# Decision-making autonomy in Ugandan health facilities:

## Does decentralization of health systems translate into decentralization of authority?

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# Introduction

***Decision space***
*"The decision-making **authority** demonstrated by entities in an administrative hierarchy"*

***De Facto***
Authority informally arising from emergent facility needs

***De Jure***
Authority allocated via enumerated policies

## The Ugandan Healthcare System

Health Center II → Heath Center III → Health Center IV → General Hospital → Regional Referral Hospital → National Referral Hospital

*Increasing complexity of care*

- Uganda extensively decentralized its healthcare system beginning in the 1990s by shifting decision-making authority away from its national Ministry of Health (MOH)
- Today, *de jure* authority over most managerial functions (i.e. general administration, personnel management, managerial oversight) rests with **district-** and **facility**- level authorities[1]

| Managerial areas | *De jure* decision-making authority | |
|---|---|---|
| | Public Facilities | Private Facilities |
| Facility administration | Facility personnel, Health Unit Management Committee | Facility personnel |
| Personnel management[1] | District Health Service Commissions | Facility personnel |
| Supply chain management[2] | Facility personnel (if hospital or HC IV) | Facility personnel |
| | Ministry of Health (if HC III or II) | |

- Research has shown that staff characteristics and variations in local need result in different *de facto* decision spaces for Uganda district-level administrators whose *de jure* decision spaces are, in theory, supposed to be equivalent[3, 4]

## Objectives

1) Determine degree to which *de facto* decision space for health facility managers differs from their intended *de jure* decision space
2) Determine whether significant associations between *de facto* decision space and managerial performance exists for facility managers

# Methods

- From data collected through the Performance Monitoring for Action (PMA) 2020 survey platform, the following measures were derived:
  1. ***Managerial Performance Measures*:** Three scales measuring essential drug availability, quality improvement, and performance management.
  2. **Authority Level Questions:** Eight multiple-choice questions measuring decision-makers responsible for specific facility decisions

**Authority Levels**

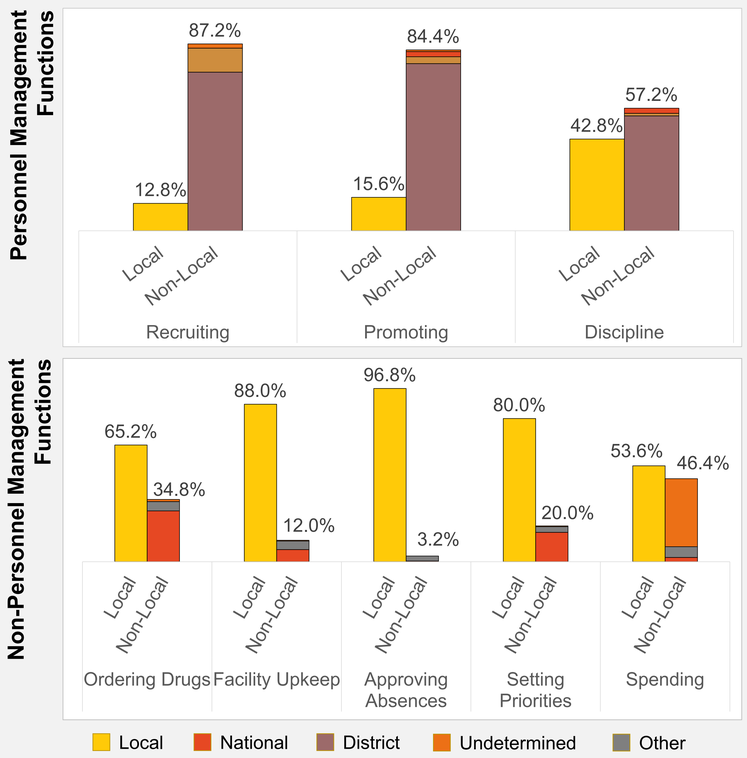
National | District | Facility | Undetermined

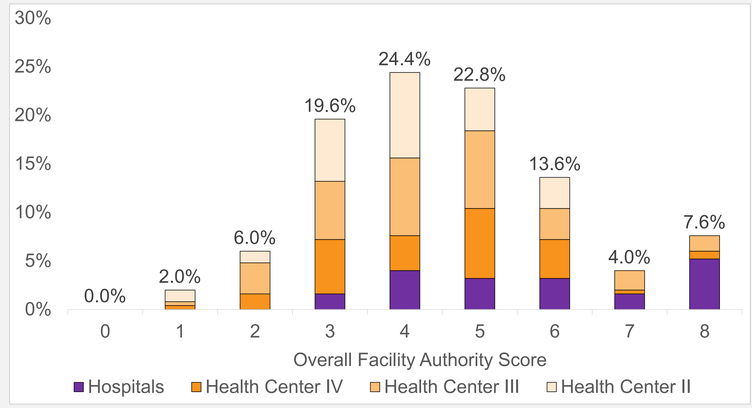
| Authority Level Questions | Possible responses |
|---|---|
| According to you, which of these groups has the most say in… | • *Ministry of Health* |
| *Ordering drugs* | • *District Health Service Commission* |
| *Facility upkeep*± | • *Chief Administrative Officer* |
| *Recruiting*± | • *District Health Officer/Team* |
| *Promotion*± | • *Director of the facility* |
| *Disciplinary action* | • *Health facility/Hospital Management Committee* |
| *Approving absences* | • *Doctors/facility staff* |
| *Setting priorities* | • *Community* |
| *Spending funds* | • *Owner* |
| | • *No response* |
| | • *Other** |

* = answers of other were grouped separately from these authority levels; ± = district authority level responses are possible responses for these questions

- From our authority level questions, we derived two variables:
  1) ***Authority level distributions for individual questions:*** *A categorical variable determining primary authorities responsible for specific facility actions.*
  2) ***Overall facility authority score:*** *An ordinal variable (0-8) measuring the total number of times a respondent answered an authority level question with a **facility-level** authority. This was our metric for overall* de facto *decision space*

# Results




- Private health facilities had significantly higher overall facility authority scores compared to public health facilities (t = -9.78, p < .001)
- Hospitals and HC IVs had significantly higher drug-ordering autonomy than HC IIIs and IIs ($\chi^2$ = 25.11, p < .001)

| Managerial Performance Measures | Level of Local Autonomy: 90th Percentile Predicted | 90th Percentile SE | 10th Percentile Predicted | 10th Percentile SE | Relative (%) Difference in Scores |
|---|---|---|---|---|---|
| **Essential Drug Availability** | 0.678 | 0.026 | 0.559 | 0.019 | **21.3%*** |
| **Quality Improvement** | 10.5 | 0.064 | 10.4 | 0.046 | 1.4% |
| **Performance Management** | 6.29 | 0.059 | 6.38 | 0.050 | -1.4% |

# Conclusions

1. Managerial functions requiring less logistical input (i.e. discipline) are more likely to see differences in *de jure* and *de facto* decision space
2. In Uganda, policies that reduce drug-ordering autonomy for smaller facilities while increasing it for larger facilities have largely been adopted
3. Although we found *de facto* decision space to be positively associated with essential drug availability, managerial autonomy alone is not sufficient for improving overall healthcare managerial performance.

## Works Cited

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