HEALTH SYSTEM
DECENTRALIZATION

Concepts, issues
and country experience

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World Health Organization
Geneva
1990
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Preface

Decentralization of health system structures and management is a key issue for many countries in the achievement of "health for all by the year 2000" and in the development of primary health care. In the WHO publication entitled *Formulating strategies for health for all by the year 2000*, it is stated that:¹

... to achieve ... coordination, countries may wish to review their administration system to ensure that coordination can take place at central, intermediate and local levels. As part of this review, they may wish to assess the degree to which they need to strengthen local and intermediate levels of the national administration, by means of delegation of responsibility and authority to the community and to intermediate levels as appropriate, and by the provision of sufficient manpower and resources.

Discussion of delegation, decentralization and similar terms has for long been a key theme in public administration, but has been somewhat neglected in the health field. The aim of this publication is therefore to introduce the subject of decentralizing health system structures and management and to illustrate how various countries are attempting to do this.

The publication is divided into three parts. Part 1 introduces the subject by referring to the historical experience of decentralization in developed and developing countries and reviews the literature on decentralization. In so doing, it clarifies the meaning of the term, and draws out a number of major issues, illustrating its points with reference to the experience of many different countries.

Part 2 is made up of ten country case-studies, from Botswana, Chile, Mexico, Netherlands, New Zealand, Papua New Guinea, Senegal, Spain, Sri Lanka and Yugoslavia. The countries included are among those with recent experience of decentralization of health management and illustrate a range of different circumstances. The authors of the case-studies were asked to discuss, each in the context of their own country, the concept of decentralization, the process of implementing the decentralization policy, changes in organizational structures and management functions, the effect of decentralization on collaboration between the health sector and other sectors, groups and communities, and finally, to give an overall assessment of country experience.

In Part 3, issues arising from the case-studies and from relevant literature are discussed and the lessons to be learned are examined. Part 3 also proposes some alternative approaches to decentralization that ministries of health may wish to consider.

Acknowledgements

This publication includes a literature review and a number of detailed accounts of the experiences of countries that have put into practice the concept of decentralization, learned useful lessons, and identified constraints in the implementation of decentralization. Our gratitude goes to the authors of the various country case-studies without whom this publication would not have been possible. Thanks are also due to the following reviewers:

Professor G. Soberón Acevedo (Minister), Secretary of Health, Mexico

Professor B. Abel-Smith, London School of Economics and Political Science, England

The contributions of Mr Norbert Dreusch who carried out the initial literature review, Ms Diana Conyers who provided us with suggestions and comments at several stages, Ms Barbara Pumfrey who assisted in the administrative work throughout and in proof-reading, and the efforts of Ms G. Dubouloz and Ms N. Tinapay in coping with the work of processing the text, are gratefully acknowledged.

Finally, we should like to acknowledge the generous assistance of the Swedish Agency for Research Cooperation with Developing Countries (SAREC) and the Swedish International Development Authority (SIDA), and the generous support given by the Danish International Development Agency (DANIDA) to the DANIDA/WHO Programme on Strengthening Ministries of Health for Primary Health Care.
PART 1

Decentralization concepts and issues: A review

Anne Mills
Introduction

Decentralization can be defined in general terms as the transfer of authority, or dispersal of power, in public planning, management and decision-making from the national level to subnational levels (37), or more generally from higher to lower levels of government. In practice, health system decentralization takes many different forms, depending not only on overall government political and administrative structures and objectives, but also on the pattern of health system organization prevailing in the particular country. Decentralization is therefore not only an important theme in health management but also a confused one. The purpose of Part 1 of this publication is to clarify the different meanings of decentralization and their implications for the organization of the health system, and to review the advantages and disadvantages of decentralization. Since health is only one of the functions of government and its organization is strongly influenced by governmental structure, this review must logically take account of the large body of literature on decentralization that exists in the general field of public administration, although the two subjects are generally treated in isolation. Indeed, it is notable that the public administration literature makes only passing reference to health, and the literature on the organization of health services largely neglects its relationship to broader patterns of government administration, concentrating instead on the establishment of a logical structure of health services as if it were not greatly constrained by its national organizational context.

This review thus draws on the broader literature on decentralization to the extent that it is helpful in thinking about the organization of health services. Two areas are excluded. One is a specific discussion of federalism since the focus here is on the more local levels of government. The other is what has been termed “territorial” decentralization, or the geographic dispersal of health services themselves as opposed to their management (14).

Apthorpe and Conyers (2) have warned that:

... unfortunate tendencies to discuss “centralization” and “decentralization” as if they were two clearly defined, completely contrasting and therefore alternative states of existence [do] not merely over-simplify the issues but can actually hinder or distort both descriptive and prescriptive analysis.

Decentralization and centralization are more usefully viewed as movements between two poles. Both central and local elements are required in any health system; the issue is what balance should be struck, in which direction a particular country should move, and what means are at its disposal to alter the existing balance. It is these issues that are explored in Part 1 of this book.

It is important to acknowledge that decentralization policies are concerned with changing power relationships between levels of
government (44). Political considerations are thus inherent in any
decisions made, and the extent of decentralization is limited by the
political environment. However, it is difficult to explain a particular
country's decentralization policies solely by reference to its political
system. Certainly political systems are one influence, but the explanations
of why countries do or do not decentralize must take account of a
complex set of factors. For example, both the United Kingdom and
Switzerland are industrialized countries with parliamentary governments,
but they have very different degrees of decentralization. Thus political
systems are not necessarily the main factor governing the decentralization
choices that countries face.

The historical background to current
decentralization policies

Developing countries

Writers on decentralization trends in developing countries point to
two major phases of interest in decentralization (12, 44). In the 1950s
and early 1960s, decentralization—in the form of a system of local
government—was promoted by colonial administrations as a necessary
element in the structure of an independent democratic state, as a means of
political education for the population, and as a way of establishing local
responsibility for providing some local services. The structures proposed
and set up were usually based on models of British or French local
government, though limited in their powers and functions. Independence,
however, brought concerns of national unity to the fore and for a while
decentralization ceased to be a major theme. In the 1970s and 1980s
interest in decentralization has re-emerged, for diverse reasons. In some
countries, particularly in Africa, governments now feel sufficiently secure
to contemplate relinquishing part of their tight control on power and
decision-making to local organizations. This also becomes more feasible
as a corps of skilled administrators is built up. Thus, in contrast to
experiences in developed countries (see below), decentralization has been
pushed by the centre rather than demanded by the periphery. In some
countries, however, particularly in the Pacific area, decentralization has
occurred in response to pressure from local or regional groups for
increased local autonomy (26).

The objectives of decentralization have thus 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 a pragmatic level,
decentralization has been seen as a way of overcoming institutional, physical and administrative constraints on development. For instance, increased local control can result in a better response to local needs, improved management of supplies and logistics and greater motivation among local officers, thus facilitating and speeding up the implementation of development projects. It has also been seen as a way of transferring some responsibility for development from the centre to the periphery and, in consequence, a way of spreading the blame for failure to meet rural needs (9). In countries with diverse, and sometimes mutually antagonistic, population groups, decentralization has been seen as a way of providing them with greater autonomy while retaining them within a single nation.

Countries that have already introduced significant organizational reforms include Botswana, Ghana, Kenya, Nigeria, Senegal, Sudan, United Republic of Tanzania and Zambia in Africa, Nepal and Sri Lanka in South-East Asia, and a number of countries in the south of the Pacific area, such as Papua New Guinea and Vanuatu. In China and Yugoslavia the entire system of government is based on decentralist principles, with strong emphasis on community organization. Many more countries are attempting to strengthen local level administrations within existing government structures, with corresponding interest in the most suitable administrative mechanisms. In Latin America decentralization of power from central and intermediate levels to local units of government has not until very recently been a major feature of contemporary administrative reforms, and the existence of an “administrative vacuum” at local level has been suggested (22).

**Developed countries**

In developed countries, debates over centralization and decentralization have taken place in a rather different context (44). Local government has historically been strong in many developed countries; indeed, central government powers have often been developed and strengthened somewhat later than those of local government. Many countries have therefore inherited local government structures that provide a wide range of services, often financed by local funds.

However, central government has tended to place increasing restrictions on local government. A common theme in the expansion of the powers of central government has been the need to promote greater equality of public services throughout the country by using central government policies, regulations, and specific and general grants to reallocate resources geographically. Decentralization has nevertheless remained a continuing cry, although often raised against a background of strong influences promoting centralization. Recently, faced with economic recession and desirous of controlling public expenditure, some central governments have tried to limit local discretion further, for instance in Sweden and the United Kingdom (21). In the report of a Committee of
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Enquiry into local government finance in the United Kingdom in 1976 (27) there is a comment that:

...what has been clearly visible over recent years is a growing propensity for the government to determine, in increasing detail, the pace and direction in which local services should be developed, the resources which should be devoted to them and the priorities between them.

This has proceeded to the point where local authorities have been called ‘the agents of central government with the additional role of statutory pressure group’ (17).

Few countries are attempting to counter this trend, though many have minority political parties in favour of strengthening local democracy. Spain provides a notable exception to the current centralizing trend (see case-study in Part 2).

Evolution of health services

The organization of health services reflects general trends in the organization of government services, though the historical development of health services and the pattern of ownership (the balance between government, insurance, voluntary and private elements) have also been strong influences. In many developing countries, particularly in Africa and South-East Asia, public health services have been developed largely in response to central government initiatives, with local government usually playing a minor role in the provision of rural clinics and urban environmental health services. Health service decision-making in such countries has been described as excessively centralized, with weak administrative capacity at the local level (24). In these countries, there is now considerable interest in decentralizing management,1 and particularly in strengthening the “district” level of health services organization (46).

However, governments rarely have a monopoly in the provision of health services. Even in the countries referred to above, there is often not only a private health sector but also a large voluntary and religious sector whose administrative structure may be very decentralized, in that each agency may provide services to only a limited geographical area. A dispersed pattern of ownership is even more marked in those developing countries with social insurance systems, since the health services were often developed for particular industries or professions.

In contrast to the largely centralized structure of health services initially created by many colonial administrations in developing countries, the

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health services in developed countries were originally created by local charitable and religious agencies and local government authorities. The historical experience of developed countries has been the gradual organization and integration of these local services into an often rather loose national structure, though in some countries, such as the United Kingdom, there are now highly integrated health systems. Since diversity of ownership and fragmented management do not fit easily into modern concepts of health service organization, a very strong theme in developed countries has been "regionalization": the rationalization of often diverse and semi-autonomous services to provide comprehensive health care to a large regional community or group of communities (36,49), including a well defined pattern of referral and supervision. Regionalization has also been of considerable interest in developing countries. Arbona & Ramirez de Avellan (3), for example, have described the experience of regionalization in Puerto Rico.

Decentralization and regionalization are not necessarily conflicting ideals; indeed, decentralization has been a strong theme in the regionalization of health services in many developed countries, though the reality may not match the rhetoric (28). However, the need to provide for a logical hierarchy of services within a health system does create an added complication that must be taken into account when one assesses the desirability and feasibility of decentralizing health service organization, as discussed later.

The meaning of decentralization

Health and health-related services, while they can be looked at as a system in their own right, are also part of a wider government and social system that places limitations on their behaviour. It is therefore important to describe the main forms of decentralization and to see what they imply for the organization of the health system.

The difficulties of discussing decentralization are well illustrated by the following quotation from Furniss (18):

... decentralization may mean the transfer of authority over public enterprises from political officials to a relatively autonomous board; the development of regional economic inputs into national planning efforts; the transfer of administrative functions either downwards in the hierarchy, spatially or by problem; the establishment of legislative units of smaller size; or the transfer of responsibility to subnational legislative bodies, the assumption of control by more people within an economically productive enterprise, the hope for a better world to be achieved by more individual participation.

Decentralization can thus mean many different things. At the outset, however, it is important to draw a distinction between functional and geographical (or what has been termed "areal") decentralization (37), a
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distinction that is particularly relevant when it comes to health system organization. In functional decentralization, authority for performing particular functions, for instance health care, is transferred to a specialized local office. In areal decentralization, broad responsibilities for public functions are transferred to local organizations that have well defined geographical boundaries. The organization of health services may be decentralized in either way, but the ministry of health may well have more power to influence the degree of functional decentralization than that of areal decentralization, where health will be only one of a number of government services that are being decentralized.

Four main types of decentralization commonly found in practice can be distinguished: decentralization, devolution, delegation and privatization (39). These reflect both different degrees of decentralization of government authority and different approaches to decentralization. The distinction between these four types relates essentially to the legal context of decentralization. However, it is useful to note early on that while the legal framework for decentralization is an important influence, there are many other factors that will influence the actual degree of discretion enjoyed by local bodies. These include their control over resources, their ability to mobilize political support, the perceived legitimacy of their position, and the general climate of rules, regulations and expectations within which they operate (28).

Deconcentration

The term “deconcentration” is applied to the handing over of some administrative authority to locally-based offices of central government ministries. In the case of health, an example would be a district-level office of a ministry of health. Since deconcentration involves the transfer of administrative rather than political authority, it is seen as the least extensive form of decentralization, as implied in the report by Mills & Odoi in Ghana in 1967 (4):

We mean by decentralization not the delegation of authority by a ministry to an official in a department or region: authority may be delegated in this way but not real responsibility—that remains with the person or office in which responsibility is legally or constitutionally vested, and that person may at any time withdraw his delegation of authority.

Nevertheless, deconcentration has been the form of decentralization most frequently used in developing countries since the early 1970s (see Rondinelli et al. (39) for interesting examples). For the ministry of health, it implies establishing local (for example, district) management with clearly defined administrative duties and with a degree of discretion that would enable the local officials to manage without constant reference to ministry headquarters.
The local administration set up under deconcentration can be of two different types (42). In what can be called a vertical pattern of local administration, the local staff of each ministry are responsible to their own ministry. Some form of coordinating structure (e.g., a district development committee) may be set up to try to ensure that the various local ministry organizations do not operate as completely independent entities. The district development committee may include local party officials and local members of parliament as well as local ministry staff. Many countries have experimented with putting some funds at the disposal of development committees, to try to overcome the difficulties in responding to popular needs and demands when there is separate funding from central level of each government function. Rondinelli et al. (39) quote a number of examples. For example, Sri Lanka put a decentralized budget at district level, to be spent on the priorities for local capital expenditure identified by a district committee of civil servants and members of parliament.

The second type of local administration can be called the integrated (or prefectoral) form. In its most extreme version, a local representative of central government (for instance, a prefect, governor or district officer), who is accountable to a central government agency such as a ministry of the interior or a ministry of local government, is made responsible for the performance of all government functions in his or her area. The local staff of government ministries would be responsible to the governor for all day-to-day matters, and government ministries would exercise only technical supervision over their local staff. Thailand presents an example of this pattern of organization, with the provincial medical officer responsible to the provincial governor.

This model is attractive for countries particularly concerned about the difficulties of encouraging rural development when each ministry operates independently. It may also be set up with the main aim of increasing the efficiency of local administration, by putting one official in overall authority. It may actually be viewed, in consequence, as a device to promote centralized power rather than decentralization (19).

The new forms of decentralization being set up in developing countries, such as the integrated form, are tending to blur the traditional distinction made between decentralization through deconcentration and decentralization to a local government system (termed devolution and discussed below) (12). Reforms that aim at the integrated form of deconcentration may set up a local body which, while it may not be fully elected or have full legal status, does provide a forum for the discussion of development issues between local people, government officials and political representatives. This local body may take the form of a district development committee, as in the vertical form of deconcentration, though the committee is likely to be more influential when local ministry staff fall under the jurisdiction of a governor, who is often the chairman or secretary of the committee.

The reforms in the United Republic of Tanzania during the 1970s (10) provide an example of decentralization through deconcentration of
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administrative authority (though recent changes have been closer to devolution). An integrated pattern of local administration and local bodies was set up. While these bodies had some legal status, they did not have the political authority of a local government system. At regional level, a regional development committee was made up of civil servants, party officials and representatives of local organizations. At district level, the old elected local government councils were removed and replaced by a district development committee made up of locally elected representatives, civil servants, party officials and members of parliament. The regional and district bodies were responsible for planning and implementing development programmes, but had no power to raise revenue. Local ministry staff—for example, the district and regional medical officers—were responsible to the senior civil servant in the district and region but received direction and advice on policy and technical matters from their ministries. The Office of the Prime Minister had overall control over regional and district administration and the regional commissioner was the supreme representative of the Prime Minister at regional level.

What are the implications for a ministry of health of decentralizing through deconcentration? Deconcentration implies establishing one or more additional management levels—for example, the district and/or region—and delegating to it (them) certain administrative functions. Perhaps the minimum requirements would be:

— one or more senior staff with responsibility for managing health activities within the district and with clearly defined discretionary powers;
— a clearly defined population and geographical area for which the managers are responsible;
— an identifiable staffing establishment and budget;
— a mechanism for communicating the health development needs of the district to higher level planners.

Deconcentration may be accompanied, as it was in the Tanzanian example above, by the amalgamation of both central and local government health services within the new district organization, in order to facilitate the planning and management of health services on an integrated basis across the whole district. In the United Kingdom, for instance, the reorganization of the health service in 1974 saw the transfer of local authority responsibility for community health services to the National Health Service; at the same time, new district and area health authorities were set up to take on district- and area-wide responsibilities for health in place of the previously fragmented system for hospital and community health services management. Whether the effect of the reorganization was to promote decentralization or centralization has been hotly disputed (28); however, in 1982 the area level of management (above the district) was removed and the district and sub-district level management structures were strengthened, to give more responsibility to the district level and to permit further delegation below it. Nevertheless, the United Kingdom Department of Health and Social Security remains ultimately responsible for the actions of the National Health Service: administrative authority has been decentralized but not political authority.
In other cases, certain services within the district, such as referral and specialized hospitals, may remain directly under central control while other services are a local responsibility. In England, for example, in the pre-1974 National Health Service, primary and secondary services were managed locally, but teaching hospitals remained separate and directly responsible to the centre.

In a vertical structure such as the National Health Service, coordination with other organizations providing complementary local services (for example, social welfare services) is notoriously difficult to achieve. There is thus some advantage in setting up an integrated form of local administration in countries that desire some measure of decentralization and wish to promote coordination of local services, but do not wish to seek integration of services through a more independent local government structure. In theory, decentralization with administrative integration should facilitate intersectoral attempts to promote health. Unfortunately there is little evidence available to assess the actual effects of an integrated administrative structure on the health service and on its relationships with other sectors. Each of the case-studies in Part 2 discusses the effect of decentralization on collaborative activities.

Devolution

Devolution is the creation or strengthening of subnational levels of government (often termed local government or local authorities) that are substantially independent of the national level with respect to a defined set of functions. They normally have a clear legal status, recognized geographical boundaries, a number of functions to perform, and statutory authority to raise revenue and make expenditures. They are rarely completely autonomous, but are bodies largely independent of the national government in their areas of responsibility rather than subordinate administrative units as in the case of deconcentration.

Well developed local government structures have not, in general, been a feature of developing countries. Moreover, during the 1970s and 1980s, relatively few countries devolved central government functions to local governments (39). In the few that have done so, e.g. Nigeria, Papua New Guinea and Sudan, it is notable that few revenue-raising powers have been granted: by far the greatest part of local government revenue comes not from local taxes but in the form of grants from central government.

Nigeria, Papua New Guinea and Sudan have all chosen to devolve a wide range of government functions, including health services. In Botswana, health services are in the process of being devolved and the senior district medical officer, head of the district health team, has been seconded to the Ministry of Local Government and Lands. This official has been made responsible on administrative matters to the council secretary/town clerk and only on professional matters to the Ministry of Health.
Papua New Guinea provides a particularly interesting example of devolution. The local government structure has been set up at the provincial level (equivalent to the district level in other countries). Each province has an elected assembly and an executive council headed by a premier (13). The provincial government can legislate and levy and collect taxes. Although provincial civil services have not been set up, national government staff are members of provincial departments and are responsible to the provincial government. Provincial governments receive a basic grant from the national level and this, together with locally raised revenue, can be spent as the province wishes without reference to the national government.

Provinces have some functions of their own and also carry out national functions on an agency basis. For example, rural health services are a provincial function (11) and, in addition, provincial governments manage general hospitals on behalf of the national government, being granted the necessary funds to do this (13). Provincial staff remain responsible to the provincial government when they carry out national functions. The functions of national departments vis-à-vis devolved services such as health care are to develop national policies and provide technical advice to provinces. The experiences of Papua New Guinea are considered in greater depth in the case-study in Part 2.

Devolution thus implies a much more radical restructuring of health service organization than deconcentration. Two major issues are likely to arise when any country considers including health functions under local government. Firstly, health makes heavy demands on recurrent expenditure. Yet local governments often have a very limited tax base and may be reliant on revenue sources such as land or property taxes whose yield cannot easily be 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 local authorities to maintain. If their cost is covered by central government grants to local governments, then this implies heavy dependence of local government on central government and a likely corresponding reduction in local autonomy. Rondinelli et al. (39) when discussing this matter said:

... at worst [this transfer of resources] is a means of cynically claiming to decentralize while retaining the crucial financial power in central hands. But at best, it can be seen as a reasonable response to the question of how one turns over to poverty-stricken and personnel-short local authorities the responsibility for complex development activities.

Secondly, devolution may complicate efforts to construct a logical hierarchy of health services and to set up a regional structure. This is not an insoluble problem, as the examples of Finland and Norway indicate. In Norway primary health care services are the responsibility of the communes, secondary services are the responsibility of the county communes, regional specialist services are developed through collaboration between the counties of a region, and a few highly specialized services are provided by central government. Although the local
government levels raise their own revenue, central government grants are an important source of revenue, providing around 75% of commune health expenditure and 50% of county commune health expenditure. The county medical officer, who is a central government employee, monitors county and commune health services on behalf of the government. In addition, all hospital construction in a region must be approved by the central government (36).

There is thus provision for coordinating the various agencies involved in the Norwegian health care system. However, one problem of this pattern of organization is that there are certain “grey” areas of responsibility between county commune and commune, particularly in the care of the mentally handicapped, the chronically institutionalized and the elderly.1

In Finland also, health services are provided by local authorities and federations of local authorities, heavily supported by national grants. However, the allocation of strategic resources (personnel and capital) and the setting of national priorities are strictly under the control of central government through its planning system and financial subsidies.2 Central government control has nevertheless been deconcentrated, in that decision-making has been shifted from the central level to provincial administrations which constitute the local administrative level of central government.

The experience of developed countries thus indicates that it is feasible to devolve health services to local government structures, but that this requires heavy state involvement in financing as well as considerable cooperation between local authorities to provide the more specialized services. With the exception of those few developing countries noted earlier that have tried to place substantial health responsibilities in local government hands, developing countries either have not made health a local government responsibility, or else have limited the health functions of local authorities, for instance to urban clinics in Zambia. Further evidence on the devolution of health services is provided by the case-study concerning Yugoslavia in Part 2.

**Delegation**

Delegation involves the transfer of managerial responsibility for defined functions to organizations (often termed “parastatal organizations”) that are outside the central government structure and only indirectly controlled

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by central government (39). Governments may see delegation as a way of avoiding the inefficiency of direct government management, of increasing cost control, and of setting up an organization that is responsive and flexible. Ultimate responsibility remains with the central government, but its agent has broad discretion to carry out its specified functions and duties. Delegation has been used, for example, in large-scale agricultural activities (e.g., cotton-growing in the Sudan) and physical infrastructure projects (e.g., hydro-electric schemes).

In the health field, delegation has been used to manage teaching hospitals. For instance, in both the United Republic of Tanzania and Zambia, the teaching hospital is organized as a parastatal institution with its own board of management, only loosely responsible to the Ministry of Health. Delegation has also been used to organize the provision of medical care financed by social insurance in some Latin American countries. For example in Mexico, “decentralized organizations” provide social services—health, education, social security benefits—and are structured as institutes or councils with their own governing boards, sources of funding, property, and legal status (22).

Such parastatal organizations may not be decentralized in the sense of providing for local management, since authority may be highly centralized within the organization. However, delegation is not incompatible with deconcentration. Both together have for long been suggested for the British National Health Service by those who feel that its present structure renders it excessively vulnerable to national political manipulation. It is thought that delegation on the lines of a public corporation model might remove the National Health Service from the political arena and permit it to become more efficient (40).

If the management of an entire, nationalized health service is delegated to a separate parastatal organization, the role of a ministry of health would be confined to strategic and policy issues. More commonly, however, only some health functions are delegated: for instance, health services for insured workers. This, then, creates problems of coordination between insurance-financed health services and those provided for the general population by the ministry of health (50), and may also bias the provision of care towards curative services and lead to duplication of services. Countries in Latin America that have substantial social insurance systems have for some years been trying to tackle these problems. The case-study in Part 2 concerning Mexico describes the attempts that are being made there to coordinate the ministry and insurance health systems.

**Privatization**

Privatization involves the transfer of government functions to voluntary organizations or to private profit-making or non-profit-making enterprises (39), with a variable degree of government regulation. Many developing country governments have long depended on voluntary organizations for
the provision of health services. Some have seen this as a temporary phenomenon, the services to be absorbed by the government once resources permit. Indeed amalgamation may be forced on a government if the voluntary organization encounters financial difficulties, as have some religious organizations in Central and East Africa.

It is now suggested, however (48), that since many governments cannot afford any major expansion of health services or even to maintain existing services, they need to seek alternative sources of financing—e.g., increased consumer payment or “cost recovery” for certain services (though still with substantial public funding)—and alternative ways of providing health services, for example through greater reliance on the private sector.

On the one hand this is a pragmatic solution. Voluntary agencies and private practitioners may be able to tap resources that the government cannot and provide some services, particularly curative services, more efficiently. They may also work in areas that the government avoids because they are: controversial—for instance family planning; too expensive—for instance geriatric care; or suited to voluntary provision—for instance home care or hospice services for care of the dying.

On the other hand, privatization, in the sense of increasing the role of private enterprise health services, has become an ideological issue in some developed countries. As a slogan it conveys the ideal of a free market, which is considered the ultimate in decentralization by proponents of a market system of health care (30). The desirability of such a system cannot be debated here at length, for it involves complex considerations of the ability of consumers to pay, the motivation of 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 to note, however, that privatization does not remove from the government all burdens of health management. A strong regulatory authority will be required to monitor the supply and quality of both health services and supply industries, such as pharmaceuticals, and to ensure the coordination of services on a geographical basis. In developed countries that have a health system with many different provider agencies, the trend has been to seek mechanisms that would facilitate a more logical pattern of health service development, and that would restrict the ability of a provider agency to develop its services without reference to the overall health needs of the locality. In the United States of America, for example, regional planning was introduced in the 1970s through the means of health systems agencies, which were non-profit-making corporations made up of representatives of the public, providers, payers and politicians (28). Their responsibilities included the production of short- and long-term plans and they were given powers to approve or veto health developments through issuing a “certificate of need”.

Similar trends are evident in a number of European countries where many health institutions are not nationalized. For example, in the Netherlands hospital services were developed by a large variety of private enterprise
and non-profit-making agencies on their own initiative (6). The consequence of this "decentralized" approach was overlap of services and little cooperation or coordination between hospitals. Reforms are now under way to develop regional and provincial health care plans backed by a licence system for new developments (see case-study in Part 2). Breemer Ter Stege & Jurkovich (6) comment that:

The proposed system is centralized when compared to the amount of autonomy that the health care services presently have. This system is, however, decentralized when compared to a system that allows for general policy making and detailed planning at a national level.

A further complication of privatization occurs when the provision of services is privatized but a substantial proportion of the cost of services is paid for by public funds. Experience in Europe and the USA indicates that under these circumstances it is notoriously difficult to develop payment systems that encourage cost control and prevent cost escalation (7).

**Patterns of decentralization**

Decentralization of government authority can thus take a variety of forms. Moreover, countries may make use of different types at the same time for different functions. For example, certain government functions may be devolved to local government, while others are decentralized to local administrations of government ministries. This is the pattern in the United Kingdom, where many local services are provided by local government, but health remains a national responsibility, albeit with administrative authority deconcentrated to regions and districts.

The distinction between the four types of decentralization is based essentially on their legal status. In reality, however, other factors (e.g., financial authority, means of representation of the local community) are also important in determining the type of decentralization. Moreover, decentralization in a particular country may have features from more than one type. Thus, the four types of decentralization presented should not be seen as necessarily clearly distinct from each other. The characteristics of deconcentration and devolution, for instance, may overlap, and a reform in a particular country may have features of both. In particular, forms of local government with a high degree of autonomy tend to be rare in developing countries; instead, local institutions have been created that provide some local discretion while retaining substantial central influence, particularly over policies and resources.

**Decentralizing various functions**

The form of decentralization adopted by a health system will to a considerable extent determine the functions that a decentralized health
agency can perform. The various functions may be categorized broadly as:

- legislating—making laws on health matters;
- revenue-raising—determining and implementing the mechanisms for raising money to finance the health system;
- policy-making—determining the broad and detailed policies that the health system should follow;
- regulation—indirectly controlling the operation of nongovernmental health services and providers by administrative mechanisms such as licensing;
- planning and resource allocation—formulating long- and short-term plans for the development of the health system;
- management—making decisions on the day-to-day operation of the health system, including staffing, allocation of budgets, ordering of supplies and equipment, and management of maintenance programmes;
- intersectoral collaboration—communicating with other sectors and undertaking joint activities;
- interagency coordination—coordinating the policies and activities of various health agencies and providers;
- training—determining and implementing training programmes for various categories of staff.

The extent to which these functions are likely to be decentralized in any particular type of decentralized system is shown in Table 1. For simplicity, “deconcentration” is assumed to be of the non-integrated type, involving only the health sector, and “devolution” is assumed to be to a moderately autonomous local system with responsibilities spanning many different sectors. The number of stars indicates the extent of the responsibilities of the peripheral administration for a particular function, and a dash indicates no responsibilities. It should be stressed that the figure assumes an ideal model of each type of decentralized system, which will not necessarily be the case in practice. For example, in reality, a devolved health system does not inevitably give more responsibility for budgeting and expenditure control to lower levels than a deconcentrated system. Thus, this matrix is a considerable simplification of reality. It is important to examine in greater detail the issues that arise in the decentralization of various functions and the power balance that results between the centre and the periphery. In this examination, decentralization is assumed to be taking place within a structure of government services; privatization is not considered further, since by definition it implies decentralizing all functions, retaining only some limited government regulatory powers.
<table>
<thead>
<tr>
<th>Functions</th>
<th>Deconcentration to ministry field office</th>
<th>Devolution to local government</th>
<th>Delegation</th>
<th>Privatization</th>
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<tr>
<td>Legislative</td>
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<td>Revenue-raising</td>
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<td>Management</td>
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<td>—personnel</td>
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<td>—budgeting and expenditure</td>
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<td>—procurement of supplies</td>
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<td>—maintenance</td>
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<td>Intersectoral collaboration</td>
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<td>Interagency coordination</td>
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<td>Training</td>
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</table>

*Key:  
*** Extensive responsibilities  
** Some responsibilities  
* Limited responsibilities  
— No responsibilities.
Issues in health system decentralization

The form that decentralization takes will influence the powers (often termed “discretion”) possessed and exercised by a health agency at local level, but it will not dictate the central–local relationship. The actual amount of discretion enjoyed locally depends on the extent of the functions decentralized and on a complex mix of influences, including the size of the country, the level to which authority is decentralized, the composition of any local body given responsibility at that level, mechanisms for community participation, the sources of finance of local levels, budgetary practices, the methods of control and supervision adopted by higher levels, the approach to planning, the attitudes of civil servants to decentralization, and methods of interagency collaboration (28, 29). These topics are considered in turn below. In addition, the amount of discretion depends on something much more difficult to define and measure, namely the “political culture” including the experience and expectations of staff involved at central and local levels, the power local officials feel they have to change their circumstances, and their ability and skills to do so.

Size of a country

The size of a country is likely to influence strongly both the type of decentralization chosen and the degree of discretion that peripheral agencies may exercise. The larger the country, the more difficult it is to ensure efficient management from the centre. In very large countries the authorities may choose a federal structure (for example, Brazil, India, Nigeria, the USA) with greater or lesser degrees of decentralization within the states of the federation. For instance, Indian states are divided into districts and blocks.

In contrast, a very small country (such as a small island state) may need no sub-national levels or only one level. For instance in the Gambia, until recently, health services were managed directly by the Ministry of Health, though the health sector is now being regionalized and management teams are being established to strengthen local management.

Choice of levels

The term “decentralization” is generally used without there being any implication of the level to which authority is decentralized, except that it is understood to be below the national level. However, the choice of level can have an important influence on the extent to which the aims of decentralization are realized.
Health system decentralization

A common aim of decentralization is to bring government nearer the people and to encourage community participation. This truly local form of government, however, implies very small units of local government or administration, an administrative structure which has at least three drawbacks: it may (i) spread often scarce managerial skills very thinly, (ii) make it difficult to organize services that can be provided efficiently only for a reasonably large population, and (iii) oblige the higher levels of government to interact with a large number of local bodies.

Two solutions are commonly adopted to avoid this dilemma. One is to set up a hierarchy of local government bodies extending down to the villages. For instance in the Sudan, the People's Local Government System set up in 1971 had a pyramid of over 500 councils, consisting of neighbourhood, market area, industrial area, village, and camp councils at the lowest level, then rural and town councils followed by area councils at intermediate levels, and, at the apex, provincial councils on which particular emphasis was placed (37).

The second solution is to choose a compromise level or levels, recognizing that complementary mechanisms will be required for grass-roots community participation. The most common level chosen is the “district”—usually a geographically compact area of 50 000–500 000 people, with a town as a focus of communications and trade (47). In addition, a regional or provincial tier may also be set up, both to make supervision of districts more manageable and to provide those referral and supporting services that can be organized economically only on a regional basis. A regional tier is particularly common for health services, a regional hospital providing a range of specialist services that the district can neither afford nor make full use of.

Many countries have recognized the need to fit the district into an overall framework of services, but differ in the degree of importance they give to the district vis-à-vis higher levels. For example, the White Paper on the reorganization of the Ministry of Health in Sri Lanka stated that:

the district is in itself not a viable entity in the development of a comprehensive health care system as it requires very high levels of professional inputs and other skills. The system of health care delivery is organized on the basis of a hierarchical system of institutions with a referral pattern beginning at the periphery and extending through District and Base Hospitals to the Provincial Hospitals . . . it is logical that an improvement of service could only be achieved by a system of decentralized administration which could cover a geographical area large enough to include the total referral system (37).

The proposal was therefore to set up provincial health authorities, but to maintain district offices with deconcentrated powers.

It is interesting to note that, in the Sudan, the very scale and comprehensiveness of the 1971 structure made it difficult to establish, since managerial and financial resources were in very short supply (32). Subsequent reforms abolished the provincial level, created the (higher)
regional level but added emphasis to the area (formerly called district) level. The establishment of lower tiers of councils of the 1971 pattern was at the discretion of areas. Thus the structure was simplified and two levels emphasized, one high (region) and the other relatively local (area).

The continuing dilemma of the degree of responsibility to give to various levels is apparent also in developed countries. In the United Kingdom, for example, successive governments have vacillated. Before 1974, management was exercised at the levels of regions and groups of hospitals. In 1974, hospital groups were reorganized into districts and an intermediate tier, the area, was created partly to provide a more accessible level below the region but primarily to introduce a management level with geographical boundaries identical to those of local government which provided many complementary services (e.g., social services, environmental health services). Subsequently, the area level was abolished with the aim of strengthening the district level.

Yet while from a national perspective the area/district level may appear appropriate for tackling specific local issues, from the grass roots it can appear as a remote source of policies and decisions. Thus Norris (32) with reference to the Sudan comments that:

... there is articulate public service support for the long established Area, which may, it is hoped, combine functional efficiency as a catchment area for most public services, with an acceptable democratic focus. In practice, however, democratic participation may be sacrificed, since the priority given to management effectiveness can hardly be doubted at this point.

This danger is even stronger in those countries that have decentralized to a higher level, where local centralization may result. For example, in Papua New Guinea there has been genuine devolution to the provincial level, but few provincial governments have chosen to decentralize below their own level (9). While district administrations do exist, they have been weakened by the strengthening of the provincial level and their exact role as a link between the villages and the province is unclear (41). In the Philippines, regionalization has dispersed economic and administrative infrastructure from Manila to regional capitals, but power has been centralized within the regions (2).

Composition of local health authorities

Where health management is devolved to local government, the members of the local authority are usually elected. Where health management remains the responsibility of the ministry of health, the deconcentrated organization may or may not have some type of local health board to control or advise health officers.

Health boards can be seen as a way of making local health services more responsive to their local community without actually devolving power to
the community in the form of local government. They can be set up at different levels: for example, as a health centre advisory committee, a hospital management board, or a district health authority. They can be elected by the general population or by a more limited constituency, or appointed by higher management levels or by local organizations. They can be intended to represent the population at large, or specific interest groups within it such as providers of care (including voluntary health groups), local government, and health professions. They can have limited advisory powers, some planning or regulatory authority, or total responsibility for local services.

Health boards exist in a number of countries, for example hospital committees in Sri Lanka (31), administrative councils at hospital level and regional committees in Italy (25), health systems agencies in the USA (7), regional councils in Canada (20), provincial and district health teams in Zimbabwe,¹ and district and regional health authorities in the United Kingdom (3).

In Zimbabwe, for example, the district level is being reorganized and strengthened with the appointment of a team to coordinate all health services in the district. The district health team includes the district medical officer, nursing officer, health inspector, and administrator, plus councillors from the district health committee, representatives from each hospital, representatives of clinic medical assistants, the district administrator, and the local government promotion officer. The team is thus designed to strengthen district management, provide for representation of health staff in the district, and encourage coordination with local government services.

The United Kingdom provides another useful example. The district health authority is accountable to the regional health authority, which is itself accountable to the Secretary of State for Health and Social Services (the Minister). Health authority members are appointed, some being knowledgeable lay people, others health professionals. A certain number of places are allocated to local government appointees (often elected councillors) and to members elected by health charities working in the district. The health authority has final authority within the district for the planning and management of health services, health service managers being responsible to the authority.

Because the health authority is neither fully elected and thus accountable to a local electorate, nor composed of appointed members with no local allegiances and owing complete loyalty to the Minister, it has been described as occupying a “twilight zone” in public administration between central and local government. It is criticized for lacking clear accountability because it has no clear local constituency, but the links of

¹ Walt, G. Oxfam’s assistance to the Ministry of Health, Zimbabwe, in the implementation of integrated primary health care in Manicaland province 1983-86. London, Evaluation and Planning Centre, London School of Hygiene and Tropical Medicine, 1985 (unpublished report).
members to local groupings (e.g., to local government) render accountability to the minister weak. Regan & Stewart (33) have argued that the role of the authority should be to challenge professional and technical judgements since many health decisions are sociopolitical decisions. Such a challenge requires the health authority to possess a source of legitimate power that can rival the power derived from technical expertise. This, say Regan & Stewart, the health authority lacks because it is not elected. Given, however, that the National Health Service is a national organization, the district and regional health authorities do provide a means for various groups in the community to influence health service managers, make the health service more responsive to local needs, and serve as a forum for debating health service issues and influencing developments. One study (28) of the area health authority (similar to but now replaced by the district health authority) concluded that:

The significance of the Health Authority was that it provided a mechanism, albeit imperfect, whereby the various interests of clinicians, local authority councillors, community health councils, trade unions and managers could be resolved via debate and negotiation and, if ultimately necessary, settled by a vote.

**Community participation**

Decentralization is often seen as a means of enabling communities to participate in making decisions on their local health services in a more direct and immediate way than is permitted by representation on the type of health service board discussed above or by election of local councillors in a local government system. On its own, however, decentralization will probably be inadequate to promote community participation. Decentralization of health service management is most likely to result in strengthening the district level. This still leaves a significant distance between health service managers and communities. Additional mechanisms are therefore required within the district if communities are to have an impact on health service decision-making.

However, a danger of decentralization and complementary policies for community participation may be that those who gain influence at local level do not use it in the best interests of the community at large. For instance it has been suggested that, in India, the establishment of elective systems and institutions of local government in early stages of development is likely to result in their capture by local magnates and dominant individuals, who thus obtain additional, institutionalized, and officially-supported power, patronage and subsidy (23). Time may be required for new leaders—for instance, people with education and successful farmers—to emerge and challenge traditional leaders. In Papua New Guinea the danger of the provincial elite becoming over-powerful has been recognized (19).

A further problem may be that local politics become dominated by a group in opposition to the government or by party rivalries. The effects of
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this on local management have been shown in a number of places, for instance the Solomon Islands (34).

Such problems will be less where decentralization takes the form of deconcentration rather than devolution. However, it can still be argued that local managers are vulnerable to local pressures. For example, in developed country health services, power at local level tends to lie with specialists in high technology hospitals who may also be able to shape local public opinion in their favour. Managers may then find it difficult to resist their combined demands for additional resources. Development of primary and community services may require the support of higher levels to counterbalance local pressures. On the other hand, it must also be recognized that the influence of pressure groups is not limited to the local level; at the centre, it may divert national decision-making from the common good. In such cases, greater decentralization may enhance local commitment to broad social goals, as seen in some cases in the implementation of the War on Poverty in the USA (for example, see reference 29).

Sources of finance and methods of allocating finance

The form and degree of decentralization is strongly influenced by the sources of finance of the local body and, where finance is granted by the state, by the method of allocation.

Local governments usually have authority to levy taxes. However, in a developing country setting, the great majority of national revenues often come from indirect taxes, especially customs and excise revenues, and buoyant local sources of revenue are hard to find. Land and property taxes are the traditional source of revenue for local government in developed countries, but land taxes may be difficult to levy where land is held in common ownership, cadastral maps are unavailable (as in Papua New Guinea (33)), or productivity is low. The yield of property taxes is apt to be inelastic and difficult to increase. Tax sources for local government tend therefore to be of limited scope, such as taxes on the issue of licences, head taxes, vehicle taxes, taxes on entertainment, and certain sales taxes.

The result is that local governments are often by necessity heavily dependent on grants from central government. In addition, governments often retain central control over finance in order to promote geographical equity. In respect of sources of finance, local government may therefore not differ significantly from the local offices of central ministries, though the way the grant is made is likely to differ.

The method of allocation of national government revenue can vary from grants that are not earmarked for any purpose (often termed "block grants") to those that are closely tied to particular activities and expenditures. At one end of the spectrum, a fixed percentage of national
Concepts and issues

revenues may be earmarked for local government and divided between local governments according to some measure of their "need", possibly including some requirement for the local authority itself to raise a certain minimum sum. For instance, in Nigeria a fixed percentage of the statutory allocation from federal level to other levels of government is earmarked for local government, as is a minimum proportion of state revenue. One-quarter of these funds is divided equally between local authorities; the remaining 75% is distributed according to population (43).

A less permissive method is to tie a grant to particular local functions. For example, in Papua New Guinea the expansion of rural health services is funded from the National Public Expenditure Plan (15). The proportion of the total available for health is first decided between the National Planning Office and the Department of Health, and the funds are then divided between provinces on the basis of various indicators of "need". Finally, each province and the Department of Health discuss how the provincial allocation will be spent.

A similar method can be used for the allocation of recurrent and capital funds to deconcentrated local administrations of ministries of health. In many countries it is customary for allocations to be made on the basis of past allocations, thus permitting inequalities between districts to persist or even worsen. This approach can be replaced by resource allocation formulae that reflect the "need" of each district (16). At the least, size of population should enter into the formula. Further refinements could be to weight the population by indicators of health service need, for instance mortality or morbidity rates, or of socioeconomic status, for instance, average local per capita income. Such a system can be phased in gradually, to avoid increasing allocations to districts before the health service infrastructure necessary to make good use of the funds has been built up.

In countries implementing cost-recovery policies, an important issue is whether local districts or health units are permitted to retain the income they collect. Retention of income creates an incentive for efficient collection and use of the funds, though ministries of health and/or finance are often reluctant to decentralize this responsibility.

Budgeting and expenditure control

Budgeting practices can be a strong influence on the degree of discretion of local administrations. In many developing countries, it is customary for the budgets of the deconcentrated local administrations of the ministry of health to be tightly controlled, though the degree of control often depends on the type of expenditure. Recurrent budgets are usually approved centrally, and districts may have no authority to shift expenditure between programmes or even objects of expenditure. Salary expenditure is often centrally controlled, even if authority to spend on other items is decentralized. Capital funds for buildings and equipment are often completely
Health system decentralization

controlled from the centre and the district authorities may even be unaware of proposed capital developments in their district.

It is quite feasible, however, to introduce some flexibility into local budgeting that will increase the responsibility and discretion of local managers. A first step is to consult the district when drawing up budgets or, better still, to request budgets from districts. A second step would be to allow the district some latitude to shift funds between objects of expenditure in order to adapt to changing circumstances, or to retain any savings it makes and spend them in approved ways.

Permission for local flexibility is easier to grant if the central authority knows that its priorities will not be overturned by local decisions. A programme budgeting system, where funds are granted by programme and transfers are permitted within but not between programmes, can be used to permit local discretion while maintaining national priorities. In India, for example, because of the national priority given to malaria control and family planning, these programmes are funded centrally and earmarked funds allocated to states, in contrast to general health services which are the responsibility of the individual states. Such a system can be used specifically to promote primary health care and to ensure that funds intended for such care are not diverted to hospitals (47).

Control and supervisory practices

The decentralization of authority requires a matching system of control and supervision to ensure that the authority is being used responsibly. Many different methods of supervision are available, and these can be a strong influence on the degree of decentralization.

Means of control and supervision can include the following:

— enacting legislation concerning local government functions;
— issuing government directives (within the limits of agreed central authority);
— providing government guidelines: these can instruct, give general policy guidance, explain new legislation, exhort, etc.; they may be mandatory or advisory;
— defining major planning procedures;
— earmarking resources for specific purposes;
— making certain types of expenditure, such as capital expenditure and additional staff, subject to specific approval;
— requiring certain information flows, such as regular reporting;
— monitoring regularly certain indicators of performance, e.g., levels of unit cost, coverage of at-risk populations;
— holding face-to-face meetings.

1 Programme budgeting as a part of the managerial process for national health development (WHO unpublished document MPNHD/84.2).
When little discretion is permitted to local administrations, supervisory practices are a matter of ensuring that they abide by the rules laid down; supervision thus tends to concentrate on financial rectitude and adherence to detailed administrative procedures. As the permitted degree of discretion increases, supervision should shift to the monitoring of performance. Setting targets and monitoring their achievement requires dialogue, consensus building, and flows of appropriate information. Face-to-face meetings between levels can be a very effective way of exercising influence or authority without the higher level functioning as a remote dictator. In Malaysia, for example, the annual planning and budgeting cycle includes meetings at state level between national and state officials to discuss the coming year’s budget.

However, much of the burden of ensuring accountability between lower and upper levels in a decentralized system is commonly placed on a planning mechanism. Since this is an important subject in its own right, it is considered further below.

**Planning responsibilities**

Planning responsibilities in a local area can range from highly independent to tightly controlled. They can include:

- largely autonomous planning, programming, and implementation, possibly done jointly with all public services in the locality, within a locally determined policy and strategy framework (as in a well-developed local government system, for instance);

- broad and detailed programming within national policy guidelines, with central approval required only for major capital projects or other special expenditures (local government system or a highly deconcentrated field administration);

- broad and detailed programming within national policy guidelines, with the whole plan subject to central approval (decentralized local administration or limited local government);

- detailed programming and implementation of a central plan (little deconcentration);

- provision of a “shopping list” of development projects to central government (minimal deconcentration);

- a mix of the above, with parts of plans and budgets locally determined and other parts centrally controlled.

In the context of a policy of deconcentrating health services management to regions and/or districts, the introduction of a planning system is frequently seen as a mechanism for maintaining some element of central...
Health system decentralization

control while permitting considerable local discretion. This is a common feature in countries as diverse as Chile, Ghana, India, Mexico, the United Kingdom, and the United Republic of Tanzania. For example, when the health service in the United Kingdom was reorganized in 1974 it was stated that "decentralization of decision-making, implicit in the patient-centred approach, can be balanced with the need for national and regional strategic direction by means of a planning system" and that "there should be maximum decentralization and delegation of decision-making, but within policies established at Regional and Area levels" (15). (The Area level was subsequently abolished, and the planning responsibilities of the regions and districts were strengthened.)

The most common planning system in use is for the national level (and the regional level, where it exists) to issue guidelines each year on policies and priorities, and on the resources likely to be available. These provide the framework within which district plans are formulated. District plans are sent for approval to regional and sometimes national level, and form the basis for the approval of annual budgets and capital projects. Such plans often also form the basis for monitoring the performance of lower levels in implementation, although such monitoring is frequently restricted to capital or development projects only.

This process is often hampered by lack of information on the future availability of resources. In most developing countries that have attempted decentralization, local administrations are highly dependent on the centre for finance. In order to undertake their planning and management functions, they require information on the funds they are likely to receive for at least one year ahead, and preferably more. Yet central governments are often unable to predict with any certainty what their future financial position will be, and are reluctant to commit themselves to a specific grant or budget until just before the beginning of the new financial year or even half-way through it. This creates considerable difficulties for local managers. For instance, in the Sudan, some of the difficulties of provincial governments have been attributed to their lack of knowledge of the resources likely to be available to them (32). Yet the central government itself was in financial difficulties and hence unable to give clear guidance.

Planning and budgeting systems are usually decentralized to the same degree, even where the two systems are not always well linked. If this is not the case, conflict and confusion may arise. For example, decentralized planning can be difficult and frustrating if there is not some measure of decentralization in resource allocation and budgeting.

The extent to which planning procedures can be decentralized may be limited, at least initially, by the availability of planning skills at local level. Decentralization should then include an effort to develop these skills, as in Zambia, though this may be hampered by staff turnover. In addition, ambitious planning processes may have to be modified. For instance, policies, priorities and strategies may all have to be developed at national and regional level, the district involvement being confined initially to making detailed work plans for the coming year and
implementing new developments until district staff have acquired more planning experience.

**Civil service attitudes**

A common theme in many reports of attempted decentralization is the opposition of the civil service. This has been reported in the Solomon Islands (34), Vanuatu (34), East Africa (37) and Sri Lanka (38). Rondinelli quotes the unpublished report of Wanasinghe¹ concerning the experience of Sri Lanka, where civil service unions intervened actively in the political process to prevent a diffusion of administrative responsibility:

The general thrust of these interventions has been towards maintaining individuality and autonomy of respective departmental cadres, strengthening the role of the bureaucracy in decision-making, enhancing career prospects through island-wide services. Those thrusts have continuously run counter to attempts at implementation of local area-focused coordination, delegated decision-making by peoples’ representatives, and creation of self-management organisations with their own personnel.

National-level civil servants fear a loss of financial resources and political influence, but also doubt the capacity of local administrations to operate efficiently and independent of local interest group pressures. Thus, training and education are required not only of local but also of national administrators.

**Interagency collaboration**

Decentralization is often accompanied by a desire to improve the integration and coordination of public services at local level. It is notoriously difficult to encourage intersectoral collaboration at national level. Ministries are rivals for resources. Each develops its own policies and may jealously guard its autonomy, especially when it feels that intersectoral collaboration may require it to use its own resources to serve another ministry’s goals. At local level, in contrast, intersectoral contacts can be less formal. Relationships between the sector heads may be strengthened by being posted to the same district and they may unite in their common feeling that their own ministries lack appreciation of local circumstances. Thus, the administrative environment is usually more conducive to collaboration at the local level than at higher levels.

Health system decentralization

The aims of an experiment in decentralizing municipal services in New York City are described (15) in the following terms:

The essence of the Office of Neighborhood Government program combines a vertical change—decentralization . . . with a horizontal change—services integration . . . The vertical decentralization is an attempt to make an overly centralized bureaucracy more responsive and relevant to neighborhood needs by vesting more power at the district level. The horizontal element in the district official’s power involves increased communication among the neighborhood counterparts. With increased authority and coordination at the district level, it was expected that district officials could then act jointly to improve the delivery of neighborhood services.

An important influence on the extent of collaboration with other agencies will be whether or not local health staff are officially encouraged to communicate directly with their counterparts in other sectors and are able to plan and carry out joint tasks. For example, if all communications have to be channelled through regional or national headquarters, local collaboration is likely to be hampered. Likewise, collaboration may be difficult if districts do not have some financial flexibility to adjust their activities to undertake joint tasks.

Experience in practice

It will by now be clear that health system decentralization is a complex subject. Decentralization has many potential advantages: it focuses attention on the community, may promote community participation, may encourage more equitable health service provision, may improve the motivation of local staff, may speed up the implementation of development programmes, and may promote intersectoral collaboration. However, for each advantage a corresponding disadvantage is possible. A decentralized system may be more inequitable, may make it more difficult to promote national policies, priorities and standards, may intensify existing shortages of trained managers, and may be less efficient.

One reason why generalization is difficult is that a decentralized health system can take many different forms, involves changes to a wide range of management functions, and is affected by the historical experience of each particular country. Thus, while models of decentralized systems can be described, as on pages 15–24, in practice many variants are possible. Similar structures may function differently in different countries because factors other than institutional patterns affect their behaviour.

Because it is difficult to generalize about the desirable forms of health system decentralization and about the modes of implementation of decentralization policies, Part 2 of this book presents country case-studies that allow the reader to explore in much greater detail what decentralization means in practice and how best it can be introduced.
REFERENCES


Health system decentralization


PART 2

Country case-studies
Decentralization of health services in Botswana

Edward T. Maganu

Concepts of decentralization and reasons for decentralization

In discussing decentralization in the health system in Botswana, it is important to consider both the central government, with its ministries, and the local government system, with the district (and town) councils, the district administration (central government departments), and the tribal administration. Generally, functions are said to be decentralized if they are performed by the district (and town) councils. Functions performed by central government departments at district level are not regarded as decentralized. Decentralization has been uneven in the sense that while some ministries or sectors have large operations carried out by the district and town councils, others have set up large departments at district level and continue to run them from the centre.

District councils were set up by an Act of Parliament just before independence in 1965. By and large, the new district councils were based on the areas that had been under the jurisdiction of district commissioners since the early days of the protectorate at the turn of the century. The original areas were in turn delineated mainly on the basis of areas controlled by different tribal groups. This system actually facilitated the formation of the district councils, as the geographical boundaries had been established for a long time and the people were familiar with them, and much of the administrative machinery already existed.

The Local Government (District Councils) Act was passed in December 1965 and has been amended several times since then. It was described as “An act to provide for the establishment of District Councils and to provide for matters incidental thereto or connected therewith.” 2 A similar law, called the Township Act, was passed for urban areas. The functions of the councils are regulated by these acts but they can be varied by the President. Obviously, at the time these acts were passed, “health” and “sanitation” were narrowly defined and clinic services were not originally included. However, the National Development Plans of 1970–1975 and 1973–1978 included a decision to build clinics under the control of the

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1 Director of Health Services and Deputy Permanent Secretary, Ministry of Health, Gaborone, Botswana.
district and town councils (hereafter referred to as local authorities), which were to be supervised by regional health teams.

The government's approach to decentralization can be summed up by two quotations from the current National Development Plan (NDP VI 1985–1991). In the chapter dealing with the strategy for development, the section on rural development states that "... decentralization of decision-making to Districts should continue to be emphasized with the accent on greater participation of the people in both planning and implementing developments." In Chapter 4, which deals with local authority administration and finance, it is stated that "[the Ministry of Local Government and Lands should] ... work towards encouraging greater decentralization of decision-making, particularly of development-related plans and projects, and promote productive activities in order to generate more employment opportunities at local levels".

It is in the context of this framework that the decentralization of health services should be reviewed.

The benefits of decentralization of the health services have been set out in various documents. Essentially, three major benefits are foreseen:

(i) greater and more effective community involvement;
(ii) improved intersectoral collaboration;
(iii) faster and more appropriate handling of administrative problems.

Structures exist at the district and village levels for facilitating community involvement in planning and for executing and evaluating socioeconomic development activities. These include the elected district council (a political body), village development and village health committees, and the family welfare educators. Having all health personnel under the local authority facilitates interaction between and within these different structures and gives the public and the officers a sense of belonging together.

A similar argument applies to intersectoral collaboration. The important structures are the district development committees, the district extension teams, the village extension teams, and various other committees at both levels. Since some extension officers came from central government departments and others from local authorities, their levels of decision-making and even commitment sometimes diverge to the extent of interfering with the effectiveness of these committees. Representation in the committees is from all sectors, irrespective of whether the sectors are controlled by a central ministry or by the district council. It is argued, for example, that some ministries do not allow their officers at district level to take major decisions, hence they have to keep referring issues to the appropriate ministry, which impedes progress. The advantage of having all sectors under the local authority therefore appears obvious.

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Personnel administration plays a major part in the management of any sector. Employees in the district are directly supervised by one authority, so their problems will tend to be more easily solved. These may include such matters as interpersonal disputes between officers, payment problems and other matters of a purely personal nature.

While the above benefits do not constitute an exhaustive list, they do show the importance of decentralization, and how it can, if it is well done, facilitate the work of a sector.

**Process of implementation of the decentralization policy**

The primary level health services in Botswana were decentralized in 1973. This followed a memorandum from the Ministry of Health in 1969 setting out the responsibilities of district councils in the field of health services, which stated:

In providing District Health Services, the relationship between the District Council, the Village Development Committee and the Central Government must be accurately defined ... Central Government is fully committed at the moment with the building of new hospitals and health centres, as well as the extension of present hospitals, and the provision of clinic buildings must be the responsibility of District Councils.

Subsequently, a rural health project was inaugurated in 1972, and this provided an example of the way in which the expansion of rural health facilities could take place. The stage was therefore set:

— for the district councils to be responsible for clinics and health posts;
— for the central government to provide capital grants and assistance with recurrent expenses;
— for the Ministry of Health to implement supervision from the hospitals and the district level.

Criteria for the building of health facilities, based mainly on population size and distance, were defined and an initial plan for the health facilities for each district was produced for the period 1973–1977.

After the decentralization of primary facilities to local authorities, the next step was to set up regional health teams to improve the level of district support and supervision. These teams consisted of the regional medical officer (team leader), the regional public health nurse, and the regional health inspector. The first regional medical officers started work

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1 Memorandum on clinics in Botswana. Medical Department, Gaborone, 7 May 1969 (File MH 13/1, Volume IV).
Health system decentralization

in February 1974 and proceeded to form their teams. The plan was to
start with a few teams each covering several districts, and to form new
ones until there was a team for each district. In 1974 there were five
teams, and by 1987 there were sixteen, that is, one team for each district
and sub-district and one for the City of Gaborone. The functions of the
regional medical officers were to: “Supervise Rural Health Services, taking
over from Medical Officers in hospitals, who would not be subordinate to
Regional Medical Officers. Advise local authorities on the development of
their services”.

It was further stated that regional medical officers would
supervise the work of council health staff but would not be responsible
for their discipline, a decision that was to prove rather frustrating to
regional medical officers as the service developed. The regional medical
officer also had to review council development plans for the health sector
and to offer advice.

By 1987 the regional health teams had become viable units giving
extensive backing to rural health care. They covered clinical referrals, the
guidance and monitoring of special programmes (e.g., maternal and child
health, immunization, disease control, nutrition), public information and
education for health, and health care organization and evaluation. Efforts
were made by the Ministry of Health throughout this period to improve
the functioning of the teams in these areas.

The regional health teams also had their problems. The most frustrating
one for the teams was that although they came directly under the
Ministry of Health, they were supervising services and personnel for
which the district councils were responsible. As stated earlier, the team
leader (regional medical officer) had no administrative powers for such
aspects as employment and discipline over the council staff that he or she
supervised. Nor did the regional medical officers have any executive power
within the council, their position being described as advisory.

These were some of the reasons why an organizational review undertaken
by the Ministry of Health in 1984 recommended that regional health
teams should be seconded to district (and town) councils. The other
reasons had to do with improving intersectoral collaboration, community
involvement and administration.

The review also recommended that the name of the teams should be
changed to “district health teams” to emphasize their role vis-à-vis the
districts. It was emphasized, however, that the Ministry of Health should
not be seen to be abrogating its role as the body responsible for health in
Botswana. The following quotation from the review sums up this concept:

While the decentralization of health services is fully supported, it is also
realized that the Ministry has to provide overall leadership and
direction as well as monitor closely the standards of professional health

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1 Notes on meeting in Ministry of Local Government and Lands with Deputy Director of
Medical Services and three new regional medical officers, 22 February 1974 (File MH
3/5/1, Volume 1).
services at national level. . . [The Ministry of Health] should develop and institute an appropriate and effective mechanism for advising, assisting and supervising District Health Teams and providing professional guidance to improve field health services.¹

Pursuant to the recommendations of the organizational review, the teams are being handed over to the local authorities and their designation has already been changed to that of district health team.

There was, of course, some opposition to the decentralization by such groups as the council health staff, senior nurses, and health inspectors. Merging them into the district health teams under the leadership of a district medical officer implied that they were going to lose power and influence. That difficulty has been partially solved by a decision that, in the future, anybody with a postgraduate qualification in public health can be a team leader irrespective of his or her basic profession. Members of the regional health teams had misgivings about losing some benefits, e.g., earnings, pensions and opportunities for promotion. In addition, some of the nurses in the regional health teams had had a poor relationship with council nurse administrators and feared they might be victimized. It was explained to the team members that the conditions of service in the central government civil service and in the unified local government service (the employing body for district and town councils) had been made exactly the same, and that consequently there would be no loss of benefits. The question of seniority among the nursing staff would be solved in the normal manner following staff rules.

Opposition also came from some officers in the civil service and the unified local government service, and from some members of the public who believed that the councils were not ready to assume these new responsibilities. After extensive consultations, and assurances of full support from the Ministry of Health, however, these fears were gradually allayed.

Implementation of the decentralization policy has been slow because of the above problems, as well as others concerning housing and transport. There were extensive consultations between the Ministry of Health, the Ministry of Local Government and Lands (including the unified local government service, which is a department of that Ministry), district and town councils, and the regional (district) health teams. Hence there were meetings and orientation seminars for officials from all these bodies, as well as full discussions at council meetings.

A new Basic Health Services Coordination Committee, made up of officers from the ministries of health and local government, was set up to oversee the implementation of this decentralization.

Changes in organizational structures

Changes in the organization of the Ministry of Health occurred in 1984 as a result of the organizational review mentioned above. Prior to that, district health services (through regional health teams) fell under the control of the Principal Medical Officer of Health (PMOH) in the Ministry. The PMOH was generally responsible for all preventive activities except family health (health education, maternal and child health, family planning, and nutrition), which had its own principal medical officer. The other officers concerned with the primary health care services were the Chief Medical Officer, who was in overall charge of health services, and the Chief Nursing Officer.

Following the review, the Ministry was organized into five major departments:

— Primary Health Care;
— Hospital Services;
— Technical Support Services;
— Health Manpower Development and Utilization; and
— Administration.

The first three were set up as professional departments headed by assistant directors, while the latter two were to be headed by under-secretaries. The Chief Medical Officer was replaced by a deputy permanent secretary, who was also to act as Director of Health Services. The post of Chief Nursing Officer also ceased to exist. The idea was to organize on service lines rather than on cadre lines.

Two service units, Health Research and Health Planning, were also established; they were to report directly to the permanent secretary.

At the district level, with the merger of the regional health team and council health staff to form the new district health teams, the district medical officer usually became team leader. In the new structure, the district medical officer was to be responsible to the district council secretary. The other senior officers were the district matron and the senior/chief health inspector, one of whom became the deputy. The other officers were the community health nurse, health education officer, nutrition officer, rehabilitation officer, tuberculosis coordinator, and administrative officers.

At the village level, depending on its size, there was to be a health centre, clinic, or health post. A large village with a health centre would usually have smaller villages around it with health posts. The nurses would regularly visit the health posts, which were to be staffed by a family welfare educator or an enrolled nurse. All the health centres, clinics and health posts would come under the supervision of the district health teams.
Changes in management functions

As a result of the current decentralization process the Ministry of Health has no direct responsibility for carrying out primary health care operations at the district and village levels. Such functions have been devolved to the local authorities.

Previously the local authorities were responsible for running village-level primary health care activities through clinics and health posts, supported at district level by nurse administrators and health inspectors. Operational support was given by the regional health teams, and central government institutions had no direct administrative responsibility for the local authority facilities they supervised. This meant that the council chief executive (the district council secretary) had no direct involvement in the monitoring process, except to respond to queries by the regional medical officer.

Since decentralization, the district medical officer reports to the council chief executive and is a member of his staff. The chief executive has the full responsibilities of a head of department.

With decentralization, the role of the Ministry of Health has also undergone several changes. Some people argue that the burden of having professional supervision separated from administrative accountability is now being felt by the district health teams, who are administered by the district council but supervised by the Ministry of Health. However, it is considered that, with good will, the rearrangement should cause no serious problems.

The changes are depicted in Fig. 1.

Policy-making in health matters, including health personnel development, is the responsibility of the Ministry of Health. The district councils, however, have independent powers to decide upon the priorities for health services development. For example, it is the duty of the district councils to decide whether to build a school or a clinic, or whether to create more nursing posts or water technician posts. These councils do not raise sufficient funds to finance health activities: they are heavily subsidized by central government through deficit grants. However, they have their own accounting system, including an independent local government audit that is not under the auditor general.

Budgeting by a district council is similar to that of central government, and the district health teams are joining this process. Each council department—e.g., education, health, water, community development—produces estimates for the coming year. These are discussed by a committee and, after being trimmed to fit the financial resources available, the collated estimates are agreed by the council. Financial limits are often set beforehand. Budgeting is by item and not by programme.
The planning process is intersectoral and complex. The most important body at district level is the district development committee, which is chaired by the district commissioner. All sectors, both central government and the council, are represented by their heads at district level; the council secretary and council chairman are also members. The district development committee initiates and monitors development projects at that level. It also oversees the work of the village development committees. The regional medical officer, formerly a member, has been replaced by the district medical officer, who has an even stronger position as head of the council health department.

The district councils manage their own purchase of supplies and the district health team is able to join in this arrangement. However, drugs are an exception; although purchased with council funds, they are supplied by the central medical stores to all council health facilities under a special arrangement with the chief pharmacist of the Ministry of Health. Special arrangements are made regarding housing and transport vehicles. The district councils own some houses, but an acute shortage affects both government and council staff. Arrangements have been made, therefore, for district health team staff to stay in central government houses. Councils are unable to absorb immediately and service the district health team vehicles and this will continue to be the responsibility of the central transport organization.

Training of health personnel, both basic and post-basic, is the responsibility of the Ministry of Health. This requires good liaison
between the Ministry and the unified local government services to identify training needs, recruit trainees, and finance the training; this liaison is ensured by a special committee. Decentralization is not expected to have any major impact on this arrangement.

Assessment of experience

The primary health care services at the peripheral level (clinic, health post, and community) have been decentralized since 1973 and this experience has been very positive. Good cooperation has existed between the Ministry of Health, the Ministry of Local Government and Lands, and local authorities (district and town councils) enabling the Ministry of Health to mobilize resources for capital development, to train personnel, and to supervise the running of health facilities, while the local authorities have implemented many district programmes. However, problems did arise because council health staff resented being monitored and supervised by the regional health teams, who were regarded as outsiders because they were central government employees. The regional medical officers also tended to be bypassed in decision-making because they were not council employees, and their advice was sometimes ignored. Decentralization to the district level should help to solve these problems.

The actual transfer of the teams to the district councils in some districts has been slow. It took a long time to convince both council and regional staff of the desirability of this change. The main worries of the health staff on both sides were loss of power in the hierarchy, and effects on career advancement. The politicians and senior administrators in the district councils were always supportive, however. The transfer is now well accepted.

The transfer has not yet been completed owing to problems of administration, finance, housing, equipment and transport. As regards recurrent expenditures, the councils have been emphatic that unless the whole of the funds for these items is permanently transferred to them they will be unable to absorb the costs. The largest amount is needed to cover salaries.

Conclusion

The main lesson to be learnt from experience in Botswana is that a strong administrative infrastructure is needed at district level in order for the decentralization of health services to be effective. Botswana has long had a local government system at the district level which, among other functions, had been running the primary health care infrastructure for several years prior to decentralization. The transfer of the district-level supervisory functions from the Ministry of Health to local authorities was
Health system decentralization
	herefore a logical next step. In another country where local government
is weak or non-existent, decentralization of the health system could
provoke serious administrative problems without improving its
effectiveness.
Decentralization and local management of the health system in Chile

C. Montoya-Aguilar\textsuperscript{1} and Patrick Vaughan\textsuperscript{2}

Introduction

Chile is a long, narrow country reaching from the tropics in the north to Antarctica in the south. There are four main geographical belts running north–south: the Andes mountains, the high plateau, the coastal mountain range, and the coastal plains. The climate also varies considerably from north to south. There were approximately 11 million people in 1984; the mortality and birth rates were low and 32\% of the people were under 15 years of age. About 40\% of Chile's population lives in the capital city, Santiago, and, in all, over 80\% of people live in urban areas.

Chile has a history of state involvement in organized medical care since independence in 1810.\textsuperscript{3} In 1924 the National Social Security Institute was established to fund and provide health care for blue-collar workers, and in 1938 the government passed the Preventive Medicine Law for white-collar workers. Until 1952 health care was provided mainly by four separate health organizations. The National Health Service (SNS), established in 1952 as a result of the merger of these four organizations, became responsible for providing curative services for blue-collar workers and the unemployed or indigents and their families (70\% of the population) and preventive care for the whole population. SNS was organized on a geographical basis consisting of 13 regions and 52 health areas, later called hospital areas. The legal basis for management was centralization of standards and administrative decentralization. In 1968, the National Medical Service for Employees (SERMENA) was established as a government administered health insurance plan for white-collar workers, who could attend private and SNS facilities. In the 1970s, it was estimated that SNS covered 65\% of the population, SERMENA 20\%, private medicine 10\%, and the armed forces and other agencies the remaining 5\%. The government of President Salvador Allende promoted

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the organization of a more integrated health service and increased public expenditure on health services. In 1979, the government of President Augusto Pinochet implemented a more free-market approach to health care, based on encouraging a reduction in the size of the public sector and an increase in privately financed health services. The 1980 Constitution transferred some financial responsibility for health care from the state to the individual, but the state retained its obligation to provide for blue-collar workers and the unemployed. In 1979, SNS and SERMENA were amalgamated to form the new National Health Fund which collects, administers and distributes the financial resources of the government health sector. At the same time health services were reorganized and greater decentralization was introduced. Policy-making and health planning powers were entrusted to the Ministry of Health, and responsibility for the provision of curative and preventive health services was delegated to 13 regions and 27 semi-autonomous area health services. In 1981, two further initiatives were introduced for greater decentralization of financial and administrative control. New government acts allowed the transfer of some clinic-based services from area health services to municipalities and the legal basis was established for promoting private health care organizations, called ISAPREs, which are wholly or partially financed from social insurance contributions (see Fig. 2).

The state health services are represented at the central level by the Ministry of Health, which has policy formulation, health planning, supervision and evaluation functions, and at the decentralized levels by the 13 regions and the 27 area health services (Fig. 3). The private services consist of private practitioners and associated facilities, which manage fewer than 10% of all hospital beds but oversee 25% of all outpatient services.

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**Fig. 2 Chilean health system following reorganization in 1980**

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Health services</th>
<th>Persons covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Fund, formerly SNS and SERMENA (80-85% population)</td>
<td>State health services (27)</td>
<td>Blue-collar workers and families</td>
</tr>
<tr>
<td>ISAPREs (2-5% population)</td>
<td>Private medicine</td>
<td>Unemployed families</td>
</tr>
<tr>
<td>Private citizens (6-10% population)</td>
<td>Hospitals for armed forces</td>
<td>White-collar workers and families</td>
</tr>
<tr>
<td>Armed Forces Medical Services (5% population)</td>
<td></td>
<td>High-Income families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Armed forces personnel</td>
</tr>
</tbody>
</table>
consultations. In 1983 the state public sector spent about US $50 per capita on health annually, of which approximately 44% came direct from the Treasury, 30% from social security contributions, and the remainder from other sources.

**Ministry of Health**

The main functions of the Ministry concern mainly national health policies, planning, and budgeting; and seven new subsections covering planning, finances, physical and human resources, programming, environmental health, and evaluation and control have been strengthened.

The Ministry is directly responsible for overseeing the delegated functions of the regional ministerial secretariats, the National Health Fund, the Public Health Institute, and the central supplies system. Each of these is organized separately and is responsible directly to the Under-Secretary for Health (see Fig. 4).

Besides its central operations, the Ministry of Health is also represented in the 13 regions by a regional ministerial secretariat (SEREMI), in
Fig. 4 Organizational structure of the Ministry of Health at national level (Chile)
accordance with a policy of delegated regional control. Each region has an appointed ministerial secretary, normally a physician, who ensures that the Ministry’s policies are implemented in the region through cooperation with the regional governors (appointed by the President) and their administration. The regional ministerial secretary and staff are responsible for supervising and inspecting the work of the 27 area health services, but the regional secretariat does not control, or directly involve itself, in the health services.

The 13 SEREMIs have been delegated considerable administrative responsibility and are the representatives of the Ministry of Health in each region. Their principal functions are to:

— adapt the Ministry’s policies and plans to the needs of the region;
— ensure that these are implemented;
— coordinate the activities of the area health services in each region;
— act as a link between the area health services and the Ministry;
— ensure intersectoral coordination with the regional authorities.

**Area health services**

The area health services are the decentralized state agencies actually responsible for running the services. They have their own legal status, control their staff, and own their premises and equipment. They are the successors of the former national health service.

The area health services are fully responsible for implementing within their areas the national health policies that cover the blue-collar workers and the unemployed. The directors of these services, who are appointed by the Ministry of Health, may or may not be health professionals. They have been given wide powers to manage health facilities and buildings, staff, equipment and the budget (see Fig. 5).

The creation of these 27 semi-autonomous area health services has introduced major organizational and functional changes in the former area health services, such as the following.

- Although hospitals are included within the area health service organization, the director is no longer directly responsible for the activities of the area hospitals, which now have their own administrative head.

- The health service management support has been strengthened with new sections responsible for finance, personnel, physical facilities and supplies.

- A separate directorate for primary-level care has been created, with its
Fig. 5 Organizational structure of the health services (Chile)
Chile

own staff and budget, responsible for all the clinics outside hospitals and the rural health posts.

- Three new posts of assistant director head the preventive, curative, and environmental health programmes.

- Each health service has its own board covering preventive medicine and disability (e.g., grants, licences and pensions) called COMPIN.

- Separate audit departments have been set up and report directly to the director. In addition, the Ministry of Health and the regions have their own auditing powers.

- Consultative councils for technical and administrative management have been set up to advise the director of the health service, and separate councils link to the managers of hospitals and primary care.

- The registration and supervision of medical and other health professions are organized separately by each health service.

- With respect to the National Health Sanitary Code (covering, for example, food and drug control, and environmental hygiene), the director of each health service has been delegated the full legal powers and responsibilities that used to be held solely by the director-general of the former SNS.

Municipal management of primary-level care

The constitution permits the transfer to municipal ownership and management of some of the educational, health, and child welfare services run by the state ministries. In 1981, the Ministry of Health began a policy of transferring to municipalities the responsibility for some urban and rural primary care clinics, but not for hospital or emergency facilities. Municipalities already administer the majority of educational facilities, unemployment benefits, minimum employment plans, and housing and latrine construction programmes. Hence, it was felt important to link health to these activities.

The transfer of the health facilities is arranged between the director of the health service and the mayor of the municipality (appointed by the President), the agreement covering the buildings, equipment and the entire staff. This agreement has to be subsequently countersigned by the Ministry of Health. The buildings and equipment are loaned free for periods of five years, but the transferred services are obliged to maintain the same level of activities and the same standards of service. The municipality is paid by the National Health Fund for the cost of the transferred services, including salaries, based on a standard scale of charges for all the services provided. The bill submitted by the municipality is verified by the health service before it is forwarded to the Fund.
Health system decentralization

Supervision and monitoring of these primary care services managed by the municipality is the responsibility of the respective health service and the regional secretariats.

The advantages of this transfer were seen to be better adaptation to local requirements, greater local community involvement, improved local supervision, and investment by the municipality of some of its own resources.

Health and welfare institutions (ISAPREs)

A law passed in 1981 decrees that workers may pay their compulsory health contribution (about 6% of taxable earnings) to any institution that agrees to provide acceptable and equivalent health services and other benefits. These institutions, which are largely private insurance systems, have to be approved by and registered with the National Health Fund. They are called “health and providence institutions” and by utilizing private facilities they replace the benefits obtained from the health services. Individuals may take out a one-year contract with an ISAPRE organization, although this can be cancelled at one month’s notice and the individual can then revert to becoming a member of the health services. ISAPREs are entitled to levy charges over and above the 6% contribution.

Achievements of decentralization

The reorganization and decentralization of the health services is in keeping with the political and economic beliefs of the government that individuals, rather than the state, should accept greater responsibility for paying for their own welfare. It is also a reaction against the former centralized political and planning control exerted over the whole health services that was centred on the capital city, Santiago. The Ministry of Health is attempting to build up a more mixed state–private system of health services, but the state still retains irrevocable obligations and duties, particularly for blue-collar workers and the unemployed and their families. The changes do not alter the state’s legal commitment to providing such health services, and all private health care organizations are still under the regulation and supervision of the state.

Through the regional secretariats and the area health services there is now considerably more local autonomy and administrative decentralization. Staff appointments, promotions and personnel matters are now directly handled by each area health service. Capital investment funds are now requested through the regional financing system, which is under the direct control of the regional governor. Most new proposals for local projects or programmes are now decided upon by the area health services themselves.
Decentralization has resulted in quicker management decisions, for example on staffing matters; as regards maintenance and equipment, these are said to be more appropriate now to local circumstances. However, decentralization has had two important adverse effects. It has made national control of the distribution and transfer of health workers much more difficult. In addition, since financial resources are more limited, it has become harder to finance large capital projects and new programmes, without new financial allocations being made by the Ministry of Health.

In general, the transfer of primary care clinics to municipalities has not resulted in extending coverage or in improving the quality of the services, largely because of a lack of professional supervision and poor health planning by the area health services. However, there has been an improvement in the administrative procedures and record-keeping of the clinics, and more resources have been made available for physical improvements to the buildings. However, the overall costs of the clinics have remained the same, whether they are administered by the health services or by the municipalities.

Conclusion

Since the 1950s a great deal of effort has gone into organizational restructuring to improve administrative efficiency and to involve the state more in social development. In the 1970s an attempt was made to create a more unified national health service that would benefit the poor. With reorganization and decentralization in the 1980s, the emphasis has been on increasing individual choice by promoting the private sector. While the state has still attempted to retain its responsibility for blue-collar workers and the unemployed, public sector health funding has declined and the economic recession has, at the same time, inhibited the growth of private health care. The overall burden on the state-supported services has increased, therefore, owing largely to the growing numbers of poor and unemployed people.

It should also be pointed out that at present there is considerable fragmentation of control over the services. Previously, the director of an area was also the director of the main hospital and had direct responsibility for all other government units in the same geographical area. In addition, the medical chiefs of specialist services had important responsibilities to the director for ensuring the quality of these services throughout district health centres.
Implementing decentralization of health services: a case-study from Mexico

Ramón Alvarez Gutiérrez

Implementing decentralization

In Mexico, decentralization is closely linked to the form of government of the republic. The United Mexican States is a federal republic consisting of 31 free and sovereign states and a federal district, with the President of the republic being the supreme executive authority. Each state has a governor and is divided into municipalities that enjoy operational autonomy. This division of powers between the levels of government is defined by the political constitution. Decentralization was adopted by the President of the republic as one of seven principles required to establish a more egalitarian society. Decentralization calls for a determined and thorough, but at the same time gradual, review of the powers and responsibilities of the three levels of government in Mexico: the federal republic, the states, and the municipalities. The aim is to seek a better balance between them, leaving the decisions to be made at the most appropriate level.

A similar process has been adopted for decentralization of the health services. This process rests on a strong legal basis, namely Article 4 of the Constitution which stipulates that: (1) every person shall be entitled to protection of his or her health; (2) the basis for and provision of health services shall be defined by law; (3) this same law shall lay down the responsibilities of the government and of the federal organizations with regard to health services and public health.

The general law on health, which establishes regulations for Article 4 of the Constitution, aims to define the right to health protection; to establish the legal bases for making that right effective; to define the participation and responsibilities of the public, social and private health sectors; to establish the operational bases of the national health system and to lay down rules for the provision of services; to update and complete central guidelines with regard to general health; and to clarify the responsibilities of the different health authorities, including the state governments.

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Decentralization is justified on at least the following grounds: (a) the need to organize a national health service to overcome the differences between the health services offered by the two social security institutions (Mexican Institute of Social Security; Institute of Social Security and Services for State Employees) and those services provided to the general population not entitled to the benefits of the above institutions; (b) to strengthen the operational efficiency and management of the health services at the level of the state governments; and (c) to link planning of the health services more closely to overall national planning.

For the above reasons a department for the coordination of health services, attached to the President of the republic, was set up in 1981 in order to develop the present health services into a national system ensuring access and coverage for the whole population.

In October 1982, the President Elect indicated that new laws to enact these changes would be introduced as soon as his presidency began.

By 1986, the Secretariat of Health had consolidated plans for the national health system, the essential features of which are:

— a mandate, incorporating the right to health protection in the Mexican Constitution, through its general law on health, promulgated in February 1984;
— an organization, the national health system, which implements the legal and social guarantee mentioned above;
— a national policy, provided by the national planning process and the national plan for development, of which the national health plans form a part.

In accordance with the decentralization strategy, the individual state congresses have been encouraged to pass state health laws, and by 1987 15 of the 31 states making up the republic had done so. New legislation has also been enacted for the third level of government, in the form of proclamations that define the health responsibilities of the municipalities.

In addition, various presidential decrees have been issued to implement decentralization. In August 1983 a decree was issued for a programme to decentralize the Secretariat of Health; in March 1984 another decree called for the decentralization of the federal health services themselves. In June 1985 an amendment to the latter decree was issued, calling for the federal agencies to be disbanded as the health services are handed over to the individual states.

**State health services**

Implementation of the decrees mentioned above has proceeded in two stages. During the first stage, a programme was drawn up for improving the coordination of the various services, to which the state health
programmes could conform; appropriate management and surveillance bodies were set up; systems were organized for the referral of patients between the different levels of health services; and omissions and duplications of services were detected. The second step consisted of the integration of the various services into a single organization forming one state health service that is controlled by the state government.

By 1987 services had been handed over to 12 of the 31 states, namely: Baja California Sur, Colima, Guanajuato, Guerrero, Jalisco, México, Morelos, Nuevo León, Querétaro, Sonora, Tabasco, and Tlaxcala. In these states, there is care for the people not covered by social security systems, who represent 42% of the population residing outside the Federal District. These 12 states contain one-third of all the primary care facilities available in the 31 states, half of the hospital beds, and 45% of the personnel.

In May 1986, the National Health Council was set up as a coordinating body for public health programming, budgeting and evaluation. It includes the heads of all the state health services and is presided over by the federal Secretary of Health.

Reorganization and decentralization of responsibilities

Several factors have been important in determining the rate at which the decentralization process has been implemented, namely:

— political willingness of state and municipal governments to accept responsibility for the running of the services;
— availability of finances, both federal and state, to support the transfer of the services;
— technical and managerial ability of the state offices to take over responsibility for the services.

The progress of decentralization has been impeded by serious problems, mostly of an administrative nature, arising from the concerns of the labour unions for their health workers, the need for management support for the new services, and delays in the transfer of financial resources. To overcome these problems, greater financial flexibility has been introduced; federal contributions are handed over to the states, and the distribution of resources has become the responsibility of the state health services. Similarly, the management of human resources has been decentralized with regard to recruitment, selection, training and promotion, while ensuring that the personnel retain the status of federal employees. The handling of labour relations in each state has been delegated to the head of the state health services.

In order to enhance its ability to coordinate the health sector, the secretariat of the Ministry of Health itself has been reorganized and
strengthened. In addition to the Secretary, there are three under-secretaries in charge of health planning, health services and environmental health, and research and development. The number of central units has been streamlined from 116 to 60 units.

As stated earlier, decentralization implies the participation of different bodies at each of the government levels concerned. Thus, at the federal level the following are involved: the Secretariat of Health, which is responsible for all the technical analysis and programming needed to implement decentralization to the state health services; the Secretariat of Programming and Budget, responsible for incorporating these proposals into an overall agreed regional development plan, which is the basis for agreements between the federal and state levels; and the office of the Comptroller-General of the Federation (Contraloría de la Federación), with responsibility for the general supervision of the implemented programmes and for ensuring that states comply with their obligations.

The state government decides on the most suitable administrative location for the state health services within its own governmental structure and decides what financial support they will receive. The same scheme applies at the municipal level.

**Decentralization and primary health care**

The main strategies for developing the national health system, in addition to decentralization, are: consolidation of the health sector, administrative modernization, intersectoral coordination and community participation. Because these strategies are closely linked with decentralization, each of them will be briefly dealt with.

The main method for consolidation (or sectorization) of the health services was the reform of the federal public administration law, which gave the Secretariat of Health (formerly, the Secretariat of Health and Welfare) the powers to establish and implement national policy in regard to social assistance, medical services, and general public health, and to coordinate all public health programmes and services. The Secretariat is likewise empowered to plan, standardize, coordinate and evaluate the national health system, as well as to control all public organizations that supply health services. All this involves improvements in programming, budgeting, and control over the resources allocated to these services. In order to create a more unified national health system, the social security and social welfare institutions were added to the responsibilities of the national Secretariat of Health. This resulted in the 1984–1988 National Health Programme, approved on 7 August 1984, which brings together all the institutions that have a direct interest in, or experience considered valuable to, a national health service.

As a result of the reorganization, the Secretariat has been transformed into an agency responsible for health policies and for standardizing.
Health system decentralization

planning, evaluating and supervising the health services. It also undertakes financial planning. However, the running of the services is left to the State Health Service.

Since national development planning assumes satisfactory links between the separate sectors and since improved health depends to a great extent on better interaction with other fields of socioeconomic life, an inter-sectoral coordination strategy was drawn up. This promoted the importance of the health sector in the federal public administration, as well as other developments in the social and private sectors.

Within this framework the Health Cabinet (Gabinete de Salud) and the General Health Council were established as collegiate bodies. The former acts at a high political level, while the second is technical in nature. Through these bodies inter-institutional committees have been set up between the Secretariat of Public Education and the Secretariats of Health, leading to advances in fields such as personnel training and health research. A basic list of drugs has been drawn up, as well as a programme for the promotion and development of the pharmaceutical industry; among the other areas covered are family planning and health promotion programmes to combat the use of alcohol, drugs and tobacco. Several environmental problems have been dealt with. As a result of these efforts, joint programmes have been drawn up with the Secretariats of the Interior, Public Education, Urban Development and Ecology, Trade and Industrial Promotion, Agriculture and Water Resources, and the National Council of Science and Technology. In all, some 20 institutions are involved, including institutes of higher education.

Finally, there is a strategy for encouraging community participation, considered to be a decisive factor in the success of health programmes. As part of this strategy, different participation mechanisms have been applied. Health committees have been set up in each health unit, with representatives of the local community being involved in running the establishments and in linking the health administrators to the user. Municipal committees have also been established which include representatives from local authorities, the community, and the organizations providing the services.

Another kind of participation in the management of the health services is that of the boards of trustees (Patronatos) of hospital units, who, apart from supporting the hospital administration, can be of great assistance in obtaining additional financial resources. The altruism of a prominent group of Mexican entrepreneurs, furthermore, has resulted in the establishment of the Mexican Foundation for Health, the aim of which is to provide financial support for the development of health services and to defray the cost of research into the main problems of the nation.

Lastly, with a view to cooperation between the Secretariat of Health and the social and private sectors, agreements have been drawn up for participation in the health programmes of various occupational groups—mainly at the state level—such as peasants' and workers’ trade union groups.
Resources for decentralization

As a result of the measures adopted to standardize and equalize salaries, 83,000 doctors and other health workers had their salaries increased by 70% during 1984 and 1985 and again when the state health services were created, when a more complete system of benefits was provided. The expenditure borne by the federal government for the first 12 states to establish such services amounted to 15 billion pesos (nearly US$21.5 million) in 1986 and benefited 18,650 workers. The additional personnel requirements of the states resulting from decentralization were largely met through a reduction in posts at the central level and the voluntary transfer of staff. Payment of salaries has been decentralized to the states.

During the process of decentralization, and in spite of the economic crisis, there has been an increase in overall investment in health. Building renovations and extensions were carried out in 90% of the health centres and in 45% of the hospitals owned by the Secretariat. Also during this period many primary-level health units and hospital beds were added to state health facilities. This is in addition to the reconstruction and reorganization programme aimed at compensating for the loss of Secretariat facilities from the September 1985 earthquake and which alone represents an expenditure of 41 billion pesos.

Responsibility for renovations and extensions of primary-level health units was transferred to the states along with the corresponding funds. Two-fifths of the investment of the Secretariat was thus decentralized during 1984 and 1985. Other financial measures included attempts to standardize expenditure by formulating standard lists of essential equipment, drugs, and other supplies. A single procurement system has been established for all the states, thus permitting the decentralization of storage and distribution and the strengthening of centralized planning for these items.

Budgetary resources have been reallocated in several ways. Although total federal government expenditure on health has been reduced, the proportion assigned to the health sector increased from 7.5% in 1982 to 8.6% in 1986. Expenditure on services for the uninsured population rose from 27% in 1983 to 33% in 1985. By 1986, 63% of the total expenditure of the Secretariat went directly to the states, as against 40% in 1982.

The operational expenditure by the states has grown by an annual 20% in real terms during the period 1984–1986, while the central administrative units have seen theirs reduced by 19%. The states increased their own contribution to health by 280% between 1984 and 1985 and the social security institutes also increased their participation in the financing of public health activities. The 12 states in which the decentralization process has been consolidated have increased their operational expenditure by 35% each year during the period from 1984 to 1986. The budget of the decentralized services comes from the state treasuries and from the federal Secretariat of Health subsidies, according to annual agreements that take
into account strategic programmes and evaluation results. Any fees recovered may now be retained by the states but most of the 12 decentralized state health services no longer charge fees. Thus health care at the primary level, including medicines, is now entirely free for most uninsured groups of people in rural areas, and also at the second and third levels if patients are referred.

Conclusion

Decentralization is seen as a very important instrument of national policy, which includes health, and the President is committed to this policy for all sectors. In a developing country such as Mexico, the historical phase of centralization, justified by the need for national integration and the need to concentrate on economic and social development, began to generate more costs than benefits. Decentralization is now seen as a way to revitalize democracy, facilitate community participation, encourage intersectoral cooperation, and improve the management and delivery of health services. Decentralization should lead to a more equitable and relevant national health service and increase the efficient use of the limited resources available for better health. Thus, decentralization is seen as an essential means of supporting the successful implementation of primary health care.
The decentralization of the Netherlands health services

G. Schrijvers

Introduction

Eight regions in the west and south of the Netherlands are experimenting with the decentralization of all health policy, and the four biggest cities, Amsterdam, Rotterdam, the Hague, and Utrecht, are to follow with a moderate form of decentralization. The rest of the country is currently involved in the decentralization of only primary care policy; any further steps must await an assessment of the first eight regional experiments.

This decentralization movement started in 1974, when the government published a report on the structure of the Dutch health services. Regionalization and primary care were key concepts in the proposed new structure. A new law formalized the ideas of this report in 1982. Since then experiments have been taking place.

This chapter discusses the trial and error method of introducing decentralized decision-making in the Dutch health services, viewing implementation as a learning adventure for all the people involved, including politicians, departmental civil servants, provincial and municipal authorities, patient groups, insurance companies, and health care providers. Is this adventure a Greek tragedy or will it have a happy ending? No answer can yet be given. The decentralization process has just started and will continue far into the 1990s: perhaps by then we shall have achieved “Dutch health regions for all by the year 2000”.

The Dutch health sector: brief history and data

The Dutch health sector assumed its present profile about 100 years ago. The general practitioner was at that time the independent family doctor

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Health system decentralization

Table 2. Health care costs in the Netherlands in 1960 and 1981 (In million DFL)*

<table>
<thead>
<tr>
<th></th>
<th>1960</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current prices</td>
<td>576</td>
<td>23481</td>
</tr>
<tr>
<td>Prices at 1970 levels</td>
<td>1415</td>
<td>9236</td>
</tr>
</tbody>
</table>


...and has remained so until now. In the second half of the nineteenth century many of the present general and psychiatric hospitals were founded by churches. Most of them are now private, independent, non-profit-making institutions without formal links with churches. Labour unions, doctors, and churches established a health insurance scheme in 1880 to safeguard the financing of health care. In the next century, more and more people became members of a health insurance scheme. From the beginning of the Second World War, all persons earning less than a certain salary were obliged to take out private health insurance. This was still the case in 1986: the health insurance companies have contracts with two-thirds of the Dutch population. After the Second World War, Dutch health care provision became more and more dependent on clinical chemistry, radiology and other medical techniques. Many hospitals were enlarged in the 1950s and 1960s. These developments, together with a high inflation rate, led to an enormous increase in the cost of health care at the beginning of the 1960s (see Table 2).

Until the 1960s, Dutch health care was not greatly influenced by the government and its administration. The Ministry of Health, or a department of the broader Ministry of Social Affairs, followed a policy of non-intervention which followed, rather than stimulated, initiatives from the health sector itself. In the 1960s, there was a period of legislative activity brought about by the cost explosion and the need for more cooperation between hospitals, and by new ideas about the role of government. The health insurance legislation was renewed in 1963 in the form of a health insurance law. In 1968, national health insurance for nursing home care, psychiatric care, care for mentally retarded persons, and other continuous and expensive care was created, covering the whole Dutch population. This stems from the general law for special health care costs (Algemene Wet Bijzondere Ziektekosten), which is still in force today. Parliament endorsed a public health report¹ which proposed that the government should assume responsibility for the health sector in collaboration with the private institutions. On the basis of this, two laws were introduced in which this governmental responsibility was delegated.

to nongovernmental agencies. The law on hospital tariffs (*Wet Ziekenhuisarbeien*, 1966) placed cost-control in the hands of such an agency. The law on hospital provisions (*Wet Ziekenhuissvoorzieningen*, 1970) did the same for hospital building and planning.

These developments following the end of the Second World War led to the development of the health care system shown in Table 3. The secondary and tertiary levels provide 223,695 beds, or 16.0 beds per 1000 inhabitants. If old people’s homes are deducted from this figure, the number is lower: 172,295 beds or 12.3 beds per 1000 inhabitants.

### Table 3. Health care facilities in the Netherlands in total and per 1000 inhabitants, 1984

<table>
<thead>
<tr>
<th>Unit for columns (2) and (3)</th>
<th>Numbers in total in 1984</th>
<th>Numbers per 1000 inhabitants in 1984</th>
<th>Cost of care (in million Dfl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
<tr>
<td>General practitioners</td>
<td>Posts</td>
<td>5,900</td>
<td>0.42</td>
</tr>
<tr>
<td>Dentists</td>
<td>Posts</td>
<td>6,511</td>
<td>0.46</td>
</tr>
<tr>
<td>Physical therapists</td>
<td>Posts</td>
<td>9,478</td>
<td>0.68</td>
</tr>
<tr>
<td>Pharmaceutical drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District nurses and mother/child care</td>
<td>Posts</td>
<td>13,980</td>
<td>1.00</td>
</tr>
<tr>
<td>Home helps</td>
<td>Posts</td>
<td>39,525</td>
<td>2.81</td>
</tr>
<tr>
<td>Social work and social services for the elderly</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory drug-addict care</td>
<td>Posts</td>
<td>550</td>
<td>0.04</td>
</tr>
<tr>
<td>Other social welfare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute hospitals</td>
<td>Beds</td>
<td>68,943</td>
<td>4.9</td>
</tr>
<tr>
<td>Psychiatric hospitals</td>
<td>Beds</td>
<td>24,303</td>
<td>1.8</td>
</tr>
<tr>
<td>Medical specialists’ care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retarded children’s homes</td>
<td>Beds</td>
<td>28,145</td>
<td>2.0</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>Beds</td>
<td>50,904</td>
<td>3.6</td>
</tr>
<tr>
<td>Old people’s homes</td>
<td>Beds</td>
<td>51,400</td>
<td>3.7</td>
</tr>
<tr>
<td>Ambulatory psychiatric care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other institutional care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total institutional care</td>
<td>Beds</td>
<td>223,695</td>
<td>16.0</td>
</tr>
<tr>
<td>Management and administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total health care costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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Health system decentralization

Table 4. The financing of the Dutch health care system, 1984a

<table>
<thead>
<tr>
<th>Source of finance</th>
<th>Total (in million Dfl)</th>
<th>Total in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance law</td>
<td>14654</td>
<td>36</td>
</tr>
<tr>
<td>Law for special health care costs</td>
<td>9,449</td>
<td>23</td>
</tr>
<tr>
<td>Taxation</td>
<td>6,095</td>
<td>15</td>
</tr>
<tr>
<td>Private or social insuranceb</td>
<td>10,128</td>
<td>25</td>
</tr>
<tr>
<td>Other sources</td>
<td>507</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>40,833</td>
<td>100</td>
</tr>
</tbody>
</table>

a Source: See footnote to Table 3.
b Out-of-pocket expenditure and premiums for private insurance.

When home help, social work, and old people’s homes are included in the care system, the sector spent 40,833 million Dutch gilders in 1984. Excluding the social services, the cost was 34,689 million gilders, or about 2400 gilders per person. This was about 9% of the Gross National Product in 1984. The total care system was financed from different sources, as shown in Table 4. Taxation payments accounted for 15%, private payments for a quarter, and social insurance (health insurance law plus law for special health care costs) for 59%. Excluding the social services mentioned above, the percentages were 6% (taxation), 25% (private), and 69% (social insurance).

Decentralization of health policy: the reasons why

Health care costs continued to grow in the 1970s and in 1974 the health care structure was reviewed. A government report concluded that there were many overlaps, inequalities and inefficiencies in the Dutch health care system. This report recommended, first, a regionalization of the system. This was an old idea in the Netherlands, which was canvassed by various political parties at the beginning of the 1950s, although coordinating provincial health councils were set up only from 1956 onwards. The other recommendation of the government report was the formation of health echelons in which health care providers would work together. Echelons were conceptualized for sickness prevention (zero-echelon), primary care (primary echelon), acute hospital care (secondary echelon) and long-stay care (tertiary echelon). The development of this philosophy led to a new phase of legislation. Sickness prevention by means of community-oriented organizations (basisgezondheidsdiensten) was
stimulated by subsidies and made legally compulsory for municipalities, or groups of them. In the primary echelon, amalgamations between organizations for mother-and-child care and district nursing were made compulsory for health insurance organizations and the Department of Health and Physical Environment. The same rules were applied to institutions for psychiatric care outside hospitals. In the secondary echelon, many fusions and federations took place between hospitals, especially outside the bigger cities.

The first recommendation of the 1974 government report, to regionalize the health services, was translated in 1982 into a new law on health care provision (Wet Voorzieningen Gezondheidszorg). Its aims were to promote public health, to restructure the health services, and to control health care costs. Health promotion, by means of a multisectoral approach as recommended by the World Health Organization, was possible because municipalities and provinces were authorized by this law to plan health services. These authorities already had power in many other sectors, such as education, public transport, social services, and housing. In this way a health policy, instead of only a health care policy, was stimulated by the decentralization to regional authorities. The second aim, to restructure the health services, covered three areas. The most important objective was to stimulate primary care and to decrease the secondary and tertiary echelons. Other restructuring objectives involved the geographical redistribution of services and the restructuring of activities within the same echelon. Control of health care costs was the third aim. Planning created the possibility of controlling costs over a period of several years and showed the effects of cost reduction on expenditure by sector.

Organizational changes and the process of implementation

The law on health care provision did not provide rules for decision-making at the regional level. The municipalities and cities were authorized to plan the health services. The health insurance companies kept their responsibilities in budgeting and financing. The health institutions, which were mostly private, retained the responsibility to provide care and to structure their own organization. Eight experimental regions in the south and west of the country were set up to find out how these different responsibilities could be made compatible.

The objective of the experiments was to realize a regional planning system. Five conditions were seen as necessary for such a system: (i) a regional health policy, (ii) well-defined health regions, (iii) block grants, (iv) planning procedures and (v) well-defined links with the financing system. The implementation of each of these conditions and the problems encountered are discussed below.
Health system decentralization

**Condition 1. A regional health policy**

The collection of regional data on patient flows, costs, building initiatives, and institutional activities was the first step towards the development of a regional health policy. Later steps included the designing of a regional health profile, which described the health status of the regional population and listed and categorized the policy goals of the different regional participating bodies. One of the first problems encountered was that statistical data were defined differently. Secondly, many of the available data were more than two years old, which was too long a period for the intended planning system. Another problem was that not all participating bodies were eager to distribute their data to other institutes or groups as this might have weakened their position.

**Condition 2. Well-defined regions**

Regions were chosen with approximately 200 000–300 000 inhabitants. This scale was big enough for the zero and primary echelons but too small for the general hospitals and more specialized institutions. However, as the law on health care provision was intended to promote primary care, the choice made by the Department of Welfare, Health and Cultural Affairs fell on regions with the above-mentioned number of inhabitants. Many problems were encountered. First, the region in South Limburg with more than 600 000 inhabitants had to be split up into three smaller regions. Secondly, cooperation at the regional level between smaller municipalities had to be established. This was not a health problem but a problem for public administrations. Sometimes there was friction between villages for historical reasons, or stemming from chauvinism or fear of annexation.

**Condition 3. Block grants**

A special venture was the creation of block grants for the experimental regions. As mentioned above, the Dutch health care system is financed from three sources—taxation, social insurance and private insurance—but the regions are allowed some flexibility in financing; a national mechanism has been developed whereby a lower or higher social insurance rate can be compensated for by a higher or lower taxation rate. To decide upon the size of the grant, a formula has been developed based on the needs of the population, taking into account, among other things, the number of inhabitants and the age-distribution.

One problem encountered was opposition from the health insurance organizations and the institutions financed by them to the “trade-off” between taxation and social insurance payments. Their fear was that the latter payments would sooner or later be replaced by taxation payments.


**Condition 4. Planning procedures**

Why regional planning? This is a question that has often been asked during the implementation process. There are three positive answers and one negative one to be given. First, such a planning system diminishes the volume of regulation for subsectors. Second, the block grants make it possible to design realizable and not merely idealized plans. Third, regional plans may decrease ad hoc governmental measures. One negative aspect of such a system is that growth in primary care and other sectors is only possible if other echelons decrease their expenditure, or if the block grants increase as a whole, which is unlikely. Fig. 6 shows the three main steps in the planning procedure, which starts with a departmental decision regarding the size of the block grant. A regional plan is designed within the limits of this grant, and this plan forms the basis for institutional plans and budgets. The needs of the population and the policy goals of institutional managers play a role in the decisions concerning block grants, planning, and budgeting.

Some of the problems encountered are of an administrative nature: for instance, how to keep such a planning process to within the period of one year, and how to organize enough forums for health providers, health insurance organizations, and patient groups to influence the decision-making process of municipalities and provinces. Other problems arise from differences in culture, language, knowledge, and trust between the different participants in the planning process.

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**Fig. 6 Main steps in the regional planning procedure (Netherlands)**

![Diagram showing the main steps in the regional planning procedure](image-url)
Condition 5. Well-defined links with the financing system

The most difficult implementation problem is that of defining the relationship between the planning and the financing system. The dilemmas are manifold. The financing system developed historically outside the framework of government administration and has its own national agencies, regulations, and local executive organizations. Just before the introduction of regional planning, decentralization from national agencies took place within the financing system for health insurance organizations. The introduction of regional planning meant that some of this freedom of decision-making was handed over to the provinces and municipalities, or at least that ambitions to achieve more freedom of decision-making had to be tempered. Although the links are now well defined on paper, with the financial section of the regional plan based on estimates from health insurance organizations and institutions, only experience will tell how well the system works.

Decentralization and collaborative activities

As mentioned earlier, the history of the Dutch health service, along with its financing, is different from that of the municipalities and provinces. The different backgrounds tend to create distrust, power struggles and misunderstandings in the collaboration between the various regional parties involved in the present implementation process.

In order to be able to discuss these points and learn from each other, all the participating organizations and institutions need a regional forum. Such a regional health forum has been made obligatory by Article 41 of the law on health care provision, which permits implementation on an experimental basis. Representatives of the patient groups, care providers, financers, municipalities, and provinces meet each other regularly in the regional health forum. The setting-up of the forum itself was a delicate process; by mid-1986, it was functioning in only three of the eight experimental regions.

Also in 1986, knowledge about the process of implementing decentralization seemed to be confined to the spokesmen or spokeswomen of each regional participating body. The groups they represented were not well informed but, nevertheless, had to play their roles in the newly designed planning procedures. There was also some lack of knowledge within government administration circles about the attitudes and skills to be found in health service institutions. The same applies to administrative staff in the provinces and municipalities in relation to the health sector.1

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A training programme, set up by the Institute of Health Sciences in Utrecht, pays some attention to these points and is being used more widely.

Collaboration within the health sector is one thing; working together with other sectors is another. During the last ten years more than one attempt has been made to stimulate the integration of the health and social services. In 1974 a government report\(^1\) pleaded in favour of general laws for education, welfare (including health care), and culture. A law on specific welfare,\(^2\) which was to take over the regulation of the health services in 1990s, was passed by the lower house of Parliament in 1981, but was withdrawn in 1982 by a new government as it was considered to be too ambitious. The difficulties experienced during the preparation of this law are still influencing the implementation of the law on health care provision. Nevertheless, the integration of health and social services has remained one of the government’s aims. A Ministry of Welfare, Health and Cultural Affairs was formed in 1982 from parts of previous ministries and physical integration started in 1986. An outline of a new law on health and social services\(^3\) has been drawn up that tries to integrate health services and parts of the welfare sector such as home helps, social work, old people’s homes, and other services closely connected with the health sector.

Within the eight health regions there is some doubt about the wisdom of rapid incorporation of the social services into the health services. Although the necessity for this is appreciated, people are wary of the disorder that would result in the short term. Perhaps a general law on health and social services should be regarded as the end rather than the beginning of an integration process, since governments in the Netherlands have in the past concentrated on reforming strategies and processes before making the necessary structural changes.

Interesting ideas on collaboration have come from the “Health for all by the year 2000” group within the Ministry of Welfare, Health and Cultural Affairs. On the basis of their studies, the Department recently published a report on health in the year 2000\(^4\) which pleads for a health policy that is needs-oriented and multisectoral, with an emphasis on changes in lifestyle. The eight health regions have again been selected as experimental areas in which to gain experience with this type of health (rather than

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Health system decentralization

The “health care” policy. Once again, there is some hesitation in the regions because of fear of chaos: too many innovations are being planned at once.

Assessment of experience

In 1986 it was still too early to evaluate the results of the decentralization experiments. Two research institutes, the TNO Institute of Preventive Health Care (NIPG) and the University of Limburg, were evaluating the process on two sets of criteria. One set concerns input or structural aspects and tries to answer organizational questions such as: do the models function efficiently? The other set is linked to the law on health care provision, which aims to promote the restructuring of health services and to control costs. The questions here are: have health-promoting activities been stimulated? Is the system more home-based and more oriented to primary care? Have the cost-control mechanisms worked over a period of several years? Although the decentralization experiments are to be concluded by 1991, it is doubtful whether these questions can be answered in the space of a few years. Regionalization in England and Sweden took 10–20 years. A decentralization process cannot be an experimental one with control groups and “all things being equal” conditions: the process is too slow and too complicated.

It would be better to adopt a developmental approach, without knowledge of the final blueprint, in which the decision-making process is continuously evaluated according to criteria such as efficiency, effectiveness, conflict minimization, and common sense. The first set of criteria that are concerned with input or structural aspects would thus serve to evaluate the speed of the implementation process. This process must involve building up the five conditions mentioned on pages 76–78 simultaneously, otherwise structures may develop without policy targets or strategies without structures. In 1986, the feeling existed in the experimental regions that although a lot of attention had been paid to structures, the time had come to initiate concrete projects to fulfill the aims of decentralization. The speed of implementation is bound to be slow because of the number of structural changes to be implemented and the many new skills and data required. Nevertheless, decentralization seems to be the only way to meet the future health needs of the population with local support and creativity.
Decentralization of health service management: a review of the New Zealand experience
L. A. Malcolm

Introduction

New Zealand is on the verge of implementing major changes in the organization of its health services. Although discussions about organizational reform have been taking place for at least a decade, legislative action and implementation began to occur only in 1984. Of these reforms, the most important is the establishment of the elected area health board as the authority to plan and provide comprehensive health services for an area. Together with service development groups to plan and coordinate area-wide services, the area health board is a concept unique to New Zealand in health services organization.

Associated with these organizational changes, and providing both direction and leverage towards their implementation, are two key elements: a new national advisory body, the Board of Health, and population-based funding of area hospital and health boards. This chapter reviews these developments within a framework of different models of decentralization.

Models of decentralization

Part I described four possible models of decentralization—deconcentration, devolution, delegation and privatization—which reflect both different degrees of government authority and different approaches to decentralization. Table 5 presents some brief advantages and disadvantages of each model and provides an example of each from New Zealand.

Deconcentration is defined as administrative decentralization, such as the transfer to a peripheral office of clearly defined duties and responsibilities including some local discretionary authority. In New Zealand, an example

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1 Department of Community Health, Wellington Clinical School of Medicine, New Zealand.
<table>
<thead>
<tr>
<th>Model</th>
<th>Deconcentration</th>
<th>Devolution</th>
<th>Delegation(^a)</th>
<th>Privatization</th>
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<tr>
<td>Operational definition</td>
<td>Administrative decentralization</td>
<td>Political decentralization</td>
<td>Transfer of specific functions to a commission or corporation</td>
<td>Transfer of functions to private and voluntary agencies</td>
</tr>
<tr>
<td>Potential advantages</td>
<td>Some local discretion, removal of pressure on the centre</td>
<td>Sensitivity to local issues, greater coordination of services</td>
<td>Greater flexibility in the management of these functions; some political independence</td>
<td>Greater flexibility and political independence</td>
</tr>
<tr>
<td>Potential disadvantages or limitations</td>
<td>Lack of coordination and of sensitivity to local needs</td>
<td>Central funding necessary in high-cost health services, and hence central control</td>
<td>Lack of coordination with other departments and agencies</td>
<td>Need for regulation and control mechanisms</td>
</tr>
<tr>
<td>New Zealand examples</td>
<td>District health office of the Department of Health</td>
<td>Hospital and area health boards</td>
<td>Accident Compensation Corporation (ACC), Health Services Personnel Commission (HSPC)</td>
<td>Numerous private and voluntary agencies, e.g., private hospitals, societies for child health (Plunket) and mental handicap (IHC)</td>
</tr>
</tbody>
</table>

\(^a\) Also known as functional decentralization.
of this model is the way the Department of Health functions through its
18 district offices, which provide for health protection and promotion and
some other related services. However, problems of limited responsiveness
to local issues and coordination with other services, agencies and
departments are apparent.

Devolution is the transfer of powers and functions to semi-autonomous
subnational political authorities, such as local and regional governments.
A strong tradition of parochialism, deriving from provincial government,
has led to devolution being the predominant model in New Zealand.
Elected hospital boards, now evolving into area health boards, have had a
large and increasing role in the provision of health and hospital services
for defined populations.

Delegation as defined by Rondinelli is the "transfer of managerial
responsibility for defined functions to organizations that are outside the
central government structure and only indirectly controlled by central
government. Ultimate responsibility remains with central government".¹
There are problems with such a use of the word "delegation" as it more
commonly means the transfer of decision-making authority within an
organization, the delegator retaining ultimate responsibility. Burns, in an
extensive review of the concept of decentralization from the literature and
experience in New Zealand, uses the more meaningful term "functional
decentralization".² He contrasts this with "spatial decentralization",
which is what is implied by decentralization and devolution. The term
"functional decentralization" will therefore be used instead of delegation
throughout this paper. An example of this model in New Zealand is the
Accident Compensation Corporation (ACC), in which is vested the
responsibility for all compensation for accident by injury. Funding is
derived largely from a tax on salaries and wages and on motor vehicle
registrations, but ACC operates as a separate centralized organization
with levels of deconcentration to district offices. Because it is a separate
authority there have been increasing problems of coordination with other
departments and agencies of government, especially in the area of shared
statistics and preventive services.

Privatization, the fourth model, according to Rondinelli "involves the
transfer of government functions to voluntary organizations or private
enterprises". The private and voluntary sectors play an important part in
the New Zealand health system and are closely linked to the statutory
sector through benefit and subsidy payments, such as private hospital
benefits and payments for pharmaceuticals. There is an increasing transfer
of some responsibilities, such as community development and care
services, to such agencies.

¹ Rondinelli, D. A. Government decentralization in comparative perspective: Theory and
practice in developing countries. International review of administrative science, 47(2):

² Burns, C. A. M. Decentralisation of state services. Master of Public Policy Thesis.
University of Victoria, 1983.
Health system decentralization

These four models of decentralization are therefore found to a varying extent in the New Zealand scene and provide a useful framework for further description and analysis. But first, a background description of the historical development and present organization of the health system is necessary.

Organizational background

Historical development

Brunton sees the present New Zealand system as having its roots still deeply embedded in the past, especially the early colonial period of the mid-19th century. The relatively autonomous provincial system of this period was founded to meet the needs of the early settlers, who valued independence, resourcefulness and humanitarianism. Locally funded and managed hospital services were established, with the state being responsible only for lunatic asylums, sanatoria, maternity hospitals and other residual services that were felt to be too much of a liability for local initiative.

Since then the historical development of the health system has been characterized by the gradual growth of central government, and the assumption of greater central responsibilities, including funding. This has occurred against a background of parochialism, demands for local autonomy, and the proliferation of numerous local authorities and agencies.

The change in the responsibilities and numbers of hospital boards is typical of this pattern. From the 12 boards proposed in 1885, the number grew to a maximum of 47 in 1925. In 1985, the number had been reduced to 29 but these covered widely varying populations, the largest being Auckland (894 000) and the smallest Maniototo (2790). The growth of central government support for and control over hospital boards led in 1957 to the removal of their powers to raise local revenues, which up to that time had been supplemented by central government up to 50%. Since that date they have been fully funded from central government taxation. However, attempts to amalgamate smaller boards into larger entities are still vigorously resisted by parochial interests, often with central political support if marginal electorates are involved.

The central organization of health services has evolved partly in response to the need to control and fund these peripheral developments and, in the public health area, as a response to the need for a central authority to be

1 Brunton, W. Hostages to history. New Zealand health review, 3(2):3-6 (1983).
Fig. 7 Organization of New Zealand health services in 1985

responsible for handling outbreaks of infectious diseases. The present Department of Health was not formed until 1920.

These historical developments have led to the evolution of what, until 1985, was essentially a tripartite system of health care, the core features of which were:

- public health services (health protection and promotion) provided through the Department of Health and 18 district health offices—a "deconcentrated" model of decentralization;

- 29 elected hospital boards, which are statutory authorities funded centrally by a capitation grant to provide free hospital services, including mental health, and some community services to geographically defined populations—a "devolution" model of decentralization; and

- private and voluntary agency services, including general practitioners operating on a fee-for-service basis, with a range of government subsidies over a wide range of benefits—a "privatization" model.

These organizational relationships are shown diagrammatically in Fig. 7. The Minister of Health is responsible to Parliament for the Department of Health and hospital boards. The Minister is also responsible for the provision of subsidies and benefits for a wide range of services provided

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by private and voluntary agencies and for services such as environmental health provided by local authorities. These subsidies and benefits are administered through the Department of Health and to a much lesser extent through hospital boards.

The need for reform

It has become apparent, especially in the past two decades, that these organizational arrangements are no longer appropriate, given the increasing complexities of the present health care system and the changing needs of the community. The organizational problems of the health service are similar to those of most developed countries and have been described in some detail.\(^1\) In brief, they include:

— inadequate control of costs,
— failure to ensure value for money,
— lack of professional accountability,
— imbalances in care between and within services,
— gross over-institutionalization of some services,
— geographical inequalities in the distribution of services and resources,
— lack of coordination between all the various components of care, complicated by the many voluntary and private agency services,
— lack of community involvement in the planning and provision of services.

The ability to find and implement solutions to these problems is severely restricted by the present decision-making structures. New Zealand hospital boards are much more broadly based than those of most countries, in that they are responsible for defined populations and for some community as well as institutional services. At the same time, however, their power to provide a comprehensive service is limited by the fact that they are not responsible for primary care or health promotion and protection services. In almost all boards, management structures are based on institutions such as individual hospitals which, although convenient administrative entities, are managerial and planning artefacts in that they impede the broad regional service view which is needed.

The central organization of the Department of Health has remained essentially unchanged for more than 60 years and is still excessively preoccupied, as are hospital boards, with the problems of the moment rather than the future. As a result there is still no overall, explicit statement of national health policies and strategies. Only recently have there been significant developments in policy-making and planning within the health services to begin to fill this gap.

\(^1\) See footnote to p. 85.
Initiatives for reform

The White Paper

In 1974, the then Labour government published a White Paper which proposed radical changes in the organization of the New Zealand health services.¹ It was closely modelled on the reorganization of the United Kingdom’s National Health Service, which was implemented in the same year. Hospital boards would be replaced by regional health authorities responsible for all health services, including those provided by the district offices of the Department of Health. Within the authority, two levels of management were proposed, regional and district, each with its own management structure. The White Paper proposals were seen by many, perhaps rightly, as a further move towards centralization, especially as a substantial minority of authority members were to be appointed by the Minister in contrast to the existing fully elected hospital board membership. A significant shift away from devolution towards deconcentration was implied. Although there was much of value in what was proposed, the White Paper was widely rejected as being too radical in the nature and extent of its reforms and was perceived as a serious threat to existing interests, including hospital boards, the medical profession, local authorities, and voluntary and private agencies.

An important outcome of these proposals, however, was the report of the Legal and Administrative Consultative Group² (LACG), one of the groups set up to discuss the implementation of the White Paper. This report to the new National government in 1976 recommended that area health boards should be established and that coordination of service planning be achieved through the appointment, under such boards, of service development groups. The report stressed that the fundamental unit of health service organization was the service. Each service—medicine, surgery, primary health care, mental health, etc.—should be planned and coordinated through its own service development group composed of practising health professionals of different disciplines drawn from all sectors of the health services, statutory, voluntary, and private.

The LACG report was critical of many aspects of the White Paper, including the emphasis upon centralized direction, with the use of such words as supervisory, instructing, monitoring and coordinating. LACG saw its own proposals instead as being concerned with reducing central control and developing a system

... in which the initiatives come not from the centre but from the workforce, in which priorities are settled by a mainly elected authority


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as close to the workforce as is consistent with effective planning and coordination, and in which high value is placed on experimentation and diversity in health promoting strategies. This is not to say that in such a system the Department must be unimportant. But it does imply that after the Department has helped set the broad restraints within which others have discretion to make decisions, its role will normally be one not of command but of guidance (informing, suggesting, persuading) and only exceptional circumstances will justify more authoritative intervention.

This quotation indicates the wide departure in thinking of the LACG report from the White Paper on this as well as many other issues. It set the philosophical framework for most of the subsequent organizational developments.

In 1976, a Special Advisory Committee on Health Services Organization (SACHSO) was set up by the Minister of Health of the new National government to follow up the LACG report’s recommendation to establish pilot projects aimed at field-testing their proposals for area health boards and service development groups. SACHSO implemented two such pilot schemes, in Northland and Wellington. Despite the initial suspicion and even antagonism that followed the White Paper, with which the LACG report was linked, these schemes, especially in Northland, were widely supported and reports recommending enabling legislation were presented to the Minister in 1981.\(^1,2\) After prolonged discussion, and despite continuing opposition, especially from hospital boards, the Area Health Boards Act was passed in 1983 and the first area health boards were formed in 1985, nearly two years later.

Area health boards

The Area Health Board Act is enabling legislation only. Responsibility for initiating action lies with individual hospital boards, which may apply to the Minister of Health for area health board status. Before granting such status, “the Minister shall satisfy himself that there has been adequate consultation, planning and preparation for the establishment of an area health board in the proposed area health district”.\(^3\)

An area health board brings together the two public sector agencies involved in health care, i.e., the hospital board and the district office of the Department. A potentially more significant role, however, may result

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from existing leadership and support, through service development groups, for coordinated planning of all health services in an area.

District health office functions are largely transferred to area health boards. Each board is required to appoint a medical officer of health in accordance with the Health Act of 1956, as well as at least one inspector of health and a principal dental officer. These officers are required to have a consultative and advisory relationship with the Director-General of the Department of Health.

In contrast to hospital boards, whose members are fully elected, area health boards may have added to their maximum of 14 members up to three members appointed by the Minister of Health. These members may be appointed for expertise seen to be lacking among the elected members, or to make the board more representative of the community—the Maori people, women, etc.

Under the Area Health Board Act, a board is required to appoint community committees to those areas formerly served by a hospital board. Such committees may also be appointed where there are communities of interest, to provide liaison between them and the board.

Area health boards should lead to an increase in the devolution of powers to a largely elected political authority. While there is nothing in the legislation to suggest that area health boards will be more autonomous than hospital boards, their powers and functions are greater in that they are responsible for all health services in an area, including private and voluntary services. Through the service development groups, they should be able to influence and coordinate the latter services in a way that is not possible now for hospital boards. The basic model is one of vertical devolution and horizontal coordination.

Board powers, do not, however, extend to the management of voluntary and private agencies. That would deny such agencies their autonomy. The role of a board is essentially one of leadership, to advise, inform, coordinate through voluntary mechanisms and to assist, if appropriate with funding, the work of all health agencies in its area.

**Bodies at national level**

A recommendation of the LACG report on the formation of a central advisory body on health policy was also followed up by SACHSO. As a result, a new Board of Health advisory to the Minister was established in 1984. It has a broad range of responsibilities including formulating general health policies and objectives as well as policies on health promotion, the treatment of disease, and the allocation of resources. Eleven standing committees have been established largely along service lines, such as child health and mental health, with membership drawn from a wide range of organizations and individuals.
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The Health Services Personnel Commission (HSPC), a further outcome of SACHSO, was established by the Health Services Personnel Act of 1983 to complement the Area Health Board Act. HSPC is a central body with authority to determine uniform personnel policies for the public sector of the health services including conditions of employment and remuneration, to promote and develop standards of training and education in management, and to develop a national career structure. Many HSPC functions had been carried out previously by the Department but a more independent authority was felt to be necessary to reduce direct control by the Department over area health board personnel policies. HSPC is also expected to bring about greater uniformity in the health service career structure to facilitate the transfer of staff between boards. In this respect, it is an example of the model of functional decentralization although, as a commission, it is less independent than a corporation and remains, like health boards, under the direction of the Minister.

Levers for reform

The structures for change described in the previous section are expected to play a growing role in the organizational future of New Zealand’s health services. Given the permissive nature of legislation for area health boards, their adoption is still contingent upon understanding and acceptance, and the quality and style of leadership exerted by the Minister and Department. There are few incentives for hospital boards to become area health boards; indeed, some see this step as threatening job security for senior staff or the autonomy of smaller boards through board amalgamation.

Two significant levers for change, however, are exerting a major influence on hospital boards. These are population-based funding and the associated requirement for boards to prepare comprehensive service plans.

Population-based funding

It was becoming apparent during the 1970s that on a population basis there were wide inequalities in the funding of the country's 29 hospital boards. A report by the Advisory Committee on Hospital Board Funding published in 1980, commissioned by the then Minister of Health, spelled out the dimensions of this inequality. After making allowance for a number of factors, including age- and sex-adjusted utilization rates, standardized mortality ratios, cross-boundary flows between boards, and the size of the private sector, boards were identified as being either under- or overfunded.

1 Advisory Committee on Hospital Board Funding. *The equitable distribution of finance to hospital boards*. Wellington, Department of Health, 1980.

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Two recommendations were made in the report. First, a population-based formula should be used to ensure equitable distribution of funds to hospital boards, and second, the government should urgently develop service planning guidelines for hospital board services. The principle underlying both recommendations was that the boards should be funded not only for their adjusted populations but also for the equitable provision of services, and hence access to such services, for their populations.

The Advisory Committee's proposals were similar to those put forward by the Resource Allocation Working Party (RAWP) in England\(^1\) and suggested a progressive move towards equity, in which overfunded boards gradually "gave up" their surplus funds over an unspecified period to underfunded boards. As the formula is based on capitation, boards now have a vested interest in the health of their catchment populations, not just the treatment of disease. After much debate and a number of refinements the formula was implemented as from 1 April 1983.

**Service planning**

Boards found to be underfunded by the formula and hence entitled to additional funds were required to produce comprehensive service development plans to show how the funds would be used. Subsequently, the Minister required all boards, both under- and overfunded, to produce comprehensive service plans by March 1985. For nearly all boards this was an entirely new task. Although they were accustomed to planning for buildings, few executive staff had had experience or training in service planning. Under pressure with day-to-day problems and lacking the necessary time, skills and support staff, they were understandably reluctant to embark upon planning for the more distant future, in the absence of clear guidelines as to what should be done. Only a substantial lever, such as money to be gained (or withdrawn), could be expected to generate the necessary motivation to plan. Population-based funding is such a lever.

One of the problems experienced by hospital boards in the preparation of their plans was the lack of a national policy framework, particularly service planning guidelines. The preparation of these guidelines has been slow, as they have required a prolonged consultative process both within the Department and among all boards before being finally promulgated by the Minister. Guidelines for paediatrics have been published and those for geriatrics, obstetrics and neonatal services, renal dialysis and transplantation, cardiac surgery, and alcohol and drug services were well advanced by mid-1986. Although primarily for hospital boards, they will

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involve voluntary and private agency services and require the formation of service development groups for implementation.

Service planning guidelines are closely linked to population-based funding in that they attempt to define what boards should provide or in some cases are required to provide, within their population-based grant. Adherence to the guidelines is expected in the submission of plans, which may be rejected if they do not comply. In this respect, both population-based funding and service planning guidelines may provide significant and complementary leverage to ensure the provision of better services (see footnote to page 85.)

Prospects for decentralization

A progressive shift from deconcentration to devolution is occurring in national and area relationships. There has been a shift towards functional decentralization in the form of HSPC and ACC, and, at the national level, it would be in tune with Labour government policies for the trend to extend to some existing Department of Health functions such as environmental and occupational health. There have also been moves towards privatization, especially involving voluntary agencies in the creation of innovative programmes of community care and development.

At the area level, the service concept through service development groups has encouraged the decentralization of decision-making so that service professionals of private and voluntary agencies as well as statutory agencies are becoming involved in service planning. The close involvement of voluntary agencies with community groups is expected to bring decision-making closer to the community level. The formation of community committees by area health boards will extend participation to smaller communities of interest.

The decision-making arrangements that are being implemented have not been developed without dissension, distrust and conflict, as well as residual misgivings on the part of those with strongly held bureaucratic views. The long gestation period required for the evolution of these policies is an indication of the extent of such resistance. Of particular concern has been the threat perceived by hospital boards to both their autonomy and, in many cases, their more limited institutional role. This stems from a traditional conservatism but also from a lack of clarity with respect to their role. Ryan identifies three interrelated functions of hospital board members. They have a trustee role deputed to them by the Minister to make decisions regarding the funds allocated by central government, secondly a constituent role to serve the community that elected them, and thirdly, a governing role to manage the services under their control.

In neither their relationships with central government nor those with the chief officers, however, does Ryan see a rigid division of decision-making responsibilities. Although there should be a centralization of policy-making and a decentralization of operational decision-making, there is a broad overlap in decision-making roles in which trust, confidence, understanding and good sense are required if the conflict and confrontation in the relationships of the past are to be successfully overcome.

Similar good relationships between area health boards and their associated voluntary and private agencies are critical for the success of the area health board and the service concept. The reports of the pilot projects\(^1\),\(^2\) and of the functioning of service development groups elsewhere in New Zealand\(^3\) indicate that there is potential for the development of a climate of confidence and trust, where bureaucratic notions of order and control are subordinate to professional relationships.

The one major area still requiring organizational change is the central organization of the Department of Health, which has remained essentially unchanged for many decades. Reform is especially urgent in order to give leadership and direction to the changes now being implemented in the health system, particularly area health boards. The first-ever effort to develop a corporate plan, undertaken in 1985, led to a review of the Department’s functions and a recognition of the need for central reform, including improved policy development and strategic planning. At present, there are wide differences of opinion as to an appropriate organizational structure and these are unlikely to be easily resolved.

The service concept should provide the framework for service programmes concerned with policy and strategic planning. A number of support functions are also required, including policy, planning and information resource management and technical services. It is particularly important to establish a primary health care division or unit to give professional leadership to this seriously divided and fragmented service and to integrate it into the evolving area health board structure.

There is thus growing recognition that central policy-making and strategic planning is necessary in order to provide the framework for operational decentralization to boards. The most important problem yet to be faced is the development of an appropriate central organization responsible for providing leadership in the implementation of proposed changes and, in conjunction with the Board of Health, formulating national health policy.

\(^1\) Northland Health Services Advisory Committee. \textit{Report to the Minister of Health}. Wellington, Department of Health, 1981.


ACKNOWLEDGEMENTS

The author is grateful for the very helpful comments on this paper from Dr Tom Hall, Mr Hugh Evans, Mr Geoff Fougere and Mr Chris Burns. However, the author accepts full responsibility for the content of this chapter and the opinions expressed. He is also grateful to Mrs Agnes Shand for typing the manuscript.
Experience of decentralization in Papua New Guinea

Quentin Reilly

Reasons for decentralization

Decentralization in Papua New Guinea means the devolution of authority, both political and administrative, to the provincial level, where provincial governments have been set up. The reasons for decentralization were basically political, to ensure a unified country and to facilitate contact between the government and the people in a nation where communications are very difficult.

Papua New Guinea consists of high mountains, deep valleys, thick rain forests, large rivers, swamps, and many offshore islands. There are many small ethnic groups on the islands and over 500 different languages have been recorded. Groups of people are thus very isolated from each other. In 1985 the population was 3.3 million. Migration between provinces is considerable, as well as from rural to urban areas. Over recent years there appears to have been a rapid decline in infant mortality from 134 per 1000 in 1971 to 72 per 1000 in 1980.

At the time of independence, in 1975, the unification of such a diverse country became a political priority, particularly since there were some secessionist movements. These movements became a major factor in promoting a decentralized system of government. Since Papua New Guinea is mostly an egalitarian society, decentralization fitted in well with the local cultural and political practices. There are now 20 provinces, including the national capital district, each with its own government and administration.

Decentralization has brought many benefits. A politically more stable country has arisen and greater coordination of government activities at the provincial level has been possible between “vertical” ministries and provincial programmes. Many major political decisions are now made within the provinces instead of in the remoter capital city. Because of the greater local input the decisions should be more appropriate and more quickly made. Likewise, administrative decisions are taken at the peripheral level where their effects will be felt.

1 Department of Health, Boroko, Papua New Guinea.
Further benefits include more community support for government programmes, leading to improved implementation and better services, with closer supervision of the remoter areas.

**Implementing decentralization**

A constitutional law was passed by the national parliament in 1976 which laid the legal basis for decentralization and which set out the authority of the provincial governments, their areas of responsibility, and their relationships with the national government and the national public service. There was to be only one national public service; members of this service would work for the provincial governments through employment in the respective departments of these governments. Responsibility for health was given to the provincial governments through decisions and directives made by the National Executive Council (Cabinet).

Conferences and seminars were held on decentralization for all public servants and provincial politicians. For the health services, the most important meetings were those held regularly between the officers in charge of the provincial health divisions and staff from the national Department of Health.

A major problem that arose early on was the opposition by senior national staff to devolving their administrative authority to staff in the provinces. A crisis arose when the Health Minister agreed to decentralize the budgetary controls over health activities and at the same time changed the head of the national Department of Health.

Some of the senior programme heads at national level also found it very difficult to switch from being in charge to serving as technical advisers to provincial programmes.

The provinces took over responsibility from the national Department of Health for selecting their health administrators and managers. This meant that the quality of leadership at the provincial level varied considerably. Those provinces that had high quality leaders in health benefited greatly whereas those with leaders of lesser quality tended to suffer. The national Department of Health instigated in-service training to help overcome some of these deficiencies but it was up to provinces to decide whether or not to have their staff take advantage of this training.

One province went one step further with decentralization and gave administrative authority to the district rather than the provincial level. This allowed much more local input, but the major problem was finding enough good quality managers.

Initially, following decentralization, staff at the provincial level tended to become confused regarding their responsibilities and loyalties. This was especially true where the health leaders were of high quality but had poor staff.
Mechanisms for involving the community in the running of the provincial health services were left to the province itself to determine. The national Department of Health recommended that provincial health boards and lower-level health committees should be established to support the services. Some provinces followed these recommendations; management committees were set up at various levels in health institutions and the community provided some financial input in support of certain services. When problems arose about accountability for these funds, the provinces were recommended to pass a Health Service Administration Act that legalized community inputs and responsibilities.

Decentralization of power and responsibility not only permitted greater local control over the health services but also tended to open more avenues for local politics and corruption. Overall, however, this has not been a major problem for the proper management and expansion of the health services.

Responsibility for implementing the decentralization policy rested with the national government through the Ministry and the Provincial Department of Decentralization (later renamed Provincial Affairs). However, much of the actual implementation was done by the “parent” departments, with technical and programme advisers from the national Department of Health visiting the provincial departments. Regular conferences were held between the assistant secretaries for health in the provinces and their counterparts in the national Department.

At the overall political level, annual meetings were held of the provincial Premiers at their Council, chaired by the Prime Minister, and these acted as conferences for sorting out major decentralization problems. In addition, elected members of the national parliament were made non-voting members of the Provincial Executive Council (Cabinet).

**Organizational changes with decentralization**

The devolution of political power from the national to provincial governments and of administrative authority from the national departments to the provincial departments greatly increased the importance of the provinces.

Rural health services were fully decentralized to provincial governments and finances were passed to them in the form of an unconditional grant. Responsibility for the provincial main hospital and for disease control and environmental health programmes was delegated to the provincial governments, with funds given by the national government specifically for these activities. The budgets for these activities were originally agreed between the provincial governments, the national Department of Health, and the Department of Finance. Later, it was agreed that negotiations could take place directly between the provinces and the Department of Finance.
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The officially designated functions (gazetted in 1977) of the provincial departments with regard to health are as follows:

- appoint and conduct advisory committees to assist in the planning and coordination of health services in the province;
- control and administer health centres, health sub-centres, aid posts, and associated ambulance services;
- manage the provincial main hospital;
- inspect and implement environmental health programmes;
- implement and supervise programmes in:
  - immunization,
  - tuberculosis, leprosy, sexually-transmitted diseases and malaria,
  - family planning,
  - health education,
  - training of nurse aides and aid post orderlies;
- provide family health services;
- implement and supervise dental health programmes;
- make the payment of subsidies to churches for operating their health establishments.

The national Department of Health retained control of more specialized activities, the supply of pharmaceuticals, and health worker training (Fig. 8). Its designated responsibilities are:

- ultimate responsibility for all hospitals and for medical, dental, nursing, preventive health, and disease control services;
- monitoring the standard of health service activities across the country and ensuring the maintenance of satisfactory standards;
- pharmaceuticals services;
- mental health, radiotherapy, and specialist medical services;
- national health planning, policy formulation, and evaluation;
- national health legislation;
- medical training of doctors;
- the provision of services to various other health organizations or committees.

The national Department of Health was reorganized and expert advisory committees were established to advise the assistant secretaries and programme coordinators. The provincial health divisions were strengthened and, although they vary from province to province, a reasonably typical structure is shown in Fig. 9.

In one province, decentralization was taken one step further. All district activities were coordinated by one assistant secretary, and health staff at the provincial centre advised, but did not administer, health workers at the district and sub-district level. Thus a similar type of relationship was set up between the districts and the province as existed between provincial and national levels. This further decentralization was seen to work well in the province concerned.

Church-supported health services play an important role in the delivery of rural health care in Papua New Guinea. Formerly, the central government paid the salaries of church health workers, supplied pharmaceuticals, and
Fig. 8 National Department of Health (Papua New Guinea)
Fig. 9  Organizational structure of a provincial health department (Papua New Guinea)
contributed to transportation costs. With decentralization these payments became the responsibility of the provincial governments. A noticeable improvement occurred in the cooperation between government and nongovernmental health services and this led to the development of a more unified service and a more rational allocation of funds.

The administrative importance of the national Department of Health decreased considerably following these changes but its importance as a technical advisory body increased substantially. To facilitate the technical input from the national level, four regional offices were set up where epidemiologists, disease control officers, and nutritionists were located. Each regional office covers approximately four provinces. Although their role is purely advisory, there are some conflicts over their responsibilities to provincial programmes. Clinical specialists were already located at the large provincial hospitals.

Changes in management functions

The national level retains responsibility for the overall health policies that are to be implemented by the provincial departments of health. The national Department of Health therefore has a strong supervisory role in ensuring that health policies are followed throughout the country.

Provincial governments can legislate in certain areas provided this does not conflict with any national government law. This is the case for most health functions, where existing legislation remains in force across the country.

The finances for health services come from both provincial and national sources, but mainly the latter. The national government allocates finances to the provinces to cover all sectoral activities, calculated largely on the basis of expenditure in the province during the year before decentralization took place. The provincial governments have powers to raise their own finances locally through various forms of indirect taxation, but this income is quite small. The provincial government then establishes a budget for running the health services in the rural areas, but national finances are used to run the provincial hospital, disease control programmes and environmental health services, which are national responsibilities delegated to the provinces. The budget proposals for these activities are formulated in the province and financial allocations are made directly by the national Department of Finance to the province. For the first three years after decentralization, the national Department of Health acted as an intermediary between the Department of Finance and the provinces in this budgetary process. However, this was altered when it became apparent that these negotiations inhibited the true decentralization of activities because the Department of Health was exercising undue control.

Since overall health planning has been retained as a national level activity, health policy, planning, and evaluation have become more closely inte-
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grated and a national health plan has been formulated. Provincial health plans and programmes were then formulated on the basis of the national plan.

Manpower requirements for the provinces are their own responsibility; the national level budgets only for staff for its own activities.

Staff of both the national and the provincial departments of health belong to the same national public service. The number of positions created in any government department is a matter for the Public Services Commission and the departments concerned. The budget estimates are a matter between the Department of Finance and the provincial department concerned, and this determines the actual number of staff to be employed. Special arrangements had to be made to keep the national Department of Health informed of provincial proposals. The national level has no say in appointments to provincial posts.

Training for health workers has remained a national function although in-service training is done by the provinces. A special training unit was set up within the national Department of Health to train the trainers of provincial health workers; technical in-service courses are given by national staff for provincial officers.

Formal training courses are run by the national Department of Health, mainly in conjunction with the University of Papua New Guinea. Agreements between national and provincial departments were signed to enable national training schools to use provincial facilities, such as hospitals.

As the national department no longer employs the health workers it trains, estimating training requirements has become much more difficult. However, these difficulties are being overcome through better cooperation with the provincial authorities.

The supply of pharmaceuticals has remained a national activity in order to maintain continuity, consistency and quality of medicines. Bulk purchasing by international tender is a feature of the standardized medical supply system in Papua New Guinea. Each health facility in the country obtains its supplies from the national medical stores. Non-medical supplies are purchased using budget allocations through the government stores and from private organizations.

Maintenance of buildings, equipment and facilities is done by the national government for its own delegated facilities, such as the main hospitals, and by provincial governments for facilities that are fully decentralized, such as health centres. This has posed problems for the maintenance of medical equipment at health centres and sub-centres, which has now been made a national government responsibility.

Although provincial hospitals have remained national assets, their administration has been delegated to the provincial governments with maintenance and improvements remaining a national responsibility.
Maintenance of rural health facilities is planned and financed by provincial authorities. However, the national government ensures some standardization of facilities throughout the country.

**Collaboration between health and other sectors**

Decentralization of the various government sectoral activities to the provinces has brought the different sectors closer together. Provincial management teams were established which consisted of the heads of the various government sectors in a province. In provinces that decentralized to the district level, this coordination was even more marked.

In contrast, collaboration with communities and community groups has increased only slightly. Where management committees and boards with community representatives have been established, the level of collaboration has clearly increased. It is intended to further strengthen this form of collaboration.

Political collaboration in health matters has been increased through the provincial government, with each elected member having some input into the health services for his or her area. Provincial health boards, where they have been established, have members from all over the province.

The churches used to run approximately one-quarter of the rural health services, supported by government grants for the salaries of their health workers, pharmaceuticals, and travel allowances. Since decentralization, the allowances and salaries have been paid to churches by the provincial governments and this has encouraged more integration of health services, a greater interchange of staff, and a rationalization of services.

The private health sector has remained largely outside the central and provincial government system. Private practice is carried on by a small number of medical practitioners, mainly in the major towns.

There are many traditional healers across the country but no one unified system of traditional healing is practised. Thus assessment and registration of each healer is not possible. The government takes the view that people themselves should choose which service they will attend.

**Assessing the experience**

At the national level, decentralization has enabled the Department of Health to become revitalized and more technically competent. Its ability to assist and guide provincial programmes has greatly increased. The regionalization of some activities has made technical advice more
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appropriate and brought it closer to the provinces. The Department has also been able to concentrate on improving the management of services for which it is responsible, particularly health training and pharmaceutical services.

At the provincial level, the results of decentralization have varied, largely depending on the leadership. Where this has been strong and capable, programmes have improved, but where it was not good some health services have actually deteriorated. With decentralization, the national department lost its power to appoint the most suitable staff for provincial health services. Provincial governments now appoint all their own staff. In a few provinces appointments were not made on the basis of leadership and administrative ability. Even though the national department brought this to the attention of the provincial authorities, it could not take any action to rectify these problems.

Even though pharmaceutical services remain centralized, the provinces have had some funds to purchase extra equipment and goods. When provinces made these purchases through the national Department, standardization of equipment could be maintained, but some wastage occurred when this was not the case.

In a similar way, the provinces have taken over the maintenance of equipment for health centres and health sub-centres without, in general, being well organized to undertake this activity.

The organizational and staffing structure of provincial departments has become a matter between the Public Services Commission and the provinces, which means that the national Department of Health is often not asked for its views on the various proposals. Likewise, budgeting has become a prerogative of the provinces and the Department of Finance. Only recently has the Department of Health been able to have some influence on levels of staffing. In fact, there has been little change in staffing but this is due more to the recent economic restrictions.

Some centralization has occurred within provinces. In a few cases the provincial headquarters has become administratively more remote from the rest of the province, but one province decentralized its power further to the district level.

Local community input has been much more difficult to obtain, and it is hoped that the implementation of the Provincial Health Administration Acts to legalize community participation will improve this.

The decentralization process in Papua New Guinea was politically determined and thus its rate of implementation could not be altered to suit administrative requirements. If decentralization had occurred over a longer period of time across the country, perhaps many of the problems encountered with leadership could have been overcome.

The initial reluctance of the national Department of Health to decentralize delayed implementation for five years; an earlier start might
have improved provincial leadership capabilities. Frustration due to this resistance caused a backlash against the Department by the provinces, which later had to be overcome. Although there were orientation programmes on decentralization arranged for central health administrators, they were very reluctant to accept responsibility for its implementation.

Some of these experiences can be anticipated and planned for, but others relate more to political climates and the characteristics of individuals. These are much harder to control or influence.
Decentralization of health services in Senegal
Jean-Michel NDiaye

Introduction

In 1972, Senegal carried out a reform of regional and local administration based on three principles: decentralization, devolution and participation. The main novelty of this reform was the creation of rural communities. In section 1 of Law No. 72–25 of 19 April 1972, rural communities are defined as follows: “Rural communities comprise a certain number of villages in the same local area, linked in particular by ties of neighbourhood, having interests in common and capable of raising the resources needed for their development. The rural community is a legal entity under public law, and shall enjoy financial autonomy ...”. The same law created the rural council, made up of councillors drawn from the rural community, elected by universal suffrage and responsible for running the rural community.

Earlier in the same year, a law on the organization of territorial administration was also enacted. This was Law No. 72–02 of 1 February 1972, which marked the beginning of a process of administrative decentralization. The law defines the territorial divisions of the country and specifies the administrative authorities responsible for their administration. Sub-prefects represent the lowest level of administrative authority. They are to be found at the level of the administrative district (arrondissement) grouping a number of rural communities. Above the sub-prefects there are prefects, at the département level. Higher up still there are governors, who are at regional level. The process of reform started by the 1972 laws has been developed step by step, and applied region by region between 1976 and 1985.

What is meant by the term “decentralization” in Senegal? It essentially means conferring upon organized communities the authority they need to assume maximum responsibility for their own destiny while allowing the authorities that represent the central government to play an active part in the life of local communities. Law 72–02 gives expression to the desire of the government for devolution since it reconciles the stewardship of local communities, more particularly the power of approval, with the possibility of taking fully informed decisions. The value of decentralization in

1 USAID, Dakar, Senegal.

Senegal lies in the fact that it "brings government closer to the governed", and above all in the fact that it allows the people to take their own welfare in hand in the framework of an organized state. It is thus possible to satisfy the people's needs more quickly, and for the people to meet their own needs.

When the policy of primary health care was introduced in 1978, it became possible to graft the organization of the health system on to the organizational structure of regional and local administration. For the sake of convenience, each time the term "decentralization" is used in this paper, it should be taken to refer to the decentralization of the health services.

Introduction of the policy of decentralization

As far as the Ministry of Public Health is concerned, the decentralization process really began in 1978. Prior to that, the Ministry essentially centred on the Director of Public Health. In 1979, the Ministry of Public Health was reorganized; six departments with responsibilities at the national level were set up in addition to the Minister's office and were made responsible for the formulation and implementation of a health policy based on primary health care.

In 1980, the forms of community involvement in public health were systematized and implemented after several trials in project areas. This involvement was centred on health committees, which were made responsible for gathering and utilizing resources to improve the quality of care in the health facilities. These arrangements are described in a booklet issued by the Ministry of Public Health.

In February 1982, an Order establishing the regional public health services was signed. It provides for the organization of all the technical and administrative services needed for a consistent health policy in each region under the authority of the regional chief medical officer. Also in 1982, Senegal produced its first health plan. The objectives, strategy and

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1 Decree No. 61–350, Ministry of Social Affairs, 11 September 1961, specifying the functions of chief medical officers of health regions and areas.

2 Decree No. 79–416 of 12 May 1979 establishing the Ministry of Public Health.

3 Order No. 3187 of 27 March 1980 establishing the Department of Hygiene and Health Protection.


5 Order No. 001047 of 4 February 1982, Ministry of Public Health/Department of Hygiene and Health Protection, establishing the regional public health services.

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programming of activities for the attainment of health for all were defined at that time. The gradual introduction of this policy was accomplished by means of regular meetings between technical officers of health and by convening regional development committees in all regions of the country.

There have been, and still are, several obstacles to decentralization. They include:

- opposition by health personnel;
- lack of qualified personnel to implement the reforms;
- inability of members of management committees to ensure good management of primary health care programmes;
- scarcity of resources;
- lack of flexibility in the law on rural communities, which authorizes only investment expenditure.

To overcome these difficulties, an intensive information campaign has been undertaken to create awareness by all available means and in all possible quarters. The training of health personnel and the members of health committees has become a priority activity for the Ministry of Public Health. In respect of resource availability and management, certain lines of approach have been defined with a view to finding the most practical solutions.

Changes in the organization of health services

The organization of health services is an integral part of the country's administration. Health sector organization, which is grafted on to the regional and local administrative structure, has undergone several changes in a general move towards decentralization. Some examples may be cited.

(a) Each facility belonging to the health infrastructure has a health committee consisting of members elected by the community in which the facility is located. Three subcommittees are established within each committee:

- a management subcommittee;
- a public health and hygiene subcommittee;
- a mothers' subcommittee.

(b) Each rural community is permitted by law to make investments in the health sector and to devote 8% of its budget to initial procurement of drugs for the community's health facilities.

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(c) The health region, which is the administrative unit with responsibility for coordinating all regional technical health activities, was strengthened in 1982 in order to provide greater stimulus to the promotion of primary health care (see footnote 5 to page 107).

(d) At the national level, the reorganization of the Department of Hygiene and Health Protection has included the creation of a Division of Primary Health Care with responsibility for policy formulation and implementation in that field.\(^1\) The outlying health facilities thus find partnership and support at the central level.

Health structures are divided into five levels, which range from the peripheral to the central (top) level and thus constitute a pyramid of health services.

**Level 1—health huts.** These are the most outlying facilities, and are to be found at village level. They are run by community health workers chosen by the people. They are managed by a health committee with extensive powers.

**Level 2—health posts.** Health posts have been constructed in the chief locality of each rural area, and are run by a nurse. A health committee is responsible for the management of the resources arising from community participation, and directs the activities of the post in accordance with the needs expressed by the population.

**Level 3—health centres.** Health centres have been established in the *département* capitals, and are run by a health team headed by a physician. As the main referral centres for the peripheral level, the health centres provide hospitalization and outpatient consultations. They also have a health committee. At this level there is a health promotion association, on which all the health committees of the *département* are represented. The health promotion association is an association recognized by the Ministry of the Interior.

**Level 4—regional hospitals.** The regional hospital is located at the headquarters of the health region. This level supervises the first three levels.

**Level 5—national hospitals.** At this level there are the national hospitals, which are the final institutions of referral in the national health system. Also at this level are the Ministry of Public Health and its national departments.

Administrative coordinating structures at each level have the task of ensuring the cohesive functioning of the national administrative system. The coordinating structures are as follows: community level—rural

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\(^1\) Order No. 252 of 7 January 1985, Ministry of Public Health, rescinding and superseding Order No. 003187 of 27 March 1980 establishing the Department of Hygiene and Health Protection.
Changes in management functions

Changes in management functions must be examined in the context of both general government administration and the health services administration.

Changes in government administration

Since 1972, rural councils, which receive part of the taxes raised on their territory and which may also receive gifts and legacies, may administer their own resources in order to meet their own needs. Although the expenditure authorized is essentially investment expenditure, the rural community may decide upon its investments and has the obligation to maintain and renew them.

Devolution has given the sub-prefects additional powers. They are responsible for ensuring that the decisions taken by the rural councils are in conformity with the law.

In both cases the decision-making powers of the peripheral administrative authorities have been strengthened. These powers may be used in local planning, budgetary control, and even in legislative matters.

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Health committees, whose functions were defined in the 1980 booklet on the involvement of the population in public health (see footnote 4 to page 107), have been established in connection with the facilities at each level of the health infrastructure. These health committees have become the channel through which the people utilizing the health services may influence them so that the facilities meet their needs. The community now participates in the selection of community health workers and the financing of their training. It decides what mass activities should be carried out in villages or city districts. It manages the money collected at health facility level from fees for patient consultations, and is allowed by its rules to spend up to 50% of the receipts on drugs. In addition to the purchase of drugs, it finances the salaries of the supporting staff of the health services.
Effects of decentralization on multisectoral activities

Since the primary health care approach has been defined as being multisectoral and multidisciplinary, of particular importance are the effects of decentralization on activities that require collaboration with other partners.

Contacts with other departments, such as agriculture, animal husbandry, education, etc., take place regularly in the framework of the local, département, and regional development committees. These coordinating structures enable local resources to be pooled and fully exploited and provide an opportunity for the exchange of the information needed by each department to function smoothly.

At the community level, decentralization means that the specific needs of communities have a better chance of being met. They are undoubtedly voiced more frequently. With increased powers of decision-making, the people manage their own resources and attach greater value to health activities. In short, decentralization acts as a catalyst to community involvement.

Social and political groups are an additional resource. Decentralization enables them to focus their efforts on more specific targets. Coordination at the local level is easier, since fewer people are involved. However, these groups may be an obstacle when they persist in attempting to impose their views, their people, or their ideologies.

As a result of the reorganization of medical regions, the private sector (nongovernmental organizations, religious associations, and private practitioners) is becoming more closely integrated into public health activities in operational terms. At the local level, it has become possible to divide up the areas to be covered and the activities to be carried out between the public and private sectors. For instance, the state often decides not to create a health facility where a private hospital or dispensary already exists.

In summary, decentralization enables the health service structures to coordinate various groups more easily in the pursuit of activities to resolve problems at the peripheral level.

Evaluation of this experiment

We feel that the major success of this experiment is to have set up a type of community organization that enables each community to take charge of its own affairs. Communities manage their assets, direct their activities, and control their situation. In short, they are involved in all the most
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important aspects of the implementation of the health programme. With
the advent of decentralization, community involvement is no longer a
mere catchword.

There have been, however, certain difficulties connected with local social
pressure groups. In effect, the political parties fight on all fronts, including
the health committee level. When a political party or faction is strongly
represented in a health committee, health problems take second place to
personal quarrels. The same applies when, for sociological reasons, certain
individuals achieve important positions in the participatory structures.

In relation to health system support, we are left with two problem areas:
the funding of recurrent expenditure and the shortage of qualified
personnel.

In the first flush of enthusiasm, and with the support of the new legis-
lation, communities embarked upon a great many investments. In many
cases, these investments were made possible by external aid (buildings,
purchase of motorcycles and other vehicles, etc.). Now that these
investments have been made, there are very limited resources to keep
them operational. The law does not allow communities to finance
operational costs and the state budget is not at present able to help. Nor
is the money collected from community participation intended for such
use, and in any case this is only a modest resource. For how much longer
must we be dependent upon external aid?

The decentralization of the health services also means that qualified
personnel must be made available to the communities to carry out the
many tasks that have been devolved to them. It is a relatively simple
matter to build and equip health posts and health centres, but quite a
different question to find the staff to run them. Most of the health posts
have only one nurse and there are no plans to double this number in the
near future, for reasons of economic constraint. The situation is the same
for other categories of personnel. How can a single nurse deal with the
10,000 inhabitants served by the post, and supervise all the health huts?
Even if an assistant is provided for the nurse, the training of that assistant
will have been essentially clinical, i.e., the assistant will have an individual
approach to health problems and will not have learned how to organize
and manage a health facility. The same applies to freshly graduated
doctors. In order to deal with this problem, the Ministry of Health has
organized many management training sessions for all categories of health
worker. These should be followed by training programmes in medical
schools.

Conclusion

The government of Senegal proclaims itself a socialist government.
The country has attempted progressively to alter the administrative
organization inherited from the colonial period. The assumption of
responsibility by the people for its own destiny so as to satisfy its legitimate needs is the government's choice. Has that aim been achieved? I have not been able to answer that question, but my feeling is that decentralization is the expression of political will at the highest level and that, whatever the results of this reform, the Senegalese population seems to appreciate the change.

The main lesson to be learnt is that decentralization of the health services is barely conceivable without an overall policy of decentralization. Senegal's good fortune was that it embarked upon a primary health care policy in 1978, after the government had already initiated a policy of decentralization in 1972. Since all the necessary structures had already been established, it was easier to implement a primary care policy.

This does not mean that everything has gone smoothly and without difficulties. There have been various forms of resistance to change at all levels. We feel that the key to success lies in the establishment of long-term objectives and a system of monitoring and evaluation by which the progress made can be assessed.
Health services
decentralization in Spain

Josep Artigas

Concepts of decentralization and reasons for the decentralization policy

In Spain, decentralization as enshrined in the 1978 Constitution has the characteristics of devolution. It represents a new organization of the State into 17 "autonomous communities". Each autonomous community is ruled by its own law which determines the functions belonging to it alone and those that it shares with the state or that belong to the state alone. In each community this special law is called the "Statute of Autonomy".

Spanish interest in devolution has two main sources. First, the reforms have revived the tradition of decentralized governments, which have proved their effectiveness in previous times. Spanish people have strongly developed regional loyalties and firmly believe that their interests are better served by this model of government. Historically, Catalonia, the Basque Country and Galicia were completely or nearly autonomous, and it is considered desirable to generalize this model of autonomy to all national groupings that have been established.

Secondly, with reference to health, it is thought that devolution permits services to be managed more efficiently and makes them more responsive to the interests of each national grouping. On the one hand, administrative proceedings can be simplified; on the other, services are brought closer to users. Decisions can thus be taken more quickly and more effectively. In addition, the participation of users, trade unions, and enterprises in the management of services is facilitated. Organizational units are smaller and distances shorter, and the service is revitalized.

To sum up, the following advantages are achieved by devolution:

- services are brought closer to the user;
- decisions are taken more quickly in each autonomous community;
- there is more effective management and greater control of activities;
- users participate more in the control and quality of services;

1 Barcelona, Spain; formerly, Secretary General of the Ministry of Health and Consumer Affairs.
services are adapted to each national grouping and its health needs;

- the right to protection of health laid down in the Constitution under Article 43 is made more effective; and

- costs are similar to those of the previous system.

Nevertheless, it is true that devolution has not been implemented without the arguments and opposition that are raised whenever a very centralized structure, such as that existing in Spain up to 1978, is decentralized. It is not possible to move from one system to another without difficulties, arguments and negotiations with the groups and professionals directly affected by the changes.

The decentralization policy and organizational changes

Moving from a centralized administrative system to greater local autonomy means a radical change in the concept of the state, and this can only be achieved through legislation and regulations. The change began with the introduction of the new Constitution on 20 December 1978. Article 2 affirms that "the Constitution recognizes and guarantees the right to autonomy of the national groupings and the areas that are part of them, and the solidarity between all of them". The third chapter regulates how to constitute and organize the autonomous communities. The process has been completed with 17 communities and the system can be considered a hybrid between administrative decentralization and federalism.

Each autonomous community has a government council and a legislative assembly, with the functions that its Statute of Autonomy attributes to them. All such communities have responsibilities in public health. All the services previously belonging to the state administration (central and peripheral) have been transferred to the autonomous communities with the same staff, resources and facilities. To perform its own functions, the state has kept for itself 5% of the staff of the provincial administration and 40% of the staff of the Ministry of Health and Consumer Affairs in Madrid.

In addition, all the hospitals and health centres that were run by the state (AISN) have passed to the autonomous communities. However, the transfer is less complete in the case of the social security (INSLUD) centres and services. Responsibility solely for INSLUD administration and management, and not financial control, will be transferred, but only to the historically autonomous communities and some of the other more important ones: Andalucia, the Basque Country, Canary Islands, Catalonia, Galicia, Navarra, and the Valencian Community. The other autonomous communities have no responsibilities for social security.
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services for the moment. If their statute is amplified they will be able to take on this responsibility, but such a modification would be slow and complex.

At the ministerial level, all functions related to public health and the planning of services have passed to autonomous communities. The Ministry retains a role in pharmaceutical legislation and general coordination, in addition to drawing up the health budget for the whole country and for the health services of social security.

Health services are now organized and executed through each autonomous community. Each community has a counsellor for health. However, provincial and municipal services still exist for the moment as local agencies.

The 1986 general health law specifies how the health services of each autonomous community should be organized and indicates the rules that are binding on them and the functions that the state reserves for itself. The development and execution of the law is the responsibility of each community. Supervision of the process involves both the state and the autonomous communities. The state acts through the territorial administration ministry. There is an interministerial commission for the policy of autonomy by whom the staff and service transfers to the communities are approved. There is also an interministerial council of financial policy, where the representatives of the autonomous communities and of the administration meet and distribute resources to each community.

In addition, conferences are organized on various topics with the health representatives of all the autonomous communities. These conferences have the objective of mutual coordination and exchange of information, and decisions or agreements, if any, are taken unanimously.

The 1986 general health law lays down the establishment of an interministerial council of the national health system, composed of a representative of each autonomous community and of a similar number of members of the state administration. It is regarded as a permanent body for communication and transfer of information between the different health services of the autonomous communities and the national administration, and coordinates the purchase of certain pharmaceutical and sanitary products. It also carries out the planning function allocated to it by law. The interministerial council is the only permanent body for general coordination and inspection. The problems that cannot be resolved at this level have to be referred to the Constitutional Court.

The law also specifies that each autonomous community shall create its own health services. Article 44-I adds that all the structures and public services dedicated to health are to be integrated in the national health system. Article 50 further specifies that the health service of each community will be made up of all the centres, services and establishments of its own community, deputations, municipal governments, and any other territorial administration.
This law gives considerable responsibilities to the autonomous community, which is to coordinate and pay for the services of local corporations and provide technical support to them. It specifies that services are to be extended to the whole population and spells out what they are to consist of. Preventive and curative services are to be integrated, and psychiatry is to be made part of general curative care. The territory of each autonomous community is divided into health areas where all aspects of health care are coordinated and executed.

The organization of health services

Before the details of management functions are presented, it is helpful for an understanding of the new arrangements to describe briefly the organization of health services in the 17 autonomous communities. Prevention, promotion, and education services are separate from curative services. The autonomous communities run vaccination campaigns and campaigns against the use of tobacco, alcohol and drugs, as the state did formerly. Campaigns are also planned to improve personal hygiene and food and nutrition.

The local corporations (municipal governments and deputations) retain their functions in welfare and environmental health. They are carried out with the technical collaboration of the autonomous community and according to its regulations.

Primary medical care is financed by the social security system for all those with social insurance and their families, including children up to 24 years old. Municipal governments are responsible for assisting those without resources. Hospital services are provided in the centres of the social security system or in those under contract with INSALUD. The hospitals can thus be public, whether belonging to the State, INSALUD, deputations, or to municipal governments; or private, either profit-making or non-profit-making. Private institutions can treat patients covered by social security if they have signed an agreement with INSALUD.

Changes in management functions

The interministerial council of the national health system exists as a permanent coordinating body, as mentioned above. A consultative committee of managers and workers is assigned to this council as a vehicle for their participation in the council’s responsibilities.

The day-to-day organization and management of services is carried out by the health service of each autonomous community. Each community has a health council of professionals, users, managers, and trade unions, which acts as an advisory body for the study of the health problems of the community.
Health system decentralization

Direct management is to be done through the health areas. Health areas have a population of at least 200,000 inhabitants and are defined for each autonomous community according to demographic, geographic, economic, and epidemiological criteria, and depending on communications and transport.

In charge of each area is a directing council, 40% of whose members are selected by local corporations and the remainder by the community. Every health area also has a health council as a mechanism for participation by representatives of the area's local corporations (50%), trade union organizations (25%), and the administration of the health area (25%).

Finally, the execution of the decisions of the directing council and the management of the services of the area are the responsibility of the manager of the area, who is appointed by the autonomous community after being nominated by the directing council.

The functions of these bodies are defined in detail in the law, without prejudice to the responsibility of the autonomous community to carry out its own functions. All these bodies are to be established as soon as the general health law is administered.

Each autonomous community is required to prepare a health plan for a defined period. The plans of the communities make up the integrated health plan for the whole country. As a basis for preparing the health plans, the state will establish minimum or basic norms for health staff, centres or services, determine the purposes or objectives of services, and lay down criteria for assessing the effectiveness and productivity of the health programmes, centres, or services. The state thus keeps certain functions in the area of planning and coordination, although each autonomous community develops and applies national policies according to its circumstances and needs.

However, the financial support of the health system is not unified. It is made up of:

— social insurance contributions,
— state transfers,
— taxes for certain services,
— contributions of the autonomous community and of local corporations.

Financial support for services transferred to the autonomous community is given through the state budget or the social security system, depending on the services transferred. Allocations from social security are made on the basis of the population covered. Services given to patients are free, although the payments to providers for giving services are laid down for the first time by law.
Effect of decentralization on collaborative activities

Reference has already been made to provision for the participation of managers and trade unions in the interministerial council, in the directing council of the autonomous community and in the health council of the area. Their involvement is one of consultation, discussion of the decisions taken by the state administration, and formulation of proposals.

Freedom of enterprise in the health sector is expressly recognized by the Constitution. Enterprises can contract with the public health administration to provide services for insured and other patients. The state administration prefers—effectiveness, quality and costs being equal—the enterprises that are non-profit-making.

Finally there is legislative provision for the integration of establishments of mutual accident insurance organizations and public or private non-profit-making institutions in the national health system. The law also allows general hospitals of the private sector to be “contracted” to the national health system, if there is a health need that justifies it, and financial resources allow it. This contract is less broad than integration.

To sum up, a framework of integration for the public sector and of collaboration with the non-profit private sector has been established. The effectiveness of these possibilities will depend on how they are applied and developed by each autonomous community. In some, like Andalucia and Catalonia, the process is more developed than in others.

Assessment of experience

Any process of decentralization is long and complex, and it is a major success that within ten years, 17 autonomous communities have been set up and are working with great competence in the health field. This is at a political level. At the level of health service management, the transfer of all state functions in the delivery of prevention, health promotion, education and curative services is also a great success, though it has only been possible to decentralize a part of curative care, except in Andalucia and Catalonia.

Another positive feature has been the 1986 general health law, which replaced a 1944 law. However, this has not satisfied all demands. There are those who desire the creation of a single national health service for the whole state, financed by the state's budget. Within the ruling Constitution this was not possible. Instead, a national health system has been created that is an integration of the 17 health services of the autonomous communities. Moreover, the present budget difficulties mean that
Health system decentralization

implementation of the 1986 general health law will require a period of 10 to 15 years.

The implementation of devolution has not occurred without difficulties. In the first place, there are the political problems that have arisen during the negotiation of health functions in each "Statute of Autonomy". It has been very difficult to define the responsibilities of each autonomous community as regards the organization of its own services.

Another difficulty has been the distribution of financial resources between the autonomous communities. In most cases, the resources are transferred from the budget of the state. The autonomous community then draws up its own investment and operating budgets. In addition, health services are also financed by the social insurance budget and by local corporations (common councils and deputations). The method of financing the services transferred to the autonomous communities has an important political impact on the community and greatly influences how it carries out its responsibilities in the planning, programming, organization and management of health services.

Neither the Constitution nor the Statutes are sufficiently clear and definitive. This has led to continuous discussion and negotiation between the state and the autonomous communities to define their respective responsibilities. In many cases where agreement could not be reached, the Constitutional Court has had to resolve the dispute.

The opposition of civil servants was another difficulty at the beginning of the process. Many who had been located in the state capital had to move to an autonomous community, and incentives were provided to encourage them to move.

A further difficulty has stemmed from the poor organization and limitations of certain autonomous communities. The lack of administrative tradition and the shortage of civil servants prepared for decentralization have delayed the introduction of services, and, in some communities, have resulted in inadequate structures. The future training and preparation of staff will be important factors in the performance of the new autonomous administrations.

Finally, as there are legislative assemblies in all the autonomous communities, they have introduced a great diversity of rules and by-laws that in some cases were not necessary, or have attempted to regulate matters that are the state's responsibility. There have been meetings between the autonomous communities and the state to exchange information and to coordinate the different communities but these have not prevented the presentation of appeals, to no avail, to the Constitutional Court.

In future years, the general health law will be fully implemented, the health services of the autonomous community will be organized, the areas’ structures will be created, and the integration of prevention and
promotion with curative services, including psychiatry and occupational health, will be made effective.

In the light of experience in Spain, we would advise that the decentralization process should take place slowly. First, create the legal framework, have the autonomous administrations ready, and transfer the services without haste, so that both administrations know exactly what services are to be transferred. A mechanism for cost control must also be established, to avoid inflation, and adequate staff must be transferred to manage the services.
Decentralization of health services in Sri Lanka

N. T. Cooray

The need for decentralization

The recorded history of Sri Lanka dates back over two thousand years. The country was a monarchy until the arrival of the Portuguese in the fifteenth century heralded the beginning of the colonial period. During the rule of kings, administration was through local chiefs called Disawes whose primary responsibility was the collection of the King’s taxes. At the same time there was considerable freedom for the people at village level to carry on their own programme of work through a system of village committees known as Gana Sabaha. Thus decentralization, or transfer of authority in public planning, management, and decision-making to sub-national levels, was integral to the way of life in Sri Lanka during the pre-colonial era.

During the colonial period, however, the system of administration became more and more centralized. This was a response to the need to develop an efficient administrative apparatus for the complex task of a colonial government. Thus the administrative structure at the time of independence in 1948 was highly centralized. It was characterized by a rigid line of authority going down from ministries and departments at the national centre to the district and divisional levels. The Ministry of Health was combined with the Ministry of Local Government and had a similar centralized structure at the time of independence.

After independence the Government launched a massive development programme, which included inter alia the expansion of the health infrastructure to provide comprehensive health care for all the people. This called for the establishment of medical care facilities and the expansion of the health unit system. The onus of translating this policy into action fell on the Department of Medical and Sanitary Services, as it was then known. In 1948 this Department too was a highly centralized organization and very little administrative or financial authority was delegated to the periphery. As the name itself indicated, the Department functioned as two separate entities for the medical and the sanitary services with little or no

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1 Director, National Institute of Health Sciences, Kalutara, Sri Lanka.
coordination between these two areas of work. The divisional offices functioned principally as forwarding offices and contented themselves with transferring almost all issues to headquarters for decision.

It became apparent to decision-makers that this type of structure was not the most appropriate for the implementation of the new health programme. Greater decentralization was called for. Therefore in 1949, Dr J. H. L. Cumpston, a former Director-General of Health Services of the Commonwealth of Australia, was requested by the Government to report on the reorganization of the health services. Dr Cumpston emphasized the need for decentralization and suggested “the decentralization of administrative authority from the centre by the setting up of territorial divisions of the Department”.

It was felt that such a reorganization would result in:

(a) improved management and financial manoeuvrability in the divisions;

(b) more effective guidance and supervision, leading to timely implementation of the Government’s programme;

(c) greater involvement of other governmental sectors and of the people in the health programme.

**First phase of decentralization in the Ministry of Health**

The process of implementation of the decentralization policy as suggested by Dr Cumpston really commenced with the introduction of the Health Services Act No. 12 of 1952. This act still provides the legislative framework of the Department of Health. It introduced the existing organizational structure of the ministry and the decentralized administration on a territorial and specialized campaign basis in 1954, and still functions, with only minor changes.

In 1954, authority, which hitherto had been exercised by the Director of Health Services at the centre, was delegated to the heads of decentralized units, which have now expanded from 15 to 20. Decentralized unit heads were delegated powers in respect of:

— appointment and dismissal of minor staff not recruited through central examinations and schemes of recruitment;
— increments to all staff in the decentralized unit;
— granting normal leave to all officers;
— transfer of staff other than medical officers and nursing staff within the division;
— holding disciplinary inquiries and sanctioning officers whose salary did not exceed a certain limit;
— placing requisitions direct with government stores and the medical supplies divisions;
— payment of all travelling claims, except for travel outside the island;
— fixing commuted travelling allowances of assistant medical practitioners, public health inspectors, public health midwives, etc.;
— issue of holiday warrants;
— appointment of boards for verification of stores;
— preparing draft estimates of expenditure, draft appropriation accounts, and monthly statements of expenditure and liabilities;
— calling for tenders for specific items of work, such as building repairs;
— recovery of salary loans, etc.;
— allocation of departmental quarters;
— rental, repairs and maintenance of buildings;
— administration of hospitals, maternity homes, peripheral units, and health units.

Implementing this decentralization process involved the establishment of divisional offices for the heads of the decentralized units (who were designated superintendents of health services), staffing the offices with the required technical and lay administrative officers, and establishing guidelines and procedures for the smooth functioning of the decentralized units. This was accomplished by way of regular conferences at the centre between the director of health services, his deputies and the heads of decentralized units, as well as regular visits by the director and his deputies to the periphery. Such meetings and discussions were augmented by the publication of a manual by the Department of Health, and the issue of instructional circulars for the guidance of the heads of decentralized units.

Thus the process of decentralization that was initiated in 1954 resulted in:

(a) delegation of adequate financial and administrative authority to permit improved management and financial manoeuvrability;
(b) delegation of increased disciplinary powers to divisional heads;
(c) transfer of officers within the division on a systematic and planned basis.

This system of decentralized administration is still functioning, with only minor modifications. During the period since 1954, promotive, preventive, curative, and rehabilitative services continued to expand in each decentralized unit with the establishment of health units and an extensive network of large and small hospitals within each division. However, the compartmentalization inherent in such a system became more and more evident, and the health unit system with its team of medical officers of health and supportive staff of public health nurse, public health midwife, and public health inspector, which made significant contributions to improving the people's health status, could not expand as rapidly as the expanding population.

On the other hand, curative care was popular and increasingly easily accessible. For instance, by 1973 a western-type government health institution could be found within 3 miles of any home. Therefore, the
heads of decentralized units found it increasingly difficult to maintain preventive services at the extremely efficient levels of the 1950s and 1960s, mainly because of the scarcity of medical officers willing to join these services.

In the 1970s, the number of decentralized units increased to 20. Just as it was difficult to attract medical officers to the preventive field, a career in medical administration, which was coveted by medical officers in the 1950s and 1960s, became less and less attractive, and the Ministry of Health experienced serious problems in finding capable medical officers to take on administrative careers. This problem has been further aggravated by the greater rewards available to medical officers in clinical specialities.

The overall effects of these constraints were first seen in the mid- and late 1970s in the continuing high morbidity levels of preventable diseases, although mortality from these same diseases fell dramatically. The shortages of medical administrators and medical officers of health also resulted in reductions in the supervision and guidance given to health teams, with consequent falls in morale and motivation of the peripheral workers. Thus, by the mid-1970s, it began to appear as if the decentralization process that had commenced in 1954 was having difficulty in reaching the objectives and goals that had been set.

Establishment of the district political authority system

An important factor that may have hindered decentralization in the health field, in addition to manpower problems, was the fact that political authority was still concentrated at the central level up to the 1970s. Although a system of local government was in operation, carrying out a wide range of health-related activities with the active participation of local people, the actual involvement and commitment of the real source of power—the political authority—was not noticeable during the immediate post-independence period. The decentralized health divisions and the mainly urban local authorities were established at a time when Parliament was taking on the role of policy and decision-maker. This was a radical change from the situation that prevailed in the colonial period and in the first few years after independence, when civil service administrators and the bureaucratic hierarchy exercised power and authority from the centre over the periphery.

The establishment of the district political authority system in 1972 heralded an important change in regional administration and gave fresh impetus to the process of decentralization in the health field. It added an avenue for thorough coordination by the political authority, and other health-related sectors operating at district level were drawn into the field of health development. The district political authority was replaced by a
Health system decentralization

system of district ministers and district councils in 1981 with further devolution of power. This led to further strengthening of the process of decentralization in all development sectors, including health.

These developments in the political structure have now created a climate that is better suited to the continuing success of the decentralization process.

Current status of the decentralization process

A health development network was established in 1981, including a National Health Council headed by the Prime Minister (see Fig. 10). Taken in conjunction with the overall decentralization of power to the districts, which is now established government policy, the climate is conducive to the successful implementation of the plan for decentralization in the Ministry of Health.

A major step in this direction was the delegation of powers to district ministers by the Minister of Health in January 1984. This has empowered district ministers to be actively associated with the formulation of health components of the annual district development plan in the context of the national health development plan and national programme project plans. The district minister is also involved in reviewing the implementation of the annual plan and ensuring corrective action. This responsibility covers service and support programmes such as:

- maternal and child care,
- family planning,
- nutrition,
- immunization,
- school health services,
- health education,
- rabies control, and
- environmental health.

Other functions devolved to the district minister include mobilizing community resources for health development and ensuring intersectoral coordination and community participation in the implementation of health development plans in the district.

Such progressive measures have *inter alia* strengthened the position of the regional directors of health (formerly the superintendents of health...
Fig. 10 National health development network in Sri Lanka

National Health Council (NHC)

National Health Development Committee (NHDC)
Standing Committees
1. Primary health care
2. Manpower
3. Drugs
4. Medical research
5. Indigenous medicine
6. Technical cooperation between developing countries, and appropriate technology for health

District Development Council Health Committee

Cabinet of Ministers

Health Minister

Deputy Minister (Health)

Secretary (Health)

Project Minister, Indigenous Medicine

Director General of Health Services

Regional Director of Health Services

Divisional Health Officer

Sub-divisional Health Officer

Public Health Inspector

Public Health Midwife

Village Health Worker
services) in guiding and directing the health programmes at the district level. At the same time, the health care delivery system is also in the process of being restructured to facilitate better access to an integrated and comprehensive health service for individuals, families and communities. The new proposed structure and its links to the health development network are shown in Fig. 11.

The restructuring of the health care delivery system and the strengthening of the district level by means of this process of decentralization have in turn required changes in the management process at all levels. The Ministry of Health has therefore initiated a programme of management training for all levels of the health care delivery system as an integral part of the management development process.

Fig. 11 Primary health care delivery and support system (Sri Lanka)

gramodaya health centres (clinic cum residence) (1:3000 population)

subdivisional health centres, complete with staff quarters (3 for each AGA Division, providing essential health care to a population of 3000 and functioning as a referral centre for a population of about 20,000)

divisional health centres, complete with staff quarters (1 for each AGA Division, providing essential health care to a population of 3000 and functioning as a referral centre for a population of about 60,000)

primary health care complex

referral level providing specialized care and training

24 district hospitals to provide referral support to primary health care

9 provincial hospitals

4 teaching hospitals

1 postgraduate teaching hospital

* Assistant Government Agent.
Results of decentralization

These measures are expected to have two main results:

(a) Greater financial independence for regional directors. For example, the funds for maintenance and repairs of all health institutions in the district are now allocated to regional directors from the centre. Close links with the district secretariat and with other sectors enable the regional director of health to obtain the technical expertise to monitor such activities. In addition, as a result of the decentralization process, regional directors are now in a position to obtain funds for health development activities from the decentralized budget.

(b) The mobilization of community participation and intersectoral coordination in health development activities. The decentralization process has also paved the way for the active participation of nongovernmental organizations and village-based government organizations in the activities of health teams at village level. A good example of multisectoral development in action is the pilot project in the village of Adikarigoda in the field practice area of the National Institute of Health Sciences.

It is anticipated that these changes will inevitably bring about problems in all areas, including training, health behaviour patterns, coordination, etc. Therefore the Ministry of Health is taking steps to establish a health services research programme, with the National Institute of Health Sciences as the focal point, in a network embracing scientists and institutions in the universities as well as other government and nongovernmental organizations, such as the Marga Institute and the Sarvodaya Institute.
Yugoslav experience of health system decentralization

Ivo Eterovic

Development of the health care system

The health care system has paralleled closely all the developments in Yugoslavia, going through many political and social changes since 1945. With regard to health care the post-war period may be divided into several phases, as follows.

(1) During the first phase from 1945 to 1952, organizational and legislative steps were taken to build a new system with the very limited resources available. The Yugoslav health care system prior to the Second World War had been based on private practice, state health services and health insurance schemes. At the beginning the new system was also tripartite, and the Government started to unite it. In keeping with the Federal Constitution, the Ministry of Health administered the health services by exercising central control over the distribution of finances and personnel for the whole country.

(2) The second phase, from 1953 to 1960, was characterized by decentralization, loosening of federal control and the development of social self-management. Health institutions became independent, with their own management boards, and expert committees were introduced which had to be consulted on all professional matters. Many of the administrative functions of the Ministry of Health were transferred to the communes and republics; the Ministry's role was limited to the overall planning and regulation of the health services in their common interest. Finances were also dealt with at the level of the commune. All this was part of what was called social management. In addition, health insurance was removed from state control, becoming an independent service with its own mechanism for social management. Decentralization thus radically changed the sociopolitical importance of communes and republics.

(3) The third phase, from 1961 to 1972, was a further period of transition to self-management and self-financing in the health sector and to district-based health insurance. A number of new federal and republic laws advanced the process of health system decentralization. In practice, indi-

1 Zagreb, Yugoslavia.
viduals could choose their own physician, and health care became the right of every citizen. A system of professional supervision was introduced. The financial independence of health institutions was enforced by law. Health insurance was reorganized, with a commune-based system replacing the previous district social insurance institutions.

(4) The most recent phase began in 1972 with the adoption of the new Constitution of the Socialist Federal Republic of Yugoslavia (1974) and the Associated Labour Act (1976). This phase has been characterized by efforts to integrate both health care users and health care providers into the management and control of the health services. A process started to foster what has been termed “associated labour” (associated labour refers to all organized forms of labour using socially-owned resources). From 1976 to 1980 new laws on health insurance and health care were introduced in all republics and provinces, taking into account these new principles.

All these developments have been aimed at avoiding, on the one hand, the market principle (supply and demand economics) and, on the other, a centralized model of health policy. The goal has been to establish the new self-management model of health care.

The dynamics of these processes have been conditioned by rapid changes in the Yugoslav sociopolitical system. It is necessary to point out that, in the post-war period, four constitutions have been adopted (in 1946, 1953, 1963 and 1974), and the country is now in the process of making further readjustments to the existing Constitution. Because each of these constitutions negated the previous ones, in each phase it was necessary to fashion new standards and laws for the health system. Owing to the dynamics of these changes and the limited ability to draw on the experiences of other countries, the changes in the health services and in society as a whole did not proceed evenly in the direction prescribed, but were characterized instead by vacillation, uncertainty and unrealistic expectations. The rapid changes did not leave time, in certain phases, for the system as a whole to be reworked as planned: health systems, as is well known, are usually resistant and slow to change. It was in these circumstances that innovative mechanisms, such as health policy centres, institutes of free exchange of labour and quality control schemes, were proclaimed inadequate even before being fully defined or tested in practice. This fact needs to be borne in mind when the results of the decentralization process in Yugoslavia are assessed. One can conclude that the health system was characterized by a pronounced gap between what was planned and what could be implemented in practice.

**Positive economic and sociopolitical consequences**

Generally, however, various investigations and comparisons suggest that the results of the decentralization process in Yugoslavia satisfy the criteria of economic efficiency and efficacy as well as meeting sociopolitical aims.
Economically, the outcome may be regarded as positive because both in theory and in practice the system makes possible the rational integration of the health services with social development, linking general and specific interests. The organization and financing of the health system provides for various ways and means of using local resources for the functioning and development of the health services. Among such sources are direct linkages between the health services and the economy, voluntary local taxes, and donations.

Sociopolitical goals have been met to the extent that health care is equally accessible to all levels of the population and makes the users of health services active subjects of the system, empowering them and making them responsible for decisions concerning their own health and the health of their immediate and broader community. To this end a set of organizational forms and functions have been created that foster the process of democratization and self-management of health services.

In the development of the Yugoslav health services the commitment of local (communal) resources is very common in practice. To take one example, statistics for 1988 in the Socialist Republic of Croatia show that 67 of 115 communes have what is called a voluntary local contribution for health service development, especially for expanding and renovating medical equipment. Through the system of voluntary local contributions, citizens allocate considerable resources for the construction and equipment of “their” health organizations. It should be stressed that all these contributions have to be decided upon by referendum, conducted by secret ballot.

The health services in Yugoslavia are able, at a rather high level of expertise, to solve not only traditional but also new health problems and medical challenges. Through intensive development, new facilities, equipment and personnel capacities are being created and are being gradually restructured to meet changing health needs. According to quantitative indicators of development, the health services have developed at a faster rate than the general economy; it is estimated that Yugoslavia has human and other resources in the health services (Table 6) which exceed the economic capacities of the country as a whole by 30–50%.

Table 6, which covers Yugoslavia as a whole, shows the growth and development of the health services and health resources in general since 1971. A breakdown by republics and smaller areas and by structure (balance between certain activities and health care, etc.) would be more significant and useful for assessing the process of decentralization. Demographic indicators and vital statistics broken down by republic show the very pronounced heterogeneity of Yugoslavia owing to different economic, geographic, historical and health conditions (see, for example, Table 7). However, quite an even balance has been achieved between certain forms of health care, especially between inpatient and outpatient health care, which is an unexpected but tangible result of a proper general policy and sound doctrines.

One indication of the democratization of the health system is the fact that
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<tbody>
<tr>
<td>Hospital beds</td>
<td>113,000</td>
<td>129,112</td>
<td>133,399</td>
<td>142,597</td>
<td>26.1</td>
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<td>Discharged patients</td>
<td>1,990,000</td>
<td>2,369,000</td>
<td>2,649,000</td>
<td>3,025,692</td>
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<td>Hospital days</td>
<td>36,859,000</td>
<td>42,087,000</td>
<td>42,790,000</td>
<td>44,206,495</td>
<td>19.9</td>
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<td>Physicians in hospitals</td>
<td>8,305</td>
<td>12,071</td>
<td>12,868</td>
<td>16,427</td>
<td>97.8</td>
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<tr>
<td>Nurses and health technicians in hospitals</td>
<td>20,848</td>
<td>32,139</td>
<td>36,461</td>
<td>46,852</td>
<td>124.7</td>
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<td>Hospital beds per 1000 inhabitants</td>
<td>5.5</td>
<td>6.0</td>
<td>6.0</td>
<td>6.2</td>
<td>12.7</td>
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<td>General practitioners</td>
<td>9,767</td>
<td>10,719</td>
<td>13,780</td>
<td>15,503</td>
<td>58.7</td>
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<td>Specialist physicians</td>
<td>10,081</td>
<td>14,057</td>
<td>17,592</td>
<td>21,601</td>
<td>114.2</td>
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<td>Stomatologists</td>
<td>3,198</td>
<td>4,707</td>
<td>6,314</td>
<td>9,574</td>
<td>199.3</td>
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<tr>
<td>Pharmacists</td>
<td>3,829</td>
<td>4,574</td>
<td>5,164</td>
<td>6,146</td>
<td>60.5</td>
</tr>
<tr>
<td>Nurses and health technicians</td>
<td>53,546</td>
<td>79,677</td>
<td>102,552</td>
<td>133,978</td>
<td>150.2</td>
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<td>Visits to doctors (general practitioners and specialists)</td>
<td>59,714,000</td>
<td>76,426,000</td>
<td>81,898,000</td>
<td>93,040,000</td>
<td>55.8</td>
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<tr>
<td>Visits to gynaecological consulting rooms and to guidance clinics for pregnant women and family planning</td>
<td>4,866,000</td>
<td>6,806,000</td>
<td>8,576,000</td>
<td>9,501,548</td>
<td>95.2</td>
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<td>Visits to guidance clinics and consulting rooms in preschool dispensaries</td>
<td>9,015,000</td>
<td>12,065,000</td>
<td>14,963,000</td>
<td>16,002,727</td>
<td>77.5</td>
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<td>Visits to physicians in school dispensaries</td>
<td>6,209,000</td>
<td>7,559,000</td>
<td>9,180,000</td>
<td>11,553,208</td>
<td>86.0</td>
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<td>Visits to dentists</td>
<td>17,716,000</td>
<td>22,202,000</td>
<td>23,933,000</td>
<td>27,655,767</td>
<td>56.1</td>
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<td>Visits to physicians in antituberculosis dispensaries</td>
<td>3,380,000</td>
<td>3,512,000</td>
<td>3,383,000</td>
<td>3,245,056</td>
<td>-4.0</td>
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Health system decentralization

Table 7. Physician/population ratios by republic, Yugoslavia, 1975 and 1986

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<th>REPUBLIC</th>
<th>Physicians per 10000 inhabitants</th>
<th>Inhabitants per physician</th>
<th>% increase 1975–1986</th>
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<tr>
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<td>7.3</td>
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<td>20.4</td>
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<td>9.5</td>
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<td>1.227</td>
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<td>11.8</td>
<td>19.2</td>
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</tr>
<tr>
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<td>13.5</td>
<td>19.9</td>
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</tr>
<tr>
<td>All Yugoslavia</td>
<td>11.1</td>
<td>18.2</td>
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in 1987 the assembly of the self-managing communities of interest of the Socialist Republic of Croatia included in its work over 5000 delegates who at the local communal level participate in decision-making about health service development. This is eloquent evidence of the wide base of the decision-making process in health care.

Main weaknesses

Not all expectations have been met. In certain areas there was inadequate coordination among health units, which hindered the proper functioning of the system. In other words, the horizontal and vertical division of labour was not sufficient. Under the influence of a communal system, the theory and practice of organization, financing and planning of the health services went through a period of uncertainty, disorientation and methodological vagueness.

Planning was often in practice regarded as étatisme (improper influence exerted by the state) and as a political obstacle to decentralization. Independence of health care organizations, and even their complete functional isolation, was considered as a prerequisite for self-management. As a result, many health organizations in the same area functioned independently of one another and without coordination. Every health organization was entitled to have, and normally had, its own organizational pattern and its own development policy. Owing to the lack of planning and evaluation of national health policy and to fragmented and unconnected health organizations, health care was of unequal accessibility and quality in the different parts of Yugoslavia, even between areas of a republic and within communes. Resources allocated for health care were not always used for solving priority problems of health status.
Research was done to find geographic, population, economic and other optima as a favourable basis for planning, financing, organization and management of the health services (health region), but the follow-up decisions have been difficult. This is a potential pitfall where there is rapid decentralization of the health system.

Part of the reason for the inconsistencies and incompatibilities of the health system lies in the as yet imperfect system of investments. Voluntary contributions and other investment mechanisms and decisions at the local level did not give sufficient consideration to the broader health policies and the overall rational functioning of the health services. Acting on the popular principle of autarky, i.e., economic self-sufficiency, the communes took decisions that in aggregate were uneconomical. Health resources were not used in a professionally and technically appropriate way.

Some mechanisms were planned but not established in practice, such as an adequate health information system, realistic norms and standards, and other instruments for regulating and measuring work and quality in health care. The costs of medical care were not realistically determined, and there was an insufficient influence of empirical and operational science, research and evaluation.

Finally, it should be pointed out that in establishing such a system of health care, based essentially on diminishing the influence of the state and on decentralization, it is very important to establish a good system of coordination between the numerous individuals and groups constituting the health system and taking the decisions at all levels. It is necessary to bear in mind that the health system is not a static and mechanical structure but a living, vital process, and that health care is a dynamic system subject to constant and relatively rapid changes and influences, although the individual health institutions make up a rigid and inert system that is resistant to change.

Questions to be answered

In the process of decentralization of the Yugoslav health services some questions, problems and dilemmas have arisen to which the Yugoslav experience has not given uniform or adequate answers. Among others, they are as follows.

1. How far should decentralization go? At what level of organization of the population should the process stop? This issue can be considered from the sociological, technological and economic standpoints. Should the main decisions about health care be made at all levels, or should this depend on the specific content of health care and the different interests involved? For instance, should primary health care decisions be taken by primary communities (local communities, work organizations, schools, etc.), secondary health care at the district and regional level, tertiary medicine by the republic or state as a whole? What are the general, common and
Health system decentralization

individual interests when it comes to health care? How may these be defined and respected? One could say, for instance, that preventive medicine represents the wider social interest and should be regulated, financed and guaranteed by the state; and that the more serious the health risks, the broader the solidarity and mutuality required in financing. Personal interests in health care call for more intensive participation, free communication, free flow of patients, free choice of institution and of certain kinds of health care provider, etc.

2. How can one maintain the conceptual unity of the system while developing and improving the direct influence of users and citizens? What should be regulated uniformly, by law and other obligatory regulations, and what should be left to the rules of self-management? Should one take the inductive or deductive approach in establishing the system of health services? To what extent may local influences, conditions, needs and possibilities be taken into account without jeopardizing the unity of the system and equal access to health care?

3. What social mechanisms and institutions should replace the traditional role of the state in the field of health care in a decentralized system? How can "scientific" principles continue to influence the development and function of the health system in a situation where lay people are making the decisions about health services?

4. How can one ensure the actual influence of citizens on the health system so that they create the material conditions for the realization of their declared rights and take over part of the responsibility for health, and not only prescribe structures and institutions? Possible ways of achieving this include an intersectoral approach to health care at the level of primary communities, changing life-styles, establishing self-help and mutual aid institutes, setting up clubs catering to various interests, etc.

5. For the decentralization of the health services to be efficient and effective, one needs realistic standards and norms and an adequate information system. One needs to evaluate socially the cost of medical work, to determine scientifically the needs for health care, to assess the system continuously, to carry out comparative studies, etc. This points to the important role of training in management of professionals at all levels of the health care system.

In our experience these are the issues which require further theoretical and practical formulation and investigation and which call for continuous evaluation of the content and structure of health care.
PART 3

Lessons from experience

J. P. Vaughan
Government policies and the meaning of decentralization

The overwhelming conclusion to be drawn from the review in Part 1 and the country case-studies in Part 2 of this book is that decentralization is an extremely complex topic and that it is very dangerous to make generalizations on why such policies were adopted and how they evolved. It is probably even more difficult to draw conclusions on how decentralization should be undertaken. Each country has had its own experiences and their relevance to other countries is probably fairly limited. Decentralization takes place within a particular historical context and is implemented by governments with different political beliefs and policies. It has been adopted by societies with different degrees of state and private control over health and in countries with a great variety of geographical and climatic features. However, many countries have, at different times, felt the need to institute large-scale organizational reforms that favour a greater degree of decentralization.

During the periods immediately before and following independence, many governments in developing countries, particularly in Africa and Asia, strengthened their national and regional administrations with a corresponding reduction in the responsibilities of local government. Many of these same countries have recently realized the need to strengthen the peripheral and local authorities and have adopted decentralization as one of the major means for implementing these reforms.

There are many complex reasons why governments in various countries are beginning to decentralize their services. For instance, demands for more regional autonomy have played a major role in Papua New Guinea and Spain; political ideologies were important in Chile and Yugoslavia; and the need to rationalize overburdened and outmoded administrations played a large role in New Zealand and Sri Lanka. These country examples illustrate the importance of a historical perspective when analysing the reasons for decentralization policies and their evolution in any particular country.

It is important to clarify what is meant by the term “decentralization”, as each particular country uses it in different ways, as shown in Part 1. Rarely are proposals for decentralization policies clear and explicit about which organizations and management functions are to be involved.

Decentralization policies are usually initiated by central governments and only subsequently are they adopted by the health sector. It appears to be rare for the health sector to take the initiative. This has meant that before the health sector becomes involved in decentralization, the central government has initiated a national policy by issuing a decree or by adopting constitutional changes that set the pattern for the reforms to be adopted by the different ministries.

As a part of any discussion on decentralization, it is also important to
clarify what is meant by “centralization”: both of these processes work together and it is false to talk about decentralization alone. What is important is the desire to move the relative balance of power and responsibility more towards local communities and away from the central government authorities. This may be achieved by making greater use of regional and district levels of government, by greater use of independent organizations set up and regulated by the state, or by legitimizing a greater role for private medical practice. In order to obtain a full and complete picture, therefore, it is necessary to analyse both the explicit and implicit policies adopted for centralization as well as for decentralization.

The situation can be made more complex when countries adopt a policy for the decentralization of certain functions while at the same time centralizing control over others. For example, it is not uncommon to decentralize the recruitment of health personnel and some administrative procedures while at the same time retaining central control over finance and budgets.

At this stage it is important to add a word of caution on the usefulness of classifying decentralization into four major types—deconcentration, devolution, delegation, and privatization. This classification is useful in clarifying the meaning of decentralization, but it is less helpful for analysing specific country examples, because of the wide variety of mechanisms adopted, even within one organization such as the ministry of health. Such a classification is probably even less useful for countries or organizations that are formulating decentralization policies, as a strict use of the four types can severely limit the possible options that they might adopt. In this situation it would be more appropriate for a country to work out its own proposals without the constraints of this classification.

**Evolution of decentralization**

Following the adoption of an overall national policy on decentralization, the next requirement is the introduction of the necessary constitutional and legal changes. Only when this has been done can the necessary legislation be enacted to make possible a thorough reorganization of the health sector, usually with the ministry of health taking the lead. This reorganization commonly follows two main directions. For the ministry of health itself, decentralization often involves either or both “deconcentration” and “devolution” of some management functions to intermediate and peripheral administrative levels, with each level being allocated responsibility for a defined geographical area, such as a province, district or municipality. Other forms of decentralization involving “delegation” and “privatization” may be instituted by central government for other health services provided through, for example, social security and voluntary agencies. During these early stages and during reorganization it is common for countries to experience considerable opposition from health professionals and government officials.
The health sector frequently adopts a variety of mechanisms for decentralization, and these depend largely on historical developments in the particular country, on the political ideology of the government, and on the means adopted for financing the health services. It is difficult and dangerous, therefore, to generalize on why different options have been chosen.

The country case-studies also indicate that it takes at least 5–10 years from the formulation of decentralization policies to their implementation. Thus, implementing these policies is a lengthy process that needs considerable and sustained political commitment at all levels, particularly from the central government. During the early stages of implementing decentralization, the focus is usually on strengthening regional or district organizations and on establishing new parastatal organizations, such as those governing social security, the main teaching hospitals, or the medical research establishments. Once these organizations are established a great deal of effort then has to be spent on clarifying their roles and responsibilities. Only later when they are beginning to plan their own activities does the necessity for comprehensive national health plans and detailed guidelines become apparent. At this point, two further requirements commonly become clear. One is the need to strengthen national and regional health planning capacity with suitably trained staff and new planning procedures. The other requirement is the need to reorganize the ministry of health and to clarify its role vis-à-vis the decentralized organizations. Both of these requirements can involve a considerable amount of time on the part of senior managers in reviewing organizational structures and management functions, and in arbitrating on disputes regarding responsibilities and control over finances.

A considerable gap often exists between the carefully chosen wording of the proposals contained in policy documents and the way in which the decentralization policies are actually implemented. Political pressures and interference and opposition from civil servants and professional groups, together with patronage and corruption, all affect the way in which the newly decentralized organizations behave in practice. In addition, confusion over management responsibilities may allow individuals to take advantage of the situation, and this in turn necessitates strong supervisory procedures and good financial control at all levels.

Decentralization is thus a lengthy process requiring continuous development and adaptation if it is finally to improve the actual coverage, efficiency and effectiveness of primary health care; the final consequences are not always clear at the beginning. It has often taken up to 10 years or more before the decentralized system works well. Thus a long-term political commitment is required to make decentralization a success.

Benefits from decentralization

The reasons that lead a country to adopt a policy of decentralization are largely political. However, the benefits that should result from decentralization in the health sector are the following.
Health system decentralization

— It is possible to organize a more rational and unified health service on the basis of geographical and administrative areas such as the district, particularly for primary levels of health care.

— Decentralization to local communities allows them greater involvement in the management of their own health, which in turn can lead to more appropriate health plans in relation to local health needs and problems.

— Decentralization can contain costs and reduce duplication of services, particularly at the secondary and tertiary levels of health care, by relating responsibilities to defined catchment populations.

— Inequalities can be reduced between regions and between urban and rural areas, in both health status and the provision of services, through the selective reallocation of central resources.

— The activities of government, nongovernmental and private health organizations can be more closely integrated.

— The health policy and planning functions of ministries of health can be strengthened by releasing senior staff from many administrative and routine responsibilities.

— The implementation of health programmes can be improved by reducing centralized control over local administrative matters.

— Decentralization can encourage greater community financing and control over primary health care facilities and staff.

— Intersectoral coordination between the health sector and other sectors is improved, particularly in local government and in rural development activities.

— Decentralization can help overcome problems and delays due to such features as long distances, inadequate communications, and poor road and air services.

Implications for ministries of health

The task of implementing the reforms and organizational changes required for decentralization is frequently delegated by the central government to the various sectors, in this case the ministry of health. These ministries are usually strong in technical skills but are relatively weak in the senior management experience necessary for planning the reorganization. In addition, if there is professional opposition as well, the health sector may well be one of the last ones to undergo reorganization.

In those countries with a mixture of government and private health organizations, there is often a practical limit to what further decentralization can be achieved through internal reorganization alone.
Indeed, new government regulations and legislation may be needed to create new or strengthened regulatory authorities to monitor the activities of new delegated and private organizations. Decentralization policies that involve the setting up of delegated institutions or the adoption of greater privatization are usually beyond the immediate responsibility of ministries of health. However, policies that involve deconcentration and devolution may come more directly under their control; management functions associated with these forms of decentralization are thus reviewed in more detail in the following section.

Decentralization often demonstrates the need for reorganization and strengthening of the ministry headquarters itself. A common feature is the need to improve its capacity in health planning so that it can formulate comprehensive national policies and plans and detailed guidelines that are suitable for use by regions and districts. This in turn often draws attention to the need for an improved national health information system. Yet another burden commonly falls upon the already overstretched ministry staff early on in the decentralization process. Staff at regional and district levels frequently require considerable help and support from the senior managerial and technical staff in the ministry on how to undertake their new responsibilities. Thus ministries must be prepared to give considerable management support to staff in regions and districts, in addition to undertaking their own new responsibilities. The ministry of health’s role as the directing and coordinating authority for health is thus clear.

There are three major organizational issues that are often overlooked early on during decentralization. First, decentralization frequently points up the poor coordination and lack of integration between the different vertically organized programmes, particularly within headquarters, and this can be a particular difficulty for districts that are expected to integrate all their health activities. Ministries of health are often slow to respond to complaints on this issue. The second problem concerns intersectoral collaboration. Involvement of nongovernmental and private health organizations in the decentralization process often proves to be very difficult. To improve collaboration and to promote a more unified health service, it is frequently necessary to resort to legislation, statutory regulations, and financial subsidies and controls. The third problem concerns agreement on district and regional boundaries. In order to promote closer intersectoral coordination and closer liaison with local government authorities, it is very important that all health areas should have the same boundaries as other regions and districts. The ministry of health should resist the temptation to set up its own health areas whose borders are not identical to other recognized boundaries.

Decentralization of management functions

Most ministries of health are organized into several levels, ranging from central to peripheral, each with its own staff and responsibilities. A degree
Health system decentralization

of decentralization can thus be achieved relatively easily in many countries through deconcentration, which may simply involve a reorganization that is largely internal to the government health sector itself.

These common forms of decentralization are implemented by reorganizing the main functions of the different levels of government administration. For health this might typically involve the ministry of health headquarters, regions or provinces, districts or development blocks, and local councils and communities. The role of the district is often emphasized. The district is the most peripheral level to have both sufficient political authority and a reasonably comprehensive range of health services, at the same time being small enough to relate closely to local government and local communities.

Experience suggests that having more than four management levels (for example, national, regional, district and local) commonly results in a cumbersome and bureaucratic organization. However, in large countries with a strong federal system of government, and where health is frequently a state responsibility, there should be not more than three levels within the state itself.

A common pattern for decentralization based on a considerable degree of deconcentration or devolution is described below.

Ministry of health

The ministry often becomes primarily a national policy-making and coordinating institution, with more or less direct control over the operation of health services or programmes. Its main functions then commonly become:

— health policy formulation, including policies on intrasectoral and intersectoral activities and the setting of national priorities;
— development of national health plans and regional and local planning guidelines;
— allocation of resources, particularly capital funds;
— monitoring and evaluation of the effectiveness and efficiency of the national health system;
— a source of high-level technical advice for specific programmes;
— control over the quality and licensing of pharmaceuticals and the distribution of supplies;
— regulation of health personnel development, including training;
— regulation of private profit-making and non-profit-making health organizations and providers;
— control/coordination of national level health organizations and research institutes;
— liaison with international health organizations and aid agencies.

In countries with a strong federal system of national government, such as Mexico, Spain and Yugoslavia, the authority and size of the ministry of
health may be quite limited, reflecting the loss of its operational responsibilities. In these circumstances, responsibilities commonly assumed by the ministry of health for planning and delivering specific services are largely decentralized to the individual states, regions or provinces, as has also occurred in Botswana, Chile, and Papua New Guinea. However, in such circumstances it becomes even more important for the ministry of health to plan and coordinate the whole health system.

With regard to the allocation of financial resources, the ministry may or may not be involved, though it can be argued that as the national coordinator of the health system, it should at least be consulted. Where there is a considerable degree of decentralization to regional or provincial health authorities, negotiations over health finance may be conducted and supported locally (e.g., Yugoslavia), directly with the finance ministry (e.g., Papua New Guinea), or through a separate “delegated” national health fund (e.g., Chile).

Where decentralization has occurred mainly through deconcentration, the ministry of health frequently retains a considerable direct role in the allocation of resources (e.g., Senegal) or in negotiations for central funds or those from health insurance and social security organizations (e.g., the Netherlands and New Zealand).

**Regions or provinces**

The management functions of the regions or provinces can vary considerably, from being similar to those of a ministry in some countries to being merely an intermediate hierarchical level in a bureaucracy, with little authority or power of their own. In particular, their control over personnel and finance ranges from very limited to quite extensive. However, regions and provinces are commonly given the following functions:

- regional health planning and programme monitoring and evaluation;
- coordination of all regional health activities;
- employment and control of some or all health personnel;
- budgeting and accounting;
- approval and financing of major capital projects;
- in-service training and supervision of the more junior health workers;
- managerial and technical supervision of district health teams and district heads of specific health programmes;
- provision of supplies and other logistic support.

**Districts and similar units**

The district can be described as the most peripheral administrative level in which local politicians and civil servants of most central government
Health system decentralization

Sectors are coordinated and linked together by some form of local government. Districts are, therefore, commonly seen as the organizational level that actually implements health services and disease control programmes. They are also the level with the critical function of coordinating and interpreting the "top-down" requirements of central government and the "bottom-up" needs of local communities and their local health services.

The district health services may come under the direct control of the ministry of health in a deconcentrated approach to decentralization, or they may come directly under the control of the local district administration or government in a more devolved system.

Districts are commonly given the following main functions:

- organization and running of the district hospital services;
- management of all other government health facilities;
- implementation of all community-based health programmes;
- management and control of local health budgets;
- coordination and supervision of all government, nongovernmental, and private health services within the district;
- promotion of active working links with local government departments;
- promotion of community participation in local health planning;
- preparation of an annual health plan;
- raising of additional local funds for capital projects;
- in-service training of health workers;
- supervision and control of all community health workers in the district;
- collection and compilation of routine health information and the forwarding of it to regional authorities and ministries of health.

Local communities

Although the district authorities usually supervise and control the government health services, there are a number of primary health care activities that are frequently decentralized to local communities. For example, such activities concern the availability of food supplies, the provision of safe water, excreta disposal, and aspects of the control of communicable diseases. Community health education may bear on nutrition, mother and child health, and the provision of essential drugs. Community health workers may be employed by local communities.

Local communities may thus have the following functions decentralized to them:

- responsibility for aspects of environmental hygiene, including safe water;
- recruitment, payment and supervision of community health workers and trained traditional birth attendants;
— provision of community finance towards the costs of health services;
— participation in local health planning initiatives and the contribution of labour and materials for the construction of clinics and staff housing;
— organization of preventive health care, particularly activities concerned with mother and child health, immunization, and oral rehydration.

Although it is often stated that communities and local organizations will be involved in decentralization, and indeed it is one of the reasons often given for these policies, it does appear to be one of the most difficult aspects to achieve. There is a common tendency for decentralization to be pursued as far as the district, community participation being neglected; for this reason the results are sometimes disappointing. From the point of view of local communities, whether urban or rural, the district or municipal government is virtually as remote as central government.

In addition, newly established regional and district health authorities have a tendency, at least during the early years, to centralize powers and management procedures at their own level. The effect on local communities can go against the spirit of community participation, with local decision-making and financial allocations being removed from community-based health organizations. Such factors can affect the support given to primary health care activities and lead to a subsequent decline in their effectiveness and local acceptability. This is why decentralization policies need to be pursued right through to the local level.

Health financing and budgetary controls

Raising revenue and controlling expenditure are commonly the most sensitive issues in decentralization. A particular difficulty concerns which organizations and levels should have the right to decide how the health budget is divided between different priority services and programmes. In addition, there are often disputes over how much flexibility there should be in the budgeting. Where decentralization mainly takes the form of administrative deconcentration, there is usually little decentralization of control over finances and budgets. However, the country case-studies indicate that a considerable amount of financial decentralization can be attempted, as shown for instance by the provincial government budgets in Papua New Guinea, the district development budgets in Sri Lanka, and the self-managing communities in Yugoslavia.

When there are many sources of finance, a major problem is how to coordinate and regulate all the sources in order to achieve reasonable control over costs and expenditure. This has proved to be a major difficulty in countries with a wide variety of health financing mechanisms, such as private health insurance, direct government payments for the poor and unemployed, and social security schemes covering mainly government workers and urban employees. The complicated financing system was a major stumbling block to the formation of a unified and decentralized
Health system decentralization

national health service in the Netherlands. The authorities in Chile attempted to overcome these difficulties by creating one national health fund which is responsible for collecting and distributing health finance to the semi-autonomous area health services. In contrast, in Papua New Guinea a very high proportion of all health finance comes directly to provinces from the ministry of finance, though the provincial governments are also responsible for raising additional funds if these are required, and they control their own expenditure.

The details of how health financing is organized vary considerably from country to country and so do the financial arrangements made for decentralization. However, there appear to be certain common problems and these are listed below.

► Coordination of the various sources of health finance. If this is not done it becomes extremely difficult to implement national health policies to monitor expenditure and to control costs.

► Whether to fix the allocation of funds for programmes and services at national level or to leave the decentralized authorities free to spend the funds according to their own priorities.

► Whether to channel financial resources or grants through the ministry of health or allocate them directly from the funding ministries or agencies. Ministries of health may argue that for them to retain effective control over national health plans all funds should go through them, but this then reduces the autonomy of the decentralized levels.

► How to determine the allocation of funds or grants to regions and districts in a more rational and equitable manner. In practice, allocations tend to be based on previous expenditure, per capita considerations, and political pressures, though commonly some attempts are made to develop resource allocation formulae based on the principle of equity.

► How to get decentralized organizations to plan and manage their health services within the limits of their financial resources. Holding costs down, and even more difficult, reducing expenditure and changing resource allocation patterns, have proved to be a universal problem.

Health personnel issues

After health finance, personnel is the next most important source of difficulty when implementing decentralization. The issues are usually concerned with how the health workforce should be deployed and controlled, the need for more staff in certain categories, or the need for more specialized skills.
Lessons from experience

Where decentralization mainly involves the deconcentration of the ministry of health itself, health personnel recruitment and distribution can be retained as a centralized function. However, when decentralization is based on devolution and delegation, it is a common practice to make the region or district the employing authority, since salaries for health workers are the largest single item in the health budget. This also makes the health workers directly accountable to the local organization or local government. However, removing control of staffing from the national level can lead to great difficulties in filling posts in less popular parts of the country and an inequitable distribution of staff may result. In addition, there can be considerable problems in reconciling the output of graduates from basic and specialist training programmes, usually controlled nationally, with the needs of the decentralized services. It can be difficult for the ministry of health headquarters to keep track of the numbers of health workers actually in employment and their attrition rates, and thus to plan logically for future staffing requirements.

As decentralization is implemented, two particular staff problems frequently occur. First, most countries have found staff with senior management and health planning skills to be in short supply; to overcome this acute shortage, brief courses and workshops have been required. This experience was emphasized in most of the case-studies in Part 2 of this book. Another important practical problem concerns the difficulty of persuading staff and their families to move to more peripheral posts. This difficulty is aggravated by the frequent shortage of suitable housing, schools and other facilities in small provincial towns.

In summary, the workforce issues include the following.

- Decentralization often increases the total number of health workers required, particularly in managerial posts at intermediate levels, and a staff shortage may be experienced before training programmes, both basic and post-basic, can correct the situation. Thus, during the implementation of decentralization serious managerial weaknesses are frequently encountered at the intermediate levels.

- Decentralization frequently requires health workers with new skills, calling for prolonged training courses or in-service training. If staff are removed from their positions for lengthy periods, acute staff shortages may be exacerbated, whereas in-service training often requires the availability of supervisors who know how to carry out the necessary training.

- To overcome the shortage of mid-level and senior managerial skills, one solution is to place doctors and nurses under the direction of non-health professionals. This may lead to further professional opposition, however, and yet the alternative—the retraining of suitable health professionals—can be a lengthy and expensive process.

- Considerable efforts are often required to overcome professional opposition to decentralization, particularly as this opposition is frequently also supported by civil servants at the national level. These
Health system decentralization

efforts are time-consuming. In countries with strong professional unions, lengthy negotiations on new conditions of service are a common feature.

Implementing decentralization

Policies that foster a greater degree of decentralization in the health sector have many advantages for supporting the implementation of primary health care and health-for-all strategies. However, decentralization is a very sensitive political issue, for it concerns the distribution of power and the allocation of resources. This is shown by the fact that many governments have attempted to decentralize administrative procedures, while at the same time retaining or strengthening central control over policy, legislation and budgetary activities. Hence it is very important to clarify which functions are being decentralized and which are to remain under central control. Decentralization and centralization must be considered together.

The adoption of a national policy on decentralization is only the beginning of a lengthy process that requires 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 to implement the policies and similarly the regional, district and local authorities being reluctant to accept their new responsibilities. The early stages, therefore, require a great deal of consultation between all the authorities concerned in order to clarify their new roles and responsibilities.

It is frequently recommended that decentralization be phased in gradually, maybe area by area or function by function, and the following suggestions have been 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;

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— 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 their greater responsibilities;
— clarify the new responsibilities of each government level and develop a process for open consultation within and between levels.

The “top-down” implementation by a strong central government of a new policy for decentralization, without due regard for a process of consultation and adaptation, is very likely to fail. The policy may well be adopted but there is likely to be a wide gap between the intentions and the 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.