Access for the poor and powerless: How changes to health funding have influenced church health service provision in low- and middle-income countries

Judith Ascroft
Nossal Institute for Global Health

Irene Semos
Divine Word University, Papua New Guinea

Alison Macintyre
Nossal Institute for Global Health
Access for the poor and powerless: How changes to health funding have influenced church health service provision in low- and middle-income countries

First draft – June 2013
© 2013 Nossal Institute for Global Health

Corresponding author: Judith Ascroft
Address: Nossal Institute for Global Health, University of Melbourne
jascroft@unimelb.edu.au

This Working Paper represents the views of its author/s and does not represent any official position of the University of Melbourne, AusAID or the Australian Government.

ABOUT THIS SERIES

This Working Paper is produced by the Nossal Institute for Global Health at the University of Melbourne, Australia.

The Australian Agency for International Development (AusAID) has established four Knowledge Hubs for Health, each addressing different dimensions of the health system: Health Policy and Health Finance; Health Information Systems; Human Resources for Health; and Women’s and Children’s Health.

Based at the Nossal Institute for Global Health, the Health Policy and Health Finance Knowledge Hub aims to support regional, national and international partners to develop effective evidence-informed policy making, particularly in the field of health finance and health systems.

The Working Paper series is not a peer-reviewed journal; papers in this series are works-in-progress. The aim is to stimulate discussion and comment among policy makers and researchers.

The Nossal Institute invites and encourages feedback. We would like to hear both where corrections are needed to published papers and where additional work would be useful. We also would like to hear suggestions for new papers or the investigation of any topics that health planners or policy makers would find helpful. To provide comment or obtain further information about the Working Paper series please contact ni-info@unimelb.edu.au with “Working Papers” as the subject.

For updated Working Papers, the title page includes the date of the latest revision.

ACKNOWLEDGEMENTS

The authors acknowledge the valuable comments from reviewers of early drafts of this paper, including Dr Nathan Grills and Dr Gillian Porter. We sincerely thank the staff of the Divine Word University, Papua New Guinea, for the opportunity to continue to support their contributions to strengthened health services in Papua New Guinea.
SUMMARY

In a number of low- and middle-income countries in Africa and in Papua New Guinea, churches and faith-based organisations play a significant role in health service provision, especially in rural and remote communities. Church health services have experienced funding shortfalls, and sector reforms and low expenditure on health have impacted on facility revenues. We conducted a review of the international literature on funding issues faced by church- and faith-based service providers in Africa and in Papua New Guinea.

In a number of countries, the abolition of user fees has had particular consequences for church health service provision. Although churches have acknowledged that user fees are a burden on the poor, they have continued to rely heavily on them. Elsewhere, the continuation of user charges has impacted on access to basic services including antenatal care and childhood immunisation in poorer communities. Initiatives to overcome the funding shortfalls have included collecting deposits prior to services, referring poor patients to government hospitals and terminating treatment early. Pressure to continue to deliver services has resulted in the closure of some hospitals and a focus on smaller community-based dispensaries.

These constraints have been overcome in some cases through greater collaboration between government and church health providers, through the restructuring of user fees to minimise the impact on the poor and through more streamlined and transparent financial reporting. However, failure to fully implement agreed government funding to church health services can cause facility closures and reduced treatments, driving up costs for government and increasing the burden on public provision. There are also mixed findings as to whether greater engagement by church health services with government has translated into broader participation in policy formulation.

Other measures include implementation of community-based health insurance schemes and micro-insurance, often as an interim measure. While these have shown mixed results, they demonstrate a commitment to finding solutions to funding shortfalls.

Funding constraints have also influenced the retention of skilled staff by church health services. Incentives offered by the government and for-profit providers attract workers from the faith-based sector. Structural impediments to equality in salaries and benefits exacerbate the movement of staff from church-managed rural and remote facilities to public facilities in urban centres.

Where churches continue to play a major role in service delivery, there are lessons to avoid the pitfalls arising from funding challenges, examples of innovative practice to maintain services to the poor and opportunities for strengthened collaboration that benefit the health sector overall.
INTRODUCTION

Mixed health systems encompass a range of government and non-government service providers. In a number of low- and middle-income countries, particularly in Africa and Papua New Guinea, church health service providers play a prominent role. Recognising the complexity in the stewardship of these mixed systems, the Health Policy and Health Finance Knowledge Hub, in collaboration with partners from the Divine Word University and the National Department of Health in Papua New Guinea, undertook a literature review in 2011 that examined the characteristics of effective relationships between government and faith-based not-for-profit health service providers with a view to identifying potential lessons for Papua New Guinea, where churches provide up to 50 per cent of health care services (Ascroft, Sweeney et al 2011).

This earlier study noted the difficulties for both government and non-government providers because of a lack of transparency and consistency in health system financing. The introduction of pooled mechanisms such as sector-wide approaches (SWAs) also suggested mixed impacts on church health service provision. In Uganda, for example, the SWA created the framework for improved institutional mechanisms and structures for public-private engagement (Balabanova, Oliveira-Cruz et al 2008) but also resulted in a loss of revenue for some not-for-profit providers, including churches. The loss in revenue coincided with other changes in sources of funding for church health services, which historically relied on broader ministries and networks but which are now supported through greater contributions from national governments and increasingly through user fees (Green, Shaw et al 2002).

Given the increasing importance of non-government contributions to universal health coverage efforts (WHO SEARO 2009) and the focus of churches on providing services to rural, remote and poorer communities, this paper examines how changes in funding have influenced church health service provision. We conducted a review of the international literature on funding for church- and faith-based service providers in Africa and in Papua New Guinea. The experience of adapting to funding shortfalls and overcoming the negative impacts of a reduction in services offers lessons for those countries where church health services remain an important part of the health sector.

METHODOLOGY

Before the formal scoping study for this literature review, a preliminary search was conducted to identify countries where Christian faith-based organisations (FBOs) provided similar levels of health care to Papua New Guinea and to assess whether government and donor funding changes had been studied in these countries. The preliminary search revealed that funding changes have influenced health service delivery differently for different providers (government, private for-profit, FBO and private not-for-profit). Given the importance of church health service providers in Papua New Guinea, the researchers focused the literature review on how changes in funding have influenced health service delivery provided by FBOs specifically, rather than general influences on health service delivery as a whole, in order to answer the research question: How have changes to funding influenced church health service provision? A broad approach to assessing funding was adopted to capture the various health financing reforms that have recently occurred in resource-poor settings and that may be most relevant to Papua New Guinea.

The searches were conducted between October 2012 and February 2013. Peer-reviewed papers were searched for using Medline, Pubmed and the University of Melbourne Discovery databases. The search terms used were ‘sector wide approach’, ‘health funding’, ‘user fees’, ‘health financing’, ‘performance-based funding’ AND ‘developing countries’, ‘church’, ‘faith’ and ‘health’. The search was extended to include additional publications and grey literature through searching Google Scholar using the same terms.

Specific inclusion criteria were that the FBOs studied were exclusively Christian and that the research was focused in resource-poor settings. Only papers that discussed or presented how changes to government and donor financing had influenced FBOs specifically were included; those which assessed financing changes generally across all service providers were not. All studies published before 2000 were excluded so that only recent changes in government and donor
funding were assessed. Research that addressed the not-for-profit sector or the non-government sector as a whole (including the private for-profit) was excluded.

All searches were conducted by one researcher, and two individual researchers reviewed the literature that arose from the searches. Themes emerging from the literature were discussed between all three researchers. Two researchers finalised the literature for inclusion and extracted and compiled all relevant data.

**Limitations**

Due to the limited number of studies addressing FBO service delivery specifically, a scoping study methodology rather than a stringent systematic review was adopted. Literature reviewed in this report did not always adopt robust study designs, and the authors did not aim to judge the quality of evidence supporting the information that was reviewed. Recommendations and evidence relevant to the themes discussed in this report were included based on their relevance to the research question and the Papua New Guinea context.

Despite the scarcity of robust and rigorously designed research evidence, content analysis was used to identify a range of themes emerging from the literature. These included the role of user fees as part of health sector reforms; models of social health insurance; human resource management challenges arising from funding shortfalls; the impact of formal agreements and strengthened partnerships between government and church health service providers; and engagement by churches in health policy and planning. While each of these themes is examined individually, they are closely interrelated.

**FINDINGS**

Most of the evidence relating to church health service delivery comes from countries in Africa, where churches continue to play a significant role in government attempts to bring about universal health coverage. The literature included specific regional or country examples from Cameroon, Chad, Ghana, Kenya, Lesotho, Malawi, Nigeria, Rwanda, Somalia, Tanzania, Uganda and Zambia as well as from Papua New Guinea and India. Although the exact percentage is contested, church health service provision in these countries ranges from 25 per cent in India to 50 per cent or more in Uganda, Zambia and Papua New Guinea (Green, Shaw et al 2002; Ascroft, Sweeney et al 2011).

**User Fees**

The literature illustrates a range of negative impacts on access to services for the poor as a result of continued user fees as well as damaging impacts on church and government service delivery from an overall decline in funding. A number of approaches to overcoming these constraints in different countries were found.

User fees have been abolished in public health facilities in a number of countries in Africa (and elsewhere) as part of broad health sector reforms. While abolition is an important measure to address poor health indicators, those seeking free health care may still be charged fees. In Malawi, for example, only 9 per cent of government and mission facilities provide free access to the entire essential health package stipulated by the government (Lawson, Mazengera 2008).

Due to declines in traditional sources of funding from overseas, user fees remain important sources of revenue for church health service providers in particular (Giusti 2002). Although recognising that user fees are considered to be an unfair mechanism of financing for health services and ‘represent a barrier to access for the poor and the powerless, and … discriminate [against] the sickest’, churches have struggled to maintain their mission to the poor and remain financially viable (Amone, Asio et al 2005).

**Impact on the poor**

Part of the rationale for the abolition of user fees stems from their detrimental impact on the poor. The experience from Uganda was that ‘patient fees … raised little revenue, exemption schemes did not work and as a result, utilisation of services by poor people was very low’ (Yates 2004). The literature also suggests: ‘[L]evels of technical quality of care attained in a system with user fees can be maintained or even improved without the fees through the adoption of basic, sustainable system modifications that are within the reach of developing countries’ (Nabyonga-Orem, Karamagi et al 2008).

In Tanzania the impact of user fees on antenatal and delivery care, combined with out-of-pocket expenditure
for drugs, supplies, ‘informal payments’ and transport, was felt most by those in rural areas, many having to sell valuable household items or borrow money (Kruk, Mbaruku et al 2008). Despite these costs, some chose mission services in preference to government services (even when they were more readily available), resulting in an overall increase in district delivery costs (Kruk, Mbaruku et al 2008).

In Uganda patients described being denied treatment or given reduced treatment if they could not afford to pay (Amone, Asio et al 2005). Elsewhere there was inconsistency in the application of user fees. The governments in Malawi and India officially provide free basic services, but some patients reported paying for antenatal care and childhood immunisation while other services were free (Rookes and Rookes 2012). In a mixed methods study in 13 countries, it was found that many church health services continued to charge fees, although most attempted to subsidise poorer patients through measures such as a ‘poor fund’ to which patients apply or adjusting fees according to a means test (Rookes and Rookes 2012).

**Impact on churches**

The Christian Health Association of Malawi (CHAM) noted that, as a result of the introduction of a mandatory fees and exemptions policy in 2007, up to 50 per cent of one hospital’s patients were exempt from charges. This loss of income, combined with declining income from other sources, was expected to put many facilities under financial pressure. In Kenya 10 church health facilities closed in two years, and the Christian Health Association of Kenya estimated accumulated debt of patients unable to pay was approximately 30 per cent of expected church health service revenue (Rookes and Rookes 2012).

The overall reduction in user fees has also reduced flexibility for church health providers. When user fees were levied in Uganda, for example, health facilities were able to purchase basic drugs outside the public system based on their requirements. When facilities were required to purchase predominantly through the public system, they experienced both a reduction in flexibility and delays (Nabyonga-Orem, Karamagi et al 2008).

In Malawi church health facilities have had to implement a range of strategies to avoid unpaid bills, some of which conflict with their mission to the poor. These include collecting deposits in advance of treatment; providing only low cost treatment; postponing discharge until patients pay; referring very poor patients to government hospitals; and terminating treatment early. In contrast, some provide high tech and high quality tertiary services that compete with private for profits—using the profits to subsidise services for the poor, a strategy more commonly used in urban hospitals (Rookes and Rookes 2012).

**Overcoming constraints**

Given the dilemma between needing to charge fees on the one hand and serve the poor on the other, churches have worked to overcome some of the constraints both in conjunction with their church network organisations and through greater collaboration with government.

Some church health services have reduced costs by focusing on small community-based dispensaries or basic hospital services (excluding expensive diagnostic investigations and treatments). Others rely on committed Christian staff to work for reduced salaries (Rookes and Rookes 2012). Reductions in salary costs are important because significant increases in costs incurred by the private not-for-profit sector have arisen from labour (Giusti 2002).

Increasingly church health services are also using grants from the government ‘to lower their fees and attract more poor patients rather than use all their funds to improve service quality for their existing clients’ (Yates 2004).

Improved utilisation of church health services is one way of expanding basic health services, and even where user fees continue to be applied, churches and governments have worked together to minimise the negative impact. An MOU between the government of Malawi and the CHAM, for example, includes agreed principles that institutions charge ‘minimum’ user fees so that poor people in rural settings are able to afford services. The Ministry of Health continues to pay salaries to all CHAM employees because the minimum user fees fall short of cost recovery and cannot cover the cost of salaries (Kalungwe 2008). The WHO has suggested that modest fees do not prevent poor people’s access and that ‘CHAM is an example of a good balance between efficiency, quality, and financial
Concerned about the impact of user fees on the poor, the Uganda Catholic Mission Bureau undertook a survey of 10 hospitals to assess differences in policies and to offer a tool for a more focused and rational structure and management of user fees. It implemented flat rates and lower fees for the most vulnerable users, to replace the fee-for-service system, in some hospitals. As a result, hospital utilisation rates improved, particularly for pregnancy, childbirth and childhood illnesses. Because of this increase, there was no detrimental effect on overall revenues, and the monthly revenue from user fees actually increased. This fee system, combined with regular revenue from government subsidies and some external aid, allowed these hospitals to survive (Amone, Asio et al 2005).

Alongside these changes to the user fee system in Uganda, accounting and financial reporting were streamlined and made more transparent; health workers received a higher and more regular salary as an incentive for improved care; and ‘the acquisition, storage and use of drugs and consumables was strictly monitored and rationalized’ (Amone, Asio et al 2005).

In Tanzania households at a distance from government facilities often choose in-patient care at faith-based providers to save on transport costs. ‘Such providers sometimes offer flexible pricing policies to poorer households’ (Mtei, Makawia et al 2012). As a result, the government policy of subsidising faith-based hospitals to act as district hospitals in some areas benefits the poor (Mtei, Makawia et al 2012). Mtei, Makawia et al further suggest: ‘[G]reater subsidies might be offered to faith-based facilities for inpatient care in rural areas, even when district hospitals are present, so as to increase access to health care for poorer groups’ (Mtei, Makawia et al 2012).

Citing the example of Uganda, Giusti (2002) suggests, while recognising some weaknesses in church health service provision, that in resource-constrained settings, subsidies to the private not-for-profit sector may be desirable, particularly where they result in increased services. As most public facilities operate at full capacity and building new institutions is an expensive option, the use of existing church health facilities and competencies could improve wider population coverage.

Health Insurance

Although health insurance was not a specific search term for this literature review, we identified examples of relevance to the research question in which church health services have piloted a range of community-based health insurance schemes and micro-insurance strategies in order to overcome the need to levy user fees.

These schemes have been implemented with mixed results. In Rwanda, for example, households contributed to a funding pool in order to access treatment at local clinics. In this way, individual risk was reduced, and funds flowed into the health system. Although this scheme remains reliant on donor funds, it has reached in excess of 80 per cent of the population. In Tanzania, by contrast, a district-based health insurance scheme was introduced but reached only a small minority (Holley 2011).

Even when church health services have been part of broader national health insurance schemes, there are risks. In Ghana church hospitals and clinics under the umbrella of the Christian Health Association of Ghana entered into an agreement with government to provide health services to the public under the national health insurance scheme. However, payments to church health services were often delayed for several months, adversely affecting cash flow (Holley 2011).

Recognising that church health services cannot rely on fees to plan effectively and that a careful balance is needed between public and private financing mechanisms in order to reduce the risk for the poor and sustain services, micro-insurance strategies have ‘emerged as an innovation aimed at providing health insurance protection to low income communities in exchange for regular premium payments ...’ (Holley 2011). The approach is similar to membership schemes offered to local communities by church hospitals, but is expected to overcome some of the challenges of managing costs and membership (Holley 2011).

The Anglican Health Network, in partnership with a leading micro-insurance organisation, established pilots in Tanzania and India to enable it to pool the risks of health expenditure. In India the pilot was based on a large teaching hospital; with the assistance from government subsidies to support payment of
Health Policy and Health Finance Knowledge Hub WORKING PAPER 31

Access for the poor and powerless: How changes to health funding have influenced church health service provision in low- and middle-income countries

remuneration packages are offered.

Salaries for church health workers are also sometimes lower than those of the public and the private for-profit sectors. In Uganda, ‘average salaries in the private not-for-profit sector are about 30 per cent less than those of their colleagues in the civil service’ (Giusti 2002). Other country case studies show that the public and private for-profit sectors provide better incentives than do church health services (Dambisya 2007; Flessa, Moeller et al 2011). For example, the pension arrangements provided for church health service workers may not be as competitive as those of government workers. In Malawi the pension package for midwives in the government is 25 per cent compared to 15 per cent for workers of the CHAM (Dambisya 2007).

By meeting funding shortfalls, governments have played a role in minimising the loss of human resources from church health services, but the experience has been mixed. Even where some assistance is provided to church health services (usually for salaries), there are few incentives to enable retention of workers. The Lesotho government provides some funding for church health worker salaries, but it is insufficient to allow the Christian Hospital Association of Lesotho to meet the gap in salary (Dambisya 2007).

The Ministry of Health and Social Welfare in Lesotho has signed an MOU with the CHAL to eliminate salary discrepancies between staff working in public and church facilities. The agreement has been explicitly developed to ‘lessen medical personnel flight from faith-based health facilities to government facilities where the pay is better’ (Ramashamole 2011). However, even with an agreement in place, difficulties in disbursements and significant discrepancies between remuneration and benefits for CHAL and government workers remain (Ramashamole 2011).

There are also structural impediments to improving health sector resource management. In Papua New Guinea, for example, the Treasury mandates that church health staff base-salaries cannot go beyond the midpoint of the salary base scale as per the Government wage structure’ (Sorensen 2011:16). As a result, government funding for salaries, disbursed through the Churches Medical Council, is insufficient to retain church health workers (Sorensen 2011).

Churches have responded to this in part by introducing

premiums for individuals classed “below poverty line”, the scheme has managed to draw in 40,000 people in its first seven months of operation’ (Holley 2011). In Tanzania the strategy differs and began ‘by targeting individuals within the parish community and seeks to pool together their contributions, while commissioning several health service providers to provide treatment’ (Holley 2011).

The emphasis in micro-insurance is on prevention and education. The Anglican Health Network has worked with insurers to increase understanding that primary health care interventions are the key to reducing the burden on the insurer and that it is in the insurer’s interests to support these initiatives to minimise their risk (Holley 2011).

**Human Resource Management**

The literature suggests that changes to funding mechanisms for church health services have had a particular impact on human resources. The adverse funding situation has impacted on the ability to retain skilled workers at the same time as financial and other incentives offered by the government attract workers from the faith-based sector. This results in competition for limited resources between government and church, as well as with the for-profit sector.

Churches are significant employers in many of the countries in this review: in Lesotho, the private sector under the Church Hospital Association of Lesotho (CHAL) and the Private Association of Lesotho employ 30 per cent of all physicians and 39 per cent of all nurses (Dambisya 2007); in Uganda, the private not-for-profit sector delivers 40 per cent of overall health services nationwide (Asiimwe 2008); in Malawi, the CHAM provides for 37 per cent of health care and a large proportion (85 per cent) of coverage in rural areas (Lawson, Mazengerera et al 2008); in Papua New Guinea, churches are responsible for nearly 4000 staff (Sorensen 2011).

Funding shortfalls have impacted staffing levels in a number of these countries, including Lesotho, Malawi and Uganda (Giusti 2002; Dambisya 2007; Asiimwe 2008) The lack of funding support to sustain human resources for church health services, combined with often poorer living conditions and a harsh working environment, results in a drain of workers to the public and for-profit sector, where enhanced salary and
a range of non-financial incentives. For example, educational benefits and training opportunities have been provided to assist in the retention of staff.

Government agreements such as service level agreements also appear to have negative consequences on the workload and the long-term retention of staff in church health services. About 87 per cent of the staff implementing the service level agreements in Malawi complained of increased workload despite the incentives provided (Kalungwe 2008). As a consequence of the increased demand for maternal and neonatal health services, many health workers resigned.

Elsewhere the implementation of sector-wide approaches has contributed to discrepancies in salaries and conditions between church and public sector employees with a perception that SWAp pensions tend to favour the public sector and lead to high attrition rates from church health services (Dambisya 2007). In 2003-04, the government of Uganda, needing to fill 6000 health worker positions, increased government salaries and offered improved remuneration packages that resulted in a substantial loss of church health service staff (Asiimwe 2008).

Inflexibility in funding mechanisms for human resources in church health services partly contributed to this situation in Uganda (Asiimwe 2008). In addition, staffing agreements which are ambiguous on the origins of appointments (that is, whether staff are employed from the public sector or the private sector and paid differently) can lead to human resource accountability issues and management difficulties (Ramashamole 2011; Boulenger and Criel 2012).

Governments have tried to address human resource shortages in some countries by allowing staff from the public sector to work for church health services. This strategy has not always been regarded as beneficial. In Cameroon at Tokombere hospital, staff recruited from the public sector to fill church health service vacancies were not considered to be suitable for the needs of the hospital and were regarded as of poor quality (Boulenger and Criel 2012).

Sorenson (2011) strongly advocates equal salary conditions for government and church health workers in Papua New Guinea because of the nature of the work that church health workers do. Chitimbre (2011) urges that greater efforts be put into health care infrastructure and amenities in rural areas, which will improve conditions in which health workers live and work.

Other factors impacting on human resource shortages in both church and public sector health facilities are low numbers of trainees and deaths and illnesses of nurses or physicians from HIV/AIDS (Dambisya 2007; Lawson, Mazengera et al 2008; Ramashamole 2011; Chimanimire 2005). Large-scale skilled worker migration is also said to have had a negative effect on the quality of health care in both public and not-for-profit institutions (Chimanimire 2005). Low salaries, inadequate medical and pension benefits and challenging working conditions are among the reasons cited by church health staff for migration (Chimanimire 2005).

**Strengthened Partnerships and Policy Engagement**

One way in which churches have responded to funding challenges in the health sector has been to recognise the need for greater collaboration with governments through more formalised partnerships, even if this results in some loss of autonomy. Public-private partnerships, along with other health sector reforms, are important for the attainment of national and international health goals. These partnerships have enabled churches to access increased government funding and to be more closely integrated into national health care delivery systems (Lochoro, Bataringaya et al 2006; Boulenger and Criel 2012; Rookes and Rookes 2012).

In Papua New Guinea the National Health Plan 2011-2020 recognises the vital role of partnerships, particularly with churches, to improve health service delivery and health system strengthening (Sorensen 2011; Ascroft, Sweeney et al 2011). Similarly, the National Health Policy and the Sector Strategic Plan in Uganda recognise the need for the support and cooperation of all of the actors in the health sector (Asiimwe 2008; Giusti 2002).

In some countries this recognition has led to broader participation in sector policy formulation and development (Giusti 2002; Adjei, Maniple et al 2009 in Ascroft, Sweeney et al 2011). But elsewhere churches have been isolated from national policy and planning, resulting in harmful effects on the health system (WHO 2007 in Ascroft, Sweeney et al 2011).
Formal contracts and agreements between church health providers or their umbrella organisations and different levels of government take many forms. In Papua New Guinea, in the context of provincial health reform, Sorensen (2011) and his colleagues suggested a purchaser-provider approach in which service delivery expectations are defined in return for funding. In contrast, in Uganda, the collaboration is wide-ranging and includes policy, coordination and planning, financial resource mobilisation and allocation, human resource management, capacity building and management, community empowerment and involvement and the management and implementation of services (Lochoro, Bataringaya et al 2006).

A study in Uganda (Lochoro, Bataringaya et al 2006) found that a strengthened partnership with government, including through the provision of increased funding and user fee adjustments, ‘brought dividends to the whole health sector in terms of increased access, quality, equity and efficiency…’. As an example of the equity dimension of this enhanced partnership, the study highlighted markedly increased hospital utilisation rates, especially for the rural poor. Since the largest jump in utilisation was observed for in-patient child health services, the authors concluded that, prior to the user fee adjustments in church health services, which government funding had addressed, very sick children were being excluded from health care.

Formalisation of the partnership in Uganda has extended the initial government funding to include additional support of salaries for government doctors posted to church hospitals and credit lines for medicines from the national level (Lochoro, Bataringaya et al 2006).

Financial contributions conditional on the preparation and approval of a comprehensive work plan and budget and the signing of an MOU with the local government have been critical elements of support in the partnership in Uganda and have addressed a number of constraints that are commonly identified in public-private relationships. These include sporadic and unpredictable funding, which has resulted in the continuation of user fees by church health providers (Lochoro, Bataringaya et al 2006).

In Zambia, Lentz (2010) reported that the lack of consistency in funds transfer resulted in downsizing of church health services, reduced treatments and delayed salary payments for staff. Other deficits in funding arise from a lack of provision for administrative costs and management. In Papua New Guinea, churches cover these from within their operational costs (Sorensen 2011).

Unpredictable funding may also exacerbate deficits in public administrative capacities, which limit transparent financial records (Lentz 2010). Improved accountability for both public funds and non-government financial resources through strengthened internal financial and reporting procedures is also necessary among church health service providers (Sorensen 2011).

A further constraint on formal contracting lies in national acceptance but much less appreciation for its value at a district level. This has resulted in slower than anticipated engagement in partnerships at sub-national levels in some countries. Lochoro, Bataringaya et al (2006) describe mutual suspicion and a sense of competition at district level in Uganda, which the government sought to address through routing the public funding through district government facilities.

Formal contractual relationships can give greater visibility to the contribution of church health services to national health objectives. The contributions of churches differ in different contexts, and even within individual countries they can be under-recognised. Churches in Papua New Guinea are responsible for more than 600 health facilities, including large district hospitals, health centres and aid posts, manage 3800 staff and run five nursing schools and 12 community health worker training schools. However, more than 151 of these facilities are ‘unfunded’, and 850 health staff positions are not covered by government grants (Sorensen 2011), in spite of Papua New Guinea being perceived as one of the few countries in which the government pays the salaries of church health staff (Rookes and Rookes 2012). Churches have addressed this deficit by directing government allocations to unfunded facilities and staff so that significantly fewer resources are available to those health centres that are nominally funded (Sorensen 2011).

While formal contracts are important, Boulenger and Criel (2012) suggest that success may lie more in genuine central partnerships and dialogue than in operational contracting at the district level. Highlighting related contracting issues from four country case
studies in Uganda, Chad, Tanzania and Cameroon, the authors note that difficulties continue to affect seriously the not-for-profit sector and remain largely underestimated by the public sector. ‘The contracting agreements read ... as a recipe for disappointing, imbalanced relationships, benefiting to some extent the public sector while draining the faith-based sector.’

CONCLUSION

A lack of funding for the health sector overall and changes in financing for church health services have resulted in the closure of some facilities and measures aimed at expenditure control. This has impacted negatively on those dependent on church health services in rural communities, especially the poor. Costs for government and the burden on public service facilities have also increased.

As Giusti (2002) and Mtei, Makawia et al (2012) suggest, it makes economic sense for governments to support existing church health services (especially those in remote areas or serving vulnerable communities) to avoid duplication or leaving poor communities with no services. Support for church health services would also improve population coverage, given that many public facilities operate at full capacity.

Importantly there are also equity, access, quality and efficiency benefits for the health sector overall that can arise from strengthened collaboration between churches and governments (Lochoro, Bataringaya et al 2006; Mtei, Makawia et al 2012).

With a range of factors impacting negatively on human resources in both church and public sector health facilities, improved cooperation could result in greater equity in employment conditions and improved retention of staff rather than the competition that currently exists in some countries.

Although church health services and governments have worked together to overcome some of the difficulties in funding for the sector, impediments to church health service operations and to the retention of skilled health staff remain. Health outcomes can be improved through greater engagement of all health sector actors in policy formulation and sector-wide planning and from greater recognition of the role of churches in service provision in some contexts.

For countries, including Papua New Guinea, where churches continue to play a major role in service delivery, there are lessons to avoid the pitfalls arising from funding challenges within the sector, and examples of innovative practice that can be utilised to maintain services to the poor.
REFERENCES


Dambisya, Y.M. 2007. A review of non-financial incentives for health worker retention in East and Southern Africa. EQUINET Discussion Paper Series 44. School of Health Sciences, University of Limpopo; Regional Network for Equity in Health in East and Southern Africa (EQUINET); Harare.


