SURE Rapid Response

What are the options for re-centralization of the health sector in Uganda?

November 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key Messages

- There is a call for the re-strengthened role of the state in the public sector backed by the fact that despite a few gains made with decentralization, there has been a slow but steady decline in services available to especially rural and vulnerable population increasing the equity divide in the population.

- Options for recentralizing services in the health sector include:

  i. No change (Pursue decentralization)
  ii. Recentralize all health functions to the Ministry of Health
  iii. Recentralize regional activities to regional health offices
  iv. Recentralize all health activities under regional referral hospitals
  v. Outsource local level health implementation to competent third parties

Who requested this rapid response?

This document was prepared in response to a specific question from a Senior Health policymaker in Uganda.

! This rapid response includes:

- Summary of research findings, based on one or more documents on this topic
- Relevance for low and middle income countries

X Not included:

- Recommendations
- Cost assessments
- Examples or detailed descriptions of implementation

What is the SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

Background

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research on the topic. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Following a wave of World Bank and IMF-backed reforms that were embraced by several low and middle income countries in the 1990s, many have begun to consider or implement options for re-centralizing some or all of the components of given social sectors, especially health.
Following several years of centralized management, which was felt to be inefficient, a major shift was to decentralize important dimensions of decision-making, transferring authority to lower levels of government. After several years of trying this form of management with varying degrees of success, outcomes and consequences (1, 2), a call for the re-strengthened role of the state in the public sector has begun to emerge.
This is because despite a few gains made with decentralization, there has been a steady decline in services available and especially to rural and vulnerable populations. This has in turn led to an increase in inequalities between rural and urban populations, and therefore also stalling development indicators for the different sectors, including the health sector. It was predicted early on that decentralization, if not carried out properly, would lead to undesirable consequences in the organization and implementation of services (3) which is now becoming apparent in many areas of different countries. A health system is a complex and highly technical operation based on scientific principles, and must have a clear vertical link from policy development to its implementation. It has been suggested that for a health service to operate effectively there needs to be a single point of budget and management accountability, with direction being provided by people with technical knowledge and skills (4). Therefore instead of reinforcing the decentralization of authority away from national governments, there is now discussion of whether state institutions should reverse course and take responsibility for substantive political and fiscal decision-making.

The decentralization reforms have had some positive impacts on the organization and management of health services. However, critical flaws that have persisted are the lack of integration and coordination between national health planning and budgetary planning, and the implementation arm of the health system. This has reached serious levels in some countries. In Uganda a few incidences have been cited in which lower level health facilities will sometimes not implement what the planning body at the Ministry of Health suggests because they claim they report to the local governments now. This is especially in terms of human resources issues. Furthermore there has emerged conflicting reporting procedures with a de-link, for instance where District Health Officers report directly to the Director General (DG) at the

Ministry of Health which is not practical for the DG's office but is what is offered under the current administrative structure.

Recentralization has already begun to take place in several European, Asian and Latin American health systems (5-7), and several Sub-Saharan African countries are contemplating the different policy options for re-centralization. Reasons for re-centralization (5) include administrative reasons: local control over health sector decision-making has and is leading to increased disparities in service provision and in outcomes to vulnerable populations thereby heightening equity problems. There is reported un-coordinated activity between the central policymaking bodies, that is, the Ministry of Health and the implementing organs, which are now under local government administration. Such a case is real in Uganda; economically, the proposed local finance bases that were generally thought to be additional funds to those from the central government are insufficient and almost insignificant in their contribution towards the resource pool needed to take care of the local health needs. Furthermore it has been noted that a lot of the local administrative arrangements are inefficient and in some cases duplicative; Politically, national politicians have noted that they are blamed when the health system fails to meet the expectations of the population, but they have limited control and so they seek to have the necessary organizational levers to correct the problems which they cannot do under the decentralization arrangements; Structural factors: these include the rapid growth of costly new medical technologies, and the economic constraints on health sector funding. Furthermore they include the fact that some countries are concerned about their aging populations although these are not yet a major issue in the Low Income Countries. At a technical level, the introduction of electronic medical records and other computerized reporting systems would be fragmented if operated at different levels, it is more feasible if such systems as health system performance or records are centrally administered.

This paper will look at the different policy options for re-centralization in the health sector so as to improve administration organization and service delivery.

Summary of findings

Policy Options for the re-centralization of the health sector

Re-centralization may be implemented wholly or partially. Partial implementation would enable the retention of areas where it is felt decentralization is of more benefit than re-centralizing of authority and so maximum benefit is made from both arrangements. Partial implementation ay also refer to a situation where re-centralization is done within the existing decentralization. Care however should be taken not to cause more fragmentation and un-coordinated activities and decision making. Options for arrangements are presented below with a framework adapted from Thomason and Kase (4).

	Policy Options	**Comments/Effects**
1.	No change (Maintain decentralization)	This option is based on the assumption that implementation of the decentralization reforms can be improved through modification and improvement of processes, thereby improving service delivery. A further assumption is that resources at lower level facilities, that is at district and local levels, will improve and that this will happen in the not too distant future. This policy option is the easiest as it involves no change but seeks rather to continue to pursue initiatives that are being undertaken by districts and local governments. This is its main advantage because it requires no further organizational and legislative change from the current status. It calls for more time for authorities to take steps to improve the implementation of decentralization. However, after more than a decade, the many failings of this option are becoming apparent for many countries.

2.	Recentralize all health functions to the Ministry of Health	This option proposes to re-centralize authority from the districts and local government administrative structures through complete transfer of power and functions to the central body of the Ministry of Health. It is likely to encounter most resistance from local governments and would be a huge undertaking in terms of planning and use of resources. There are however perceived advantages in re-centralizing services. It yields a single point of accountability and allows for centrally-planned resource allocation and prioritization of key health programs. However, since a decentralized political and administrative system was adopted, it has become ingrained in the minds of people, with several local government administrations pursuing it and learning a lot from the experience, having invested a lot of time, resources and effort in the process. Therefore choosing recentralization implies unlearning the processes and systems developed, and relearning centralized political and administrative systems. For this option the policymakers have to consider and answer the question of whether full re-centralization of health services is a fundamental necessity to improve health service delivery and consequently improve health status indicators for the population.
3.	Recentralize regional activities to regional health offices	This option also seeks to affirm the concept of re-centralization, but recognizes the necessity for coordination, and aims to utilize established coordination mechanisms at the regional level. Under this policy option, regional health administration would take over management of the health system in a given region. This is a familiar model and one that most regions would consider favourably. It retains control of resources and staff at the regional level, but centralizes coordination and management of resources from the districts.

		The obvious advantage in adopting this option, is that it is consistent with the original intention of the decentralization reforms. Furthermore, it bases its rationale on assisting regions to be self-reliant and it is sustainable in the long run. As with the other options, however, there are also some disadvantages. It needs major institutional, administrative, economic and political restructuring and manipulation, as there have been no regional offices or governments in the Ugandan structure. Furthermore, regions are in different and varying development stages, with some having already demonstrated their effectiveness on a continuing basis and others still struggling. And in addition, unless hospital staff become employees of the regional administration, this system retains the disadvantage of the hospitals and lower level health services being managed separately, that is centrally and under local governments which is a source of management confusion and would continue to challenge coordination and integration. It is also likely to be resisted by district administrators, as it reduces their power and span of control. Finally, if hospital staff are directed by the regional administration, there is a risk that the poor management of hospitals witnessed in some countries during that time they used delegation may re-emerge and gains in hospital management may be lost.
4.	Recentralize all health activities under regional referral hospitals	This option seeks to affirm the concept of re-centralization, but rather than taking the concept holistically, it aims to utilize alternative established mechanisms to advance the cause. The option proposes to re-centralize authority from the local governments but rather than fully transferring power and functions to the centre, shifts it to the public hospitals which are physically located in the regions. If the public hospital services are a national function they could be utilized for this objective. But while they are a national function, as they are located in the regions they provide a potential mechanism for central coordination and monitoring of priority

		health programs. Under this option, rural health staff would be transferred to the existing hospital structure, which would establish a division of rural or public health services. This option is very attractive to many who believe that hospitals can play an influential role in guiding, setting and monitoring clinical, public health and management support standards in the provinces. It would be relatively simple to achieve. Hospitals are large organizations, and are the focal point for the greatest health sector expertise and resources in each region. They could provide a central management and coordination point in each region for health services. The policy of designating all public hospitals as in-service training centres for a region indirectly supports this option. The technical skills and management expertise of hospital staff can be applied to the benefit of rural health services as well as the maintenance of biomedical equipment, and logistic, financial and human resource management skills. However, this policy option may be criticized on the grounds that the main focus of hospitals tends to be curative health provision, and less so as centres of public health expertise. Many would be fearful that as hospitals are increasingly pressured by their immediate population, they will fail to prioritize public and rural health. The local government health officials may not be supportive of this option, as it would mean the loss of their mandate and power to the public hospitals' administrators and therefore a loss of control and resources. If the hospitals are accountable for health services, then decisions on the allocation of local government funds for health services would be channelled through the hospitals. This is likely to meet with resistance and speculation that funds could stay at the hospital level and not filter through. It may also compromise local government funding. Local governments may not continue to provide funding to health if the responsibility for service delivery is shifted to hospitals. In addition while CEOs and hospital superintendents

		have been chosen for their hospital management skills, these are not necessarily the same skills required to run a public health system. The hospitals may be strained by the additional responsibilities, especially at the district level. Hospital CEOs have not had to cope with the difficulties of administering staff and activities at a distance. A final shortcoming as a national policy is that some regions have more than one regional hospital, so this option would create quite an amount of stir in making choices of which hospital would be in charge.
5.	Outsource local level health implementation to competent third parties	This policy option would enable districts and local governments which are unable to self-manage (and are able to recognise this) their health services to outsource health implementation to competent third parties, including the Ministry of Health, private sector entities, NGOs and churches to act as health implementers. This option also provides a choice that would enable several local governments or districts to form a network which could service their requirements. This approach would provide for poor performing areas to opt for outside assistance to manage and coordinate their health services. It could take advantage of economies of scale by consolidating service delivery mechanisms. To its disadvantage, it would require a funding process agreed between the local government officials and the third party implementers, and regular and complete reporting of the use of these funds.

<u>Making a choice of which option to take on should consider the following among other things:</u>

Services should be managed at local government or district level only if the local authorities have the capacity. It is acknowledged that if decisions and planning are done at a level closer to the population they are likely to be more in line with their priorities and relevant to their needs. This is what is desired. However this should not be done at the expense of the capability of authorities to do this planning and decision making which would in the end lead to a waste of resources if not done well.

No matter which policy option is chosen, funding arrangements need to ensure the timely flow of resources to priority programs. Funds availed from the central pool are often late and untimely leading to poor planning and implementation of activities. However those from the districts or local governments are also insufficient leading to a high dependence on the central funding. Funding arrangements in terms of allocation and disbursement have to be improved.
Furthermore, reform of intergovernmental financial arrangements is needed to provide for tying funding to health system performance. The health financing arrangements have to be re-visited to see how they fit with the objectives of the new re-centralized administrative and organizational arrangements. A case in point is that of a National Health Insurance Scheme if present, which would have to consider the different arrangements under a fully, partially or non-centralized health system.

Some options will require legislative change, enabling line reporting by district staff other than to the district administrator. For example, options 2-5 in the policy options provided above require modification of legislation at the very least and formation of new laws at most. There would be formation of new structures of administration say if regional health offices as proposed in option 3 are to be set up.

In countries or areas with serious civil or ethnic conflict, or in areas with highly charged political environments, it has been shown that decentralization may be essential, in that various forms of local control are typically linked to the survival of the state itself. This has been shown to be the case in Bosnia-Herzegovina and Macedonia in the Balkans among other places.

Conclusion

After several decades of reforms that have seen low and middle income countries decentralize their administration issues, there is still a gap in getting the health of their populations to an optimal level. Several analyses have suggested that re-centralizing some or all components in the different social sectors may be of advantage. This paper has shown the reasons for re-centralization and also what policy options may be considered in the process. It has also pointed out the factors that the decision maker needs to keep in mind as they contemplate this process.

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Regional East African Community Health Policy Initiative

The **Regional East African Community Health-Policy Initiative (REACH)** links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States.

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Conflicts of interest

None known.

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