SURE Rapid Response

Can decentralization of health services improve health service delivery in Uganda?

March 2011

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

Key messages

- Decentralization has more potential of improving health service delivery than centralized government
- Despite the noted and anticipated successes, it should also be noted that not all functions are better performed by a decentralized health system; for example policy and guideline formulation, and drug operations are better left to the central authority
- There is need for more rigorous appraisal and evaluation of decentralization to establish its effectiveness and effects on health service delivery and other public services

UNHRO

SURE Supporting the Use of Research Evidence

JUMUIYA YA AFRIKA MASHARIKI

REACH Regional East African Community Health Policy Initiative

MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES

EVIPNet EVIDENCE-INFORMED POLICY NETWORK

Who requested this rapid response?

This document was prepared in response to a specific question from a policy maker in Uganda.

! This rapid response includes:

- Key findings from research
- Considerations about the relevance of this research for health system decisions in Uganda

X Not included:

- Policy or practice related recommendations
- Detailed descriptions

What is 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. 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

Many countries in the developing world are faced with challenges of providing quality and equitable health care services to their populations amidst high population growth rates not equally matched with growth in resources. Within these populations are groups that present even more challenges to the governments than others; those with the greatest distance (social, political, or geographical) from the centres of decision making suffer the most, which suggests that reduction of this distance may be a beneficial direction for reform [1]. Decentralization has the potential to improve the delivery of public services and in fact many countries, especially developing ones, decentralization has been implemented for over two decades in different designs and institutional arrangements. Decentralization usually refers to a political reform, which is intended to reduce the extent of central influence and encourage local autonomy. While this reform is rarely focused on improving health services, it does prompt changes in the management and often financial responsibility for health services. This in turn means that decentralization can have a large impact on health service performance.
Decentralization transfers fiscal, administrative, ownership, and political authority for health service delivery from the central Ministry of Health to alternate institutions, and may thereby improve efficiency and quality of services in several ways; technical efficiency improves through greater cost consciousness at the local level; allocative efficiency increases because local decision-makers have access to better information on local circumstances than central authorities, and they use this to adapt services and spending patterns to local needs and preferences; quality of service improves because the public provides input on local decision-making processes and holds local decision-makers accountable for their actions.
It is also argued that it creates space for learning, innovation, community participation and the adaptation of public services to local circumstances. However, the effects of decentralization have been difficult to estimate because it requires major research effort to gather relevant data in a systematic manner over time [2].
Several of the objectives of decentralization are meant to be complementary of each other, but there may be generated tensions and conflicts, sometimes to the detriment of the very goal being aimed at, calling for a few trade-offs.

Not much rigorous appraisal has been done of the decentralization strategy as a means to improve health service delivery, and what is found in the literature is mostly case studies of countries or regions within countries that have implemented it.
This paper will present a summarised experience of decentralization in Uganda highlighting the issues arising from it and will show that when these are dealt with decentralization of health services can improve health service delivery in Uganda.

Summary of findings

Decentralization in Uganda

Decentralization of the public services like health in Uganda has been implemented alongside broad economic and political reforms, and this therefore is the light in which it gets appraised. Decentralization as part of the structural adjustment programs has been implemented in Uganda since the early 1990s. The main intention of this reform for the health service was to bring services closer to the lower administrative levels and the beneficiaries, that is, the population. It was intended to improve the quality of health services with resultant improved utilization of health services [3]. Of the different forms of decentralization, Uganda generally adopted the devolution style. Some analysts have actually described Uganda's style as a combination of delegation, deconcentration and privatization [4]. The Ministry of Health though, adopted delegation of authority and responsibility from the central office to the regions and districts [5] which delegated authority covers budgetary discretion, human resource management, and planning and programming activities according to the needs and characteristics of the population served. To evaluate the effects of the decentralization process, its ability to achieve broader objectives of health reform like quality, efficiency, and equity should be considered and in addition, its impact on factors like levels of facility utilization, prescribing behaviour and stock levels of essential drugs [5].

There have been lessons learnt along the way: a paper on analyzing the prospects for improved service delivery by decentralization in Uganda concluded that as a policy for improving service delivery, decentralization falls short of realizing that objective in Uganda, despite a few isolated examples of successful service delivery, as in the case of immunization, education and participatory planning [4]. It however also disclosed that despite the challenges of decentralization, that are hindering effective service delivery in Uganda, in consideration of the benefits of decentralization, if such challenges could be addressed, decentralization has more potential of improving service delivery than centralized government [4].

As noted earlier, the immunization program has shown a marked success following decentralization with coverage of up to 80% in some areas, up from levels of 30-40% before it was implemented [4, 6]. It is thought that this program succeeded (in part but largely) because of the involvement and participation of local leaders in mobilizing the locals, thereby fulfilling one of the objectives of decentralization [7].

Despite the few successes, it has been noted that not all functions are better performed by a decentralized health system, other functions are better left centralized; for example policy and guideline formulation, and drug operations, like procurement and distribution. In 2009, the procurement and distribution of drugs was recentralized (after it had been decentralized), as a result of under-utilization of Essential Medicines and Health Supplies (EMHS) grants by local governments; only an average 60% EMHS Primary Health Care (PHC) grants had been utilized in the previous year [3].

The relationship between service delivery and local needs is still very suboptimal; the gap is created by among other things, lack of adequate funding at the local level, and this is largely reflected in several sectors. This has led to one of the commonly reported problems facing the health sector, that is, the absence or frequent stock out of drugs [4, 8]. This scenario is caused by the fact that most of the grants transferred to districts for health are used for salaries. These transfers are often late and furthermore, it is noted that spending on primary healthcare has halved, from 33% to 16%, since decentralization was introduced [9].

A lack of financing notwithstanding, a number of problems with accountability have been noted; the lower levels of government lack the ability to manage public finances and maintain proper accounting procedures [10]. It should be noted that for decentralization to achieve its targets, there has to be high level of public accountability between the different actors. There have been weak budgetary procedures with regard to record-keeping and auditing and a lack of transparency in the allocation of resources. In addition, it has been argued that the success of decentralization depends on the capacity of districts and urban governments to raise their own revenue and use it efficiently in the provision of services [4]. However, the generation of local revenues in Uganda is quite limited, with local governments largely depending on central government financial transfers. The abolition of the Graduated Personal Tax (GPT) in 2006 means that the local governments have limited financial sources to fund public services and as a result this enhances their reliance on the central body. This lack of financial autonomy affects the implementation of development plans and consequently limits service delivery [4], further compromised by the fact that most funds are diverted before their final destination. The noted over-dependence on central transfers also undermines the accountability of local government officials to the local electorate, and facilitates shifting of blame for poor service delivery to upper levels of government [9].

One of the biggest challenges facing decentralization as a framework for service delivery in Uganda is a lack of capacity and personnel at lower administrative levels to exercise responsibility for service delivery. In the first instance, decentralization led to staff retrenchment through civil service reform but recruitment and retention later has also been a problem for these governments as many personnel either do not have the capacity and level

of training, or prefer to work in urban settings [4, 5]. The District Service Commission (DSC) established under the Local Governments Act 1997 stipulates that each local Government is supposed to handle all human resource management aspects [11]. The health system has however been dogged by nepotism and other forms of corruption with health workers not being recruited on merit [4]. Personnel payments have also been known to delay thereby becoming a demotivating factor for many of them. This may be due to the poor coordination brought about by staffing decisions being made at the district level yet district funding comes largely from the central government in the form of conditional grants with explicitly identified uses [11]. In terms of accountability, the lack of financial autonomy and insufficient funds to facilitate local government officials means that many of the local government officials including councilors have remained voluntary, without compensation [4].
Decentralization as an approach to service delivery is also limited by the failure of politicians to cede political power to the local governments [4]. It is documented that politicians at the centre have little wish to cede power to the local governments which limits democracy and autonomous decision-making at the local level.
Another limitation of the decentralization policy that has been noted comes from the response to programs determined and directed by external sources that differ from local needs [4]. In one district, residents argued that funds to implement decentralization were usually obtained from donors who fund specific projects even when these may not match their priorities.

Issues arising [12, 13]

There are several pertinent issues arising from the experience of Uganda and these are not very different from those noted by other countries that have implemented decentralization. A study done by the University of Maryland assessing decentralized health and education services in the Philippines and Uganda found that decentralizing service delivery offers benefits, but these benefits have not always materialized for many reasons. It is believed that if these are ironed out, countries should be able to realize the goals and benefits of decentralization and therefore should realise an improvement in the level of service delivery.

i. It found that local officials do recognize local demands and needs but have limited authority to regulate services. In both these countries, officials at the lower levels were more aware of local preferences than officials at the higher levels. Decentralization increases allocative efficiency if local governments have the authority and willingness to adjust resource allocations and functions are devolved to a low enough level.

ii. Decentralization may increase productive efficiency by limiting the leakage of funds and other resources. In several countries corruption is usually less pronounced at local levels than at higher levels. Therefore if power and authority is ceded from the centre and local

authorities are truly autonomous, decision making and allocation may be better and so would production and accountability to the masses (if the right capacities are involved).

iii. Capabilities of the local authorities – it is not enough to pass authority to the lower levels, they have got to be capable to handle this authority and make good use of it. In many countries, deconcentrated units of the health ministry are both technically and administratively weak. If administrative and management capacity in the local government body is inadequate, decentralization may not meet its intended objectives because authorities may mismanage finances and waste resources. In addition, a shortage of skilled staff and lack of training hamper delivery. Furthermore, when decentralization transfers spending and revenue-raising authority, lack of administrative capacity can lead to financial mismanagement, waste of resources, and corruption.

iv. Information asymmetry: Local governments or agencies can pursue their own agenda if the central ministry is not well informed about their activities. And similarly locals may not realize their responsibility in the new arrangement. Limited information on local politics and events constrains the effectiveness of decentralization. Citizens of Uganda have been found to be less informed about local government than national government. While citizens rely on the media for information about national politics and corruption, they rely largely on community leaders for such information at the local level. Media coverage of local politics and events is limited yet in fact analysis confirms the importance of the media by indicating that better access to the media is associated with better education and health care.

Furthermore, for decentralisation to achieve its goals, citizens should have channels to communicate their preferences and get their voices heard in local governments. But the existence of such channels is not enough to help locals effectively influence public policies and oversee local governments if they do not have access to information about government policies and activities as pointed out above.

v. Local politics: If local powerful groups for example physicians, churches, NGOs, etc, have significant investments in health care issues, they may use their influence to limit the intended objectives of decentralization. In a study in Bangladesh, it was found that the medical community strongly resisted decentralization as it contradicted with some of their interests. It is also shown how the local church resisted programs to do with contraception in the Philippines despite the central government having established clear policies on these. Both these examples show the need for harmony between local and national stakeholders as each has a different level of influence that is important to the government realising the objectives of decentralization.

vi. Mismatch between authority and responsibility: this problem can be found in many different forms, for instance, within sectoral decentralization efforts; for example responsibility for managing public health workers may be delegated to regional or municipal health units, but the central ministry retains authority for hiring, firing, and

promotion of staff. Another example is between administrative and fiscal decentralization, where local governments may be responsible for health care spending, but have no revenue-raising authority and have to wait on dispatches from the central body. A common scenario to emphasize this point is seen when the central government assigns additional responsibilities to the regional or local authorities but provides no additional resources. These and several other mismatches of authority cause clashes and scenes of shifting and apportioning blame for failed programs with no clear paths of accountability.

vii. Tensions between vertical and horizontal integration: If local health services consist mainly of a collection of vertical programs funded by the central body and development partners, local decision-making discretion will be quite low, and the goals of decentralization will be limited. Decentralization aimed at achieving integrated service delivery at the local level needs to offset the effects of these vertical lines of control. The establishment of district health committees to carry out planning, management, and financial oversight functions may be a valuable response to this.

viii. Political and process dimensions: Groups with a vested interest in the status quo and who will lose power, influence, and resources as a result of administration or fiscal decentralization often oppose it. While there may be strong technical arguments in favour of health sector decentralization, without attention to the politics of decentralization, reforms may fail to yield the expected increases in efficiency, effectiveness, and equity. And for decentralization reforms to be put in place, they need support from policy makers and other stakeholders. Without signs of success, support for decentralization may wane, leading to reversals. The process dimension of decentralization highlights the importance of stakeholder participation, effective communication, and political will.

Conclusion

This paper has shown that decentralization of health services would and is indeed intended to be helpful in improving health service delivery. Its implementation in different countries and regions has revealed several but similar issues that would need to be taken care of for it to achieve its objectives. It is echoed here that considering the benefits of decentralization, if the challenges already met while implementing it can be addressed, decentralization has more potential of improving health service delivery than centralized government. There is however need for more rigorous appraisal of this form of reform.

References

1. Nirvikar Singh, *Decentralization And Public Delivery Of Health Care Services In India*. Health Affairs, 2008. **27**(4): p. 991-1001.
2. Partners for Health Reform*plus*, *Insights for Implementers: Decentralization and Health System Reform*. 2002.
3. Julie Najjunju, *Time to review decentralization of health services* 2010, Action Group for Health, Human Rights and HIV/Aids (AGHA) Uganda Kampala.
4. Roberts Kabeba Muriisa, *Decentralisation in Uganda: Prospects for Improved Service Delivery*. Africa Development, 2008. **XXXIII**(4): p. 83-95.
5. AGHA Uganda, *Time to review decentralization of health services* 2010, Action Group for Health, Human Rights and HIV/Aids (AGHA) Uganda Kampala.
6. WHO, *Health reform and priority health interventions: the case of immunization services*. 1999, World Health Organization: Geneva.
7. Apollo Nsibambi, *Decentralisation and Civil Society in Uganda: The Quest for Good Governance*. 1998, Kampala: Fountain Publishers.
8. Muzoora Tom, et al., *Kihagani site report: Participatory Poverty Assessment*. 2002, Actionaid Uganda: Kampala.
9. Junaid Ahmad, et al., *World Bank Policy Research Working Paper 3603: Decentralization and Service Delivery*. 2005, World Bank: Washington DC.
10. Shah Anwar and Theresa Thompson, *Implementing Decentralized Local Governance: 'Treacherous Roads with Potholes, Detours and Road Closures'*. Policy Research Working Papers, Washington, DC: World Bank., 2004.
11. Sylvester Wenkere Kisembo, *A HandBook on Decentralization in Uganda*. 2006, Kampala: Fountain Publishers.
12. Satu Kahkonen, *Decentralization and governance:does decentralization improve public service delivery?* The World Bank: PREM notes 2001(55).
13. Omar Azfar, Satu Kähkönen, and Patrick Meagher, *CONDITIONS FOR EFFECTIVE DECENTRALIZED GOVERNANCE: A SYNTHESIS OF RESEARCH FINDINGS*, The World Bank, Editor. 2001, IRIS Center, University of Maryland.

This summary was prepared by

Rhona Mijumbi, Supporting Use of Research Evidence for Policy (SURE Project), Office of the Principal, College of Health Sciences, Makerere University, New Mulago Hospital Complex, Administration Building, 2nd Floor, P.O Box 7072, Kampala, Uganda

Conflicts of interest

None known.

This Rapid Response should be cited as

Rhona Mijumbi, MPH, MSc. **Can decentralization of health services improve health service delivery in Uganda?** A SURE Rapid Response. March 2011.

For more information contact

Rhona Mijumbi, mijumbi@yahoo.com