

Management of Decentralization of Health Care

*Report and Documentation of the Technical Discussions
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Part I – Proceedings^{*}

^{*} Originally issued as "Consideration of Recommendations Arising out of the Technical Discussions on Management of Decentralization of Health Care" document SEA/RC55/16 dated 11 September 2002

1. INTRODUCTION

TECHNICAL DISCUSSIONS on “Management of Decentralization of Health Care” were held on 6 September 2002. Dr Kyi Soe, Director-General, Department of Health Planning, Ministry of Health, Myanmar, was elected Chairperson and Dr Deddy Ruswendi, Head, Centre of Health Policy Analysis, Ministry of Health, Indonesia, as Rapporteur. The Agenda and Annotated Agenda (SEA/PDM/Meet.39/TD/1.1 and 1.2 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.39/TD/1.3) formed the basis for the discussion.

1.1 Introductory Remarks by the Chairperson

WELCOMING the participants and representatives of nongovernmental organizations, the Chairperson highlighted the further need for evidence-based information and practical experiences from the countries in order to understand the process and implementation of decentralization of health care and to provide appropriate support to countries. He stressed that the primary intention of decentralization of health care is to improve efficiency, quality and equity. Therefore, every effort should be made to ensure that the above objectives are achieved to improve the health status of people, particularly the poor and marginalized sections of the population. However, he said that the experiences so far are mixed. He urged the participants to carefully analyse the prevailing situation in the countries and provide suggestions for future improvements.

1.2 Introduction of the Working Paper on Management of Decentralization of Health Care

DR MONIR ISLAM, Director, Family and Community Health, WHO/SEARO, presented a summary of the working paper. He highlighted the rationale for countries adopting the process of decentralization of health care services. He elaborated on the various forms of decentralization, emphasizing that in the

Regions countries are at different stages and levels of the decentralization process. Dr Islam explained that for successful implementation, countries need to fulfil some basic conditions like political commitment to fiscal decentralization, development of appropriate and adequate human resources, and establishment of an in-built system of monitoring and evaluation. During the implementation process, countries must maintain or further improve efficiency and quality, ensuring equitable access to health care services. He explained that a step-wise implementation may be more appropriate as lessons learnt and capacity built from such implementation can help improve services in other districts or regions of the same country. The central government, particularly the Ministry of Health, needs to play a crucial role to ensure the success of decentralization. Significant achievements were made and lessons were learnt during the decentralization of health care in the Region. However, a lot needs to be achieved in sustaining political commitment and leadership, building appropriate capacity for fiscal responsibility and management, adequate human resource development and deployment for health care delivery, adequate supervision, monitoring and evaluation. The Member Countries in the Region, considering the prevailing socio-cultural, political and economic situation, may need to consider an appropriate mix of approaches in implementing decentralization. The Regional Office will be ready to provide evidence-based information and technical support to achieve the objectives of decentralization to improve the health of the people, particularly the poor and vulnerable section of the population.

2. DISCUSSIONS

DURING the general discussion, it was clear that some form of decentralization was practised in every country. Different countries had different experiences, successes and constraints in this process. It was clear that the question was not whether or not to decentralize health care services but how to design and implement the process taking into consideration the prevailing situations in each country to achieve set goals and objectives of the national health policies. The participants were divided into three groups to further discuss the critical issues related to decentralization. The group discussions covered the following issues:

- Experiences in Member Countries
 - Policy formulation
 - Implementation - maintaining equity, quality and efficiency
 - Monitoring and evaluation
 - Lessons learnt
- Mechanisms for technical cooperation and exchange of expertise among Member Countries to improve management of health care in decentralized settings
- Identification of needs for evidence-based information and areas for future research needs
- Role of WHO/SEAR

The following are the highlights of the group discussion:

- The groups emphasized that decentralization is not a new political, administrative or management process which many other sectors had experienced. In some countries, even constitutional changes were made to achieve decentralization of health care within a given period of time. The decentralization process in the health sector is fairly new and ministries of health need to learn from other sectors where decentralization is either in place and functioning successfully or has been completed.
- Decentralization should take place at the centre and percolate to the periphery, within the overall governmental system across all sectors, rather than in the health sector in isolation.
- It was also felt that different forms of decentralization may be necessary in different countries.
- People at the local level should be actively involved in planning, implementation and monitoring. Advocacy was needed to put health on the local priority list and increase awareness among people to demand for their rights.
- Partnerships with NGOs and civil society should be promoted. In the process the Ministry of Health needs to play a very important role in defining policies, setting guidelines (financial and technical),

maintaining quality and ensuring equity. The ministry will need to adopt various mechanisms to deliver at least essential health care services to all sections of the population, particularly the poor and marginalized.

- There should be central control in regulating profit and non-profit-making organizations including NGOs. Support from donors and other partners should be coordinated by the ministry.
- The health ministry should be responsible for specialized health care services and medical supplies in order to make sure the population has equitable access to necessary and quality care services.
- Human resource development is a critical issue for the success of decentralization and needs to go hand-in-hand with adequate resource allocations and retention of some income generated in local settings.
- The centre should also play an important role in basic education and training, with the local authorities taking the responsibility for in-service training or retaining the existing pool of human resources.
- An efficient division of responsibility among different levels is necessary but the responsibilities, particularly at the lower level, must match its capability in respect of necessary and appropriate expertise and human resources.
- Health sector spending at the local level was gradually decreasing because of a lack of understanding, information and advocacy regarding the importance of investment in health. It was felt that the proportion of public sector spending allocated to the health sector under decentralization needs to be determined, particularly at the level of self-governing local authorities.
- The centre, in consultation with local governments may need to make appropriate legislative and/or administrative arrangements for the level and distribution of health spending and local discretion in expenditure decisions. In a few countries, such initiatives are already in progress.

- Implementation of decentralization should be a step-wise process where WHO can play an important role in providing evidence-based information and technical support in coordination with other partners. WHO may also facilitate the identification of technical deficiencies and assist in human resource development.
- WHO needs to facilitate and promote coordination among research institutions in Member Countries through the use of WHO collaborating centres and sharing of experience and information, acting as a clearing house of information.

3. CONCLUSIONS AND RECOMMENDATIONS

DECENTRALIZATION is not a new process in countries. Health sector decentralization, although new, needs to take into account ongoing processes of decentralization in other sectors.

Health problems are not the same across societies and cultures; health and social services are organized differently; the democratic process and socioeconomic conditions are different; public versus private providers, including NGOs and community-based organizations (CBOs), are playing different roles; and countries or even different states within a large country are at different stages of development. Therefore, the most appropriate form of decentralization will depend on individual country situations.

- WHO should assist Member Countries in reviewing and analysing ongoing implementation of decentralization of health care services. Evidence-based information and lessons learnt should be documented and disseminated to Member Countries.
- Advocacy to policy-makers should be intensified to increase adoption of appropriate public health policies and increased and sustained political, financial, administrative and management support. The central government, particularly the Ministry of Health, should play an important role in defining the roles and responsibilities of different levels and work in close collaboration with local governments.
- Similarly, efforts should be intensified at the community level to promote better understanding of the rationale and process of decentralization and to increase their active participation.

- Assessment of human resources needed for effective implementation of decentralization should be carried out and human resource development and deployment should be enhanced accordingly .
- An in-built system of monitoring and evaluation needs to be established at all levels of the health care system to ensure efficiency, quality, equity and accountability.
- WHO should provide necessary technical support to the Member Countries in coordination with respective governments and other partners.
- Adequate support should be provided to carry out appropriate research and to strengthen dissemination of research findings.

**Part II – Resolution, Agenda
and Working Paper**

Resolution*

The Regional Committee,

Recalling its own resolutions SEA/RC41/R8 and SEA/RC53/R3 on the development of district health systems and equity in health and access to health care,

Recognizing the need to have effective management of decentralization of health care within the context of national health sector reforms and ensuring equity in access to health care, and

Having considered the report and recommendations of the Technical Discussions on "Management of decentralization of health care" (SEA/RC55/16),

1. ENDORSES the recommendations contained in the report;
2. URGES Member States to ensure equity in access and efficiency of quality health care while implementing national policies, strategies and plans for decentralization of health care and strengthening their district health systems, and
3. REQUESTS the Regional Director to share evidence-based information and country experiences on the process and products of management of decentralization of health care.

* SEA/RC55/R3

Agenda*

1. Introduction
2. Rationale
3. Various forms of decentralization
4. Basic conditions for successful decentralization
5. Critical issues for decentralization of health care
6. Local governments and health system delivery
7. Role of ministry of health in the decentralized system
8. Implementing decentralization in the health sector
9. Lessons learnt
10. Conclusions
11. Points for discussion

* Originally issued as document SEA/PDM/Meet.39/TD/1.1 dated 26 August 2002

Annotated Agenda^{*}

1. INTRODUCTION

- Decentralization policies - benefits
- Performance of decentralization

2. RATIONALE

- Objectives of decentralization
- Character of recent reforms, including decentralization (political, managerial and financial)
- External drivers of reform and decentralization - WHO, UN agencies, international financial institutions
- Important factors influencing the changing policy process of governance - forces of democratization, globalization, economic crisis, demographic transition and rapid urbanization

3. VARIOUS FORMS OF DECENTRALIZATION

- De-concentration
- Delegation
- Devolution
- Privatization

^{*} Originally issued as document SEA/PDM/Meet.39/TD/1.2 dated 26 August 2002.

4. BASIC CONDITIONS FOR SUCCESSFUL DECENTRALIZATION

- Political commitment
- Constitutional and/or legislative framework
- Financial decentralization and resource mobilization
- Management functions
- Human resource management
- Community participation

5. CRITICAL ISSUES FOR DECENTRALIZATION OF HEALTH CARE

- Improving equity
- Improving efficiency
- Improving quality
- Level of decentralization
- Stewardship

6. LOCAL GOVERNMENTS AND HEALTH SYSTEM DELIVERY

- Role and functions of local governments in decentralization
- Extent of authority and responsibilities transferred
- Prerequisites for such a transfer
- Obstacles to devolution of power and responsibilities

7. ROLE OF MINISTRY OF HEALTH IN THE DECENTRALIZED SYSTEM

- Formulation of policies
- Setting norms and standards and development of protocols of service delivery
- Equitable allocation of resources
- Maintaining health and management information system

- Assessment of health system performance
- Quality control and licensing of drugs
- Regulation of private sector health care services
- Liaison with international health organization and aid agencies

8. IMPLEMENTING DECENTRALIZATION IN THE HEALTH SECTOR

- Adoption of policy on decentralization
- Phasing of decentralization

9. LESSONS LEARNT

- Country/Regional experience in decentralization of health care

10. CONCLUSIONS

11. POINTS FOR DISCUSSION

- Experience from countries in
 - Policy formulation
 - Maintaining equity, quality and efficiency
 - Monitoring and evaluation
 - Lessons learnt
 - Technical cooperation and exchange of expertise to improve management of health care in decentralized setting
- Role of WHO/SEARO

Working Paper^{*}

1. INTRODUCTION

In the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world, usually as part of a broader process of political, economic and technical reform. New efforts of democratization and modernization of the state have fuelled this process.

Decentralization policies are usually adopted by the central government and only subsequently by the health sector. It appears to be rare for the health sector to take the initiative. This has meant that governments have initiated national policies by issuing decrees or by adopting constitutional changes that set the pattern for the reforms to be adopted by the different ministries. In the health sector, decentralization, involving a variety of mechanisms to transfer fiscal, administrative, managerial and/or political authority for health service delivery from the central ministry of health to alternative institutions has been promoted as a key mechanism of improving health sector performance. It has usually been argued that the benefits of such policies include:

- Decision-making closer to the communities served. This is in accordance with the principle of community participation. It also brings decision-making closer to the field-level providers of services;
- Greater potential for multisectoral and multi-agency collaboration at the lower service delivery levels;

^{*} Originally issued as document SEA/PDM/Meet.39/TD/1.3 dated 26 August 2002.

- Improved 'allocative' efficiency by allowing the mix of services and expenditures to be shaped by local needs, epidemiology and provider skills and performance;
- Enhanced ability to tap new forms of finance generation;
- Improved 'technical' efficiency through greater cost consciousness at the local level;
- Service delivery innovation through experimentation and adaptation to local conditions;
- Improved quality, transparency, accountability and legitimacy owing to user oversight and participation in decision-making, and
- Greater equity through distribution of resources among traditionally marginalized regions and groups.

However, to date, the performance of decentralization has, at best, been mixed. Even where there appear to be gains in efficiency, decentralization has often been criticized because of its effect on equity. In some places, it may have caused further disparities in the quality of services provided by local authorities. Affluent and well-equipped communes have decidedly been in a better position to fend for themselves than the rest and have better access to higher quality health care services. Disparity of resources, both human and financial, was frequently compounded by a serious deficit in managerial capacity. The process of decentralization, often resulting in increased cost and initial decline in the quality of service delivery, may have influenced people's attitude to decentralization and ultimately, therefore, to the progress of reform.

In principle, decentralization can be a powerful instrument to improve health service delivery, but it can also pose significant risks and challenges that have to be carefully addressed if the potential benefits are to be realized. The issue is not whether or not to decentralize but rather how to design and implement better decentralization policies to achieve national health policy objectives.

2. RATIONALE

While policies and programme direction often originate at the national level, health services are provided, though not necessarily administered, at the local level. In a move to bring administration and direction of health care services closer to communities, many countries have used a variety of mechanisms to decentralize health care services. The expressed goals of decentralization are to better meet local needs, improve the efficiency and quality of services, and ensure equity in health care.

There are many complex reasons why governments in various countries have started or are beginning to start decentralizing their services. Looking at the historical perspective and analysing the reasons for the decentralization of policies and their evolution, it is evident that different local factors have played a major role in different countries, e.g. political ideology, demand for more regional autonomy and the need to rationalize overburdened and outmoded administrations.

Many countries have realized the need to strengthen peripheral and local authorities and have adopted decentralization as one of the major means of implementing reforms for better efficiency, quality and equity. The objectives of decentralization have been diverse. On a philosophical and ideological level, decentralization has been seen as an important political ideal, providing the means for community participation and local self-reliance, and ensuring the accountability of government officials to the population. On the pragmatic level, decentralization has been seen as a way of overcoming institutional, physical and administrative constraints on development. It has also been seen as a way of transferring some responsibilities for development from the centre to the periphery.

The 1990s witnessed globalization occupying centre stage at both international and national policy debates along with the issue of decentralization. Within the health sector, decentralization of finances, through untied/un-earmarked grants and responsibilities, emerged as an important topic in the agenda of national governments, international organizations and development agencies. The increasing trend towards privatization of health services and the expansion of the private sector as a motor of economic growth has fostered closer partnerships in health.

Globalization has also influenced the community structure, family values, life styles and the disease pattern. A decentralized system is considered to be more able to address these changing situations by acting promptly and appropriately according to the local environment.

In addition, globalization has enhanced the spread of market-oriented reforms in health. The economic decline in developing countries has eroded public health resources resulting in widespread degradation of health infrastructure and decline in the health status. The poorest section of the population is affected the most from the increasing inequity in health. Decentralized self-governing local institutions are seen as a vehicle for identifying and reaching the poor more effectively and for mobilizing additional resources for public health.

3. VARIOUS FORMS OF DECENTRALIZATION

Usually decentralization is seen as a process in which the authority, resources, and functions are transferred from central government agencies to other institutions at the periphery of the national system with decision-making largely vested with the people. The following are the various forms of decentralization:

De-concentration involving shifting of workload or expertise without decentralizing the decision-making power from the centre to the regional or district offices within the structure of the ministry of health. Since de-concentration involves the transfer of administrative rather than decision-making power, it is seen as the least extensive form of decentralization. Nevertheless, de-concentration has been the form of decentralization most frequently used in the developing countries since the early 1970s. For the ministry of health, it implies imbuing local (for example, district) management with clearly-defined administrative duties and a degree of discretion that would enable the local officials to manage without constant reference to ministry headquarters. De-concentration may be accompanied by the amalgamation of both central and local government health services within the local organization, in order to facilitate the planning and management of health services on an integrated basis.

Delegation refers to transfer of functions and responsibility to the local level to achieve greater efficiency by increasing cost control, flexibility and responsiveness. The ultimate responsibility remains with the central government, but its agents have broad discretion to carry out its specific functions and duties. In the health field, delegation has been used to manage teaching hospitals, for example. Delegation has also been used to organize the provision of medical care financed by social insurance. Delegation is not compatible with de-concentration. If the management of entire national health services is delegated to a separate organization, the role of the ministry of health would be confined to strategic and policy issues.

Devolution in the stricter sense is closest to the complete form of decentralization in which the lower levels, with respect to resource control, policy formulation, implementation, monitoring and evaluation, achieve autonomy. In fact, devolution is the creation or strengthening of sub-national levels of government (often local government or local authorities) that are substantially independent of the national level in respect to a defined set of functions. They normally have a clear legal status, recognized geographical boundaries, and a number of functions to perform, and a statutory authority to raise revenue and control expenditure. They are rarely completely autonomous, but are bodies largely independent of the national government in their areas of responsibility rather than subordinate units as in the case of de-concentration. In the health sector, devolution implies much more radical restructuring of the health service organization than de-concentration.

Privatization involves the transfer of government functions to voluntary organizations or to private profit-making or non-profit making (or nongovernmental) organizations, with a variable degree of government regulations. Since many governments cannot afford any major expansion of health services or even maintain existing services, they need to seek alternative sources of financing and service provision. Financing mechanisms may include free service delivery by nongovernmental organizations, indirect or third party payment in the form of various insurance schemes, or increased direct consumer payment or "cost-recovery" (though with substantial public funding), while the options for service delivery may involve nongovernmental and voluntary organizations providing services or greater reliance in the private sector.

The above forms of decentralization are useful for identifying the institutional location of the newly-transferred powers; however, it tells us little about the crucial aspect of decentralization; namely, the range of choice that is granted to the decision-makers at the decentralized levels. Decentralization is often considered a one-off event to transfer power at one time and in one quantity to the new institutional locations. That may not be true in most settings because variations and changes do occur over time in the process of decentralization. In fact, decentralization is a dynamic relationship of changing powers between the centre and the periphery; not granting of full powers to the periphery. In practice, these different types of decentralization are used at the same time for different functions and may not necessarily be found in their pure form.

4. BASIC CONDITIONS FOR SUCCESSFUL DECENTRALIZATION

Political commitment: The will of the relevant political actors at the national as well as at the sub-national levels to go ahead with decentralization and taking actions for appropriate policy and legislative changes for orderly transfer of power is the key prerequisite to decentralization.

Constitutional and/or legislative framework: A constitutional and/or legislative framework is needed to reinforce the legitimacy of the political decision and commitment for reform and to provide coherence, direction and purpose to the whole exercise. It underscores the primary responsibility of the executive branch of the government to take the initiative and the importance of providing a locus of initiative for the reform at an early stage.

Financial decentralization and resource mobilization: There is a need to build a secure and adequate revenue base. The central government needs to decide on the allocation of funds to decentralized entities. The proportion of public sector spending allocated to the health sector under decentralization needs to be determined. In a decentralized system, the centre should make appropriate legislative and/or administrative arrangements for levels and distribution of health spending (fiscal decentralization), income sources, fiscal autonomy and local discretion in expenditure decisions. In the case of multiple sources of finance, these need to be coordinated and regulated in

order to achieve reasonable control over cost and expenditure. Responsibilities for capital investment and recurrent cost of the system also need to be decided.

Management functions: An efficient division of responsibility among different levels (centre, provincial/regional and district) is crucial in order to minimize unnecessary duplication and overlap, and maximize the efficient use of scarce resources. The role of each level must match its capability, and a set of rules defining who has authority and who will be held accountable is necessary. These rules should be explicit and transparent.

Human resource management: Human resource management is a critical component of a coherent strategy on decentralization. Control over human resource management has far-reaching effects on health sector performance. Financial decentralization and human resource management go together as a large proportion of health sector resources in developing countries goes to salaries and personnel. An appropriate legislative framework is generally needed to create a suitable environment for recruiting, retaining, developing and motivating men and women of appropriate calibre for the health sector. There is also a need to improve the quality of the professional inputs into health service delivery and, in many cases, re-professionalization of the public service.

Community participation: Community participation is crucial for promoting successful decentralization. Whether decentralized management of health care will be more responsive to the local needs depends on decentralization being accompanied by increased involvement of the community in some way in order to define those needs. Access to information on the health system performance is critical for the promotion of accountability. Unless the community knows what goods and services are provided, how well they are provided, who the beneficiaries are, and how much they cost, the community cannot demand effective governance and service delivery. The decentralization process needs to provide a means of enabling communities to directly participate in local decision-making affecting health services delivery. The decentralization process in itself may be inadequate to promote community participation. Additional mechanisms are, therefore, required within the local institutions if communities are to have an impact on health services delivery.

5. CRITICAL ISSUES FOR DECENTRALIZATION OF HEALTH CARE

Policy-makers and other leaders often underestimate the complexity of designing and implementing the fundamental changes in management systems that decentralization requires if health care delivery is to improve significantly. Therefore, the following issues need to be addressed in the decentralization of health care.

Improving equity: In order to improve equity in health care, the decentralized system needs to ensure that resources are allocated according to need; that quality health care services are available and accessible according to need, regardless of the prevailing social attributes; and that payment for health services is made according to the ability to pay.

Improving efficiency: Improvement of overall efficiency of health care services will depend on allocative and technical efficiency. Allocative efficiency will occur by allocating resources to cost-effective and appropriate level of care, and according to the local needs. Technical efficiency, on the other hand, will occur when the right mix of inputs (human, money, material and method) is used.

Improving quality: The process of decentralization needs to ensure that the quality in health care is not compromised. Appropriate mechanisms need to be established for quality assessment and continuous quality improvement at all levels and sectors of health care services – public, private, voluntary or non-profit organizations.

Level of decentralization: Almost all countries of the Region have embarked upon decentralization of health care as part of overall political and civil service reforms in general and health sector reform in particular. Depending upon the socioeconomic and political realities, each country has to consider or identify an appropriate mix and level of centralized and decentralized functions, responsibility or authority to best meet its policy objectives.

Voluntary agencies and the private sector may be able to tap resources and provide more efficient services, particularly curative services which the government cannot provide. They may also work in areas that the government

avoids because they are controversial or are too expensive or suited to voluntary provision. It involves complex considerations of the ability of the consumers to pay, the motivation of the providers, and patterns of government regulation, and requires detailed examination of the extent to which privatization may contradict government objectives such as equity of access to health care. It is important, therefore, that privatization does not remove from the government all burdens of health management. A strong regulatory authority is required to monitor the supply and quality of both health services and supply industries and to ensure the coordination of services on a geographical basis.

Stewardship: Stewardship becomes more important in decentralization. The government should take responsibility for the welfare of the population and be concerned about the trust and legitimacy of the services provided. It will require vision, intelligence and influence, primarily by the ministry of health which must adapt itself as a learning organization coupled with management of change. As capabilities of the lower level to implement tasks that have been handed over improve, the central level should focus more on this stewardship.

6. LOCAL GOVERNMENTS AND HEALTH SYSTEM DELIVERY

Local government control offers the advantage of making health services more accountable to the public. Many countries have created full-fledged government systems at the local level that have powers and resources to deliver services. The decentralization of authority for health system functions and decision-making to local governments is an outcome of political, economic and health policy trends. The local government, within the health sector, may have the responsibility for the provision of basic health care and preventive and public health programmes in addition to healthy living: basic education, water and sanitation, environment, social care and housing etc. This gives the health sector managers an opportunity, as a member of the local government management team, to interact with other development partners and incorporate health into all development projects and programmes. The local government also takes more responsibility for indirect

health-related functions such as citizens' rights and obligations, enforcing and maintaining standards.

Two major issues are likely to arise when any country considers including health functions under the local government. First, health makes heavy demands on recurrent expenditure. Yet, local governments often have a very limited tax base and may rely on revenue sources such as land or property taxes whose yield cannot be easily increased. In developed countries, therefore, the trend has been to shift health services ownership and/or financing out of local government hands, as health services have become too expensive for the local authorities to maintain. If the cost is covered by the central government through grants to local governments, then this implies heavy dependence of the local government on the central government and a likely reduction in local autonomy. But at best, it can be seen as a reasonable response to the question of how to turn over the responsibility for complex development activities to poverty-stricken and under-staffed local authorities.

Secondly, decentralization may complicate efforts to construct a logical hierarchy of health services and to set up a regional structure. This is not an insoluble problem. In many countries, primary health care services are the responsibility of the local government and the provincial or central governments remain responsible for secondary and specialist services.

Although local governments raise their own revenue, central government grants are an important source of revenue. The allocation of strategic resources (personnel and capital investment) and setting national priorities are strictly under the control of the central government through planning and financial subsidies. The experience so far from developing and developed countries indicate that it is feasible to decentralize health services to local government structures, but this requires heavy state involvement in financing as well as considerable cooperation among the local authorities to provide the more specialized services as well as maintaining equitable and quality services throughout the country.

7. **ROLE OF MINISTRY OF HEALTH IN THE DECENTRALIZED SYSTEM**

Given that equity and quality are often compromised in the decentralization process, a certain degree of centralization in the health sector is necessary to ensure equitable access to and quality of health care. Therefore, decentralization does not relieve the ministry of health of all roles and responsibilities but rather give further importance to critical and important functions. In a decentralized system, the ministry of health plays the primary role of steward in general and policy-making and coordination in particular. The main functions may be:

- Formulation of policies related to health sector priorities, human resources management and health financing, including cost recovery and health insurance schemes taking into consideration efficiency, equity and quality.
- Setting norms and standards and development of protocols of service delivery and clinical case management, including the provision of technical assistance for specific programmes.
- Equitable allocation of resources, particularly capital and development investment, taking into account the ability of local levels to generate resources.
- Maintaining health and management information system and providing feedback.
- Assessment of health system performance at both national and local levels.
- Quality control and licensing of drugs and distribution and ensuring good manufacturing practices.
- Regulation of private sector health care services, both profit and non profit-making, and research institutes.
- Promoting basic and operational research.
- Liaison with international health organizations and aid agencies.

8. IMPLEMENTING DECENTRALIZATION IN THE HEALTH SECTOR

Decentralization is a sensitive political issue; it concerns the distribution of power and the allocation of resources. Many countries have attempted to decentralize administrative procedures, while at the same time retaining or strengthening central control over policy, legislation and budgetary activities. It is very important to clarify which functions are being decentralized and which would remain under central control. Decentralization and centralization must be considered together.

The adoption of a policy on decentralization is only the beginning of a lengthy process that requires a strong political commitment over many years to achieve good results. The early stages are often characterized by the national authority (in this case the ministry of health) being reluctant or lacking in expertise to implement the policies and, similarly, the regional, district and local authorities being reluctant or lacking in expertise to accept their new responsibilities. The early stages, therefore, require a great deal of consultation between all the authorities concerned, including the community, in order to clarify new roles and responsibilities.

It is frequently recommended that decentralization be phased in gradually, area by area or function by function. The following suggestions are made for improving its success, based on a large-scale review of experiences in developing countries:

- Keep the reforms, reorganization, or programme small in scope, at least initially.
- Allow a long period for any changes to be adopted and to prove themselves.
- Set up clear management procedures for all financial matters.
- Transfer management responsibility and authority gradually and incrementally.
- Develop a strong orientation and training component for senior managers.

- Encourage mid-level and local staff to accept increasing responsibility through a system of close supervision and training.
- Strengthen regional and district health authorities so that they can assume greater responsibilities.
- Clarify the new responsibilities of each government level and develop a process of open consultation within and between levels.
- Monitor and evaluate progress, and make timely and appropriate changes involving all parties concerned.

In decentralization, the lower level has a better opportunity to adapt or translate policy, strategy and targets to suit local needs without too much compromise on quality. However, guidance and technical support from the centre will be continuously needed.

Despite many important tasks that should be maintained by the centre, gradually programme implementation in general should become the main task of the local or lower units. As mentioned earlier, the centre will have to focus on stewardship rather than on implementation or steering.

"Top-down" implementation by a strong central government of a new policy for decentralization, without due regard for a process of consultation and adaptation, should be avoided. The policy may well be adopted but there is likely to be a wide gap between intentions and reality. Decentralization implies greater responsibility and authority for local governments, organizations and communities, but it will only be accepted and made to work through a process of consultation that allows genuine "top-down" and "bottom-up" interaction. And that, it may be argued, is what decentralization is all about.

9. LESSONS LEARNT

The experiences of the countries in the Region in terms of health sector reforms in general and decentralization of health care in particular have been very different. While some countries have established elaborate administrative and financial structures and have already started implementing the

decentralization programme quite successfully, others are still at the early stages of taking the necessary policy decisions.

Some of the constraints for implementing successful decentralization programmes are:

- Sustaining political commitment and translating it into operational means;
- Lack of common understanding of a comprehensive health system development framework resulting in ad hoc perceptions and sporadic decisions;
- Inadequacy of analytical and action-oriented information and clear directions for action and feedback;
- Absence of appropriate mechanisms for planning, implementation, monitoring and evaluation; and
- Inadequate research support to provide information on the impact of public policies on health.

It is envisaged that decentralization will achieve general objectives such as improvement in the quality of care, equity, and efficiency, as well as the objectives of specific health programmes. However, the experience in the Region shows that some objectives may be achieved at the cost of others. The recent economic crisis and civil disturbances in many countries of the Region may have compromised equity and the quality of service delivery. In future, independent in-depth analysis and studies need to be conducted in order to determine when and in what form decentralization leads to expected benefits and outcomes. This will help countries in taking evidence-based decisions for improvement and future implementation.

10. CONCLUSIONS

It is clear that effective decentralization cannot rest simply on the transfer of authority, functions and resources from the national to the local authorities but that it must be accompanied by a range of measures, including adequate training designed to support the newly-empowered local authorities and creating a conducive environment. Depending on the policy conditions,

decentralization can give rise to equity or inequity. In order to give rise to equity, the programmes of decentralization have to be linked to policies, for example, on national health planning, resource allocations and community participation. Relatively stronger groups may have louder voices, thus reducing the likelihood that the needs of the poor will be heard unless specific measures are taken to assure that relatively disadvantaged and/or marginalized groups' perspectives are taken into consideration. With increasing enthusiasm for decentralization as a strategy of promoting efficiency and public accountability, it is important not to overlook the role of the center, particularly in relation to equity issues. In a decentralized system, the centre needs to establish equitable means for allocating resources between districts and to ensure the existence of effective mechanisms for managing the health labour market.

The most appropriate form of decentralization depends on the country situation. Health problems are not the same across societies and cultures; health and social services are organized differently; the democratic process and socio-economic conditions are different; public versus private providers, including NGOs, are playing different roles; and countries or even different states within a large country are at different stages of development. Thus, different forms of decentralization, from de-concentration to privatization, may be appropriate. It is clear that there is no unique formula, nor any simple technical fix for meeting the health needs in an effective and efficient way maintaining quality and equity. What is needed is a right mix of approaches.

11. POINTS FOR DISCUSSION

- Experiences from countries
 - Policy formulation
 - Implementation - maintaining equity, quality and efficiency
 - Monitoring and Evaluation
 - Lessons learnt
- Technical cooperation and exchange of expertise among Member Countries to improve management of health care in a decentralized setting
- Role of WHO/SEARO.

Suggested Reading

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