

**Decentralization and budgeting: the Uganda health sector experience**  
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**Abstract:**

*Like a number of other developing countries in recent years, Uganda has adopted a decentralized management structure for its public sector. Along with this restructuring came the devolution of budgetary responsibilities. This study presents findings from a study of the impact of decentralization on Ugandan health sector budgeting. A questionnaire was used to seek the expert opinion of key participants in health sector budgeting regarding the affects of decentralization on budgetary participation and the use of budgets for planning and control. The findings suggest that, while decentralization cannot be thought of as a miracle cure for the challenges of public sector budgeting, it has the potential to create a context for improved budgeting practices in developing nations.*

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Introduction: public sector decentralization and budgeting

There has been an increasing trend towards public sector decentralization within developing countries (World Bank/International Bank for Reconstruction and Development, 1999). A number of explanations, both political and economic, have been advanced to account for this trend. In the political context, a key impetus for decentralization is seen to be the spread of multiparty democracy, which has placed increasing pressure on central governments to allow for more local voices in decision making (World Bank/International Bank for Reconstruction and Development, 1999). On the economic side, decentralization is credited with increasing efficiency, and improving decision-making as a result of informed local participation (Pollitt et al., 1998; Kaplan and Atkinson, 1998; Dillinger and Fay, 1999; World Bank/International Bank for Reconstruction and Development, 1999).

In 1993, the Government of Uganda moved to a decentralized system of public sector management. A combination of political and administrative decentralization, with selective devolution of public sector management responsibilities, was adopted as the new structural system for governance. The stated aim of this restructuring was to improve the efficiency and effectiveness of service delivery in a number of areas, a key one being health care (Ministry of Local Government (MoLG), 1994). Along with the move to decentralization came changes to financial management. In particular, the devolution of budgeting responsibilities became an important mechanism for operationalizing the new health sector management structure. This paper focuses on the impact of the move to decentralized financial management on budgeting in the Ugandan health sector.

The importance of budgeting in the public sectors of both developing and developed countries is beyond debate.

Public sector budgets serve three macro aims:

- (1) tools of accountability;
- (2) tools of management; and
- (3) instruments of economic policy (Premchand, 1983).

More generally, budgeting serves many purposes that are important to public sector management. It is a tool for planning, coordinating, organizing and controlling activities (Henley et al., 1992), it can enhance communication in organizations (Coombs and Jenkins, 1991), and it may also serve as a political tool (Wildavsky, 1986).

Academic studies, particularly those adopting a contingency theory framework, have identified possible relationships between budgeting practices and organizational structure. Although most of these studies are based on private sector organizations, their findings are informative in public sector contexts also. Overall, it appears that managers in highly structured (implicitly decentralized) organizations tend to perceive themselves as having more influence on the budgeting process. They participate more in budgeting and appear to be more satisfied with budget related activities. Conversely, managers in organizations where authority is concentrated (i.e. centralized) generally perceive budgets as being less relevant, useful and flexible (see, for example, Bruns and Waterhouse, 1975; Gordon and Miller, 1976; Otley, 1980; Chapman, 1997). Decentralization is, therefore, generally perceived as conducive to enhancing managers' experiences of, and commitment to, the budgeting process. As a result, decentralization might be expected to enhance the efficiency and effectiveness of public sector management.

Despite the recognized importance of budgeting and its suggested links to organizational structure, there has been little empirical exploration of how public sector budgeting has developed within increasingly decentralized frameworks of governance. This is particularly the case for developing countries adopting decentralized structures[1], despite recognition that appropriate budgeting practices are consistent with all societies' legitimate expectations that public resources be employed efficiently and effectively (Henley et al., 1992; World Bank/International Bank for Reconstruction and Development, 1998).

The study reported in this paper contributes towards filling this research gap. It explores, via the expert opinion of key health sector actors, the extent to which decentralization has brought about expected changes in Ugandan health sector budgeting. The findings have the potential to inform our understanding of budgeting practices in a range of countries that have faced (or are currently experiencing) similar structural changes within their public sectors.

Before turning to the research method and findings, it is useful to reflect on the context for this study. A brief overview of the structure of Ugandan health sector budgeting before and after decentralization is presented next.

#### The case of the Uganda health sector

In Uganda, as in many other countries (Henley et al., 1992), public sector budgeting can best be described as "incremental" in its approach (Coombs and Jenkins, 1991)[2]. In the

health sector, an accepted "base" budget is modified each year without any comprehensive budget review taking place (Ministry of Health (MoH), 1998). While open to a number of criticisms (Coombs and Jenkins, 1991), this incremental approach has been used in the Uganda health sector both before and after decentralization reforms. Three main groups of actors are involved in Ugandan health sector budgeting. At the highest level, officers of the Ministry of Finance and Economic Planning (MoFEP) guide and coordinate government ministries and departments to manage the overall government budget. Their involvement in health sector budgeting lies at the level of final budget oversight and approval. The main input to the design and management of health sector budgets comes from officers in the finance department of the MoH, and from district directors of health services. In the pre-decentralization era, the MoH was responsible for total administration of the health care system, including budgeting. Although the MoH was expected to consult with district directors of health services, the tight time constraints involved in meeting the multiple levels of budget approval meant that consultation was effectively limited. As a result, district directors had minimal input to budgeting processes.

Since the delivery of effective health care lies high in Uganda's social priorities, the health sector has been at the forefront of decentralization reform processes since 1993. While the MoFEP continues to guide and coordinate with other ministries (including the MoH) in generating annual budgets, the MoH's role has been narrowed to "standard setting, strategic planning, technical supervision and training" (MoH, 1993). From 1993, local district authorities progressively assumed more of the functions of central government, including responsibilities for financial management. The final batch of 17 districts assumed local financial responsibility in 1996/1997, meaning that decentralized management structures have been fully in place for three years now. Local district health authorities, though guided by national policy objectives and strategies, are now responsible and accountable for planning and budgeting for health care services[3]. Budgetary discretion at district level depends on the source of funds, however. Article 193(3) of the constitution specifies that "conditional" grants can only be used by a local authority for the purposes specified by central government (GOU, 1995). District health bodies have no powers to reallocate such funds to any other activity without the authority of the MoH. However, a further "unconditional" grant is paid to local governments to run decentralized services (GOU, 1995). Local authorities (such as district health authorities) may allocate this grant according to their own needs, as long as they make adequate provision for expenditure on areas of national priority (MoLG, 1997). Although it should be recognized that there remain "strings attached" to some amounts of funding, therefore, it is clear that a significant amount of budgetary discretion has now passed to lower-level (district) health managers.

The Ugandan government envisaged that this budgetary decentralization would remove the hierarchical management structures that had stifled the contributions of lower-level health sector managers. It was also hoped that decentralization and devolution of control would encourage participation by local people, empowering them to make informed decisions about health services for their community (MoLG, 1994). The next section

outlines the research method used to explore the extent to which the move to decentralized budgeting has promoted such changes.

#### Research method

In line with the aims of this exploratory study, a confidential questionnaire was used to gather "expert opinion" from within the main groups of actors involved in health sector budgeting. In June 2000 the questionnaire was sent to 15 key participants: five district directors of health services, six officers of the MoH, and four officers within the MoFEP[4]. Of the responses, 12 were received by the end of July 2000 (an 80 per cent response rate): four at district level; five in the MoH; and three in the MoFEP. The responses offer a reasonably balanced representation of perceptions across these three levels of budgeting policy and practice, therefore.

Most of the questions required respondents to select an answer from a range of possibilities (for example, "very high/high/low/very low/none"). Responses were assigned a numerical value (0 to 4) for analysis purposes, so that a weighted-average response score could be determined. In addition, some open-ended questions were used, allowing respondents to elaborate on their answers or to raise points not covered explicitly in the questionnaire. These open-ended comments informed the interpretation of the questionnaire results.

The questionnaire addressed three key issues related to the impact of decentralization on Ugandan health sector budgeting:

- (1) Were there any changes in the nature and outcomes of budgetary participation?
- (2) Was the planning utility of budgeting enhanced?
- (3) Were there any changes in the use of budgets as a tool of control?

The use of budgets for planning and control was explored across several dimensions. Respondents were asked whether the accuracy of budgets had improved under decentralization (i.e. **whether there was now less variance between planned and actual expenditure**), and **whether they felt better able to prioritise budget allocations under the decentralized system**. They were also asked **whether decentralized budgeting had improved the match between planned and implemented activities (i.e. controlling the direction of resources)**, and were asked to comment on the extent to which budgets were now used as tools for approving planned expenditure and for monitoring actual results. Results are presented below.

#### Results

##### Participation in the budgeting process

The decentralization of budgeting processes in Uganda was expected to empower lower-level health sector managers, motivate them to participate in budgeting processes, and enhance their productivity within their managerial roles. The findings of this study suggest that these aims have been largely achieved.

Of the 12 respondents, 11 rated as "low" or "very low" the motivation of district level managers to participate in planning and budgeting activities before decentralization. As shown in Table I, the overall view of respondents was that managers at the higher MoH level had the greatest level of participation in budgeting (rated at "high" to "very high")

prior to decentralization. Participation at district level was considerably lower, while community participation was negligible.

After decentralization, there was a significant shift, with all respondents perceiving district managers' motivation to participate in budgeting as "high" (58 per cent) or "very high" (42 per cent). One respondent noted that: "[District managers'] ownership of budgets has increased because of changes in the budgeting process."

Actual district level participation was thought to have risen considerably, now exceeding that of the MoH, which had fallen to moderate levels of involvement. Responses broken down by source (i.e. from the MoH, MoFEP and district level respondents) confirm this overall result. All MoH respondents considered their own budgetary participation to be "very high" before decentralization and the majority similarly thought it was "low" afterwards. District level respondents also rated their own participation as "very low" prior to decentralization and "very high" afterwards.

The expected shift of responsibility towards lower levels of management as a result of decentralization may explain the fall in perceived MoH participation and the rise in district level input. However, the MoH continues to issue planning guidelines that specify what may be included in district level budgets. One respondent noted that these guidelines are "issued from the centre without district participation", suggesting that the MoH in fact maintains a substantive level of influence on the planning phase of district health sector budgeting. The responsibility for shaping budgeting policy appears to remain fairly centralized, therefore, despite the increased participation of district level managers in budgeting processes.

Although, as Coombs and Jenkins (1991) point out, the links between budgeting and motivation are complex, it has been suggested that participation in the budgeting process can be motivational for managers (Shields and Shields, 1998; Nouri and Parker, 1998; Coombs and Jenkins, 1991). This potentially motivating effect of participative budgeting could in turn be expected to enhance the productivity of health sector managers (Nouri and Parker, 1998).

To gauge the expected positive relationship between managerial motivation and productivity, respondents' views were sought as to whether the productivity of district level health care managers had changed with the shift to decentralization.

The majority of respondents (83 per cent) felt that productivity had increased. They attributed this increase to:

- opportunities offered by decentralization where "ownership" of plans/budgets has increased;
- closer monitoring within the new system; and
- improvements in planning and management skills leading to more self reliance at the district management level.

It was also noted that improved resourcing in the post-decentralization era had in turn promoted productivity.

The outcomes of improved managerial productivity are difficult to identify, however. One respondent cautiously suggested that, although in terms of managerial input productivity had definitely increased, "in terms of actual health services provided [i.e. outputs] it is very questionable". Literature on public sector budgeting acknowledges that incremental budgeting approaches tend to ignore budget outcomes (Coombs and Jenkins, 1991), and although incremental budgeting practices are not directly related to the move to decentralized budgeting structures in Uganda, it seems that they may nevertheless act to reduce the benefits of decentralization. A majority of respondents also identified the low technical capabilities of personnel at some levels of district health care as obstacles to realizing greater benefits from decentralized health care management.

A further notable change in post-decentralization budgetary participation pertained to community involvement. It was hoped that increased participation by local communities under decentralized management structures would enhance the efficiency and effectiveness of budgeting, with priorities better reflecting the needs of the local community (MoLG, 1994). Since decentralization, community participation is perceived as having increased to levels similar to those of MoH participation, representing a substantial increase on pre-decentralization levels. As one respondent noted of post-decentralization budgeting: "The local community determines what affects them most, and participate in prioritizing activities."

However, this was not a universal view. At the district level (i.e. closest to the community), two respondents felt that community participation was now "very high", while a third thought that it remained "low". At higher MoH and MoFP levels, there was a similar mix of "high" (three responses) and "low" (five responses) scores.

This division of respondents' opinions may be explained by an apparently problematic notion of community participation. Ugandan community participation in health expenditure planning operates either through actual contribution by consultative mechanisms (e.g. through meetings), or indirectly via local council structures (Makerere Institute of Social Research, 1997). Those respondents who believe that community participation had increased may perceive participation in the context of the local council structures, while those who believe it has remained low may be referring instead to direct community participation, which appears to be limited.

Interestingly, the apparent lack of consensus on the nature of community participation in this study corresponds with a lack of theoretical consideration of this subject. Although behavioral attributes of budgeting are often considered in the context of organizational employees, the public sector presents the community as an additional stakeholder group that has attracted less attention from researchers. Pearce and Ellwood (2000) do offer some insight into this area, but their UK study notes that it may be misleading to assume that the local councils acting as vehicles for community participation might be similar across European countries. It may be even more problematic, therefore, to attempt comparisons between experiences in developed nations and a developing country like Uganda. Further examination of whether, and how, effective community participation in planning and budgeting can take place seem desirable, particularly in the context of developing countries where consultative frameworks may be less formal and structured.

Overall then, the findings of this study suggest that while the motivation, participation and productivity of district level health care managers have increased with the shift to

decentralization, the implications for community involvement and the provision of health services to the community are less clear.

#### Budget accuracy

**Decentralized budgeting is thought to reduce variations between budgeted and actual expenditure (i.e. increase budget accuracy), by placing responsibility for budgeting in the hands of those who are best able to forecast expenditure requirements.** Uganda health sector actors were asked to comment on whether there had been any significant change in the accuracy of their budgets since decentralization.

Respondents generally (83 per cent) agreed that prior to decentralization there was "low", "very low" or "no" accuracy in the costing of activities within district health sector budgets. There was an equal perception (83 per cent) that budget accuracy has become "high" or "very high" since decentralization. Attaching a ranking of 4 to "very high" accuracy and 0 to "none at all", the weighted-average response ranking rose from 1.67 to 2.92 after decentralization, an increase of 75 per cent. The overall trend therefore appears to suggest a significant increase in accuracy.

However, two respondents at MoH level believed that the accuracy of district health sector budgets remained low. One suggested that this could be explained by the lack of information on market prices and unit costs for various services. Another respondent suggested that district health sector budgets were not driven by outputs, which would encourage use of more accurate unit costs. This problem appears to relate to the incremental nature of budgeting in the Uganda health sector, as noted earlier.

Aside from this concern about possible inaccuracies in cost data, the overall view of respondents seems to fit well with the expectation that decentralized units have a better idea of their organizational environments (Kaplan and Atkinson, 1998) and are therefore able to budget more accurately. Some respondents reinforced this view in their open-ended comments. For example, an MoH officer notes: "... before decentralization, activity costs were merely guesses or estimates. The accuracy has greatly improved with decentralization as the budgeting is now done nearer the places of implementation, although this still requires improvement."

Overall, this exploratory study suggests that, in terms of their constituent items and activities, Uganda health sector budgets are more accurate in the era of decentralized budgeting. It is recognized, however, that improved availability of basic cost information could further increase budgeting accuracy, and that the incremental budgeting approach used in the Uganda health sector remains subject to a number of shortcomings. In particular, a substantial portion of any incremental budget is barely reviewed (Coombs and Jenkins, 1991), so it is possible that some inaccurate budget items are progressively rolled over. It may therefore be worthwhile to periodically scrutinize district health sector budgets using an approach such as zero-based budgeting, and to carry out occasional efficiency and effectiveness studies. This periodic review may also contribute to other aspects of Uganda district health sector budgeting such as prioritization, discussed next.

#### Prioritization of budget allocations

The ability of managers to prioritize budgetary expenditure according to local needs ought to be enhanced under a decentralized management structure (Kaplan and Atkinson, 1998). In Uganda, it was hoped that decentralized budgets would help to direct health

sector resources to areas of priority, as determined by district level managers who are closest to the populations served.

Respondents in this study revealed some difference of opinion on this issue, however. More than half of the respondents (55 per cent) opined that districts have been "much more able" to allocate resources towards their unique health problems since decentralization. Their open-ended comments supported this view, for example: "There is now a more integrated approach to prioritizing resource allocations." "... individual districts have particular needs, especially with reference to disease patterns, so they can now try to cater for them in their allocations."

Some respondents perceived improved resource prioritization to be directly linked to increased community participation since decentralization, as the following comment reveals: "The new planning and budgeting cycle encourages consultation with beneficiaries [the community] ... and plans of local governments are integrated into district plans, so the priorities of beneficiaries are now considered."

Respondents unanimously perceived a substantial increase in health care resources in the decentralized era, so it is not surprising that this may lead to perceptions of enhanced resource prioritization. However, additional resources cannot directly be attributed to decentralized budgeting, so it is difficult to argue that decentralized budgeting per se has generated improved effectiveness of prioritization. Indeed, 36 per cent of respondents thought that districts were only "slightly more able" to target their local health priorities now that budgeting was decentralized, and 9 per cent felt there was "no discernible difference" in allocation priorities. Some respondents identified potential conflicts in setting health expenditure priorities: "The integration of local priorities into the national priorities is not yet streamlined. [National] policy may conflict with local objectives and priorities."

Other respondents referred to funding sources that are tied to designated purposes, leaving little room for district level prioritization. Such funding conditions assure that budgets reflect national health priorities. However, they also reduce the scope for local budget prioritization, so act against the objectives of decentralization.

One objective of Ugandan decentralization was "to bring political and administrative control over services to the point where they are actually delivered" (MoLG, 1994, p. 2). This signified more involvement of district level politicians in Uganda's public sector management. It is possible that their increased involvement could act against effective resource prioritization however, due to the relatively short-term decision-making focus of many politicians (Henley et al., 1992). Some respondents acknowledged this possibility, referring in their open-ended comments to "pressure" or "interference" by local politicians.

Although the questionnaire did not directly seek respondents' view on corruption, one respondent acknowledged its existence, reporting that "there is an increasing abuse and manipulation of budgeting to misuse funds". Similar concerns about public sector corruption are reflected in the popular national press. For example, Uganda's Monitor newspaper (Monitor, 2000) reported in an editorial article: "Tororo district is in shambles. Money for development, building bridges, fixing roads is stolen."

Although this newspaper article was not referring to the health sector, the local council level to which it does refer is involved in all district level planning and budgeting

activities. Therefore, it is entirely possible that a parallel situation may exist in the health sector. Although it is difficult to gauge the impact of corruption on district health sector budgeting, it is possible that it may lead to changes in resource allocations. The prospect that such problems are contributing to perceived difficulties in prioritizing budgeted resources cannot be discounted.

#### Uses of budgeting as a control tool

The budgeting literature suggests that budgets form an important basis for financial control (Coombs and Jenkins, 1991; Premchand, 1983; Coates et al., 1989; McEntegart, 1983; Ashton et al., 1995). At the crudest level, total annual expenditure should not exceed the budget. To achieve organization-wide control, the same requirement can be applied to expenditure on and within services, and to discrete expenditure items.

Under decentralized management structures, altered accountability relationships might be expected to change the way in which budgets are used as control tools for approving and monitoring expenditure. This appeared to be the case in this study. All respondents recalled "low" or "very low" use of budgets for the approval of expenditure during the centralized management era, while the majority (83 per cent) felt that there was now high use of budgeting as an approval tool, post-decentralization. It was noted, for example, that district directors of health services and hospital medical superintendents are, since decentralization, mandatory signatories to approved health sector budgets.

Budgets are also perceived as more closely monitored since decentralization. All respondents agreed there had been "low" or "very low" use of budgets for monitoring purposes prior to decentralization, with 17 per cent saying that budgets were not monitored at all. The majority (83 per cent) also believed that the use of budgets as monitoring tools has become "high" or "very high" post-decentralization.

This perception appears to arise from the fact that district health sector performance reports are now generated on a quarterly basis and are widely circulated across all levels of health sector management. This was not required prior to the devolution of budgetary responsibility to the district level.

But, has the increased use of budgets for expenditure approval and monitoring helped to control money spent on public health services? The majority of respondents (67 per cent) suggested that there was poor control over where monies were spent prior to decentralization, with significant differences between activities planned and budgeted for and those actually implemented. Scores were applied to responses to the question: "how much difference is there between planned and implemented activities?" (4 = none; 3 = they are very close; 2 = they are close; 1 = they are different; 0 = they are very different). The post-decentralization weighted-average score was 2.17, compared to the pre-decentralization weighted-average score of 1.25, suggesting a general view that the match between planned and implemented activities has improved somewhat since decentralization. It seems that there are still some difficulties with maintaining the execution of planned activities however, so decentralization has not provided a comprehensive solution to this problem.

#### Summary and conclusions

This paper has reported an exploratory study of the effects of decentralization on health sector budgeting in Uganda, based on the experiences and perceptions of key actors involved in budgeting activities.

Decentralization appears to have enhanced local managers' motivation to participate in health sector planning and budgeting. District level managers, barely involved in budgeting prior to decentralization, are now highly involved. It also appears that decentralization has served to broaden, rather than simply shift, the range of actors contributing to budgeting processes. The findings of this study do not indicate any clear positive relationship between budgetary participation and productivity, however. While district level managers are now perceived as more effective in implementing planned activities, productivity improvements in terms of actual health services delivered are not as apparent.

The study produced mixed findings in regard to budgetary participation at the level of the general community. While community involvement appears to have increased post-decentralization, the evidence may not suggest any change in the level of direct involvement. Rather, the community may have participated indirectly through local council systems. The effectiveness of the latter mode of involvement in enhancing the budgeting process is uncertain, and requires further investigation. It is worth noting here that, although the accounting literature is rich in work on budgetary participation of managers and other organizational employees, the public sector presents the community as another set of actors in the budgeting process that warrants greater attention. In particular, further examination of whether and how effective community participation might enhance the quality and usefulness of public sector budgets seems desirable. Such studies may inform the evolution of public budgeting in developing countries that are increasingly embracing decentralization as a system of governance.

This study has indicated an improved match between budgeted and actual activities and costs in the era of decentralized budgeting. However, key health sector actors believe that there is still room for improvement in the accuracy of Uganda health sector budgets. A lack of basic cost information and the continued use of incremental budgeting approaches remain problematic. The possibility that these factors lead to inaccurate health sector budgets raises an important concern that cannot be addressed by decentralized budgeting structures alone. Instead, the budgeting process might be enhanced by periodic scrutiny and efficiency and effectiveness studies, within a zero-based budgeting framework.

Such periodic reviews may also contribute to other aspects of the Uganda district health sector budgets, for example the prioritization of resource allocations. This study revealed no discernible difference in the prioritization of resource allocations since decentralization. Some respondents suggested that more resources were now directed at priority expenditures, but they also noted that the level of resources given to districts had increased since decentralization. It is not clear that this improvement in resources is due to the structural change however, so it is difficult to attribute any improvement in the availability and prioritization of resources to the effects of decentralization.

It was noted that the low level of technical skills amongst some district health managers poses a potential threat to the effectiveness of devolved budgeting. Within decentralized financial management structures, it becomes increasingly important that appropriate accounting skills exist throughout lower levels of financial management. Appropriate

training is, therefore, a factor that must be considered in developing (and indeed, developed) countries if decentralized financial management structures are to be effective. It is noteworthy that Ugandan local politicians are now closely involved in planning and budgeting processes. The possibility of such political involvement acting against effective budget prioritization cannot be ruled out. In addition to the short-term decision horizon of many politicians, corruption was alluded to as a possible factor impeding improvements in the prioritization of district health resource allocations. Decentralization does not in itself reduce the potential for corruption, so appropriate control mechanisms are required to minimise its possible effects. Since the possibility of corruption is rarely considered in mainstream public sector budgeting literature, further work on this area would be useful. Corruption may be a more significant issue in developing countries, but in the face of a dearth of management accounting literature its existence in developed countries also cannot be ruled out.

Regarding the use of budgeting as a control tool, the findings of this study suggest a positive relationship between decentralized budgeting and control. Since decentralization, the match between planned and actual health activities at district level has improved, although some difficulty remains in maintaining the execution of planned activities. The exercise of control via formal budget approval appears to have increased substantially since the onset of decentralized budgeting. The routine production and circulation of district level performance reports is indicative of this change. Such reports also serve an accountability role, since districts that fail to demonstrate adequate accountability are liable to sanctions such as suspension of their central government funding.

The findings presented here suggest that decentralization, while not a miracle cure for public sector management and its associated political problems, can create the potential for participative decision-making and control. If thoughtfully implemented, such conditions may be positively exploited to enhance budgeting practices, and to respond to the challenges facing public sector management within developing nations.

#### Notes

1. Caiden (1980) and Caiden and Wildavsky (1974) noted some time ago that budgeting within developing countries has been a particularly neglected research domain.
2. See Okello (1992) for a detailed discussion of government budgeting in Uganda.
3. Loan financed expenditure on development projects has been exempt from decentralized management, remaining under central control up to this point in time.
4. The total populations of actors from which this sample was taken were: 45 district directors of health services, 20 officers of the MoH, and 30 officers of the MoEFP.

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**[Illustration]**

Caption: Table I.; Participation in budgeting before and after decentralization