STRATEGIC PLANNING AND FUNDING FOR MEDICALS IN REGIONAL REFERRAL HOSPITALS IN UGANDA

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ABSTRACT
The study explored the effect of funding on planning for medicals by regional referral hospitals in Uganda. The research was carried out in regional referral hospitals, one from each region, and these included Gulu, Masaka, Mbale and Mbarara regional referral hospitals. The findings showed that: 1) there was a positive significant relationship \( r (206) = 0.586, P < 0.01 \) between funding and planning for medicals in regional referral hospitals; 2) only 30% of the respondents had received capacity building training in planning; 3) regression analysis yielded an \( R^2 \) value of 0.34 implying that 34% of the success of planning for medicals in regional referral hospitals can be explained by funding.

Key Words: strategic planning, funding, referral hospitals

INTRODUCTION
Strategic planning is practised in the health sector as evidenced by various strategic plans (Health Sector Strategic Plan I for the period 2001/2 – 2004/5; Health Sector Strategic Plan II for the period 2005/6 – 2009/10; and the Health Sector Strategic and Investment Plan III for the period 2010/11 – 2014/15). These Strategic Plans were developed by Ministry of Health with a primary objective of availing essential medicines, health supplies, medical equipment and medical resources in the Regional Referral Hospitals among other public health facilities. However this top-down approach to planning has not been successful as expected and in the recent past dissatisfaction has arisen because medicines, medical equipment, facilities and resources have been in short supply in regional referral hospitals (Ssali, 2013; Mafabi, 2013; Kitatta, 2012; HURINET – U, 2012; Walker et. al., 2010; MOH, 2009b; Kakaire, 2008). As a result the usefulness of the top-down planning model employed by Ministry of Health was questioned. Therefore this study sought to establish the linkage between funding and planning for medicals in the regional referral hospitals.

Problem Statement
Strategic planning in the health sector is a top-down approach with Ministry of health being at the pinnacle and charged with development of plans for the entire health sector. The objective of the top-down approach to planning was to ensure that medicals are procured and are available in all the health centres in the country, including regional referral hospitals. One of the main reasons for this dominance of the top-down planning approach is that it is seen to allow rapid, large scale spending of budgets in accordance with pre-established timetables. It also gives government planners, donors and the bureaucrats an illusory feeling of control and efficiency (Cooksey and Kikula, 2005). This approach to planning has not been effective as regional referral hospitals have experienced rampant shortage of even life saving medicines (Mafabi, 2013). Lack of funds to purchase drugs
also affects their availability (HURINET – U, 2012) as the credit lines are not sufficient thus the orders have to be reconciled with the available money by way of prioritisation which may lead to shortages of some essential medicines (Wandawa et al., 2012). The above problems precipitated the need to further understand the linkage between funding and planning for medical in the regional referral hospitals. Why should regional referral hospitals lack equipment, devices and medicines yet the strategic plans are in place to ensure availability of the same.

**PURPOSE AND HYPOTHESIS OF THE STUDY**

The main purpose of this study was to analyse the relationship between funding and strategic planning for medicals in Uganda’s regional referral hospitals. The central question for this study was: Does funding have an effect on strategic planning for medicals in regional referral hospitals? The key hypothesis of this study was:

- **H₀₁**: The funding of regional referral hospitals has no effect on strategic planning.
- **H₁**: The funding of regional referral hospitals has an effect on strategic planning.

**REVIEW OF THE LITERATURE**

The study reviewed literature under strategic planning and funding.

**Strategic planning**

This study defined strategic planning as the process of identifying organisational objectives, devising appropriate strategies to allocate the available resources by way of priority to realise the set objectives, assessing the impact of the chosen strategy, and finally taking remedial action where the chosen strategy does not achieve the set objectives. This study considered the strategic planning process to involve five steps: analysis of the status quo; determination of needs; allocation of resources; implementation; and finally monitoring and evaluation.

**Environment Analysis**

The environment within which an organisation operates can be classified as internal and external. Scanning this environment is therefore crucial at the beginning of any planning process (Trainer, 2004) because basically, strategic planning is all about creating an alignment between an organisation’s day-to-day activities and its environment (Sevier, 2003). Ruocco & Proctor (1994) suggest SWOT analysis as an effective and systematic way of matching the organisation’s strengths and weaknesses with the opportunities and threats that exist in the environment. This is further supported by Trainer (2004) who endorses the use of SWOT analysis to analyse the environment, for it lies at the heart of strategic planning. The analysis of opportunities and threats is not only an important part of the planning process but the mere existence of these external forces can be a catalyst for planning as many organisations are driven by the desire to outperform their competitors.

**Determination of needs**

A need is a gap between what is and what should be (Jacobsen, 1999), it is a systematic exploration of the way things are and the way they should be. Conducting a needs assessment involves performing a “gap” analysis and identifying priorities and importance (Rouda & Kusy, 1995). Gap analysis involves determining and documenting the difference between organisational requirements and current capabilities. Gap analysis will quantify the variance between your current position and that of best in class (Janneti, 2012). The difference which in this case is referred to as the "gap" between the current and the necessary will identify the needs (Rouda & Kusy, 1995). By
conducting a Gap Analysis, you can identify what you need to do to "bridge the gap" and make your organisation a success. It can also be used at any stage during the duration of a project to analyse the progress made so far, but it is more critical at the beginning.

**Allocation of resources**
The main reason that advocates stress the importance of linking strategic planning with allocation of resources is that strategic planning initiatives should inform how financial resources are used in the organisations (Eadie, 1983; Canary, 1992; Ingham et. al., 2002). By identifying strategic goals during the planning process, organisations can prioritise what is important to accomplish in the near future and allocate resources accordingly (Berry & Wechsler, 1995). Bryson (2004) writes that strategic thinking should precede budgetary decisions, not the other way around, though being involved in the budgetary process can be an effective way for officials to design, adopt, and execute the strategic plan. Human resource management is likewise an integral part of planning (Kerr, 1994; Rainey, 2003) as it ensures that organisations have the workforce to meet strategic goals (Joyce 2000). Linking human resource management with strategic planning has mutual benefits for each process as Eadie (1983) writes that strategic planning should help inform human resource decisions, such as analysing the human capital needs. It is therefore critical that resources, both financial and human be allocated effectively and efficiently if the process of strategic planning is to be successful.

**Implementation of the strategic plan**
After strategy formulation and allocation of resources, its implementation must be programmed because even the best formulated strategies without correct implementation don’t have practical value (Rezvani et. al., 2011). For strategy implementation there should be coordination of organisation’s skills, resources and capabilities at the executive level as well as cooperation and sympathy among managers and employees of all sections and units of the organisation (Rezaian, 2008). Thompson & Strickland (2003) (cited in Schaap, 2006) have stressed that the strategy-implementing/strategy-executing task is the most complicated and time-consuming part of strategic management. This may explain why some strategies that are clearly spelt out or perfectly prepared are never realised by the respective organisations. Dransfield (2001) states that effective communication systems are needed in implementing strategy to make sure that everyone within the organisation shares the vision, mission, objectives and values and has a good grasp of the strategy and how it relates to their own efforts. The real challenge therefore is not in development of the strategic plans, but in implementation, as many organisations assume that strategy is about what happens in the future, yet it is about what the organisation does today to create its desired future.

**Monitoring and evaluating the implementation of strategic plans**
To determine how much the goals are achieved, implemented strategies should be monitored and controlled. Strategy evaluation includes three main activities: Review of main principles of organisation’s strategy; Compare expected results with actual results; and Taking corrective actions to ensure the accuracy of performance and operating based on plans (Forouzandeh, 2005). No strategic plan can help an organisation to make and sustain forward momentum if it is “shelved,” not updated or revised in light of subsequent events or new realities. In situations where the expected results do not rhyme with the actual results, Bryson (2004) not only suggest a re-assessment of the chosen strategy, but also the strategic planning process as well. The
monitoring and evaluation process should therefore ensure that the anticipated results are being achieved and not any other results, irrespective of how good they may appear.

**Funding of regional referral hospitals**

Health financing provides the resources and economic incentives for the operation of health systems and is a key determinant of health system performance in terms of equity, efficiency, and health outcomes (Schieber, Baeza, Kress & Maier, 2006). Sustainable financing is one of the critical determinants of equitable access to medicines and the team responsible for procurement planning of strategic public health supplies should carry out a review of all sources of financing that will become available during the lifetime of the strategic plan and verify conditions for using these funds (WHO, 2006). Health financing can be mobilised from internal or external sources with due consideration for sustainability. This study considered the sources of financing to include Government, user fees, donor funds, health insurance schemes and public private partnerships.

**Government funding**

In the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis, and other Related Infectious Diseases, African leaders pledged to increase health spending to 15 percent of their government’s budgets (Haines & Cassels, 2004). However, public financing of services does not imply that all services can be provided. Indeed, given the resource constraints low income countries face (Gupta et. al., 2004; Schieber et. al., 2006), it is often very difficult to choose between what to include (and exclude) in the universal benefits package (Jamison et. al., 2006). This implies that the health sector, and by extension the regional referral hospitals cannot deliver fully since with the limited resources available, the government priorities may not rhyme with the sector priorities which is further complicated by issues like pilferage and irrational use. The government’s budget for the health sector is insufficient to address the identified issues as it is on average 8.58% of total government expenditure, which is below the Abuja Declaration target of 15%. This meagre allocation is affected by corruption tendencies and is further complicated by the fact that even when the money does get through, spending priorities often seem skewed as funds meant for medicine are diverted to other areas like foreign travel and purchase of vehicles.

**User fees**

The need to significantly scale up resources to meet the millennium development goals (MDGs) in low income countries has pushed the user fee issue to the forefront (World Bank, 2003). The Bamako Initiative shows that user fees may be an important revenue source where institutions are weak, resources are limited, and the choice is between having drugs or not having them (World Bank, 2003). User fees can improve benefit incidence if user fee policies have been well designed and implemented, and more so where the fees are set below private market levels, which may result in a net reduction in overall out-of-pocket spending for the poor (Bitrán & Giedion, 2003). Drugs are often targeted for such fees because it is felt that patients will pay for them if they have no other choice. But the main problem is that user fees discourage some people, particularly the poor, from seeking care at all. And among those who do seek care, the resulting costs can be financially crippling, to the extent that households may sacrifice food, education, or other important purchases to pay for drugs.

**Donor funds**

Historically, many countries received a steady distribution of donor assistance for pharmaceutical procurement in the form of
donated essential medicines for specific disease prevention programs and bilateral aid (Rao et al., 2006). The Annual Health Sector Performance Reports revealed that on-budget donor support to the health sector averaged 37.21% between fiscal years 2000/01 to 2014/15. This is a significant percentage considering the fact these donor funds should only supplement government funding of the health sector. The new resources may overwhelm the system, and the donors’ reporting and administrative requirements may impose additional burdens on countries (Schieber et. al., 2006). Another major concern is that the donor agencies may substitute their priorities for countries’ priorities which creates a mismatch with regard to country preferences. However, criticisms of donor aid would seem to suggest that, in the absence of foreign funds, domestic governments would do a good job funding their respective health sectors. This is however not the case in Uganda as donor funds play a major part and have been a constant in the national budget and the health budget in particular, which makes this source of funding significant.

**Health Insurance Schemes**

Health Insurance schemes have emerged because of high out-of-pocket spending, uncertainty surrounding anticipated financial flows from donors and unregulated private sectors (Bennett, Creese and Monash, 1998). While an individual may have some idea about their need for future medical services, the exact amount they spend on healthcare remains uncertain to them to a great extent. Therefore, in such a situation, health insurance is one important method which helps significantly to spread the risk associated with failure to receive treatment or procure the necessary medicines due to lack of resources. In Uganda, the National Health Insurance Bill (2007) proposes a National Health Insurance scheme as one of the mechanisms for financing the health sector. The bill requires civil servants and formally employed Ugandans to make a mandatory contribution of 4 per cent of their monthly earnings to the Health Insurance Scheme, while their employers remit an additional 4 per cent. The schemes can therefore be part of an overall solution to financing health care, but they are unlikely to play a major role. This is because the cost associated with receiving treatment is too high as compared to the levels of income of the potential subscribers.

**Public Private Partnerships as a financing option for hospitals**

In the past, the private and public sectors in health operated more or less independently in most countries with the assumption that the private sector provided services mostly to the wealthy, while the government served the poor who were unable to pay for services (Berman, 1998). However, recent evidence has suggested that this assumption does not accurately represent reality, and that the private sector often is the primary source of treatment for the poor while the government system often provides far more services to the rich than the poor (Gwatkin, 2000). This is largely true for Uganda because a large portion of health care budget is spent on sophisticated hospital care in national and regional referral hospitals, which are found in urban settings, rather than primary care or preventive care that serves the needs of the rural poor. The latter are mostly served by private clinics or health facilities which have medicines and health practitioners readily available.

The recognition of the interdependence between the public and private sectors in the provision of healthcare has lead to the formation and maintenance of partnerships between the two. With regard to the health sector, these partnerships provide alternative means to fund expensive and long-term investments for which the state may not have sufficient resources to invest in a lump sum given it priorities. In
Uganda, the Public Private Partnership Bill (2012) governs the relationship between government and private entities in public private partnerships and provides for guidelines and procedures for the development of PPP projects.

**METHODOLOGY**
This section highlights the research design, unit of analysis, the sample size, methods of data collection, validity and reliability of the research instrument as well as analysis of the data.

**Research Design**
The study adopted the survey design, and it involved the use of questionnaires to gather data about people and their thoughts. It is the most widely used method for primary data collection, the major advantage being its flexibility, given that the target population was elite (Polit & Hungler, 1995). Quantitative paradigm was used to describe and test relationships and examine cause and effect interactions among variables (Burns & Grove, 1993). Qualitative approach was used to analyse descriptive data.

**Unit of Analysis**
The unit of analysis for this study were the members of the Medicines and Therapeutics Committees’, Top Management, Hospital Management Committees’, PDU’s, Ward In-charges(s) and general staff of the regional referral hospitals of Gulu, Masaka, Mbale and Mbarara. It also included selected members from NMS and MOH.

**Sample size**
The sample of 206 respondents was determined using the formula proposed by Saunders, Thornhill and Lewis (2009). 51% of the respondents were male and 49% were female. Majority of the respondents had a diploma (39%) while 28% had professional qualifications related to the health sector.

**Data Collection methods**

**Interview**
The study adopted the recommendations of Saunders et. al. (2000) and adopted a range of different interviewing styles. The interviews were carried out with the consent of the respondents after explaining the purpose and assuring confidentiality. The interviews were tape-recorded and later transcribed because the study was not just interested in the kind of responses that were provided, but also in the way that the respondents provided the information.

**Observation**
Observation involved recording notes to assist in determining what the observed events might mean and acting as leads to provide answers to the research questions during subsequent data analysis (Pitney and Parker, 2009). The issues that were observed ranged from whether the plans are displayed on the notice boards through to actual delivery of the medicals. It also included physical observation of the hospital wards, operating theatres, storage areas and general hospital premises.

**Document review**
The documents reviewed included the annual procurement plans for the respective referral hospitals, Health Sector Strategic Plans, Annual Health Sector Performance Reports, relevant Ministry of Health reports, National Health Policy, National Hospital Policy, National Drug Policy, Order forms for medicals, delivery schedules, journal articles, books, magazine articles and publications, among others.

**Focus group discussion**
The specific topic for discussion was introduced and followed up with guiding questions and the participants freely deliberated on the topic, giving their ideas/opinions. The major advantage of this method was that it involved real
stakeholders (Mbabazi, 2008) and was thus helpful in bringing to the surface issues that had otherwise not have been emphasised by the other methods employed by the study.

**Questionnaire**
The choice of the questionnaire was dictated by the nature of research and respondents given that they were elite and capable of filling it. Questionnaires were inexpensive to administer and respondents felt free to express their views and answer questions at their own pace without fear of information being linked back to them (Burns & Grove, 1993). The questionnaire consisted of 50 items divided into three sections: i) Personal Characteristics; ii) Strategic Planning; and iii) Funding of Regional Referral Hospitals. The questions in sections ii and iii were scored in a Likert scale (5: “strongly agree”; 4: “agree”; 3: “uncertain”; 2: “disagree”; and 1: “strongly disagree”).

**Validity of the Instrument**
Content validity was measured using judgemental or panel evaluation with content validity ratio (Cooper and Schindler, 2006). The study employed three content experts as recommended by Lynn (1986), which was also in line with Gable & Wolf (1993) who recommend between 2 to 20 experts. The item-rating continuum advocated by Davis (1992) was used where 4 = “highly relevant”; 3 = “quite relevant”; 2= “somewhat relevant”; 1= “not relevant”. The content validity index (CVI) was computed as the total number of items rated relevant (“highly relevant” and “quite relevant”) divided by the total number of items. The CVI, using the above formula was 0.918, which was higher than the acceptable value of 0.80 (Davis, 1992; Polit & Beck, 2004). This indicated that the items on the questionnaire were valid and could accurately measure the study variables.

External validity was established by conducting a pilot survey where a total of 30 questionnaires were distributed to respondents in Jinja regional referral hospital. This exercise was carried out to highlight any deficiencies and possible weaknesses in the questionnaire design, and the questionnaire was accordingly revised to suit the objectives of the study (Polit & Hungler, 1995).

**Reliability of the Instrument**
Reliability of the questionnaire was measured with Cronbach’s alpha statistics using SPSS 18.0 software. The average Cronbach alpha was 0.811, which showed that the questionnaire was a good measure of the study variables based on George and Mallery (2003) who state that a Cronbach Alpha value of between 0.80 and 0.89 is good.

**Analysis of data**
The data obtained from the questionnaires were quantitatively analysed using the SPSS 18.0 software program. At the univariate level descriptive statistics were used and this included distribution analysis of frequencies and percentages. At the bivariate level analysis inferential statistics were applied to study the relationship between the variables under study to determine the correlation. Multivariate level analysis included regression analysis to determine the effect of the independent variable on the dependent variable.

The responses and opinions obtained from interviews and focus group discussions were qualitatively analysed using three methods: i) thematic analysis ii) comparative analysis and iii) content analysis.

**RESULTS AND INTERPRETATION**

**Quantification of requirements**
Strategic planning in the health sector is a top-down approach with Ministry of health being at the pinnacle and charged with development of
plans for the entire health sector. In order to improve on planning for essential medicines and health supplies, the Pharmacy Division in the Ministry of Health set up the Quantification and Procurement Planning Unit (QPPU) in 2010. The unit is aimed at providing a reference point on quantification and procurement of medicines and health supplies and it provides information on national stock gaps in medicines and health supplies. This unit is responsible for estimating the quantity of medicals that are required by each regional referral hospital and consequently the amount of funds that are to be allocated to each of them during preparation of the draft budget estimates for the Ministry of Health.

The quantification unit uses software packages Quantimed and QuanTB for forecasting and quantification using one of three methodologies (consumption based methodology, morbidity based methodology and proxy consumption methodology). It supplements these three methodologies by adjusting for other variables like bed capacity, catchment area and number of specialities that the hospital handles. Observation in the hospital wards indicated that the number of patients that receive treatment while sleeping on the floors of the wards is almost the same that occupies the hospital beds. The bed capacity is therefore not reflective of the number of patients that are treated in the hospital.

The catchment area served by the regional referral hospital also fluctuates because regional referral hospitals are located in urban areas which makes their accessibility quite easy for anyone seeking treatment. There are also instances where patients are referred from one regional referral hospital to another, a case in point being Mbarara regional referral hospital that handles patients that have been referred from Masaka and Kabale regional referral hospitals.

This study also established that some regional referral hospitals utilise the services of the lecturers (specialists/consultants) that are employed by the teaching universities and nursing schools. This is problematic since the specialities offered may not be available when the lecturers and internship students go on leave, semester breaks or when they retire from service, which makes the whole idea of service provision complicated. The above proxy consumption parameters (bed capacity, catchment area and number of specialities) as used by the Quantification and Procurement Planning Unit do not provide a genuine analysis of the requirements of the RRH’s given their drawbacks as indicated above. There should be more reliable information, like historical data regarding patient numbers and the associated medicals so that a trend analysis can be generated.

Allocation of Resources
These requirements as prepared by the Quantification and Procurement Planning Unit are then passed on to the Sector Working Group in the Ministry of Health for incorporation into the overall budget estimates of the health sector, which estimates are then prepared into a draft budget for the financial year by MFPED. Though the SWG in Ministry of Health provides budget estimates, its input is very limited because the important decisions on the budget are agreed between MOFPED, World Bank, IMF plus the different donor agencies. It is also unclear who has the power to determine budget priority areas, since government priority may not necessarily be in tandem with health sector requirements. There is therefore a lack of harmonisation of the priority areas of the government as compared to those of the health sector in general and the regional referral hospitals in particular, for they both have no control on the ceiling of priority areas.
Aggregation of requirements
When the budget has been approved, MFPED communicates to NMS how much is available for the respective regional referral hospitals to spend on medicals based on the approved budget estimates. After MOFPED has informed NMS how much is available for the financial year, the latter likewise informs the regional referral hospitals what is available for them to spend and therefore require them to indicate on which medicals they would like to spend. The hospitals thus initiate the planning process based on the amounts that have been indicated as available. This process starts with the Units/Wards that are required to prepare their annual requirements (in quantities). These lists are then compiled to come up with a requirements list by the entire department. The departmental lists are then aggregated to come up with a single requirements list (without indicating the prices of the medicals) for the entire regional referral hospital irrespective of the funding that has been indicated by MFPED as available.

The requirements by the RRH’s can also be estimated based on the stock cards, which indicate the quantity of drugs that have been issued to the different units within the referral hospital. The challenge with this method of quantification is that it does not consider other factors like irrational use. There are also some drugs that expire in the wards and units yet the stock cards indicate that they were issued. This lack of synchronisation between the stock cards and the patient prescriptions coupled with irrational use, expiry and pilferage implies that there is a lack of strategic thinking in the planning process for medicals in regional referral hospitals. There should be measures taken to ensure that what is issued from stores finally ends up with the patients in order to ensure that what is indicated as required by the referral hospitals is based on accurate figures as opposed to speculation.

Annual planning for medicals in RRH’s
After the requirements of the entire regional referral hospital have been compiled, they are passed on to the Medicines and Therapeutics Committee. The mandate of this committee, among others is to ensure that these quantities are scaled down to fit into the budgeted funds as indicated by MOFPED/NMS. In scaling down the requirements, the Committee applies one of two formulas; the VEN classification or the ABC classification. VEN is an acronym for Vital, Essential, Necessary. Vital medicals are used to diagnose and manage life-threatening diseases. Essential medicals are effective in diagnosis and management of less severe, but nevertheless, widespread illnesses while Necessary medicals are used to diagnose or manage diseases with less impact on the population, or items with a high cost for marginal therapeutic benefit. Vital items have first priority, because they are lifesaving or critical for achieving targeted health outcomes and if these items are not available, it could mean the death of a patient or irreparable injury. Essential items have second priority because if these items are not available, the patient could suffer pain or great discomfort. Necessary items are needed and are therefore on the order form; however, they have third priority given that their absence may not have any adverse effects on the health of the patients. Regional referral hospitals are therefore expected to order Vital products first, and if the budget allows, order Essential products followed by Necessary products.

The Medicines and Therapeutics Committee can also apply the ABC classification where A class medicals are those that are very expensive and treat approximately 10% of the population. An example is the anti snake venom, where no patient may come for such a medical in a very long time yet it is quite expensive. B class medicals are those that are moderately expensive
but likewise serve a moderate population while C class medicals are those that are cheap but serve a bigger population.

Approval of annual plans
After the Medicines and Therapeutics Committee has scaled down the requirements to match the approved budget estimates, they are forwarded for consideration and approval by the Hospital Management Committee. This process is just for purposes of formality as the latter rarely make any alterations to the decisions of the Medicines and Therapeutics Committee. This is so because even in instances where there is need for more funding, they have no mandate to increase the budget. When the annual plan of the regional referral hospital has been approved by the Hospital Management Committee, it is signed by the Hospital Director, who is the chairperson of the committee. This plan is then forwarded to National Medical Stores as the final approved annual plan of the respective Regional Referral Hospital, which completes the planning process for medicals in regional referral hospitals. This implies that if any medicals are not captured in the annual plan submitted by the regional referral hospital, they cannot be supplied by NMS, since there is no flexibility given that the budget estimates are already fixed. The determinant is therefore the amount of funds that have been indicated as available by MOFPED, which makes funding a very critical component of the planning process in regional referral hospitals.

Testing of hypothesis 1
The hypothesis was tested using correlation analysis and the significance level was 0.05 implying that a 95% confidence interval was used.

| Table 1: Correlation of strategic planning vs funding of regional referral hospitals |
|-----------------|-----------------|-----------------|
| Strategic Planning | Pearson Correlation | Funding |
|                 | Sig (2-tailed) |     |
| Strategic Planning | 1 | .586** |
|                 | 206 | .000 |
| Funding          | .586** | 1 |
|                 | 206 | .000 |

** Correlation is significant at the 0.01 level (2-tailed).

The correlation coefficient (0.586) shows that there is a positive and significant relationship between strategic planning and funding of the regional referral hospitals. In order to quantify the contribution of funding to planning, a regression analysis was performed.

| Table 2: Model summary |
|------------------|------------------|------------------|------------------|
| Mode | R | R Squared | Adjusted R Squared | Std. Error of the Estimate |
| 1 | .586 | .343 | .340 | .401 |

a. Predictors: (Constant), Planning

The R² value indicates how much of the total variation in strategic planning can be explained by funding. Based on table 2 above, it can be concluded that 34% of the success of strategic planning can be explained by funding. The remaining 66% can be explained by other factors like availability of qualified human resource.

| Table 3: Goodness of fit of the model ANOVA* |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Model | Sum of Squares | df | Mean Square | F | Sig. |
| 1 Regression | 17.148 | 1 | 17.148 | 106.600 | .000* |
| Residual | 32.815 | 204 | .161 | |
| Total | 49.963 | 205 | | | |
a. Dependent Variable: Funding RRH

b. Predictors: (Constant), Strategic Planning

The goodness of fit model was $F (1,204) = 106.600, P < 0.01$ (table 3). This shows that there is a linear relationship, which implies that an increase in funding leads to an increase in realisation of strategic plans and the reverse is also true.

The relationship between funding and strategic planning was only moderate $[\beta = 0.586 \ P < 0.01]$. It can be concluded that the funding of regional referral hospitals has an effect on strategic planning. Therefore the null hypothesis was rejected and the alternative hypothesis $(H_A1)$ “The funding of regional referral hospitals has an effect on strategic planning” was supported.

**CONCLUSION**

The top-down approach to planning clearly shows that the regional referral hospitals are detached from direct involvement in the strategic planning process for the quantities of medicals that are required. These hospitals are likewise not involved in determining the amount of funds that are allocated to them. They are only confined to preparing “shopping lists” by way of budgeting for the available funds. This implies that they have to operate with what is provided on an annual basis. The annual budgeting by the regional referral hospitals clearly lacks a strategic aspect since it does not embrace a long term planning horizon, which is one of the hallmarks of strategic planning. The budgeting as carried out by the regional referral hospitals by way of preparing “shopping lists” belongs to the second phase in the evolution of strategic planning.

During this second phase in the evolution of strategic planning, organisations emphasised the utilisation of the available resources (efficiently and effectively) without necessarily looking elsewhere for additional resources. The RRH’s are therefore focused on what can be done using the available resources yet they can be granted the authority to mobilise additional resources. There has however been a shift in the RRH’s long term strategy with regard to additional sources of income through setting up of private wings. This shift needs to be strengthened through adoption of strategic thinking which would place the RRH’s in the fifth stage in the evolution of strategic planning.

Strategic thinking will involve granting the individual regional referral hospitals autonomy to plan independently because each region has its unique environment which may require a specific strategic plan. For example the western region is experiencing and influx of refugees from DRC and Burundi due to the instability in the two countries. The northern region is experiencing the nodding disease syndrome which is specific to that area coupled with entire populations that are returning from camps of internally displaced persons. This is in addition to refugees from South Sudan and DRC. The eastern region is prone to mudslides while the central region has a high population and higher incidence of HIV than other areas. The planning process should therefore be decentralised to the regional referral hospital level because these hospitals know their individual challenges as opposed to collectively suggesting the same solutions to situations that are not similar.

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12


