SECTORAL DECENTRALISATION AND INTERGOVERNMENTAL ARRANGEMENTS IN AFRICA

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SUMMARY

A critical issue in decentralisation is the assignment of services to sub-national governments. This article examines normative arguments, legislated models and actual experiences of Sub-Saharan service assignment in two key service sectors, primary health care and rural roads, each of which is a common target for decentralisation efforts and has substantially different characteristics. In analysing intergovernmental provision and production arrangements and the way in which different service components are organised in these sectors, it is apparent that legislated models of decentralisation are largely informed by normative theory. In both sectors, however, a disjoint is evident between what governments decentralise in a formal sense (i.e. in the law) and what they decentralise in an actual sense. This disjoint can be partially explained by normative arguments about the limits to decentralisation, for example, spillovers and economies of scale, but also result from the influence of factors such as intergovernmental and bureaucratic politics, local level capacity constraints and particular production issues associated with each service. Copyright © 2003 John Wiley & Sons, Ltd.

INTRODUCTION

The shibboleth ‘finance follows function’ is often recited in the fiscal decentralisation literature to emphasise that appropriate financing arrangements depend critically on the services assigned to sub-national governments. At the same time, the literature is not extremely specific regarding which services should be decentralised; instead, it generally provides only broad normative advice concerning the nature of services that would be good candidates for decentralisation or ignores the issue and focuses on financing mechanisms. 1 Ultimately, however, it is specific public services that are ‘decentralised’. Statutes or rules governing decentralisation must specify which services are to be administered at which level.

This article concentrates on the service assignment issue by analysing decentralisation arguments and arrangements across and within two key service sectors in Sub-Saharan countries—primary health care and rural roads. 2 These common targets for decentralisation efforts have characteristics that differ substantially. Health care is a labour-intensive social service whereas rural roads require infrastructure investments and maintenance. In analysing these sectors, we consider how well theory works in explaining functional allocations to different levels of government within and between sectors and what factors (theoretical and practical) are most important in making service assignments.

We begin by briefly reviewing the conceptual basis for decentralisation and highlighting factors that theory suggests should be examined when evaluating the efficacy of decentralising sectoral services. We then turn to

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1For example, in his review of some issues in fiscal decentralisation, Bird (1993, p. 209) takes the assignment of functions and boundaries of jurisdictions to be fixed.

2A longer version of this article, Schroeder and Andrews (2001), is available. In it we include discussions of two other popular targets for decentralised provision—drinking water and education.
an empirical examination of decentralisation experiences in both sectors in Sub-Saharan Africa. We examine the service assignment issue at three different levels—theoretical (what theory suggests) the legal (what the statutes say) and the actual (the degree to which service components have actually been decentralised). From these perspectives, we summarise what seems to be known about decentralisation of each and what remains to be known for future theoretical and policy advances.

Altering arrangements for public service delivery in any country is a complex process that is unlikely to be fully replicable elsewhere. Thus, it is not possible to draw definitive generalised conclusions. Indeed, a key lesson to be drawn from conceptual arguments is that decentralisation must be approached on the basis of highly specific analysis of the environment. 3

SECTORAL DECENTRALISATION: THEORETICAL ROOTS

The theory underlying decentralisation argues that its principal rationale is an anticipated efficiency gain. 4 The theory further suggests that a sector is a prime candidate for decentralisation if:

- local demands for a service differ across localities;
- there are no substantial economies of scale associated with the service;
- there are no substantial spillovers of costs or benefits from the service;
- the service is amenable to at least partial local financing through taxes or charges;
- local governments have the capacity to deliver the service;
- the service is not meant to provide substantial redistribution of income or wealth.

These principles are imbedded in the normative literature on ‘assignment of service responsibilities’ (e.g. Shah, 1994). Thus, theory suggests that, as a first approximation, sectoral decentralisation policies should review the nature of the service and the situation of local governments to determine if conditions are conducive for decentralisation.

Even though national constitutions or local government statutes commonly state that an entire sector is a local government responsibility, most sectors consist of a number of activities. For example, rural roads provision includes planning and design, construction (or reconstruction), maintenance and regulation of use. Furthermore, since rural roads are one component of the transport system of the entire country, policies regarding them will necessarily be a part of the national policy rather than determined entirely locally.

Various components of a sector may be differentially subject to the limitations listed above, i.e. they may exhibit economies of scale, spillover effects or be intended to yield redistribution of incomes or wealth. Because of these complexities, decentralisation of a ‘sector’ may take different forms in different circumstances with certain components decentralised in some cases and not in others. The existence of complexities is not, however, always a rationale for service centralisation. For example, the literature distinguishes between the service provision and service production responsibilities.5 Since economies of scale are attributes of production, the responsibility to make the service available (i.e. provide it) can be assigned to local governments even though they contract out to produce it.

Decentralising services also do not have to be uniform across all local governments in a country. There may be different service requirements in different locations; for example, urban versus rural municipalities. Likewise, perceived differences in the technical and administrative capacities of local governments can result in differential assignments of service responsibilities. It is even possible for decentralisation to be approached in phases with jurisdictions given authority over certain service components only after necessary capacity has been established.

3 Oates (1999) states that the specific services provided by local governments are likely to differ across time and place. The same conclusion is reached by Dafflon (1992) in one of the few published articles that focus exclusively on the assignment of functions to decentralised local governments.

4 This was formalised in Oates’ (1972) well-known ‘decentralisation theorem’.

5 This distinction has been emphasised by many students of local governments. See, for example, Musgrave (1959) and Ostrom et al. (1961).
Since specific conditions related to the local public service environment differ from place to place, the normative theory outlined here can result in theoretically based differences in service assignments. However, bureaucratic and political phenomena are even more likely to result in inter-country differences. Decentralisation entails changes in institutional arrangements, i.e. it alters rules governing intergovernmental interactions. Because it modifies relative power, it typically estranges some groups who may actively attempt to undermine it whereas those who benefit are likely to support it. A full evaluation of sectoral decentralisation policies must include recognition of such ‘political’ behaviour, as well as the institutional settings in which such behaviour takes place.

DECENTRALISATION WITHIN THE PRIMARY HEALTH AND RURAL ROADS SECTORS

This section identifies, in light of the theory regarding service assignment in decentralised systems, the nature of disjoints between the normative, formal and experiential models, so as to inform a discussion of factors affecting service assignment.6

Provision of health services

The health sector produces at least three service types: primary care, secondary/tertiary care and highly specialised care (Burki et al., 1999, p. 2). Primary health care services involve preventive care and the treatment of common illnesses. Secondary, tertiary and specialised health care services generally involve the treatment of conditions in which there are referrals or where significant in-patient care is required. Here we concentrate on primary health care since this service is usually the focus of decentralisation in developing countries.

The ‘primary health care sector’ entails a number of services including immunisations, family planning, maternal and infant and child health services and education and treatment for sexually transmitted diseases (STD) and HIV. These services are dispensed through complex processes comprising various components, including: (1) resource access and allocation, (2) policymaking and planning for primary health care provision, (3) organisation and implementation of primary health care agencies and (4) operation and maintenance. While many countries agree that primary health care should be decentralised and are in the process of decentralising, efforts to decentralise have seldom involved wholesale devolution of all these components.

Normative theory and service provision arrangements

Decentralisation theory argues that services should be decentralised if demand and supply conditions are highly localised, as is the case of primary health care. Local benefits include improved health and productivity in particular jurisdictions and reflect the local nature of demand (which is closely tied to socio-economic status or geographic circumstance that lead to locally specific incidences of, and vulnerability to, disease). On the supply side, local conditions affect both service selection (e.g. immunisation might differ between areas) and specific details of production and provision (related, for example, to location and staffing of clinics and to cultural dimensions of service provision) (Kasande and Janovsky, 1997). Thus, local information and conditions are vital in providing effective primary health care (Kolehmainen-Aitken, 1999).

These attributes of primary health care demand and supply suggest decentralised service provision and production, at least for some service components. In terms of resource access and allocation, the benefit principle calls for primary health care services to be financed by local users. The localised nature of supply conditions also provides a justification for decentralising organisation, implementation, operations and maintenance of primary health care services. The argument is that local workers are better able to identify problems and opportunities, more likely to use area- and culture-specific solutions and better able to match supply decisions to local situations. They can also generate higher morale, commitment and productivity in the workplace, where partnerships with local groups are vital to identify local needs and to ensure location-specific responses (Kolehmainen-Aitken, 1999).

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6Note that we are not attempting to measure the effect of decentralisation on service outcomes. For an interesting study of the effects of decentralisation on the Human Development Index see Lindaman and Thurmaier (2001).
Some primary health care components are most appropriately not decentralised. Benefits from primary health care extend beyond local jurisdictions, with spillovers relating to broader disease prevention and nationwide productivity (Burki et al., 1999, p. 76; Kasande and Janovsky, 1997). Benefits from primary health care services also influence other areas of health care provision, e.g. quality primary health care systems alleviate the burden of long-term health care provision. Central governments should be involved in policymaking and planning where spillovers are evident and should also subsidise certain primary health care interventions like immunisations and control of vector-borne diseases (Hutchinson et al., 1999, p. 85; World Bank, 1987, p. 6, 44).

Beyond the issue of inter-jurisdictional spillovers, there is also a redistributional argument in favour of a central (and/or regional) government role in primary health care financing. The gap between service costs and ability to pay in poorer areas of developing countries may necessitate service subsidisation. Poorer communities may find the service unaffordable if financing is totally localised. This necessitates some type of equalising role by regional or central governments in providing resources (mostly finance) for service provision and in ensuring that health provision decisions are equitable (Hutchinson et al., 1999, p. 80).

Formal decentralised arrangements
Legislation typically decentralises some components of primary health care service provision while centralising others (Donaldson, 1994; Burki et al., 1999). The details vary between countries with different components assigned to different government levels and to different types of production and provision agents. Some laws shift responsibilities to districts, others to local governments and others to new public management forms like executive agencies, area health boards or autonomous provider institutions (Kasande and Janovsky, 1997; Zipperer, 1999).

Legislation commonly decentralises significant planning, management and operation and maintenance responsibilities. The Zambian District Health Management System devolves planning and clinic development and implementation responsibilities to districts and area-specific, legally constituted Health Management Boards, which are also meant to play a central role in operating clinics (Kalumbe, 1997; Bossert et al., 2000a, p. 6). Similarly, Tanzania decentralises operations to district level and Uganda’s 1997 Local Government Act makes districts responsible for planning, implementation and management of primary care clinics. The Ugandan law requires central agencies to transfer employees to districts so that planning and management activities can take place at the district and lower levels (Hutchinson et al., 1999, p. 74). Legislation in Ghana decentralises authority to quasi-private entities by giving individual hospitals responsibility for the management of direct service decisions and operations (Govindaraj and Chawla, 1996; Atkinson et al., 1999).

The formal decentralisation of planning and operations is intended to devolve significant decision-making responsibilities, especially regarding production and short-term management. Other components relevant to primary health care provision tend to be centralised because they are considered critical to attaining central goals. These components include national health policy, strategic decisions on accessing health resources (e.g. a national health insurance programme), regulations concerning public safety and monitoring, assessing and analysing both the health of the population and health care provision (Kasande and Janovsky, 1997; WHO, 1997). Central and regional governments also tend to have legislated involvement in financing primary health care, with control over major tax instruments and broad allocation decisions. However, legislation in countries like Uganda and Ghana includes devolving some fiscal authority. The Uganda 1997 Local Government Act requires block, conditional and equalisation grants to be used to channel funds from the national treasury to districts but also accords districts new freedoms to use alternative financing mechanisms like user fees and community prepayment schemes (Hutchinson et al., 1999, p. 74). Reforms in Ghana formally require decentralisation of fiscal allocation decisions to districts (Govindaraj and Chawla, 1996; Atkinson et al., 1999).

Actual decentralised arrangements
Actual primary health decentralisation initiatives often differ significantly from both normative and formal models. Hutchinson et al. (1999, p. 84) found that in Uganda, for example, ‘There have been discrepancies between the decentralised structure as it appears on paper and the system as it has actually worked’. Generally, many decentralised systems simply do not locate intended authority in local agents.
The discrepancy between formal and actual decentralisations is observed in many countries. In Zambia, while legislation reserves significant service provision components for districts and district Health Management Boards (HMBs), the central Health Ministry still enjoys an influential role overseeing districts and the HMBs. As a result, the central government has retained political responsibility for broad primary health care service provision and remains the central role player. Similarly, whereas the law requires significant devolution of authority to districts in Uganda, ‘in practice, health managers in the districts have had only limited authority’ (Hutchinson et al., 1999, p. 84).

The difference between law and practice is also evident in terms of specific primary health care components. While some elements of management, operations and maintenance are often decentralised, other components legislatively decentralised remain centralised (Hutchinson et al., 1999; Bossert et al., 2000a; Bossert, 2000b). The extent of managerial decentralisation varies between countries, indicating a tension in this key component. Most decentralisation initiatives appear to be in formative stages with central governments building local management capacity required for service localisation. In Kenya’s Decentralised Reproductive Health and HIV/AIDS Project, for example, the national government is building planning and financial management capacity at the district level to facilitate legislated decentralisation. Benin’s Integrated Family Health Project (PROSAF) is a step ahead, with a decentralised and integrated family health services programme having been ‘fast tracked’ such that day-to-day management tasks for primary health care provision are localised (URC, 1999).

In countries like Kenya and Benin, the central government sees a need to involve itself in management issues, either directly controlling day-to-day management or manipulating it through ‘decentralising agents’. Central control is especially manifest in influences over personnel management and drug procurement. In South Africa, national conditions of service require local governments to pay salaries they cannot afford, limiting local autonomy (Kolehmainen-Aitken and Newbrander, 1997). In Ghana, decentralised hospital boards are still influenced by the Ministry of Health, which controls personnel and procurement (including medicine) management (Russell et al., 1999). In Zambia, the central health ministry enjoys significant influence over the decentralised health board management decisions (Kalumbe, 1997). Thus, while legislation specifies a high level of decentralisation in planning, operating and maintaining health care service facilities, the activities are often actually quite centralised.

Regional and central entities dominate resource allocation and financing activities even where legislation requires decentralisation. In Uganda, for example, legislation required the decentralisation of central budgets but most districts remain dependent on central resources and on central allocations (Hutchinson et al., 1999). The situation is similar in Ghana and Zambia where central involvement in primary health funding is linked to national dependence on donor resources. Centralising primary health care finance limits the autonomy of local entities; experience shows that central entities in most African countries use their fiscal strength to influence provision and production decisions at the local level. In Zambia this occurs through a ‘commissioning procedure’ which influences district behaviour (Kalumbe, 1997), whilst in Ghana the central ministry uses standard grants processes to influence decisions in semi-private hospitals and district governments (Russel et al., 1999).

**Provision of rural roads**

Rural road services involve provision and maintenance of transport infrastructure in rural areas. Common uses of such infrastructure involve transporting agricultural products to market, essential products to residences and people to economic and social services. Countries generally build one or two-lane *rural roads* or *rural footways* for such transportation needs. The following components are involved in such provision: (1) resource access and allocation, (2) transport policymaking, (3) planning, organisation and construction and (4) ongoing operation and maintenance (Riverson et al., 1991; Humplick and Moini-Araghi, 1996).

**Normative theory and service provision arrangements**

As with primary health care, decentralisation theory yields a strong argument for decentralisation of core rural roads provision components. Local users are the main beneficiaries of rural road provision and these users often have specific road demand profiles (which depend on intended use of the road and type of transport available). Similarly,
supply conditions are also sensitive to local needs with western roads designs often favoured by central government engineers sometimes inappropriate in rural areas (Barwell, 1996; Mahapa and Mashiri, 2001).

It is argued that local demand and supply information can be best accessed, understood and incorporated into provision and production decisions if planning, implementation, construction and maintenance components are localised. Starkey (2000) describes the logic as developing ‘local transport solutions’. Decentralising these components makes even more sense when one considers potential use of local contractors and labour in producing and maintaining such infrastructure. Local construction and maintenance is also expected to encourage local ownership and to stimulate incentives for efficient production and resource use (Narayan, 1995). Similarly, because of the local nature of benefits from rural roads and the incentives created by local financing and maintenance (for responsible resource use and maintenance), there is a strong argument for localising resource access and allocation responsibilities. The benefit principle holds that local users should pay for the benefits they derive from using rural roads, either directly through user fees or indirectly through labour contributions and taxes (Lippman and Lewis, 1998, p. 7).

Some inter-jurisdictional benefits can accrue from rural roads (e.g. where rural areas constitute important agricultural, tourism or production centres). When non-local users benefit from rural roads provision, central and regional governments should be involved in making policy (and standard setting), constructing and maintaining roadways, and financing road development (for roads that local jurisdictions probably could not afford and would not demand). National and regional governments should also provide necessary technical skills for road development in these cases and in local projects that are technically beyond the capacity of the locality (Humplick and Estache, 1995).

**Formal decentralised arrangements**

As with primary health care, many African governments are embracing the normative argument for decentralised rural road provision through legislation. In Mali, for example, laws passed between 1993 and 1995 created a ‘decentralised’ governing system in which local communes, district-level circles and regions were all responsible for roads (Lippman and Lewis, 1998). In Ethiopia, legislation created a semiautonomous national agency, the Rural Road Organisation, to spearhead the process of decentralised rural road provision (Riverson et al., 1991; ILO, 2000). In Tanzania, legislation makes local authorities under the Ministry of Regional Administration and Local Government responsible for building rural roads (UNCDF, 2000; Tanzanian Government, 2001). Formal policy underlying decentralisation efforts in Tanzania include the establishment of the Local Development Fund and the District and Feeder Roads project (UNCDF, 2000).

Planning, implementation and construction of rural roads and their subsequent operation and maintenance are the main activities that legislation typically decentralises to sub-national public or private community groups. In Ethiopia, the vision is for local governments to enjoy responsibility for planning, implementation, construction and maintenance of rural roads. Local communities and local governments in Tanzania are expected to lead rural road development by identifying needs and contributing significantly to road construction and maintenance (UNCDF, 2000). The Kenyan Rural Access Roads programme formalised a rolling contract system whereby central government agencies work with local contractors (‘lengthmen’) for routine maintenance. In Gambia, central agencies are required by law to work with community-based organisations to ensure maintenance localisation (Kessides, 1993).

Still, legislation reserves important and influential roles for central government, with significant aspects of planning and construction, as well as funding and resource access and allocation routinely centralised. The Rural Road Organisation was created at the central level in Ethiopia to ‘oversee’ local projects until local capacity was developed; however, in the long-lived interim capacity-building period it has cemented its place as the main vehicle for planning, implementation and construction (Riverson et al., 1991; ILO, 2000). In Tanzania, a similar, semi-autonomous executive agency, the Tanzania Roads Agency (TANROADS), is responsible for most actual rural road development and local authorities take their place under the Ministry of Regional Administration and Local Government (Tanzanian Government, 2001). The Tanzanian Government also established a centrally controlled Road Fund as the main source for construction and maintenance resources (Tanzanian Government, 2001). Whilst grants provided by the fund are unconditional and some local governments are being encouraged to develop user fees, finance in countries like Tanzania remains highly centralised and constitutes a tool for central control over rural roads provision activities.
Actual decentralised arrangements

Evidence suggests that governments do decentralise some rural roads service components in practice. A recent World Bank study concluded that ‘Local institutions and communities (which include local government below state level) have usually been involved in rural road projects at the planning stage and in maintenance’ (Riverson et al., 1991, p. 31). Approaches vary between countries, but planning, organisation and construction components are generally less decentralised than operations and maintenance components.

Actual decentralisation initiatives focused on planning, organisation and construction components generally involve capacity-building exercises at the local level (Humplick and Moini-Araghi, 1996). An example is Rwanda, where local entities, particularly community-based organisations, have been the subject of interventions focused on increasing local capacity to manage and implement small-scale infrastructure investments, like rural roads (ILO, 2000). In Côte d’Ivoire, managerial decentralisation has been introduced in conjunction with aggressive training of (technical) local government staff involved in infrastructure development (particularly roads) (ILO, 2000). Tanzania and Ethiopia also focused their decentralisation policies on developing local planning, construction and maintenance capacity. While practice in such cases certainly reflects legislated decentralisation, the actual devolution of production and provision authority is limited by slow capacity development (Lippman and Lewis, 1998). As a result, central entities often still dominate planning, supervise construction, contract out maintenance (or allocate it to local councils) and monitor rehabilitation. In Botswana, for example, the national Roads Department outsources certain construction and maintenance roles but maintains a supervisory and oversight role (ILO, 2000).

Road maintenance and rehabilitation is often decentralised (Humplick and Moini-Araghi, 1996). Two models exist: (1) central government charges local governments or community-based organisations with functional responsibility or (2) central government hires private contractors to perform these tasks (decentralisation through privatisation of production). A project in Zambia’s Northern Province provides an example of the first model, with district brigades rehabilitating and maintaining district roads (ILO, 2000). The private contractor model is being used in the UNDP/World Bank financed feeder roads programme in the Democratic Republic of Congo. Small contractors build donor financed roads (with community assistance in places) (ILO, 2000). These arrangements are often flexible (to seasonal demand fluctuations) and cost effective. But gains from the contracting model depend on the existence of an adequate supply of, and competition between, private contractors (Humplick and Moini-Araghi, 1996).

In practice, governments tend to centralise resource access and allocation (Riverson et al., 1991, pp. 30–31). Resources for rural road development are often not available at the local level. In order to ensure sufficient technical and fiscal resources, therefore, most governments source and manage personnel and finances from the centre (particularly when construction projects are complex). Technical personnel are often provided through dedicated national-level units who manage road development. Examples are the Feeder Road Unit in Senegal, Kenya’s Special Programmes Branch of the Roads Department and Cameroon’s Feeder Road Project (Riverson et al., 1991, p. 30). These central roads agencies usually are involved in planning and are used to attract and disburse fiscal support, especially from international donor agencies (Riverson et al., 1991).

In many countries fiscal resources are centralised because donor agencies channel funds through central rather than localised development partners. Burkina Faso’s programme involving local, labour-based rural roads development, for example, was resourced from a central government Social Development Fund (ILO, 2000). Malawi also has a Road Fund, with central agencies providing a channel for earmarked funds (Riverson et al., 1991, p. 30). Other examples are Benin’s Service des Doutes de Dessert Rural (SRDR), Togo’s Service Nationale des Pistes Rural (SNPR) and Ghana’s Department of Feeder Roads (DFR) (ILO, 2000).

FACTORS UNDERLYING THE DISJOINT BETWEEN THEORY AND REALITY

The empirical review of decentralisation in the primary health and rural roads sectors in Sub-Saharan Africa supports many of the points raised in the introduction. First, the normative decentralisation model has guided service assignment in both sectors. And economies of scale, concerns for jurisdictional spillovers, potentially negative effects on income and wealth distributions and the lack of technical capacity have all led some governments to
limit formal decentralised authority. Second, services within and between sectors are seldom candidates for wholesale decentralisation. Instead, individual service components are variously open to decentralisation, resulting in 'decentralised' service provision within sectors actually taking the form of complex intergovernmental interaction. Finally, service assignment in decentralised settings can take many forms, depending on which components are decentralised and how they allocate authority over provision and production decisions.

It is, however, also the case that the normative service assignment model does not consider all factors relevant to decentralisation. Formal decentralisation policy embodied in legislation and actual decentralisation arrangements can vary significantly from the normative model. Differences between normative, institutional and de facto models emerge because of a variety of influences related to decentralisation structure and public sector reform. It is these other factors that have great influence over the nature of de facto service assignment within key sectors. The bulk of these factors are ‘institutional’ in character, reflecting decentralisation tensions in established governance structures. These include intergovernmental and bureaucratic politics and capacity constraints.

**Intergovernmental politics**

A recent study on health care reform makes explicit what most participants in the process understand all too well—‘decentralisation is a political issue’ (Kolehmainen-Aitken and Newbrander, 1997, p. 58). Intergovernmental politics influences decentralisation as national politicians attempt to maintain central control over crucial service provision components, notably fiscal resource management and implementation and construction of service access points.

National politicians generally exhibit a desire to maintain their influence over local public services because: (1) they are highly visible to political constituencies, (2) they provide important opportunities for donor funding and (3) decentralisation can create political threats. Highly visible services such as rural roads and clinics have limited devolutionary policies in both Swaziland and Zimbabwe. Likewise, the centralised management of donor funding has constrained decentralisation policies in Tanzania and Zambia. A recent study on health care decentralisation concluded that, ‘reforms appeared to offer few concrete benefits but many political risks: they . . . made politicians vulnerable to accusations of ‘privatisation’, and could lead to strikes, public opposition and electoral losses’ (Atkinson et al., 1999, p. 770).

**Bureaucratic politics**

National level bureaucracies attempt to ensure that crucial components related to service provision, especially construction and resource management, are centralised. In some instances these components are centralised in legal processes. Where legislation decentralises them, other bureaucratic behaviours limit localisation, including informal process requirements and direct forms of inter-organisational conflict. These factors substantially explain why the ‘norm’ in decentralisation experiences has been ‘only shifting a few functions to the district or regional MOH offices’ (Bossert et al., 2000a, p. 8).

Procedural requirements, whether legislated or informal, limit the operational authority of local entities and complicate procurement and personnel management. For example, health decentralisation in Zambia entailed transfer of staff from the central public service to local governments; however, with the transfer came decreased benefits which, in turn, created disincentives for staff members (Kalumbe, 1997). Such problems often result in an ‘unwillingness of government employees to be decentralised’ (Blair, 2000, p. 27). The implications of decentralisation for human resources development are generally poorly considered in reforms (Kolehmainen-Aitken, 1999). At least four important issues require specific attention—the adequacy of information available on human resources at various government levels, the complexity of transferring staff, the impact of the policy on professional associations, unions and registration bodies and the morale and motivation of workers.

Inter-organisational conflict arising from clashing rule structures also thwarts decentralisation initiatives. An example is Ethiopia where an early decentralisation initiative involved creation of a semi-autonomous Rural Road Organisation (RRO) that was intended to work with local governments. The RRO had to compete with another central agency, the Transport Construction Authority (ETCA) in providing services. Tension between the two limited decentralisation potential (Riverson et al., 1991). Such bureaucratic tension is not unusual, particularly in the
areas of rural roads and rural water provision, as these services often invite cross-sectoral interests (particularly from agriculture and other development agencies). All interested parties attempt to influence the process of decentralisation which strengthens the tendency to maintain the status quo.

The status quo bias in bureaucratic organisations also provides very little incentive to accelerate or complete the process to national bureaucracies charged with the task of creating and developing capacities in local administrative entities. James (1998) argues that decentralisation reforms require the development of a specific institutional framework that supports any changes in financial incentives or human resource management.

**Local level capacity**

Central bureaucrats and politicians regularly excuse continued involvement in local level provision because of capacity limitations at local government level. The argument is simply that financial management, project implementation, construction and planning have to be centralised because of poor local capacity.

It is commonly held that decentralisation requires local level managerial and technical capacity, particularly planning, operations and maintenance. In Senegal, for example, rural roads decentralisation was built around developing local technical capacity, which facilitated localisation of planning and implementation and operations and maintenance (Riverson et al., 1991). Researchers have found that technical and managerial competence is central to effective assignment of primary health care services to district and local governments (Kolehmainen-Aitken, 1999). Hutchinson et al. (1999) identify human resource capacity constraints as a major limit to the planned decentralisation of planning and administration responsibilities in Uganda. Ndiaye provides similar comment of experience in Senegal, saying that ‘it is a relatively simple matter to build and equip health posts, but quite a different question to find the staff to run them’ (Ndiaye in Mills, 1990, p. 112).

A second aspect of capacity involves institutional abilities for intergovernmental coordination. Such coordination devices facilitate provision of different service components at different levels of government. Most central agencies have systems and procedures conducive to effective control and internal coordination but not external organisations. Without such capacity, central governments have no way of organising the different components across government levels, resulting in a tendency to keep them all in-house. This is experienced in many services, but particularly health care and education. Service provision in these areas requires the coordination of a variety of components across levels, which can be difficult to achieve.

A third aspect of capacity pertains to fiscal management. Effective decentralised service provision requires an adequate level of local governance, including legal and financial capacity (Burki et al., 1999). This requirement extends to both monetary resources, i.e. a fiscal base sufficient to ensure funding for maintenance and operations, and personnel and process, i.e. appropriate staff and systems for managing the money. Where these capacities are limited locally, fiscal management tends to be centralised. Nigerian primary health care decentralisation was limited because the policy failed to recognise local fiscal capacity problems. As stated by Donaldson (1994, p. 17) ‘issues such as the financial sustainability of local government authority-based services soon required attention’.

Health decentralisation has been implemented in countries like Zimbabwe and Kenya without ‘system wide changes in financing and payments’ (Bossert et al., 2000a, p. 8). Similarly, ‘Zambia’s local districts are receiving less funding than before the reform and user fees may be limiting access’ (Chita, 2000).

Governments attempting to develop local fiscal capacity have encountered problems of equity and access in both primary health care and rural roads sectors. Attempts to localise resources in primary health care have been particularly problematic, often leading to reduced access for marginalised groups. An example is the Bamako community financing initiative in Mali which yielded the most basic health services out of reach for poor people groups (McPake et al., 1993).

**Other complicating issues**

‘Timing’ constitutes another issue that can help explain a divergence between statutory decentralisation and reality. Responsibilities are often not fully devolved either because the initiative has not reached that part of its plan or because it tried to devolve responsibilities before intergovernmental structures or local capacities were in place. Either slow or rapid implementation can also be used to sabotage the process. Those wishing to subvert the process
can try to stretch it out over such long periods that devolution always occurs over the horizon or may try to fast-track the process in order to limit its potential for success.

The issue of coordination between primary health care services and related centrally provided services can significantly affect decentralisation of health care. The questions have arisen in Zambia where the small size of many local governments has separated primary care from its secondary referral facilities (Kolehmainen-Aitken, 1999). Primary health care providers typically work at a level that necessitates upward referral because they constitute the first line of reference in a patient’s treatment and because the skills to deal with complex illness are unavailable in primary care institutions. The question regarding coordination is: ‘how can primary health services be decentralised from others, yet linked for effective treatment?’ There are no easy answers and many decentralisation initiatives have not dealt with the question formally, defaulting back to centralised monitoring and organisation structures. For example,

In Senegal, after years of efforts to decentralise to district health offices within the health sector, the government imposed a radical decentralisation to local municipalities with no guidance on how to fund and operate the health system. This led to widespread breakdown of the health system and almost no communication between health officials and newly empowered mayors (Bossert et al., 2000a, p. 5).

The result is a re-centralisation of health service provision; similar outcomes have occurred in Zambia.

Another issue complicating rural roads provision is an emphasis on ‘western’ standards in roads design. A common criticism of centralised policymaking is that rural roads are treated similarly to urban roads or primary feeder roads (Barwell, 1996). This often leads to policies that force inappropriate and expensive road requirements on rural service providers, slow down provision and facilitate a pro-centralisation argument by overemphasising local capacity constraints. Government policies bind local governments by specifying road design and engineering quality often with a lack of understanding of the quantity and types of vehicles using the roads.

**CONCLUSIONS**

This article focused on issues concerning decentralisation of particular local public services and sectors. The theoretical literature provides some very general guidelines for service assignment. Local public service responsibilities should be decentralised in order to improve service efficiency, but with certain limits, such as significant interjurisdictional spillovers, substantial economies of scale, major income redistribution goals or insufficient local government capacity. At the same time, the institutional analysis literature suggests that it is not possible to declare, *a priori*, that certain services should *always* or *never* be decentralised. Furthermore, the approach emphasises that provision and production responsibilities are separable and that sectoral service responsibilities should be considered on a component-by-component basis.

The empirical portion of the article focuses on issues associated with the decentralisation of two ‘sectors’—primary health care and rural roads. Each is a common target for decentralisation in Africa and some empirical literature suggests that decentralised arrangements can improve services. For example, the World Bank’s *World Development Report*, 1994 (p. 75) reports that a review of 42 developing countries determined that decentralised road maintenance was associated with lower maintenance backlogs, improved condition of roads and a higher proportion of paved highway. Humphlick and Moini-Araghi (1996) find that those countries with very high levels of decentralised rural roads provision in the sector (notably South Africa and the United States) enjoyed some definite efficiency gains from the arrangements. Similarly, in the health sector, the Niger Family Health and Demography Project is seen to have facilitated improvements in systems management, enhanced clinic-level skills and increased community engagement (URC, 1999). Bossert et al.’s work (2000a,b,c) suggests similar positive experiences in some Latin American decentralisation initiatives.

Success is not guaranteed, however, and the process of decentralisation is considerably more complex than simply declaring that a sector is ‘decentralised’. The article illustrates that statutory decentralisations of primary health services and rural roads in many Sub-Saharan African countries differ from what normative theory predicts and how, in turn, actual arrangements for providing these services also differ from the statutes. While some of those
differences correspond to the conceptual limits of decentralisation, others can be attributed to factors such as intergovernmental politics, bureaucratic politics and insufficient capacities in local governments.

Finally, we acknowledge that the sector-based literature does not address adequately certain questions that would be of great interest to policy makers. These as yet unanswered questions include the following:

- What are the advantages and disadvantages associated with decentralising services in two or more sectors? That is, are there economies of scope that can be gained from decentralising multiple services to local governments in developing countries?
- If multiple sectors are decentralised, what are the appropriate funding mechanisms? Are various sectoral block allocations preferable to a single block allocation? Is there an appropriate ‘phasing’ of different types of intergovernmental transfers, e.g. initially use specific sectoral grants then, as local capacity is built, switch to sectoral block allocations and ultimately move to a single block grant allocation mechanism?
- What mechanisms can be used to phase in decentralisation across different types of local governments? That is, is it feasible (and, if so, how) to decentralise sectoral services to only a subset of local governments within a country and then allow local governments that initially were given no decentralised powers to ‘graduate’ into the decentralised class of localities?

All of these issues deserve greater study if the promise of service decentralisation is to be realised in Sub-Saharan African countries.

REFERENCES


