The Health Sector in Uganda: Making a Case for Political Economy Analysis

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Abstract

Health is a critical sector on Uganda's socio-economic development agenda. However, politicians and technocrats have frequently focused on the health sector mainly from the political and technical perspectives, respectively yet the achievement of the objectives of the health sector are dependent on political economy factors. Indeed, the reform of the health sector should be premised on a clear understanding, analysis and management of how the political economy influences and shapes the occurrence of the reform process. This paper argues for the recognition of the political economy analysis (PEA) to effectively manage the country's health policy and its change process. It should also be integrated into technical analysis to strengthen the effective coordination of national health mechanisms.

Key Words: health sector reform, political economy, and PEA.

Introduction

The health sector is critical to Uganda's socio-economic development agenda. Unfortunately, politicians and technocrats have frequently focused on the health sector from the political and technical perspectives, respectively. Yet, achieving the health sector's objectives are dependent on political economy factors. Indeed, health policy reform hinges on a clear understanding, analysis and management of how political economy influences whatever occurs in the reform process.

This paper argues that in Uganda, policymakers and implementers in the health sector do not understand the political economic analysis (PEA) of health. Therefore, the paper seeks to help policymakers and implementers to appreciate the PEA, to manage health policy and its change process effectively, and to have it integrated into technical analysis to strengthen the effective coordination of national health mechanisms.

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The paper will address this discourse by: defining PEA of health; discussing the three analytical frameworks of the political economy of health; highlighting the main challenge associated with PEA; and suggesting remedies to the challenge.

Explaining the PEA of Health

Political economy is the study of politics and economics, particularly the interactions between them and their consequences for specific outcomes of interest.[2] It focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes.[3] Staniland (Handelman 1996, pp. 216-7) defines the field of political economy as the study of how politics determines aspects of the economy, and how economic institutions determine the political process and the dynamic interaction between the two forces.

The PEA of health refers to a body of analysis and a perspective on health policy which seeks to understand the conditions which shape population health and health service development within the wider macro-economic and political contexts.[4] Applied PEA supports policy processes in three ways. It:

- Generates an assessment of the political landscape, including a stakeholder map, an assessment of power and position of key political actors, and an estimate of political feasibility for policy change;
- Focuses attention on how political strategies shape the feasibility of a policy reform and on the importance of politically managing the change process; and
- Underlines the role of political economy factors throughout the policy cycle, including agenda setting, policy design, adoption, implementation, and monitoring and evaluation (M&E).

[2] Reich Michael R. (2019), p. 513.
[3] Ibid., p. 513.
[4] Fieno et. al. (2016), p. 14.

The political landscape of health

Politically, Uganda is a presidential republic in which the President is both the Head of State and Head of Government. She is characterized as a hybrid regime (Tripp 2010). Tripp (Ibid) notes that a hybrid regime embodies two divergent impulses: one, it promotes civil rights and political liberties, and yet, two, it unpredictably curtails those same rights and liberties.[5]

In terms of realpolitik,[6] Uganda is practicing multiparty politics with periodic elections being held.[7] Constitutionally, executive power is exercised by the government. Legislative power is bestowed upon both the Government and the Parliament.

Since 1986, the NRM Government has introduced several structural reforms, which have contributed to high growth and poverty reduction (1987-2010) – a situation which has greatly been affected by Covid-19. This reform is similar to those in other countries.[8]

With the introduction of ambitious public sector[9] and Public Finance Management (PFM) reforms supported by Development Partners, government effectiveness has improved and is relatively high – Uganda has a Country Policy and Institutional Assessment (CPIA) score of 3.6 compared with an average score of 3.1 in sub-Saharan Africa (SSA).[10]

However, the reform process has slowed down. The country's voice and accountability scores, which had improved by 2008, have also recently declined. Implementation gaps in procurement

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[5] Tripp (2010, p. 1) notes that hybrid regimes in Africa, Uganda inclusive, "… are situated at a crossroads between democratization and authoritarianism, rarely if ever reverting to full-blown authoritarianism of the kind we saw during Idi Amin's rule in Uganda – but rarely transitioning fully to democracy either."

[6] Realpolitik, a word coined in 1914 and originates directly from German which literally means "practical politics", is a system of politics or principles based on practical rather than moral or ideological considerations. It is a political system that is not based on beliefs, doctrines, ethics, or morals, but rather on realistic, practical ideas. It is a form of politics based on the needs of the state.

[7] In the movement political system, political parties continued to exist but could not campaign in elections or field candidates directly (although electoral candidates could belong to political parties).

[8] Nickson Andrew (2006), p. 25.

[9] Shaw R. Paul (2004), pp. 4-7.

[10] UNICEF (2018).

and anti-corruption struggles are still problematic. Nevertheless, policy and legal frameworks continue to improve, notably through the PFM Act (2015).

Furthermore, the NRM Government has devised ways to revamp the deteriorated health sector and other social services.[11] All Hospitals and Health Centres in the country, which total around 700, were rehabilitated, provided with vaccination stores and equipment, and staff members have been trained to offer routine vaccination.[12] On 25th January 1987, President Museveni officially re-launched the Uganda National Expanded Immunization Program at Entebbe.[13]

The implementation of the health sector reform was to be effected by the different health sector actors. Uganda's stakeholder map is impressive.[14] Briefly, her health system is composed of health services delivered to the citizens by the public sector, private providers and traditional and complementary health practitioners. It also includes community-based health care and health promotion activities.

Power and position of key political actors is a critical factor under the political landscape of health. In governance terms, the MoH is currently implementing the HSSIP, which is the third iteration of health sector strategies. Specifically, the MoH coordinates stakeholders and is responsible for planning, budgeting, policy formulation and regulation.

The health sector at the district and sub-district levels is governed by the District Health Management Team (DHMT). The DHMT is led by the District Health Officer (DHO) and consists of managers of various health Departments in the district.

The Heads of Health Sub-districts (HSDs) (i.e., Health Centre IV managers) are included on the DHMT. The DHMT is responsible for overseeing the implementation of health services in the district, and ensuring coherence with national policies. A Health Unit Management Committee

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[11] Mbonye Anthony K. (2018), p. 97.

[12] A cadre of super-trainers was developed and they carried out a massive training campaign to build capacity in districts (Ibid, p. 99).

[13] Ibid, p. 100.

[14] Their Reports assist in the production of National Health Accounts (NHA) (Government of Uganda 2010).

(HUMC), composed of health staff, civil society, and community leaders, is charged with linking health facility governance with community needs.

Political strategies shaping the feasibility of policy reform

Political feasibility for policy change is a crucial PEA factor. Recognizing the failure-prone nature of the health system, the GoU initiated a comprehensive health sector reform.[15]

A Sector-Wide Approach (SWAp) was introduced in 2001 to consolidate health financing. In the same year, another demand-driven reform was introduced which abolished user-fees at public health facilities, which triggered a surge in outpatient attendances across the country.

In the mid-1990s, decentralization of health services commenced alongside wider devolution of all public administration.[16] Because Local Governments (LGs) are closer to the local people, they were seen as being in a better position than higher-level governments to develop innovative, creative and cost-effective methods for providing public services.[17] Bloom[18] notes that:

> A health service is a … complex structure consisting of a large number of individual facilities and specialized programmes … As the focus shifts towards establishing sustainable services and raising standards, success becomes increasingly dependent on the capacity of local services to plan and organize their own activities.

Uganda's decentralized health sector was sealed in 1998 with the definition of the (HSD), which extended into the early 2000s. Murindwa et. al. (2006, p. 97) note that "in the National Health Policy and the Health Sector Strategic Plan (2000/01-2004-5), the sector has sought to decentralize health services even further by creating lower level management structures at a sub-district and county…"

[15] Yates Rob et. al. (2006).
[16] Reschovsky Andrew (2000), p. 148.
[17] Ibid., p. 148.
[18] Bloom Gerald H., op. cit., p. 227.

Although decentralization was meant to transfer power and authority from the MoH to LGs to manage the health facilities, the situation in the districts is the opposite because the local populace does not fully own the decentralized health sector. In Bushenyi district, for example, Asiimwe (2011, pp. 168-9) noted that:

> … local people are expected to embrace the system and own programs and projects and have a say in the decision making process. However, this has not been the case. The donations got have not been well looked after. There are no budgets made for repairs and renovations, especially at the sub-county level where the budget is very small and has to cater for veterinary, agriculture, health, forestry, education and management services…

Thus, in 1999, Mbonye (2018, pp. 117-118) argued that the NRM Government diagnosed the problem by recognizing that poverty was the underlying cause of the poor health situation in the country and its associated factors.

He further noted that this diagnosis led to the enactment of the then Poverty Alleviation Action Plan (PEAP)[19] which was succeeded by the National Development Plan (NDP).[20] He adds that after PEAP, the GoU developed the National Health Policy (1999) whose main focus underscored the diversification of health financing in support of the national goals of improving the status and equity of health in the country.

In 2010, the review of the National Health Policy led to a number of reforms. The net effect of the reforms saw an improvement in all four key functions of the health system as defined by WHO, namely: stewardship; service delivery; resource generation; and financing.[21]

Political economy of policy cycle

[19] PEAP emphasized the modernization of agriculture, improvement of rural infrastructure, development of marketing opportunities, Universal Primary Education (UPE), Primary Health Care (PHC), and Water and Sanitation, among others.
[20] Today, the GoU is developing NDP III which mainly emphasizes industrialization and wealth creation. It is a successor to NDP I and NDP II.
[21] Yates Rob et. al., op. cit., pp. 17-18.

The importance of politically managing the change process in the health sector is another critical PEA factor. The PEA plays a crucial role throughout the health policy cycle. These factors impinge on agenda setting, policy design, policy adoption, policy legitimation, policy implementation and policy evaluation.

Agenda setting is the process that decision-makers use in selecting issues they think the government should address.[22] Politically, agenda setting is the redistribution of scarce economic resources on the basis of values – i.e., ideas, issues, policies and actors compete with each other.

Furthermore, agenda setting is often seen as the process through which social, economic, environmental and political problems attract the attention of government officials to desire a resolution of the problem through legislation or other instruments.[23] Thus, the activities are politics *par excellence* where the context, resources and interests of some groups are treated as the 'general interests'.[24]

Kalu (2004, p. 70) asserts that:

> … the fundamental question of practical politics is the competence of the actors that determine both the possibilities and the actual events of public policy.

Indeed, within the structure of constitutional government, the prioritization of health policy becomes an outcome of debates, bargaining, consensus and compromise between competing interests within and outside governmental institutions.

In Uganda, the fundamental objective of the national health policy is not clearly defined. If good health is the paramount objective, then preventive efforts to change people's personal behavior (i.e., habits and lifestyles) are more likely to improve health than anything else.[25]

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[22] Kalu Kelechi A. (2004), p. 70.
[23] Ibid, p. 71.
[24] Ibid, p. 71.
[25] Dye Thomas R. (1995), p. 149.

The implementation of Uganda's national health policy objective is characterized by many sub-objectives being implemented at the same time amidst insufficient resources.

The second stage is policy design. This involves the effort to more or less systematically develop efficient and effective policies through the application of knowledge about policy means gained from experience, and reason, to the development and adoption of courses of action that are likely to succeed in attaining their desired goals or aims within specific policy contexts. Therefore, designing policies involves identifying goals and selecting policy instruments with which the goals can be reached.

Designing a policy is also about policy formulation. The policy formulation process commences with collecting evidence through extensive study.[26] After the problem has been identified, it is isolated and policy issues are generated around it through a rigorous process of situational analysis.

In Uganda, the stakeholders [i.e., health professionals like doctors, pharmacists and nurses, health planners, health researchers, community members who are the consumers of health services, Development Partners, World Health Organization (WHO), MoH], are responsible for formulating and designing health policies. However, a number of policy contents – i.e., the design of appropriate interventions that are specified for each course of action as defined by the politics of the day[27] - and outcomes are sometimes driven more by the interests of the key health actors.

This is because they ensure that the interventions in the health policy content must agree with politics obtaining in the country at the time of its formulation. Unfortunately, some health policies gravitate towards personal gain rather than improving on societal welfare.

The other stage in the policy cycle is policy adoption. Policy adoption is a phase of the policy process in which policies are adopted by government bodies for future implementation. Adoption can be affected by the same factors that influence what issues move into the earlier phase of agenda setting.

[26] Matsiko Charles W. B. (2009), pp. 34-35.
[27] Ibid, p. 35.

In Uganda, powerful politicians, e.g., ministers, use their political influence to determine the aspects of the health policy that are adopted. It is unfathomable that officials at the local level (e.g., districts) can cause the adoption of health policies to bring about change. It is the Presidency and Parliament that are central institutions responsible for health policy adoption.

Another stage in the policy cycle is policy legitimation. Policy legitimation is where the Parliament will support or reject the policy in ways consistent with promises made to relevant constituencies and their goals.[28] Most of the discussions at the agenda setting stage are between representatives of different institutions within the government and different professional associations as well as NGOs.

At the legitimation stage, depending on the degree of the citizens' political efficacy and if the issue appears to have a wide appeal, citizens will mount pressure on representatives to vote for or against the policy. In addition, the interests of the governing elites are more likely to be emphasized, especially if such interests are inconsistent with those of the citizenry.

Unfortunately, in Uganda, there is a disconnection between what takes place in Parliament regarding whether or not promises were made on various policies. Frequently, elections of political parties and their leaders are largely influenced by personalities rather than policies. So, the discussions on health policy become the responsibility of the political leadership and senior government officials in the MoH. This is not to say that nothing really happens in the parliament but it does not correlate with what people indeed expect regarding decisions related to health matters.

Furthermore, the involvement of citizens in policy formulation through their Councilors at the lower levels is largely a routine exercise because they, too, exert minimal influence on national health policy thus weakening the very essence of the decentralization policy.

[28] Dye Thomas R., op. cit., p. 71

Yet another stage in the policy cycle which is central to PEA is policy implementation. Implementation is the continuation of politics by other means.[29] In the health sector, policy implementation determines the severity and impact of the policy. The extent to which the health policy receives support depends on the resources and the level of organization the beneficiaries of such a policy have in support of their goals.

In Uganda, although policies belong to the citizens, politicians, the President and the Cabinet are the designated custodians. Technocrats perform the role of implementation. They are led by the Permanent Secretary (PS) of the MoH. Together with the technical team, the PS champions the process of ensuring that the policy works through the development, monitoring and supervision of the Plans of Action, with the support of the citizens who are the owners.

At the District level, the District Development Plan (DDP) Committee serves as a reference point for the implementation and M&E of the activities and utilization of funds. The DDP is linked to the national strategic plan and the national health policy by clearly identified priority development programs to be implemented at the district level.[30]

However, instead of following the above laid out policy implementation process, the manner in which the policy agenda is set on health issues is often *ad hoc* and elite-based which is promoted as ‘public interest’. The relationship between the Central Government and LGs on health issues are largely those that have been approved by the ruling elite and driven by the presidency through the MoH. The practical politics characterized by bargaining, consensus and compromise is usually minimal.

Hence, understanding Uganda’s health policy requires a clear knowledge of individual actors, their interests and beliefs about existing institutions and rules.

Furthermore, in Uganda’s political environment, matters of social justice in areas like health are vividly ignored until a crisis occurs. Even then, this crisis is forced on the public policy agenda by

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[29] Ibid, p. 311.
[30] Matsiko Charles W. B., op. cit., p. 57.

other actors such as NGOs and the media whose existence depends on bringing health issues to public debate. However, how well health debates are followed by an actual policy and resolution is largely consistent with the interests of the governing elite.

The failure to adhere to an established health policy framework has created opportunities for mismanagement of public resources. The mechanism for holding health officials accountable for their roles in government are flouted with impunity.

The last stage in the policy cycle is policy M&E. Policy monitoring is a process by which stakeholders follow and assess policies to ensure they are developed, endorsed, enacted, and implemented as intended.

Matsiko (2009, p. 71) correctly states that:

> Policy is monitored using monitoring tools that should be included in the documents at the time of developing plans and action.

Further, the policy monitoring framework contains tools with indicators[31] of performance, benchmarks,[32] 'means of verification'[33] and timeframes which are stated as numbers, proportions or percentages.

Policy evaluation is learning about the consequences of public policy.[34] It is the assessment of the overall effectiveness of a national program in meeting its objectives, or assessment of the relative effectiveness of two or more programs in meeting common objectives.[35]

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[31] Indicators may be defined by inputs, processes, outputs or outcomes depending on what needs to be measured and the policy implementation stage.
[32] Benchmarks define standards, yardsticks, levels, targets or points of reference for a given programme.
[33] 'Means of verification' may be defined as ways of establishing progress. They give an explanation of the method used to confirm that an activity has taken place. These are usually qualitative and may include: commissioning of studies; conducting support supervision; commissioning reviews; carrying out assessments; and producing reports.
[34] Dye Thomas R., op. cit., pp. 320-321.
[35] Ibid., p. 321.

The Health Management Information System (HMIS) managed by the MoH, is the main source of data for M&E.[36] However, it needs to be strengthened through filling in the human resource vacancies, in-service training, and providing both software and hardware.

In addition, the monitoring framework and supervision face several challenges. Murindwa et. al. (op. cit., p. 106) note that:

> … all levels of the health sector need to internalize the importance of appropriate performance assessment in order to guide decision-making and achieve more efficient use of resources to improve service delivery.

In spite of Uganda's health policy being monitored and evaluated by stakeholders in the health care system, it lacks customer or client satisfaction and creating the change process – i.e., policy, operation and implementation - that is desired, for a number of reasons.

First, with regard to market penetration, in spite of the improvements that have been registered, generally, the health deliverables (products and services) are not getting through to the poorest.[37] Community information available in village registers in Health Centres, Parish and Sub-county Development Committees show the inadequacy of health goods and services.

Second, as regards customer satisfaction, the objectives that the health sector seeks to achieve are not as credible to the citizens as it should be. The political actors, particularly Councilors, do not perform their role effectively with regard to monitoring the performance of the Health Centres, especially regarding the extent to which the services actually reach the beneficiaries. Yet, one of the roles of the Councilors is to monitor – through weekly surveillance and quarterly, bi-annual or annual monitoring - to ascertain that medicines which were procured have reached the designated Health Centre in the right quantities.

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[36] Government of Uganda (2010).
[37] Ssengooba Freddie et. al. (2006), p. 109.

Consequently, Councilors, as watchdogs, have failed in holding policy implementers accountable for their actions or inactions. Even some government technocrats, who are expected to monitor the performance of the health policy through a formally established monitoring system of objectives and performance indicators, have failed to do so. In the end, the poor suffer most as a result of this malfeasance.[38]

Third, as regards policy, operation and implementation of change, the knowledge which is provided by those involved in the monitoring exercise does not help much in altering the way the policy is (re)designed, organized and implemented. Indeed, once the policy has been implemented, the quantity and quality of outputs resulting from the policy action does not satisfy the poor.

The challenge and remedy of using PEA

The major challenge of using the PEA is to provide a robust method of analysis that is easily learned and applied by practitioners to generate usable knowledge and assist in policy decisions and effective implementation.[39] This challenge can be solved in three main ways (Reich 2016).

- There is a need to advance PEA in the health sector through specific actions;
- Health bodies should give systematic attention to PEA and factors on health policy reform, e.g., in health financing; and
- Hiring of more staff with training and experience in applied political economy who are capable of giving practical guidance to the MoH and health facilities at the local level on how to incorporate it to improve public health.

Conclusion

The PEA is critical in the effective analysis and management of health policy and change process in Uganda. It needs to be integrated into technical analysis to strengthen the coordination of national health mechanisms.

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[38] Tashobya Christine Kirunga et. al. (2006), p. 57.
[39] Reich Michael R., op. cit., p. 514.

The PEA supports the health policy in three ways. Hence, the PEA can enable Uganda's health sector to make better use of knowledge concerning politics, power and political analysis to improve the effectiveness of the health policy process.

Health stakeholders from the public and private organizations, civil society and Development Partners are critical in health services delivery to the citizenry. However, they will have to use the PEA to do so.

Finally, the major challenge of using the PEA is to provide a robust method of analysis that is easily learned and applied by practitioners to generate usable knowledge and assist in policy decisions and effective implementation.

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