

# id21 insights

research findings for development policymakers and practitioners

## Financing primary health care

Today, millions of people in low- and middle-income countries do not have access to basic, good quality health services. The Alma Ata Declaration in 1978 defined primary health care as basic health care built on technically sound and socially adequate approaches, universally accessible and affordable to all individuals. This issue of *id21 insights* explores the challenges facing donors and national governments in providing and financing primary health care for all.

### Selective primary health care

Soon after the Alma Ata Declaration, the concept of 'selective primary health care' was proposed in an article by Walsh and Warren in 1979, justified on the basis of scarce resources and a need for rationing. It argued that comprehensive primary health care was too idealistic and difficult to achieve. Instead, the idea emerged to concentrate efforts on controlling a few selected infectious diseases through cost-effective interventions, based on disease mortality and morbidity rates.

### Cost recovery mechanisms

Similarly, in the 1990s international agencies, led by the World Bank, proposed new mechanisms to organise financial contributions from users towards the cost of care through, for example, user fees and community-based health insurance. These proposals emerged in the context of broader health sector reforms and suggestions to use the private sector in health service provision.

The rationale behind these cost recovery mechanisms was the need to increase healthcare revenues and improve quality and efficiency through greater community involvement in primary health care (PHC) management. Although some studies have shown that this was partially achieved, the main criticism is that cost-recovery also increased inequity in access. As **Barbara McPake** points out, methods of achieving good quality PHC for those living in poverty have not been identified in most low income countries.

Driven by continuing resource scarcity, international agencies and low- to middle-income country governments continued to look for ways to cut costs in the late 1990s and early 2000s, including basic or essential packages based on a list of cost-effective interventions.

### Strengthening health systems

The international community, notably the World Health Organisation, recognised the limits of providing disease specific interventions without a functioning delivery system, and called for greater attention to strengthening the health system as a whole. This led to the creation in 2002 of the Commission on Macroeconomics and Health, which advocated the use of a 'close-to-client' system, including outreach services, health

## Contents

Editorial	1
Skilled delivery care in Indonesia	2
The story of primary health care	3
Contracting out health services	4
Effective antimalarials	4
SWAps in Uganda	5
Malawi's staffing crisis	6

centres and local hospitals most accessible to poor people. It highlighted the various constraints affecting demand and supply which limit the ability of poor people to access such services.

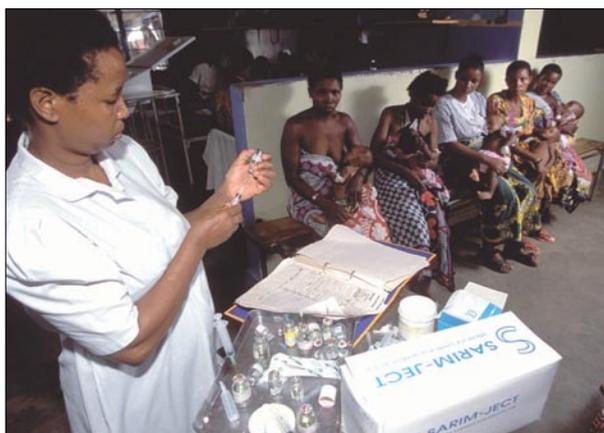
### Overcoming barriers to health care

Historically, greater emphasis has been placed on reducing supply side barriers – which negatively affect quality, volume and price of available services – with a focus on key health service inputs, notably human resources and drugs. As **Eilish McAuliffe** suggests, staff motivation and ultimately staff performance are associated with the availability of other necessary resources, such as drug supplies, for service delivery.

However, the assumption that free public-sector health services result in universal access to PHC has become less plausible. Growing preferences for non-free over free services, and the resulting growth in providers of differing public and private characteristics, requires strategies that extend beyond public sector provision.

Contracts with the private sector emerged as another supply side strategy that may improve access to PHC. **Maureen Lewis** indicates that contracting out may increase efficiency (through greater competition), quality (staff morale, for example), and coverage (providing services to high risk groups or people in remote areas). Yet, strong government capacity, often lacking in low- and middle-income countries, is required in order to design and oversee all stages of the contractual arrangement.

Strategies to remove or at least reduce demand side barriers, which disproportionately affect the poorest and most vulnerable in society, also need to be prioritised. Demand side barriers can include physical, financial, cultural and social barriers, such as opportunity costs, lack of knowledge about appropriate care, or distance to the health centre.



A nurse dispenses drugs to malaria patients in Kenya.  
Caroline Penn, Panos Pictures

The balance between supply and demand is reinforced by research from Indonesia: **Tim Ensor** provides evidence that improving the availability of trained midwives and emergency obstetric care is not enough to reduce maternal mortality if mothers cannot afford services. And lowering prices for essential health commodities, such as effective anti-malarial drugs, as discussed by **Lindsay Mangham** and **Kara Hanson**, needs to be accompanied by community strategies to improve the knowledge of those purchasing the drugs.

### Aid harmonisation

Given the high dependency of low income countries on aid, methods of aid delivery are central to the debate on how best to finance PHC. Sector-wide approaches (SWAs) and General Budget Support (GBS) emerged in the late 1980s to 1990s, in response to frustrations with the delivery of aid through 'vertical' projects. Such programmes were problematic because they were defined by donors giving little country ownership. Poor donor coordination led to fragmentation and duplication of efforts, and governments were unable to respond effectively to different donor requirements.

In 2005, further efforts by the international community to improve aid effectiveness resulted in the Paris Declaration. It highlighted the need for increased donor harmonisation and alignment with recipient governments.

In contrast to vertical projects, the principles behind GBS and SWAs include:

- pooling of government and donor funds to contribute towards nationally agreed policies and expenditure frameworks
- country ownership and leadership
- increased use of government procedures to eventually disburse and account for all funds.

SWAp funds are allocated to a specific sector such as education or health, whilst GBS funds are channelled to the recipient government budget without allocation to a specific sector, programme or activity. PHC funding can benefit from such shifts in resource allocation, when government funds increase due to a change in the donors' method of budget delivery. This happened in Uganda in 2000, as discussed by **Freddie Ssenigooba**, when a SWAp was introduced with other reforms that prioritised PHC services.

### Global Health Initiatives

Yet the advantages of vertically delivered donor projects – such as the ability to respond swiftly to urgent health problems and increased flexibility in avoiding recipient countries' capacity problems – continue to make them a popular method of delivery for aid. In the past decade, project-based Global Health Initiatives such as the Presidential Emergency Plan for AIDS Relief and the Global Fund for AIDS, TB and Malaria have posed additional coordination challenges at the national level. This is mainly due to the high volumes of funds they manage and the resulting potential to disrupt existing health

system development, and the policy and planning processes of recipient countries.

### Conclusion

In the 30 years since the Alma Ata Declaration, there has been tension regarding whether to centre efforts on a few selected interventions or strengthen the health system as a whole. Focusing on a limited disease intervention package or a particular element of the health system, such as human resources, risks neglecting aspects such as management systems and compromising the effective and efficient functioning of health services.

Policymakers in donor agencies and recipient countries need to ensure adequate funding is allocated to the entire health sector. They also need to channel new funding sources through pooled mechanisms, such as SWAs, and use established government processes.

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#### See also

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## Skilled delivery care in Indonesia

### Providing adequate access to maternal health care is a test of the entire health system.

Care for most women before, during and after delivery can be provided within a well equipped primary care setting. Where complications arise there is the need for speedy referral to higher level facilities. Primary care is thus a main care provider as well as a crucial link to more specialist forms of care.

Since the 1980s Indonesia has attempted to improve women's access to maternal health

care by assigning professional midwives to each village. But although the number of midwives has increased, maternal mortality remains high compared to other countries with similar Gross Domestic Product per capita.

A recent study in Zanten Province, Java, demonstrates a positive association between the presence of midwives and the use of professional care. However, even in areas with relatively large numbers of midwives, the proportion of births attended by a professional remained low at 33 percent, and access to emergency obstetric care is inadequate. The higher uptake of care by the wealthiest women and those with health insurance suggests that economic barriers are deterrents to use. Findings include the following.

- There is a strong relationship between wealth and use of professional care during delivery. Three-quarters of births in the richest households are attended by a midwife or doctor, compared to less than ten percent amongst the poorest households.
- Village midwives rely on private income (representing nearly two-thirds of earnings) so may be unwilling to deliver women who cannot pay.
- The costs of emergency obstetric care are enough to push non-poor households into poverty.

The study indicates that while increasing the supply of midwives is important in improving maternal health, their presence alone is not sufficient. The financial cost of delivery care is a barrier both to accessing skilled help for normal delivery and in reaching emergency obstetric care.

Implications for the Indonesian maternal health financing strategy at primary care level include:

- Increased investment in local health centres will support midwives' services, offer basic emergency care and organise referrals.
- Increased incentives for maternal health care staff will serve poor rural clients.
- Covering the costs of emergency obstetric care for all who need it will help, as poor people are often unable to meet such unexpected payments.
- Health insurance for poor people was introduced to overcome financial barriers to care, but targeting those living in poverty is notoriously difficult, and may leave many without help.
- Increased investment is necessary to overcome other demand side barriers to care, such as perceptions of the quality of care, lack of knowledge about services, or the opportunity costs of accessing care.

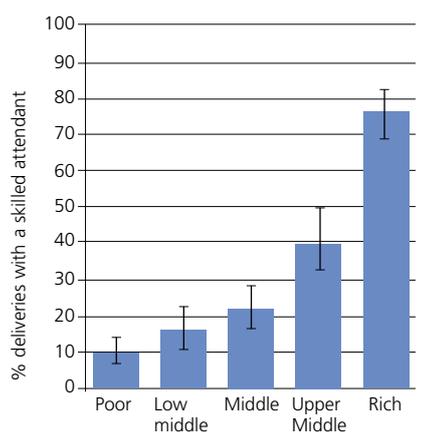
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#### See Also

'Public Funding for Community-Based Skilled Delivery Care in Indonesia: To What Extent are the Poor Benefiting?' *The European Journal of Health Economics*, by Tim Ensor *et al*, 2008  
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Figure 1: Deliveries with a health professional by income group (combined for both districts)



# The story of primary health care

*From Alma Ata to the present day*

**The idea of primary health care (PHC) emerged in the 1960s, in recognition of the shortcomings of the health systems inherited by developing countries after independence. Such urban, centralised and curative-oriented health systems were poorly matched to the needs of their people.**

## Health for all

By the time of the Alma Ata conference in 1978, a consensus had emerged placing fresh emphasis on preventive, rural, peripheral and 'appropriate' services, integration and inter-sectoral collaboration, and participation of local communities. The conference itself affirmed the right to health – and its definition as a state of complete, physical, mental and social wellbeing.

The Conference demanded 'an acceptable level of health for all the people of the world by the year 2000' or 'Health for All 2000', implying an emphasis on equity as well as effectiveness and efficiency.

**The Alma Ata conference affirmed the right to health: a state of complete, physical, mental and social wellbeing**

Fissures in the consensus appeared almost immediately. In 1979, the paper 'Selective Primary Health Care' proposed a limited list of cost-effective interventions to respond to most health needs in low-income countries, especially those of children. It prompted a host of critical responses which argued that cost-effectiveness did not ensure a universal health system or give sufficient space to equity, and that the holistic notion of health espoused in the Alma Ata declaration had given way to one of avoiding disease. They argued that the strategy provided a short-term fix rather than a long-term solution and that this implicitly medical notion ignored the need for collaboration and integration.

## Affordable primary health care?

A cornerstone of the initial consensus was that a PHC system would be affordable to low-income countries. The Rockefeller Foundation published the 'Good Health at Low Cost' case studies in the mid 1980s, which showed that some places such as China, Costa Rica, Sri Lanka and the Indian state of Kerala, had achieved affordable and effective health systems. All had dramatically improved health outcomes, despite economic constraints within widely differing political systems, but all emphasised PHC within an overall social welfare-oriented development model.

## PHC delivery system ignored

However, others argued that PHC is not cheap and that simple interventions require a delivery system that is frequently lacking in practice and ignored in the debate. The realities of PHC delivery systems failed to

match up to the ideal. Services intended for poor people were often perceived as cheap and second class. Governance issues affected the delivery of services in a number of settings. Political commitment voiced at Alma Ata was often not followed up through implementation.

By the 1990s, proposals looking for alternatives to over-stretched public sector budgets emerged from international agencies. Increased debt levels were undermining the credibility of increasing public expenditure and there was a growing emphasis on markets as the basis of public sector reform. The World Bank's Agenda for Reform promoted centralised user fees, insurance mechanisms and greater involvement by the private sector. And the Bamako Initiative proposed local revenue-generating mechanisms alongside measures to strengthen the delivery of PHC.

These approaches, however, undermined access by the poorest people, threatening the universal principle enshrined in Alma Ata. User fees were widely implemented and equally widely maligned: evidence emerged, for example from Ghana, which resulted in reduced use of health services and exclusion of poor people.

**The realities of PHC delivery systems failed to match up to the ideal**

Several new approaches have emerged in the last decade, whilst those of the 1980s and 1990s continue to inform current thinking. Conflict between new aid modalities, most notably the sector-wide approach – where aid effort in each sector is brought under a single management framework governed by national government and bilateral and international agencies – and international mechanisms with specific disease focus, such as the Global Fund to fight Aids, TB and Malaria, has similarities with the dispute between selective and comprehensive PHC.

- Should local ownership, integrated service provision and system development be emphasised, or measurable outcomes, specific objectives, and short-term efficiency?
- 'Essential packages' itemising a limited set of priority cost-effective interventions, are now everywhere in aid dependent countries, but raise



**Pharmacist dispensing drugs to a customer at a village pharmacy in Burkina Faso.**

*Jeremy Hartley, Panos Pictures*

the same questions that selective PHC did 30 years ago. How does a health system based on an essential package respond to a patient with a condition not covered by the package? What are the equity implications of allowing the private sector to fill the less cost-effective gap?

**One can argue that PHC 'failed' in the sense that 'Health for All 2000' was not achieved**

It is possible to argue that PHC 'failed', in the sense that 'Health for All 2000' was not achieved. Advocates of comprehensive PHC have critiqued advocates of more selective approaches for their tendency to prioritise 'technical fixes' over larger social development processes. Nevertheless, if it is recognised that a more comprehensive PHC vision is more than a longer list of technical fixes, PHC failure can only be addressed in the same terms as those that evaluate wider development processes.

These in turn perhaps can also be seen to have largely failed over the same period, owing to global economic and political forces and national failures of governance. These are likely to be the critical factors that determine success with PHC and other elements of social development over the coming decades.

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## See Also

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# Contracting out health services

**Broadening coverage, raising quality, lowering cost**

**Contracting out public services is a way for governments to complement their own delivery of services. It is particularly effective for high risk or hard-to-reach populations that can be more effectively served by private groups. It can also contribute to more efficient delivery of primary health care (PHC).**

Contracting out allows governments to use public funding to pay non-state providers, such as non-government organisations (NGOs) or for-profit groups, who have the capacity to deliver an agreed set of health care services. Because it offers greater flexibility than the public sector, it can tackle problems of low quality public services or unmotivated staff more effectively.

Advantages of contracting out include economic incentives resulting in more measurable performance and increased efficiency due to competition. NGOs are more flexible than governments, can respond faster to changing circumstances and have more decentralised decision-making. They often have ties to local communities or experience of specific services, which enable them to scale up or intensify their activities. NGOs can also more easily modify the type, location and staffing of services they offer as needs and available resources change.

Some services are better suited to contracting out, such as those reaching high risk groups affected by conflict or with little health system contact. NGOs have the appropriate infrastructure and approach, and typically already serve such groups, who are often physically or socially isolated.

**Contracting out has resulted in better provider performance, lower costs, shorter waiting times and higher patient satisfaction**

Contracting out services has worked well in many settings. In post-conflict situations, such as Afghanistan, it has become the only way to provide health services. In Brazil, a successful HIV and AIDS programme, that resulted in rapid prevalence reduction, relied on contracted NGOs to provide prevention, treatment and counselling services to high risk groups.

Various programmes that contract out PHC services have also been successful. Experiments in contracting out nutrition, hospital or PHC services across the five Central American countries showed impressive results. Programmes in Uganda, Cambodia, Haiti and Madagascar have also resulted in combinations of better provider performance, lower costs, shorter waiting

## Better access to effective antimalarials

**The Affordable Medicines Facility for malaria**

**Malaria is one of the main reasons why people use health services in sub-Saharan Africa, placing a considerable burden on primary health care.**

The Affordable Medicines Facility – malaria (AMFm) is a supply-side intervention designed to reduce malaria mortality by improving the availability and affordability of effective treatment. It also aims to delay the development of drug resistance through the use of artemisinin, in combination with other medicines, rather than as a monotherapy.

In most malaria-endemic countries artemisinin-based combination therapies (ACTs) are the recommended first-line treatment for malaria and the only effective treatment against its most lethal forms. Governments have made progress in expanding access to ACTs through the public health system, although many patients have limited access to public facilities and use the informal health sector, including non-governmental organisations (NGOs), private vendors and traditional healers. However, the high price makes ACTs inaccessible to the 50 percent of patients who seek malaria treatment from drug retailers in sub-Saharan Africa.

The key features of the AMFm are:

- A global buyer co-payment for ACTs that lowers the manufacturer sales price paid by first-line buyers, such as national wholesalers, Ministries of Health and NGOs.
- An increased supply of ACTs to public and private sector providers and lower prices paid by patients, resulting in increased access via primary healthcare centres, private sector pharmacies and drug stores.

times and higher patient satisfaction. In Nicaragua, contracting out PHC provision tripled coverage while costs declined 39 percent; waiting times were reduced by over 20 minutes and patients were more satisfied with the care.

While contracting can provide significant benefits, there are several issues governments need to consider when deciding whether to contract out PHC services. Where government oversight is weak, there are limited private and NGO options, or where shifts in government administration lead to changes in contracting arrangements, the use of contractors can be problematic. Managing a poorly performing contractor can be costly in terms of both time and money.

While contracting out can work, it is not a panacea; its design, incentives and oversight are important factors that determine success.

- The contract must be clear and specify funding and expected results.
- The contracted party must have sufficient autonomy and flexibility to work without government interference.
- Contracting governments must have clear criteria to assess performance.

- By reducing the price of ACTs, it is anticipated that AMFm will discourage the supply of the less-effective treatments that dominate the market and of artemisinin-based monotherapies that increase the risk of drug resistance.

There is a risk that the subsidy intended to make ACTs affordable would in practice be reduced and absorbed as the drugs move along the supply chain. This risk will be reduced by using complementary interventions, such as consumer information, or setting a recommended retail price.

Access to ACTs by people living in poverty – those without public facilities and unable to afford ACTs at subsidised prices – is a concern. The AMFm will support an enhanced public sector and NGO distribution of ACTs, often without charge but supplementary

initiatives at PHC level, such as home-based management of malaria, will still be needed.

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### See also

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- Governments must monitor performance and be able to modify contracts in response to problems rather than merely terminate them.
- Appropriate monitoring and evaluation of contractor performance is required; without it results remain impressionistic and it is difficult to know what has been achieved.

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### See also

'Innovations in Improving Efficiency and Impact in Health Care services – Lessons from Central America', in *Health System Innovations in Central America*, edited by G. La Forgia, World Bank Working Paper 57, by Maureen Lewis, 2005  
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# Efficiency and equity through a sector-wide approach in Uganda

**Financing Uganda's health care services used to be based on a minimum package which cost more than the financial resources available. Donor aid contributed between 40 to 50 percent of these costs. Financial allocations were also biased towards national level hospitals and wages.**

For Uganda's health care system to become more efficient, reforms in the coordination and allocation of donor aid were essential. The first national Health Sector Strategic Plan (HSSP-1) envisaged strengthening a minimum health care package (MHCP) within a decentralised, district-based primary health care approach. Four main reforms aimed to improve the financing of health care from 2000 to 2005:

- formal suspension of user-charges in the public sector
- substantial increase in the health budget
- better coordination of donor aid
- redirection of resources away from tertiary level services towards primary level MHCP provision.

At the end of HSSP-1 in 2006, the Health Systems Development Programme evaluated the efficiency and equity of the health budget and donor fund allocation between 2001 and 2005. The main findings included:

- The Ministry of Health (MOH) and donors were committed to sector-based planning and resource allocation: during this period the health care budget increased by 18 percent.
- Half of donor aid was channelled through the government's national budget as part of a budget support mechanism, but large volumes of donor funds were still channelled vertically.
- The suspended user-charges led to increased service use and demand for resources such as medicines, while workloads and staff shortages reached crisis levels. This pressure resulted in higher expenditure.
- Guidelines were introduced to improve the efficiency of financial resources. They included grants for private not-for-profit providers and mechanisms to protect funds for medicines and supplies. Overall, expenditure on medicines increased from US\$0.88 to US\$1.65 per capita.
- Vertical funding reduced from 45 percent of the health sector budget in 1990 to 2000 to 34 percent in 2003 to 2004. However, only 32 percent of donor project funds were assigned to priorities listed in the National Health Sector Strategic Plan. Technical and administration costs absorbed most of these funds.

Changes in health care consumption between 2000 and 2003 are also

highlighted in household surveys undertaken by the Uganda Bureau of Statistics. Findings included:

- Self-medication reduced from 23 to 11 percent between 2000 and 2003. Although overall health service use remained low and hospital use declined from 20 to 11 percent, health centre use increased from 3 to 11 percent. This may demonstrate improved access to, and confidence in, lower level health service provision, in line with the national sector plan.
- Use of informal drug shops and the private-for-profit sector increased from 39 to 50 percent between 2000 and 2003. These increases, in a sector that depends on expensive out-of-pocket payments, indicate that further progress is needed to ensure resource allocation benefits most Ugandans.

## **SWAps in Uganda increased resources and allowed the Ministry of Health greater flexibility to implement reform**

- Shortfalls in medical supply budgets meant medicines were frequently out of stock. An estimated US\$3.5 per capita is required for essential medicines (excluding anti-retrovirals) and US\$28 for the MHCP. However only US\$1.65 and a maximum of US\$11 respectively were available during the review period.

These findings show that efficiency gains can be made with a minimal budget increase and shifting of budget priorities. For these shifts to be feasible and sustainable, more donor aid needs to be channelled in a way that enables sector planners and government to implement reforms that affect broader health systems.

The sector-wide approach (SWAp) in Uganda increased resources, allowed donor aid to be channelled through budget support arrangements, and gave the Ministry of Health (MOH) greater flexibility to implement reforms.

However, the findings also show that increased efficiency cannot necessarily fill the resource gap as needed to achieve sustained and broader welfare objectives. Although global financial initiatives can



**Enrolled Nurse Miriam Chisizwa takes the blood pressure of a patient in Bwalia Hospital in Lilongwe, Malawi, where she has worked for seven years. Her Salary is 28,000 Kwacha (£100 per month). She works 24 hour shifts and says 'I feel very tired.'**

*Abbie Trayler-Smith, Panos Pictures, 2007*

help to address the resource gap, they also need to strengthen SWAp arrangements, channel more funds through budget support and allow the MOH to adopt the long-term reforms needed for better health system developments.

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### **See also**

'Have Systems Reforms Resulted in a More Efficient and Equitable Allocation of Resources in the Uganda Health Sector?', by Freddie Ssengooba *et al*, Chapter 7, in *Health Systems Reform in Uganda: Processes and Outputs*, London School of Hygiene and Tropical Medicine, UK, edited by Christine Kirunga Tashobya, Freddie Ssengooba, Valeria Oliveira Cruz, 2006 (PDF) [www.hsd.lshtm.ac.uk/publications/books/Uganda\\_book.pdf](http://www.hsd.lshtm.ac.uk/publications/books/Uganda_book.pdf)

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# Tackling Malawi's human resources crisis

**The achievement of the Millennium Development Goals (MDGs) by 2015 will only be possible if we can successfully strengthen the capacity of health systems in middle and low-income countries.**

The World Health Organisation's Commission on Macroeconomics and Health identified human resource issues as major constraints in meeting targets to scale up interventions and meet the MDGs. Primary health care (PHC) services have been greatly affected by the shortage of human resources. In some countries the combination of large numbers of HIV patients and the serious weakening of health systems from the loss of skilled workers to HIV/AIDS, means that vulnerable groups are denied access to even basic PHC. The depletion of human resources is particularly acute at the district and community levels, as there are fewer incentives and support structures available to attract and retain staff.

Malawi is one of the poorest nations in the world, with some of the worst health worker to population ratios. Most health services are provided by clinical officers, medical assistants and enrolled nurses. The government has taken action to address the staffing shortfall, estimated at 15,000.

In 2001, a Six-Year Emergency Training Plan for health workers was supported by Malawi's major donors. Further programmes included a health initiative launched in 2004 to deliver an Essential Health Package, including an Emergency Human Resources Programme. This aimed to improve staff recruitment and retention through salary top-ups and increased training. It also included international technical assistance to support planning and management capacity, and short-term use of international volunteer doctors and nurse tutors.

In 2005 the government introduced a 52 percent salary top-up which, combined with further increases, resulted in professional health workers being the highest paid civil servants. However, although there have been some increases in staff numbers, there is as yet little published evidence regarding the impact of these salary increases.

**Factors other than pay, such as training and career advancement, are critical in retaining and motivating staff**

Research in Malawi's health facilities has shown that factors other than pay, such as training and career advancement, are critical in retaining and motivating existing staff. Resource shortages in clinics negatively affect staff motivation and inadequate management support leads to job dissatisfaction.

Progress on the training and career development aspects of the Emergency Human Resources plan has been slow. The 2007-2011 Human Resources Strategic Plan set out to address the complex problem of motivating and retaining staff, particularly in rural areas, and other issues highlighted by research. The new Human Resources Development Policy (2007) focuses on training and the importance of performance monitoring to maximise human

resource capacity. Ensuring that these strategies and policies result in improved health outcomes will depend on:

- regular and rigorous monitoring of indicators and targets
- sufficient HR management capacity at local level to implement the HR development policy
- equal emphasis on motivating and retaining existing staff versus recruiting additional staff
- a long-term strategy to ensure adequate funding for health worker salaries.

**Eilish McAuliffe**

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**See Also**

*Survival and Retention Strategies for Malawian Health Professionals: Regional Network for Equity in Health in Southern Africa*, EQUINET discussion paper, No 32, by S Adamson, D Muula and F C Maseko, 2005 [www.hrresourcecenter.org/node/537](http://www.hrresourcecenter.org/node/537)  
*'Human Resource in the Health Sector: Towards a Solution'*. Ministry of Health, Republic of Malawi, 2004  
*'Tackling Malawi's Human Resources Crisis'*, *Reproductive Health Matters*, 14, pages 27-39, by D Palmer, 2006 [www.id21.org/health/h1dp3g1.html](http://www.id21.org/health/h1dp3g1.html)

## Useful web links

The Declaration of Alma Ata 1978

[www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

United Nations Millennium Development Goals

[www.un.org/millenniumgoals](http://www.un.org/millenniumgoals)

Affordable Medicines Facility for Malaria

[www.rbm.who.int/globalsubsidytaskforce.html](http://www.rbm.who.int/globalsubsidytaskforce.html)

Roll Back Malaria Partnership

[www.rollbackmalaria.org](http://www.rollbackmalaria.org)

Impact, University of Aberdeen, UK

[www.impact-international.org](http://www.impact-international.org)

The People's Health Movement

<http://phmovement.org/cms>

WHO Poverty Reduction Strategy Papers database

[www.who.int/hdp/database/PRSPwhat.aspx](http://www.who.int/hdp/database/PRSPwhat.aspx)

WHO and Global Health Initiatives

[www.who.int/trade/glossary/story040/en](http://www.who.int/trade/glossary/story040/en)

WHO and SWApS

[www.who.int/trade/glossary/story081/en](http://www.who.int/trade/glossary/story081/en)

The World Health Report

[www.who.int/whr/en](http://www.who.int/whr/en)

15 by 2015 Campaign

[www.15by2015.org](http://www.15by2015.org)

For further web links please visit

[www.id21.org/insights/insights-h12/weblinks.html](http://www.id21.org/insights/insights-h12/weblinks.html)

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