VERTICAL OR HOLISTIC DECENTRALIZATION OF THE HEALTH SECTOR? EXPERIENCES FROM ZAMBIA AND UGANDA

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SUMMARY

Many countries in Africa have embarked on health sector reforms. The design of the reforms differs considerably. A key feature of the reforms is decentralization, of which Uganda and Zambia are implementing two different models. This paper analyses the two models of health sector reform, and their implications for ultimate development goals. In Uganda, the whole government has been decentralized, with a wide range of powers and resources transferred to the districts. The health care system is part of the political set up of the country. In Zambia, only the health sector has been decentralized. Power and resources for health care have been divested to new parallel organizations. While useful lessons can be drawn from the managerial and administrative experience in the two countries, not least concerning donor coordination, it seems that neither form of decentralization has so far led to a clear and appreciable improvement of health services and, ultimately, to a clear focus on development goals, such as poverty alleviation. The conditions for this to happen are discussed in this paper. Copyright © 2000 John Wiley & Sons, Ltd.

KEY WORDS: health sector reform; decentralization, health services; legitimacy

INTRODUCTION

A number of African countries, including Uganda and Zambia, have implemented major reforms of the health sector. The reforms include civil service reform, restructuring of government institutions, decentralization, and coordination of external aid. The paper compares health sector reform in the two countries. First, it compares the socio-economic context of the countries. Second, it describes and compares the historical context of the health sector in both countries. Third, the paper describes the different reform measures, especially their depth and width. Lastly, it assesses the extent to which service provision has changed given all these reforms in the health sector of the two countries and, the process needed to move towards development goals.

The paper draws on the findings of a study tour by a Uganda Government team to Zambia in March 1998. The team consisted of policy decision-makers, health

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planners, financial experts and district health and administrative leaders. The visit was inspired *inter alia* by the remarkable success Zambia was said to have achieved in donor coordination and in streamlining the use of external aid through a sector wide approach (SWAp). In Uganda, the Government had been implementing a package of public sector reforms, including decentralization and civil service reform for a decade. But uncoordinated use of donor funds in Uganda had become an increasing problem in the health sector. One of the purposes of the visit was therefore to study various reforms that facilitated successful control and coordination of donor funding in Zambia.

The findings from the study tour have been followed up by a review of documents from Zambia and Uganda, as well as by first hand experience from the health sector reform process in Uganda.

The paper examines the different packages of reforms that involve the health sector in each of the two countries. Documents were reviewed and a large number of key informants were interviewed at all levels of the health care system. One of the authors of this paper (Jeppsson) had worked for several years in Zambia and had had first hand experience of the health system there. The two authors have many years’ experience of working in the Ugandan health system.

Conceptually, the paper reflects upon Øvretveit’s comparative analysis framework (1998) which takes into account how complex systems operate within a larger context. The article further reflects upon Gill Walt’s policy analysis framework which takes into account the contextual factors, processes of policy making and the influence of actors, as well as the substantive content of the policy (Walt, 1996). Further, the analysis draws on the categories of decentralization defined by the Public Administration Approach (Rondinelli and Cheema, 1983). Finally, the paper draws on Rothstein’s work on political legitimacy (1998).

**COUNTRY PROFILES**

Zambia is a landlocked country in southern Africa. It is three times larger than Uganda, covering 752 600 square kilometres. Its population of 8.09 million people (1990 census) is about half that of Uganda, which was about 16 million in 1990. Zambia is administratively divided into 9 provinces and 72 districts. There are no political councils at the provincial level. A Deputy Minister and a Permanent Secretary manage each province. The role of the provincial administration is the management of central Government departments.

Districts constitute local authorities in Zambia. Each local authority council consists of elected district councillors, members of parliament and two representatives of each chief. Of the 72 districts, 4 are city councils, 14 are municipal councils and the rest are ordinary district councils. Each district’s delimitation proceeds from constituency to ward, before it reaches the lower levels of section and finally village. The political, administrative and financial power held by each of these levels is, however, strictly limited.

Landlocked Uganda is located in East Africa, just north of Lake Victoria, astride the equator. Its population is projected to be 22 million in 1999. The country is
divided into 45 districts with populations ranging from 17,000 to close to 1 million (Rwabwoogo, 1997). There is no intermediate level of administration between the district and the centre. Each district consists of counties, which in most cases are also constituencies. A county consists of sub-counties, a sub-county of parishes and a parish of villages (Government of Uganda, 1995a).

A representative hierarchy of councils has been established at these levels. The important ones are the district level and the sub-county level, which both have directly elected councils with considerable powers. Each level also has an administrative head, with a separate line of command.

Table 1 compares the social and economic indicators of the two countries.

HEALTH CARE SYSTEMS PRIOR TO THE 1990s

Both countries had highly centralized health care systems prior to the 1990s, with a considerable difference of health services standards between urban and rural areas (Öjermark, 1992; MacRae et al., 1996). In both countries, the centre was responsible for resource allocation. There were differences in the organization, however, Zambia had the intermediate provincial level, responsible for coordination. In Uganda this

Table 1. Socio-economic indicators of Uganda and Zambia

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Uganda</th>
<th>Zambia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total population (million)² in 1990</td>
<td>16.7</td>
<td>8.09</td>
</tr>
<tr>
<td>2. Population in rural areas in %²</td>
<td>89%</td>
<td>62%</td>
</tr>
<tr>
<td>3. Crude birth rate per 1000 people</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td>4. Crude death rate per 1000 people</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>5. Population growth rate³</td>
<td>3.1%</td>
<td>2.8%</td>
</tr>
<tr>
<td>6. Total fertility rate³</td>
<td>6.9 children</td>
<td>6.1 children</td>
</tr>
<tr>
<td>7. Infant mortality rate (per 1000 live births)</td>
<td>97</td>
<td>109</td>
</tr>
<tr>
<td>8. Under 5 mortality (per 1000 children)</td>
<td>147</td>
<td>197</td>
</tr>
<tr>
<td>9. Maternal mortality rate² (per 100,000 live births)</td>
<td>506</td>
<td>649</td>
</tr>
<tr>
<td>10. Life expectancy at birth²</td>
<td>Male 43 years</td>
<td>Male 44 years</td>
</tr>
<tr>
<td></td>
<td>Female 43 years</td>
<td>Female 45 years</td>
</tr>
<tr>
<td>11. Illiteracy rate</td>
<td>Male 20%</td>
<td>Male 14%</td>
</tr>
<tr>
<td></td>
<td>Female 50%</td>
<td>Female 29%</td>
</tr>
<tr>
<td>12. Gross national product per capita in US$²</td>
<td>320</td>
<td>360</td>
</tr>
<tr>
<td>13. Gross domestic growth²</td>
<td>5.3%</td>
<td>7.9%</td>
</tr>
<tr>
<td>14. Inflation rate²</td>
<td>7.7%</td>
<td>18.6%</td>
</tr>
<tr>
<td>15. Government per capita expenditure on health in US$³</td>
<td>3.95</td>
<td>6.06</td>
</tr>
</tbody>
</table>

level had disappeared. In Uganda, the Ministry of Local Government was responsible for lower health units and the Ministry of Health for the hospitals. In both countries, health facilities run by church missions constituted a large proportion of the health facilities (40% in Uganda [Government of Uganda, 1996] and 35% of the hospitals in Zambia and 4% of lower health units there) and probably an even larger share of the actual services provided. Generally the quality of services provided by the missions was better. In Zambia government employees staff the mission health facilities and a big proportion of the budget comes from the government. In Uganda the mission facilities hire and fire their own staff, although the government has recently started seconding staff. The Ugandan mission facilities have only recently received funds from government, and currently face financial problems, since the previous external funding has diminished. Zambia had probably reached further in terms of collaboration between the mission and the government systems, which have just recently started at national level in Uganda.

HEALTH SECTOR REFORMS

The origins of the health sector reforms in the two countries differ significantly, a fact which has significant importance for the way in which the reforms are carried out. In Uganda health sector reform is part of an overall reform of the public sector, which consists of liberalization, constitutional reform, civil service reform, decentralization and privatization (Villadsen, 1996). Decentralization consists of political, financial and administrative components. The political component is very strong, with elected councils at district and sub-county levels having a considerable influence, including the right to raise revenue (Government of Uganda, 1993; 1997). Health was not high on the political agenda during the reforms, but was rather an area that happened to be affected by the reforms.

In Zambia, the health sector reform started within the health sector itself (Choongo and Milimo, 1995). The Movement for Multiparty Democracy (MMD) which came to power in 1991 had within its ranks strong advocates for a radical reform of the health sector. During the general national elections of 1991, health was one of the important political issues.

Thus, in Uganda, it was the public sector reform that was driving changes in the health sector. In Zambia it was health sector reform that was influencing changes in the public sector as a whole.

Reforms at central level

Zambia’s Ministry of Health (MoH) was split into provider and purchaser institutions (Government of Zambia, 1995). The aim was to create internal markets, through which efficiency could be attained by competition among different providers. The MoH remains the purchaser of services on behalf of the population. A body called the Central Board of Health (CBoH) was created and contracted by the MoH as the service provider. The CBoH commissioned a network of hospital and district health boards through which it operates. Four CBoH regional offices

replaced the former nine provincial medical offices. Due to heavy workload, it has recently been decided to increase the regional representation of CBoH to one office in each of the nine provinces.

As a result of this restructuring at central level, the MoH has been downsized from 220 to some 66 employees. The roles of the MoH and the CBoH have been defined clearly. The MoH is responsible for the formulation of health policy, mobilization of funds, legislation, donor coordination and monitoring of the health status and services. The CBoH is responsible for commissioning other boards, regulating health care practice, carrying out the functions of boards that have failed to work and human resource management. The Board is free to out-source services from the public and private sectors on a contract basis.

Uganda’s MoH has been reorganized significantly as a consequence of the altered roles due to decentralization and reduced in size due to the civil service reform (Government of Uganda, 1998a). The establishment of the Ministry of Health Headquarters has been reduced from about 800 to under 400 posts. However, a substantial part of the reduction comprised support staff. It is no longer responsible for service provision except through regional and national hospitals to which it has increasingly divested management functions. The intention is to make these hospitals financially and operationally autonomous.

The new functions of the Ministry are to formulate policy, set service standards, assure quality, provide training and human resource development guidelines, provide technical supervision, respond to epidemics and other disasters, and monitor and evaluate health services (Government of Uganda, 1998a).

Reforms at lower levels

The district councils in Zambia have little say in the district health activities. The health sector has been de-linked not only from the provincial administration but also from the district local authority. Because the health sector in Uganda has been decentralized with the rest of the Government, Uganda did not need to create parallel systems or structures. The formal power over the implementation of health services lies with the political bodies in the district. Management boards are, however, being considered for the hospitals.

In Zambia, Hospital Boards and District Health Boards manage hospitals and health services outside the hospitals respectively. The Health Boards are strong and powerful, but with similar roles and functions as health unit committees in Uganda.

The Zambian hospital boards are appointed (and can be dissolved) by the Minister of Health. This is true for mission hospital boards as well. Thus, the ultimate power over the boards lies with the minister. Because the minister appoints the board members and the local leaders are not involved in their selection, there is not much incentive for the latter to participate in the management of health services. This is in contrast to Uganda, where all health committees are appointed by elected local councils.

In both countries, technical management teams are charged with the day to day running of health services. The District Director of Health Services and the
Executive Director head the teams respectively for District Health and Hospital Services. In Uganda, the District Health Team headed by the District Director for Health Services (DDHS) provides the technical leadership for the health sector in the district including hospitals. However, the DDHS plays only an advisory role in the affairs of regional and national referral hospitals, which are under the leadership of Medical Superintendents and hospital committees or boards.

Sub-county and health sub-district in Uganda. The sub-county is the lowest level of government in Uganda. It is a corporate body empowered to collect taxes and other revenues. At least 65% of locally raised revenue at the sub-county is retained and used at this level (Government of Uganda, 1997). The remaining revenue is remitted to the district headquarters. The sub-county Council can and does make and implement development plans. However, locally raised revenue is usually too small to plan meaningful development. Therefore, the sub-county relies on the district Government, which itself depends on grants from the central Government.

The sub-district is an innovation in the health sector and is not a formal structure of the decentralized system of the Government. The health sub-district is a further effort to decentralize services so as to increase access to health care and to improve equity (Government of Uganda, 1998b). The desired level to decentralize health services is to the sub-county. But there are too many sub-counties (about 900) for the existing health care infrastructure and resources. Therefore, in most cases, the sub-district is a county or a constituency. However, large counties have been divided into two or more health sub-districts. Altogether, there are 214 health sub-districts.

The headquarters of a sub-district is a hospital or an upgraded health centre where there is no hospital. The idea is to use qualified and skilled labour, usually pooled in hospitals and large health centres, for decentralized health services. The main difference is that surgical services will be available with the deployment of a medical officer. Experiences so far are encouraging when it comes to improving the curative services, but less encouraging as far as preventive and promotive services are concerned (Baganbisa et al., 1999). The establishment of the health sub-district system, which has been phased to take 3 years, requires reconstruction of health centres to include small operating theatres, and to upgrade the staff to include doctors, medical assistants, nurses and midwives (Government of Uganda, 1998b). A health sub-district is expected to serve between 70 000 and 100 000 people.

Neighbourhood committees in Zambia. Whereas lower levels of the government have a negligible role to play in health services in Zambia, efforts have been made to institutionalize a link between the local communities and the health care system (Government of Zambia, 1996b). Neighbourhood committees have been formed to increase the involvement and control by the civil society over local health facilities. In many cases, the committees emerged from existing village health committees (Choongo and Milimo, 1995). A neighbourhood committee usually consists of more women than men. A study carried out in 1997 identified major problems in the performance of the neighbourhood health committees. To a large extent they did not fulfill their task as a link between the community and the health workers (Likwa, 1998). Health centre committees have also been established in certain areas but...
are less frequent and less important than the neighbourhood committees (Government of Zambia, 1996b).

The role of NGOs and private sector. Non-Governmental Organizations (NGOs), especially church missions, have played an important part for rural health services in both countries. Zambian mission hospitals receive substantial funding from the Government, often adequate to meet about two thirds of the running costs (Zambia Health Sector Expenditure Review, 1995). Mission hospitals fall under the statutory boards, which are also appointed by the Minister of Health. It is estimated that church health institutions provide 30% of the health services nationally in Zambia and 40% in the rural areas (Government of Zambia, 2000).

In Uganda the collaboration between the Government and the private sector is in its infancy. The Government of Uganda has in the recent past started to give NGO hospitals financial assistance. Many mission hospitals that previously received much of their recurrent financing from overseas are in financial problems as external support has been reduced drastically in the recent past. As a result, the churches can longer afford to run their facilities as well as they used to and several mission health facilities have been under the threat of closure. It has been estimated that NGO health facilities contribute 64% of the formal health services in Uganda (Government of Uganda, 1995c), a significant proportion, which is most likely higher in remote and poor areas of the country.

The ‘private for profit’ sector is very small in both countries. In Zambia, there have been successful attempts to encourage private practitioners to organize themselves into local associations, which can then collaborate with the local health board. In this way, the private practitioners also carry out certain tasks (for example, immunization) on behalf of the boards. They are given vaccines free of charge and they get a commission for carrying out the task. Private practitioners are obliged by law to cooperate with the Board and a mechanism is in place whereby non-complying practitioners can be sanctioned. This has, however, not yet occurred in practice. Private for profit services have increased in urban but not in rural areas (Government of Zambia, 2000). In Uganda, the formal private for profit sector remains an urban phenomenon. However, a large informal sector is blooming in urban as well as in rural areas.

Reforms of systemic functions

Planning and budgeting. While in Zambia extensive consultations are done with health units in planning, in Uganda it is mainly the district health team that carries out planning. However, NGOs, the lower political and administrative levels, and health units are now increasingly involved in planning. In Uganda, local councils formally approve plans for the areas over which they have jurisdiction. This means district councils approve district health plans and sub-county councils approve sub-county plans. In Zambia, it is the CBoH that approves annual work plans for district and hospital boards (Central Board of Health, 1998). Uganda’s Ministry of Health is mandated to provide technical guidance on health planning, but no sanction is instituted against districts that do not follow the guidelines.
The crucial difference in financing between the two countries lies with who has the last word concerning the budget: in Uganda it is the district council that has the last word while in Zambia it is the CBoH in Lusaka.

Financial, administrative and management systems. One requirement for successful decentralization is that financial and administrative systems are in place at the local level. In Zambia, a new system for the health sector, the Financial and Administrative Management System (FAMS), was developed and put in place. The development of this system took a lot of effort and resources. To train all the relevant district staff in FAMS took about 3 years.

In Uganda, the financial and accounting system is based on regulations that apply to all sectors at the district level. There is a number of adequately experienced accounts staff at the district level. Specific training has been undertaken for accounting technicians.

A typical district health department in Zambia has only two bank accounts, one for the Government (the basket funds), and the other for medical fees. This greatly simplifies the management of the funds including bookkeeping and financial reporting. In Uganda, the district health department has, on average, seven to eight different bank accounts, in response to the requirements of the different donors or funding sources. According to the government regulations, each account has to have its own vote book as well, which makes the account system complicated.

Medical fees in Zambia consist of monthly prepayments and user fees (per visit). Prepayments constitute 75%–80% of the total collection of medical fees. In Uganda, prepayment schemes are only being piloted in a couple of health units. Unlike in Uganda, medical fees collected at health units in Zambia are remitted to the district. However, 80% of the collection in a health facility is supposed to be used for payments on behalf of the facility.

In Uganda, user-fees are retained in the facility where these are collected. Funds for drugs are not fully decentralized in Zambia. Instead, the funds are deposited on a bank account at the CBoH. Each district has its own ‘customer account’ with the CBoH where transactions for the particular district are recorded. The CBoH issues regular statements to the districts (customers). Some districts have suggested that it would be better if the funds are released directly to them to enable them purchase drugs themselves.

The packages. The purpose of ‘packaging services’ is to identify and deliver cost-effective health services. When a package was being developed for Zambia, representatives from the districts participated actively (Government of Uganda, 1998d). Emphasis was put on understanding the underlying concept. No computer programs were used. Calculations were done manually, which facilitated an understanding of the process.

The Zambian methodology is now used as a key tool in the management training of district directors for health. The development of the package started with the basic level. In Zambia, interventions have been specified for primary level health facilities. However, interventions at higher levels have not yet been identified.
In Uganda, there were two entry points to the discussions on what is now called the ‘Minimum Health Package’: the burden of disease analysis carried out in 13 districts in 1995–6 as a World Bank initiative, and discussions on the new health policy in 1997–9, (World Bank, 1995; Government of Uganda, 1996; Government of Uganda, 1999). The programmes to be included in the package have been agreed. Furthermore, standards have been developed for the district and sub-county levels (Government of Uganda, 1998c). Although the burden of disease analysis involved officials from the districts, the development of the package is part of the new health policy process, which has, however, mainly involved central level actors.

Personnel management issues. In Uganda all staff, except at the national and regional hospitals, have been transferred to the districts. Decentralized health personnel are also of two types: those paid by the district from the Government block grant and those paid from locally raised revenue. Those paid out of the block grant are on the district payroll and usually receive salaries on time. But those paid from locally raised revenue at the sub-county level nearly always have their salaries delayed or not paid at all.

In Zambia, the strategy was to ‘de-link’ staff employed by the Ministry of Health, and to transfer them to the boards. Although efforts have been made to make such employment arrangements more attractive, employees have been skeptical. De-linking of personnel has currently come to a standstill, and its future has remained unclear until recently. In Uganda, all decentralized staff have now been put on one single payroll per district, with the intention that no further salary arrears will occur. However, salaries are still low, and earlier commitments by the government to offer all civil servants a ‘living wage’ have not yet been honoured.

Procurement. In both countries, procurement of goods and services is done through already established local and central tender boards. In Zambia, however, every health board has its own tender board. In Uganda the districts have to make their procurements through the district tender boards which are appointed by the district councils. The tender boards serve not just the health sector, but all sectors of the district administration. While many district officials complain about the lengthy procedures of the district local tender boards in Uganda, it seems the decentralized tender system for the health sector in Zambia functions efficiently. Apart from the lengthy procedures, the Ugandan district tender boards convene infrequently and their sittings are far apart. There is now a proposal to decentralize procurement to institutions, ministries and departments.

Monitoring and supervision. In Zambia, the user-friendliness of the health management information system (HMIS) was emphasized and achieved. The health personnel are able to collect, analyse and use the information at different levels. Attempts to simplify the HMIS in Uganda have now resulted in the definition of a limited number of ‘benchmark indicators’ to monitor the performance of the health sector as a whole.

The regional offices of the CBoH carry out support supervision of districts in Zambia (Government of Uganda, 1998d). This intermediate level with a regional
responsibility makes the undertaking of supervision a manageable task. In Uganda, supervision of health services has been and continues to be the responsibility of district health authorities. The centre also provides vital technical support particularly through the national health programmes and quality assurance visits.

In Uganda, the absence of an intermediate level causes a problem for monitoring and supervision. The central ministry has the responsibility to supervise and monitor the districts from a technical perspective, in order to ensure that a satisfactory quality of services is ensured. It has, however, proven difficult to directly relate to 45 districts, some remote.

**Donor coordination.** The application of the sector wide approach (SWAp) concept has brought the number of annual donor missions to Zambia down to two from over 20 separate missions previously. Now, only two major meetings are held in a year in which all the donors participate. Furthermore, donors’ representatives now attend quarterly ‘basket meetings’. This has not only greatly reduced the time spent on donors but also created openness in negotiations. In Uganda, arrangements to adopt a SWAp have emerged out of the development of the new national health policy. There is a major donor interest to abandon project support in favour of various kinds of budget support.

Table 2 presents a framework of the key features of decentralization in the two countries.

### DISCUSSION

The ultimate purpose of a public sector reform is to improve the economic and social service performance. However, different reforms in the public sector have different intermediate or sub-objectives. Health sector reform aims to improve the performance of the sector. The health sector has well known objectives. These include better access, equity, efficiency, quality and sustainability of health services (Knowles et al., 1997), which are the objectives of the health sector reform in both countries. The focus is on decentralizing the actual provision of services.

Decentralization, on the other hand, has other objectives to be derived from the context. These, in the case of Uganda, are to bring political power closer to local communities, to respond to local needs, to build local capacity and to improve accountability. The focus of the reforms in the two countries has, thus, been different. In the case of Zambia, the focus has been on the health sector, whereas in Uganda, health has not been in focus at all. Ideally, the objectives of different reforms in the public and private sectors should be mutually reinforcing. Since the reforms have started recently, it may be too early to evaluate the actual impact of the reforms. For instance, the district health systems in Zambia were established in 1995, and did not start operating until later. Uganda is just carrying out a stage of rehabilitating dilapidated health facilities, and this process has not yet been completed. The new health policy was adopted in 1999. What could be worthwhile is not to assess the accomplishment of development goals, but rather, in due course to assess the mediating factors of reform.

Table 2. The key features of health sector decentralization in Uganda and Zambia

<table>
<thead>
<tr>
<th>Aspect of reform</th>
<th>Uganda</th>
<th>Zambia</th>
</tr>
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<tbody>
<tr>
<td>1. Type of decentralization</td>
<td>The whole government has been decentralized</td>
<td>Only the health sector is decentralized</td>
</tr>
<tr>
<td></td>
<td>Health sector decentralization follows and uses administrative/ political structures</td>
<td>New structures formed specifically for the technical health sector</td>
</tr>
<tr>
<td>2. Central level reorganization</td>
<td>Establishment reduced in size, most functions have been decentralized to districts</td>
<td>MoH split into purchaser and provider agents</td>
</tr>
<tr>
<td></td>
<td>The centre has fewer roles</td>
<td>Reduced in size</td>
</tr>
<tr>
<td>3. Intermediate level reorganization</td>
<td>Revival of the regional tier as resource centre</td>
<td>Reduced from 9 to 4 offices with coordination role</td>
</tr>
<tr>
<td>4. District level reorganization</td>
<td>Strengthening of DDHS’s office Supervisory role of DDHS has increased</td>
<td>District boards responsible for management of services</td>
</tr>
<tr>
<td></td>
<td>Service delivery further decentralized to lower level (health sub-district)</td>
<td></td>
</tr>
<tr>
<td>5. Hospital management</td>
<td>Committees/boards present but weak Appointed by district councils Technical staff are administrators</td>
<td>Boards are powerful, appointed by the Minister</td>
</tr>
<tr>
<td>6. Role of MOH in the appointment of Board/Committees</td>
<td>Provide general guidelines</td>
<td>Minister appoints boards and can dissolve them</td>
</tr>
<tr>
<td>7. NGOs and the private sector</td>
<td>Formerly not funded by the Government But a closer collaboration has been initiated Funding of NGO facilities by Government has increased</td>
<td>Funded considerably by the Government</td>
</tr>
<tr>
<td>8. Lower levels of health care</td>
<td>Sub-county as lowest level of Government plans for development including health Sub-district is a unit for further decentralization of services below the district level</td>
<td>Neighbourhood committees established as local planning and health action initiators</td>
</tr>
<tr>
<td>9. Planning and budget at district level</td>
<td>Three types of planning practised at district level: 1. Consultative comprehensive(desired under decentralization) 2. Technocratic comprehensive (old style) 3. Technocratic multiple (driven by donors and vertical programmes)</td>
<td>Highly consultative involving all health sector stakeholders under the umbrella of SWAp</td>
</tr>
<tr>
<td></td>
<td>From multiple, fragmented and disjointed to consultative, comprehensive and transparent planning and budgeting</td>
<td>From involving only MOH and a few donors to extensive consultation that has now been adopted under SWAp</td>
</tr>
</tbody>
</table>
Based on the definitions of the Public Administration Approach (Rondinelli and Cheema, 1983), decentralization of the public sector in Uganda can best be described as a devolution, i.e. a shift of authority from the central level of government to separate administrative and political structures of the government, in our case, to the district administrations. Formal power has then been transferred to lower levels. However, the central government still has power over finances that will affect the districts. Thus, a discrepancy is apparent between formal powers given to the districts and the financial means to exercise them. Accordingly, the decentralization of the health sector in Zambia can best be described as a delegation of power from the central level, which still controls the local boards through appointment of the board members and approval of plans and budgets. The central level hence controls the local level not only through finances, but also through the formal administrative procedure.

The reforms in Uganda and Zambia have resulted in extensive political and administrative changes. To a large extent, short- to medium-term (management) objectives have been achieved. For example, in Zambia, there has been a considerable amount of innovative thinking and willingness to experiment with new

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Table 2. (Continued)

<table>
<thead>
<tr>
<th>Aspect of reform</th>
<th>Uganda</th>
<th>Zambia</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Financial management</td>
<td>Built on the existing local Government financial regulations but not yet well established Average of 7 different health accounts at the district level</td>
<td>Well established financial and accounting system A district has one health basket fund</td>
</tr>
<tr>
<td>12. User-fees</td>
<td>Collected and used at source Prepayment is still a negligible method of health financing</td>
<td>User-fees remitted to districts Prepayment constitutes high proportion of financing</td>
</tr>
<tr>
<td>13. Selection of the minimum package</td>
<td>Computerized and complicated method Rationale of priority setting not well understood Package not accepted by a considerable number of stakeholders, and not well applied</td>
<td>Manual and simple Method widely understood and applied</td>
</tr>
<tr>
<td>14. Staffing</td>
<td>Generally qualified staff regularly paid but their salaries are below subsistence Many untrained staff have several months of salary arrears The trend has been to reduce staff numbers It has been realized that improvement in health service requires more and not less staff</td>
<td>Staff are better paid but feel insecure in job</td>
</tr>
<tr>
<td>15. Donor coordination</td>
<td>Through donor coordination desks and meetings Through SWAp</td>
<td>Effective coordination through SWAp</td>
</tr>
</tbody>
</table>
concepts. As a result, donor coordination through the sector-wide approach and the creation of hospital and other statutory boards have been successful. Also in Uganda, the SWAp process has now taken off well at central level. It remains to be seen to what extent service providers in the districts, and ultimately the users, get involved as partners. Contrary to Zambia, the districts in Uganda have the entire responsibility for delivering the services.

The goal of any reform is to make an improvement in performance. In the health sector improvement is expected in the form of increased utilization of health services, better access to health services, more coverage of the population with basic services, better quality of health care and, ultimately, decline in the rate of illness and death.

An assessment of public sector reform objectives (Table 3) indicates that not much improvement has occurred in social services or in people’s quality of life during the period of the reform. Many indicators have either remained the same or have worsened. Table 3 summarizes some selected indicators of the health sector objectives. However, a step with capacity building may be a necessary priority

Table 3. The trend of health sector objectives in Uganda and Zambia over 20 years

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Infant mortality/1000</td>
<td>116</td>
<td>97</td>
<td>90</td>
<td>112</td>
</tr>
<tr>
<td>Life expectancy years (M = male; F = female)</td>
<td>M = 42/F = 42</td>
<td>M = 43/F = 43</td>
<td>49</td>
<td>M = 44/F = 45</td>
</tr>
<tr>
<td>Access to PHC care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care</td>
<td>49%</td>
<td>49%</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>Sanitation</td>
<td>42%</td>
<td>34%</td>
<td>Not available</td>
<td>23%</td>
</tr>
<tr>
<td>Safe water</td>
<td>60%</td>
<td>57%</td>
<td></td>
<td>43%</td>
</tr>
<tr>
<td>Equity of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of population below poverty line</td>
<td>55%</td>
<td>46%&lt;sup&gt;b&lt;/sup&gt;</td>
<td>68%</td>
<td>85%</td>
</tr>
<tr>
<td>Quality of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical</td>
<td>30% (Study)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Estimate 30%</td>
<td>Not available</td>
<td>Interviews indicate quality has worsened</td>
</tr>
<tr>
<td>Consumer satisfaction</td>
<td>30% (Study)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Estimate 30%</td>
<td>Not available</td>
<td>Estimate 3%</td>
</tr>
<tr>
<td>Sustainability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of GDP on health</td>
<td>1.6%</td>
<td>Estimate 3%&lt;sup&gt;c&lt;/sup&gt;</td>
<td>2.4%</td>
<td>Estimate 3%</td>
</tr>
<tr>
<td>% of Public spending on health</td>
<td>3-5%</td>
<td>9%</td>
<td>Not available</td>
<td>8%</td>
</tr>
</tbody>
</table>

for a limited period of time. What matters is whether this capacity building is put in the perspective of improved services that are demanded and accepted by the respective catchment population. Access to basic health services has also declined over the period of the reforms. The extent to which they conform to the minimum technical standards and the extent to which people are happy or satisfied with the services can assess the quality of health services. Neither aspect of quality has improved in Uganda (Jitta, 1998; Ocom, 1997). In Zambia, while there are no figures available, interviews indicated that both aspects of quality were declining. Both countries are heavily dependent on external support and there is not sufficient internal commitment of resources for the health sector. Therefore, the sustainability of services is still precarious.

Thus, the desired intermediate service outcomes have not yet been achieved. Deterioration of some health services has been linked to decentralization and related reforms. In both countries, concern has been raised over the effects of health reform on immunization (Feilden and Nielsen, 1998). By the time the decentralization process got underway, the decline in immunization coverage had been established. But this decline was not reversed even when decentralization enabled greater amounts of resources to be transferred to the districts. The paradoxical decline in the immunization coverage was partly due to management incompatibility between the vertical immunization programme and the new government structure at lower levels.

The other reasons for the declining immunization coverage—all related to decentralization—include the failure by districts to prioritize immunization, reduced support at the central level for supervision, and inadequate capacity to enforce national policies and regulations. In Zambia, the quality of health care has reportedly decreased, in spite of or perhaps because of extensive reform (Government of Uganda, 1998d).

Thus, while the two forms of decentralization are significantly different, neither has facilitated the attainment of health sector objectives. The major difference between decentralization in Uganda and Zambia is that in the former it is part of reforming the government as whole; in the latter, it is only in the health sector. In Uganda, the managerial, financial and administrative systems are being built on the government systems. As a consequence, health services are, to a large extent, integrated with the political system at the district level. Uganda offers substantial opportunities to involve political and administrative leaders in the local decision process over the health services at local level. These are opportunities that have, so far, not been used very much. Health is still seen, to a large extent, as a technical issue rather than a social or political one.

In Zambia, health services have been de-linked from the political and administrative set-up of the country, and parallel systems are being put in place. The political and administrative links with the communities are weaker than in Uganda. However, informal links between the health workers and the communities can also play a paramount role here. These are the type of links that are often seen in mission health facilities, where no formal control mechanisms exist, but where a basic trust in the facilities still prevails. Our strong impression is that such links are often very strong in Zambia in government facilities.

One of the paramount questions is the one of political legitimacy (Rothstein, 1998). The fact that the reforms have been promulgated in good democratic order
does not in itself suffice to achieve legitimacy. Other factors also need to be accomplished. Do the users accept the system? What are the mechanisms whereby the users can control the system? Improved quality of services can in itself result in an increased demand for services and legitimacy. This seems to be the major strategy in Zambia. In Uganda, the local government system is strong and provides a potential mechanism for the users to institutionalize the control of the services through various political bodies. Also in Zambia there are attempts to establish bodies with this effect. However, these possibilities are still largely under-utilized and remain a theoretical possibility not yet realized. Rather than focusing on the issue of legitimacy there has been an emphasis on producer-oriented efficiency. Basic packages and administrative reforms are some examples of this.

Each type of decentralization – vertical or holistic – has strengths and shortfalls. Vertical health sector decentralization in Zambia has the advantages of focusing on health problems and of putting health high on the political and macro-policy agenda. In both respects, Zambia’s reform has been useful. However, it is weak in integrating health into the overall socio-economic development, and in sustaining changes that are not rooted in the political and administrative structures of the government.

Uganda’s holistic decentralization offers opportunities to embed health locally as a political issue because health sector reforms are shaped to fit the wider political and economic reform. However, this has not yet been done to any large extent. It also provides more opportunities to expand the concept of health from a narrow biomedical one to a broad one that incorporates political, social and cultural elements. But it can easily lose focus on health problems and priorities. Faced with competing priorities in education, agriculture, infrastructure development, and trade and commerce, the government does not usually rate health high on the priority list as reflected in the budgets.

We find the Zambian arrangement with all members of statutory boards appointed personally by the minister questionable, since the arrangement retains considerable power not only at central level but also with an individual. In the long run this arrangement is an impediment to the empowerment of local communities and to the development goals overall.

CONCLUSION

Health sector reform and decentralization are instruments to improve services, but by themselves are not the ultimate objectives. Administrative, economic and political reforms will, in the long term, only be judged on the basis of whether or not the quality of life of the citizens has improved. Health sector reforms in particular will be judged on the basis of whether health services have improved.

We believe that while considerable experience has been gained in Zambia, health sector reforms are more likely to be sustainable in Uganda because they go beyond the sector and are rooted in the wider political and administrative structures of the government. Nevertheless, many reforms in Zambia, such as autonomy of hospitals, coordination of donors and district health financing, are effective innovations that can improve the management of health services.
In both countries, better management has so far been a focus rather than a means to improving services and, ultimately, people’s living conditions. The linkage between reforms and development objectives has not been clear or strong in the two countries. It is important to design and implement reforms with the explicit purpose of improving the living conditions of the poor.

One of the crucial issues is to ensure legitimacy of the health care system. This can be achieved through attractive services, demanded and accepted by the users, but also through political ownership. In order for this to happen, strategies have to be developed to create a demand for the services, and to ‘sell’ health services to the users, thereby offering them an influence over the services. So far both countries have to a large extent practised a push rather than pull system of the services, which is more sensitive to the views of the health professionals than to the users of the services.

REFERENCES


