Financial priorities under decentralization in Uganda

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This paper explores changes to budget allocations for health during the decentralization process in Uganda. When the districts were given the authority to allot their own budgets, allocations for health were reduced considerably. The rationale for this by district leaders is investigated and analyzed. Their criteria for budget allocations for health are often based on views different to those held at central level, hence there can be conflict between the two. The mechanisms instituted by central government in reaction to what was perceived as a lack of local support to the health sector are described. In conclusion, while conditional funding may be a useful short-term step, long-term development requires less conditionalities. Health professionals need to work closely with local leaders and district officials to make health a political priority in order to develop and allocate resources for health at local level.

Introduction

Decentralization of government in Uganda dates back to the war fought by the National Resistance Army (NRA) between 1981 and 1986 (Ksikaye 1996). During this war, its political wing, the National Resistance Movement (NRM), mobilized and politicized the people in the areas under its control. The NRM introduced a system of elected councils of governance at various local levels. The people were given the opportunity to elect leaders themselves, setting seeds for a democratization process and a civil society in a country that had witnessed years of civil strife. These councils came to be known as Resistance Councils. They had a great political importance, laying the foundation for a new local government system that came into place when the NRM attained power nationwide in 1986.

In 1992 the local government decentralization programme was introduced. Decentralization of the entire government in Uganda is just one area of public sector reform in Uganda. Other areas of reform initiated by the government include the civil service reorganization and restructuring, economic recovery programmes, privatization, army demobilization and constitutional reform.

The decentralization reforms included three components: political, administrative and financial (Villadsen 1996). Political decentralization was based on the Resistance Councils and was implemented throughout the country immediately after the NRM government was formed in 1986. Administrative decentralization was introduced after the adoption of the Local Government Statute (1993), and comprised new administrative structures with a non-subordinated, comprehensive and judicially answerable local administration. Financial decentralization was carried out in phases with the introduction of an unconditional block grant to the districts and through the introduction of locally decided budgets.

With the 1995 Constitution (Government of Uganda 1995), the local government system was consolidated further, and the Resistance Councils were renamed Local Councils (LCs). The consolidation process continued with the adoption of the Local Governments Act (1997). There are now two main political levels in the districts, the district proper (LC5) and the subcounty (LC3), which are both corporate bodies. Tax collection is the responsibility of the subcounty.

The decentralization and other reforms in the public sector, driven forward by political reasons, were largely opposed by the technocrats, who claimed it would not be possible to make such systems work (Okuonzi and Lubanga 1997).

Study background

The central government provides financial support to the districts through a block grant, with the purpose of covering non-wage activities. Preceding the introduction of block grants was a system of earmarked votes for different areas, including health, decided by the Ministry of Finance (this again was for non-wage activities). This vote system was replaced by the block grants in phases, and from financial year 1996/97, all districts received block grants. The block grant comprises funding that had previously been channelled through a number of ministries, of which health was one (Decentralization Secretariat 1994). In addition to the block grants, the Constitution (1995) provides for conditional grants. These conditional grants were introduced at an early stage of the decentralization process for education and feeder roads.

For the health sector, funds provided through the block grant were supposed to cover primary health care (defined as health care outside hospitals). The amount given in a block grant was in principle the amount of the previous earmarked votes for various areas lumped together. Hospitals still
received their delegated funds directly from the Ministry of Finance, but from financial year 1997/98 these funds have also been decentralized to the districts, earmarked for individual hospitals according to a formula developed by the Ministry of Health. There was concern from the central level that the districts might otherwise reallocate funds from what they might have perceived as over-funded hospitals.

One problem with the block grant is that there is little in-built incentive for districts to spend money on primary health care. As originally envisaged, the conditional grants (i.e. on education and feeder roads) would have been released only if and when the block grant had been spent on ways consistent with national priorities, including primary health care, but this was never applied.

Another problem is that, at the time of decentralization, salaries for staff on the payroll were a central responsibility (this has now been decentralized through a special conditional grant). In the past, professional staff were hired centrally and put on a national payroll; there were also local payrolls for locally employed staff. For the health sector, the locally employed cadres comprised mainly the nursing aides, a cadre that dominates the health sector in the rural areas and particularly in peripheral health units. These categories had previously been catered for through the Ministry of Local Government. Since they were not on the central payroll, their salaries and wages became the responsibility of the districts and had to be funded by either the block grant or locally raised revenue. This change created problems in many districts, and in many cases the non-professional staff were not paid for long periods of time. Many districts still have salary arrears that have not yet been cleared.

From the financial year 1993/94, the District Local Council has become the main budgetary unit in the district, and local governments are no longer required to forward their budgets to the central level. The budget process in the district now starts and ends in the District Local Council, involving all other levels in the process. So far, only the recurrent expenditure budget has been decentralized, but decentralization of the capital or development budget is currently being piloted in four districts.

At central level, a tension was obvious during the decentralization process between the key policy-making bodies: the Ministry of Local Government, in favour of decentralization but with very little capacity in technical issues; the Ministry of Health, in favour of maintaining the health services under its jurisdiction; and the Ministry of Finance, in favour of decentralization but also concerned with ensuring that national priorities were followed and that value for money was achieved.

From a health sector perspective, it is of interest to look at what priorities the districts made once they had the power to do so for a budget that, at least to some degree, was flexible and could be decided at district level. Was health actually a prioritized area? What justifications governed the district politicians in making their priorities?

Methods

District budgets from all districts of Uganda were studied with regard to the allocation for health.Allocations were also compared with the shadow budgets made by the Ministry of Finance. Interviews were held with officials from the Ministry of Finance and the Ministry of Local Government. Possible reasons for deviations from the shadow budget were discussed with senior civil servants and politicians in the districts. Resident District Commissioners, the district representatives of central government, were also interviewed. Ministry of Health officials conducted the informal interviews and discussions on an individual basis, during district visits over a period of 3 years. In addition, to further obtain precise arguments from district leaders, the author held three focus group discussions with mixed groups of administrators and politicians representing 14 districts. The groups consisted of 15, 8 and 6 individuals respectively from different parts of the country. Health professionals were excluded from the focus groups since the purpose was to extract the views of politicians and administrators.

The study draws on the local fiscal choice model (Musgrave and Musgrave 1989), which was developed to analyze choices made by local governments using their own revenue as well as transfers from higher levels of government. The model is based on the assumption that the preference of the local government is also the preference of the median local voter (Chubb 1985). This assumption implies an inherent conflict between the priorities made by the central government on one hand, and the priorities made by local decision-makers on the other.

Findings

When the vote system was abandoned and the block grant introduced, the Ministry of Finance made a shadow budget for financial year 1995/96 as a reference point to monitor the priorities and allocations made by the districts. The shadow budget was made with the assumption that funds would be prioritized by districts in the same way that they had previously been prioritized by the central government. In other words, the shadow budget was equivalent to the budget based on votes for various areas, health being one of them.

Against this background, the actual allocation for primary health care came as a surprise. While the shadow budget projected an overall allocation of 4 billion Ugandan shillings for primary health care in 1996/97, the district administrations allocated only 1.1 billion shillings, i.e. just over one-quarter of the shadow budget.1 The source of these allocations was the block grant provided by the Ministry of Finance and the locally raised revenue merged together. The pattern differed from one district to another, but the overall amount indicated a considerable discrepancy between the anticipated allocations by the Ministry of Finance and the actual prioritization of the districts. During the subsequent financial year, 1997/98, the overall allocation for primary health care made by the districts rose to 2.6 billion shillings. Although a considerable increase took place, actual allocations were still far from the level of the shadow budget of 1995/96 (Figure 1).
The allocation and actual expenditure pattern differed substantially between the districts. There were also districts that actually increased their allocations for health compared to the shadow budget projection. Comparing the actual expenditures on health drawn from the block grant and locally raised revenue in the districts for the financial year 1997/98 with the original shadow budget, the proportion ranged from 27 to 390% (Figure 2).

The outlier representing 390% is actually the smallest district in Uganda, and the total amount allocated for health was not large as such, but still represented a political commitment to health. From the examples so far, it is difficult to find any clear relationship between the allocations for health on one side and issues like revenue raising capacity, availability of donor funds or political commitment on the other.

It was obvious that the actual financial priorities made by the districts deviated from the political ones held by the central government, and that in this case decentralization did not automatically bring more resources for the local health sector. The fact that allocations for primary health care decreased in most districts prompted the central government to institute a conditional primary health care grant, which came into effect in 1997/98. It channelled resources for non-salary expenditures to the districts. Starting with 1.7 billion Ugandan shillings in 1997/98, the overall amount of the conditional primary health grant rose to 6.4 billion shillings in 1998/99 and remained at a similar level in 1999/2000 (Bergman and Claesson 1998). This was generally seen by the districts as an increase in control from central government, since the districts have no power to allocate these funds to other sectors. However, the grant was additional, and the overall amount available to the districts has gone up considerably.

This conflict illustrates not only the different views on priorities held by the central and the local governments, but also the different views on how to reach common development goals. Central line ministries tend to favour their own technical area of responsibility, whereas the local authorities have the overall responsibility for all sectors within the district and have to maintain a balance between different priority areas. During recent years, a major proportion has been allocated for the establishment of so-called health subdistricts, which in practice has meant mini-hospitals with a focus on curative services. A number of case reports suggest that the availability and quality of services have improved at this level.

![Figure 1. Comparison of actual expenditures and shadow budget for primary health care in Ugandan districts](image1)

![Figure 2. Actual allocation 1997/98 as a percentage of shadow budget 1995/96 for primary health care](image2)
What criteria were the districts following when making their priorities? According to information obtained from the informal interviews and focus group discussions, the districts’ rationale can be summarized under the following categories, in the order of importance as perceived by the interviewees: insufficient local revenue, lack of funding from the central government, expenses too high, lack of ownership, other sectors also contributing to health and the existence of donor funds available for health.

Insufficient local revenue
Graduated tax – a flat amount paid annually by all adult citizens – is the major source of income in the districts. It has two main problems. First, it is not a cost-effective way to collect revenue, with some 50% being spent on cost-recovery. Secondly, calamities, like fish poisoning in some districts surrounding Lake Victoria, insurgency in the north, drought in the west, all cause difficulties for people in paying tax. Market tax has also been difficult to raise in war-prone areas. Furthermore, politicians have not been too responsible during the elections: campaigning politicians have encouraged voters not to pay tax. This has caused continuous problems in raising tax since the elections for the Constituent Assembly in 1995 and throughout a number of subsequent election campaigns.

The political and administrative set-up with locally employed civil servants and full-time politicians is also expensive. These costs have to be covered by the districts.

Lack of funding from central government
When decentralization was implemented, the funds made available to the districts were insufficient to carry out the responsibilities transferred to the district. In addition, the central government has made new commitments, such as universal primary education, feeder roads and agricultural innovations, which the districts have to implement. This has created a gap between the expected tasks and the means to fund them. In fact, there was a built-in budget deficit in the decentralization process. Central government now allocates 17% of the overall central budget to the districts, which is considered insufficient by the districts.

The districts had more funds before decentralization, although the power to decide over them remained with the central government. Not only did decentralization lead to decreased funds, it also meant that the subcounties could now retain 65% of the revenue they managed to collect. The district level can no longer influence how these funds are used.

During decentralization, funds for salaries were covered by the central government. However, a number of health workers were recruited locally and were consequently not on the central payroll. One such cadre was the nursing aides, who have generally been trained on the job and now constitute the backbone of the health services in the rural areas. Their salaries were to be paid by the district or the subcounty, and since local revenue was not enough, funds had to be taken from the block grant to pay their salaries.

The districts have all along been facing a lack of flexible funds. The block grant was one of the few sources of funding which they had the power to distribute.

Expenses are high
Salaries and wages are given high priority by the districts, and they form the major part of the overall budget. Health is a demanding and expensive sector: ‘With other sectors you do something little, and it is very visible. If you consider the amount spent on health it is billions and billions, and what is the result?’ (district politician in a focus group). District officials commonly feel that it is more difficult to satisfy the needs in the health sector than in any other.

Lack of ownership
The politicians often feel left out, even excluded, from health care planning. Health care is a highly technical issue, dealt with by experts. Traditionally, the medical community has closer links with the Ministry of Health than with the local authorities: ‘You see a new Pajero or Landcruiser stopping in front of the DMO’s office. Somebody leaves the vehicle and enters the office. After 2 hours this somebody gets into the car and leaves. We don’t know who it was or why he came to the district’ (district politician).

The district leaders feel they are left out of such interaction and communication, which is often held at a very technical level. They feel that the Ministry of Health has not yet accepted the Local Government Act as it is still often involved in micromanagement at district level. Furthermore, district leaders have a sense of ignorance about health care issues, and they state that it is difficult to prioritize areas that they are not familiar with.

Other sectors also contribute to health
District leaders expressed the view that sectors other than health are also important to health and to the health sector. For instance, people need education in order to improve their health. They also need roads for easy transport when they are sick. Health cannot be obtained in isolation from other sectors, and funding should therefore be looked at from an integrated and holistic perspective.

Existence of donor funds
It was commonly expressed that the health sector is relatively well funded. Many donors have made commitments to the health sector. If the districts were to contribute more resources to health, it was felt that they would ‘end up giving those who already have from the little that is left in the basket’.

The way forward
Most district leaders do not believe that there would be any major problems with sustainability should donors cease funding the district health sector. In such a scenario, new priorities would have to be made. There seems to be consensus
that the main way forward is to widen the local revenue base by introducing new revenue sources, for instance property tax. There is also a very strong consensus that decentralization is an important and positive step. The districts are not in favour of interventions that limit their power over resources, such as conditional grants.

Discussion

Most of the opinions presented above were shared between politicians and administrators. There was a tendency, however, of the administrator to focus more on the technical problems, like the difficulties in raising local revenue and the increasing costs from employing more full-time politicians in the districts. The politicians emphasized to a lesser extent overall allocation priorities and, in their view, the insufficient collaboration between politicians and health professionals.

There is a belief among proponents of health sector decentralization that decentralization leads to more resources in the health sector, and more power over them by the local community and by local authorities. This may be true if the health sector alone is decentralized, but this is not the case in Uganda, where the whole government has been decentralized. No such automatic cause–effect mechanism is in place. The de facto financial priorities made by the district leaders are different from the political ones declared by Ministry of Health officials. This does not mean that the theoretical priorities are different; the conflict seems rather to lie in the way to achieve them. Furthermore, it seems obvious that decentralization per se will not create more resources for primary health care.

The justification given by district leaders for prioritizing areas other than health seem logical from the district leaders’ point of view. Health was not given lower priority because people believed it was not important. The views of the district leaders on health issues were often more holistic than those expressed by officials from the Ministry of Health, who often lacked a multi-sectoral approach to health care interventions altogether. Several other sectors contribute to the health and well-being of the population, such as roads, agriculture and education. These areas are, however, not catered for in the health budget as such. Further, there was disbelief from both the politicians and the administrators on the usefulness of the considerable resources spent on hospitals.

The view held by district leaders is, in fact, an expression of one of the true rationales behind decentralization: increased responsiveness to local needs (Smith 1985). In prioritizing areas for development, needs other than health were identified and responded to. Another problem may be inherent in this reasoning, namely, to a certain extent, overoptimistic assumptions about revenue collections. Many would argue that the level of funding was less of a problem than was the actual capacity of the districts to absorb and use the funds effectively. The Ministry of Finance was reportedly open to the idea of providing more funds for the health sector and encouraged the Ministry of Health to provide ideas and programmes to support. The Ministry of Health, on the other side, claimed that the Ministry of Finance still eventually reduced allocations for health.

According to the Local Fiscal Choice model, local politics and accountability by local leaders to the local population are important issues when priorities are made. Such priorities may deviate significantly from the ones made at central level, especially when individual line ministries make the priorities. The model helps to explain the logical reasoning behind local priorities which may deviate from policies made at central level. This is further illustrated by the examples provided through the interviews. However, while this model explains the origins of the conflict, it does not suggest how such conflicts should be overcome. While health is likely to be a priority for an average voter, the district leaders held the view that the issue was largely catered for through other sources of funding and did not warrant substantial local funds. The small amounts actually allocated could be seen rather as a means to fill minor gaps.

One critical issue is the sustainability of health care. If health care is to be developed with a decreased dependency on donors, local allocations are crucial. It may be difficult to reallocate funds abruptly when needed. Such abrupt changes are also likely to affect other sectors negatively, and new priorities would have to be made without much time to reach a political consensus.

Government spending on primary health care is also relatively insignificant in terms of overall spending. During the financial year 1997/98, donors contributed to 87% of the actual spending on primary health care (salaries excluded), whereas the government contributed with the remainder (Ministry of Health 1998). Most donor funds are earmarked for specific activities, so the block grant and the conditional primary health care grant have represented the only relatively flexible sources of funding available to the districts. Donors are now starting to fund this conditional grant directly, which is likely to increase the flexibility of its use as long as the funds are used for health and not for other sectors.

The institution of the conditional grant for primary health care increased the total amount that the districts could spend on health care, but at the expense of a decreased flexibility for the districts in the way they could use their funds. The question now being debated is whether this was an inappropriate recentralization or whether it was a legitimate fine tuning, putting in place mechanisms which should have been there at the outset.

Conclusions

Decentralized power over budgets does not automatically provide more resources for the health sector, not even if health is an agreed political priority. District leaders perceive the health sector as one sector among others in a wider context. Budget priorities are made according to an appreciation of the health sector as well as the resources available for health and other sectors within the respective districts. One
obstacle against making the available funds meet the needs has, to a large extent, been over-ambitious plans and budgets made by the districts and an overoptimistic view of the revenue base. A second, inherent problem in the district has been a lack of actual capacity to utilize the funds available.

In Uganda, the low degree of funding from the districts actually prompted a major increase in funds for health from central government, although restricted by conditionalities. During the first years of the conditional primary health care grant, a priority was construction and expansion of physical structure. The long-term effect on the health services, however, still remains to be established.

Temporary conditionalities on resources from the central level may be useful to ensure resources for priority areas like health in the short term. However, such conditionalities on finances contradict the intention of political decentralization, namely to empower lower levels to set their own priorities. Earmarked funds, which still dominate the sources for primary health care, imply less involvement by local decision-makers, and thereby tend to keep health as a vertical and isolated technical issue.

Long-term development requires a minimum of conditionalities over the implementing level, in the case of Uganda, over the districts. Sufficient funds have to be ensured through other means, such as involving the politicians and administrators in the planning process and by instituting incentive mechanisms rather than restrictions. It is therefore important that the health sector, at all levels, works closely with district politicians, officials and other leaders in order to ensure long-term, sustainable development of the health sector. To make this happen, it would also be useful to define health in a wider context, and thereby make it a political topic, not just a biomedical or physiological one. Health should therefore be dealt with in a discourse that district leaders and lay people can understand.

Endnote

1 At the beginning of financial year 1996/97 1 US$ = approximately 1100 Ugandan Shillings (Ministry of Finance and Economic Planning).

References


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Biography

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