Major Applied Research 6
Technical Report 1

Decentralization of Health Systems: Preliminary Review of Four Country Case Studies

January 2000

Prepared by:

Thomas Bossert, Ph.D.
Harvard School of Public Health

Joel Beauvais, B.A.
Harvard School of Public Health

Diana Bowser, M.P.H.
Harvard School of Public Health

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:
Development Associates, Inc. ■ Harvard School of Public Health ■
Howard University International Affairs Center ■ University Research Co., LLC

Funded by:
U.S. Agency for International Development

Partnerships
for Health
Reform
PHR

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *Better informed and more participatory policy processes in health sector reform;*
- *More equitable and sustainable health financing systems;*
- *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

January 2000

Recommended Citation

Bossert, Thomas, Joel Beauvais and Diana Bowser. January 2000. *Decentralization of Health Systems: Preliminary Review of Four Country Case Studies.* Major Applied Research 6, Technical Report No. 1. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

For additional copies of this report, contact the PHR Resource Center at pub_order@phrproject.com or visit our website at www.phrproject.com.

Contract No.: HRN-C-00-95-00024
Project No.: 936-5974.13

Submitted to: Robert Emrey, COTR
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

This study reviews the experience of decentralization in four developing countries: Ghana, Uganda, Zambia, and the Philippines. It uses two analytical frameworks to describe and compare the types and degrees of decentralization in each country. The first framework specifies three types of decentralization: deconcentration, delegation, and devolution. The second framework uses a principal agent approach and innovative maps of "decision space" to define the range of choice for different functions that are transferred from the center to the periphery of the system. The analysis finds a variety of types and degrees of decentralization among the four countries, with the Philippines demonstrating the widest range of choice over many functions that were devolved to local government units. The least choice was transferred through delegation to an autonomous Health Service in Ghana. Uganda and Zambia display variations between these extremes. This review was designed as a preliminary assessment to produce a comparative analysis of the impact of decentralization; a more in-depth study of one country, Zambia, will be funded by PHR.

Table of Contents

List of Tables

List of Maps

Acronyms/Glossary

GENERAL

CIHI	Center for International Health Information
IGF	Internally Generated Funds (i.e., user fees and cost sharing)
IMF	International Monetary Fund
LGU	Local Government Units
MOH	Ministry of Health
NGO	Non-governmental Organization

GHANA

BMC	Budget Management Center (Where transfer of financial management and administration of health sector is being made under the Ghana Health Service's 1997 Five Year Programme of Work)
Busia Government	Formulated new governmental model based on four tiers: central government, regional councils, district councils and local councils in 1969-1972
CPP	Convention People's Party (Independence government of Kwamu Nkruma 1957-1966)
DA	District Assemblies (Created under Law 207 to govern 110 subregional districts)
DAO	District Administrative Officers
DCF	District Common Fund (Established through 1992 Constitution to ensure that at least 5 percent of national revenues are distributed to district governments)
DHA	District Health Administrations (Below regional level, composed of director and team)
DS	District Secretary (Centrally appointed secretary to lead each DA)
DMO	District Medical Officer Groups (Groups of young professionals)
FE	Financial Encumbrance System (System through which BMCs receive funds from regional directors)
ERP/SAP	Economic Recovery Program and Structural Adjustment Program (Program implemented in early 1980s under IMF to bring hyperinflation under control and reverse negative GDP growth rates)

GHS	Ghana Health Service (Autonomous public institution that will eventually receive responsibility for health service delivery from MOH. Regional and district health administrations are bureaucratically appointed levels under the GHS)
IGF	Internally Generated Funds
NLC	National Liberation Council (Attempted reconcentration of Ghana 1966-1969)
NDC	National Defense Council (Formed out of PNDC)
NCD	National Commission for Democracy (Ruling party of early 1980s that implemented IMF-sponsored ERP/SAP)
NRC	National Redemption Council (1972-1979)
POW	1997 Programme of Work
PNDC	Provisional National Defense Council (Lieutenant J.J. Rawlings' government that started program of decentralization in 1988 with Law 207 to create additional subregional districts)
RCC	Regional Coordination Council (Regional councils of DS, DA chair, and regional secretary)
RHA	Regional Health Administrations (Level of GHS administration directly below central level, composed of Regional Director of Health Services and a Regional Health Management Team)

ZAMBIA

CBoH	Central Board of Health (Semiautonomous public institution [centrally appointed] contracted by MOH for functions related to health service delivery and overseeing and coordinating a host of semiautonomous district and hospital management boards)
DHB	District Health Boards (Supervisors and employers of district health management teams)
DHMT	District Health Management Teams (Technical managers of district health offices)
EHP	Essential Health Package (or, Essential Package of Health Services)
FAMS	Financial, Administration, and Management System
GRZ	Government Republic of Zambia
HCAC	Health Center Advisory Committees
HMB	Hospital Management Board (Appointed and controlled by the central MOH)
HMIS	Health Management Information System
HRIT	Health Reform Implementation Team (Coordinates health reforms from national level)

LGA 1980	Local Government Act of 1980 (Passed by United National Independence Party) to reorganize political and administrative system but basically failed)
LGA 1991	Local Government Act of 1991 (Passed in 1991 and supported by the Movement for Multiparty Democracy)
MMD	Movement for Multiparty Democracy (1991-Present)
MUZ	Mine Workers' Union of Zambia
NHC	Neighborhood Health Communities
PACU	Provincial Accounting Control Unit
PMO	Provincial Medical Offices
PSRP	Public Sector Reform Program (Health Sector Reform Program of 1993)
UNIP	United National Independence Party (President Kaunda 1965-1991)
UTH	University Teaching Hospital

UGANDA

HUMC	Health Unit Management Committee (Popular Participation at the District level)
DDHS	District Director of Health Services (Head of district health team and secretary of district health committee)
DHC	District Health Committee (Policymakers of district level health sector)
DHT	District Health Team (District government's executive minister of health department)
DRC	District Resistance Councils
MLG	Ministry of Local Government
NRA	National Resistance Army
NRM	National Resistance Movement (Government led by Yoweri Museveni and NRA)
RC	Resistance Councils

PHILIPPINES

BHS	*Barangay* (neighborhood, ward) Health Stations
CHCA	Comprehensive Health Care Agreements
DILG	Department of the Interior and Local Government
DOH	Department of Health (Involved in performance contracting with local governments accompanied by discretionary grants)

IRA	Internal Revenue Allotment
LGAMS	Local Government Assistance and Monitoring Service
LGC 1991	Local Government Code 1991
LGU	Local Government Units
MANCOMDEV	DOH Management Committee for Development
MCHCW	Magna Carta for Health Care Workers
RHU	Rural Health Units
RPT	Real Property Tax
SEF	Special Education Fund

Acknowledgments

This report was prepared with significant support from Maryse Simonet at the Harvard School of Public Health; and Sara Bennett, Grace Chee, and Charlotte Leighton from Abt Associates Inc. They were actively interested in the subject matter and very well informed on the issues and empirical details of some of the countries reviewed. We should also thank Nelson Kasfir from Dartmouth College and Paul Hutchinson for comments on issues related to Uganda. We have attempted to incorporate their comments and suggestions in this work. The authors however are responsible for this work.

Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact." This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The program comprises Major Applied Research studies and Small Applied Research grants.

The Major Applied Research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- Analysis of the process of health financing reform
- The impact of alternative provider payment systems
- Expanded coverage of priority services through the private sector
- Equity of health sector revenue generation and allocation patterns
- Impact of health sector reform on public sector health worker motivation
- Decentralization: local level priority setting and allocation

Each Major Applied Research Area yields working papers and technical papers. Working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work, such as multi-country studies and reports presenting methodological developments or policy relevant conclusions. These more polished pieces will be published as technical papers.

All reports will be disseminated by the PHR Resource Center and via the PHR website.

Sara Bennett, Ph.D.
Director, Applied Research Program
Partnerships for Health Reform

1. Introduction

1.1 Background and Theoretical Review

In the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world. Decentralization, often in combination with health finance reform, has been touted as a key means of improving health sector performance and promoting social and economic development (World Bank 1993). The preliminary data from the field, however, indicate that results have been mixed, at best. In some cases, these limitations have resulted in a backlash against the reforms and an initiative for recentralization. We believe that this rejection is often premature or misplaced, and that the issue at hand is how to better adapt decentralization policies to achieve national health policy objectives. In this context, it becomes increasingly important to adequately understand the dynamics of health sector reform processes in diverse contexts, to draw both general and case-specific lessons, and to formulate effective strategies for future research and policy making.

This report provides preliminary case studies of health sector decentralization in Uganda, Ghana, Zambia, and the Philippines. It seeks to evaluate several closely related dimensions of decentralization policies. First, it identifies and characterizes the overall political and administrative reform process in the country in question. This requires an analysis of the strategy and mechanisms of the reforms within the public administration context, including the local government system, ministry of health (MOH), and civil service. Second, it looks at the ways in which the reforms affect local health sector decision makers and the range of choice available to them. It also analyzes the effect of decentralization on performance of the health system in providing equity, efficiency, quality, and financial soundness. Finally, it explores the influence of the reforms on civil society, non-governmental actors, and popular participation. Although these case studies are primarily surveys meant to serve as a point of departure for more in-depth research, it is our hope that they also may provide some more general insight into the early lessons of decentralization policies.

The term “decentralization” has been used to connote a variety of reforms characterized by the transfer of fiscal, administrative, and/or political authority for planning, management, or service delivery from the central MOH to alternate institutions. These recipient institutions may be regional or local offices of the same ministry, provincial or municipal governments, autonomous public service agencies, or private sector organizations. Decentralization has been predicted to improve health sector performance in a number of ways, including the following: (1) improved allocative efficiency through permitting the mix of services and expenditures to be shaped by local user preferences; (2) improved production efficiency through greater cost consciousness at the local level; (3) service delivery innovation through experimentation and adaptation to local conditions; (4) improved quality, transparency, accountability, and legitimacy owing to user oversight and participation in decision making; and (5) greater equity through distribution of resources toward traditionally marginal regions and groups. At the same time, fears have been raised about potential macroeconomic destabilization and the aggravation of interregional disparities in wealth and institutional capacity as a result of decentralization (Prudhomme 1995).

The recent proliferation of decentralization policies is part of a broader process of political, economic, and technical reform (Litvack, Ahmad, and Bird 1998). These include “democratization”

and, perhaps more importantly, the neoliberal "modernization" of the state. The latter movement promotes institutional and territorial decentralization as a means to introduce competition and cost consciousness into the public sector, and develops a new role for the state in "enabling" and "steering" rather than replacing private sector activities. The promotion of cost-effective investment in primary care and outreach services, beginning with the Alma Ata Conference on Primary Health Care in 1978 and reinforced in the World Bank's 1993 World Development Report, have provided a further technical impetus for health sector decentralization.

The range of policies grouped under the rubric of "decentralization" is quite diverse with respect to objectives, mechanisms, and effects. This report make use of widely accepted terminology developed by Rondinelli (1981), who identifies three principal categories of decentralization: deconcentration, delegation, and devolution. *Deconcentration* is generally the most common and limited form of decentralization, and involves the transfer of functions and/or resources to the regional or local field offices of the central government agency in question. Within a deconcentrated system, authority remains within the same institution (e.g., the ministry of health) but is "spread out" to the territorially decentralized instances of this institution. *Delegation* implies the transfer of authority, functions, and/or resources to an autonomous private, semi-public, or public institution. This institution assumes responsibility for a range of activities or programs defined by the central government, often through the mechanism of contracting. *Devolution* is the cession of sectoral functions and resources to autonomous local governments, which in some measure take responsibility for service delivery, administration, and finance.

1.2 Methodology and the Decision space Approach

Our analytical framework for the evaluation of these cases is based on a principal–agent approach. In this perspective, the central government, generally in the figure of the ministry of health, is viewed as setting the goals and parameters for health policy and programs. Through the various modes of "decentralization" described above, the central government delegates authority and resources to local agents—municipal and regional governments, deconcentrated field offices, or autonomous institutions—for the implementation of its objectives.

This approach acknowledges that the central and local governments have at least partially differing objectives. Agents often have distinct preferences with respect to the mix of activities and expenditures to be undertaken, and respond to a differing set of stakeholders and constituents than do national-level principals. Local institutions, therefore, may have incentives to evade the mandates established by the central government. Moreover, because agents have better information about their own activities than does the principal, they have some margin within which to "shirk" centrally defined responsibilities and pursue their own agendas. The cost to the principal of overcoming this information asymmetry is often prohibitively high. Within this context, the central government seeks to achieve its objectives through the establishment of incentives and sanctions that effectively guide agent behavior without imposing unacceptable losses in efficiency and innovation. Diverse mechanisms are employed to this end, including monitoring, reporting, inspections, performance reviews, contracts, grants, etc.

The process of decentralization may be seen as one of selectively broadening the "decision or range of choice of local agents, within the various spheres of policy, management, finance, and governance (Bossert 1998). The central principal voluntarily transfers formal authority to the agent in question in order to promote its health policy objectives. The degree and nature of this transfer differs by case, and shapes the function of the principal–agent relationship and the decentralized system as a whole. The case studies presented in this report do not seek to quantify

formal decision space, but rather to offer a preliminary characterization of its range—narrow, moderate, broad—within an array of health system functions. The nature and extent of decision space is presented through "maps," similar to Map 1, which are complemented by an analysis of the history and context of decentralization reforms. (see Annex for criteria for decision-space maps)

Map 1. Standard Decision-space Map

Function	Range of Choice		
	Narrow	**Moderate**	**Wide**
Finance			
Sources of revenue	⇒	⇒	⇒
Allocation of expenditures	⇒	⇒	⇒
Income from fees and contracts	⇒	⇒	⇒
Service Organization			
Hospital autonomy	⇒	⇒	⇒
Insurance plans	⇒	⇒	⇒
Payment mechanisms	⇒	⇒	⇒
Contracts with private providers	⇒	⇒	⇒
Required programs/norms	⇒	⇒	⇒
Human Resources			
Salaries	⇒	⇒	⇒
Contracts	⇒	⇒	⇒
Civil service	⇒	⇒	⇒
Access Rules			
Targeting	⇒		
Governance Rules			
Local government	⇒		
Facility boards	⇒		
Health offices	⇒		
Community participation	⇒		

This study expands the scope of the principal–agent framework to include reference to fiscal choice and social capital approaches through analysis of resource allocation, popular participation, and civil society. The data utilized come from a variety of secondary sources, but are primarily based on existing studies and project reports focusing on decentralization. This exercise offers a rapid review and comparison of the nature and performance of decentralization policy in different contexts, as well as a point of departure and orientation for further primary research and analysis.

1.3 Case Study Overview

The four cases analyzed represent an array of approaches to decentralization and thus offer an interesting and useful basis for comparison. The following analysis represents our tentative conclusions based on a detailed literature review and are likely to be significantly revised by the detailed studies to be implemented by the subsequent phase of this study.

Two of the countries examined, Ghana and Zambia, are pursuing strategies of delegation to semiautonomous public institutions. In each case, the ministry of health has sought to redefine its role from the traditional all-inclusive health sector manager to one of policy formulation, regulation, and monitoring. Responsibility for health service delivery is to be delegated to an autonomous public institution, the Ghana Health Service in the case of Ghana, and the Central Board of Health in the case of Zambia. These new service delivery institutions will ostensibly have greater flexibility in human resource management, administration, and relations with private and non-governmental providers. The models for each of these institutions vary in important ways. While the Ghana Health Service will function essentially as a unified independent bureaucratic hierarchy, the Zambian Central Board of Health will oversee and coordinate a host of semiautonomous district and hospital management boards. The latter system was originally intended to confer a greater degree of decision space to the boards, but the MOH has retained responsibility for board appointment, thus significantly limiting their decision-space.

The other two countries, Uganda and the Philippines, have undertaken strategies of authentic devolution of health service delivery functions to local governments. In both cases the MOH has redefined its role to that of "steering" the health sector through policy making and regulation, while local governments have become primarily responsible for health service delivery. In each case there has been a transfer of health sector infrastructure, personnel, and financial resources from the MOH to local governments. There is a notable distinction, however, between the level of political, economic, and institutional development and the extent of devolution in the two cases. The Philippines is a middle-income country of 77 million inhabitants and over 43,000 local government units (LGUs). Health sector devolution in this context has involved the transfer of nearly 50,000 health workers and has been accompanied by a comprehensive program of fiscal decentralization and democratization. Uganda, by contrast, is one of the poorest countries in the world, and the health sector is heavily dependent on foreign aid and technical assistance. Local government capacity—fiscal, administrative, and technical—is much more limited in this context, and exerts significant constraints on effective local health sector management and autonomy.

Of crucial importance to this analysis is the understanding that the character and extent of the decision-space transferred to local actors is heavily influenced by the nature of those actors. The local actors analyzed here include a relatively broad range, including, in descending order of autonomy and civil society participation: the comparatively strong and independent LGUs of the Philippines, the somewhat weaker but still independent and democratically elected Ugandan district councils, the semiautonomous but centrally appointed Zambian boards of health, and finally the bureaucratically appointed and governed regional and district health administrations of the Ghanaian Ministry of Health or Ghana Health Service. It must also be recognized, however, that the unit of analysis may influence the picture of local decision space. A more highly centralized system, such as that of Zambia, may actually afford greater decision-space at the facility level than does the Philippine case. Overviews of the decision-space maps for the four cases are presented below in Maps 2-5.

Map 2. GHANA: Regional and District Health Administrations

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue		•	
Expenditure allocation		•	
Income from fees & contracts		•	
Service Organization			
Hospital autonomy	•		
Insurance plans	•		
Payment mechanisms	•		
Contracts with private providers		•	
Human Resources			
Salaries	•		
Contracts	•		
Civil service	•		
Access Rules			
Targeting	•		
Governance Rules			
Local governments	•		
Facility boards	•		
Health offices	•		
Community participation	•		

Map 3. ZAMBIA: District Health Management Teams and District Health Boards

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue	•		
Expenditure allocation		•	
Income from fees & contracts			•
Service Organization			
Hospital autonomy	•		
Insurance plans			•
Payment mechanisms			•
Contracts with private providers		•	
Human Resources			
Salaries	•		
Contracts			•
Civil service		•	
Access Rules			
Targeting		•	
Governance Rules			
Local governments	•		
Facility boards	•		
Health offices		•	
Community participation		•	

Map 4. UGANDA: District Councils

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue		•	
Expenditure allocation		•	
Income from fees and contracts		•	
Service Organization			
Hospital autonomy		•	
Insurance plans	•		
Payment mechanisms	•		
Contracts with private providers			•
Human Resources			
Salaries	•		
Contracts			•
Civil service		•	
Access Rules			
Targeting		•	
Governance Rules			
Local governments			•
Facility boards	•		
Health offices		•	
Community participation	•		

Map 5. PHILIPPINES: Local Government Units

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue			•
Expenditure allocation		•	
Income from fees & contracts			•
Service Organization			
Hospital autonomy			•
Insurance plans		•	
Payment mechanisms		•	
Contracts with private providers		•	
Human Resources			
Salaries	•		
Contracts		•	
Civil service		•	
Access Rules			
Targeting		•	
Governance Rules			
Local governments			•
Facility boards	•		
Health offices	•		
Community participation		•	

Overall, the Philippines represents the case of the greatest range of local decision-space, followed by Uganda, Zambia, and Ghana, in descending order. In comparing the devolution cases, it is observed that Philippine local governments enjoy a greater degree of local autonomy than the Ugandan district councils. This is attributable to their greater administrative and fiscal capacity, the larger and less earmarked transfers they receive, and the comparatively minimal influence of international donors and central vertical programs. In the two "delegation" cases, there is a qualitative distinction between the unified bureaucratic hierarchy implied by the Ghana Health Service and the more pluralistic and potentially independent system of central and district health boards established in Zambia. Even though the Zambian system has been somewhat centralized through the board appointment process, the opportunities for autonomy and civil society and local government influence on health sector management are greater than in the Ghanaian case.

With respect to health sector finance, local actors are heavily dependent on central transfers for revenue in all of the cases examined. In the devolution cases, local governments have greater latitude in expenditure decisions which, to some extent, compensates for their limited fiscal autonomy. In the Philippines, central transfers account for 65 percent of local government expenditures, but are of significant magnitude and are formula-based, thus permitting some fiscal security to LGUs. While only 25 percent of these transfers are technically earmarked, a much larger percentage is absorbed by salary requirements over which local governments have little power. Likewise, in Uganda, centrally determined salaries and vertical programs account for 75 percent of the transfers that the district councils receive. The tax base and user fee policies are much weaker in Uganda, however, thus reducing local governments' fiscal latitude in comparison with the Philippines. In the case of Zambia and Ghana, not only are the district-level health offices financially dependent on central budget allocations, they are also subjected to a central budget approval process. In Ghana, regional and district administrators have a fair degree of latitude in budgeting but are monitored through a performance contracting mechanism between hierarchically organized budget management centers. In Zambia budgets are controlled through centrally determined earmarking requirements.

In the service organization sphere, the comparative picture of the four cases is more heterogeneous and less clear. Hospitals are not fully autonomous in any of the cases examined. Facilities are administered by local governments in the Philippine and Ugandan cases, and by the MOH or its delegate (Ghana Health Service or Board of Health) in the Ghanaian and Zambian cases. Zambia's hospital management board system offers significant potential for independent administration, but central MOH appointment and control of board membership appears to severely limit this autonomy. Also of note, Zambia and the Philippines show a wide range of decision space and local innovation and heterogeneity in insurance and prepayment schemes. Uganda and Ghana have relatively undeveloped insurance systems. All of the African cases represent examples of experimentation with independent contracting with non-governmental health service providers. It is not clear to what degree such mechanisms are being used in the Philippines, where non-govenrmental organization (NGO) health service providers are common and the private sector is much more developed.

Local autonomy in human resource management is fairly limited in all four cases, although there is definitely significant variation among them. In the Philippines and Uganda, local governments have been given authority to hire and fire devolved personnel and there has been an authentic delinkage of local government and national civil service. However, in both cases the political influence of public sector health workers has brought about central imposition of salary levels, benefits, and employment conditions. This represents a major constraint on local decision space not only in human resource management per se, but in a more pervasive way as well because of the high percentage of recurrent costs and budget allocations represented by personnel. Zambia and Ghana are even more centralized. Whereas the Ghanaian MOH/Health Service has a unified and hierarchical personnel structure, the

Zambian district health boards are expected at some point to have decentralized authority to hire and fire (although conditions of employment are likely to continue to be centrally determined).

Targeting and health service programming is moderately decentralized in all cases, with notable differences in the mechanisms used for central control. In the Philippines, the department of health has turned to performance contracting with local governments accompanied by discretionary grants in order to promote provision of preferred health service programs. Health programming in both Uganda and Zambia is guided by a centrally defined package of essential services, but there appears to be some degree of local latitude over the delivery of this program. Ghana represents the extreme case of centralization in targeting and programming.

Turning, finally, to health sector governance, health policy is centrally determined in all cases. There is an important distinction to be made between the devolution cases, in which local government directly manages health service delivery, and the Zambian and Ghanaian cases, in which local government representation in local health sector management institutions is severely limited. The degree of community participation, however, does not break down so evenly along the devolution/delegation line. The Philippines provides for ample citizen participation not only through elected local government, but also through representative sectoral institutions and NGOs. Uganda has democratic local elections, but mechanisms for participation in health sector governance appear weak. On paper, Zambia has a rather impressive structure of citizen participation from the facility to the district level, but to date these mechanisms have only been implemented to a limited degree and their viability and effectiveness is not yet clear. Ghana represents the extreme case of the almost total lack of participatory governance, though an initiative is now underway to examine this issue and make recommendations.

1.4 Research

Despite some general similarities between countries pursuing the two reform strategies mentioned above, the foregoing discussion illustrates the great diversity of the four countries analyzed. The organization and history of the health sector and the political economic context of the different countries vary considerably, and each has employed a unique mix of tools and mechanisms in its decentralization policy. Consequently, the selected cases provide a useful basis both for preliminary comparison as well as for more detailed primary research.

Plans for such investigation could be based on a combination of national data analysis and case studies of local health system units. Analysis of national and regional financial allocation data could be analyzed in relation to utilization and epidemiological data to the extent possible in order to determine trends in allocation and impacts on performance associated with decentralization. Local health management units, including local and regional governments, local and regional health boards, and/or local and regional health management teams, could be analyzed in order to provide a more in-depth understanding of their political, economic, and institutional characteristics. Case studies of selected local management units could then be undertaken. The latter would focus on assessment of the qualitative factors which influence health sector performance in the context of decentralization. These studies could employ comparative analysis of selected pairs of local management units identified as successful or poor performers through the national-level data analysis.

The general view of the effects of decentralization on health sector performance provided by the national data analysis could thus be complemented by attention to some of the more nuanced and qualitative aspects of decision processes and policy implementation in diverse local contexts. The results would provide the basis not only for country specific recommendations, but also for further

comparative data relevant to the broad array of countries engaged in implementing decentralization reforms. The Partnerships for Health Reform is undertaking an in-depth applied research study in Zambia using the methodology discussed above.

2. Case 1: Ghana

2.1 Introduction

The decentralization of Ghana's health sector began in 1988 with the World Health Organization-supported Strengthening District Health Systems project and has led, most recently, to the 1996 enactment of a comprehensive program of administrative deconcentration and delegation. While the early years of this program focused primarily on the institutional strengthening of Regional and district health administrations within the Ministry of Health, more recent proposals have gone yet further toward increasing the range of decision-space of these regional and local institutions. Notable among the proposed reforms is a new system of budget decentralization to regional and district level offices of the MOH, implemented through the 1997 Programme of Work (POW) in the form of a hierarchy of semiautonomous budget management centers (BMCs). This program of fiscal decentralization within the MOH has already had significant results in reallocating health resources toward district-based services and primary care. The second principal element of the current reform program is the establishment of a Ghanaian Health Service (GHS), autonomous from the Ministry of Health. Under the proposed reforms, not fully implemented as yet, the MOH's role will be reduced to one of policymaking and regulation, while delegating health service delivery functions to the GHS.

The health sector has been largely isolated from the simultaneous and ongoing process of local government reform that began in 1988. At that time the Provisional National Defense Council (PNDC) government of Lieutenant J.J. Rawlings embarked on a much-heralded program of decentralization, based on a system of 110 elected district administrations throughout the country. This program was actively supported by the international community and has received extensive treatment in the literature (Ayee 1996; Haynes 1991; Mohan 1996; etc.). Nearly a decade after the policy's implementation, however, it has become clear that the nature and gains of decentralization have been both limited and heavily influenced by the political aims of the ruling PNDC (now NDC) party. Although the 1988 reforms have achieved some political mobilization at the local level and some limited fiscal decentralization, they have had little visible impact on the health sector or public service delivery, with the possible exception of road and infrastructure development.

Ghana is a Gold Coast country of some 17.5 million inhabitants, approximately 64 percent of whom live in rural areas.[1] Although following independence from British colonial rule in 1957 Ghana was one of the most prosperous countries in sub-Saharan Africa, the following two decades saw a drastic deterioration of its economic situation, leading it to the brink of crisis in the early 1980s. The ruling National Commission for Democracy (NCD) government gained international renown for its successful implementation of an International Monetary Fund (IMF)-sponsored Economic Recovery Program/Structural Adjustment Program (ERP/SAP), bringing hyperinflation under control and reversing the negative GDP growth rates of the early 1980's. At present, per capita GDP is US$ 463, and the economy is growing at a rate of around 5 percent per annum.

[1] Population is expected to exceed 20 million in the year 2000 (Center for International health Information [CIHI] 1996), of which the urban population is anticipated to account for fully 40 percent.

Unlike many other African countries, such as Uganda, whose health systems have been heavily based on clinical medicine, Ghana has distinguished itself for its focus on public health concerns (Hiscock 1995). Its health indicators have deteriorated considerably under the burden of economic crisis, but are on the mend. In 1995, the infant mortality rate was 77 per 1000 live births, down from 122 in 1965 and 94 in 1985. This is significantly better than the 1995 sub-Saharan average of 97 (CIHI 1996). Average life expectancy is 58 years for women and 55 for men. Public spending on health represents nearly 14 percent of overall government expenditures, an unusually high level by developing world standards (Hiscock 1995). While Ghana's commitment to the health sector has brought significant donor support, foreign aid represents no more than 25 percent of overall expenditures on health (Hiscock 1995; McQueen 1997). Emphasis on parallel vertical programs initiated in the 1980s, such as the Expanded Program on Immunization (EPI), has to some extent begun to shift toward greater efforts at institutional development of the MOH (Hiscock 1995) and the implementation of a Sector Wide Approach (MOH 1998).

The following issues will be considered in the case of Ghana:

- The effects of Ghana's unique health sector reform, incorporating both fiscal decentralization within the health sector and delegations of service delivery activities to an autonomous state agency, the GHS
- The significance of the 1997 Five Year Programme of Work in terms of fiscal decentralization to the delegated health systems of budget management centers and overall decision space
- The change in decision space with the implementation of the new district assemblies
- The amount of control retained at the local level

2.2 History and Character of Decentralization Reforms

2.2.1 Local Government and Political-Administrative Deconcentration

The history of decentralization in Ghana has, to a large extent, been shaped by political instability at the national level. Frequent coups and nondemocratic transfers of power have brought periodic reform, including apparent decentralization or recentralization in the interest of consolidating the power of the ruling party and weakening the opposition. In a country of over 90 different ethnic groups, successive administrations have been wary of authentic political decentralization, and have opted instead to extend central influence at the local level through policies of administrative deconcentration.

In 1957, Ghana was the first sub-Saharan African country to receive independence from British colonial rule. Although regional decentralization was recommended by several study commissions in the period leading up to 1957, the independence government of Kwamu Nkruma rejected this idea for fear of fomenting regional and ethnic separatism. Nkruma's Convention Peo government ruled through existing district administrations and held power until 1966 when it was ousted by a coup. A period of centralization followed, as the ruling National Liberation Council (NLC) sought to break the power of the CPP at the local level through the consolidation of Ghana's districts from 185 to 40 and the imposition of centrally appointed district administrative officers (DAO).

Over the course of the following years, several commissions were appointed to study local government policy, resulting in the formulation of a model based on four tiers: central government; regional councils, district councils; and local councils based on traditional chiefdoms. This model was codified in the 1969 Constitution, but the Busia government, that presided over its formulation, was removed from power by a 1972 military coup. The National Redemption Council (NRC) which took power eliminated the regional and local governments, maintaining only the district councils, which became increasingly unpopular. The NRC was deposed in 1979 and was followed by a number of short-lived regimes, leading ultimately to the 1981 accession to power of the Provisional National Defense Council government.

In 1982, the PNDC dissolved the district councils and replaced them with management committees nominated by centrally appointed district chief executives (changed to district secretaries in 1983). The PNDC pursued a populist-corporate strategy of political mobilization within a single-party system, and its initial economic policy included rent, price, and fare controls, protectionism, and support for a mixed economy. However, Ghana's deepening economic crisis forced the government to make a U-turn in economic policy and in 1983 the IMF-sponsored Economic Recovery Program/Structural Adjustment Program was adopted. This period was accompanied by political instability, including several coup attempts, and the PNDC held off on earlier plans for administrative deconcentration. Five years of growth between 1984 and 1989 brought GDP levels back to those of the early 1970s. Inflation was brought under control, and some measure of political stability was achieved (Gyimah-Boadi 1990; Mohan 1996)

In 1988, the PNDC passed Law 207, establishing the basis for a comprehensive decentralization policy. This policy centered on the expansion of subregional districts from 65 to 110, which were to be governed by newly established district assemblies (DAs). Two-thirds of the DA members would be directly elected and the remaining third would be appointed by the PNDC from recognized social groups, including primarily traditional chiefs and leaders. Elections were held over the course of 1988-89, resulting in the establishment of functioning assemblies in all 110 districts. The DAs were granted 86 specific functions including planning, finance, budgeting, infrastructure development, and internal security, among others. Each DA would be led by a centrally appointed district secretary, and all of the district secretaries and DA chairs within a given region, together with a centrally appointed regional secretary, would form a regional coordination council (RCC). Each of the ten regions has an RCC, charged with regional planning and coordination. At the subdistrict level, local/town/area councils were established, and below this, unit committees, each representing a population of 500 to 1,500.

Some positive results have emerged from the decentralization policies. There has been some increase in local participation and access to central government resources, and a dramatic expansion in political opportunities for aspiring local leaders (Ayee 1997). There is some evidence of increased and more equitable investment in public infrastructure, but the record is somewhat mixed. In general, however, the DAs have not received good reviews from their constituents. Crook (1994) found that 70 percent of those surveyed indicated that the DA was incapable of addressing their development needs, while only 22 percent considered the DAs to be an improvement over the district councils that preceded them.

The political and administrative reforms of 1988-89 have, for the most part, been divorced from the reform of the Ghanaian civil service, and the health sector is no exception. Whereas Law 207 stipulates that the DAs are to coordinate the decentralized line ministries, no institution has been established to take responsibility for the restructuring and reorganization of the ministries and the civil service. No legislation has been passed to provide for the basis for such restructuring, and no hiring and firing responsibility has been devolved to the newly created structures of local government.

Beginning in 1987, there has been a major investment in civil service reform, but this has been essentially unconnected to district-based decentralization and has, in fact, acted to distract the bureaucracy from the latter. Moreover, the Ministry of Finance and Economic Planning has come into conflict with the newly established district planning system guided by the National Development Planning Commission, creating obstacles to integrated budgeting and planning for the districts (Ayee 1997).

Beginning in the 1990s, the ruling party has been forced to permit some opening of national political space through the establishment of a multiparty system. And while decentralization policies have served to mollify international and domestic opponents, the NDC has consistently avoided relinquishing to local governments any significant power over fiscal policy or the bureaucracy, including the health sector. Several commentators (Gyimah-Boadi 1990; Mohan 1996; Jeffries 1998) argue that local government reforms have been pursued, not for their technical or democratic merits, but rather for the political advantages which they have conferred on the ruling party.[2]

2.2.2 Health Sector Reform

Health sector reform, including administrative deconcentration and delegation, has come not in the context of the local government system, but rather in the separate process of civil service reform initiated in the late 1980s and early 1990s. In 1996, the Ghana Health Service and Teaching Hospital Act was passed, ushering in a process of major administrative reorganization of the national health system. The reforms are based on an integrated decentralization program, incorporating both fiscal decentralization within the health sector, and delegations of service delivery activities to an autonomous state agency, the GHS.

The Ghanaian MOH is organized on the basis of four distinct levels of administration: central, regional, district, and sub-district. The institutions embraced by the sub-national levels are as follows:

- 10 regional health administrations (RHAs)
- 9 regional hospitals
- 110 district health administrations (DHAs)
- 85 district hospitals
- Subdistrict administrations and health centers

The RHAs are composed of a regional director of Health Services and a regional health management team, and likewise the DHAs will have a director and team. The sub-district level will serve as an administrative liaison between the district level and individual health centers.

Based on the Ghanaian MOH's 1997 Five-Year Programme of Work (POW), financial management and administration within the health sector is in the process of being converted to a budget management center scheme. Under this model, sector resources are managed through a hierarchy of BMCs, whose accounting and management capacity must be certified in order to be

[2] Several commentators conclude that the decentralization policy is essentially a PNDC attempt to build a rural power base and to legitimate its rule without effectively opening up national politics to multiparty competition (Gyimah-Boadi 1990; Ayee 1996; Ayee 1997; Jeffries 1998).

eligible for donor funding. Funding for the POW comes from the government, internally generated funds (IGF), and external funds. Government funding is directed to the MOH budget and district assembly common funds. BMCs may be a division of the MOH (soon to be GHS), a regional or district hospital, a department of the Regional Health Administration, etc. Central BMCs will supervise regional BMCs, which will in turn supervise district BMCs and so forth down to the sub-district level. Some 800 potential BMCs have been identified, of which 227 at the district level and above are presently operational. Subdistricts did not manage funds in 1998, but it is anticipated that they will ultimately do so. There is not, as of yet, any intention of decentralizing funding to the Health Centers, whose budget will be managed at the subdistrict level (Bouchet 1998).

The MOH assigns the various regional directors with budget ceilings for regional (RHA, office of director, public health, regional hospitals), district (DHA, district hospitals), and subdistrict BMCs. The directors then allocate budget ceilings to BMCs on the basis of district population, number of health facilities, and distance from the regional capital. BMCs prepare their own budgets, except with respect to salaries and capital investment, which are centrally determined. In 1997, 70 percent of MOH recurrent expenditure was allocated to wage bills (MOH 1998). BMCs receive funds on a quarterly basis through the Financial Encumbrance (FE) system, which is divided by budget line. BMCs may retain unspent quarterly funds, and may change funds from one subbudget line to another, but not between budget lines. As of 1998, lower-level BMCs are no longer required to submit plans with their budgets, but are required to establish service performance contracts with supervising BMCs. Performance contracts specify the resources to be provided by the supervising BMC and the health services to be rendered by the lower BMCs. Services are to be measured by agreed upon performance indicators, and will be subject to quarterly reviews. Rewards and sanctions contingent upon these evaluations are provided for, but are not specified (MOH 1998).

In complement to the fiscal decentralization program, the Ghanaian government has initiated the creation of an autonomous Ghana Health Service (GHS) for the provision of public sector health services (still in the implementation stage) and the reduction of the role of the MOH to that of policy formulation and oversight. Henceforth, there will be no MOH presence in the regions and districts, its structure having been reduced to the central offices. While the GHS will be part of the Ghanaian Public Service, it will not be part of the civil service. It will not be fully independent from the MOH, but will enjoy full administrative autonomy and greater flexibility than civil service departments in service delivery, contracting, and cooperation with the private sector. The GHS will be governed by a national headquarters overseen by a National Governing Council, a Director General, and a Health Sector Executive Management Group. Below the central level, the four existing administrative levels will be maintained: regional health administrations, district health administrations, subdistrict health management teams; and health centers. All MOH fixed assets and personnel associated with health service delivery will be transferred to the GHS, which will have authority to make decisions over the elimination or replacement of staff.

This transition has not, as yet, been implemented, but important preparatory steps have been taken in the course of 1997 and 1998, particularly in the sphere of human resource management. The GHS' projected relationship with local government and budget management structures are discussed in the following sections.

2.3 Decision Space and Decision Makers at the Local Level

Changes in local decision space as a result of health sector reform are confined to the internal governance of the MOH/GHS. As indicated above, the local government system remains relatively undemocratic and largely excluded from health sector governance. Within the MOH/GHS itself, there is a move toward the decentralization of resources and decision making. The opening of decision space to deconcentrated instances of the central agency, however, is controlled through a hierarchical system of BMCs and centrally determined human resource policy. The "mixed" results of deconcentration and delegation on the formal decision space of local instances of the MOH/GHS, including regional health administrations, district health administrations, and hospitals, is summarized in the following map.

As the Map 6 demonstrates, within the MOH/GHS itself there are elements of both centralization and decentralization. The GHS will gain some degree of autonomy from the MOH in the administration of health service provision, but its National Governing Council and Director General remain presidentially appointed offices. The GHS will have authority over human resources, but staffing norms, salaries, allowances, options for private practice employment, etc. will all be centrally determined (MOH 1998).

Regional and district health directors within the MOH/GHS will gain influence as budget decentralization proceeds, though this will be closely controlled through FE earmarking and performance contracting. Hiscock (1995) has pointed to the positive repercussions of the strengthening of district health systems in the generation of a "critical mass" of younger reform-oriented health management professionals. This new generation of professionals is organized, to some extent, through the district medical officer (DMO) groups, which provide, among other things, a type of "association which allows medical officers to speak out" (Hiscock 1995: 32). While this may tend toward real decentralization of administrative decision making over the intermediate term, it should be emphasized that current health sector reform policy reinforces the longstanding tendency toward "decentralized centralism" on the part of the Ghanaian government.

The new model established by the 1996 health sector reforms is at odds, legally and practically, with the local government reforms instituted in 1988-89. This conflict has generated opposition from some in the district administrations who advocate the subordination of the district-level health sector to them as stipulated in Law 207. The current reform does provide the DAs with some influence in the management of the GHS, but this is likely to be minimal given the continuing separation between governmental bureaucratic organization and local government. Under the new policy the DAs will have some representation on the district health committees, and they will have some role in the appointment and approval of a further five members of the Health Committees, including the chairman. The DAs may ultimately be given some role in approving district GHS budget submissions (MOH 1998). However, it seems clear that the role of local government has been intentionally limited to one of advising the GHS, and it will be minimal at best (Mensah 1997).

Map 6. Map of Local Decision Space: RHAs/DHAs (Ghana)

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue		RHA, DHA, and hospital revenue is hierarchically determined by BMC budget ceilings. - MOH/GHS allocation to RHAs and DHAs has increased to ~25% and ~35% respectively. -User fees (20% of MOH spending) dramatically increase revenues for direct provider levels (i.e., DHAs, hospitals).	
Expenditure allocation		Regional, district, and hospital directors have significant latitude in the allocation of non-wage expenditures within budget ceilings (30% of recurrent budget). Allocation decisions evaluated and influenced via performance contracting.	
Income from fees and contracts		User fees account for nearly 20% of MOH funding and significantly expand DHA and hospital resources	
Service Organization			
Hospital autonomy	Hospital admin centrally controlled by MOH/GHS		
Insurance plans	N/A		
Payment mechanisms	Centrally determined		
Contracts with private providers		Contracting with mission health assistance providers (CHAG) initiated	
Human Resources			
Salaries	Salaries to be determined by central office of the GHS		
Contracts	Little or no contracting of non-permanent staff		
Civil service	Central GHS will have hire/fire and human resource policy authority		
Access Rules			
Targeting	Central MOH/GHS will have authority over defining health service package and targeting		
Governance Rules			
Local governments	Dist. Administrations undemocratic and largely excluded for health sector governance. Some representation to District Health Committees to be provided, but limited authority		
Facility boards	National Governing Council and Director General of GHS presidential appointments; no autonomous facility boards		
Health offices	RHA, DHA, and hospital management centrally appointed		
Community participation	Extremely weak; while there are some community health committees, no mechanisms exist to link these local institutions to health policy		

The DAs, for their part, have their own shortcomings with respect to decentralization. Despite the rhetoric surrounding Ghana's local government reforms, the level of authentic power sharing and expansion of local decision space has been rather limited. This is evident not only in the fiscal arena, but also in the fundamental structuring of local governments under the reforms. First, the centrally appointed office of the district secretary has proved to be exceptionally powerful, allowing the ruling party to effectively control the operation and decision-making processes of the district assemblies. This is reinforced by central appointment of one-third of the assembly members, who in practice exert a disproportionate influence on DA decision making. Finally, under Law 207 the PNDC retains the authority to dissolve the DAs and replace them with an interim management committee, a power that has been exercised on several occasions.

2.4 Resource Allocation after Decentralization

2.4.1 Local Government

Fiscal policy has been the weakest element of the Ghanaian local government system under Law 207. The transfer of fiscal authority to the district assemblies, in particular, has been limited from the outset, and fraught with difficulties. Although the revenue situation of the districts in 1996 was poor, it was significantly better than prior to the 1988-89 reforms (Ayee 1996). As of 1996, only 3 percent of national revenues were spent through local governments in Ghana, an extremely low proportion even by regional standards (Mohan 1996). The 1992 Constitution called for the establishment of a District Common Fund, through which at least 5 percent of national revenues were to be distributed to the district governments. Although there have been complaints that the allocation formula is less than transparent (Mohan 1996), there has been evidence that district assemblies have made use of DCF resources to support capital investment in the health sector. Formula-based central transfers do not, at present, exceed the districts' own-source revenues (Ayee 1996).

The composition of district-level budgets has also changed in the wake of decentralization. Investment in development and capital projects has increased from 3 percent of district budgets in 1986 to 13-15 percent in 1991. The lion's share of district budgets (85-87 percent) has continued to be devoted to recurrent expenses, but the composition of these expenses has changed somewhat. The proportion going to salaries has decreased, while administrative expenses, including perks for district officials, has increased. In one district it was noted that the amount spent on vehicles, travel, and entertainment of district officials was four times that spent on the development budget (Crook 1994). In 1995 an attempt was made to channel MOH funds through the DAs via the National District Common Fund Administration, but some of these funds were used for projects outside of the health sector for which they were budgeted. As a result of these problems, the program has been suspended and the Ministry of Finance (Mensah 1997) is holding the funds.

2.4.2 Health Sector

The MOH's fiscal decentralization program, based on the newly implemented BMC hierarchy, has already begun to show some significant results. Between 1996 and 1997, the proportion of government recurrent expenditure directed to the health sector rose from 7 percent to 8.4 percent. However, inflation eroded the value of expenditure so that, in real terms, expenditure in 1997 remained constant. The MOH's 1997 Five Year Programme of Work called for significant decentralization of resources to the regions and districts and away from tertiary care, as indicated in the Table 1 (MOH 1998).

Table 1. Percentage of Non-wage MOH Budget Expenditures by Administrative Level

Administrative Level	1996	1997
Headquarters	28.0	29.0
Tertiary Care	31.3	22.0
Regional Health Services	17.0	25.0
District Health Services	22.8	34.0
Total	100.0	100.0

The early results of fiscal decentralization have been quite positive. While in 1995, only 10 percent of the non-wage budget was under district-level control (Hiscock 1995), by 1996 this had increased to 22.8 percent (MOH 1998). The proportion of the MOH budget that is spent on health care at different levels, channeled through the district level, has increased from 22.8 percent to 34.0 percent from 1996 to 1997, with a corresponding decrease in the percentage allotted to tertiary care from 31.3 percent to 22.0 percent over the same period (see Table 1 above) (MOH 1998). Between 1996 and 1997, the most influential increase in the recurrent budget is in salary and wages (MOH 1998). Overall, district recurrent expenditure has risen from approximately US$ 25 million to US$ 32 million between 1996 and 1997, a 5 percent real increase (MOH 1998). There is some concern over interregional equity with respect to internally generated funds (IGF–user fees, cost-sharing, medical examinations, consultations, and drugs), which constituted approximately 19 percent of MOH expenditure in 1997 (MOH 1998: 33). Drug sales account for 46 percent of IGF revenues, while service charges including consultation and hospital fees provide the remaining 54 percent. IGF revenues in 1997 were C 24 billion (US$ 1=Ghanaian cedis 3,438), a significant increase from the previous year, and nearly two and a half times what was expected. Some survey information indicates that the population feels that user fees are too expensive and that this may be a significant factor in underutilization of public health facilities, particularly in poorer areas. IGF revenues are generally used by facilities to cover non-wage operational costs, and exert a strong influence on the reallocation of health sector resources among levels as indicated in the Table 2 (note that columns do not add up to 100 in original source (MOH 1998: 38) .

Table 2. Influence of User Fees on Allocation of Resources

Recurrent Expenditure by Level	1996 Expenditure	1997 Budget	1997 Actual	
			MOH	MOH + IGF
Headquarters	28.1%	22.3%	29.4%	**19%**
Tertiary Institutions	31.5%	31.5%	21.9%	**27%**
Regional	17.1%	16.5%	14.8%	**10%**
District	23.3%	37.6%	33.9%	**44%**
Total	100.0%	107.9%	100.0%	**100.0%**

The level of IGF varies considerably by region, from approximately US$ 1.9 million annually in Greater Accra to around US$ 200,000 in the Upper East. Likewise, there are variations within intraregional allocations, with wealthier regions allocating a considerably greater percentage of resources to the subdistrict level than do poorer regions (MOH 1998). This latter trend may be the result of greater concentration of resources in the regional and district hospitals within poorer regions. The lower-income regions exhibit greater limitations in management capacity of lower-level

administrative units and primary care facilities, and hence may be more prone to internal fiscal centralization than wealthier regions.

2.5 Social Capital, Participation, Community Initiatives

Relatively little attention has been given to analyzing the nature and degree of popular participation under the Ghanaian decentralization reforms. One of the few studies that has attempted to do so concluded that the district assemblies, like the district councils that preceded them, have been a relatively ineffective fora for popular participation. While the relationship between elected assembly members and their constituents has involved participatory consultations and community meetings, the assembly members themselves are not well-heard in the DAs. Ayee (1996) identifies a marked tendency for the elected representatives to defer to the views of the appointed representatives, who are better educated and often represent established forms of traditional authority. Moreover, in the districts he surveyed, nominated members dominated the functional committees including the powerful executive committee, which is chaired by the district secretary. It has also been pointed out that the Committees for the Defense of the Revolution, the PNDC's local organs for popular mobilization, have exerted a strong influence on District Assembly elections and decision making (Mohan 1996). In general, the assemblies are considered to have performed poorly as a conduit for transmitting local preferences to the national level (Herbst 1993; Ayee 1996).

Attempts at the fomentation of self-help projects have been largely unsuccessful and evidence poor completion rates. These projects have generated opposition from community members whose expectations have been raised by the establishment of the DAs and who believe that the local government should fully subsidize projects. The district assemblies' emphasis on revenue generation through taxes and public enterprises has reinforced popular sentiment that they should finance development projects (Ayee 1996).

One study of decentralization reforms in Ghana's educational system showed that local stakeholders perceive decentralization to have brought a fairly limited degree of local participation. While stakeholders, including headmasters, parents, teachers, and community leaders, had significant influence in supervisory issues of staff and student discipline, etc., they had very limited decision space with respect to more important issues of control of financial and material resources, salaries, and appointment of teachers (Mankoe and Maynes 1994).

With respect to the health sector, participation has been even more limited. Although there has been some investment in the training of community health workers and traditional birth attendants, there has been no attempt to directly introduce local participation in health sector governance. The 1997 review of the five-year program of work indicates that the functioning of participation is "cumbersome" and that, in general, the interface between health sector providers and beneficiaries is "weak" (MOH 1998: 57-8). Local health committees are often not active in health promotion etc., particularly the case in the country's northern regions. A policy options paper has been drafted on this subject, but no steps have been taken as of yet to implement any specific mechanisms of participation (MOH 1998).

2.6 Conclusion

2.6.1 Summary

This analysis has demonstrated the relatively sharp distinction between local government and health sector reform in Ghana, within the context of a politically centralized system.

The political realities of decentralization in Ghana should, however, not detract from the more recent attempts at health sector improvement. Ultimately, the reform of Ghana's health system must be analyzed under the rubric of administrative deconcentration and delegation, quite apart from the local government system. Early indicators seem to suggest that some improvements in fiscal management and resource allocation have already been achieved. The historical competence of the Ghanaian Ministry of Health, its commitment to public health, and international support for the newly inaugurated Sector Wide Approach would seem to augur well for the success of these reforms. As has been emphasized in relation to the 1988 reforms, however, there is a significant difference between policy formulation and implementation, and it remains to be seen how Ghana's health system will ultimately perform.

One of the distinguishing elements of Ghana's reforms to date is the use of innovative mechanisms for decentralization. These tools are particularly evident in the field of fiscal decentralization (i.e., the BMC and performance contracting) but also with respect to the internal administration and governance of the MOH (delegation to the GHS). Such mechanisms appear to represent an attempt to hybridize the efficiency and innovation gains of decentralization, with the maintenance of central capacity to guide and control the mix of resource allocation and health service delivery. On the other hand, Ghana also demonstrates a notable lack of investment in mechanisms to connect the health sector with local government and the beneficiary population. This is consistent with historical tendencies towards political and administrative centralization and separation between the civil service and local government, but over time may represent an obstacle to efficient intersectoral coordination and democratization.

2.6.2 Further Research

Ghana's novel approach to health reform and the transitional state of the reform program offer much opportunity for further investigation. Further research and evaluation of the sector's performance would be useful in a number of areas:

- *Delegation and Health Sector Governance*: To date, there has been no systematic review of the Ghanaian health sector since the delegation of responsibility for executive functions of health service provision to the Ghana Health Service. Clearly, this is a reform of major significance and merits evaluation and monitoring. What results can be seen as a result of the transition from the "old" MOH to the "new" MOH/GHS system? What kinds of changes in the organization of health service delivery, resource allocation, etc. can be observed as a result of the transition to GHS management? What patterns can be observed in aggregate spending, and central allocations to the "new" MOH for its policy and regulatory activities? What kind of relationship emerges between the GHS and the MOH?

- *Finance*: It has now been nearly three years since the adoption of the BMC system and performance contracting, meaning that a broader scope for analysis of the results of this system is now possible. What effect does fiscal decentralization have on the historically inequitable pattern of distribution of resource among the regions and districts? How transparent, and how equitable, are the criteria for the allocation of BMC budget ceilings? What changes can be observed in patterns of allocation to primary versus hospital care in the various BMCs? What mechanisms of fiscal sanction and/or reward have been employed in relation to the performance contracts? What differences, if any, can be observed between different BMCs in the utilization of performance contracting?

- *Health Sector Performance*: Systematic investigation of the efficiency, quality, equity, and financial soundness of the deconcentrated/delegated health sector is necessary. Comparative research on changes in performance before and after the 1993-98 reforms, as well as on the differences between different regions, districts, subdistricts, and facilities would be extremely helpful. The isolation of factors significantly contributing to changes in performance would be of great use. How well does performance contracting work in improving performance? What innovations, if any, are emerging from the deconcentrated instances of the MOH/GHS? What differences can be observed between the performance of different BMCs and what accounts for this? What effects if any is delegation having on health worker conditions of employment and morale?

- *Local Government and Popular Participation:* As mentioned repeatedly in this analysis, the connection between local government, communities, and the health sector is one of the weakest elements of the reform program. However, there has also been some anecdotal evidence of cooperation between the district administrations and the MOH. A more systematic look at this relationship, and at recent policy options for popular participation is necessary. How much, if any, support are the DAs providing for health sector activities? How does the MOH coordinate with the DAs to promote environmental health and other intersectoral health issues? What differences are there in this relationship in different districts, and what accounts for these differences? How much, if at all, do differences in the level of cooperation with local government and community participation influence health sector performance?

3. Case 2: Zambia

3.1 Introduction

Zambia has attracted considerable attention in recent years for its ambitious program of health sector "decentralization." The Health Sector Reform Program, initiated in 1993, may be more properly referred to as a program of administrative deconcentration and delegation. In the Zambian case, the Ministry of Health has redefined its role as one of policy making and regulation and will contract out functions related to health service delivery to an autonomous Central Board of Health (CBoH). The CBoH, in turn, will be responsible for the coordination and supervision of the country's 72 autonomous district health boards (DHB) and 20 hospital management boards (HMB). These reforms are, to some extent, still in their infancy, but Zambia has already seen extensive fiscal decentralization within the Ministry of Health, which is allocating an increasingly large percentage of its budgets directly to the district health offices.

The health reform program is part of a broader process of democratization and decentralization in Zambia, following the transition from the one-party state of the United National Independence Party (UNIP), which ruled under the leadership of President Kaunda from the date of independence in 1965 until 1991. Under two successive local government codes, the UNIP government had pursued a policy of "decentralized centralism," under which district councils were given increasing administrative responsibility under the close guidance of the party's central committee. The Movement for Multiparty Democracy (MMD), which has come to power since the 1991 elections, is intent on the reform of the local government system, but political decentralization and devolution has lagged behind the reform of the line ministries, particularly the Ministry of Health. At present the deconcentration and delegation of health sector activities is almost completely separated from the issue of political decentralization.

Zambia is a landlocked East African country with a population of approximately 9.5 million, close to 45 percent of whom live in urban areas (CIHI 1996). The infant mortality rate, which had improved to 80 per 1000 live births in 1981, has since climbed to 107 in 1995. Average life expectancy is 47 years, and is declining in the face of the growing AIDS pandemic. Between 1981 and 1991, there was a 30 percent real decline in public expenditures on health and a massive flight of doctors and dentists from the country. More recently health expenditures have stabilized somewhat, having decreased by only 1.5 percent between 1994 and 1997. However, there have been some positive shifts in the allocation of these dwindling funds, including a 20 percent decrease in hospitals' share of funds and a 20 percent increase the share of the district health management boards (Makinen 1997). Zambia's health situation must be placed in the context of its economy, which has suffered serious deterioration with the collapse of the market for its major export commodity, copper. While per capita GNP was near Africa's highest in the early 1980's at $700, it fell to a dismal $265 in 1987. It has since risen to $350, but Zambia's debt burden remains a staggering 3.4 times its GNP (Van Bergen 1995).

A number of interesting issues present themselves in the Zambian case, in some cases generating more questions than answers. These will be considered at some length in the following discussion, and include:

- The separation of health sector reform (deconcentration and delegation) from local government reform
- The central importance of the fiscal decentralization to the deconcentrated health system
- Financing innovations, including district control of user fee policy and management and sector-wide "basket funding" from donors
- The significance of technical innovations such as the definition of the Essential Health Package
- The ambiguous and often conflicted relationship between district health personnel, hospital management boards, district health boards, and the Central Board of Health
- Limitations on local decision space due to central appointment of local health boards, politicization of the appointment process, and intervention in human resources policy

3.2 History and Character of Decentralization Reforms

3.2.1 Local Government and "Decentralization"

Much has been written on political and administrative "decentralization" in Zambia prior to the inauguration of the Public Sector Reform Programme in 1993 (Chikulo 1981, Chikulo 1982, Lungu 1986, Mukwena 1992, Tordoff 1994). While the Ministry of Health has been largely isolated from these processes, some analysis of the history and character of the local government system seems justifiable by way of setting the scene.

The 1965 Local Government Act, enacted immediately after independence, replaced the colonial Native Authorities system with democratically elected local councils organized under the Ministry of Local Government. The provincial and district administrations, however, acted primarily as deconcentrated extensions of the central government, under the authority of the politically appointed provincial heads and district governors, respectively. Not only did these governments perform poorly, but they also failed to satisfy the aspirations of local UNIP functionaries to some material benefit from party membership and activism (Lungu 1986).

In 1980, the UNIP government passed a new Local Government Act (LGA 1980), which reorganized the country's political and administrative system. Although accompanied by much rhetoric about local empowerment and decentralization, the central objective of LGA of 1980 was the unification of the UNIP party structure and local administration in the figure of newly established District Councils.

The composition of the district councils was heavily dominated by UNIP functionaries and included:

- District governor, a presidential appointee and UNIP member
- District political secretary, a UNIP member

- Two district trustees, appointed by the UNIP provincial committee and approved by the central committee
- All chairmen of ward committees, all UNIP members
- District members of Parliament, primarily UNIP members
- One representative for each district-based mass organization, including the UNIP youth chairman and the UNIP women's league chairlady
- One representative for each district-based trade union
- One representative for each security force
- One chief, elected by all chiefs in district

Furthermore, LGA 1980 made UNIP membership a requirement for voting in local elections. Thus, while the establishment of the district councils did permit a certain measure of local representation, this was closely controlled by the party both in the electoral process and through party domination of council membership. Mukwena (1992) has suggested that UNIP domination of the councils and district administration afforded not only central control over local politics and administration, but also a means of providing material benefits to local party functionaries through employment and other forms of patronage. These benefits were important to shore up party loyalty at the local level and to combat the demoralization which had crept into UNIP ranks prior to the implementation of LGA 1980.

The reform brought opposition from the labor unions, such as the Mine Workers' Union of Zambia (MUZ) and the Zambia Congress of Trade Unions, and others. These groups asserted that LGA 1980 would result in a centralization of power and constriction of the representative nature of local government, and might lead to failures in service delivery (Mukwena 1992). Despite these objections, the government began to organize district council elections before the bill was even passed by the legislature.

The district council was to act as the legislative, deliberative, and consultative body at the district level, whose executive was the district secretariat. The secretariat was formed of an executive secretary, administrative secretary, financial secretary, social secretary, development secretary, commercial and industrial secretary, legal secretary, security secretary, and political secretary. The latter two offices were not introduced in all councils, but this nonetheless left a sizeable institution. Problems arose with the overlapping functions of these offices, and the considerable salaries drawn by so many officials, leaving few resources for sectoral activities. Moreover, the integration of the party and local administration led to widespread misuse of local administration funds for UNIP campaign and popular mobilization activities. Clientelism and patronage were rampant, both in the discretionary collection of taxes and in hiring and contracting decisions (Mukwena 1992).

The district councils were given responsibility for some 74 specific functions, embracing district administration in the political, social, and economic spheres. In theory, they were to be the highest authority at the district level, to which all administrative agencies would be answerable. They were to be given increased responsibility for district-level development programs, but these responsibilities were, for the most part, unaccompanied by necessary funding. In the health sector, the district councils did take responsibility for the administration of some health centers in Lusaka, Ndola, Kitwe, and Livingston in 1984 (Mukwena 1992), but grants to local governments for public health activities

gradually dried up (Rakodi 1988). In all other districts there was little or no formal transfer of authority for health to the district councils.

In the following decade LGA 1980 was only partially implemented. Only the offices of the district secretary and district governor were integrated into the district councils. Furthermore, there was no integration of these offices with the district-level instances of the central government agencies. The local offices of the central government agencies continued to function vertically, as before, receiving funding and direction from Lusaka via their respective ministerial provincial headquarters. The latter problem was supposed to be resolved through a strategy known as the "dual supervision formula," in which local instances of central government agencies were ls, but "technically" responsible to the ministerial headquarters. This strategy proved both incoherent and a recognized failure, leading most central government agencies including the Ministry of Health to simply ignore the councils (Mukwena 1992).

The reforms' failure was evident by the end of the decade, and in 1991 a new Local Government Act (LGA 1991) was passed, which de-linked the party and local administration apparatus and established a unified, transferable local government service. The enactment of the 1991 code was quickly followed by the replacement of the UNIP government by the Movement for Multiparty Democracy (MMD), which won a landslide victory in the first multiparty elections in nearly 25 years in Zambia. The MMD supported LGA 1991 with some amendments, and local government reform was successfully de-linked from the UNIP apparatus. Provincial and district development committees were established to coordinate decentralized development planning. Local councils were given authority to hire, promote, or fire council officers and employees with the approval of the independent Local Government Service Commission. The latter provision provoked some opposition from the Zambia United Local Authorities Workers, but has nonetheless been implemented (Tordoff and Young 1994).

Under the new code, there has been some involvement of municipal and city councils in promoting preventive health through clinic administration and cooperation with the Ministry of Health in providing immunizations, prenatal, and under-five health services (Tordoff and Young 1994). Local councils have maintained responsibility for sanitation and environmental health (Fielden and Nielsen 1998), but it is not clear what mechanisms exist for coordination with the health sector.

3.2.2 Health Sector Reform

In general, there has been a clear distinction between local government administration, on the one hand, and the Ministry of Health and other central government agencies on the other. The MMD government has pursued health sector reform through the parallel but separate track of the Public Sector Reform Programme (PSRP), initiated in 1993. The Ministry of Health has quickly taken the lead in the PSRP, outpacing the other line ministries and local government in reform efforts. The core of the health sector reforms has been the move towards deconcentration of administrative powers to the regional health offices at the regional level, and the establishment of the district health boards as the supervisors of the districts and the lead institutions in health service delivery.

The roots of the current reform program date back to the Medical Services Act of 1985, which provided for the creation of semiautonomous hospital management boards for all major hospitals (more than 200 beds). The hospital boards were appointed by the Minister of Health in 1992 and have authority to set fees and manage staff (Mpuku and Zyuulu 1997). In 1992, further legislation was passed requiring the districts to establish district health boards to oversee the districts.

In 1993, district health management teams (DHMTs) were established as the technical managers of the district health offices in each of the country's 58 (now 72) districts. This same year saw the establishment of the Health Reform Implementation Team (HRIT) at the national level to act as a coordinating body to promote the full implementation of the legislated reforms. This body was established outside the Ministry of Health and had a close association with foreign technical assistance, giving it greater flexibility and autonomy in exercising its mandate. In 1994, the DHMTs were followed by the creation of the district health boards, which were to act as the supervisors, and ultimately, employers of the DHMTs. The DHBs were set up side-by-side with the pre-existing hospital boards, but the relationship between the two remains somewhat unclear (Comprehensive Review 1997).

In 1995, the National Health Service Act was passed, calling for significant changes in the role and structure of the Ministry of Health and for the establishment of an essentially autonomous health service delivery system. The MOH Directorate of Medical Services was replaced by the semiautonomous CBoH, which is to "monitor, integrate, and coordinate the programs of the Health Mpuku and Zyuulu 1997: 116). The transition to CBoH has entailed a reduction in management personnel at the central level. The MOH headquarters staff has been cut from 400 to 67, and the new CBoH headquarters will have a staff of 118 when fully implemented (Fielden and Nielsen 1998).

The "new" MOH is to be primarily a policymaking and regulatory institution and its directorates have been reduced to three: Human Resources and Administration, Planning, and Development. The MOH will have no direct health service delivery responsibilities, and will instead contract these services to the CBoH. The CBoH, for its part, will take responsibility for executive functions related to health service delivery, including (Foltz 1997):

- Commissioning health services
- Regulating health services
- Directly administering failing district or hospital management boards
- Quality assurance
- Human resource policy and management
- Budgetary administration and management

The organization of the health service delivery system will be based on four distinct levels:

- The *Central Board of Health*, operating as the national coordinator of health service delivery with three technical directorates:
    - Health Services Commissioning (handles support for services, contracting, and budgeting)
    - Monitoring and Evaluation (information, health systems research, quality assurance, and performance auditing)
    - Systems Development (human resources, public and clinical health systems, and administration)

- The *Regional Directorates*, of which there are four, serving as liaisons between the CBoH and the district-level health offices, providing supervision, human resource management, technical assistance, and training to the latter.

- The *district*-level health offices and *major hospitals* governed by the *district health boards* and *hospital management boards*, respectively. Under the coordination of the CBoH, the district and hospital boards will act as supervisors and, ultimately, employers for the DHMTs and hospital management units. The district-level offices will be responsible for policy implementation and service provision through a network of health facilities.

- *Health centers* will provide services under the supervision of DHMTs and district health boards.

The reform program also provides for the creation of a number of structures for popular participation, including area health boards, health center advisory committees (HCACs), and neighborhood health committees (NHCs).

The deconcentrated organization of the MOH/CBoH forms the basis for a significant decentralization of health expenditures. Under the new system, the DHMTs prepare costed, district annual work plans on the basis of inputs from constituent health facilities. District budgets and work plans must be approved by the CBoH, and budget transfers are made directly to the district level on a quarterly basis, contingent upon satisfactory quarterly performance audits by the regional directorate (Fielden and Nielsen 1998).

In complement to fiscal decentralization, user fees have been reintroduced as one of the cornerstones of the health reforms. Districts and hospitals are permitted to set their own fee levels and some appear to set their own exemption policies. National exemption guidelines are set for certain diseases. Districts do have control over exemptions for the poor. Some DHMTs, e.g., Lukasa and Kitwe, go to district councils to get approval for fee increases. Official regulations require all facility revenues to be submitted to the district-level offices for accounting. Some portion of the fees is then to be redistributed to the facilities, but apparently the accounting procedures and guidelines for allocations are not transparent. While the management of cost-sharing revenues differs significantly from district to district, there does not seem to be any correlation between the level of fees generated by a facility and those redistributed to it by the district. Official policy dictates that 25 percent of fee revenue is to be retained by the district level, but there is confusion in many facilities as to the level of revenues to which they are entitled (Daura et al. 1998).

The impact of introducing user fees has generally been a short-term decrease in utilization followed by a gradual recovery of previous utilization levels. There have been exceptions, however, where utilization levels have been depressed over the longer term (Daura et al. 1998). In addition, several districts and hospitals have also initiated prepayment plans and in-kind payment, in an attempt to diversify cost-sharing and cost-recovery mechanisms.

Another innovation within the health reform program has been the establishment of an Essential Health Package (EHP), based on calculations of Zambia's burden of disease and the relative cost effectiveness of health interventions (Fielden and Nielsen 1998). The EHP specifies those primary care services which are to be offered to all users of the public sector health system, including: child health, reproductive health, AIDS and sexually-transmitted diseases, treatment of tuberculosis, malaria, and drinking water/sanitation. Protocols have been developed for at least 20 conditions and the EHP has been used as the basis for reform of the training curriculum (Fielden and Nielsen 1998). However, it has been noted that the EHP has not been fully exploited as the basis for standardization

of drug supply, referral guidelines, and treatment protocols, nor have the results of the EHP policy been adequately disseminated to the DHMTs (Sukwa and Chabot 1997). Interestingly, while the district level health offices are required to provide the EHP in their health service programming, it has been noted that the cost of the package exceeds available district resources by US$7-20 per capita (Sukwa and Chabot 1997; Fielden and Nielsen 1998). It is unclear what effects this disproportion between responsibilities and resources has on district decision space.

The current reform program also incorporates a number of further elements relevant to decentralization, including:

- The decentralization of the *Essential Drugs Program*, replacing centralized drug distribution system with district-level selection and purchase through the central procurement apparatus. This policy was approved in 1996, but it is unknown to what degree it has been implemented.

- The creation of a unified *Financial, Administration, and Management System (FAMS*), with uniform and transparent financial and progress reporting, and a national *Health Management Information System (HMIS)* to monitor health inputs, outputs, and outcomes data. FAMS is operational in all districts and some lower-level facilities, and the HMIS has been piloted in 15 districts but is not yet fully implemented.

Initial results of the decentralization reforms on health sector performance have been mixed. As will be discussed below, the degree of fiscal decentralization has been considerable, and some analysts consider this to have significantly improved service delivery at the local level (Visshedijk Liywalii, and Oosterhout 1995). In the context of the 1997 independent review of the Zambian health reforms, Foltz (1997) identifies a notable improvement in the districts as a result of the reforms, specifically with respect to facility maintenance and health care worker morale. Daura et al.'s (1998) analysis of cost-sharing, however, appears to contradict these favorable reports, indicating that there is considerable variation in the service quality between districts and facilities, and that in many districts service quality, drug and supply availability, and worker motivation remains quite low.

More recently, the viability of the reforms has come into question in the context of major public upheaval. Beginning in mid-1998, the Zambian public health sector has been rocked by a series of work slowdowns, protests, and strikes organized by the Zambian National Union of Health and Allied Workers, which decries the deterioration of health facilities and supplies and demands payment of delayed salaries and benefits. These upheavals have centered on a nine-day strike at the University Teaching Hospital in Lusaka in June 1998, but have been widespread and ongoing throughout the country. A simultaneous crisis has developed concerning hospital management boards, two of which have been dismissed by the Minister of Health in the second half of 1998. The replacement of the boards has occurred amidst allegations of financial mismanagement by the boards, and counter-allegations of discrimination and autocracy on the part of the minister. Despite the absence of any more systematic information, these journalistic accounts appear to indicate a profound crisis in the functioning of board management in human resources in the Zambian health sector, and a threat to the viability of the reforms.

3.3 Decision Space and Decision Makers at the Local Level

While the Zambian health reforms appear to have brought significant decentralization to the health service delivery system, it is important to recognize that the opening of local decision space has occurred primarily within deconcentrated instances of the MOH/CBoH and not outside it. The

reforms are still in an early phase, making it difficult to evaluate some of their effects. District health boards are only partially implemented, and as of the most recent information available, they had not yet received the full authority anticipated, including hiring, promotion, transfer, and dismissal of health sector personnel, including the DHMTs. The principal results of the current reform program for the district level (DHMT and DHB) are summarized in Map 7, Local Decision Space in Zambia.

The composition of the DHBs is somewhat unclear, but includes representatives of the Ministry for Community Development and Social Welfare, the area boards, the district councils and prominent citizens. While the DHBs have some representation of local interests through the area health boards, the latter have yet to be implemented nationally. Meanwhile, the degree of local government (e.g., district council health departments or committees) representation and influence on the DHBs is unclear. It should be mentioned here that the relationship between the MOH and the district councils is a cautious one. Apparently, the district councils were originally considered for possible devolution of health service delivery responsibilities, but their limited institutional capacity and fears that resources for health would be diverted to alternate sectors militated against such a policy (Comprehensive Review 1997).

District and hospital management boards are to be appointed and dismissed by the Minister of Health, thus significantly reducing the effective autonomy of the boards and opening the appointment process to politicization. This means of appointment was not the original intent of the reform, but was inserted into the National Health Service Act by the Minister of Health at that time for political reasons (Foltz 1997). The minister in question was succeeded in 1996 by an individual ostensibly more friendly toward decentralization. However, the resignation of one major hospital management board under criticism by the current minister and the dismissal of at least one DHB indicate the limited autonomy of district and hospital management boards. It is, likewise, noted that each successive minister has appointed his or her own management boards, leading to rapid turnover in board membership and centralization of authority (Foltz 1997).

Foltz (1997) also notes an important dynamic between the DHMTs and the district boards. The DHMTs were established first, consist of medical personnel, and exert a controlling influence due to their technical proficiency in health sector policy and issues. While the boards are ultimately supposed to be the employers of the DHMTs, according to the 1997 independent review they were generally considered to have an advisory role. The boards have received little training, often do not meet, and appear unsure about their role and relationship with the DHMTs. As of mid-1998, the boards were scheduled to be given power to hire and fire district health staff. Tension between the boards and the DHMTs has been reported, as the latter question the technical capacity of the boards and express anxiety regarding employment issues (Foltz 1997; Huddart and Mbao 1997).

It remains unclear what authority the boards are ultimately to have over salaries, benefits, and career structures for health personnel. Accounts of direct hiring of hospital personnel by the Minister of Health (Foltz 1997) and recent strikes over salaries and working conditions would seem to indicate that human resource policy and management remains firmly in the hands of the MOH. Tellingly, one union leader involved in the strike at the University Teaching Hospital (UTH) was quoted as saying: “What we want is the Government which is our employer. What can we discuss with the UTH management? They don’t handle the conditions of service.” (Times Reporter 1998b)

The most recent information available (Foltz 1997) indicates that as of 1997 the district health boards had only been implemented in about half of the country’s 72 districts. The area health boards have been established in only the most urban areas, and the neighborhood health committees have not been fully established either.

Map 7. Map of Local Decision Space: DHMT and DHB (Zambia)

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of Revenue	DHMT and DHB almost totally dependent on central allocations, but currently receiving ~50% of MOH/CBoH budget		
Expenditure allocation		DHMT and DHB develop and manage budget plans with central review, but restrictions on % spent on admin., capital, % allocated to different levels	
Income from fees and contracts		DHMT & DHB set user fees and exemptions for the poor (exemption according to disease is set nationally) and receive 25% of fees, which finance 2-8% of District recurrent costs	
Service Organization			
Hospital autonomy	Major hospitals managed by centrally appointed boards. Facility committees composed of health workers and community reps. Facility action plan and budget prepared with tech support from DHMT, and approved by DBH and CBoH		
Insurance plans			Prepayment schemes allowed in all districts
Payment mechanisms			Prepayment schemes and in-kind payment widely used and vary widely among districts and facilities
Contracts with private providers		Contracting with (CMAZ) mission health assistance providers initiated	
Human Resources			
Salaries	Still undefined: salaries, allowances, career structures, likely to be centrally determined		
Contracts			Contracting of non-permanent staff
Civil service		District health boards will have hire/fire authority, but anticipated delinkage has only occurred for a few offices at district level	
Access Rules			
Targeting		Explicit targeting from MOH/CBoH with respect to delivery of EHP Services, but latitude within EHP	
Governance Rules			
Local Government	District councils democratically elected but little representation or authority in DHMTs		
Facility boards	District and hospital boards appointed by Minister of Health		
Health offices (DHMT)		Appointment by DHB but rules centrally determined	
Community participation		NHCs and HCACs democratically elected, but area boards are a weak link between local and district levels. HCACs involved in user fee policy and revenue management in some areas	

Although the district councils have been given greater autonomy and authority over district personnel, they have little influence over the health sector except through their minimal representation on the DHBs. With respect to district employees, the central government maintains control over civil service policy, wages, and salaries. In a 1992 agreement, subsistence, sitting, and transportation allowances for councilors were raised, irrespective of local government ability to pay. Moreover, the same year saw the centrally mandated retirement of all local government employees with 22 years or more of service. district council senior staff were reduced from eight to four, leaving only the district secretary, deputy secretary, director of works, and the treasurer.

3.4 Resource Allocation after Decentralization

3.4.1 Local Government

The revenue sources available to local councils include rent from council houses, property taxes, user fees for water, fishing, etc., license fees, and commercial fees. By law, 35 percent of local sales tax, which is collected by the central government, is to be remitted to the district councils. However, these funds are often delayed or not received at all, and the criteria for their distribution are not at all transparent. There is also a beer surtax whose revenues are to be directly allocated to local governments. Here, too, there are problems with delays and failure to transfer funds. Meanwhile, taxes on central government properties in the districts go largely unpaid. In 1992, central government agencies were mandated to provide grants to the councils for sectoral activities, but criteria as to levels and distribution of grants have not been transparent. Not surprisingly, the implementation of this policy has been limited and fragmentary.

As a result of the foregoing, the councils have almost no assets and spend some 90 percent of their expenditures on personnel emoluments (Tordoff and Young 1994). Despite the precarious financial situation of most local governments in Zambia, the central government continues to seek to further withdraw support in favor of local self-sufficiency. In 1992, the Ministry of Finance discontinued central support for nine urban councils, representing one-third of all municipal budgets. The resulting budget gaps generated were subsequently softened with ad hoc grants.

Since the early 1980s, government finance in Zambia has been organized under the Provincial Accounting Control Unit (PACU) system. The Ministry of Finance disburses funds to the PACUs, which in turn disburse them to the provincial headquarters of the various ministries. Originally, PACU money was pooled, without respect to ministry, but after 1992 discretionary transfer of funds between departmental budgets has been discontinued. The PACU system has been unpopular with line ministries, including the Ministry of Health, which have done whatever possible to circumvent it (Tordoff and Young 1994).

3.4.2 Ministry of Health Deconcentration/Delegation

In 1993, as part of the Health Reforms Programme, the MOH initiated a pilot project for fiscal decentralization in three districts (Mansa, Monze, Senanga), that has subsequently been expanded to include all 72 districts. Under the old system, allocations to the Ministry of Health were distributed to the four national health institutions and to the country's nine Provincial Medical Offices (PMOs). The PMOs were required to approve all expenditures to be undertaken by district officials who, in turn, approved all health facility spending. Under the new system the district health offices receive direct transfers to their own bank accounts, and have been given authority to develop and manage budget

plans with central approval. Drug, supplies, vehicle, and equipment purchase is now generally made through the central procurement apparatus, though there is evidence of some independent local procurement of smaller equipment such as refrigerators (Fielden and Nielsen 1998).

As was mentioned above, centrally approved annual work plans and budgets are monitored through quarterly performance auditing. Moreover, central guidelines specify limits on administrative and capital investment spending, as well as set-asides for different levels of the district health system (i.e., DHO, hospitals, health centers, etc). These are defined in Tables 3a and 3b.

Table 3a. Budget Ceilings by Cost Item

Cost Item	Maximum % of Total Budget
Allowances	20%
Emergency Drug Purchase	4%
Fuel	15%
Capital	15%

Table 3b. Set-aside Requirements by Level of Service Delivery

Level	Districts w/out HMB		Districts with HMB	
	Minimum	Maximum	Minimum	Maximum
District Office	5%	15%	10%	25%
1st Referral Hospital	20%	40%	0%	10%
Health Centers	45%	60%	60%	70%
Community	2%	5%	2%	5%

Source: Fielden and Nielsen (1998) from District Planning Guide 1998.

As was mentioned above, the centrally defined essential package of health services is considered too expensive for the districts to fund under existing allocations. This may exert some constraint over expenditure allocations or provide latitude depending on the mode of policy implementation and enforcement. In several districts, rural health centers, were given revolving petty-cash funds for maintenance, etc., but there is still evidence of "bottle-necking" of funds at the district level, preventing health facilities from having adequate control over "decentralized" resources (Foltz 1997).

One of the more innovative elements of the fiscal decentralization policy has been the extension of public fiscal resources to the support of the mission hospitals. The Ministry of Finance recently signed a memorandum of agreement with the Churches Medical Association of Zambia whereby select mission hospitals will be eligible for funding equivalent to 75 percent of that received by MOH hospitals (Mbanefoh 1997).

The overall development of funding to the health sector shows positive trends within the context of a generally difficult situation (Mbanefoh 1997). Social expenditures dropped dramatically during the 1980s, declining at an average of 12 percent per year. By 1994, these expenditures had reached a mere two-thirds of their 1980 levels. These declines were exacerbated for the health sector under increasing pressure from population growth, estimated at 3.1 percent per year. As a result, per capita real health spending declined from K 39 in 1982 to K 13 in 1994 (US$ 1=Zambian kwacha 2,797.9). However, more recently the health sector's share of government expenditures has been on the rise, increasing from 5.3 percent in 1991 to 8.7 percent in 1994 (see Table 4). The MOH can claim that

actual expenditure were as high as 13 percent in 1994 because of the public service reform program that requires the government to allocate at least 13 percent of its revenue to health. The share of health sector public resources allotted to primary care through district health services has also expanded dramatically, from 29.9 percent in 1992 to 47.7 percent in 1996. These changes, accompanied by the significantly expanded fiscal decision space provided to the districts, have brought a major reorientation of public resources toward deconcentrated health service delivery, even within the context of continuing fiscal stress.

Table 4. Health Expenditure, 1990-1995 (K million)

Year	Total GRZ	Health	% of GRZ
1990	31382	1897	6.04
1991	84724	4485	5.29
1992	157741	6371	0.40
1993	303127	19897	0.66
1994	459500	39378	8.57
1995	853900	92781	10.87

USAID 1995: Annex N

The current reform program incorporates a return to the use of user fees at health facilities at all levels. User fees were first introduced in 1987, but were withdrawn after widespread public opposition. A diluted version of the policy was implemented in 1988 and has been in place since. User fees were set at K 10-50 in 1990, and average levels have remained relatively stable in real terms (K 500-1000 in 1997). Fees are very minimal in comparison with costs, but are argued to provide greater user "ownership" of health service delivery and promote accountability in health facilities. The major change that has occurred under the current reforms is that the districts set user fee levels and define exemption policies. Official regulations stipulate that districts receive 25 percent of user fees collected, but lack of transparent accounting procedures make evaluation of this policy difficult. Fee levels and cost-recovery rates vary widely between districts, the latter ranging from 1 percent to 20 percent of total operational costs excluding salaries and drugs. Many districts permit user fees to be paid in-kind, usually with maize or chickens. Only 50 percent of districts surveyed by Daura et al. (1998) had exemption guidelines, while 75 percent of those surveyed permitted health personnel discretion regarding exemptions. The percentage of users exempted varied from less than 5 percent to greater than 35 percent between districts, but was generally lower in those districts which used in-kind payment (16.7 percent) than in those which did not (21.3 percent) (Daura et al. 1998).

Initial experiments with prepayment schemes undertaken in urban centers were shown to have some distortionary effects on demand, for instance providing incentive for users to bypass primary facilities in favor of hospitals (Mbanefoh 1997). Consequently, general outpatient facilities at these hospitals were closed and prepayment schemes were shifted to the districts. At least five districts currently operate some kind of prepayment scheme, though these do not cover all facilities. Where prepayment schemes are operating user fees are generally higher in order to increase level of participation in the scheme.

A final element of health sector finance reform has been the introduction of a "basket" or sector-wide approach to donor financing. Under this scheme, major donors including DANIDA, DGIS, IrishAid, JICA, ODA/DEID, SIDA, UNICEF, USAID, and the World Bank, make contributions to a central resource pool for the financing of district health plans. Although no data are available on the level of funding which is now being offered through the "basket," this is considered a significant step

toward greater district control over donor resource allocation and reduction of centralized programming through vertical programs (Mbanefoh 1997; Fielden and Nielsen 1998).

In general, a significant expansion of financial decision space can be noted at the district level, both through the greater availability of resources and through increased district control over a diversified group of revenue sources, including central transfers, user fees, and prepayment schemes. The effects of this financial decentralization remain somewhat unclear and ambiguous. The encouraging reports offered by Visshedijk, Liywalii, and Oosterhout (1995) and Foltz (1997) contrast with the more varied and less positive data offered by Daura et al. (1998). In general, however, there appears to be agreement that further decentralization of resources to the facility level is necessary in order to promote the hoped for gains in efficiency and quality. Bottlenecking of transfers in the districts and inability of facilities to retain and administer user fee revenues promote a reconcentration of resources at the district level to the disadvantage of facility management. Successful management of resources at the facility level seems to be, to some extent, dependent on effective local participation and accountability.

3.5 Social Capital, Participation, Community Initiatives

Zambia's health reform program incorporates a number of mechanisms for community participation in the health sector, though in many cases these have only been partially implemented. The structures for participation have been developed at four different levels, and include neighborhood committees, health center committees, area health boards, and the aforementioned district health boards.

The concept of neighborhood health committees is not new to Zambia, but has been newly adopted as the most basic level of popular participation in the health sector. The committees are to be constituted by popular election, and will be primarily responsible for health outreach and promotion and environmental health at the community level. Where environmental health technicians are present, they have been important catalysts in the formation of the NHCs. At present the NHCs are only partially established, and the 1997 Comprehensive Review found mixed results from their activities. In some areas they were found to be highly dependent on health sector personnel, such as the environmental health technicians, for their functioning, whereas elsewhere they were found to be highly motivated and independent (Sumaili and Milimo 1996).

The next rung in the ladder of popular participation is that of the health center advisory committees, which are to be constituted by popular election to provide popular oversight and consultation for each health facility. The HCACs are even less common than the NHCs at present, and it is difficult to evaluate their impact. In general, the HCACs have not been involved in the design of user fee policy and the management of cost-sharing revenues. The exception to this has been in Mongu district, where HCACs directly manage user fee revenues and where significant improvements in service quality, drug availability, etc. have been noted and attributed to community participation (Daura et al. 1998). This is apparently associated with the long-term investment the development of community involvement in the health sector through the Primary Health Care Program in West Province.

As was mentioned above, the area health boards are to form an intermediate institution between health facilities and the district health boards, thus providing for popular representation in health policy and management at the local level. At present, the area boards have been established only in urban areas and little information is available concerning their functioning. It has been noted that the composition of the area boards is not well specified; they are to have between 5 and 13 members, but

the origin and character of these members is unclear. There is confusion as well as to whether these are to be democratically elected representatives of the local population or whether they may be health service professionals, representing the various facilities in a given area. Further investigation is necessary to determine the viability and effectiveness of the area boards as a mechanism for participation.

It bears repeating that the district health boards, although originally conceived as an important mechanism for popular representation in health sector management, are not democratic in character. While provision is made for local representation on these boards, this is primarily through the area board members. As mentioned above, few of the area boards are constituted, and it is not yet known how representative they will be of civil society and popular interests. In any case, the DHBs are not elected, but rather appointed by the Minister of Health, a factor that decreases their relevance as an instance of popular participation or a basis for public accountability.

Finally, one cautionary note should be offered regarding citizen participation in Zambia. Voter turnout for the 1991 presidential and parliamentary elections was only 42 percent of registered voters and 1992 local government elections drew only 14 percent of the registered electorate (Bratton and Liatto-Katundu 1994). Although it is not clear how this political apathy reflects on Zambian social capital and the viability of community participation, it is certainly troubling.

3.6 Conclusion

3.6.1 Summary

The Zambian health reforms of the past five years constitute a significant program of decentralization with far reaching effects for health service delivery and policy. This program embraces two distinct but interrelated initiatives: *deconcentration* and *delegation*. The administrative deconcentration of the health sector has been based primarily on the establishment of new institutions for the management of hospitals and district health offices. In the country's 72 districts, district health management teams have been established to manage the district health offices. The districts have been given expanded financial resources and decision space through the implementation of a financial decentralization policy, whereby districts undertake independent budget planning and management with central approval and monitoring. Districts have also been given control of user fee policy and management, and have been given latitude to develop in-kind payment and prepayment schemes. Health service programming is guided by the centrally determined Essential Health Package, but appears open to district-level adaptation.

Hospital and district boards have been established to govern major hospitals and districts. Although originally conceived of as autonomous institutions of health sector governance, the boards' independence has been significantly limited by the centralization of board appointments in the person of the Minister of Health. This policy, codified in the National Health Services Act, has opened the appointment process to politicization and may limit the effectiveness of the boards. The boards are ultimately to be given full authority to hire, promote, transfer, or dismiss health sector personnel. Understandably, tensions have emerged between the technical personnel of the DHMTs, on the one hand, and the boards on the other. The former are concerned not only about the capacity of the boards, but also about the security and conditions of their employment.

The second element of the health reform program has been the reduction of the MOH's role to one of policymaking and regulation, and the delegation of responsibility for health service provision

to an autonomous Central Board of Health. The CBoH will maintain regional and district health offices and coordinate the district and hospital boards. It will have full hire/fire authority, but its own composition will be controlled through central appointment by the Minister of Health.

Although the devolution of some responsibility for health service provision to Zambia's district councils was considered, this option was rejected on the basis of limitations in the councils' institutional capacity, and fears that they would reallocate resources away from the health sector. The overall separation of the health sector reform program is in keeping with a long tradition of division between local instances of central government agencies and the country's local government system. Local councils retain responsibility for environmental health and sanitation, but it is unclear what mechanisms exist for coordination between local administrations and the health sector on health issues.

Recent events have raised some concern regarding the viability of the Zambian reforms. The year of 1998 saw widespread protests, slowdowns, and a major strike among health care workers at the University Teaching Hospital. These upheavals are held to be the result of the continuing deterioration of the working conditions of Zambian health sector employees, as well as the lack of adequate supplies and resources to health facilities. Unrest among employees has been echoed by events in the management sector, where one major hospital board has resigned and a district health board has been dismissed.

These events have taken place against a background of animosity between the current minister and the boards, amidst accusations of mismanagement by the boards and counter-accusations of autocratic management and discrimination. These events call attention to the profound tensions generated by the reform process, both in human resource and health sector management policy. The success or failure of the reform program as a whole will, to some extent, be predicated on the Zambian government's capacity to resolve these tensions.

3.6.2 Further Research

The reform program is a relatively recent phenomenon, particularly with respect to the delegation of authority called for in the 1995 National Health Services Act. The 1997 independent review of the health sector undertaken in 1996 has provided a great deal of information regarding the emerging trends and questions in the reform program, but many areas for further investigation remain relatively uncharted at present. These include the following:

- *Health Sector Governance*: Some attention has been directed to the emerging issues and questions surrounding the functioning of the hospital management boards and the district health boards, but further and more systematic analysis is necessary. This is particularly important because of the sector has changed significantly in the course of the past two years and may be changing again under the new minister. How autonomous will the CBoH truly be, and what will be the effects of its implementation? What is the relationship between health management boards and district health boards? What is the nature of the relationship and relative authority, formal and informal, of the district health boards and the district health management teams, respectively? How will the respective roles of the DHBs and DHMTs shape the degree of power sharing and/or decision space afforded to them? How similar or disparate are the different boards with respect to institutional capacity? What effects does central appointment of boards have on health sector management and service delivery? What will be the extent of control over human resource policy and management given to hospital and district boards? How will the transfer or hire/fire authority to the

district boards change the relationship between health sector personnel and the MOH/CBoH?

- *Financial Decentralization*: While some information exists concerning the increasing amount of aggregate resources being transferred to the district-level health offices, there has been no attempt as yet to analyze the distribution and use of these resources more closely. What are the criteria for the distribution of resources among districts, and what are the equity effects of current patterns of allocation? How do the districts allocate the resources they receive among different facilities and types of services? How have patterns of allocation within the districts changed as a result of fiscal decentralization? Also, what are the trends in centralized MOH and CBoH funding after financial decentralization? These and related questions concerning the specific nature and effects of financial decentralization within the MOH/CBoH system are extremely important for any evaluation of the decentralization program as a whole.

- *Health Service Delivery and Health Sector Performance*: There is anecdotal evidence concerning the changes in quality and efficiency of health service delivery as a result of reforms, particularly financial decentralization. A more systematic approach is needed, involving quantitative and qualitative data, to analyze the nature and extent of changes in health sector performance under decentralization. How much has quality and/or efficiency changed, if at all, as a result of decentralization? How have health outcomes/indicators changed as a result of these reforms? What factors have been most significant in contributing to these changes (e.g., governance changes, financial decentralization, user fees, etc.)? Are there significant differences between the performance of different districts and/or different facilities? What factors account for these differences? To what extent does the Essential Health Package determine district health programming? To what degree to the districts vary in their application of EHP guidelines and what are the effects?

- *Local Governments*: Although this analysis has argued that the health sector reform program is parallel to but separate from changes in Zambia's local government system, the latter remains relevant to health system performance. This is true not only with respect to instances of direct involvement of local government in facility management or service provision, but also with respect to intersectoral coordination for environmental health, etc. What, then, is the status of the relationship between the district councils (local government) and the MOH/CBoH, district health boards, and district health management teams? What factors, if any, influence successful cooperation between local government and health sector institutions? What conclusions can be drawn from local government performance under current reforms and what role, if any, might they play in the continuing implementation of health sector reform?

- *Participation and Social Capital*: Reference was made above to the partial nature of both implementation and evaluation efforts with respect to the mechanisms for popular participation in Zambia's health system. More systematic study is necessary to evaluate the viability and effectiveness of these mechanisms where they have been implemented. What differences, if any, can be seen between areas where participatory institutions have been established and those where they have not? How democratic and representative are these institutions and what degree of influence do they exert over health service delivery institutions?

4. Case 3: Uganda

4.1 Introduction

Beginning in 1993, Uganda embarked on a major program of health sector reform, centering on the devolution of primary health care responsibilities to the country's 45 district councils. This program is unique in Africa, where "decentralization" has more frequently referred to administrative deconcentration or delegation than to authentic political devolution. Uganda's reform program has, in many ways, been more radical and comprehensive, investing democratically elected local governments with responsibility for service delivery and financial management, not only in the health sector but in the education, development planning, transportation, and social sectors. The uniqueness of the Ugandan case makes it a particularly relevant subject for analysis.

Uganda is a landlocked East African nation of 19.5 million people,[3] some 89 percent of which live in rural areas. With a per capita GDP of US$ 212, it is one of the poorer nations in Africa and the world, and some 90 percent of the nation's wealth is controlled by 10 percent of the population (Okuonzi and Macrae 1995). The infant mortality rate is currently around 97 per 1000 live births, down from 122 in 1989. Life expectancy is 47 years for men and 50 for women; these figures are some of the lowest in the world and are expected to continue to worsen due to the increasing prevalence of HIV/AIDS, which now infects some 16 percent of Ugandans.

In the years following independence from Britain in 1962, Uganda's health status indicators, health system, and quality of civil service were touted as the best in sub-Saharan Africa. This status was reversed over the course of the 1970s and 1980s under the onus of political instability and civil war. The country's first independent government, headed by Milton Obote, was overthrown by a military coup led by Idi Amin in 1971. During the course of its eight-year tenure, the Amin government was responsible for the killing of over a million Ugandans, and the civil service and health system deteriorated rapidly. Amin was overthrown in 1979 by an insurgency led by Ugandan exiles, and Obote resumed his role as president. The Obote government was unable to quell the country's political instability, however, and was overthrown in 1986 by the National Resistance Army (NRA) led by Yoweri Museveni. It is estimated that during the period between 1970 and 1986 half of Uganda's doctors and an even greater percentage of its pharmacists left the country. In this same period, there was a 90 percent real decline in government health spending (Smithson 1995).

Since its accession to power in 1986, Museveni's National Resistance Movement (NRM) government has pursued a policy of administrative and political decentralization, which has attracted significant attention throughout the region. Decentralization has been undertaken in two distinct phases, an initial attempt at administrative *deconcentration* begun in 1988, followed by a later process of authentic *devolution* to the country's 39 (now 45) district governments beginning in 1993. The latter reform period has embraced the transfer of government health personnel from central government to district council employment, as well as the phased decentralization of health sector financing through the institution of conditional and block grants. These reforms have dramatically expanded the decision space of local governments, and have had significant effects on the

[3] U.N. estimates suggest that the population should reach 23 million by 2000 (CIHI 1996).

organization, governance, and financing of Uganda's health system. This paper will attempt to characterize some of these effects, highlight issues of concern for health system performance, and indicate avenues for further research and evaluation of the decentralization program.

The following issues for the case of Uganda will be presented below:

- How the 1993 government reforms, which increased political decentralization and devolution of government functions, expanded the decision space of the local governments
- The effects of the devolution of Uganda's health care system into district health committees and district health teams run at the local level
- The significance of the changes in human resource management with devolution
- The changes in revenue sources and health sector spending at local levels after the implementation of devolution
- The amount of fiscal decision space granted to district governments
- How popular participation in health care has increased over the years through village health committees and health unit management committees (HUMCs)

4.2 History and Character of Decentralization Reforms

4.2.1 Local Government and Deconcentration Prior to 1993

Uganda's tradition of local government dates from 1947, when the British Secretary for Colonial Administration made it colonial policy to promote the creation of local governments. This policy was instituted through the 1949 African Local Government Ordinance which established councils in all districts accompanied by a system of standing functional committees. The 1955 District Councils Ordinance expanded the councils' powers to administer a variety of functions including primary education, road maintenance, local police forces, local courts, etc. Uganda's regional and district governments gained significant autonomy during the early years following independence, but their authority was severely curtailed in 1966 under the Obote government. This recentralization of power accompanied military intervention by the central government to curb the federal aspirations of the Buganda region in the South. Under the Amin dictatorship power was further centralized, and by the early 1980s local government was anemic or non-existent in Uganda.[4]

"Decentralization" became one of the cornerstones of the NRM political platform and government, along with democratization and the consolidation of national unity. Museveni was at pains to demonstrate his government's divergence from the dictatorial regime of Amin and the authoritarian Obote, while at the same time consolidating control over the national territory. Following its 1986 installment, the NRM government instituted a political-administrative system based on the resistance councils (RCs) established in NRA-controlled areas in the course of its rural-based insurgency. This system, codified in the 1987 Resistance Councils and Committees Statute, has

[4] The suppression of the Buganda Kingdom in the South is associated, among other things, with prevailing north-south conflicts in Uganda. Both Obote and Amin were northerners, whereas NRM leader Museveni is from the south.

six tiers; each is governed by an elected resistance council. The central level is governed by the 278-member National Resistance Council (L6), composed of 210 elected members and 68 members appointed by the central NRM government from recognized social groups. The country is divided into 39 districts (L5) of 20,000-1,000,000 inhabitants, each of which is in turn composed of three to eight counties (L4). Counties are divided into an average of five subcounties (L3), each of which has a population of 15,000-30,000. Subcounties are further divided into parishes (L2) and villages (L1). The RC system's official objectives included: securing grassroots participation in decision making; popular mobilization for local economic development; raising of local political consciousness; and the elimination of the inefficiencies of the central-local duality of administration at the local level (Lubanga 1996).

4.2.2 Devolution and Health Sector Reform after 1993

Although the institution of the RC system is credited with raising political consciousness and promoting deconcentrated field administration of Uganda's line ministries, there was little or no local control of funds or personnel during the first phase of the NRM government (Okuonzi and Lubanga 1995). The NRM "decentralization" policy was decidedly oriented toward deconcentration rather than devolution, and its failure to improve service delivery and development planning prompted the central government cabinet to pass a 1991 memorandum calling for further reforms. A Standing Committee on Decentralization was established in 1992, and in 1993 a Local Government Statute was passed calling for more significant political decentralization and devolution of governmental functions.

The objectives of the 1993 reforms, ratified in the 1995 Constitution, were typical of the contemporary rationales for decentralization, and included:

- Transfer power to local officials and decrease the workload of the central government
- Bring political and administrative control of public services closer to the point of service, thus increasing accountability, effectiveness, and local "ownership" of service delivery
- Free local managers from central constraints, thus increasing innovation and adaptation of public services to local circumstances
- Increase fiscal responsibility through establishing a closer connection between taxation and public service provision
- Increase capacity of local councils for the planning, financing, and management of public services (Okuonzi and Luganga 1995)

The decentralization legislation abolished the country's 10 regions and focused on the devolution of powers to the district (L5) and subcounty (L3) levels of local government.[5] These two levels of resistance councils (or at least their chairpersons) were now to constitute true governments elected by universal adult suffrage, while the L1, 2, and 4 governments were maintained as administrative units.

[5] The abolition of the regions and focus of power on the districts is noteworthy for its political import. This may be interpreted as intended to curtail Buganda's resurgent drive for federalism. It is noted that the reforms were undertaken quite rapidly, which may be interpreted as a move to shore up the NRM's majority in the Constituent Assembly elected in 1994 to ratify the new Constitution. Decentralization was first undertaken in Buganda's most powerful districts, presumably with the intention of co-opting their leadership and thus deadening federal aspirations (Kasfir et al. 1996).

The parish (L2) and county (L4) levels recede into de facto dormancy, while the village level (L1) remains a significant nexus of administration and service delivery for the district and subcounty governments (Kasfir et al. 1996).

The core element of the reforms is the devolution of responsibility for primary education, primary health care, feeder roads, and the field services of the already deconcentrated line ministries to district and subcounty local governments. The central government's role, under this scheme, is reduced to policy formulation, planning, inspection, and management of national programs, and the administration of certain core areas including defense, banks, currency, income taxation, etc. The devolution of service delivery functions involved the transfer of the civil service personnel system to the district resistance councils (DRCs), which would now have the capacity to hire and fire staff through the independently appointed district service commissions. The devolution of civil service personnel was accompanied by significant fiscal decentralization, under which local governments would have expanded taxation powers and would receive direct central government transfers via block and equalization grants. The DRC chief administrative officer (formerly the district executive secretary) replaced the central government representative as the political head of the district government. The process of decentralization was overseen by the Decentralization Secretariat of the Ministry of Local Government (MLG), which is supposed to provide training and supervision to the newly expanded district and subcounty governments.

At the district level, the reforms called for the restructuring of the health sector through the establishment of district health committees (DHC) and district health teams (DHT). The DHC is an elected group under the district council and provides legislative policymaking and oversight of the district-level health sector, where this does not circumvent the national policymaking and regulatory prerogatives of the Ministry of Health. The DHT is the district government's executive administrator of the health department, and is charged with advising the DHC on technical matters, implementing health policy, and managing service delivery. Health departments are to include a Primary Health Care Unit, a Curative Services Unit, and a Medical Supplies and Special Programmes Unit, though the de facto organization of departments varies by district and is dependent on local circumstances (Fielden and Nielsen 1998). The DHT is headed by the district director of health services (DDHS), a civil servant, hired by the district council, who serves simultaneously as the executive head of the DHT, the secretary of the DHC, and as an assistant commissioner-level functionary in the Ministry of Health. The other members of the health team include the district health inspector, the district health visitor, the district leprosy and tuberculosis control supervisor, and the district health educator.

A new aspect of health services at the district level is the development of 214 health subdistricts, each of which is centered on a hospital or an upgraded health center which provides supervision of lower-level facilities. Responsibility for primary care under this system is completely devolved to the district governments and is overseen by the community health department of the subdistrict's central facility. The community health department is staffed by a minimum of six professionals and receives a minimum of 10 percent of the subdistrict's non-wage recurrent funds for community health activities.

Hospital administration at present remains a function of the Ministry of Health, but is ultimately to be delegated to its district field offices under the authority of the deputy district medical officer for curative services. All hospitals will ultimately fall under the district MOH offices, except for the Mulago and Butabika national referral (quaternary) hospitals, which will continue to be directly administered by the central MOH. While hospital directors are supposed to sit on the DHCs and hospital management has ostensibly been delegated to the committees, at present hospital personnel management and funding remains centralized in the MOH. For the time being, the committees can do little more than to submit complaints to the MOH regarding hospital administration (Okuonzi and

Lubanga 1995). Presumably, this will change as hospital budgets and personnel are transferred to the districts.

4.3 Decision Space and Decision Makers at the Local Level

4.3.1 Introduction

The 1993 reforms have dramatically expanded the decision space of local governments, particularly in the health sector. Under the new system the district councils, headed by the district administrative officer and represented by the DHCs, become the primary decision makers with respect to health sector policy, staffing, and budgeting. At present this includes primary care provision, but should ultimately expand to include all secondary and tertiary care facilities in the country. The DDHS and the DHT assume all health sector executive functions. The independent district service committee, for its part, is responsible for the recruitment, promotion, discipline, and termination of staff. District tender boards have been established for district-level procurement, and hospital boards are ostensibly to take responsibility for hospital administration (Okuonzi and Lubanga 1995). The autonomy of the district government, however, is not unqualified. As we shall see below, the central government retains control over a significant portion of district funding, and continues to exert influence over human resource and health policy matters. The scope and nature of decision space now available to district governments are summarized in the following map of formal decision space, and are examined at length in the following sections.

Map 8. Map of Local Decision Space: District Councils (Uganda)

Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of Revenue		Recurrent budget now completely decentralized. Development budget to follow. High dependence on central transfers. Tax base and collection relatively weak, making own-source complement funding minimal	
Expenditure allocation		Unconditional grants, but salaries and vertical programs reduce discretionary funds to 25% of aggregate	
Income from fees and contracts		User fees set and administered at facility level and 70% absorbed for salary augmentation	
Service Organization			
Hospital autonomy		All hospitals except 2 to be directly administered by district councils (DCs), via deputy DMO for curative services. Financing to be decentralized to DCs	
Insurance plans	N/A		
Payment mechanisms	N/A		
Contracts with private providers			Districts permitted to contract out services to NGO providers

Function	Range of Choice		
	Narrow	Moderate	Wide
Human Resources			
Salaries	Centrally fixed and distributed through delegated block grants.		
Contracts			Districts have mandate to contract out non-permanent personnel.
Civil service		DCs have hire/fire authority. Qualifications and conditions of service determined by district service comm. within parameters set by central Health Serv. Commission.	
Access Rules			
Targeting		MOH sets guidelines for targeting based on delivery of Essential Package of Health Services, but Districts maintain latitude	
Governance Rules			
Local elections			District councils democratically elected under universal adult suffrage.
Facility boards	Hospitals presently centrally administrated. Health unit management committees administer user fees, but do not exert authority over management decisions.		
Health offices		DHT led by DDHS, civil servant employed by DC.	
Community participation	DHCs dominated by technical personnel; subdistrict and village committees weak. HUMCs not seen as participatory or representative.		

4.3.2 Human Resource Management

The transfer of staff hiring and firing decisions to the district governments through the district service commissions is considered to be one of the cornerstones of the reforms.[6] Districts have also been given a mandate to create or abolish positions, or to contract out to non-governmental institutions (Feilden and Neilsen 1998). When one looks more closely at personnel policy, however, it becomes clear that the nature and extent of decentralization is qualified. Under the new scheme, district-based MOH personnel become district employees, salaried under delegated block grants. No breakdown of the number of staff by facility is stipulated by these grants. Differentials in district vs. central government pay scales were "harmonized" prior to devolution, and the district governments are required to adhere to a unified national pay scale. Districts may, however, set their own benefits

[6] This transfer has paralleled a major civil service reform initiative in Uganda that has resulted, among other things, in the reduction of the civil service from 320,000 to 150,000 employees, and the consolidation of government departments from 38 to 21. Civil service salaries have been increased by an average of 50 percent per year during the period following 1992, though they still do not approach the minimum living allowance which is their objective (Langseth 1995).

and allowances, a policy that is said to have contributed to the deterioration in conditions of health care workers after decentralization (Okuonzi and Lubanga 1995; Hutchinson 1998). Hospital workers, meanwhile, are not decentralized, but continue to be salaried under direct delegated transfers from the Ministry of Finance. These centrally paid hospital workers are more likely to receive their full salaries on time, while locally hired staff go months or even years without being paid.

There are significant equity and quality issues associated with changes in human resource management. As the MOH system is no longer nationally unified, district health professionals no longer have the same geographic mobility and access to promotion, making it significantly more difficult for poorer, rural districts to attract qualified personnel. Different levels of resources and prioritization of the health sector tend to lead to non-uniformity in the training and capacity of district health personnel. Moreover, wealthier urban districts provide better amenities, as well as opportunities for complementary private sector employment (Okuonzi and Lubanga 1995). DDHSs surveyed noted that hiring and firing decisions are susceptible to tribalism and clientelism, which contribute to a deterioration in staff quality (Hutchinson 1998).

4.3.3 District Health Policy and Planning

Another factor that mitigates the new powers vested in the district councils is the nature of politician-civil servant interaction on the district committees (Kasfir et al. 1996). Elected politicians often have considerably lower educational levels than their civil servant colleagues on the committees, and certainly have less technical knowledge of the health sector. As a result, at least in the initial phase of decentralization, civil servants have tended to dominate sectoral decision-making at the district level.

With respect to the targeting and mechanisms of health service delivery, district governments have a fair degree of latitude. The MOH provides guidelines stipulating that district health policy follow national priorities, centering on the provision of the Essential Package of Health Services. The enforceability of these guidelines is primarily determined through the process of resource allocation.

Annual work plans and budgets are prepared at the district level through the sector technical committees, including the district health committee, in consultation with subcounty governments. Sector work plans and budget proposals are then reconciled under the leadership of the district chief administrative officer. The Constitution requires that the district budget process be democratic and permit public participation, though the application of this mandate, or lack thereof, varies among districts. In some cases, this is accomplished through a district budget conference, which brings together relevant stakeholders for discussion and negotiations. In other districts, there have been examples of bottom-up planning based on subcounty government work plans. The changes in local financial decision space accompanying devolution and their results on the level and mix of allocations at the local level are discussed at length in the following section.

4.4 Resource Allocation after Decentralization

4.4.1 Revenue Sources and Health Sector Spending

While the 1993 reforms do not appear to have had a major impact on overall levels of government health expenditures, shifts in the allocation of these resources are noteworthy. Although the proportion of government expenditure allotted for health rose considerably following the NRM's

accession to power (from 4.8 percent in 1989 to 7.1 percent in 1992), it has remained fairly steady around 9-10 percent since 1993 (Okuonzi and Lubanga 1995). The majority of the early increases in the health budget between 1986 and 1990 went to capital costs and vertical, single disease-oriented programs, whose recurrent costs are, of course, difficult to sustain (Okello et al. 1998).

Complementary own-source funding is unlikely to do much to compensate for this fact. Subcounty governments are given authority to collect taxes and fees, including a graduated tax, market dues, licensing and other fees, 50 percent of which can be retained and the remainder of which is transferred to district governments (Kasfir et al. 1997). Hutchinson classifies district revenue into unconditional grants (18.7 percent), conditional grants (62.6 percent), donations (12.2 percent), and local revenue (6.5 percent) (Hutchinson, personal communication). Due to inconsistency in the data, for the health sector the proportion due to donor revenue may be as much as two times that of central government transfers. Although difficult to monitor at the district level and even harder at the lower local level, some of the local revenue is invested in improving health centers and conducting outreaches. Subcounty revenues vary from US$ 4,000 to US$ 200,000 per year, and it can be expected that this will negatively affect horizontal equity (Villadsen 1996). Uganda has a tax collection rate of only 6-8 percent of GDP, which is significantly lower than the 18-20 percent average for the African region. Revenue shortages are likely to be exacerbated for rural areas where there the formal economy is largely nonexistent.

The system for central transfers to local governments in Uganda is based on two distinct budgetary categories referred to as “recurrent” and “development.” The recurrent budget includes salaries, hospital maintenance costs, district administrative costs, etc. Approximately one-half of the national recurrent budget is spent through the districts. The development budget is so named because it is partially comprised of capital expenditure, but it too incorporates recurrent costs associated with vertical programs. The development budget is over 90 percent donor-financed and provides over 50 percent of the total health budget (Hutchinson 1998). Beginning in 1993, the recurrent budget has been gradually decentralized to the regions. The decision to decentralize the recurrent budget before the development budget is indicative of the authenticity of devolution in Uganda. In programs tending toward administrative deconcentration, it is more common for minor portions of the development budget to be decentralized first, while the central government retains control over the core of recurrent spending (Kasfir et al. 1996).

In Uganda, three cohorts of districts (composed of 13, 14, and 12 districts, respectively) have gone through a two-year phased decentralization process. The recurrent budget was decentralized to the first 13 districts on the vote-system (earmarked) in FY 1993/94, and then on the basis of block grants as of FY 1994/95. The remaining two cohorts have also completed this two-year phased decentralization process, resulting in the decentralization of the recurrent budget through block grants nationwide as of FY 1996/97. The decentralization of the development budget has now been piloted in three districts, and is expected to be implemented in all 39 by FY 1999/2000 (Hutchinson 1998). At present, secondary and tertiary hospitals continue to receive delegated funds directly from the Ministry of Finance, but this budget is likewise expected to be decentralized in the near future. The 1995 Constitution also calls for the establishment of an equalization grant to promote intergovernmental horizontal equity, but as yet this has not been implemented.

4.4.2 District Health Spending

Under the decentralized block grant system, central transfers are divided into unconditional block grants, delegated salaries, delegated non-wage transfers, earmarked grants for district urban administration, and conditional grants. The formula for block grant distribution has received mixed

reviews, considered by some to be equitable and by others to provide perverse incentives to perpetuate high infant mortality rates, and so forth (Hutchinson 1998). Although the Ministry of Finance has provided "shadow" budgets in some cases, the district councils have discretion over the use of non-wage block grant funds. Salaries are paid directly by the Ministry of Finance via delegated block grants, and drugs are provided through "kits" from the donor-financed National Medical Stores. District expenditures of transfers are summarized in Table 5.

Table 5. Total District Public Expenditure by Category—All Districts

Item	1996/97		1997/98	
	Amount ('000 Ush*)	%	Amount ('000 Ush*)	%
Unconditional Grant	*45,317,604*	*25.7%*	*48,111,003*	*24.5%*
Salaries				
Teachers' Salaries – Primary	61,514,949	34.8%	69,196,998	35.2%
Teachers' Salaries – Secondary	22,833,000	12.9%	25,407,334	12.9%
Staff Salaries	6,249,669	3.5%	6,879,998	3.5%
Medical Workers Lunch Allowance	-	0.0%	5,149,999	2.6%
Subtotal	*90,597,618*	*51.3%*	*106,634,329*	*54.3%*
Delegated (Non-wage)				
District Hospital Services	8,020,648	4.5%	6,447,000	3.3%
Referral Hospitals	5,500,110	3.1%	4,020,000	2.0%
District NGO Hospitals	-	0.0%	1,000,001	0.5%
Health Training Schools	489,240	0.3%	1,543,001	0.8%
Transfers to Local Authorities/Sec. Ed.	4,290,000	2.4%	4,299,998	2.2%
Sub-total	*18,299,998*	*10.4%*	*17,310,000*	*8.8%*
District Urban Administration	*3,400,000*	*1.9%*	*3,672,001*	*1.9%*
Conditional Grants				
Transfers to Primary Education	14,000,000	7.9%	13,999,997	7.1%
Transfers to Road Maintenance	4,900,000	2.8%	4,990,003	2.5%
Transfers to Primary Health Care	-	0.0%	1,700,000	0.9%
Sub-total	*18,900,000*	*10.7%*	*20,690,000*	*10.5%*
GRAND TOTAL	176,515,220	100%	196,417,333	100%

Source: Hutchinson 1998: p. 39.
*US$ 1=Ugandan shilling 1,492.5.

While the fiscal decentralization described above is fairly radical by African standards, it should be emphasized that the real magnitude of fiscal decision space granted to district governments is limited. Because delegated salaries and vertical program funding comprise such a large percentage of the funding transferred to the districts, the actual amount of discretionary funding is fairly minimal, corresponding to approximately 25 percent of the funds in district annual work plans.

Approximately 10 percent of these discretionary funds are allotted to health, making it a considerably lower budgetary priority than education or feeder roads (Hutchinson 1998). The relative shortage of discretionary funds available to local governments makes the allocation of these funds somewhat less significant, but nonetheless indicative of tendencies within the decentralization reforms. One of the major issues in the Ugandan health system has been a major bias toward urban and curative care, with over 50 percent of recurrent costs being spent on hospitals, half of which goes to the major national referral hospital (Smithson 1995). Fully 70 percent of trained health staff are

urban hospital based, despite the fact that nearly 90 percent of the Ugandan population lives in rural areas (Okuonzi and Lubanga 1995). While Uganda has made some investment in local health committees and community health workers, the expansion of health services into rural areas has been primarily based on the construction of district hospitals (Macrae et al. 1996).

Unfortunately, decentralized district expenditures on health appear to perpetuate this bias in favor of curative care. While there has been a 110 percent increase in the overall district expenditure on health between FY 1995/96 and FY 1997/98, this has been accompanied by an 8 percent *decrease* in the allocation to primary health care (Hutchinson 1998). While, to a certain extent, this is to be expected given the political attractiveness of capital investment and curative care, it remains an area of major concern for the health sector, particularly as the development budget is likewise decentralized. Ministry of Finance grants have been structured to provide incentives for a focus on primary education and feeder road construction as of FY 1996/97, and more recently a conditional grant has been established to encourage spending on primary health care as well. Originally, this grant was equivalent to only 0.9 percent of total district recurrent expenditures, or 10 percent of overall district spending on primary health care, at which level conditional grants are unlikely to have much impact (Hutchinson 1998). In FY 1998/99, however, the primary health care conditional grant was to be expanded from Ush 1.7 billion to Ush 6.358 billion, which would significantly improve its effectiveness.

As was mentioned above, hospitals currently remain centrally financed through direct subventions from the Ministry of Finance. To date, non-wage financing has been on the basis of available beds, but the MOH is in the process of shifting towards a catchment basis (MOH 1997). It remains to be seen when hospital management and financing will be devolved to local governments and what this will entail.

4.4.3 Donor Influence

Any discussion of health sector resource allocation in Uganda would be incomplete without referring to the health system's severe dependency on international aid. As of 1995, 60 percent of all government spending and 66 percent of total primary health care spending was donor financed (Okuonzi and Macrae 1995). Uganda receives international aid for health on the order of US$ 2 per capita, 70 percent of which is spent on recurrent costs. International aid covers 55 percent of all recurrent costs for the health sector, and 80 percent of the recurrent costs of primary health care (Smithson 1995). It has been alleged that in the past, donor policy has promoted a lack of consideration for future recurrent costs associated with capital investment and vertical programs and has neglected investment in training and institutional development of the MOH (Macrae et al. 1996). Some of these problems have been overcome more recently, especially with the initiation of a Sector Wide Approach to funding. Regardless, the influence of donors on health sector organization and functioning remains potent and worthy of comment.

Although primary care is the responsibility of the district governments, it is mostly centrally funded through vertical programs such as the Uganda National Expanded Program on Immunization (UNEPI) and the Essential Drugs Management Program, which have been essentially untouched by decentralization (Feilden and Neilsen 1998). It has also been noted that the percentage of the development budget devoted to primary health care has increased from 37.5 percent to 69.2 percent between FY 1992/93 and FY 1998/99 (Hutchinson 1998). Given that the development budget is presently 90 percent donor controlled, this is essentially a reflection of donor and, to a lesser extent, central government priorities. It remains to be seen what effect the devolution of the development budget will have on the composition of this spending. Moreover, a recent survey of district health

officials suggests that the inclusion or exclusion of items in the district annual work plans is primarily based on the likelihood of securing external funding for these items rather than on the basis of their merit as cost-effective health interventions (Hutchinson 1998). A significant question then becomes what mechanisms the government and donors will or will not implement to encourage continued investment in primary health care by local governments

4.5 Social Capital, Participation, Community Initiatives

Community participation in health service delivery and administration is supposed to be promoted through a number of means. Subcounty (L3) and village (L1) health committees ostensibly serve to provide local representation equivalent to the aforementioned district health committee. Subcounty health committees have now been established in most districts, but the 1997-2001 Health Plan Frame's call for the nationwide establishment of village health committees has yet to be implemented (Hutchinson 1998). Little information is available as to the effectiveness of these recently established institutions.

Another potential avenue for popular participation is the health unit management committee. These are nine-member committees that are elected, appointed, or named *ex-oficio* to oversee health facility personnel, inspections, expenditures, construction, and maintenance concerns, and to decide how revenue from user fees will be used by facilities at the district level. While this would seem a praiseworthy institution for local participation and oversight, Hutchinson (1998) has noted numerous problems, particularly with the issue of revenue management.

In districts surveyed, it was found that HUMC members generally perceived themselves as financial administrators and overseers, but not as representatives of or liaisons for local communities. Moreover, although user fees are supposed to be used to improve quality of care through the purchase of drugs and supplies, for instance, it was found that the majority (62.9 percent) of revenues in the sample was directed to staff salaries and incentives. Districts with stronger administrations, in which more resources were invested in training and oversight of the HUMCs, showed significantly lower levels of revenue expenditure on staff (13-37 percent). In general, however, the HUMCs have not been associated with any noteworthy improvement in service quality, and in fact have been accused of complicity in drug leakage and other abuses (Hutchinson 1998).

Another issue relevant to civil society involvement in the health sector is the widespread presence of mission and NGO health providers. NGOs manage nearly a fifth of all health facilities in Uganda and have a significant influence on the health system. This influence may grow as decentralization permits contracting of NGOs for health service provision. This practice has already been adopted in West Nile, where an NGO hospital has been contracted to supervise health centers (Fielden and Nielsen 1998). It is generally agreed that there is a marked difference between governmental facilities and their NGO counterparts, the latter providing higher quality care at lower cost (Hutchinson 1998). This difference in performance is apparently quite pronounced at lower-level primary care facilities (Okello et al. 1998). In 1990, NGOs provided 38 percent of Uganda's hospital beds, but accounted for 54 percent of inpatient bed-days. NGO bed occupancy rates are approximately 90 percent, compared with about 40 percent for public hospitals. One survey shows NGO facilities to treat approximately three times more outpatients per professional employee than government facilities (CIHI 1996b).

While the government remains the main primary health care provider, it dedicates a much greater percentage of its resources to secondary and tertiary care. NGOs, by contrast, are strongly focused on primary care, indicating a tendency toward a division of labor between the two sectors

(Macrae et al. 1996). It is uncertain to what degree this reflects Ugandan government priorities, and to what degree it is the product of adaptation to complement donor prioritization of primary care. In any case, given differences in technical efficiency, this division of labor may be seen as a positive trend to be encouraged through contracting.

4.6 Conclusion

4.6.1 Summary

Uganda's health reforms are unique among the African cases. The extent of devolution of functional responsibilities, civil service personnel, fiscal authority, and resources to local governments has been significant and continues to expand. The country's 45 district councils have undergone a transition from partially centrally controlled representative institutions to democratically elected local governments. As of 1993 they have been given major functional responsibilities, including primary education, primary health care, feeder roads, and local development. Within the health sector, this has meant a major reorganization of health planning and service delivery, which is now based on district health departments managed by executive health management teams and deliberative district health committees. District responsibilities for health will continue to expand as Uganda moves toward devolution of secondary and tertiary care as well.

The devolution of health care workers to the districts has been an area of major contention and is still in transition. There have been serious problems with the deterioration of salaries, working conditions, and career structures of devolved civil servants, and this appears to have generated a troublesome decline in morale and possibly productivity. Equity questions arise from the personnel transfer, as district capacity to provide compensation and amenities varies widely, despite the supposedly unified national pay-scale. Moreover, questions have been raised about the influence of tribalism and patronage in the staffing decisions made by the independent district service commissions. These issues attain yet greater importance as Uganda moves toward the transfer of hospital management to the districts.

Major decentralization of health sector financing has been achieved through the establishment of unconditional block grants for the districts' recurrent budget. Some 50 percent of Uganda's recurrent budget is now spent through the district councils, which at present have full discretion over approximately 25 percent of the funds they receive. Central government control of delegated salaries and vertical programs limits the financial decision space open to local governments, but this space is projected to expand further as the development budget and hospital financing are devolved.

Questions have arisen regarding the impact of financial decentralization on the health sector, as early results seem to indicate decreased spending on primary care, an already underfunded element of the health system. This trend is understandable, given political pressures toward investment in curative care, and represents an area of concern for health policymakers. The Ugandan government is presently attempting to increase incentive to invest in primary care through conditional grants. While the initial funding levels have been minimal, it is hoped that the expansion of these grants will make them more effective in guiding local government health expenditures along lines desired by national policymakers.

Other elements of health sector reform remain subjects for further inquiry. There is relatively little decentralization of resources to the facility level, and health units are heavily dependent on user fees. Cost-sharing, however, has been problematic, particularly as a result of the poor performance of

the recently established health unit management committees in managing revenues from fees. This may be largely the result of a lack of early investment in training and capacity building. Overall, there is little information available concerning the performance of the participatory institutions established through the reforms, and there is a need for further investigation of the capacity of these institutions and of Ugandan civil society to effectively promote transparency and accountability in the health sector. Meanwhile, the role of NGO providers, already major, may be destined for expansion as the Ugandan government seeks improved cooperation through sector-wide financing and governmental contracting of non-governmental institutions.

In general, the Ugandan case represents many distinctive elements of decentralization, particularly within the African context, and merits further research and investigation in the interest of health policy development.

4.6.2 Further Research

The comprehensive analysis of national level data on health sector allocations in Hutchinson (1998) has provided an excellent basis for understanding the effects of decentralization in Uganda. It also points the way to further questions of interest, including investigation of recent developments as well as more in-depth information regarding health sector performance at the subnational level.

- *Health Sector Finance*: While Hutchinson (1998) provides an excellent summary of national and district expenditures on health, some areas for further research remain. It would be interesting to know, for instance, to what extent districts demonstrate different patterns of allocation in discretionary spending, and what accounts for this? Also, how do the significant differences in local revenue generating capacity impact on the health sector? Do local governments spend own-source revenues on health, and if so, how does this differ between districts and why? Further questions concern changes implemented in the period following recent analyses. Specifically, what has been or will be the effect of the devolution of the development budget on patterns of district expenditure? This was piloted in three districts last year and is to be implemented nation-wide in the coming fiscal year. Also, what effects can be seen from increased levels of funding for the primary health care conditional grant program?

- *Health Sector Performance*: Further analysis of existing performance data would be helpful to better understand how changes in allocation levels and patterns are affecting issues of quality, efficiency, and equity of health service delivery. The relevant data are often elusive, particularly in a context such as Uganda, but further work might be done to go beyond aggregate analyses and look at comparative performance of districts.

- *District Health Sector Decision Space & Governance*: Existing analyses provide an overview of the evolving organization of the health sector, but there is a marked lack of close-up analysis of health sector functioning at the district level. It would be particularly useful to undertake some detailed case studies of decision making and priority setting in the districts. Who are the key decision makers and stakeholders, and how does the policy process work at the district level? A more precise picture of formal and informal decision space at the local level would be helpful in attempting to guide health reform strategy to better structure incentives and sanctions for desired results. In this same context, it would be worthwhile to look more closely at the relationship between district governments and their constituencies. How representative, legitimate, transparent, accountable, and participatory are these governments? To what degree do local government decisions reflect popular

preferences and to what extent is health sector performance influenced by civil society? What variations can be seen among districts in this respect, and what accounts for these differences?

- *NGO Providers*: The prominence of NGO providers in the Ugandan context, and the differences noted in governmental and non-governmental performance, invites a more in-depth evaluation of these providers. A closer look at comparative performance, as well as an analysis of early efforts at government contracting of NGO providers, would be useful in the ongoing evaluation of governmental and non-governmental roles in the health sector.

5. Case 4: Philippines

5.1 Introduction

In 1991, the Philippine Congress enacted a new Local Government Code (LGC 1991), providing a mandate for one of the most radical programs of political decentralization in Asia. This program led, in the ensuing two-year period, to the devolution of majority of government social services, including health, agriculture, roads and transport, to the country's multitudinous local government units (LGUs). The devolution of social service functions and personnel was accompanied by significant fiscal decentralization in the form expanded unconditional revenue transfers and broadened tax authority. The decentralization program brought with it the transfer of some 70,000 government employees, including nearly 50,000 health workers, to LGU payrolls. Public infrastructure, including 490 of the country's 534 public hospitals (Perez et al. 1995), were likewise transferred, and local government expenditures increased from 7.0 percent of total government expenditures in the 1985-91 period to 14.7 percent in the 1992-97 period (Loehr and Manasan 1999).

The decentralization program has dramatically changed the political and administrative landscape of this Asian Pacific nation of 71 million, and transformed its extensive public sector health system. The Philippines' Department of Health (DOH) has a respectable record in health service delivery, and is responsible for one-third of total health care spending (Solon et al. 1993). The private sector is also significant, providing nearly half of the country's hospital beds through some 1,180 private hospitals. The Philippines Medical Care Commission was one of the first compulsory health insurance systems in the developing world, and its Medicare I program currently covers all government employees and private sector non-owner wage employees and their dependents. As of 1988, this program covered some 38 percent of the population, though it accounted for less than 6 percent of total health expenditures (Solon et al. 1992). The country's infant mortality rate in 1995 was 50 per 1000 live births, down from 62 in 1985, and average life expectancy was 62 years (CIHI 1996). Although the Philippines has seen significant improvement in its health indicators in the past two decades, it still lags behind Asian countries of a similar level of socioeconomic development, and it is noted that, at less than 2 percent of GNP, health sector expenditures have been quite low (Solon et al. 1993). Some 70 percent of DOH funding goes to curative care, and that there are problems with underfunding of maintenance, drugs, and supplies for health facilities (Perez et al. 1995).

The Philippine case has raised a number of significant issues with regard to decentralization, particularly in the health sector. Among these are the following:

- The impact of the considerable increase in resource allocation to LGUs and the relatively broad decision space over health sector and other expenditures that has been permitted to them
- The strong resistance of the DOH and government health care workers to decentralization, and accompanying problems with employee morale and quality of care
- The central imposition of significant restrictions over LGU human resource policy (contracting, salaries, and benefits) resulting in limitations on local decision space

- Changes in the mix and variation of local government expenditures
- The initially mixed record of health sector performance under decentralization, including anecdotal accounts of both improved efficiency as well as decline in the quality of care and evidence of increased disparity among LGUs
- Evidence of central "steering" of the health sector through comprehensive health care agreements, and "creeping recentralization" of health sector finance in recent years

5.2 History and Character Of The Decentralization Reforms

Prior to the enactment of the 1987 Constitution and the 1991 Local Government Code, the Philippines was a highly centralized unitary state in which local governments were the creatures of Manila. This centralism was the legacy of Spanish, and to a lesser extent American, colonial administration, which attempted to govern the ethnically diverse and fractious archipelago and subdue the endemic warlordism and bossism of the provinces (Tapales 1992; Sidel 1997; Ruland and Sajo 1988). The 1935 Constitution subjected all local governments, including provinces, municipalities, cities, and *barangays* (neighborhoods or wards), to direct presidential control.

The emphasis on centralization was reinforced during the Marcos dictatorship of the 1970s. Although the Marcos regime's 1973 Constitution and 1983 Local Government Code gave lip service to local autonomy, the national Congress was simultaneously abolished, all national and local elections were suspended, and all local officials were directly appointed by the president. Under the Marcos regime, an Integrated Reorganization Plan was also implemented, promoting centrally directed administrative deconcentration on the basis of 11 (later increased to 13) administrative regions. The DOH participated in this process,[7] and in 1982 went further to integrate the public health and hospital subsystems into a unified health service delivery network based on the administration of the Regional Health Offices (Perez et al. 1995). During this period, LGU functions were limited to low-level service provision, including garbage collection, the administration of public markets and some secondary roads, and the implementation of some elements of central agency programs. The level of LGU fiscal control was fairly minimal, and in 1988, for instance, fully 73 percent of LGU budgets were directly controlled by the central government agencies under which they were executed (Miller 1998).

The return to democracy in 1986 under the leadership of President Corazon Aquino brought a major break with the centralism of the past. Aquino considered political decentralization to be the key element of redemocratization, and her administration actively promoted this policy before the national Congress. The 1987 Constitution made local government autonomy national policy, gave LGUs a voice in national agency resource allocation through the establishment of local and regional development councils, and called for the enactment of a new local government code. In 1989 the Mindanao and Cordilleras regions were granted political autonomy,[8] and proposals for significant expansion of local government autonomy were strongly advocated in Congress by a number of representatives with regional power bases, including Sen. Aquilino Pimentel of the newly established Autonomous Region of Muslim Mindanao, Congressman Celestino Martinez, Jr., and others (Tapales 1992). The debate lasted nearly five years and resulted in the passage, in 1991, of a new and

[7] The DOH had anticipated the deconcentration program, to some extent, having already established eight regional offices as early as 1958 (Perez et al. 1995).

[8] The autonomous regions have their own internal local government codes.

comprehensive Local Government Code (LGC 1991) calling for the devolution of significant service delivery functions, responsibilities, and financial resources to the country's 77 provinces, 60 autonomous cities, 1548 municipalities, and 42,000 barangays.

The successful enactment of LGC 1991 after a five-year legislative debate has been attributed to a number of factors, including the popularity of the reform and of its prime advocate, the president. President Aquino was a nontraditional politician and political widow who did not face customary electoral incentives and was thus willing to promote significant power-sharing with local governments. Eaton (1998) has noted that Philippine legislators, particularly in the lower house, operate within a virtually partyless system in which electoral incentives are highly particularistic and dependent on a representative's capacity to broker resources and influence for local interests. However, he notes that the instatement of term limits through the 1987 constitution gave congressional representatives greater incentives to strengthen local government political offices to which they would hope to accede in the medium to long term.[9]

As mentioned above, LGC 1991 calls for the devolution of services from the government's regional offices to LGUs in the areas of agriculture, health, social services, highway and public works maintenance and construction, and environmental protection. The DOH was dramatically affected by these reforms. Approximately 46,000, or 62 percent of the DOH's 70,000 employees, 12,580 rural health units, municipal health centers, barangay health stations, and 595 public hospitals were transferred from DOH to LGU administration in the course of less than two years (Perez et al. 1995). The reaction to these changes was extremely adverse, particularly as the DOH had been excluded from the formulation of decentralization policy until relatively late in the legislative process (Perez 1998). Whereas the Department of Education, Culture, and Sports had been exempted from devolution, the DOH was at its very center. Opposition to the reforms was based not only on opposition to the loss of power and control over the health sector, but also on fears regarding LGU fiscal, administrative, and professional capacity to administer the sector's vast human and physical resources. DOH officials opposed to the reform became a bulwark of antidecentralization sentiment, and lobbied strongly for the health sector's exclusion from the provisions of LGC 1991.

Moreover, at least initially, decentralization brought a significant deterioration to the employment conditions of devolved health care workers. Salaries of devolved workers decreased relative to central government employees (by one-fifth to one-third on average), and civil servant vertical career mobility was interrupted by the fragmentation of the public health system (Miller 1998; Tapales 1992). Public sector health care workers had been an organized and significant force in the opposition to the Marcos dictatorship and the push for democratization. Following the 1991 reforms, health care workers engaged in public protests and rallies, and lobbied strongly before the Philippine Congress for renationalizaton and/or the passage of legislation guaranteeing their employment conditions. Soon after the passage of LGC 1991, an executive order was issued requiring the LGUs to absorb all devolved central government positions and making public health care and other civil servants' dismissal virtually impossible. Moreover, in the face of health care worker opposition to devolution, Congress passed the 1992 Magna Carta for Health Care Workers (MCHCW), which guaranteed a unified national pay-scale for health care workers, as well as special benefits such as hazard-pay, subsistence allowances, etc. This defused some of the opposition within the DOH, but would later become a significant problem for the reform process (Perez et al. 1995; Perez 1998).

[9] In 1998, for the first time, over 90 percent of congressional incumbents were barred from running for office due to term limits. Fluidity and interchange between congressional and LGU office is increasing among Filipino politicians (Eaton 1998).

Amid these political struggles, decentralization proceeded apace. Owing to the immensity and complexity of the health sector, the DOH was given two years to implement devolution reforms rather than the six months specified in the code. By the end of 1993, the majority of functions and personnel had been officially turned over to the indicated LGUs. Under the new scheme, LGUs assumed the following facilities and responsibilities:

- The country's 77 provincial governments were given responsibility for medical, hospital, and support services, including the provincial health offices, provincial hospitals and hospitals of component cities, and district, medicare, and municipal hospitals.

- City governments assumed responsibility for city health offices, city hospitals in highly urbanized cities (except the National Capital Region) and corresponding rural health units (RHUs, with minimum staff of one physician and one public health nurse), and barangay health stations (BHSs, with minimum staff of one midwife).

- The municipal governments, in turn, took the main responsibility for the administration of primary health care and other national program field services through the municipal health offices and corresponding RHUs and BHSs. Municipal governments were also made responsible for ensuring access to secondary and tertiary care through vertical referrals.

- Barangay governments were given responsibility primarily for the maintenance of facilities of the RHUs and BHSs.

The DOH, for its part, retained control of:

- All foreign-funded programs

- All national experimental and pilot programs

- Health service and disease control programs associated with international agreements

- Regulation, licensing, and accreditation of health professionals

- Regulation and monitoring of health facilities and food service establishments

- Regulation of drugs

- Training and technical assistance for medical professionals

- Administration of regional hospitals, medical centers, and specialized health facilities

The regional health offices, rechristened the DOH integrated regional field offices, remain the cornerstone of the DOH structure, and now focus on monitoring health policy implementation and LGU performance.

As it became increasingly clear that decentralization was a reality that was not going to go away, the DOH sought to establish mechanisms by which to secure its long-term role in the health sector. Principal among these have been the creation of the DOH Management Committee for Development (MANCOMDEV) and the Local Government Assistance and Monitoring Service (LGAMS). MANCOMDEV was responsible for interagency coordination, including the Oversight Committee for the Code, analysis and discussion of devolution-related issues within the DOH, and development

of new organizational mechanisms for coordinating between the central, regional, and field units of the DOH (Perez et al. 1995). LGAMS, on the other hand, was created to oversee LGU health programs, and provide technical assistance and guidance in LGU health policy formulation and implementation. Although LGAMS was originally instituted as a temporary program, it has since been institutionalized within the DOH. The LGAMS is responsible for information, education, and communication activities associated with decentralization, and has worked extensively with LGUs by means of newly established Comprehensive Health Care Agreements (CHCAs) (Perez et al. 1995). These are essentially contracts or memoranda of understanding between the DOH and LGUs regarding health sector activities.

Under the CHCAs the LGU agrees to undertake, support, or assist health programs, while the DOH provides services, technical, and financial assistance to augment LGU resources (LGAMS 1997). Some have suggested that the CHCAs represent primarily a fiscal incentive mechanism by which the DOH can encourage LGUs to undertake targeted programs. The core programs targeted by the CHCAs are maternal and child health, tuberculosis, hospital management, and institutional capacity building, which may be supplemented by core regional programs determined jointly by the DOH regional offices and the LGU. By 1994, 94 percent of all provinces and cities had signed a CHCA with the DOH, and it is reported that the establishment of LGAMS and the advent of CHCAs have brought a turn from opposition toward greater collaboration between the DOH and the LGUs (Perez 1998).

With respect to LGU performance in service delivery, reviews have been mixed. There have been ongoing problems with health service quality and civil servant morale in the aftermath of decentralization. Poor availability of drugs in comparison with the period prior to devolution has also been noted (Perez et al. 1995). Miller (1998) contends that, in general, hospital care quality has declined with devolution, but the quality of other health services has improved. Elsewhere, improvements have been noted, including the LGUs markedly superior production efficiency in school and transportation infrastructure construction (Loehr and Manasan 1999). There is ample anecdotal evidence of increased innovation and decreased corruption in local governments as well (Miller 1998; Markillie 1996; Loehr and Manasan 1999).

In 1995 a bill calling for the reform of the LGC 1991 and the renationalization of the health sector was submitted to the Philippine Congress. President Fidel Ramos, who remained committed to devolution and called for its full implementation, vetoed the bill. President Estrada, elected in 1998, has maintained this commitment, appointing a DOH minister sympathetic to devolution. While Internal Revenue Allotment (IRA), a non-conditional formula-based transfer system that already existed prior to decentralization, was cut by 10 percent in the 1998 fiscal emergency brought on by the Asian financial crisis, central government agency budgets were cut by a full 25 percent (Miller 1998).

5.3 Decision Makers and Decision Space at the Local Level

There is a definite lacuna in the literature on the Philippine case with respect to analysis of local government structure and functioning in the post-decentralization period. Provinces, municipalities, and barangays are organized hierarchically though elections and representation at each level are independent and not delegated. Under the Philippines' local government system certain higher income cities are autonomous, while the remainder are "component" cities or municipalities under provincial supervision.

Each level of government—provincial, municipality, and city—is governed by a chief executive (governor, mayor) and a legislative council known as the *Sanggunian*. The barangays are represented by barangay "chairmen" who are delegates to the *Sanggunian*. LGC 1991 provides for the participation of social sectors in the *Sanggunian* as well, including groups representing youth, women, workers, ethnic minorities, and the urban poor.

The code also provides for a number of local sectoral boards and councils, including local development councils, local school boards, local peace and order boards, and local health boards. The health boards exist at the provincial, city, and municipal levels. They are chaired by the LGU chief executive (governor or mayor) and vice-chaired by the LGU health officer (nominated by the chief executive). Their membership includes a representative of the *Sangunnian* (chair of the *sanggunian* health committee), a representative of the DOH selected by the regional health office, and a representative of the private sector or a local health sector NGO. The health board proposes annual health budget, advises the *Sanggunian* on health matters, and creates health committees to advise local health agencies. The rules and procedures for these health boards are centrally defined.

The decentralization program brought a significant expansion of the decision space at the local level. Far exceeding the DOH administrative deconcentration reforms of 1952 and 1973, LGC 1991 devolved direct control of much of the health sector and other public services to provincial, city, municipal, and barangay governments. This, of course, took place within the context of redemocratization in the aftermath of the Marcos regime, meaning that democratically elected local officials now had significantly expanded control over service delivery and finance. The nature and range of decision space within different functional areas is summarized in Map 9.

Map 9. Map of Local Decision Space: Local Government Units (Philippines, 1993-present)

Function	Range of Choice		
	Narrow	**Moderate**	**Wide**
Finance			
Sources of revenue			LGU's local sources account for 35% of total spending, a relatively high level
Expenditure allocation		Only 25% of IRA is earmarked, but centrally defined staff salaries account for a large % of expenditures	
Income from fees & contracts			LGU health facilities permitted to set user fees
Service Organization			
Hospital autonomy			Devolved hospitals are now totally autonomous from the DOH, but remain under direct administration of the LGU
Insurance plans			Provinces allowed to establish and administer their own insurance plans
Payment mechanisms		Centrally defined for IRA, but LGU decides insurance payment mechanisms	
Contracts with private providers		LGUs are allowed to contract some private physicians	
Human Resources			
Salaries	Salary levels are mandated by unified central government pay-scale		

Function	Range of Choice		
	Narrow	Moderate	Wide
Contracts		LGUs are contracting some non-permanent personnel	
Civil service		LGUs have hiring/ firing authority, but required to absorb all devolved personnel in local civil service	
Access Rules			
Targeting		Some central definition of targeting through CHCAs	
Governance rules			
Local elections			Democratically elected local chief executives and legislative bodies
Facility boards	Rules centrally determined		
Health offices	Rules centrally determined		
Community participation		Statutory NGO and community representation on health boards and *sanggunian*	

The genuine autonomy provided to local governments with respect to public services is evident in the shifts recorded in local government expenditure patterns since 1993 and the increased variation in the service mix between LGUs (Loehr and Manasan 1999; Miller 1998). In 1993-94, LGUs spent four times the amount necessary to sustain 1991-92 real expenditures (allowing for inflation and population growth) on education, reflecting local government's high preference for spending in this sector even though it remains nationalized. Spending on social welfare did not keep pace with inflation and population growth, while health spending declined in 1993 and rose again in 1994 to keep pace with inflation and population growth. Changes in local government expenditures on health are summarized in Table 6.

Table 6. Local Government Health Expenditures after Devolution

	Local Government Health Expenditures (in millions of pesos*)			
	Total	Provinces	Mun's.	Cities
1993 Actual	5233.0	2488.9	1746.5	997.6
1993 Level needed to maintain 1991 real per capita**	5744.1	2977.7	1894.3	872.1
% difference	**-8.9%**	**-16.4%**	**-7.8%**	**+1.4%**
1994 Actual	6534.7	3046.9	1980.3	1507.5
1994 Level necessary to maintain 1991 real per capita*	5744.1	2977.7	1894.3	872.1
% difference	**+13.8%**	**+2.3%**	**+4.5%**	**+72.9%**

Adapted from Loehr and Manasan (1999), Tables 6a. & 6b.
*US$ 1=Philippine peso 39.6
** Adjusted for inflation and population changes.

LGUs' expenditure preferences in agriculture have tended to emphasize commercialization and marketing, in contrast to the national government's focus on food security. Moreover, it is interesting to note that in areas with good health indicators, resources have been shifted away from health toward other sectors, whereas the reverse has occurred in areas with poor health indicators (Loehr and Manasan 1999).

However, there are some limits to the expanded decision space afforded to local authorities. The local treasurer and the local auditor remain nationally appointed offices. Their responsibility for the critical areas of fiscal administration and oversight of LGUs allows Congress and the central government to continue to exert some control over local finance (Eaton 1998). Meanwhile, the Department of the Interior and Local Government (DILG), charged with overseeing the devolution process, has maintained a paternalistic attitude toward LGUs (Loehr and Manasan 1999; Miller 1998).

A further and more important limitation concerns human resources, specifically the aforementioned requirement that local governments retain all devolved personnel and that they adhere to a unified civil servant pay-scale. These requirements and those of the 1992 Magna Carta for Health Care Workers have essentially functioned as "unfunded mandates" on the LGUs. While the national government assumed responsibility for these costs in 1993-94, the LGU share of the costs was to increase to 45 percent in 1995 and 90 percent by 1997 (Perez 1998). In 1994, however, President Ramos decreed that benefit payments be frozen until the LGUs were capable of paying for them, effectively permitting LGUs to evade doing so. No figures are presently available concerning LGU expenditures on MCHCW benefits, but they are generally considered to be low (Perez et al. 1995). Due to the growing clamor among health care workers the central government has intervened to finance some of the mandated benefits and salary increases. In 1994, the central government provided P 50 million in "augmentation funds" to the DOH for this purpose. Furthermore, the DOH used end of year savings to implement salary increases for devolved health workers, and approximately 5 percent of current DOH expenditures are allocated to the payment of MCHCW benefits (Perez 1998).

5.4 Resource Allocation after Decentralization

As was mentioned above, the devolution of central government functions to LGUs was accompanied by a major fiscal decentralization program. Local government expenditures increased by 10.7 percent in 1992 and again by 51.9 percent in 1993 (Diokno 1995). This is particularly significant for the health sector, given that health services account for 66 percent of the total cost of devolved national government functions (Perez et al. 1995). The primary mechanism for fiscal decentralization is the IRA. Prior to LGC 1991, the LGU share of IRA was equal to 20 percent of total taxes collected, with distribution based on a formula incorporating population, land area, and equal sharing elements. Following decentralization, the LGU share of the IRA has been expanded to 40 percent of total revenues collected, with a three-year lag.[10] The previously existing National Assistance to LGUs program was abolished, but the expanded IRA allotment was augmented by a one-time P 4 billion allocation for the initial cost of devolution. The code specifically adopts a vertical allocation formula for the IRA, which assigns 23 percent to provincial tier governments, 23 percent to city governments, 34 percent to municipal governments, and 20 percent to barangays. The formula for the horizontal distribution of these resources to individual LGUs within a given tier is calculated on the basis of 50 percent for population, 25 percent equal share to all, and 25 percent by land area (Miller 1998).

The IRA is relatively unburdened with earmarking, set-asides, and other expenditure constraints. LGUs are required to spend at least 20 percent of the IRA on "development" projects, and although LGUs must furnish the DILG with copies of its development plans, this categorization is relatively fungible (Perez et al. 1995). A further 5 percent of the IRA must be set aside for disaster relief efforts, and no more than 45-55 percent (depending LGU revenue class) of LGU regular income may be

[10] This lag, of course, leads to significant erosion by inflation of the resources allotted to LGUs.

spent on personnel (Diokno 1995). These minimal requirements actually leave significant latitude to Philippine LGUs in expenditure decisions.

The expansion of the central-local transfer system was accompanied by an increase in the LGU share in taxes. The real property tax (RPT) has been given a maximum limit of 2 percent total, including a baseline of 1 percent of assessed value, plus an additional 1 percent to be set aside for the "Special Education Fund" (SEF), which is given directly to local school boards. The non-SEF portion (1 percent) is divided among LGUs as follows: 35 percent to provinces, 25 percent to barangays, and 40 percent to the municipal governments that collect it. Tax collection is a major problem for local governments, with the revenue collection rate for the RPT falling below 55 percent and the cost of collection exceeding the actual revenues. These problems are in part related to antiquated assessments and poor property inventories, but can also be attributed to incentive problems. Because the municipalities which collect the RPT receive such a small proportion of the tax, it is suggested that they have relatively little incentive to do so efficiently. The only level of local government that has been able to successfully increase the proportion of its revenue accounted for by local taxation is the city (Loehr and Manasan 1999).

LGUs also gained the authority to take out loans from government banks to finance development projects, with stipulations limiting debt service to no more than 20 percent of regular local government income.

It has been recognized that the benefits and costs of decentralization have not fallen equally on all LGUs or on all levels of government. Loehr and Manasan (1999) find that while the IRA is sufficient to cover the devolved functions in aggregate, the barangays and cities have been fiscal net winners and the provinces and municipalities net losers as a result of LGU 1991. While the provinces and municipalities receive 57 percent of revenue transfers, they have borne 92.5 percent of the costs of devolution. The cities and barangays, for their part, have received 47 percent of the transfers and borne only 7.5 percent of the costs (Eaton 1998). In the health sector, for example, the tertiary hospitals devolved to the provincial governments constitute the most costly element of devolution to local government, but this has not been accounted for in any way in the IRA. This is particularly problematic because the provinces have such a limited tax base. As a result, by the end of 1997, at least four of the 72 provincial hospitals devolved to provincial governments have been returned to the DOH and a further 10 are under consideration (Perez 1998). In an effort to rationalize the distribution of central transfers, the government has developed the Devolution Financing Burden, an indicator which categorizes LGUs according to their fiscal capacity to assume devolved functions.

In terms of horizontal equity, Miller (1998) indicates that per capita allotments from the IRA vary by a factor of 23 between the top and the bottom province. Per capita own-source revenues are even more disparate, varying by a factor of 83 among provinces. While Miller (1998) contends that the revenue distribution system as a whole is mildly regressive, Loehr and Manasan (1999) state the IRA per se is mildly equalizing, though not intentionally so. This is due to the high weighting (25 percent) of land area in the IRA distribution formula, which tends to favor the more extensive, low population density, rural LGUs, which also tend to be the poorer areas.

Despite the dramatic decentralization of resources towards the LGUs under LGC 1991, Loehr and Manasan (1999) indicate that public sector finance in the Philippines remains relatively centralized. The revenue decentralization rate, i.e., the proportion of total government revenue controlled by local governments, expanded a scant 0.9 percent from 4.9 percent in the 1985-91 period to 5.8 percent in the 1992-97 period. The expenditure decentralization rate, i.e., the proportion of total government expenditures made by LGUs, expanded from 7.0 percent in the 1985-91 period to 14.7

percent in the 1992-97 period.[11] Also noteworthy is the degree of local government dependency on central transfers. Total local government receipts expanded from 1.7 percent to 3.4 percent of GNP between the 1985-91 and 1992-97 periods, but the percentage of these receipts accounted for by own-source revenues declined from 50 percent to 35 percent. Not surprisingly, the increase in local government dependence on central transfers has led to a corresponding increase in substitution effects of central for local resources.

There is also evidence of a "creeping renationalization" in government finance. Despite a massive devolution of functions and personnel, central government spending between 1992 and 1994 only decreased from 11.6 percent to 11.4 percent of GNP and by 1998 it had actually increased to 13.2 percent of GNP (Loehr and Manasan 1991). Continued high levels of central government spending have been particularly noted in the two agencies most affected by devolution, the Department of Health and the Department of Agriculture (Miller 1998).

5.5 Social Capital, Participation, Community Initiatives

LGC 1991 creates important mechanisms for popular participation including traditional modes such as plebiscites and referenda, as well as the more novel media of "initiative" and "recall" (Tapales 1992). Local initiative refers to the process by which registered voters of an LGU may directly propose, enact, or amend local government ordinances, and requires the petition of 1000 voters in the case of provinces and cities, 100 in the municipalities, and 50 in the barangays. Recall provides the legal mechanism by which registered voters may directly petition to remove local government officials from office. Tapales (1992) contends that the latter mechanism has not been widely used, and the local populace more frequently files charges against wayward officials in the Department of the Interior and Local Government. In addition to these provisions for direct popular participation, it is also noted that shorter electoral terms and term limits for political office, both at the local and national levels, are considered to favor greater political responsiveness and accountability to local constituencies.

Brillantes (1994) comments on the rise of NGOs as a medium of popular participation in government policy following democratization and devolution. The 1987 Constitution explicitly calls for state encouragement of NGO formation and participation, and NGO accreditation is provided for through the *Sanggunian*. LGC 1991 provides for NGO representation on local development councils (at least 1/4 of total council membership), local school boards, local health boards, and local peace and order councils. A dramatic expansion in the number of NGOs and the level of their involvement has occurred since the shift to democracy in 1986 and there is extensive NGO participation in health service delivery in rural and underserved areas. Miller (1998) reports that more than 17,000 of the country's 52,000 NGOs have been approved by the *Sanggunian* for participation in local government activities under LGC 1991.

[11] Loehr and Manasan (1999) also calculate the modified revenue decentralization rate, which removes debt servicing expenditures from the equation. The difference between the pre- and post-decentralization periods remains similar to that indicated above.

5.6 Conclusion

5.6.1 Summary

Clearly, the Philippines constitutes a case of significant devolution of political, fiscal, and governance authority to local governments. This is particularly evident in the health sector, where the majority of central government service delivery functions and resources have been transferred to LGUs.

On the financial side, there has been a major reallocation of public resources to local government units, resulting in a two-fold increase in the LGU share of total government expenditures. The expansion of funding available to local governments and the relatively low degree of earmarking of intergovernmental transfers have given local governments considerable control over the mix of local government services to be offered. The level of allowable taxation has been increased, and health facilities are granted control over resources generated through cost-sharing. Through the Comprehensive Health Care Agreements, the central government appears to be promoting a type of ad hoc performance contract-based grant program for local government health service delivery. It is unclear, at this point, what the magnitude of the supplementary DOH resources are, how the CHCAs affect LGU autonomy, and what results they have on health service delivery.

However there are a number of limitations to the fiscal decentralization observed. One is that the downward reallocation of resources has not been distributed equally; city and barangay governments have been net "winners" from this devolution, while provincial and municipal governments have been sers". Moreover, despite the increase in the tax base under the new code, persistent obstacles and disincentives to efficient tax collection continue to limit the fiscal autonomy of local governments, which are highly dependent on central transfers. Finally, the financial burdens imposed on the LGUs, through the central control of human resource policy constrict the decision space available to local governments in service delivery. Despite central attempts to ease some of the burden of centrally mandated salaries and benefits, devolved health worker loyalty and morale remain low. A "creeping recentralization" of government finance has been evidenced in recent years, as the DOH and other central ministries obtain increased budgetary resources from the central government, despite the significant decline in their responsibilities and functions due to devolution of service delivery.

With respect to changes in the quality and performance of health service delivery under devolution, there is relatively little systematic data available. There are some reports that the quality of care in hospitals has deteriorated while other health services have improved, but these remain anecdotal. This may be evidence of LGU favoring of primary health care at the expense of secondary and tertiary care, but this is difficult to determine without further study. Improved production efficiency in education and transportation infrastructure construction under LGU administration has been documented, but there are no data available on whether similar results have been achieved in health service delivery. While there are clear changes in the expenditure mix at the local government level, it is not clear to what extent these changes reflect LGU preferences and to what extent they may reflect changes in production efficiency or other factors. LGU expenditures on health have kept pace with inflation and population growth, but disaggregated information on how these expenditures are being used have yet to be presented.

5.6.2 Further Research

Because of the degree of devolution implemented, the relative availability of data, and the magnitude of the country, the Philippines constitutes an important case for analysis of the effects of health system decentralization. "Decentralization" reforms often mask a centrally controlled program of administrative deconcentration, or a shifting of financial responsibilities to the periphery without an accompanying devolution of resources and authority. The Philippines, however, has undergone an authentic and radical process of health sector devolution in the context of democratization. Nearly a decade after the passage of LGC 1991, and five years into full-scale implementation of health sector reform, the Philippines provides an excellent case for a more focused analysis of the effects of expanded local decision space on the efficiency, equity, financial soundness, and quality of health service delivery.

- *Governance*: As alluded to above, there is relatively little analytical literature available on the functioning of local governments in the Philippines and how this may influence the functioning of the health sector. What is the nature of stakeholder relationships and the decision-making process at the local government level? What factors most influence health sector policy at the local level? How does the relationship between the DOH and local government health administrations function? To what degree is the DOH able to "steer" local government, and to what degree do local governments exercise authentic autonomy in health sector management? How does the CHCA process function and how important is it in influencing policy, service delivery, and allocation decisions? What institutional and political factors affect the relative performance of different local governments? Case studies offering a clearer picture of the functioning of Philippine local government and health sector management after devolution are needed to better understand and influence health system performance.

- *Finance*: While a number of excellent studies have examined the aggregate flows of health sector resources after decentralization, there has been comparatively little analysis of patterns of health sector resource allocation at the local government level. The continuing effects of devolution will be better understood when a disaggregated and comparative picture of local government spending within the health sector is available. What degree of variation is seen among LGUs in patterns of spending within the health sector? What factors are responsible for these variations? What performance effects can be observed as a result of different patterns of resource allocation and investment? Another issue of interest is the question of the resources associated with the CHCA process. What is the magnitude of DOH resources provided through the CHCA process and how significant are these resources in influencing allocation decisions by local governments? Detailed analysis of selected local government case studies could provide greater insight into what precisely local governments are doing with the expanded resources over which they now have control, and what effects this is likely to have on the structure and performance of the public sector health system.

- *Performance*: This report has alluded both to national-level health sector data analysis and to anecdotal accounts regarding local government innovation and changes in public service equity, efficiency, quality, and financial soundness as a result of devolution. While some studies have taken a closer look at local government performance in transportation and educational infrastructure, for example, there seems to be little systematic information available on local government performance in the health sector. More detailed study of changes in performance in health service delivery would be extremely useful in gaining a deeper sense of the effects of devolution and what factors appear to influence these

variables. What changes in equity, efficiency, quality, and financial soundness can be observed in the health sector as a result of devolution? What degree of variation do local governments show in these factors and what accounts for this variation? What tools or factors appear to promote improved performance? Data availability and the very complexity of these questions pose limits to such an analysis, but national-level data analysis of performance variables can orient the selection of detailed case studies necessary for performance evaluation and recommendations.

Annex A. Indicators for Mapping Decision Space

Indicators for Mapping Decision Space

Function	Indicator	Range of Choice		
		Narrow	Moderate	Wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total local health spending	High %	Mid %	Low %
Allocation of expenditures	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service Organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Insurance plans	Choice of how to design insurance plans	Defined by law or higher authority	Several models for local choice	No limits
Payment mechanisms	Choice of how providers will be paid (incentives and non-salaried)	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms
Human Resources				
Salaries	Change of salary	Defined by law or higher authority	Moderate salary range defined	No limits
Contracts	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service
Access Rules				
Targeting	Defining priority populations	Law or defined by higher authorities	Several models for local choice	No limits
Governance Rules				
Facility boards	Size and composition of boards	Law or defined by local authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by local authority	Several models for local choice	No limits
Community participation	Size, number, composition, and role of community participation	Law or defined by local authority	Several models for local choice	No limits

Source: Bossert 1998

Annex B. References

Introduction

Bossert, Thomas. 1998. "Analyzing the Decentralization of Health Systems in Developing Countries: *Social Science and Medicine* 47(10): 1513-1527.

Collins, C. and A. Green. 1994. "Decentralization and Primary Health Care: Some Negative Implications in Developing Countries." *International Journal of Health Services* 24(3): 459-475.

Litvack, J., J. Ahmad, and R. Bird. 1998. *Rethinking Decentralization in Developing Countries.* Washington, DC: The World Bank

Mills, Anne. 1994. "Decentralization and Accountability in the Health Sector from an International Perspective: What Are the Choices?" *Public Administration and Development* 14: 281-292.

Mills, Anne, J.P. Vaughan, D.L. Smith, and I. Tabibzadeh. 1990. *Health System Decentralization: Concepts, Issues and Country Experience*. Geneva: World Health Organization.

Prud'homme, Rémy. 1995. "The Dangers of Decentralization." *World Bank Research Observer* 10(2): 201-220.

Rondinelli, Dennis. 1981. "Government Decentralization in Comparative Perspective: Theory and Practice in Developing Countries." *International Review of Administrative Science* 47(2): 133-145.

Rondinelli, D., J.S. Mccullough, and R.W. Johnson. 1989. "Analysing Decentralization Policies in Developing Countries: A Political-Economy Framework." *Development and Change.* 20: 57-87.

World Bank. 1993. *World Development Report: Investing in Health.* New York: Oxford University Press.

Ghana

Ayee, Joseph R.A. 1997. "The Adjustment of Central Bodies to Decentralization: The Case of the Ghanaian Bureaucracy." *African Studies Review* 40(2): 37-57.

_____. 1996. "The Measurement of Decentralization: The Ghanaian Experience, 1988-92." *African Affairs* 95(378): 31-50.

_____. 1994. *An Anatomy of Public Policy Implementation: The Case of Decentralization Policies in Ghana.* Brookfield, VT: Ashgate Publishing.

Bouchet,, Bruno. March 1998. *Trip Report.* Bethesda, MD: Quality Assurance Project: Ghana, University Research Corporation.

Center for International Health Information. 1996. *Ghana Health Statistics Report.* (www.cihi.com).

Crook, Richard C. 1994. "Four Years of the Ghana District Assemblies in Operation: Decentralization, Democratization, and Administrative Performance." *Public Administration and Development* 14: 339-264.

Gyimah-Boadi, E. 1990. "Economic Recovery and Politics in the PNDC's Ghana." *Journal of Commonwealth and Comparative Politics* 28(3): 328-343.

Haynes, Jeff. 1991. "The PNDC and Political Decentralization in Ghana, 1981-91." *Journal of Commonwealth and Comparative Politics* 29(3): 283-307.

Herbst, Jeffrey. 1993. *The Politics of Reform in Ghana, 1982-1991*. Berkeley, CA: University of California Press.

Hiscock, Julia. 1995. "Looking a Gift Horse in the Mouth: The Shifting Power Balance Between the Ministry of Health and Donors in Ghana." *Health Policy and Planning* 10 (Supplement) 28-39.

Jeffries, Richard. 1998. The Ghanaian Elections of 1996: Towards the Consolidation of Democracy? *African Affairs* 97: 189-208.

Mankoe, Joseph and Bill Maynes. 1994. "Decentralization of Educational Decision-Making in Ghana." *International Journal of Educational Development* 14(1): 23-33.

McQueen, Suzanne. 1997. "Republic of Ghana: Current Donor Activities and Options for Additional USAID Involvement in Health Reform." Unpublished Manuscript.

Mensah, E.N. 1997. "The Ghanaian Decentralization Process and Health Care Reforms." A Paper Presented to the East/South Africa Regional Workshop in Health Financing: Lessons Learned, Harare, Zimbabwe, May 26-29, 1997.

Ministry of Health. 1998. *Health Sector Five Year Programme of Work: 1997-2001*. Accra, Ghana: Ministry of Health.

_____. 1997. *A Summary of Preparatory Actions on Human Resources Towards Establishment of the Ghana Health Service, 22 June 1997.* Report prepared by Director of Human Resources Development, Ministry of Health.

_____. 1996. *Health Sector Five Year Programme of Work, August 1996.* Accra, Ghana: Ministry of Health.

_____. 1995. *Medium Term Health Strategy: Towards Vision 2020, September 1995.* Accra, Ghana: Ministry of Health.

Mohan, Giles. 1996. "Adjustment and Decentralization in Ghana: A Case of Diminished *Political Geography* 15(1): 75-94.

Smithson, Paul. 1995. "Quarts into Pint Jugs? The Financial Viability of Health Sector investment in *Health Policy and Planning* 10 (Supplement) 6-16.

Zambia

Atkinson, Sarah, Jacob Songsore, and Edmundo Werna, eds. 1996. *Urban Health Research in Developing Countries: Implications for Policy.* London: CAB International.

Berman, Peter, Kasirim Nwuke, Ravindra Rannan-Eliya, and Alast Mwanza. 1995. "Zambia: Non-Governmental Health Care Provision." Unpublished Project Report. Data for Decision-Making, Harvard University/RTI/USAID.

Bratton, Michael and Beatrice Liatto-Katundu. 1994. "A Focus Group Assessment of Political Attitudes in Zambia." *African Affairs* 93: 535-563.

Bwalya, Mac Trevor. 1998a. "State to Spend $40 Million on Health Centres." *The Daily Mail*, June 8, 1998.

_____. 1998b. "UTH Workers Divided over Strike." *The Daily Mail*, June 10, 1998.

Central Board of Heath, Zambia. 1998. *District Health Planning Guide Vols. I, II*. July. Lusaka, Zambia.

Chikulo, B.C. 1982. "The Reorganization of Zambian Local Government: An Analysis of the Implications of the Local Administration Act of 1980." *Africa Quarterly* 22(3): 49-61.

____1981. "The Zambian Administrative Reforms: An Alternative View." *Public Administration and Development* 1(1): 55-65.

Ciardi, Paola. 1997. "Socio-Cultural Dimensions: The Vision and the Community Partnership Programme." In *Comprehensive Review of the Zambian Health Reforms, 1997.* Volume II: Technical Reports.

Center for International Health information. 1996. "Zambia: Health Statistics Report." (www.cihi.com).

"Comprehensive Review of the Zambian Health Reforms, Volumes I, II, III." 1997. Unpublished Report. May 1997. Prepared by a Joint Working Group from WHO, UNICEF, the World Bank, and the Zambian Ministry of Health.

Curreri, Shannon. 1998. "Implementation of Essential Health Package Policies at the District Level in

Daura, Maureen, Musa Mabandlha, Kamima Mwanza, and Sara Bennett. 1998. An Evaluation of District-level Cost Sharing Schemes. Draft Report Prepared for CBOH Meeting On Cost Sharing, 13-14 March 1998.

Dresang, Dennis L. 1975. *The Zambia Civil Service.* Nairobi: East Africa Publishing House.

Feilden, Rachel and Ole Frank Nielsen. 1998. "Immunization and Health Reform: Making Reforms Work for Immunization." Draft no. 3, April. WHO/GPV/EIP.

Foltz, Anne-Marie. 1997. "Policy Analysis." In *Comprehensive Review of the Zambian Health, Reforms. 1997*. Volume II: Technical Reports.

Daily Mail, May 21, 1998.

Makinen, Marty. 1997. "Health Spending Inequalities and Government's Role in Zambia." Major Applied Research 3, Working Paper 4. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Mbanefoh, Gini F. 1997. Financing/Resource Utilization. In *Comprehensive Review of the Zambian Health Reforms, 1997*. Volume II: Technical Reports.

Momba, Jothan C. 1989. "The State, Rural Class Formation, and Peasant Political Participation in *African Affairs* 88(352): 331-357.

Mphaisha, Chisepo J.J. 1996. "Retreat from Democracy in Post One-Party State Zambia." *Journal of Commonwealth & Comparative Politics* 34(2): 65-84.

Mpuku, Herrick C. and Ivan Zyuulu, eds. 1997. *Contemporary Issues in Socio-Economic Reform in Zambia*. Brookfield, VT: Ashgate Publishing.

Mubiana, Sandra. 1998. "UTH Workers Reject Government's 'Three Months Grace Period'." *The Post*, June 9, 1998.

Mukwena, Royson M. 1992. "Zambia's Local Administration Act, 1980: A Critical Appraisal of the *Public Administration and Development* 12(3): 237-247.

Mwamba, Mutale. 1998. "Luo Tight-lipped Over Health Board's Resignation." *The Daily Mail*, May 9, 1998.

Mwanza, Benjamin. 1998. "UTH Consultants Fire Warning Shots." *Times of Zambia*, June 3, 1998.

Phiri, Patson. 1998. "Luo Blasts District Health Boards." *The Sunday Mail*, September 6, 1998.

Rakodi, Carole. 1988. "The Local State and Urban Local Government in Zambia." *Public Administration and Development* 8: 27-46.

Republic of Zambia, Ministry of Health. 1998a. "National Health Care Financing Policy." Directorate of Planning and Development, 22 May 1998.

_____. 1998b. "National Health Strategic Plan 1998-2000." Draft Version 6, May 20, 1998.

Times of Zambia, December 10, 1998.

Tordoff, William. 1994. "Decentralisation: Comparative Experience in Commonwealth Africa." *Journal of Modern African Studies* 32(4): 555-580.

Tordoff, William, ed. 1980. *Administration in Zambia*. Manchester: Manchester University Press.

Tordoff, William and Ralph A. Young. 1994. "Decentralisation and Public Sector Reform in *Journal of Southern African Studies* 20(2): 285-299.

United States Agency for International Development. 1995. "Zambia Child Health Project: Draft Project Paper." Project No. 611-0237.

Van Bergen, J.E.A.M. 1995. "District Health Care Between Quality Assurance and Crisis *Tropical and Geographical Medicine* 47(1): 23-29.

Visshedijk, J.H.M., I.M. Liywalii, and J.J.G. Van Oosterhout. 1995. "Pilot Project for Financial Decentralization in Senanga, Zambia." *Tropical and Geographical Medicine* 47(1): 39-42.

Zambia Consensus Building Initiative. 1996. "Using Political Mapping for the Sustainability in Reforms in the Health Sector, Essential Drugs, and User Fees." Unpublished project report.

Uganda

Center for International Health information. 1996a. "Uganda: Health Statistics Report." (www.cihi.com)

_____. 1996b. “Uganda: Country Health Profile.” (www.cihi.com)

Fielden, Rachel and Ole Franck Neilsen. 1998. “Immunization and Health Reform: Making Reforms Work for Immunization.” Draft no. 3, April. WHO/GPV/EIP.

Furley, Oliver and James Katalikawe. 1997. “Constitutional Reform in Uganda: The New Approach.” *African Affairs* 96(383): 243-260.

Hutchinson, Paul. 1998. “Decentralization in Uganda’s Health Sector.” April 1998 draft. Uganda: World Bank.

Kasfir, Nelson, Judith Geist, Melissa Brown, Chris Sabatini, and Tina West. 1996. “Democracy and Governance Assessment of Uganda.” Report prepared for USAID, Sept.-Dec.1996. Kampala, Uganda: USAID.

Langseth, Peter. 1995. “Civil Service Reform in Uganda: Lessons Learned.” *Public Administration and Development* 15(4): 365-390.

Lubanga, F.X.K. 1996. “The Process of Decentralization.” In Villadsen and Lubanga, eds. *Democratic Decentralization in Uganda* pp. 47-59.

Macrae, Joanna, Anthony Zwi, and Lucy Gilson. 1996. “A Triple Burden for Health Sector Reform: -Conflict Rehabilitation in Uganda.” *Social Science and Medicine* 42(7): 1095-1108.

Ministry of Health, Uganda. 1997. “Decentralization and Health Care Delivery in Uganda: The Recent Experience.” Paper presented by the Director General of Health Services at the Regional Policy Seminar on Sustainable Health Care Financing, Nairobi, 23-28 February 1997.

Okello, D.O., R. Lubanga, D. Guwatudde, and A. Sebina-Zziwa. 1998. “The Challenge to Restoring Basic Health Care in Uganda.” *Social Science and Medicine* 46(1): 13-21.

Okuonzi, Sam and Francis Lubanga. 1995. *Decentralization and Health Systems Change in Uganda.* Geneva: World Health Organization.

Okuonzi, Sam Agatre and Joanna Macrae. 1995. “Whose policy is it anyway? International and national influences on health policy development in Uganda.” *Health Policy and Planning* 10(2): 122-132.

Smithson, Paul. 1995. “Quarts into pint jugs? The financial viability of health sector investment in low-income countries.” *Health Policy and Planning* 10 Supplement: 6-16.

Villadsen, Soren. 1996. “Decentralization of Governance.” In Villadsen and Lubanga, eds., *Democratic Decentralization in Uganda*. Pp. 60-78.

Villadsen, Soren and Francis Lubanga. 1996. *Democratic Decentralization in Uganda: A New Approach to Local Governance.* Kampala, Uganda: Fountain Publishers.

Philippines

Borlagdan, Salve B., Gloria Gabronino, and Apollo C. Tracena. 1993. "Health Service Delivery: Issues, Problems, and Prospects of Devolution." *Philippine Journal of Public Administration* 37(1): 22-40.

Brillantes, Alex. B. 1994. "Redemocratization and Decentralization in the Philippines: The increasing leadership role of NGOs." *International Review of Administrative Sciences* 60: 575-586.

Busse, Reinhard and Friedrich W. Schwartz. 1997. "The Philippines' National Health insurance Act: *International Journal of Health Planning and Management* 12: 131-148.

Center for International Health Information. 1996. *Philippines Health Statistics Report*. (www.cihi.com).

Ching, Panfila. 1995. "User fees, demand for children's health care and access across income groups: The Philippine case." *Social Science and Medicine* 411: 37-46.

Diokno, Benjamin E. 1995. "A Policymaker's Guide for the Use of Central-Local Transfers: The Philippine Case." Unpublished manuscript.

Eaton. 1998. "Political Obstacles to Decentralization in Argentina and the Philippines." Unpublished paper. Presented at the September 1998 Conference of the Latin American Studies Association, Chicago.

Griffin, Charles C., Bienvenido Alano, Maricar Ginson-Bautista, and Rhais M. Gamboa. 1994. *The Private Medical Sector in the Philippines. Health Finance Development Project.* Monograph No. 4, April 1994. Philippines Department of Health and USAID.

Herrin, Alejandro N. 1992. *Towards Health Policy Development in the Philippines. Health Finance Development Project.* Monograph # 1. March 1992. USAID and Department of Health of the Philippines.

Hotchkiss, David R. 1998. "The Tradeoff Between Price and Quality of Service in the Philippines." *Social Science and Medicine* 46(2): 227-442.

Local Government Assistance and Monitoring Service. 1997. *The Comprehensive Health Care Agreement*. Manila: Local Government Assistance and Monitoring Service.

Loehr, William, and Rosario Manasan. 1999. "Fiscal Decentralization and Economic Efficiency: Measurement and Evaluation." Unpublished draft report, January 1999. IMCC Consulting Assistance for Economic Reform (CAER) II Paper. Harvard Institute for International Development and USAID.

Manasan, Rosario Go. 1996. "Local Government Financing of Social Service Sectors in A Decentralized Regime: Special Focus On Provincial Governments in 1993 and 1994." Unpublished report.

Markillie, Paul. 1996. "The Miracle They Call Ceboom." *The Economist* 339(7965): 14.

Mcbeth, John. 1989. "Remote Control: Heel-dragging Congress Debates Regional Autonomy." *Far Eastern Economic Review*, November 23, 1989: 32-33.

Miller, Tom. 1998. "Fiscal Federalism in Theory and Practice: The Case of the Philippines." *Economists Working Paper Series* # 4. USAID.

Perez, Juan A. 1998. "Health Worker Benefits in a Period of Broad Civil Service Reform: The Philippine Experience." Unpublished manuscript.

Perez, Juan, Maria C. Alfiler, and Monina Victorian. 1995. "Decentralization and Health Systems Change: Managing Transition Dilemmas in the Early Years of Devolution in the Philippines." Unpublished country report, World Health Organization, Decentralization and Health Systems Change Project.

Republic of the Philippines, Congress of the Philippines. 1991. Republic Act No. 7160. "An Act Providing for a Local Government Code of 1991." 5th Regular Session. Manila, Philippines.

Republic of the Philippines, Department of Health. 1993. *Guidebook for Governors and Mayors in Responding to Questions On Devolution of Health Services*. Manila, Philippines.

_____. 1991. *Department of Health Rules and Regulations Implementing the Local Government Code of 1991*. Manila, Philippines.

Romero, Segundo E. 1998. "The Philippines in 1997: Weathering Political and Economic Turmoil." *Asian Survey* 38(2): 196-202.

Reisman, D.A. 1996. "Payment for Health in the Philippines." *International Journal of Social Economics* 23(8): 46-75.

Ruland, Juergen and Thomas A. Sajo. 1988. "Local Government and Development in a Regional City: The Case of Iloilo City, Philippines." *Public Administration and Development* 8: 261-287.

Schroeder, Larry. 1989. "A Comparative Analysis of Grants to Local Governments in Southeast and *International Review of Administrative Sciences* 55: 59-84.

Sidel, John T. 1997. "Philippine Politics in Town, District, and Province: Bossism in Cavite and Cebu." *The Journal of Asian Studies* 56(4): 947-966.

Solon, Orville; Rhais M. Gamboa, J. Brad Schwartz; and Alejandro N. Herrin. 1992. *Health Sector Financing in the Philippines*. Health Finance Development Project, Monograph # 2. USAID and Department of Health of the Philippines.

Tapales, Prosperina Domingo. 1992. "Devolution and Empowerment: LGC. 1991 and Local *Philippine Journal of Public Administration* 36(2):. 101-114.

Vian, Taryn. 1995. "Lessons Learned from the Family Planning Management Development Project, 1993-1995." Unpublished report for the Family Planning Management Development Project, Management Sciences for Health and USAID.

Zialcita, Fernando N. 1990. "The Nation as Arti *Philippine Quarterly of Culture & Society* 18: 227-254.