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Primary Health Care Services Delivery (PHCSD) Under Revenue Autonomy: Proposed Innovative Options Within Own Source Revenue

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Abstract
Through quantitative and qualitative account (mixed explanatory method), this empirical investigation portrayed a pragmatic perspective of the primary health care services in Mbale District, Uganda under the fiscal decentralization with revenue autonomy in particular. The evidence based data were elicited from the respondents selected through purposive sampling utilizing a researcher devised research tool tested scientifically for its validity and reliability. Quantitative measurements consisted of means and standard deviations elucidated by qualitative data from observations and interviews. The constructs of primary health care services under study were as follows: public education, maternal and child health care, proper nutrition, provision of accessible treatment and drugs, clean water and sanitation, immunization and local diseases control, accountability in service delivery. The general findings revealed existing challenges and gaps in these indicators. Therefore, this study advocated the need for improvement of health services delivery outcomes in rural and remote communities through improved access to health services while this study also recommended that progress can be made by reflecting on enhancing service access through the wider implementation of innovative options proposed in this study.

Key words: Innovative options, primary health care services delivery, revenue autonomy

1. Introduction

This empirical investigation embarked on the prevailing scenario in Mbale District Uganda related to the primary health care services under revenue autonomy. Based on the findings, innovative options for generating own source revenue was underscored to address the challenging issues derived from the evidence-based data.

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The autonomy of sub-national governments and division of functions by level cannot be sustained not unless there is empowerment for appropriate primary health care services delivery. The health sector was expected to report improvement 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 healthcare and ultimately, a decline in the rate of illnesses and deaths (Jeppson, 2000). In order to meet those expectations, major investments have been made in physical infrastructures such as the construction of health centers and the introduction of a general increment in the level of financing for the sector (Ministry of Health, 2013). Despite improvement efforts and expectations,(1) recurrent budgets under the primary health care grants have gaps; (2) the health sector in all the districts health center have performance challenges with conspicuous issues in the aspects of staffing, availability of drugs and equipment, absenteeism of health workers and accountability mechanisms (ACODE, 2014).

2. Review of Related Literature

2.1 Revenue Autonomy within Fiscal Decentralization

Okidi and Guloba (2006) spelled out that Uganda's fiscal decentralization system empowers local governments to access revenues for adequate financing for devolved responsibilities. The local governments execute their functions using resources transferred from the center, mobilized locally, and directly received from donors. Fiscal decentralization comes in these forms of grants (conditional, unconditional and equalization grants). The conditional grants (about 80 percent of transfers from the center) largely comprise the Poverty Action Fund, which is to be spent on centrally determined priorities (Kamugisha, 2014).

Fiscal decentralization is an issue of considerable practical importance facing many developing economies and has been championed by international bodies such as the World Bank and the Organization for Economic Cooperation and Development (World Bank, 2003). Some writers describe the term fiscal decentralization as *central-local* (or inter-governmental), *fiscal relations* by European writers and *fiscal federation* by American writers. Intergovernmental fiscal relations focus on the fundamental problem of allocating expenditure and revenue responsibilities among levels of government (Shah, 1994). It also refers to the devolution of authority for public finances and the delivery of governments services from the national to sub-national levels (Tanzi, 1996). The conceptual framework of fiscal decentralization is well established, drawing largely on the contributions by Stigler (1957), Musgrave (1959), Oates (1972) and Brennan and Buchanan (1980). The core logic is based on the premise that, one should be concerned about efficiency-supplying services if growth and poverty issues are to be taken into account and the welfare benefit to society matches its cost (Ebel &Yilmaz, 2002).

Under Uganda's decentralization, local governments are expected to finance 10 percent of their budget and to fulfill their obligations; they exercise devolved powers to raise revenue locally from cities, municipalities, town councils and rural areas. In the rural areas, local government revenue is collected by sub-county officials, who retain 65 percent of the revenue (for local administrative expenditures) and remit the rest to their local government headquarters (Okidi and Guloba, 2006). The allocation of income sources refers to the

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distribution of fiscal resources among the different levels of government. It ensures sub-national autonomy, promotes accountability and ownership, realizes decentralization efficiency gains and facilitates cash flow management (Ebel & Yilmaz, 2002). The *revenue potential economic efficiency* (revenue instruments structured to minimize economic distortions in investments, production, consumption and local decisions) is a basic principle in allocating revenue sources (Ebel & Yilmaz, 2002). A weak revenue administration, is a primary obstacle to successful sub-national revenue mobilization (Boex and Martinez, 2005) where the problems range from lack of citizen credibility, lack of political will, enforcement is practically non-existent, and the revenue base information is lacking, incomplete or outdated (Ebel & Yilmaz, 2002).

Like in most developing countries, local governments in Uganda do not rely on locally mobilized revenues. Mbale district generates only 1-2 percent of its total annual budget and relies the rest on the central administration and other donors. According to the Mbale District Final Accounts FY2014/15, the district received UGX 19 billion ($5.6m) of which central government funding accounted for 91 percent, local revenue and donor funds accounted for 2 percent and 7 percent of the district revenue respectively. Despite the central government increasing fund over time, the disbursements were mainly in the form of conditional grants. As such, there is little or no room for the re-allocation of funds by Mbale district local government to other service delivery priorities (ACODE, 2015).

In order to generate more local resources, sub-national governments should discover more potential sources of revenue. Hence the central government should devolve more tax levying powers to lower tier governments in order to increase their sources of revenues, which later will relieve the central government in the form of grants transfers. Restructuring of resource allocation and establishment of resource sharing mechanisms should be reintroduced.

2.2 Primary Health Care Services Delivery under Revenue Autonomy

A study carried out by Advocates for Coalition and Environment (ACODE) in 2015 revealed that one of the main factors affecting the public service delivery of Mbale District was budgetary constraints. The district only raised 2 percent of its total budget in 2013/2014 fiscal year far from the government-set target of 10 percent. Currently, in order to deliver primary health care services among others, the district administration generates revenue from the levy of property taxes, licenses, fines and user fees. The local governments cannot levy taxes from acceptable sources and get non-tax revenue. Kamugisha (2012) argues that despite some fiscal autonomy being given to local districts to levy taxes, many of these sources have been cut off.

People living in small rural and remote communities of Mbale face significant health disadvantage. Generally, mortality and illness levels increase with distance from major sites (Kamugisha 2012). Moreover, these communities are characterized by higher hospitalization rates and higher prevalence of health risk factors compared with metropolitan areas. These rural and remote communities are further underprivileged by condensed access to primary health care (PHC) services, leading, in turn, to lower utilization rates than in urban areas and consequent poorer health status for rural residents.

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3. Methods and Techniques

The research strategy employed in this study was the mixed explanatory method to elicit both quantitative and qualitative data relevant to the constructs of primary health care services. From a 170 target population, the stratified sampling method was executed to decipher the sample from various types of respondents (health workers, community members, and local district health officials) and arrive at 120 qualified respondents based on non-probability sampling (purposive sampling) and unbiased selection through simple random sampling. Derivative elements of purposive sampling technique utilized inclusion criteria on demographics (civil status, age, gender, education and number of years experience). Data quality control was ascertained through construct validity and reliability testing with results that indicated acceptability of the researcher devised 4 point scaled questionnaire matched with interview questions within the context of the following: construct validity=.697/acceptable (Hutcheson & Sofroniou,1999); and Cronbach's alpha reliability coefficient=.968/good (George & Mallery, 2003). Item analyses in means and standard deviations elicited quantitative data on the indicators of primary health care services delivery in logical order based on the highest means (public education, maternal and child health care, proper nutrition, provision of accessible treatment and drugs, clean water and sanitation, immunization and local diseases control, accountability in service delivery). Further, the qualitative data were collected through follow-up interviews.

4. Results and Discussions

The demographics of the 120 respondents highlighted in this study were in terms of (1) civil status: married (47.5%), single (43.3%), divorced (7.5%) and the separated at 1.7%; (2) age and gender: majority were between 21-29 years (39.2%); 70.0% were male and 30.0% were female; (3) level of education: certificate (16.7%); diploma (26.7%); bachelors degree (36.7%); masters degree (15.8%) and doctoral (4.2%); (4) number of years experience with the health sector: less than 6 months (8.3%), 6 months-1year (13.3%),1-2years (24.2%), 3-5years (26.7%) more than 5 years (27.5%).

4.1 Primary Health Care Services Delivery under Revenue Autonomy

Figure 1 summarized the primary health care services delivery determined in this study based on 7 constructs and were arranged from the highest to the lowest average means and all were interpreted as high in terms of gaps: public education (2.84); maternal and child health care (2.74); proper nutrition (2.74); provision of accessible treatment and drugs (2.72); clean water and sanitation (2.69); immunization and local disease control (2.69); and accountability in service delivery (2.60). These specific indices under each construct were found among other indices reflecting some gaps and challenges in the primary health care services delivery:1) public education (assessing individual and community needs for health education=2.73); 2) maternal & child healthcare (importance of hand washing as hygienic measure most especially for the children=2.68); 3) proper nutrition (emphasis on healthy diet=2.68); 4) provision of accessible treatment & drugs (easy road for the patients to move=2.68); 5) clean water and sanitation (unsafe water from rainfall reaching drinking waterways=2.61); 6) immunization and local diseases control (treatment of animals to control

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spread of disease=2.61); 7) accountability in service delivery (signing for drugs taken in and out of the health center=2.14).
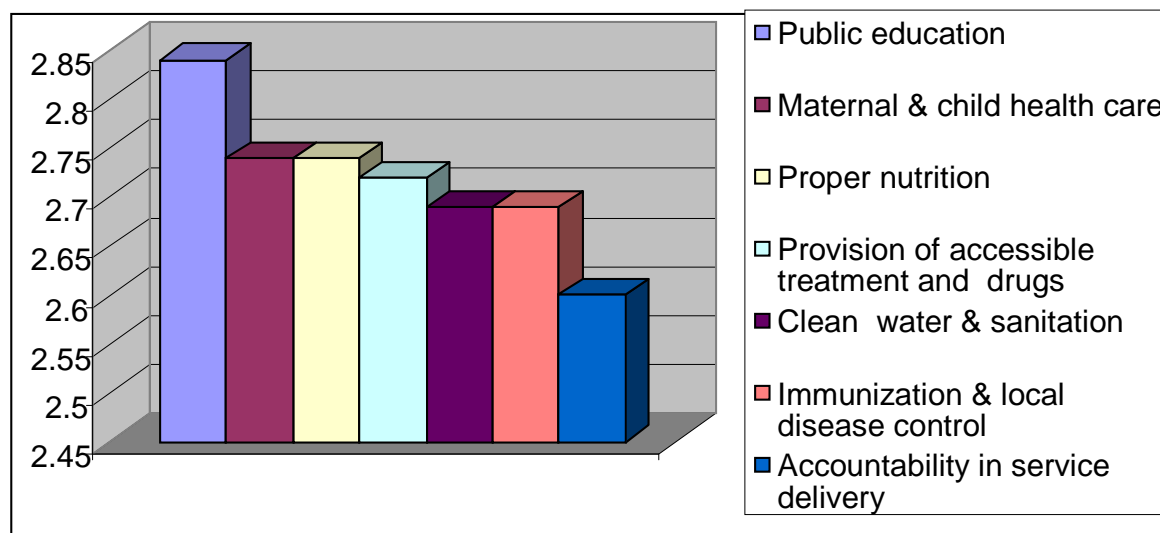

Figure 1: Primary Health Care Services Delivery under Revenue Autonomy

Legend for interpretation of the means

Mean Range	Response Mode	Interpretation (in terms of gaps)
3.26-4.00	Strongly Agree	Very High
2.51-3.25	Agree	High
1.76-2.50	Disagree	Low
1.00-1.75	Strongly Disagree	Very Low

The constructs under the primary health care services delivery (Figure 1) were analyzed and discussed as follows:

A. ***Public Education:*** Public education is the first, and one of the most essential components of primary health care. By educating the public on the prevention and control of health problems, and encouraging participation, the World Health Organization works to keep disease from spreading on a personal level (McKenzie, Neiger, Thackeray 2009). Education for health begins with people (Donatelle, 2009) and further impresses that,

> "It hopes to motivate them with whatever interests they may have in improving their *living conditions*. Its aim is to develop in them a sense of responsibility for health conditions for themselves as individuals, as members of families, and as communities. In communicable disease control, health education commonly includes an appraisal of what is known by a population about a disease, an assessment of habits and attitudes of the people as they relate to spread and frequency of the disease, and the presentation of specific means to remedy observed deficiencies"

> Donatelle, 2009

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Health education does not only teach prevention and basic health knowledge but also conditions ideas that re-shape everyday habits of people with unhealthy lifestyles in developing countries. This type of conditioning not only affects the immediate recipients but the future generations will benefit from improved and properly cultivated ideas about health education (Donatelle, 2009).

B. *Maternal and Child Health Care:* Ensuring comprehensive and adequate health care to children and to mothers is another essential element of primary health care according to Ikeanyionwu (2000). By caring for those who are at the greatest risk of health problems, WHO helps future generations have a chance to thrive and contribute globally. Every parent would surely wish to nourish their children in a loving, caring and secured atmosphere. The parents would want to give proper care and attention to the little ones, especially during their initial stages of development.

C. *Proper Nutrition:* Eating a proper, nutritious diet offers numerous health benefits that keep individuals mentally and physically well. Proper nutrition does not mean starving oneself, but instead, proper nutrition means eating a diet balanced in lean proteins, carbohydrates and fats. Mayo Clinic, which is among the top 10 best health organisations in the USA recommends in its 2012 annual report getting between 45 and 65 percent of daily calories from carbohydrates, between 10 and 35 percent of daily calories from proteins and between 20 and 35 percent of daily calories from fats.

D. *Provision of accessible treatment and drugs:* By treating disease and injury at once, caregivers can help avoid complications and the expenses for more extensive medical treatment. According to Kann (2001) by providing essential drugs to those who need them, such as antibiotics to those with infections, caregivers can help prevent disease from escalating, This makes the community safer, as there is less chance for diseases to spread widely.

E. *Clean water and sanitation:* A supply of clean, safe drinking water and basic sanitation measures regarding trash, sewage and water cleanliness can significantly improve the health of a population, reducing and even eliminating many preventable diseases (Pariyo *et al*., 2009). Nowhere is the relationship between healthy ecosystems and healthy people more apparent than in the global water system. Clean water is the single most important building block of ecosystems around the world, says the Centers for Disease Control and Prevention (Hagopian *et al.,* 2009).

F. *Immunization and Local Diseases Control:* Prevention and control of local diseases is critical to promoting primary health care in a population. Many diseases vary based on location (Inanga & Osei-Wusu, 2004). Taking these diseases into account and initiating measures to prevent them are key factors in efforts to reduce infection rates.

G. *Accountability for Services Delivery:* The delivery of health services is one of the primary objectives of any government. Particularly under the local government act of Uganda, medical and health service delivery are generally considered decentralized services.

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5. Conclusions

5.1 Insights and new meanings: (a) Responsiveness and accountability of local government is important to note in favor of fiscal decentralization; (b) Diversity, education and leadership development are aspects for consideration in revenue autonomy;(3) Primary health care services delivery is a constituted effort of both central and local government, therefore, centralization and decentralization should have appropriate balance essential to effective and efficient functioning; (4) Not all functions can or should be financed and managed in a decentralized fashion. Even when national governments decentralize responsibilities, they often retain important policy and supervisory roles.

5.2 Pragmatic Perspective of the Primary Health Care Services Delivery Under Revenue Autonomy: With due justice to the true meaning of pragmatic view (reasonable and logical way of dealing with an existing problem in a specific situation), in this study then, creating or maintaining *enabling conditions* that allow local units of administration or non-government organizations to take on more responsibilities as in the case of primary health care services delivery should not be underestimated.

6. Recommendations

6.1 Proposed Innovative Options Within Own Source Revenue

6.1.1 Rationale: In order to generate more local resources sub-national governments should discover more potential sources of revenue for the district administration. Thus, the central government should devolve more tax levying powers to lower tier governments to increase their own sources of revenues, which later will relieve the central government in the form of grants transfers. Restructuring of resource allocation and establishment of resource sharing mechanisms need to be re-introduced.

6.1.2 Objective: To realize expectations of the community for better delivery of primary health services with local government officials being result-oriented.

6.1.3 Proposed Courses of Action and Implementation Strategies

   (a) **Personalized sensitization projects** for a focused understanding of health information (prevention of diseases, first aid, sanitary measures, safe water and sanitation, healthy diet, treatment of animals) through free clinics and health fares in collaboration with health oriented and health directed non-government organizations.

   (b) **Integrated approach to primary health care services delivery**: Rural communities require revitalization and rehabilitation regarding access, equipment, and workforce.

   (c) **Provision of services in primary health care from close range for better chances of recovery and social integrations.**: At the time of this research, some of the sub-counties like Bukyiende and Bumasikye did not have health centers and most people in other sub-counties in the district are treated far from their homes because of the distances to the health facilities this disrupted normal daily life, employment and family life. It removed individuals from their normal supports, essential to recovery, and it imposed more burden on families and caregivers

   (d) **Partnership with private sector organizations/PSO with impacts on the health system** such as linking health insurance, laboratory services, medical supplies, safe

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water installations, food supplies, electronic recordkeeping for proper tracking and delivery of health records to the clients, research and evaluation methods to highlight health issues challenges, work efficiencies and effectiveness of health care delivery as bases for improvement and policy development.

(e) Vigilant monitoring of accountability through internal and external audit interventions

6.1.4 Target Periods and Persons Responsible: These are recommendations referring to the implementation time span of the proposed courses of action and individuals responsible (in brackets)

A. Personalized sensitization projects: Every three months (health officials and health providers)
B. Integrated approach to primary health care services delivery: Year round (local and health authorities)
C. Provision of services in primary health care from close range for better chances of recovery and social integrations: Year round (local and health officials, health providers)
D. Partnership with private sector organizations/PSO with impacts on the health system:
   Year round (local and health authorities, PSO)
E. Vigilant monitoring of accountability: Quarterly (local and health authorities)

6.1.5 Expected Outcome Indicators: Within six months, the proposed courses of action must have reached obvious implementation at least above 50%. In the context of full implementation, by the end of the year, a 100% achievement status is underscored.

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