The Public-Private Partnership Dilemma in Uganda

Penelope Sanyu

Introduction

Ugandans desire to live in a country where all the citizens can enjoy a productive life with gainful employment, access to education and the right to quality healthcare. This desire is reflected in the national vision, Uganda Vision 2040, and the national vision statement approved by Cabinet in 2007: *"A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 Years"* (National Planning Authority 2023, III). The marker will be movement from low-income to middle-income status, from per capita income of $506 to per capita income of $9,500 (National Planning Authority, 2023).

The mainstream narrative asserts that it is an impossible feat to achieve especially in social infrastructure sectors like health delivery and education if left to the government alone. It is assumed that the private sector has a major role to play. Based on a review of experience in Uganda and other African countries, I will argue that given the history and experience of private sector engagement in public service delivery, public-private partnerships (PPPs) can only play a role in the context of people-centred robust laws and policies that consider the plethora of implications of such models for the poor, particularly women. While the public is important in the delivery of services, Awor et al., in a justification of PPPs, posit that partnerships are most "justified when traditional ways of working independently have a limited impact on a problem" (2017, 152). They further stress how important it is to note that PPPs do not involve divestiture of public interests or entities and that they are distinct from privatisation.

Governments of developed and developing countries have increasingly adopted PPPs based on the assumption that they will expand access to higher-quality services by leveraging capital, managerial capacity, and know-how from the private sector. Originally confined to the traditional infrastructure sectors of transport, water, and energy, PPPs are increasingly applied in social

infrastructure sectors, particularly in education and for delivery of health services.

The effectiveness of PPPs in these sectors has been contested, although they are expanding very quickly. In a 2023 book edited by Corina Rodríguez and Masaya Blanco, titled *Corporate Capture of Development: Public-Private Partnerships,Women's Human Rights and Global Resistance,* the chapters highlight the alarming rate of PPP projects across the Global South and the varied impacts on end users. They particularly show that women are the most affected by these deals.

PPPs cover a spectrum of possible relationships between the public and private actors who are supposed to jointly participate in defining the objectives, methods, and implementation of an agreement regarding cooperation. The result is a legally enforceable contract in which a contracting authority (usually a public institution) partners with a private sector partner to build, expand, improve, or develop infrastructure or services. The contracting authority and private sector partner contribute expertise, financial support, facilities, logistical support, operational management, investment, or other input required for the successful deployment of a product or service, for which the private sector partner is compensated in accordance with a pre-agreed plan. The payment may include an amount to cover the risk assumed and the value of the result to be achieved. Payment to the private partner can be through service user fees, budget allocation, or a combination of the two (Government of the Republic of Malawi 2011).

PPPs in Health

A PPP in health is thus "any formal collaboration between the public sector at any level (national and local governments, international donor agencies, bilateral government donors) and the non-public sector (commercial or non-profit) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications or education." (Barnes 2011, 2).

There remains a need to justify this collaboration because there are arguments for and against PPPs in health. Parker et al. (2019) posit that PPPs enrich the capacity, quality, and reach of public health services; that partnerships

help to put health in all policies; that they improve self-regulation; and that PPPs promote sustainable business models that allow innovation in more healthful design and content of products. PPPs are also seen to transfer risk in relation to infrastructure and service delivery to the private sector, resulting in the state realising better value for money.

Hellowell (2019) on the other hand notes that governments often favour PPPs over public procurement because they provide access to private capital. This is seen to impact on public budgets, enabling up-front expenditures to be deferred. Hellowell (2019) further shows the devastating impact of a hospital PPP in Lesotho. Other critiques of PPPs include the fact that alliances between public and private sectors have inherent conflicts of interest that cannot be reconciled when the products or services provided by the private partner are harmful to health. Collaboration in health promotion can confer legitimacy and credibility on industries that may harm health, thereby eroding the credibility of public health institutions. Public-private interactions are seen to potentially lead to institutional capture, such as when companies influence governments to undermine regulatory measures to protect the health of the population. Some of these regulations relate to taxation. An evaluation of 36 PPPs in different high- and low-income countries concluded that some PPPs were costly and difficult to manage by the public sector (Parker et al. 2019). The conclusions show that PPPs of this nature exacerbate gender inequalities in access to health services. This is because of the risk of privatising essential services in a way that disproportionately disadvantages women.

Uganda's health system is faced with many challenges that include poorly remunerated and demotivated health workers, low motivation that decreases retention of health specialists, underfunding of referral and sub-district hospitals, drug leakage, corruption, poor servicing of donated equipment, challenges of deployment and inefficient supervision of decentralised human resource for health (Parliamentary Committee on Health 2012). The problem of rising population growth with varied demographics and different health needs is compounded by the lack of sustained State investment in the sector. The Uganda PPP Act (2015) provides the legal mandate for the implementation of PPPs by all sectors. On health, the government provided direction to strengthen partnerships with the private health sector for equitable and improved health outcomes in the national

public-private partnership in health (PPPH) policy. PPPH made it possible for the government to provide subsidies to support private not-for-profit (PNFP) health facilities, which led to an increase in the scope of services they provided and reduced user fees. These resulted in increased access to health services by Ugandan communities, especially hard-to-reach and under-served poor areas where eighty-five per cent of PNFPs are located (Ssengooba et al. 2017). It is noted in many studies that health sector PPPs lead to an increase in user fees, making access to health a challenge for the poor (see Roy 2011 for a discussion on the topic in West Bengal, India).

The regulation of private health providers has provided some contradictions to note. For example, more than half of the 20,000 private clinics and drug shops in Uganda remain illegal or unlicensed, which means there is no guarantee that these unregulated facilities provide the requisite quality of care.

While the reasons for the licensing problems remain unknown, some community-based innovative regulatory mechanisms and models in the PNFP sector can provide some lessons. Since they are community-based, they are also peer supervised. At the same time, the government unilaterally made decisions to recruit health workers into the public system from existing PNFP facilities. About sixty per cent of the personnel left, depleting and crippling the sector, although they serve the same health sector goals (Ssengooba et al. 2017). Meanwhile, the government's budget allocation to the PNFPs declined sharply from 2006 (Ssennyonjo et al. 2018). These budgetary and human resource crises have left a burden of care work to a few health workers who must serve an ever-increasing women-dominated rural population, so that the poor quality of services rendered has persisted. The recruitment challenges also affect the government sector where private facilities recruit government-trained health professionals, which also has deleterious effects on the sector. This is a result of fragmented and uncoordinated public and private actors, leading to competition for health workers and resulting in a depletion and crippling of the healthcare system.

The Feminist Lens

PPPs in health care, particularly those dealing with women's health, are wide-ranging. Two common trends are emerging, namely a focus on reproductive and maternal health linked to the Millennium Development Goals (MDGs) and the obligations they impose on global institutions and States (Gideon et al. 2017). The sequel is the Sustainable Development Goals (SDGs) which, in addition to stating several global responsibilities towards women, have also included partnerships as Goal 17. However, in terms of maternal health, the service delivery model for many PPPs is to improve access through cost subsidy programmes such as the voucher system. Nonetheless, the approaches have not addressed the central questions of equity and quality of health service delivery. It has been argued that, instead of health service delivery being implemented in an integrated manner and holistically, PPPs in the health sector tend to focus on specific diseases while neglecting other important issues. This approach leads to health access inequalities (Gideon and Porter 2016).

Another concern is the power relations between the global partners, NGOs, and receiving communities and states. The structural inequalities and power imbalances shape the models that are implemented, which in the long run promote market-oriented health sector funding. In this structure, it is women who are the most vulnerable and often at the receiving end of the solutions handed down to them. Also, PPPs promote the instrumentalisation of women's health needs within maternal and reproductive health concerns.

From my position as a health service user in the context of a crippling public sector, PPPs can deliver some services, but specific concerns relating to user fees and accessibility must be addressed. PPPs cannot be accepted without a thorough reflection on their implications for different social groups. The State has a social contract to protect vulnerable people. This means that PPP services must be accessible physically and economically to the very poor.

While some actors praise PPPs for improving the efficiency and effectiveness of public services, their impact on gender equality and women's empowerment remains underexplored for several reasons. PPPs have traditionally been viewed as a technical and financial mechanism for delivering infrastructure and services, with less attention paid to social and gendered impacts. As a

result, gender considerations have often been overlooked in the design and implementation of PPPs. This is due largely to the model's focus on finance and technical designs. Furthermore, there is a lack of gender-disaggregated data and research on the gendered impacts of PPPs, which makes it difficult to assess the effectiveness of gender-responsive ones and to identify good practices. The cultural and social barriers to women's participation in PPPs, particularly in sectors that are traditionally male dominated, such as infrastructure and construction, can limit the opportunities for women to engage in PPP projects and contribute to their design and implementation. The fact that the model's structure remains patriarchal and not diverse and gender-sensitive gives room for failures and biases that tend to disfavour women.

Recommendations for Gender Responsive PPPs

Uganda's health sector is struggling to meet the needs of the growing population. The problem is even more dire for women whose health issues remain instrumentalised, with multiple actors, namely NGOs, global health funding agencies and institutions, and corporate institutions getting more involved in varied ways. These have inherent power imbalances, with the women being mainly recipients of health sector interventions in maternal, child and reproductive health services.

While PPPs have many caveats, they can function well in an environment of shared respect, partnership, and transparency, as Joudyian et al. (2021) have reiterated. This means that women's voices should be centred on decision-making and should not be an afterthought. Women should be represented in PPP governance structures and decision-making processes to ensure that their needs and concerns are integrated and considered in the projects. PPP designs must also draw lessons from existing schemes and research. In addition, the context matters. Given that Uganda and many other African countries have toed the privatisation line, there is always history to guide the State and its involvement in such models to ensure that the specific needs and priorities of women are identified. PPPs can be used to promote women's economic empowerment by providing opportunities for women entrepreneurs through targeted financing and capacity-building programmes. Gender-sensitive monitoring and evaluation should be conducted to ensure that PPPs are meeting their gender goals

and objectives through collecting and analysing sex-disaggregated data and conducting gender-sensitive impact assessments.

PPPs in Africa have the potential to both empower and marginalise women depending on their design and the social considerations of their impacts. By considering the diverse ramifications of PPPs for women across the African continent, policymakers can work towards alternatives that are more equitable with strong government funding and backing in diverse ways – the political will to improve health access, financial allocation to the health sector and empowerment of community-based health service providers, among many others. These can improve access while limiting discrimination that particularly affects poor women. Above all, the State must make sure that PPPs do not prioritise profit over the health of people. Finally, health sector PPPs should not work in isolation. They will require existing state social protection programmes such as those in health and nutrition to cushion the poor even more. The time has come for a public-private community partnership to fix our countries and put them back to work, but they cannot exist in isolation from other market players. We must ask ourselves key questions such as: what are the theoretical and practical dimensions in creating gender transformative partnerships? What is the shared ethical vocabulary serving as the basis of successful partnerships in the future, and what is the place of gender in these spaces?

References

Awor, Phyllis, Harold Bisase, Peter Lochoro, and Filippo Cortale. 2017. "How is the Partnership between the Public and Non-Public Sector Evolving to Strengthen Universal Health Coverage?" In Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress, edited by Freddie Ssengooba, Elizabeth Ekirapa-Kiracho, Elizeus Rutebemberwa and Suzanne Kiwanuka, 150-165. Kampala Uganda: Makerere University.

Barnes, Jeffery. 2011. *Designing Public-Private Partnerships in Health*. Shops Project. Bethesda: MD Abt Associates.

Gideon, Jasmine and Fenella Porter. 2016. "Unpacking 'Women's Health' in the Context of PPPs: A Return to Instrumentalism in Development Policy and Practice?" *Global Social Policy* 16(1): 68–85. https://doi.org/10.1177/1468018115594650

Gideon, Jasmine, Benjamin Hunter and Susan Murray. 2017. "Public Private Partnerships in Sexual and Reproductive Healthcare Provision: Establishing a Gender Analysis." *Journal of International and Comparative Social Policy* 33 (2): 166-180. https://doi.org/10.1080/21699763.2017.1329157

Government of Uganda. 2012. *National Policy on Public Private Partnership in Health*, *Government of Uganda*. Kampala: The Republic of Uganda.

Government of Uganda. 2015. "The Public-Private Partnerships Act 2015." Kampala: The Republic of Uganda.

Government of the Republic of Malawi. 2011. Public Private Partnership Policy Framework, Office of the President and Cabinet: Lilongwe.

Hellowell, Mark. 2019. "Are Public-Private Partnerships the Future of Healthcare Delivery in Sub-Saharan Africa? Lessons from Lesotho." *BMJ Global Health*, (4 2): 1-6. http://dx.doi.org/10.1136/bmjgh-2018-001217

Joudyian, Nasrin, Leila Doshmangir, Mahdi Mahdavi, Jafar Sadegh Tabrizi, and Vladimir Sergeevich Gordeev. 2021. "Public-Private Partnerships in Primary Health Care: A Scoping Review." *BMC Health Services Research* 21(4):1-18. https://doi.org/10.1186/s12913-020-05979-9.

National Planning Authority. 2023. "Uganda Vision 2040." Accessed October 17, 2023. http://www.npa.go.ug/wp-content/uploads/2021/02/VISION-2040.pdf

Parker, Lucy, Gustavo Zaragoza and Ildefonso Hernández-Aguado. 2019. "Promoting Population Health with Public-Private Partnerships: Where is the Evidence?" BMC Public Health 19(1438): 1-8. https://doi.org/10.1186/s12889-019-7765-2

Rodríguez Enríquez, Corina and Blanco Masaya Llavaneras, eds. 2023. *Corporate Capture of Development: Public-Private Partnerships, Women's Human Rights and Global Resistance*. London: Bloomsbury Publishing Plc.

Roy, Bijoya. 2011. "Public-Private Partnership and User Fees in Healthcare: Evidence from West Bengal." *Economic and Political Weekly* 46 (38): 74-38.

Ssennyonjo, Aloysius, Freddie Ssengooba, Justine Namakula, Ronald Kasyaba, Sam Orach and Sara Bennett. 2018. "Government Resource Contributions to the Private-not-for-profit Sector in Uganda: Evolution, Adaptations, and Implications for Universal Health Coverage." *International Journal for Equity in Health* 17 (130): 1-12. https://doi.org/10.1186/s12939-018-0843-8

Uganda Parliamentary Committee on Health. 2012. *A Report to the Parliamentary Committee on the Ministerial Policy Statement for the Health Sector for the financial year 2012/2013*. Kampala: Parliament of the Republic of Uganda.