government through regulation should work to address challenges of PHS (ibid.). Therefore Mills *et al*. (2002) suggest that direct consumer education on better health practices can help to empower consumers in health care markets of LICs. However, Taylor (2011) basing on his study about regulation of private health insurance in Uganda indicates that regulation requires strong leadership which he says is still lacking in most LICs because of constrained resources. He is therefore skeptical about depending on government to address market failures in health sector yet PHS itself came as a response to government failures.

5.3.5 Targeting

Uganda has been focused towards a goal based approach by targeting specific problem especially access to health services (MOH, 2013). The government has also been trying to work on a number of laws aimed at streamlining the regulation of health services. Different laws are under review like Consumer Protection Act, Public Health Act among others in order to suit them into the modern situation (MOH, *et al*., 2012). Incentive-based regulation in which government has been offering specialized training to the PHS workers, prepackaged drugs, vouchers, and contracting the PHS to carry out certain projects has helped to realize results especially in maternal and child health (Awor, *et al*., 2012; MOH, 2013). This has been a good step towards enforcing the 'targeting' principle of regulation. NGOs and donor agencies have tried to ensure regulation is targeted towards the most needed services. For instance HIPS has been working closely with different private clinics to increase their capacity through staff training, accessibility to loans, opening up new areas for cheap supply of drugs and medical equipment as well as regular monitoring to ensure the realization of targets (HIPS Annual Report, 2013). By increasing access to financial credit, HIPS has helped to increase the capacity of these providers since a study that was carried out in Kenya and Ghana indicated that inaccessibility to credit was the biggest obstacle facing PHS (Burger *et al*., 2012). Scholars argue that Uganda is using market-based approach rather than consumer-based approach to regulation which explains why emphasis is more on distribution than price and quality (Birungi, *et al*., 2001). Standback, *et al.* (2011) indicates that government seems to have intentionally relaxed on unlicensed drug shops since they operate openly in most areas without interruptions.

This part has helped the researcher to answer the third research question about the quality of regulation in Uganda in relation to best known practice suggested by different scholars. The study has found out that regulation is responding to a genuine cause but level of enforcement is still low. The level of accountability has to be improved since regulators do not give much information to those being regulated. The government has worked on various legislations to ensure that they are consistent with already existing ones internationally much as the speed at which this is done is very low citing Acts like PHA which have taken over 15 years on floor of parliament. Much as different stakeholders are consulted, transparency is still low since outcomes of those consultations do not reflect interests of all stakeholders especially PHS. There is still a big room for improvement on all principles.

Chapter 6
6. Conclusions and recommendations

Here the researcher will highlight key findings in a more concise way as they link to the research problem. The researcher will make key recommendations as well as pointing out key areas for future research. Conclusions are in line with research questions beginning with facts about how regulation is done in Uganda, the market failures addressed by regulation, the quality of regulation and how regulation can be improved.

6.1 Conclusions

In conclusion, Uganda is using different mechanisms to regulate PHS including legislation, licensing, incentive-based regulation, self-regulation through professional bodies, and market regulation. These regulatory mechanisms are influencing prices, quality, distribution, and access of health services. Self-regulation is widely used especially in regulating the quality of the professionals in the PHS. UMDPC, UNMC, AHPC and Pharmacy Council are working towards regulating the quality by scrutinizing the training of professionals, the premises of private facilities, qualifications of professionals, the equipment used in PHS, as well as following up on malpractice by handling complaints.

UNDA which is a body responsible for regulating drugs has been very instrumental in cracking down on illegal sell of drugs, unlicensed drug shops, and sensitizing the public through workshops about dangers of buying drugs from unlicensed dealers. This body has also worked towards ensuring distribution of drug shops and pharmacies by being strict on distance from one shop to another.

Regulation is trying to address market failures in PHS by improving on the quality and distribution of services. Incentive-based regulation has stimulated PPPH especially where government offers contracts to PHS to implement certain projects like immunization. Giving out vouchers and prepackaged drugs has worked to improve quality and access since such drugs are either free or subsidized. This has helped in stimulating quality and ensuring access of services in areas where public services are not accessible. Market regulation in which government has liberalized markets has given room for many actors to join health care market hence improving distribution of services. This has also stimulated competition among providers but this study has not found a close link between increasing number of providers and increasing quality or reducing price of services. This is partly because many people lack knowledge about what constitutes good quality service as some studies in Uganda showed

that quality could be judged by many as seeing high technology equipment in the facility or nice looking buildings (MOH, *et al.,* 2012).This study shows that regulation is helping to influence quality, distribution and competition through laws, professional bodies and incentives, but little has been done or achieved concerning reducing prices.

Looking at the quality of regulation, this study has found out that regulation has not been effective in rural areas and newly created districts. Weaknesses within VHTs, CHWs, and low involvement of communities leave people unaware about good medical practice and as such cannot put pressure for better services from PHS. Patient organizations are few and only concentrated in urban areas. The government has tried on the part of legislation by having different laws in place which operationalize the work of regulating PHS. The challenge still remains with enforcing these laws which scholars have attributed to limited funding not only to regulatory bodies but to the MOH which for example only received 7% of the national budget in 2013/2014 which is far below what is recommended (MOH, 2013).Whereas different regulatory bodies are doing a great job, they are facing a number of challenges. The first challenge is underfunding from the government which has affected their regional offices leading to poor monitoring in rural areas. The second challenge is related to the fact that members of these bodies are themselves part of PHS and as such they don't effectively regulate themselves. The study shows that many stakeholders are allowed to take part in regulation. These include PHS, donor agencies, NGOs, local leaders, police, and community members. In this case donors and NGOs have contributed greatly especially where they have provided incentives to PHS in form of subsidized drugs, equipment in order to improve the standard of their facilities. However, studies show that the outcomes of most consultations do not reflect input of some stakeholders especially PHS. In this case, it is seen that PPPH is still low and needs to be improved.

In relation to what has been discussed above, there are various issues which should be improved in order to improve regulation in Uganda. There is need for more collaboration in which PHS should be seen as key partners in HCD. Engagement through negotiation to jointly define targets can help to improve compliancy with regulations. Incentives should be extended to areas where they haven't been used, and more resources should be allocated to regulation which will improve capacities at local levels.

This study has fulfilled its purpose of studying the regulation of PHS with the view of improving HCD in Uganda. This is because the researcher has been able to answer the research questions that were posed at the beginning of the study. The researcher has explained how regulation is done in Uganda, the market failures addressed by current

regulation in Uganda, has also assessed the quality of regulation in relation to best known practice and this has helped the researcher to come up with what can be done to improve regulation with the view of improving HCD in Uganda.

6.2 Recommendations on how regulation can be improved in Uganda

Under this part, the researcher will discuss ways of how regulation of PHS can be improved in Uganda. The researcher has pointed out those aspects basing on propositions made by different scholars on regulation of PHS. This will help to answer the forth research question of how can regulation be improved with the view of improving HCD in Uganda.

6.2.1 Collaboration

There is need for more collaboration with PHS and to look at them as complimentary partners. Since most of private clinics and drug shops are run by unlicensed, poorly skilled and unregistered practitioners, the government should focus on raising their capacity through training them and availing them with regular supplies like prepackaged drugs, and providing subsidized equipment like gloves, syringes which can improve their facilities for the good of the populace whom government is not able to provide for (Awor, *et al*., 2012). Collaboration will also help to enhance preventive care rather than concentrating on curative care since preventive care may need more resources and government hand.

6.2.2 Negotiation not coercion

There is a need for a collaborative engagement between PHS and regulators in order to develop a shared understanding and define roles and targets together and defining how those targets are to be met. There is need for information sharing about the activities of the PHS. The government should initiate dialogue with PHS and sanctions should only be employed in extreme cases. Having in place organizations to collect information about services of the PHS and publishing it can induce PHS to work hard in order to win public reputation as this has worked well in other countries (Peters & Muraleedharan, 2008).

6.2.3 More incentives

Incentive-based regulation has been found to be effective in influencing price, quality and distribution. By offering incentives to providers who operate in rural areas in form of credit facilities, training of staff, providing equipment and essential drugs at affordable prices is

likely to reflect on the prices and quality of the services in PHS. Here the government has to be critical to ensure that incentives target the right people (Awor*et al*., 2012).

6.2.4 Decentralizing regulation

Attempts should be made to improve capacities at district and lower levels. VHTs and CHWs should be facilitated to carry out their work. Monitoring at the district level should be strengthened since most illegal operators are found in rural areas. Local leaders and councils should participate in monitoring the activities of the PHS.

6.2.5 More accountability

The regulators need to exhibit high level of accountability by accounting for their actions as well as reporting to the MOH, parliament, district councils, and sub-county councils. This can help regulators to bring important aspects concerning their work to key policy makers.

6.2.6 More funding

The government should allocate more funds to the health sector and in turn the MOH should also allocate appropriate funds to regulatory institutions in order to carry out their work. New sources of funding especially targeting NGOs and donors can help to improve regulation.
Under this part, the study has pointed out key areas where regulation need to be improved especially the aspect of engagement where the government should foster collaboration with PHS, improving capacities in rural areas, involving the general public, more funds targeting regulation as well as extending incentives to more areas. These have the potential to improve HCD in Uganda. This has helped the researcher to answer the forth research question of how regulation of PHS can be improved with the view of improving HCD in Uganda.

6.3 Areas for the future studies

Future research could be directed towards finding out the effectiveness of using incentive-based regulation with specific reference to private clinics and drug shops operating in rural areas. Such studies can shed light on which kind of incentives are good at influencing key variables in health sector such as price, quality, access and distribution. Another area for future research is about the role of sensitizing consumers towards improving outcomes from the PHS. This is because scholars indicate that consumers in Uganda lack knowledge of good health practice needed to demand good services but no studies have been done linking patient knowledge and the kind of services provided by the PHS in Uganda.

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