Institutional challenges to decentralization of health services in Uganda - a traditional review

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Whereas the theory of decentralization holds a serious promise for efficient, effective, responsive, accountable, sustainable but also participatory service delivery and poverty reduction, in practice, the approach is dotted with bottlenecks, obstacles, and inefficiencies. Particularly in Uganda, the institutional challenges to the philosophy, theory, and practice of decentralization are numerous. This paper presents a review of the challenges within the health sector in Uganda. Among these include the ever increasing financial and budgetary constraints, and revenue mobilization or fiscal challenges; crippling institutional, managerial and human resource incapacity; accountability, transparency, auditing and institutional corruption within both central and sub-national governments; the gap between the receivers and providers of decentralized health services, and the associated challenges of information, participation, and civil society involvement in the decentralization processes. Closely related to this, there is a gap in Uganda between health service provision and local needs and the overwhelming or excessive demand for health services by masses beyond the supply levels of the decentralized units of government. The identification of these challenges should serve as the stimuli of reforms and improvements in decentralization to achieve its original aims and objectives for all service sectors including the health sector in Uganda.

Key words: Decentralization, health services delivery, Uganda.

INTRODUCTION

Decentralization may mean different things to different people. Okidi and Guloba (2006) defined decentralization as the transfer of planning, decision making, and administrative authority from the central government to local governments. But decentralization should be understood to mean a theory, practice, and discipline concerned with how central government transfers some of its powers in various degrees to subnational governments such as local governments, public corporations, and non-state agencies such as the private sector and charitable agencies.

Bitarabeho (2003) observes that Uganda adopted a system of democratic decentralization to improve systems of governance and foster economic growth especially in rural areas primarily to eradicate poverty. Through the four dominant forms of decentralization (de-concentration, delegation, devolution, and privatization), Muriisa (2008) argues that decentralization aims at speedier and more responsive services, enhances efficiency, freedom of access to services and freedom to decide among other benefits.

This paper presents a review of the various challenges, weaknesses, pitfalls and threats to the theory and practice of decentralization in guiding health service delivery in Uganda.

CHALLENGES

Whereas the theory of decentralization holds a serious
promise for efficient, effective, responsive, accountable, sustainable but also participatory service delivery and poverty reduction, in practice, the approach is dotted with bottlenecks, obstacles, and inefficiencies. Particularly in Uganda, the institutional challenges to the philosophy, theory, and practice of decentralization are numerous. In the discussion below, we have illuminated these challenges, giving practical examples within the health sector from the Ugandan context.

First, the decentralization policy is faced with a multitude of financial and budgetary constraints, and revenue mobilization or fiscal challenges. Devas (2005) observes that local governments and therefore decentralized units have limited local taxing powers from which to finance the services assigned to them, and therefore services fall short of what is usually required. The taxable and revenue sources are often limited to few visible sources that are difficult and often expensive to collect. Whereas many urban local governments and privatized enterprises may be able to raise revenues, for rural local governments, that taxable capacity is very limited (Sexena et al, 2010; Saito, 2000). As such, many local governments suffer from chronic budgetary shortages amidst limited funds. Besides, with limited management of financial resources or proper auditing of the dispensing of financial resources, much is wasted through corrupt tendencies. It has become a norm in Uganda for local governments to depend on grants from the centre to function, yet this source is dotted with weaknesses and challenges. Given that sub-governments are limited in their borrowing, investment, and revenue generated programmes, the issues surrounding financing are more likely to continue in the foreseeable future. In fact, the recent withdrawal of donor funding to a number of government programmes will further cripple the financial situation in sub-governments. The abolition of graduated personal tax left local governments with limited finances to fund public services (Local Government Act, 1997; Muriisa, 2008).

Many decentralized health units in Uganda suffer from crippling institutional, managerial and human resource incapacity (Muriisa, 2008) to perform their mandate. In some local governments, Devas (2005) asserts that decision making processes are unsystematic, mechanisms of accountability between the technocrats and elected officials are inadequate, and there is shortage of officials with the necessary technical, managerial and financial skills. This is compounded by lack of financial capacity to attract and retain high quality staff. The attrition and turnover rates in Uganda’s local governments for health workers are high as these sub-governments lose staff to the Non-governmental organizations (NGO) and private sectors that pay competitive wages. Because of these limited technical skills, many local government health services are devoid of responsiveness to local needs. For Uganda, again the payment regime in local governments is wanting. Low salaries amidst galloping inflation, limited staff benefits beyond salaries, and the tendency to recruit from the “locals” have led to attraction of personnel with limited skill sets. For Muriisa (2008) the lack of capacity and personnel at sub-national government level has greatly hampered the exercise of their responsibility for service delivery. These shortfalls in staff are wide reaching in the decentralizes sectors of health in addition to education, agricultural extension, environment and water management and many other like road construction and maintenance.

It should be pointed out that one of the most daunting challenges facing decentralization of health services in Uganda derives from the concerns relating to accountability, transparency, auditing and institutional corruption within both central and sub-national governments. The theory of decentralization assumes that both the elected and technical staff should be accountable to the people. But evidence Muriisa (2008), Devas (2005) indicates that both the ordinary citizens and the elected local representatives are rarely in position to check in details the use of resources. Instead, accounting systems are extremely weak in local governments and open to all manners of resource misuse and dispute. In many cases, annual accounts are finalized long after the end of the financial year and the central government has displayed inept capacity to perform comprehensive audits on all local governments. Corruption is ever present within decentralization, and critics have argued that decentralization has equally decentralized corruption. In his Bushenyi experiences, Bitarabeho (2003) argued that within decentralization, corruption manifested in the forms of abuse of office; fraud and embezzlement; misappropriation of public funds and assets; paying for goods/services not supplied or “air”; paying “ghost employees”; bribery and extortion; and nepotism and favouritism.

Another challenges to decentralization of health services in Uganda is the gap between the receivers and providers of decentralized health services, and the associated challenges of information, participation, and civil society involvement in the decentralization processes. To Devas (2005), decentralization still suffers from the lack of sufficient information available to citizens for comprehending how resources are used and there is lack of a dynamic civil society that is able to engage with local governments on serious local interests. Muriisa (2008) argues that decentralization service delivery has a perception gap. He contends that whereas on one hand public service officials perceive that decentralization has improved control and mobilization of resources, the service receivers on the other hand perceive that services have not improved in recent years. A walk across Uganda to examine education and health service provision and access since decentralization will largely indicate that little if any improvement has been achieved. Questions abound of how genuine the citizenry can partake in planning, decision making, monitoring and
evaluation of decentralized services and governance. It’s important to observe that decentralization is top-bottom and the “real locals” do not understand the basic structure of decentralized service delivery. The case in point is when patients directly go to Mulago national referral hospital and by pass other lower levels of health service delivery.

Closely related to the above argument, there is a gap in Uganda between health service provision and local needs (Muriisa 2008:90) and the overwhelming or excessive demand for health services by masses beyond the supply levels of the decentralized units of government. This gulf is created by lack of adequate resources and funding at the local level. Particularly in education, water and sanitation, garbage and waste management in urban areas, health services, agricultural extension and road infrastructure, this gap is very visible.

With the introduction of Universal primary education (UPE) in 1997, enrolment rates more than doubled but this has not been met by a corresponding increase in both manpower and infrastructure. And in the health sector, access to quality health services has remained a dream for many citizens even under decentralization. The picture in agricultural sector is not better either—as a solitary agricultural extension officer may exist at sub-county level to serves all the area farmers.

An even great challenge to decentralization of health services in Uganda lies in the obstacles and impediments originating from the central-sub-government relations (Devas, 2005) and the relations between the various inter-governmental arms or agencies. The central government has an overriding concern to ensure the proper usage of all public resources at whatever level it was collected or used; and should deploy a raft of instruments to oversee the use of money by local governments. Yet, these all raise concerns about the nature of decentralization, and queries what should be the balance between central direction and local choice in a centralized system. In Uganda, we have seen a senseless attempt within decentralization for the centre to control and direct local resource usage. Besides, central supervision of local governments is weak and quite often the central controls have created more problems than it has solved including delays, frustrations, additional costs and perverse behaviour. Besides, the central monitoring of local government health facilities is equally questionable. The use of conditional transfers, approval of budgets and plans, the auditing and supervision of sub-governments are only effective if the centre has the ability to verify what is actually happening at the local levels in the health facilities.

Decentralization of health services suffers from the interference of, imposition, and response to externally determined programmes that differ from local needs. In many decentralization programmes, the service structure is influenced by donors who fund specific projects even when these may not meet the priorities of the local areas (Muriisa, 2008). It’s needless to say that such interventions may fund road construction when what is needed are health centres or may offer books and buildings in schools instead of mobilizing communities to embrace educational programmes.

A fundamental discomfort in decentralization of health services in Uganda relates to the challenges in the relationship between politicians and civil servants, and the conflicts between politicians and civil servants (Muriisa, 2008) and the politicization of decentralization. The conflicts largely emerge from the performance of roles and some-times the demand for accountability. It’s a common in Uganda for tensions to occur between the chairman LCV and the CAO, the LCV and the RDC, the RDC and the Technical staff, etc. due to role confusion, personal interests, and demand for accountability. In some cases, these kinds of standoffs have delayed or even derailed service delivery including health services. More detrimental to decentralization is the politicization of the decentralization programme. Many politicians including high ranking officials have taken decentralization for political gains rather than service delivery and use its programmes to “reward” or “punish” political supporters or opponents respectively. The current impasse in KCNA between the executive director and the Mayor is an illustration of this argument.

According to Kyohairwe and Karyeija (2012), decentralization has been ruined by the focus on the doctrine of concerning the disaggregation of units in the public sectors by breaking up large entities into smaller cooperate agencies in the search for efficiency. Policy makers for example have needlessly re-divided the existing local governments to the tune of 112 districts with 23 more in the pipeline. UEB was broken down into several agencies (e.g. UEDCL, UETCL, ERA, REA, UEGCL, etc.) but little informal of service delivery has change to talk about. The concept of shifting to greater completion by contracting out has largely failed to produce tangible results-and public contracts and tendering processes have continuously raised accountability and transparency concerns. The bicycle contract scam in the ministry of Local government and the queries arising from Karuma project tendering have put more questions than answers to outsourcing and contracting as a form of decentralization. This is also true for the health sector in Uganda under the decentralization frame work.

**Conclusion**

A thorough review and appraisal of the decentralization doctrine, theory, practice and discipline in Uganda projects a system strewn with challenges. On the basis of these challenges, a pessimist may even conclude that decentralization is a failure. However, by closely analysing the entire decentralization process, there are
positives amidst the gloom. In their assessment of KCCA case as an agency, Karyeija and Kyohairwe (2012) observed that "...explicit performance indicators in terms of city cleanliness, road maintenance, and law enforcement may suggest a focus on value for money when technically evaluated." The identification of the above challenges should be stimuli of reforms and improvements in decentralization to achieve its original aims and objectives for all service sectors including the health sector.

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