

Decentralization of Health-Care Services in the South-East Asia Region

Report of the Regional Seminar
Bandung, Indonesia, 6-8 July 2010



**World Health
Organization**

Regional Office for South-East Asia

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Abbreviations

BMN	Basic minimum needs
DHS	District health system
GO	governmental organization
GP	general practitioner
HFA	Health For All
HIS	health information systems
HMIS	Health management information system
HNPSP	Health Nutrition and Population Sector Programme
HSS	Health systems strengthening
MCH	Maternal and child health
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MEP	Management Effectiveness Programme
MoH	Ministry of Health
NGO	Non-governmental organization
NTP	National Tuberculosis Programme
PCU	Primary care units
PHC	Primary health care
QOL	Quality of life
SOP	Standard operating procedures
VHW	Village health workers

Executive summary

The Regional Seminar on Decentralization of Health-care Services in the South-East Asia Region was held from 6 to 8 July 2010 in Bandung, Indonesia.

The overall objective of the seminar was to agree on strategic approaches for decentralization of health-care services within the context of health-care reform. The specific objectives were to share experiences in implementing decentralization of health-care services in the South-East Asia Region; to discuss issues and challenges of implementing decentralization of health-care services in the Region; and to identify strategic approaches for decentralization of health-care services.

Sixty-seven participants representing Member States of the South-East Asia Region, national and sub national ministries of health, hospitals, other ministries, academicians, UN agencies, bilateral agencies and experts as well as nongovernmental organizations attended the three-day seminar.

The seminar was inaugurated by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. Dr Budihardja Singgih, Director-General of Community Health, Ministry of Health, the Republic of Indonesia read a message from Her Excellency Dr Endang Sedyaningsih, Minister of Health, the Republic of Indonesia.

The concept paper on Decentralization of health-care services in the South-East Asia Region: perspective and challenges was presented by Dr Poonam Khetrpal Singh, WHO Deputy Regional Director for South-East Asia. The paper focused on the strategic framework of decentralization of health-care services, addressing the issues and challenges to improve health-care services to be more efficient, responsive and equitable.

A presentation on Decentralization of health-care services in Java: implications for Asia was made by Professor Peter Heywood, University of Sydney, Australia. The paper focused on the decentralization experience in Java, on the importance of decentralization opportunities for health system responses tailored to local problems, and how to find the right level of decentralization.

The technical sessions were focused on different aspects of decentralization of health-care services and were organized under four themes:

- (1) Role of MoH vis-à-vis local government in health-care services
- (2) Improving management capacity of local government by strengthening District Health System (DHS)
- (3) Improving quality of health-care services
- (4) Vertical/semi-vertical health programmes in a decentralized setting

Panel discussions were held on these topics through presentation of country experiences and for the improving quality. The main paper on referral systems to improve quality of primary care was presented by Dr Athula Kahandaliyanage, Acting Director, Department of Health Systems Development, WHO-SEARO.

Group discussions were organized and focused on six topics:

- (1) Decentralization and centralization of government functions
- (2) Capacity building of health system with emphasis on DHS
- (3) Role of civil society in improving accountability of local government
- (4) Improving quality of health-care services
- (5) Referral care system in decentralized health-care
- (6) Public-private partnerships

Conclusions

Decentralization of health-care services has the potential to improve efficiency of health services and equity of outcomes. The countries which are at different levels of decentralization agreed on the strategic framework and that there was a need to address factors influencing the process of decentralization, including health decentralization as a stand-alone policy; weak local management;

ineffective referral care; management of vertical programmes; fragmented health information systems; and low civil society participation.

For effective decentralization of health-care services, improvement of managerial capacity and clear understanding of the decentralization concept at all administrative levels is a prerequisite. It is a challenge to keep the amount and quality of health information including information from the private sector. Decentralization is an opportunity to improve public health service with private-sector involvement as well as regulation of the private sector. Civil society empowerment to participate in policy formulation, implementation and monitoring is necessary to ensure transparency, accountability and efficiency. There is also an opportunity to reduce the need for referral care by improving community-based health care in the light of the changing burden of disease and the ageing population.

Recommendations

For Member States

- (1) Develop need-based policies for decentralization.
- (2) Provide legal framework for decentralization and ensure adequate resources - both human and financial.
- (3) Involve communities and civil society in planning, budgeting, implementation and monitoring.
- (4) Develop a framework to involve and regulate the private sector in decentralization services.
- (5) Local government should allocate resources for decentralization of health-care services.
- (6) Strengthen health information systems (HIS) at national and sub national levels to collect, analyze and use data for programme improvement.
- (7) Improve primary care services and strengthen referral systems to ensure continuity of care for achieving the Millennium Development Goals (MDGs) and high quality of services distributed in an equitable manner.
- (8) Develop and strengthen the human resource development and deployment policy, taking into consideration measures for retention of skilled staff, career development and performance-based incentives.

For WHO

- (1) Facilitate exchange of information between countries through horizontal collaboration and multi country activities.
- (2) Collaborate with countries in operational research for improving effectiveness of decentralization.
- (3) Assist countries in evaluating their experiences with decentralization and disseminate successful examples.
- (4) Disseminate global experience of decentralization of health-care services.

Introduction and background

Decentralization is one important tool in improving governance. Yet not all government functions can be decentralized. Legislation, national defence, foreign and monetary policy are some functions that should remain with central government.

Management of decentralization of health care was the topic chosen for the Thirty-ninth Consultative Committee for Programme Development and Management (CCPDM) in 2002. After seven years, in 2009, decentralization in health was a topic discussed at the Regional Meeting on Health-care Reform for the 21st Century.

This Regional seminar on decentralization of health-care services in the South-East Asia Region aimed to discuss experiences among Member countries of the South-East Asia Region, which have varying degrees of decentralization in health. This is an important forum within the context of the revitalization of primary health care that all Member countries have agreed to implement and our continual pursuance of HFA and health-related MDGs, wherein the improvement of health equity is one of the overarching goals. Without proper planning and acknowledgement of the lessons learned by other countries, decentralization of health-care services can be disappointing at best and detrimental at worst.

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General objective

To agree on strategic approaches for decentralization of health-care services within the context of health-care reform.

Specific objectives

- (1) To share experiences in implementing decentralization of Health-care services in the South East-Asia Region.
- (2) To discuss issues and challenges of implementing decentralization of health-care services in the South-East Asia Region.
- (3) To identify strategic approaches for decentralization of health-care services.

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Inaugural session

In his opening remarks, Dr Samlee Plianbangchang, WHO Regional Director for South-East stated that it is time to review and discuss the issues relating to decentralization of health-care services, because all countries worldwide are now attempting to achieve several time-bound health targets. Most important among these are the targets for the achievement of the health-related MDGs.

Decentralization of health-care services becomes an essential element of health systems strengthening (HSS) to ensure improved effectiveness of public health interventions that can lead to the achievement of those goals. The aims of decentralization of health-care services are to improve the efficiency of their delivery and the equity of their outcomes.

Decentralization helps ensure availability and accessibility of the services to all people in need. Globally, decentralization has been launched in various forms and its achievement and success vary from country to country, but in .developing countries decentralization of health-care services is rarely evaluated.



Dr Samlee Plianbangchang delivering his inaugural speech



Dr Budihardja Singgih (Indonesia) addressing the seminar

Much decentralization has been motivated by political concerns. It is a common government policy measure and also an important tool to improve the functioning of governance, a dynamic political process, a learning process, and a mix with centralization. Decentralization should not occur in isolation as a separate entity of a country's governance system.

Decentralization is context-specific, related to political, geographical, social and economic conditions. Therefore, although countries can learn from each others' experiences of decentralization, comparing decentralization outcomes between countries is not easy.

This Regional seminar is a continuation of the Regional Meeting on Revitalizing Primary Health Care in 2008 and the Regional Meeting on Health-Care Reform in 2009. The seminar aims to look at decentralization of health-care services within the context of health systems based on primary health care (PHC) and within the context of health-care reform. Important components of decentralized health-care systems will be discussed, such as: referral systems to ensure effective back-up to health-care services in the community; the essential role of local governments in the management of health-care services; and the indispensable role of community health workforce at the grassroots level; policy direction, supervision and oversight from the centre; health policy reform and human resource reform.

Decentralization in health needs to be made a part of the total government decentralization system. The capacity of local government is a prerequisite for successful decentralization. It can be built through processes that permit learning by doing on the ground. Various factors that influence capacity building are institutional support and the role of universities as well as the strength of the central government. A good disease-specific programme will be planned

at the central level but implemented through decentralized a health system in an integrated fashion. For their effective involvement, the role of stakeholders such as the private sector, NGOs, civil society and the community should be clearly defined.

This seminar is to provide an opportunity for sharing experiences among countries about how to make such decentralization happen more efficiently and effectively. Decentralization is a process of improving national health services management and has to be operated with a multidisciplinary and multi sectoral approach. With the accumulated experiences of these countries, we should be optimistic that future endeavours in this area in the South-East Asia Region will be more promising.

Decentralization is an essential measure towards the achievement of equity and social justice in health. WHO will continue providing a platform for information exchange in this important area. WHO will also continue supporting countries that pursue decentralization within the context of health systems based on PHC and health-care reform.

Opening address

The Director-General of Health Services, Ministry of Health, the Republic of Indonesia, delivered the opening address on behalf of Her Excellency the Minister of Health, the Republic of Indonesia. In her address, Her Excellency stressed that the philosophy behind the implementation of decentralization, including decentralization of health-care services, is to provide better health-care services to the community. Decentralization is the only way to go for community development in a large country such as Indonesia. Improvements in community participation and efficiency were envisaged.

The experience of decentralization after 10 years of implementation showed the need to adjust not only to the change of decentralization policy *per se* but also to the demands of the people and the political elites to create new provinces, districts and municipalities. In its role as governance implementation law coordinator, the Ministry of Home Affairs also acts as local government performance evaluator. The performance evaluation was recently published and revealed only 61% of districts and municipalities have performed well.

Rapid decentralization without adequate preparation and capacity building leads to problems. Many problems in the decentralization were caused by the unpreparedness of the regions to take over the responsibility of providing health-care services, particularly the unprofitable services.

The problem of decentralization of health-care services is more profound when there are serious health problems such as disease outbreak and disaster. Quality of care and health information flow have emerged as major issues.

The lack of coordination in problem solving among the various levels of government, between the health sector and other sectors, as well as geographical problems, create barriers to health services for the people. In many

cases, central government intervention is necessary to overcome the health problems due to the inaccessibility of the site, transportation difficulties and lack of human resources, facilities and funds. There are several breakthroughs to overcome these problems, namely identifying districts with serious health problems, greater focus on the health workforce, civil society empowerment and networking with partners such as district health offices associations and district hospitals associations.

Although implementation of decentralization of health-care services is local-specific, this seminar will provide ample opportunities to learn from one other and come up with innovative thoughts and recommendations.

Presentation

Dr Poonam Khetrpal Singh, Deputy Regional Director, WHO South-East Asia Region, presented the draft strategic framework. She began her presentation with a definition of “Decentralization of health-care services in the South-East Asia Region”:

- Decentralization is a process by which authority, resources and functions are transferred from the central government agencies to other institutions at the periphery of the national system with decision-making largely vested with the people (Rondilleni 1981).
- Decentralization of health-care services relates to the transfer of responsibility for planning, financing and management of health-care services from central or regional government and its agencies to local government, semi-autonomous public authorities or corporations.

Types of decentralization

- Administrative decentralization: the transfer of responsibility of public functions from the central government to local governments.
- Fiscal decentralization: transfer of authority for self-financing, co-financing and intergovernmental transfers that shift general revenues from taxes collected by the central government to local governments.
- Political decentralization: transfer of power in public decision-making to citizens or their elected representatives.

However, the above three are not mutually exclusive and can overlap.



Dr Poonam Khetrpal Singh, Deputy Regional Director, WHO South-East Asia Region presenting the strategic framework

Forms of decentralization

- *De-concentration* – redistributes authority, financial and management responsibilities among different levels of government.
- *Delegation* – transfers responsibility for decision-making to organizations ultimately responsible to it.
- *Devolution* – transfers responsibility to local governments who elect their own functionaries and raise their own revenues.
- *Privatization* – shifts responsibility for functions from public to private sector (for-profit and not-for-profit).

Objective of decentralization of health-care services is to improve efficiency of delivery and equity of outcomes. The potential benefits are many, including :

- Cater to local needs
- Decrease in duplication of services
- Innovation in service delivery through experimentation
- participative decision-making
- Increase in accountability and transparency of health services through user oversight
- Reduction of inequity between rural and urban areas

- Greater integration of activities of different public and private agencies
- Improved intersectoral coordination

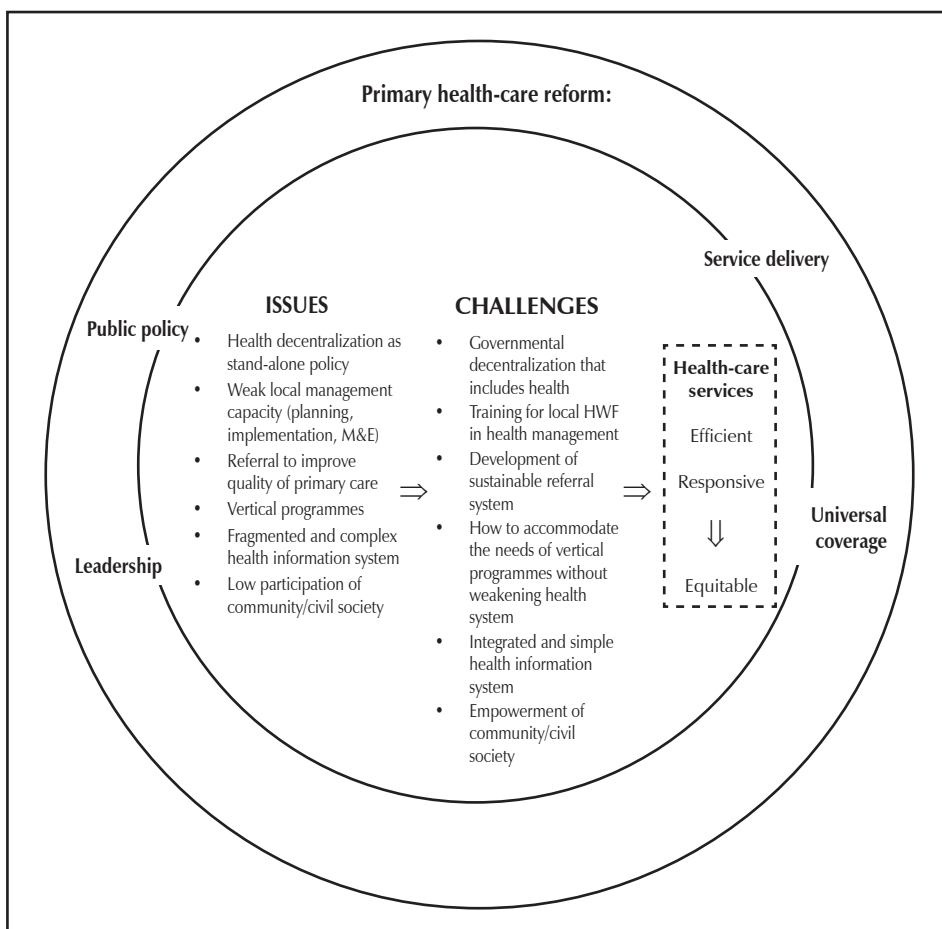


Professor Peter Heywood, University of Sydney, Australia presenting the main paper

Previous meetings have also discussed decentralization:

- Regional Committee in 2002. Resolution adopted “Decentralization of health care and strengthening district health systems to ensure equity in access and efficiency of quality health care”.
- Regional Meeting on Health-care Reform for the 21st Century – October 2009: Decentralization as public policy succeeds only if centralized and decentralized bodies are clear about roles and shared understanding.

Strategic framework: decentralization of health care services



A strategic framework depicting some common issues faced in implementing decentralization in health along with challenges that need to be addressed. These challenges have to be dealt with within the context of PHC reform envisioned in the World Health Report 2008 “Primary Health Care: Now More than Ever”.

The framework focuses on issues and challenges in decentralization of health-care services as follows:

Issues	Challenges
Health decentralization as stand-alone policy	Governmental decentralization that includes health
Weak local management capacity	Training for local HWF in health management
Referral to improve primary care quality	Development of sustainable referral system
Vertical programmes	to accommodate the needs of vertical programmes without weakening health system
Fragmented and complex health information system	Integrated and simple health information system
Low participation of community/civil society	Empowerment of community/civil society

Outcomes of decentralization

- Little evidence exists to date to confirm the positive outcomes in developing countries; this is due to the fact that it has rarely been evaluated.
- In developed countries, the most frequent negative reported outcome was inequity, particularly between rich and the poor districts.

Decentralization and primary health-care reforms

There are four areas of PHC reforms envisioned in the World Health Report 2008:

- Universal coverage reforms will contribute to better health equity.
- Service delivery reforms to be people-centered, and more responsive health-care services.
- Public policy reforms to secure healthier communities through establishment of healthy public policy.
- Leadership reforms to be more inclusive, participatory, and accountable health governance.

Decentralization of health-care services can contribute to the four areas of PHC reforms as follows:

**Correlation between potential benefits of decentralization
and PHC reforms**

Potential Benefits	Areas of PHC Reforms			
	<i>Universal coverage</i>	<i>Service delivery</i>	<i>Public policy</i>	<i>Leadership</i>
Caters to local needs		+		
Decreased duplication of services	+			
Increased innovations	+	+		
Increased accountability				+
Reduced inequity	+			
Greater integration	+			
Improved intersectoral coordination			+	

A change of roles at both central and local government levels, depending on what functions are decentralized in the administrative, fiscal and political areas, is mandatory. In general, the functions of stewardship – legislation, standard-setting, supervision, monitoring and evaluation (M&E) – should remain with the central government.

With more countries in the South-East Asia Region experiencing decentralization of health-care services, there is a need for more research, particularly operational research, as a learning-by-doing way to explore the potential of decentralization from the supply side as well as from the demand side of health-care services.

Technical discussion

Main Paper: Health-care services decentralization in Java: implications for Asia, *Professor Peter Heywood, Menzies Centre for Health Policy, University of Sydney, Australia*

Development of the Indonesian National Health System

At Independence, the Government of Indonesia inherited a weak and unevenly distributed health system to which most of the population has only limited access. In the early 1950s a new health system, in which curative and preventive medicine were integrated, was piloted in Bandung. This system - subsequently known as the Bandung Plan - became the blueprint for the new national health system: a network of public health facilities throughout the country with a health centre at the sub district level and a hospital at the district level.

By the mid-1990s, there were more than 7 000 health centres based on ensuring distribution of public facilities, staffed through obligatory government service for all new graduates in medicine, nursing and midwifery. The doctors, most nurses and midwives staffing these facilities were also allowed private practice after hours. A village midwife programme was in the mid-1980s. All staffing and funding was implemented through central control.

The whole public system, including staffing and funding, was managed in a top-down, hierarchical manner consistent with the Health For All paradigm. Almost all resources were transferred to district governments through centrally specified earmarked grants. The provincial level had an important role for supervising programs and providing technical assistance.

Alongside these public facilities there was also a range of private ones which included a limited number of private hospitals and clinics as well as a large number of private facilities established by private providers to staff public institutions. These private practices become an important source of ambulatory health care, but they are not routinely included in the health information system. The source of health care from nurses' private practice is seldom acknowledged; in fact, government regulations forbid them to provide private practice.

By the late 1990s, the Indonesian health system was basically a private health system, with two thirds of the financing and more than half of the services being private. The health facility distribution allows consumers to choose a facility and/or provider. This was the result of a transition that commenced with the original staffing strategy. There was low government spending on health, with out-of-pocket spending approximately 70% and two-thirds of all ambulatory care from private providers. The private sector was an important source of care for the poor as well. Half of all hospital beds were in private hospitals, with low levels of utilization by the poor. The government ignored the transition to a predominantly private system, and the health strategy statements still read as if the public sector were the main provider.

Decentralization came in 2001, with the responsibility for delivery of services assigned to districts within a year. Experienced observers at the World Bank declare that "Central regional transfers remain the dominant means of financing but the earmarking is gone"; and "since decentralization districts decide how to spend their own resources". These moves all seemed consistent with the idea that decentralization expands choice at the local level and leads to an increased "decision space".

Expectations from decentralization in the health sector were high. However, decentralization in Indonesia was not a planned event, but rather a political event implemented following the 1997 financial crisis. Improvement of health services was at best a secondary objective. The central health ministry was not prepared to assume a new role as system manager. Nor were the districts, which lacked many of the skills needed to plan and manage the health sector. The provincial level of government was assigned a minor role, and the central government now had the task of dealing directly with more than 400 districts, something it had not done before and was not equipped to do now.

The challenges of implementing this new decentralized system were compounded by the absence of regulations needed to clarify the roles and tasks of the central, provincial and district levels.

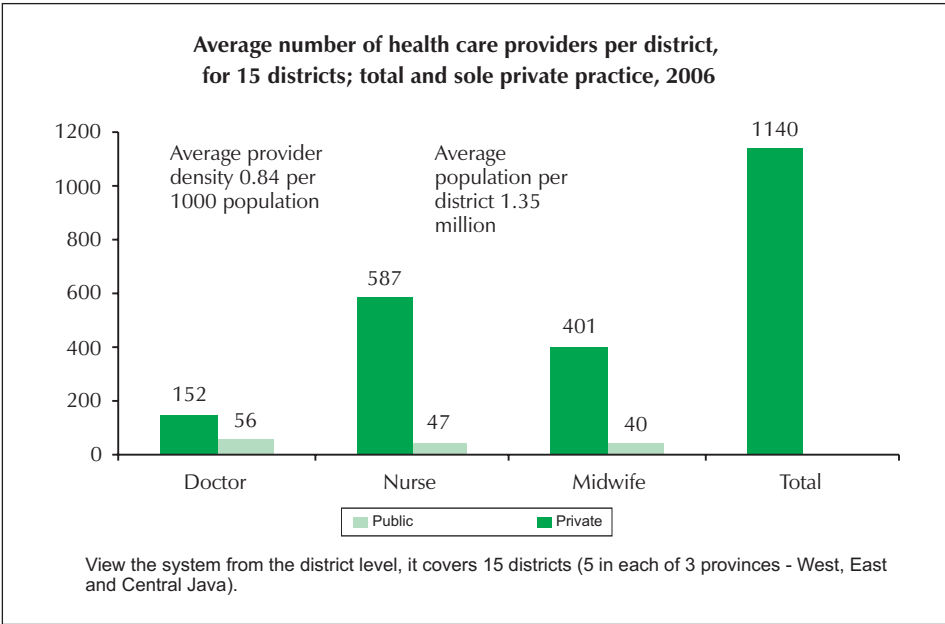
As the district is the crucial level in decentralization of the health sector in Indonesia, we have been looking more closely at how the system is functioning

there with emphasis on health facilities, human resources, public funding and system performance. Here we summarize the results as they apply to the topic of decentralization.

District-level human resources

The average number of health care providers across the 15 districts is shown in Figure 1. On average there were more than 1 100 health care providers - public and private - in a district (an average district population is 1.35 million). Nurses made up the largest group, midwives were next and the smallest numbers were doctors. The average provider density, 0.84 per 1 000 population was low.

Figure 1: District-level human resources



The central, provincial and district governments hire health staff on the public payroll, but with essentially no coordination between the three levels.

District-level health facilities are comprised of those which house multiple providers and cater for inpatients and outpatients (hospitals), those which house multiple providers but only cater to outpatients (health centres and private clinics) and those in which the services are provided by a solo practitioner. The distribution between these various types is shown in Figure 2. The vast majority of facilities are for solo providers (86%), all of whom are private; multiple-provider facilities for outpatients comprise 13%, and most of these are public. The distribution of solo provider facilities by type of

provider is shown in Figure 3. Nurses in part-time private practice comprise the largest group (almost 50%), followed by midwives (about 30%) and doctors (about 20%). These numbers have increased in recent years as various levels of government hire new staff.

Figure 2: Distribution of district-level facilities

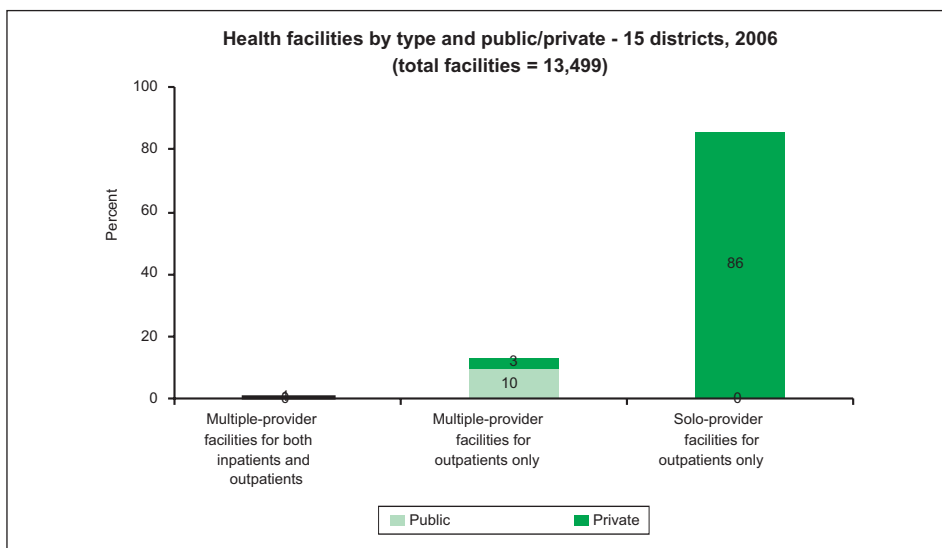
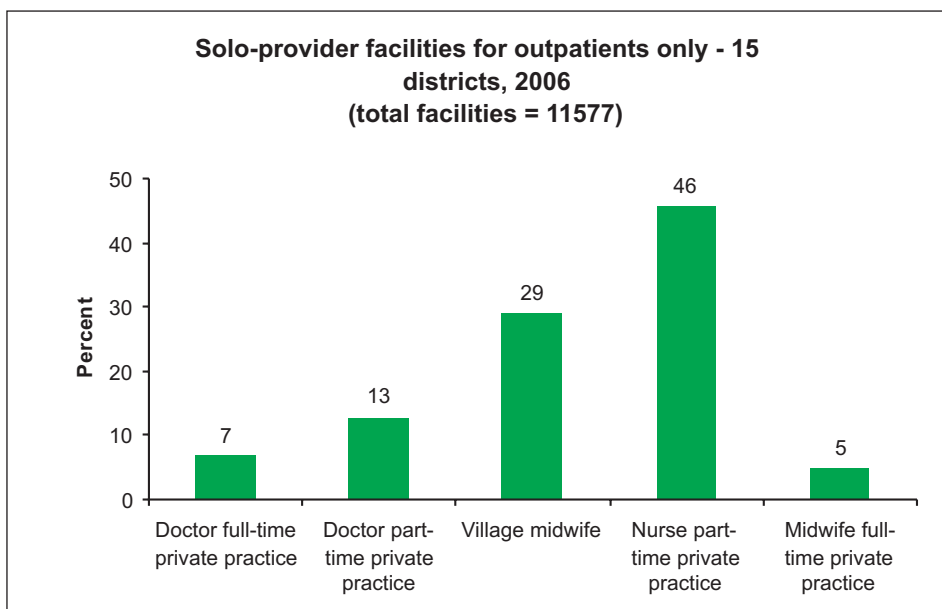


Figure 3: Distribution of solo provider facilities by type of provider
Public funding at district level



It has become common for observers and the government to refer to the funds expended on salaries as being under the control of the district government. However, the reality is that almost all the public-sector staff at the district level remain under the control of central government, which retains control over hiring and firing.

Overall, 45% of total public expenditure is at the district level; and at least 40% of this district-level expenditure is on staff salaries and remuneration, over which the districts have essentially no control. The result is that there is limited discretion at the district level on the use of public funds expended for health at that level.

Structure of the public component of the health sector at the district level

The system is fractured along four different lines with the result that there is no overall view of the sector. Each of these fractures reflects funding in some way:

- (1) Public/private: one third of funding comes from the public sector and two thirds from the private sector.
- (2) District/centre: About half of all public funds spent at district level.
- (3) District health office/Health centres and hospitals: Separate budget documents and accountability and no effective coordination between the two. There is usually greater discretion over use of funds in the hospital.
- (4) Discretion/no discretion: Across the 15 districts studied, less than half the funds expended at the district level are controlled by the district governments.
- (5) In effect decentralization has contributed to the fracturing of the system, as there is no longer a mechanism for coordination that was possible under the pre-decentralization structure.

A decade later: observations about decentralization in the health sector in Indonesia

The health system is essentially a private system lightly regulated and with a substantial public subsidy, especially in the form of the salaries of publicly employed staff.

The decentralization experiences are:

- (1) Decentralization in the health sector was not a planned event which the government spent time working out the best way to implement.
- (2) There were high and unrealistic expectations that government services would improve quickly and markedly.
- (3) Overall decentralization was not welcomed by the central bureaucracy, which has managed to claw back much of the devolution of authority to the districts.
- (4) The district had limited capacity to assume the new roles in the decentralization arrangements. The situation was further complicated by lack of regulations to support the main decentralization legislation.
- (5) All the levels of governments are hiring new health staff with little coordination.
- (6) Civil service reform and new policies of human resources in the context of a vision about the future health system are critical to reforming the health sector as a whole.
- (7) Decentralization has effectively further fractured the health system. Hospitals have the capacity to respond to local situations more rapidly and effectively provided they decide to do so.
- (8) The role of the province is critical in supporting the districts. Provinces need to show that they are really value added.
- (9) Central government transfers to the districts under the new system retain several incentives that work against change in the district health system. The district has no incentive to increase productivity in the health system as all new civil servants will be paid by the central government.
- (10) The central government has always been reliant on the districts for the provision of health information.

Since decentralization many districts have stopped providing information, seriously limiting the integrity of the health information system.

- (11) There appears to have been no improvement in the performance of the health system since decentralization, despite the increase in government funding.

- (12) The government of Indonesia has not used its leverage to promote the changes in the role of government implied by decentralization.

Lessons for Asia

Reflecting on the experience in Indonesia leads to the following points that might be considered in decentralization:

- (1) It is important to see and manage the health care system as a whole, including both public and private sectors.
- (2) The future holds diverse challenges for which there are no clear answers.
- (3) In facing these challenges, those systems that can innovate quickly at the sub national level and evaluate effectiveness will have an advantage.
- (4) Because many of the changes and their effects will be local in extent and impact, variation and innovation at the local level are key to effective response.
- (5) Decentralization is a means to encourage and reward effective local responses.
- (6) Decentralization is a means to an end with the goal of allowing and encouraging more appropriate local responses to local problems and increasing accountability. The challenge is to find the right level of decentralization for a given place and time and to make sure that all stakeholders are involved in that decision.

8

Panel discussions

Theme 1: Role of Ministries of Health vis-à-vis local government in health care services

Country experience:

Functions decentralized to local government,

Professor P.K. Michael Tharakan, India

A report in 1983 articulated the need for a national health policy, emphasizing a decentralized system of health care for India. The national health policy of 2002 supported decentralization of the health-care system through *Panchayat Raj* institutions.

In 2005, the National Rural Health Mission was made operational in 18 states to provide primary health care, especially to the poor and vulnerable population. Community cadres and accredited social health activists (ASHAs) were created to give support.

Using Kerala State as an illustration, Professor Tharakan showed the improving trends over time in terms of health facilities and health expenditure. Kerala's success highlighted the importance of community participation and broad-based planning at the local level along with political commitment and support. The existing land reform policy and high education level were also key factors.



Panel discussion: Dr Budihardja Singgih and Prof. Michael Tharakan

Since health is a state responsibility and local government relies on transfer of funds from central and state budgets, allocations of considerable proportions of planned funds to local government were crucial for effective health-care service delivery, which only happened in a few states like Kerala.

Safeguarding decentralization in implementing minimum service standards for health, *Dr Budihardja Singgih, Indonesia*

Decentralization was implemented in 2001. Through repeated amendments of law in 1999, 2004 and 2010, decentralization was established and strengthened. There was a paradigm shift from free medical service and a vertical disease control programme to a people-centered public health system. The key challenges were disparity among districts, changing political commitment and political leadership, weak community empowerment and human resources.

A national minimum services standard for health, with four broad areas and 18 indicators, was adopted for all districts to maintain uniformity and quality of health-care services. Implementation of the minimum service standards safeguards critical functions under decentralization.

A few challenges which are being addressed are related to community health reform.



Panel discussion: Dr Asjikin Iman Dahlan, Prof. Ramji Dhakal, Mr Prayuth Sangsurin, H.E. Mr Ahmed Mujthaba

Privatization as a means of decentralization,

H.E. Mr Ahmed Mujthaba, Maldives

Maldives is a small archipelago with 1 190 islands. The current health care system has a five-tier referral system. Previous systems had issues such as misuse and wastage of resources, inefficiency, politicization and lack responsiveness.

The government recently adopted reforms which involved corporatization of health-care services at the local level, without compromising the social needs of underprivileged populations and people living in remote areas.

Involved service providers are making demands which have financial implications.

Theme 2: Improving management capacity of local government through strengthening of District Health System (DHS)

Training in health management,

Dr Asjikin Iman Dahlan, Indonesia

In Indonesia, management of training for civil service officials is established, including for structural officials in the health sector. The training was provided by an established curriculum and is a prerequisite for a structural appointment for all bureaucracy.

In the Ministry of Health, the health training centre was the institution that conducted these structural trainings. The training centre's task is to carry out the planning, implementation and evaluation of career ladder training as well as technical and functional training of health management. Health personnel training is designed to meet the needs of the organization, teams, and individuals.

Training programmes:

Government Official Leadership Training Programme

- (1) Leadership Training Programme (management-leadership training for structural MoH career prerequisite)
- (2) Training for government prospective employees

Training centre strategy to support decentralized health service:

- Strengthen provincial training centres by providing trainer and master of training
- Strengthen district/city ability in managing technical training and clinical training.
- Improve the knowledge and skill of the health personnel who work in MCH services to support the achievement of MDG targets
- Build up community participation through Desa Siaga.
- Improve the management skill of MoH and provincial health office to support decentralization in district/city.
- Improve the knowledge and skills in health financing at all levels.

Strengthening Health Management Information System (HMIS) in a decentralized health-care system: a case from Nepal, Professor Ramji Dhakal, Nepal

Policy and institutional context of HIS in Nepal:

- Data are used for preparation of periodic and annual plans; allocation of resources; supervision; disease surveillances, logistics and research.
- HMIS data support patient care, health facility management and health system management functions.

- HMIS monitors work progress - e.g., assess vaccination coverage and FP , Maternal and newborn health and disease control programmes.
- HMIS section generates statistical tables on a three-monthly basis and produces annual performance report.
- However, the use of HMIS is limited due to issues with its reliability and consistency.

Gaps and constraints

- Data not analyzed, used and disseminated adequately.
- Data is often not reliable and consistent.
- Reporting is delayed and incomplete.
- Inadequate coordination among other HIS.
- Shortage: personnel, infrastructure, equipment.
- Captures only facility-based data in quantitative form.
- Lack of community involvement in data collection/verification.
- Lack of evidence-based decision-making culture.
- Challenges in implementation (macro and micro level).
- Lessons learned in HMIS reporting
- If health systems are inadequate and unprepared, decentralization may lead to poor functioning. Therefore, implementation challenges at central and local levels must be addressed adequately.
- Preparation, participation and preparedness for implementation must be a priority.
- Technical skills of health workers must be improved for processing/ utilizing data at the level of districts and below.
- Participation of local level in data collections/analysis will improve quality and use of information.
- Need to maintain regular feedback from all levels.
- Conclusion
- HMIS has information by facilities on monthly basis, yet use of information in rationalizing decisions is poor.

- Good design is not adequate – preparation, participation and commitment at all levels are important.
- Adequate resources and technical capacity needed to sustain a functioning health information infrastructure.
- HMIS need to address not only biomedical issues but also social ecologies and information-based economies.
- Need for a simple and integrated recording-reporting system to minimize data gaps and maximize utilization.
- Recommendations to improve HMIS in decentralized settings
- Address the existing challenges at policy and implementation levels.
- Maintain inventory of infrastructure in each HF and regular central updating mechanism.
- Revisit HMIS design to adjust quality, process, social and political dimensions of the information.
- Establish a strategic approach to link database for local planning, M&E of programmes.
- Strengthen capacity for using data in planning/monitoring.
- Strengthen M&E to enable LGB s participation in HMIS.

Partnership with civil society, *Mr Prayuth Sangsurin, Thailand*

Past experience shows that PHC achievement depends on social capital in the community including strong community organization. This means that key persons are prepared, there are participating agencies that agree to share the risk, and people themselves are able to undertake PHC innovation and show the strength of their enterprise for social development.

Thailand has many models for capacity building of local governments and communities to plan, finance and manage their health responsibilities, such as:

- (1) Nationwide training in new appropriate techniques of decentralized administration from national and local officials.
- (2) Campaigns to increase public concern and social mobilization for health promotion.

- (3) Increasing healthy public spaces; this requires strong support from civil society.
- (4) Shift the Health for All (HFA_ goal to “Quality of life (QOL) for all” goal to generate joint ownership and shared responsibilities among different sectors.
- (5) Basic Minimum Needs (BMN) tool design for gathering local information and using it for local self-planning. The advantage of the QOL and BMN approaches are their synergistic effects on health improvement.
- (6) Volunteer Health Visitors have been developed to assist health workers in provision of simple care, and have become effective entry points to build up sustainable community participation.
- (7) Apply Strategic Route Map for capacity training at all levels, include financing and administrative framework to facilitate decentralization from national health administration.
- (8) The universal coverage policy under the National Health-Care Reform: (NHCR) improves the access of the poor to sophisticated health technology when needed. Due to the NHCR, health centres have been transformed into primary care units (PCUs) or Tambon Health Promotion Hospitals, and Community Hospitals to CUPs . The portions of the health budget earmarked for health promotion and disease prevention were transferred to each subdistrict to run their own health activities.
- (9) The strong commitment to decentralize authority to the peripheral level, under the “Determining Plans and Process of Decentralization” law of 1999, resulted in increasing government budgets which were delegated to the local government for self-management.

These challenges include the use of innovative approaches, encouraging income generation and political decentralization.

Recommendations for MoH on efforts to improve partnership with civil society:

- All levels of government and social sectors should be trained for practising decentralization of health-care services.
- Seek political commitment and support by setting new approach of PHC management and implementation by sub districts as a national policy agenda.

Theme 3: Improving quality of health-care services – referral system to improve quality of primary care, *Dr Athula Kahandaliyanage, WHO South-East Asia Regional Office*

An ideal referral system would ensure that patients can receive appropriate high-quality care for their condition at the lowest cost from the closest facility possible. The quality of care provided by primary care institutions is important to prevent the bypass phenomenon and establish a functional referral system. Strengthening district health systems supports improvements in the quality of PHC. Though much has been done by governments in the past to establish and improve PHC, establishing referral systems has lagged behind. Currently there are global attempts to revitalize and further strengthen PHC and these may not be effective if referral systems are not made functional, effective and acceptable to the community.

Health authorities need to involve the local government in establishing functional referral systems, especially with regard to provision of resources and coordinating with other sectors and with other adjoining districts.

The private sector needs to be considered as an important stakeholder in the referral system, but it needs proper regulation and social security support by way of insurance to ensure universal coverage. The use of information technology to support referral system needs to be given due consideration.

The WHO South-East Asia Regional Office and Member States need to undertake a special effort to strengthen and improve the quality of primary health-care, supported by effective and efficient referral systems in the respective countries. National policies and guidelines need to be developed in countries where these are not in place. It is important to share experiences of other countries and success stories for further development. Further research may be required to fill the information gaps.

Country experience:

Improving referral care in Sri Lanka, *Dr Kesavan, WHO Country Office, Sri Lanka*

Curative services in Sri Lanka range from primary care institutions to secondary and tertiary care institutions, mainly in-ward patients are transferred or referred to specialized clinics.

There is a back-referral system whereby patients can be transferred back to the primary health-care institution, and a lateral referral system works within

an institution where patients are referred to different specialists for specialized treatment.

Preventive services are functional in the public sector, such as referral of antenatal care patients, immunization, and for non-communicable diseases.

There are some positive developmental features which have a negative impact on referral system, such as better infrastructure (transport, road) which enables people to reach major institutions easily; a better economy and improved literacy increase expectations and may lead people to bypass smaller institutions; and decentralization of health-care services.

Other constraints on a better referral system

- Human resource constraints and lack of infrastructure and facilities at the peripheries
- At the peripheries, civil war has prevailed in the country.
- Facilities for health staff at the peripheries, which affects the attitude and the quality of care and also decentralization of health-care services.

Decentralization through provincial councils

The highest level of decentralization took place in 1987 with the creation of provincial councils under the 13th Amendment to the Constitution. Provincial health service was established in 1989, with the majority of administrative functions and service provisions being decentralized. The 1987 decentralization did not have a major impact as the district system was maintained parallel as the decentralized administrative unit, but when the provincial system becomes more effective the referral system may have to be addressed.

Re-categorization of hospitals for better equity

In 1997, the presidential task force recommended greater equity in health-care delivery in the country, and at least one hospital in each district was upgraded with all facilities. Hospitals were re-categorized, and the effect was that the lower hospitals were under-utilized and the routine referral system was affected.

Decentralization of health services could have an adverse effect on the referral system unless the flow of referrals is harmonized in the provincial and central systems and strengthening of provincial health institutions is done in a bottom-to-top approach.

Referral system - private health sector

There is no organized referral system in the private health sector; any patient is free to seek treatment from any private healthcare institute, be it a general practitioner (GP) or a specialist.

Constraints in the present referral system

Although a referral system is in place in the government healthcare system, it is not strictly enforced. There is no specific demarcated draining population allocated for healthcare institutions even after decentralization.

The GP system in Sri Lanka is not well regulated. There is no organized GP referral system. The back-referral system also does not function optimally. Overcrowding of secondary and tertiary health-care institutions affects the quality of service provided to the patients.

There is a certain degree of inequity in distribution of healthcare facilities, and the primary level is mainly affected.

Patients perceive that they will get better treatment at tertiary care institutions and seek treatment there, bypassing other institutions

Referral system – equity and right for health

The referral system could be better implemented through advocacy and provision of facilities than by making it mandatory. The present system allows any citizen to walk into any type of hospital without strict compliance with referrals. This could be a fundamental human rights issue.

Community-based health-care, Dr Somchit Hanucharunkul, Thailand

The essence of the CCM is that of interaction between *an informed, activated patient and a prepared, proactive practice health team*. The case study of community and home-based care of patients with chronic obstructive pulmonary disease was shared. Most of the patients are highly dependent on others for their care and daily activities. The readmission rate was more than 20%, about 1-2 times per month with a prolonged hospital stay (some more than 2 months) and the quality of life index was low.

The intervention:

- (1) Nurses with advanced skills work with and lead a care team. Later the patient is encouraged to perform self-care and carry out daily

activities. The nurse provides knowledge and technical support to patients, family caregivers and community health workers and teaches SM program to patients and families.

- (2) Family members help the patient identify and meet care needs while neighbours assist in delivery of medications and equipment such as oxygen to the patient's home.
- (3) Home care is ensured by a district health team.
- (4) Local government workers create a healthy environment, such as avoidance of burning waste products in the community, living place and transfer patients to hospital when needed.

The results:

Decreased numbers of patients with acute exacerbation each year, decreased severity of illness and of readmission rate, shortened length of hospital stay and reduced cost of care. Equally important, the initiative has led to improvement in the QOL index.

Benefits of home- and community-based care include reduced hassle for patients, reduced risks from hospitalization as well as empowerment of families.

Improving programme management effectiveness, *Dr Swe Win, Myanmar*

The presentation is about the Management Effectiveness Programme (MEP) in Myanmar. MEP:

- (1) Is an approach to develop managers and their team to improve delivery of health services and the performance of health organization.
- (2) Adopts a multidimensional framework for assessing and improving organizational performance.
- (3) Has a basic concept of strategic management at township level.

The target group:

- (1) Managers of state/division, township (district) health office, managers of health service organizations, managers of health programmes
- (2) National health authorities or policy-makers in the Ministry of Health.

The approaches:

- Building the managerial skills and competence of individual and teams.
- Assessing, enhancing and monitoring organizational performance, and providing feedback on implementation experiences to national authority.
- The training modules: Orientation on MEP; training of trainers for facilitators. Continuous personal and professional development.
- Team building and leadership and managing the health service delivery.

The area:

- 2004-2005: Thonegwa, Kyonepyaw, Punde, Ayadaw, Singgang, Yatsuk
- 2006-2007: Yertershi, Myinmu, Aunglan, Moekaung, Namkhan, Paung
- 2008-2009 Longlone, Ponnagyun, Hlaingbe, Demosoe, Hakha, Maiphyat

Results:

- Skilled birth attendance rate increased from 42.8% in 2004 to 63% in 2009 in Thonegwa and 58.42% in 2007 to 78.59% in 2009 in Moekaung township.
- Case detection rate of TB increased from 14% in 2004 to 90.45% in 2009 in Ayeradaw and 28% in 2004 to 81% in 2009 in Namkham township.
- Antenatal care coverage increased from 60% in 2004 to 97% in 2009 in Yatsawk and 67.3% in 2008 to 99.8% in 2009 in Myinmu township.

Challenges:

- Rapid turnover of key staff such as township medical officer
- Dominance of vertical programmes and special projects (ad hoc programmes)
- Training teams at state and divisional level do not take a facilitating role in MEP

- Central training team can't travel for supervision and monitoring of township activities and their performance

Recommendations:

- MEP should be expanded to all townships in Myanmar.
- Enhance the facilitating and leadership role at state and division levels for training and supervision of MEP.
- Develop financial resources for training and supervision of MEP.
- Enhance the coordination mechanism between MEP and other programmes.
- Deliver second-line leaders for substitution in rapid turnover areas.

Theme 4: Vertical/semi-vertical health programmes in a decentralized setting

Country experience:

Effective vertical health programme in a decentralized setting,

Dr Gado Tshering, Bhutan

Health-care system in Bhutan

- PHC is the backbone of the health-care system focused on preventive, promotive, rehabilitative and curative care
- No private sector service delivery
- Integration of traditional with national health-care system

Primary Health Care

- 1978, Bhutan became signatory to Alma-Ata Declaration.
- At present more than 90% of the population has access to PHC.
- The selected national programmes are fully integrated into the general health delivery system.
- A network of hospitals, Basic Health Units and ORC s.
- 1 327 village health workers an integral part of the PHC; they assist in maintaining the ORC link between communities and health services.

Integration of vertical programmes

- EPI started in 1976 with 6 antigens (DPT, OPV) as a vertical programme and was integrated in the 1980s after achieving more than 90% coverage.
- Adequate human resources were trained and infrastructure such as a cold chain was well set up at the community level.
- The leprosy programme was started as a vertical programme in 1966 with support from missionary workers such as SANTHAL and TLM missions and finally integrated into the mainstream in the 1980s.
- Tuberculosis programme started as a vertical programme in 1976 and was integrated into the general health-care services in the mid-1980s. It started with long-course chemotherapy for 18 months and now DOTS-Plus is being implemented.
- The treatment success rate in the 2010 evaluation is 91% and all categories of health workers are trained to prevent and treat TB.
- Village health workers (VHWs) are fully involved in IEC of tuberculosis.

Disadvantages of decentralization

- Focused on target achievement, such as percentage of children immunized, percentage cured of TB and leprosy, percentage of cases detected and treatment started for HIV/AIDS, etc.
- Not mindful of sustainability in the future
- No ownership at the community level
- No ownership by other health workers
- Staff trained to achieve targets/goals in that particular field/programme
- Health system development is not considered.

Disadvantages of vertical programmes

- Once the target is achieved, the staff become redundant (success works adversely) like PMW in leprosy programme, vaccinators in EPI.
- Resources are not used judiciously, leading to wasteful activities like unnecessary tours and visits by staff and overtraining of the staff repeatedly in the same programme.

- Too many advisors and technical consultants.
- Political interference from various levels.

Advantages of vertical programmes

- Rapid achievement of targets/goals.
- Focused action to reduce morbidity and mortality.
- Timely intervention with dedicated staff to implement the programmes.
- Easy to get political support and resources owing to clear targets and goals.
- Support from donors and UN agencies is more forthcoming.

Recommendations

- Vertical programmes should be started with clear focus on integration or decentralization.
- From the beginning, community involvement and ownership building should be an integral part of a vertical/semi-vertical programme.
- HSS at all levels is critical.
- Sustainability of the vertical programme during integration or decentralization should be considered from the beginning.

Strengthen/revitalize PHC

- Vertical programmes should involve communities from the beginning.
- Community health workforce should be adequate, skilled and competent including VHWs.
- Health infrastructure at community level such as BHUs and ORCs should be adequately set up.
- Local governments should be involved.

Managing tuberculosis programme through public-private partnership, *Dr Faruque Ahmed, Bangladesh*

- TB was prioritized through reinstitution as separate directorate for Mycobacterial Disease Control under the Health Nutrition and Population Sector Programme (HNPSPP).

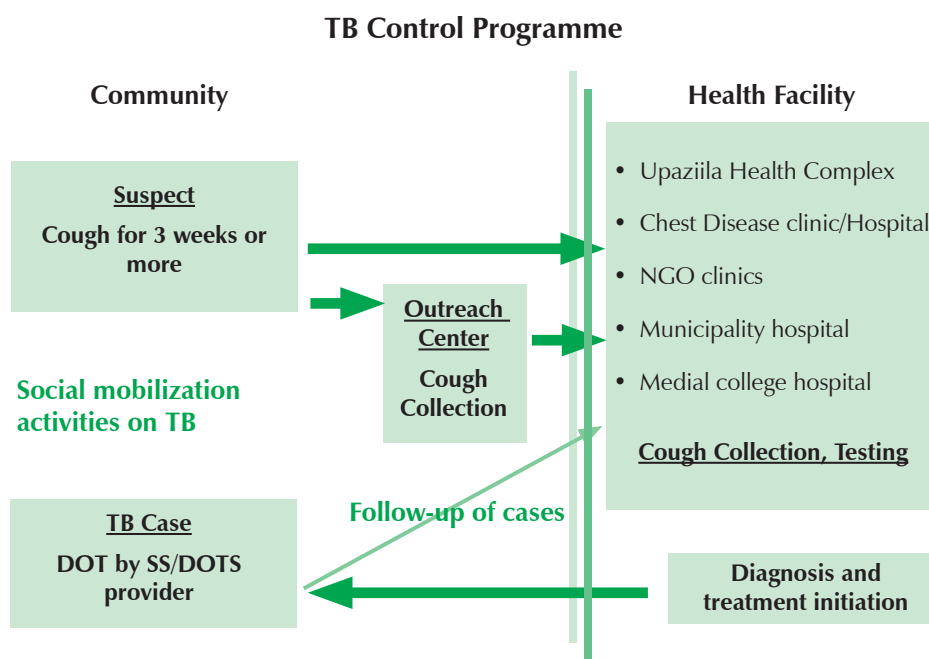
- At the subnational level, the National Tuberculosis Programme (NTP) is integrated into the general health services.
- An MoU was signed between the government and NGOs in 1994 for rural areas and in 2001 for urban areas.
- NGOs collaborate with the NTP in delivering services and creating demand and support generation and operations research.
- WHO has cited the Bangladesh TB control programme as a successful example of partnership.

The BRAC model

- Focus on sustainable, comprehensive development solutions.
- Health builds on the micro-finance and other developmental platforms (agriculture; livelihood; education and human rights).
- For health services: move from facility-based services to community-oriented approach.
- Perceived to be cost-effective and sustainable.
- Use of community volunteers as catalysts of change.
- Service delivery in under-served and hard-to-reach areas.

TB control strategy

- Initiated community-based TB control programme in one subdistrict in 1984. Extended to 10 districts by 1992.
- At present, NTP–BRAC joint programme expanded to cover around 90 million people.
- Shasthya Shebikas (SS) provide TB info during household visits and health forums.
- Identify and refer TB suspect.
- Sputum examined at government/BRAC laboratories.
- Medical doctors treat patients as per NTP guidelines.
- SS ensures daily intake of medicine (DOTS).



Key areas of government-NGO partnership

- Participatory planning and joint review
- Resource mobilization
- HSS and capacity building
- Advocacy, communication and social mobilization

Participatory, planning and joint review of performance

- TB national strategic plan developed involving all NGO partners and professional associations.
- Local-level planning and quarterly progress monitoring conducted jointly at district level.
- District and sub-district level monthly DOTS committee meeting with participation of government, NGOs and civil society.
- NGO steering committee with members from government, technical agencies and implementing NGO representatives.

Resource mobilization: GFATM funds

TB	Principal Recipient Government	Principal Recipient NGO-BRAC	Total	Sub-recipients (partner NGOs)
Round 3 (Period: 2004-2009)	15.45	27.02	42.47	9
Round 5 (Period: 2006-2011)	26.45	22.74	49.19	29
Round 8 (Period: 2009-2014)	36.23	40.85	77.08	44
Total	78.1	90.6	168.7	

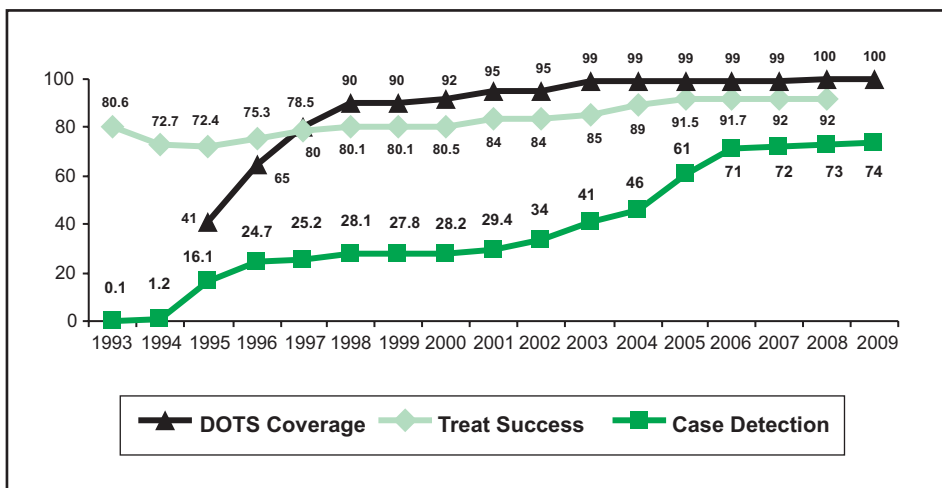
Health system strengthening and capacity building

- Additional human resources recruited and trained
- Expansion of TB laboratory and treatment facilities in remote and uncovered areas
- Community-based DOTS services
- Joint supervision and monitoring
- Ensure uninterrupted supply of drugs/logistics
- Quality assurance of services
- Expansion of EQA services

Advocacy communication and social mobilization

- Awareness raising and demand creation: Social communication and media campaign
- Empowering stakeholders by involvement: cured TB patients, village doctors, drug sellers, private medical practitioners, local opinion and religious leaders, micro-credit members, school students
- Advocacy: interaction with policy-makers, professionals, media personnel, implementers, civil society representatives through roundtable discussions.

Progress of TB control



Contributory factors for success

- Political commitment through definitive policies for collaboration between governmental organizations (GOs) and NGOs under HNPSP
- Presence of national NGOs with demonstrated capacity and focus on results
- Creative tension between GOs and NGOs leading to mutual accountability and accountability to the communities served
- Involvement of national and field NGOs through a civil society consortium approach
- Wider stakeholder participation
- Improving capacity of field NGOs
- Well-functioning monitoring and accountability structures

Is the model replicable?

- Sufficient evidence within Bangladesh
- Similar approach being adopted in other countries by BRAC
- What are the essential prerequisites and steps for scaling up BRAC model in other settings?

- Is micro-finance/related development agenda an essential element?
- Which other health interventions can co-benefit from TB model?
- TB project under the Essential Health-care Programme of BRAC – are there opportunities for improving efficiency?
- Can we use the same staff to deliver wider range of services with only some incremental cost?
- Is it a useful approach to scale up maternal and child health (MCH)/ nutrition interventions?

9

Group discussion

Group 1 : Decentralization and centralization of government functions

Reasons for recentralizing some governmental functions previously decentralized

- Communicable diseases control programmes/activities and disaster management as these are not localized in one province/state.
- Logistics management in some of the countries due to insurgency in the provinces/states.
- Programmes where local government is not functional or has inadequate capacity to run the decentralized programmes or clearly violates their responsibilities of provision of services.
- Human resource management: as doctors and other health workers did not feel secure in the decentralized system, higher-level human resources (doctors, specialists) are centrally managed and nurses (with community health training) and other paramedics managed by the local government.
- MCH, nutrition, EPI-like programmes are recentralized to meet the MDGs.

Experiences in securing and managing adequate financial and human resources in the health sector under the decentralized system

- Local government can collect a user's fee (such as for consultants, laboratory tests) but unable to properly utilize those funds.

Community drug scheme is implemented in some of the countries. There is no safety net for poor people.

- Budget allocation from the central government as well as from the local government has been ensured by policies and laws .However, proper utilization of those funds is not up to standard.
- Extra budget has been endorsed (in Thailand and Indonesia) to retain human resources at the health facilities at local level.



Group discussion 1: Decentralization and centralization of government functions

Components of health-care services to be managed by central authority

- Communicable diseases control and prevention, especially during epidemics
- Health human resources for higher level of health workers
- Health financing mechanism should be in place to monitor the fund utilization of the decentralized programmes.
- National standards, protocols, guidelines related to health-care services
- Monitoring and evaluation for the national scope
- Cooperation and coordination with partners and other international agencies establishing international links (international health)

Group 2: Capacity building of health system with emphasis on DHS

Issues:

1. Policy related

- Political commitment for decentralization
- Decentralization of health services cannot occur in isolation from overall decentralization.
- Lack of synergy between and among central and peripheral units of administration
- Empowerment of community to demand service



Group discussion 2: Capacity building of health systems with emphasis on DHS

2. Programme management

- Managerial skills for the process of decentralization
- Capacity building for planning at district level
- Disconnect between responsibility and authority given to districts
- Lack of clarity and overlap between role-definition between centre, province and district
- Weak system of M&E and supportive supervision

3. *Human resource development*

- Human resource development and deployment policy
- Public health workforce is limited leading to vacuum in health systems.
- Absence of accountability (incentives and disincentives)
- Low motivation to work in peripheral areas due to poor living conditions and lack of career development opportunities.

Recommendations :

Policy

A clear policy and legislation for decentralization, with clear definitions of roles and responsibilities at the central and peripheral levels, and with adequate financing and legal backing, should be developed in countries.

Managerial processes

- Establish processes (short-term and medium-term) to build public health management capacity in provincial/district levels.
- Strengthen accountability systems both for central- and provincial/district-level personnel.
- Consider phased-in decentralization after piloting in a few areas.

Human resource policy/plan

Countries to develop needs-based human resources development and deployment policy and plan giving due emphasis to public health workforce, career development opportunities and performance-based incentives, especially for the community-based health workforce.

Group 3: Role of civil society in improving accountability of local government

Country experience/issues

1. Involved at all levels: conceptual, policy making, planning, implementation and monitoring.
 - Work closely with the community and gain trust.

- With a right policy and government commitment, civil society can scale up health service delivery.
 - Organized platforms to produce annual health watch reports submitted to the government to make evidence-based policy and decisions.
2. As members of national committees related to policy, plan and budget allocation to community:
 - National Health Commission, National Health Security Committee, National Health Promotion Committee, National Decentralization Committee.
 - Can tackle health risks related to social determinants of health.
 - District health council, empower NGOs
 3. Can be a good watchdog. Can advocate and implement effective health programmes: health promotion, family planning and HIV.
 4. Can provide successful EPI programme and provide feedback to government on quality improvement.
 5. In the context of right to information, can put a pressure on the government to be accountable and can sensitize the community by informing people of their right.
 6. Together with Ministry of Health and Community Services, monks also play crucial role in health promotion and development.



Group discussion 3 : Role of civil society in improving accountability of local government

Best practices

Bangladesh: Report card to assess people's perception of quality of service and satisfaction

Bhutan: Strong influence of monarchy on health in marginalized and poor

India: Mid-term review of the 11th five-year plan to assess beneficiaries' perception of civil sector progress including health.

Thailand: Thai Health Promotion Fund: use of 2% sin tax in supporting CS activities in health promotion

Recommendations:

1. Civil society could improve accountability of local government through:
 - Empowering/educating people on their rights, entitlements/programmes in health;
 - Involvement in formulation of policy and planning at district and national level;
 - Actively participating in policy development/setting national agenda;
 - Raising awareness on health impact, safety and inequity;
 - Building capacity of grassroots health functionaries;
 - Providing feedback reports, platforms;
 - Knowing right contacts/resources or responsible officers.
2. Monitoring at local district:
 - Is money in place, and has it been used?
 - Is there transparency?
 - Has quality of service been delivered?
 - Have quality goods been procured?
3. Mechanisms to enhance transparency and effectiveness:
 - television/media, public hearings
 - report cards, reviews/surveys
 - open communication (senior public officer/district officer)
 - National Health Assembly

3. Others:

- MoH and/or NGOs/network should build capacity of civil society, provide necessary tools, create enabling environment.
- Local government should support the work of civil society.

Group 4: Improving quality of health care services***Issues:***

- Good HMIS important to measure and improve the quality and coverage of services. Health information for whom? Ensure feedback and information flow to those collecting data in order to offer incentives and create purpose/motivation for them so they can see the point of data collection.
- Use of data to influence policy and for change at decentralized level.
- Create incentives for staff working in remote areas – retention of staff is important.
- Non-adherence to standards set by central level should be addressed through monitoring and supervision of lower levels.
- Need to strengthen capacity of local governments.
- Decentralization will reflect the values at central level. Improvement in quality care cannot be ensured at district level unless central level clearly shows commitment to quality at all levels.
- Quality of health care can be improved through the use of existing resources and skills at district/decentralized level, including private sector and partnerships with NGOs.
- Address/create demand-side mechanisms for involvement in health – creating an environment that enables communities and their representatives to participate in policy discussions, planning and monitoring of PHC. This will enhance influence of communities in the design of health care and in creating client satisfaction.
- Facilitate innovative ways of involving and motivating communities.
- Local health authorities and NGOs should be mutually accountable to the communities that they serve.

- Introduce the concept of minimum service standards to ensure that limited funds are not invested in sophisticated technology instead of basic technology and supplies responding to the needs of the community. The standards need to be socialized, the performance of staff needs to be assessed against standards, capacity building should be provided for health workers and support should be provided at each level for successful implementation of the standards.
- Implications of lack of quality of care at primary level include: bypassing the primary level, added burden on hospitals for treatment of minor affections, added costs to clients for transport.
- A good referral system is a prerequisite for quality of primary care.
- Use vertical programmes to enhance the efficiency of the health system and increase quality by addressing cross-cutting issues including human resources, lab functioning, communications, transport, supply management and so on.

Recommendations:

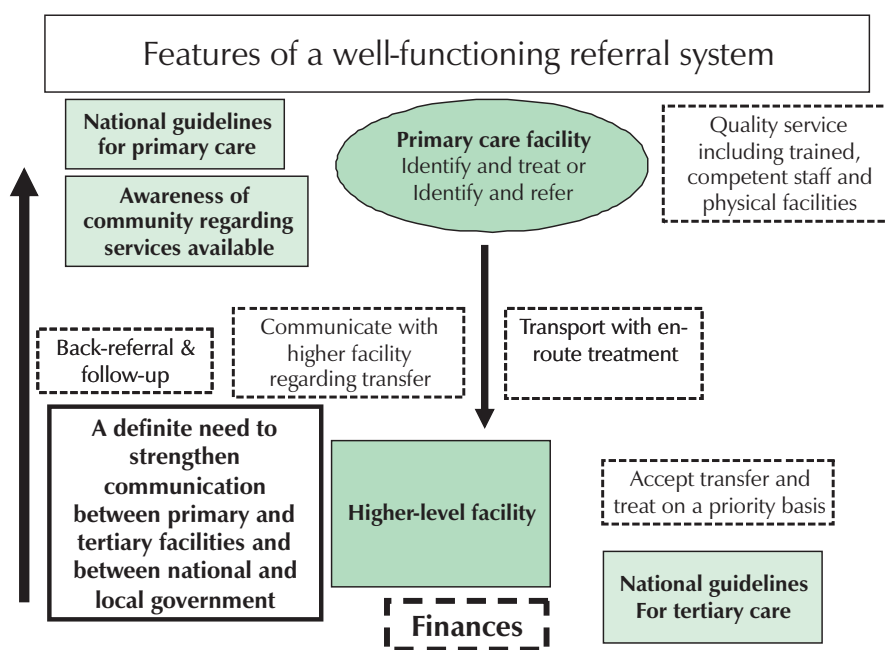
- Involve community in design and implementation of health programmes, institute community audits.
- Strengthen health worker accountability, institute performance based incentives/ disincentives.
- Establish standard operating procedures (SOP), plan a phased-in introduction.
- Provide legal framework for implementing and enforcing SOPs.
- Establish formal linkages between health centres and hospitals. Higher-level facilities must support peripheral centres. Strengthen “two-way” referral system.
- Re-examine whether existing skills-set of health care providers is appropriate to current burden of disease.
- Countries to do situational analysis and chart country-specific plan of action for quality improvement.
- Responsibilities of different levels of the health-care system should be clearly defined to ensure continuity of care.
- Establish accreditation systems for health-care facilities.

Group 5: Referral care system in decentralized health care

Restrictive regulations of decentralized settings as a barrier for referral care from other districts, role of national and subnational governments to ensure continuity of referral care.

To work towards reducing the need for patients to want to seek alternative centres:

- Central government to establish guidelines on the expected capacity of different levels of care, and local authorities should convey this information to the recipients and implement them.
- As clients are shifting out of the district seeking advanced treatment, some districts have developed complete primary, secondary and tertiary health-care facilities.
- The national and local governments need to work together to establish all components of referral care.



- Entry point nearest and convenient to people.
- Good quality primary care service with trained, competent staff and other essential facilities organized based on national guidelines.
- The recipient public made aware of the services available so that they can use them more readily.

- System to direct referrals to the best care for a particular disease.
- Fully organized transport service with treatment available *en route* with trained staff and equipment.
- Communicate the transfer to the recipient centre beforehand and with duly completed documents.
- The recipient centre to accept the transfer on a priority basis.
- Back-referral and follow-up to be organized with good feedback.

Barriers to effective referral:

- Geographical barriers
- Practice of “passing the buck” by some centres
- Economic barriers: community-based trust funds, community insurance to reduce out-of-pocket expenses for the patient
- The lack of agreement and interaction between all stakeholders who include the national government, the local government, the local staff, community, private sector, insurance companies.

Involvement of the private sector

What are the implications of including the private sector in the referral package?

- Lack of accountability, lack of quality service, possibility of commercial interest, etc.
- Needs careful consideration with establishment of guidelines and a system for strict monitoring and prompt action if needed.

Role of government

Government is overall responsible for establishing policy and in general terms ensuring that the referral service is established and is functional.

- The provision of guidelines for all levels of care (primary, secondary and tertiary), including those for referral.
- Establish an M&E system within the national organization for quality enhancement with an emphasis on being instructive rather than mere fault-finding.
- Supervise and promote the generation of adequate resources.

Group 6 : Private-public partnership

Rationale

- Private sector provides decentralized services to the community: diverse providers of different systems of medicine; both for-profit and not-for-profit.
- Private health sector in most countries growing rapidly.
- Is an integral part of health-care delivery; over two-thirds of the Region's population utilize private health care.

Issues:

- How to secure political and civil society commitment for public-private partnerships.
- How to systematize the process of developing public-private partnerships for effective health care at the different levels of administration in the context of decentralization.
- How to link these partnerships effectively with wider HSS efforts.
- How to involve the private pharmaceutical sector to the greater benefit of health programmes in general and vertical programmes in particular under decentralized systems.

Country experiences:

Thailand: Consensus by civil society, central and local governments on need for private sector involvement; private facilities included under universal care package; are allocated resources for service delivery; government provides support for strategic planning and bringing together civil society and NGOs together through health development committees; oversight through management committees; knowledge management through involving teaching institutes.

Nepal: Targets for an identified health priority could not be met despite free services from public sector, and uptake remained poor. This led to contracting private sector services; targets surpassed as a result.

Maldives: Private sector involvement still at a formative stage; government facilitating private sector involvement to improve access to services.

Bangladesh: Long tradition of excluding the private for-profit sector in health; involvement of private not-for-profit sector led by donors and championed by the MoH in early 1980s. Corporate sector responsibility/accountability called for in large employment sectors to increase access to services; declaration of high-level commitment for private health care.

Bhutan: Private sector limited to a few pharmaceutical outlets; private sector provision being considered.

Indonesia: Large private sector providing services, need for better regulation to ensure quality.

Sri Lanka: Private sector largely for outpatient services; legal authority for engaging with the private sector.

Lessons learned

Government commitment and strong stewardship for involving the private sector is key.

Governments need to balance their regulatory and facilitation roles.

There are good examples of involving private providers in many countries.

Successes driven by:

- Principle of true partnership, based on mutual trust, joint planning, implementation, monitoring, including communities.
- Agreement on clear roles and responsibilities, e.g., for capacity building, supply management, reporting of data, etc., based on comparative advantages.
- Sharing of resources from both sides based on identified gaps.
- Agreement on regulatory mechanisms, joint monitoring, joint accountability.
- Drawing on market forces to engage with corporate sector, e.g., price reduction for anti-retroviral drugs.

Challenges:

- Health not generally on the political agenda.

- Most MoH lack capacity to engage effectively with the private sector.
- Level of involvement therefore remains limited; most private health care runs parallel to public health care.
- Limited scale-up of existing partnership models (but can scale up given optimum inputs from both government and private sector).
- Difficulties in ensuring quality while expanding service delivery through private sector.

Recommendations:

For Ministries of Health at the central level:

- Acknowledge the role of the private sector.
- Provide strong leadership and policy guidance for engagement.
- Introduce necessary regulation, monitor quality of services and ensure accountability for outcomes.
- Ensure effective public-private health service management, initiate early dialogue for joint policy, guideline development, planning and implementation.
- Build capacity of public health sector to effectively engage with the private sector.
- Adopt effective drug policies and strengthen national drug regulatory authorities; design incentives and disincentives to ensure good pharmaceutical practices.
- Document data and disseminate evidence for greater commitment from both policy-makers and private sector partners.

For local governments:

- Map and analyze different providers in the region/province/district.
- Convene forums for dialogue, consensus with interested partners; establish interfaces for engaging with multiple providers and ensure capacity for implementation (including mechanisms for accreditation).

- Undertake joint planning and sharing of resources, and clearly define responsibilities for joint implementation, monitoring and reporting on outcomes.
- Empower the community to understand best practices in health-care provision.

For WHO South-East Asia Regional Office and multilateral partners:

- Strategically engage with MoH in developing broad guidance on engaging with the private sector.
- Consider a resolution on greater engagement with the private sector to address health priorities.
- Coordinate with MoH to engage with other ministries e.g. Finance, Home, External Affairs, Education, Labour, etc.
- Disseminate best practice examples and build national capacities for effectively implementing health-care delivery through both public and private sectors.
- Facilitate discussions with the corporate/pharmaceutical sector for technology transfer and self-regulation of trade/retail practices to promote rational use, equitable pricing of essential drugs.

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Conclusions

Decentralization of health-care services has the potential to improve efficiency of health services and equity of outcomes.

1. Countries in South-East Asia are at different levels of decentralization.
2. Several factors affect the process of decentralization. These include:
 - Health decentralization as a stand-alone policy
 - Weak local management
 - Referral care
 - Vertical programmes
 - Fragmented health information systems
 - Civil society participation
3. Managerial capacity and clear understanding of the decentralization concept at all administrative levels is a prerequisite for effective decentralization.
4. Amount and quality of health information is often compromised in decentralized health systems. In almost all countries information from private sector is not available in HMIS.
5. Private sector involvement in delivery of public health services is low. Decentralization is an opportunity for increased involvement and regulation of the private sector.



Plenary session



Plenary session

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Recommendations

For Member States

- (4) Develop needs-based policies for decentralization.
- (5) Provide legal framework for decentralization, ensure adequate resources, both human and financial.
- (6) Involve communities and civil society in planning, budgeting, implementation and monitoring.
- (7) Develop a framework to involve and regulate the private sector in decentralization services.
- (8) Local government should allocate resources for health-care services decentralization.
- (9) Strengthen HIS at national and subnational levels to collect, analyze and use data for programme improvement.
- (10) Improve primary care services and strengthen referral systems to ensure continuity of care to reach MDGs and high quality of services, distributed in an equitable manner.
- (11) Develop and strengthen the human resource development and deployment policy, taking into consideration measures for retention of skilled staff, career development and performance-based incentives.

For WHO

- (1) Facilitate exchange of information between countries through horizontal collaboration and multicountry activities.

- (2) Collaborate with countries in operational research for improving effectiveness of decentralization.
- (3) Assist countries in evaluation of their experiences with decentralization and disseminate successful examples.
- (4) Disseminate global experience on decentralization of health-care services

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Closing

Dr Amnuay Gajeena, a representative of the participants, thanked the Government of Indonesia for hosting the meeting and the local organizer for warm hospitality and support. He felt that the meeting was useful. It helped him to review what his country is doing regarding decentralization of health care and get ideas on what else should be done. He thanked WHO for giving opportunity for countries to share information and experiences and requested WHO to organize a Regional meeting again in the near future.

In the closing, Dr Samlee Plianbanchang, the Regional Director, said that decentralization of health-care service is a process of transferring of health-care services from the central to the peripheral level. It aims to improve the efficiency of health-care delivery in order to enhance accessibility and equity as well as the achievements of time bound targets or goals. In the meeting, we learned that countries in the South-East Asia Region define and implement the decentralization of health care in various forms. Some are in the early stage. Further evidence, and evaluation are needed. The success of implementation depends on many factors. The capacity of the local government is a prerequisite. Educational institutions, central government and NGOs are also key players in decentralization.

Dr Samlee encouraged the countries to organize a similar meeting at the country level with various stakeholders and find ways to implement the recommendations. He said that when there is more evidence, WHO could provide a platform for information and experience sharing especially on the outcomes of decentralization of health care.

Dr Samlee thanked Dr Budihardja Singgih, the chair person, Dr Gado Tshering the co-chair, and Dr Kalilullah, the rapporteur, for their contribution. He thanked the participants for their interest in the subject and their active participation and appreciated the work of the Secretariat team.

Then Dr Budihardja Singgih announced the closing of the meeting.

Decentralization of health care services in the South-East Asia Region: perspectives and challenges

1. Introduction

There are various notions on decentralization depending on its context. For the sake of simplicity we define decentralization as the transfer of power - either in administrative, fiscal or political authority- from the central to the local government of a country or from higher to lower level of an entity. The aims are more convergence i.e. improvement of effectiveness and efficiency of decentralized subjects. Thus the aims of decentralization of health care services in general are to improve efficiency of its delivery and equity of its outcomes. Evidences abound on mixed outcomes of decentralization in health systems. However, there is yet no confirming evidence of the influence of decentralization on increasing equity and efficiency in health systems.

Decentralization is one important tool in improving governance. Yet not all government functions can be decentralized. Authorities related to legislation, national defense, foreign and monetary policy are some functions that should remain with central government.

Management of Decentralization of Health Care was the topic chosen for the 39th Consultative Committee for Programme Development and Management (CCPDM) in 2002. In 2009, decentralization in health was a topic discussed in Regional Meeting on Health Care Reform for the 21st Century.

This Regional Seminar on Decentralization of Health Care Services in the South-East Asia Region intends to discuss experiences among member countries of WHO South-East Asia Region having varying degree of decentralization in health. This is an important forum within the context of revitalization of PHC that all member countries have agreed to implement and our continual pursuance of Health for All and health related Millennium Development

Goals whereby improvement of health equity is one of the overarching goals. Without proper planning and acknowledgement of the lessons learned by other countries, decentralization of health care services can be disappointing at best and detrimental at worst.

A Strategic Framework depicting some common issues faced in implementing decentralization in health along with challenges that need to be addressed is used in outlining this working paper. These challenges have to be dealt with within the context of PHC reform envisioned in the World Health Report 2008: “Primary Health Care Now More than Ever”.

2. Scope and objectives of decentralization in health care services

Decentralization is one of the commonest government policy measures found in the past 20 years, most of it done in line with democratization. Much of it has been motivated by political concerns. It holds different meaning for different people in terms of what it is and what it is for. Decentralization should be seen only as a means to an end, not as an end in itself.

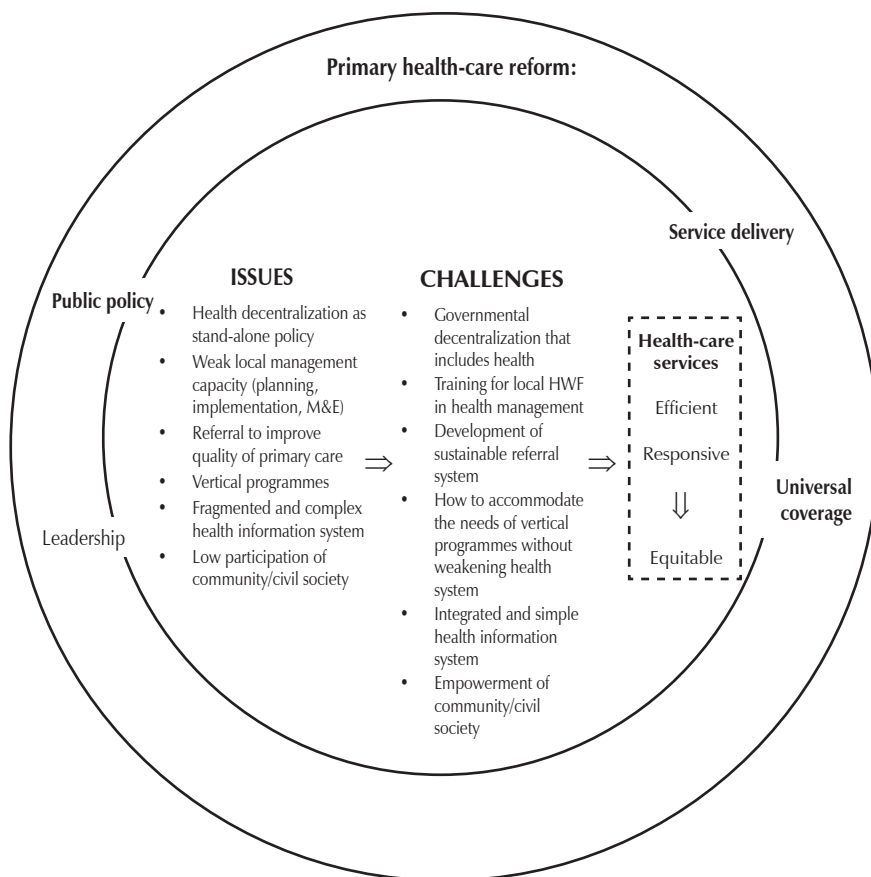
Decentralization definition usually explained a shift of power through different level of a government system. The most common definition used by researchers is from Rondinelli (1981): **Decentralization**—is a process in which the authority, resources and functions are transferred from the central government agencies to other institutions at the periphery of the national system with decision making largely vested with the people. It encompasses de concentration; delegation; devolution; transfer to non-government organizations or privatization¹.

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

De concentration is the weakest form of decentralization and is used most frequently in unitary states-- redistributes decision making authority and financial and management responsibilities among different levels of the national government

Delegation is a more extensive form of decentralization. Through delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous organizations not wholly controlled by the central government, but ultimately accountable to it

Devolution usually transfers responsibilities for services to local governments that elect their own elected functionaries and councils, raise their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform public functions ⁽²⁾.



Decentralization of health care services definition:

The transfer of responsibility for the planning, financing and management of health care services from the central governments or regional governments and its agencies to local governments, semi autonomous public authorities or corporations.

Privatization. Another type of decentralization, privatization and deregulation shift responsibility for functions from the public to the private sector. They allow functions that had been primarily or exclusively the responsibility of government to be carried out by business, community groups, cooperatives, private voluntary associations and other non-government organization ⁽³⁾.

2.1 *The scope of decentralization*

There are three types of decentralization namely:

- **Administrative decentralization:** the transfer of responsibility for the planning, financing and management of public functions from the central government or regional governments and its agencies to local governments, semi-autonomous public authorities or corporations.
- **Fiscal decentralization:** the transfer of authority for self-financing or cost recovery through user charges, co-financing and intergovernmental transfers that shift general revenues from taxes collected by the central government to local governments for general or specific uses.
- **Political decentralization:** gives more power in public decision-making to citizens or their elected representatives ⁽¹⁾

Each type of decentralization is not mutually exclusive; in general there is some overlap among those three types.

2.2 *Objectives or potential benefits of decentralization of health care services:*

There are a multitude of potential benefits of decentralization of health care in the literatures. Some of the most cited are:

- A more rational and unified health services that caters to local needs
- Decrease in duplication of services as the target populations are more specifically defined
- Increased innovation of service delivery through experimentation and adaptation to local condition
- Increased accountability, transparency and quality of health services through user oversight and participative decision making
- Reduction of inequity between rural and urban areas
- Greater integration of activities of different public and private agencies
- Improved intersectoral coordination

It must be noted that little concrete evidence exists to date to confirm that these potential benefits can be realized in developing countries. This is due to the fact that it has rarely been evaluated. Thus, the debate whether decentralization does improve equity, efficiency, accountability and quality of care continues without data to inform it.

In some European countries⁽²⁾ among positive reported outcomes of decentralization are the capacities to innovate, improved efficiency, a more patient oriented system and enhanced cost consciousness. Inequity, particularly among the rich and the poor districts, was reported as being the most frequent negative consequences

Other negative experiences of decentralization:

- **Creates new responsibilities for inexperienced actors:** the chance of fail if specific steps are not taken to build local technical and managerial capacity.
- **Can disperse scale economies/expertise groups:** The need for specialized personnel is related in part to the size of the territory covered by the entity. Below a certain size, it might be counterproductive or cost inefficient to have specialists or technical personnel.
- **Introduces more levels into the state:** Decentralization, especially political decentralization creates a class of government workers which may have different preferences than workers at the next higher level. This divergence in views and convictions can create conflict within the civil service that will require mechanisms to manage effectively.
- **Creates a tension between local autonomy and national standards:** Decentralization relaxes national control and creates the potential for more regional variation in civil service conditions. Can also lead to personnel expenditures beyond some local capacities;
- **Can increase administrative costs:** Creating additional layers of government is an expensive proposition, and while the central government - in the best of cases- might reduce its role and shed personnel in the context of decentralization, empirical evidence suggests that these workers are often reabsorbed by local governments. There is thus no net change in public sector employment. In the worst of cases, central government employment remains unchanged, while local government employment grows ⁽³⁾.

There is no set model, no perfect or permanent solution that all countries should seek to adopt in implementing decentralization. There are multiple models that developed to fit the particular context and circumstances of an individual country. Decentralization is a dynamic organizational attribute; it reflects a permanent process of readjusting the mix, the balance between decentralizing and recentralizing forces in every health system. It is also important to understand history of a specific country health system.

For policy-making strategies the complexity that surrounds the decentralization and recentralization debate can be confusing and misleading. Centralization and decentralization are not “either-or” conditions. An appropriate balance of decentralization and centralization is essential to the effective and efficient functioning of government. Not all functions can or should be financed and managed in a decentralized fashion. Even when national government decentralizes responsibilities, they often retain important policy and supervisory role. They must create or maintain the enabling conditions that allow local governments to take on more responsibilities. The success of decentralization frequently depends heavily on training for both national and local officials in decentralized administration. The most important policy lesson is that decentralization is a learning process rather than a fixed managerial framework.

Past experience shows that achieving the benefits of decentralization depends heavily on policy design i.e. in deciding which functions and programs to decentralize and which to centralize. If a function is critical to the attainment of central-level goals and its sustainability at the local level cannot be guaranteed, it should not be decentralized. The following table is an example of a general framework for assigning responsibilities to central and local levels.

Table 1: Assigning responsibilities to central and local levels

Function	Assignment/Rationale	
	Central	Local/Sub national
Program Design	Information dissemination and parameters for priority national programs e.g., Family planning or vaccination programs	Details of service delivery mechanisms.
Financing	Transferring resources to ensure local government's ability to carry out responsibilities, setting minimum requirements for expenditure on maintenance and training in order to assure consistent quality and sustainability.	Setting user charges/ cost-recovery mechanisms, planning expenditure allocations within parameters set by national standards.
Standard-Setting	Central government should carry out functions such as licensing health professionals, registration and quality -control of drugs.	
Legal Responsibility	The legal and/or regulatory implications of decentralization for the work of health personnel must be considered to avoid placing health staff at risk.	

Adapted from World Bank ⁽³⁾

3. Issues and challenges in decentralization of health care services

There are various issues and challenges encountered in implementing decentralization. Some important ones are:

- Health decentralization as stand alone policy
- Weak local management (planning, implementation, M&E) capacity
- Referral to improve quality of primary care
- Vertical programmes sustainability
- Non-compliance in reporting
- Low participation of community/civil society

3.1 Health decentralization as stand alone policy

The outcome of decentralization in health sector alone will not as good as where health as a part of whole government policy decentralization. However that was what some countries experienced.

Examples

- **Uganda:** Health care decentralization followed by other sectors Uganda begins decentralizing health care services in the 1980s following the Alma Ata declaration. Supported by international agencies the ministry of health design vertical programmes to be executed at the sub national levels, resulted in fragmentation of vertical programmes.

In 1995 the government declared a new constitution that decentralize power to sub national (Local self government act) which was detailed further in 1997. A new feature was the right for collecting tax. Despite this no significant improvement in health service access.

Impact of decentralization in the health system: Fragmented information more input based information, no budget support from the national level, less budget for public health programmes increased the dependency to donor support ⁽⁴⁾

- **Vietnam:** PHC local mobilization followed by economic and public administration reform.

Vietnam delivered primary health care successfully in the 1980s due to a strong local mobilization. “Doi Moi”, the economic reform began in 1986. In 1990s the government health outlays at province and commune level was already significant. The local officers had experience with decentralization when the state budget law implemented in 1996, assign additional health tasks to province and districts. The law established financial links delegated national authority to lower levels and budget preparation and implementation are the responsibility of the people’s council.

The access and output indicators showed positive results. Between mid-1990 and 2002, there were significant increase in immunization and birth attended by health personnel ⁽⁵⁾.

3.2 Weak local management capacity

The trend toward decentralization has provoked a lively debate about the capacity of local governments and communities to plan, finance and

manage their new responsibilities. Assessing, improving, and accommodating varying degrees of local capacity has become more and more important as decentralization policies transfer larger responsibilities as well as budgets from national governments to local governments and communities.

While one of the common rationales for decentralization proposes that local governments' proximity to their constituents will force them to be better than central governments at managing resources and matching their constituents' preferences, it is not at all clear that local governments and communities have the capacity to translate this information advantage into an efficiency advantage. Inexperienced, small local governments may not have the technical capacity to implement and maintain projects and they may not have the training to effectively manage larger budgets.

Central governments have used "lack of capacity" excuse for refusing to transfer their authority, financial resources, and the accompanying privileges to local units. However the evidence increasingly shows that local capacity can be built by the process of decentralization that permits learning by doing and to build up capacity through practice.

Good management capacity is indispensable in implementing administrative, fiscal or political decentralization. Weak capacity may be due to shortage of health workforce, inappropriate mix and low quality of health workforce. It may also be caused by insufficient funds transferred by the central government or in mobilizing resources through user charge, increased local taxes etc.

Examples:

- **Laos:** Decentralization with lack of experienced staff and insufficient training

The central government decentralized all sectors to the provincial level in 1987. There were fragmented management between national and local level due to lack of experienced staff and insufficient training required for practicing decentralization of health care services at district level. The outcome was increased inequity among provinces.

Similar problems were encountered in other sectors, such as agriculture, education, and communication which prompted the central government to retake control from the provinces in 1992⁽⁶⁾.

- **India:** Improving fiscal capacity of state government

Recent empirical evidence suggests that decentralization has improved local responsiveness, targeting and service delivery in some cases.

To improve fiscal capacity of the state government and to reduce the need for transfer of funds from the central government, some kinds of tax authority need to be transferred to the state government. By so doing the outcomes of the national goal of improving rural health may be achieved while simultaneously putting the onus on them to carry out their constitutional responsibilities for health care ⁽⁷⁾.

- **Nepal:** Weak planning and implementation in a political conflict situation

A decentralization study in Nepal in 2009 identified the challenges to the implementation of decentralization in the public health sector as: i) centralized and weak management and programming practices of the government. Inappropriate organizational structure, MOHP exercise national and local authorities and no space for dialogue for district plan ii) Lack of clear policy objectives and guidelines iii) poor financial and human resource management system, IV) Lack of participation, preparation and preparedness for implementation v) Political instability ⁽⁸⁾.

3.3 Referral system to improve quality of primary care

Since appropriate secondary or tertiary level of care may not be available within the decentralized local government, proper arrangement with other local governments or central government must be made. Development of a sustainable referral system may pose a big challenge since it has to consider various factors such as finance (including cost containment), responsiveness and right to choose (health facility) of patients to mention but a few.

Example: Development of sustainable referral system

- **Brazil Challenge:** Decentralizing primary care to improve referral care

Improving the quality of primary care can overcome the problem of bypassing the primary care level within the same catchments area as well as to other catchments area.

A study of the effectiveness of a community-based primary care approach on child health can be enhanced by administrative

decentralization. Post neonatal mortality is lower in more decentralized municipalities and higher family health coverage ⁽⁹⁾.

3.4 Vertical/semi-vertical programme sustainability

In general vertical/semi vertical programme is the initiative of the central government. Once decentralization takes place this initiative may not be compatible anymore with local government priorities. Many of those programmes are part of national commitments made by the central government towards a global targets e.g. polio eradication, leprosy elimination, control of TB, HIV/AIDS and Malaria. Challenges are continual advocacy by the central government and health system strengthening based on PHC

Example

- **Cambodia:** TB programme in decentralized setting as part of a Health Care Reform (moving from hospital to community based)

The recognition of Cambodia's heavy burden of tuberculosis (TB) and the lapse of TB control strategies during the transition to democracy prompted the national tuberculosis programme's relaunch in the mid-1990s as WHO-backed health sector reforms were introduced with TB treatment focused in hospitalization.

Lesson learned for sustainability of TB programme in decentralized setting: medium-term financial stability; exposure to successful DOTS in other country, community-based delivery and ensure the ongoing engagement of managers of the national TB programme in the broader reform process ⁽¹⁰⁾.

Stop TB in SEA Region: decentralization have altered the functioning of national TB programme that relies on well-functioning health systems. In 2006 a programme reforms revised the approach in terms of human resources management, logistics & procurement, and information management. National multi years plan for TB were developed in member countries along with identification of health system gaps to be rectified.

There was significant increased in coverage (from about 80 percent in 2003-2004 to more than 90 percent of population coverage in 2007) and sustainability after this strategy was implemented. All 11 Member states have sustained country wide access to DOTS. Services have been restored in all districts in Timor-Leste and all over Sri Lanka after the civil strife in 2209; case detection rate was 73% and treatment success rate was 89% in 2009⁽¹¹⁾.

3.5 *Health Information System: Non-compliance in reporting by the local government*

Accountability is a prerequisite for improved public sector performance, and information is the key to accountability. Good health information system is important for decentralization programs because information can be used to verify compliance with policy goals, to analyze alternative outcomes, and to guide future decisions. Information on financial flows (i.e., budgeting and expenditure reporting) as well as on other inputs, outputs and, where possible, outcomes is also needed. Such information is essential both at the local level -- to inform local constituents and to encourage public participation in the political/decision making process -- and at the central level -- to monitor and supervise local activities funded (at least partially) by central sources.

Even before decentralization era many of the local governments do not comply with requirement for reporting to higher level. Reasons cited are too complicated reporting system, too many variables and no analytical feedback.

In view of intensification of privatization or public-private mix, reports from private health facilities are very important in policy development, monitoring and evaluation of this undertaking as well as for health care services in general. Reports are not only needed in the field of morbidity and mortality of diseases/ill health and programmes activities but also in the areas of health workforce logistics and finance. Challenges include development of a simple and integrated recording-reporting system that covers the totality of health care services, public and private and a sustainable feed back used for monitoring of programmes delivery as well as planning and evaluation at all levels.

Examples

- **The Philippines and Indonesia** : Loss of data after decentralization

Decentralization in the Philippines and Indonesia has fragmented the health information system and undermined coordination.

In the Philippines in spite of department of health representatives deployed to provinces, cities, and municipalities to help monitor disease outbreaks and coordinate vertical programs, the flow of information was remain slow.

In Indonesia the central ministry relies on local governments to report information voluntarily. Only 36 percent of health centers reported infectious disease surveillance data in 2002, thus the central health

ministry less able to monitor the quality of laboratory services, hospitals and other devolved services. ⁽⁵⁾.

3.6 Low community/civil society participation

Participation and decentralization have a symbiotic relationship. Sub-national governments' proximity to their constituents will only enable them to respond better to local needs and efficiently match public spending to private needs if some sort of information flow between citizens and the local governments exist. On the other hand, the process of decentralization can itself enhance the opportunities for participation by placing more power and resources at a closer, more familiar, more easily influenced level of government. In environments with poor traditions of citizen participation, decentralization can be an important first step in citizen-state interaction. To sustain this interaction empowerment of the community/civil society is mandatory.

Unfortunately empowerment of the community is most frequently neglected or at most taken care of in an unsustainable fashion. Challenges include the use of innovative approach, link to income generation and political decentralization.

Examples

- **Thailand:** An operational research in community empowerment

The operational research was on overcoming fluorosis in Thailand, Lampang province. Mottled enamel or dental fluorosis is an abnormality due to excessive fluoride intake mainly from drinking water.

The health authorities facilitate the community to make a decision to deal with fluorosis. By informing the community, encourage decision making, implementation and monitoring by themselves plus support from the local government the community manage to change their drinking water source to a safer, containing less fluor ⁽¹²⁾.

- **India experience:** Low community participation from low social class

A study conducted in Kerala to evaluate decentralization impact on of inequity in the state of health. The study compared pre and post-decentralization situation using information from the two rounds of National Family Health Surveys between the period 1992-93 and 1998-99. The dimensions considered for examining inequities includes infrastructure, utilization and outcomes.

The preliminary results indicate declining inequity in health outcomes along with a greater public-private divide in utilization of health care. The widest of disparities continues to be between the social groups and categories of living standards. Thus, the low social class remains inaccessible to health care services ⁽¹³⁾.

Another issue in decentralization that is worth looking into is the speed of the decentralization process, i.e. rapid or gradual.

Example

- **Indonesia and The Philippines:** “Big bang”, rapid implementation.

Indonesia completed a health personnel and health facilities transfer in 2001, less than two years after enacting Laws 22 and 25. This rapid decentralization process do not provide enough detail on functional and operational responsibilities, resulting in confusion and divergence between provinces and districts, some indicators worsened: immunization rates fell.

The Philippines completed the transfer of 45,896 health personnel, along with hospitals, clinics, and other facilities, in 1993, two years after passing the Local Government Code. The administrative preparation was inadequate, local officials unaware of their new responsibilities and the Ministry of health was slow to transform itself ⁽⁵⁾.

- **Vietnam:** Gradual implementation of health care decentralization

In Vietnam, output and access of health care were positive between the mid-1990s and 2002 ⁽⁵⁾

- **Bhutan:** Gradual implementation of health care decentralization

Bhutan process of decentralization was very gradual since late 1980s with many small changes.

It will be important to monitor this process carefully and to ensure that adequate donor funding is available to assist with implementation. Without such funding, the whole process of decentralization may falter.

There are recommendations in the literature for countries' specific strategies for adjustment to decentralization² that can be used as a reference.

4. Decentralization and Primary Health Care Reforms

There are four areas of PHC reform envisioned in the World Health Report 2008:

- reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection– *universal coverage reforms*;
- reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes – *service delivery reforms*;
- reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors – *public policy reforms*;
- reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other by the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems – *leadership reforms*.

What contribution can decentralization on health care services make on the four areas of PHC reforms?

Table 2 below provides the link between potential benefits brought about by decentralization and the four areas of PHC reforms.

2 Adjusting to Decentralization: General Guidelines for Country-Specific Strategies

- The legal framework should clearly define responsibilities and standards.
- Consistency and transparency gain support.
- Reporting mechanisms need to be clear and precise.
- Channels for citizen-civil servant communication need to be created.
- Training should contribute to the formation of new working relationships.
- All levels of government should be encouraged to define and plan for the types of workers they will need in order to carry out new responsibilities ⁽¹⁴⁾.

Table 2: Correlation between potential benefits of decentralization and PHC reforms

Potential Benefit	Areas of PHC Reforms			
	Universal coverage	Service delivery	Public policy	Leadership
Caters to local needs		+		
Decreased duplication of services	+			
Increased innovations	+	+		
Increased accountability				+
Reduced inequity	+			
Greater integration	+			
Improved intersectoral coordination			+	

Examples of potential benefit to the four reforms:

- catering to local needs is linked to more responsive or people centered care
- decreasing duplication will improve efficiency and ability to reach the unreached.
- increasing innovations will increase the service delivery coverage as well as responsiveness of health care.
- increasing accountability will improve leadership.
- reducing inequity and greater integration will further improved universal coverage.
- improved intersectoral coordination will facilitate development of healthy public policy.

In theory decentralization if well formulated and implemented will be beneficial to the four objectives of PHC reforms.

Example

- **Indonesia:** District health system performance after decentralization, the challenge of people centered care and regulation

A study comparing demographic and health survey results 2002-2003 and 2007 in 10 Indonesian districts showed that there has been little improvement in the district health performance since decentralization occurred in 2001. Private providers where most of their salary was paid by the government were preferred due to perceived better quality of care. These private providers work as civil servant in the morning and have private practice in the evening resulting in further inefficiency of health care services. This happened in spite of significant increases in public funding for health due to the unregulated private system ⁽¹⁵⁾.

5. Conclusion

Decentralization as elaborated in this concept paper is a dynamic political process, a learning process, a mix with centralization and is a means to reach a goal. It is very much context specific be it political, geographical, social and economical. Therefore comparing decentralization outcomes among countries or even within country is not a straight forward exercise.

Change of roles at both central and local government- level depending on what functions are decentralized in administrative, fiscal and political area - is mandatory. In general the functions of stewardship – legislate, standard setting, supervision, monitoring and evaluation – should remain with the central government.

With more countries in the SEA region experiencing decentralization of health care services, there is a need to do more research particularly operational research as a learning by doing ways to explore the potentials of decentralization from the supply side as well as from the demand side of the health care services.

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Opening remarks by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia

Dr Budihardja Singgih, Director General, Community Health, Ministry of Health, Jakarta, distinguished participants, honourable guests, ladies and gentlemen:

I warmly welcome you all to the Regional Seminar on Decentralization of Health Care Services in the South-East Asia Region: Perspectives and Challenges.

My grateful thanks are extended to the Government of the Republic of Indonesia for agreeing to host the meeting in this beautiful city of Bandung.

It is indeed timely to review and discuss the issues relating to this important subject. It is timely because all countries worldwide are now attempting to achieve several time-bound health targets. Most important among these are the targets for the achievement of the health-related MDGs.

Decentralization of health-care services becomes an essential element of Health Systems Strengthening (HSS). This is to ensure improved effectiveness of public health interventions that can lead to the achievement of those goals. The aims of decentralization of health-care services are to improve the “efficiency” of their delivery and the “equity” of their outcomes.

Decentralization helps ensure availability and accessibility of the services to all people in need. Globally, such decentralization has been launched in various forms. However, its achievement and success vary from country to country. Unfortunately, in developing countries, decentralization of health-care services is rarely evaluated.

Distinguished participants, during the past many years, decentralization has been one of the common government policy measures. Much decentralization has been motivated by political concerns. Decentralization is an important tool

to improve the functioning of governance. It is a dynamic political process, a learning process, a mix with centralization. Decentralization should not go in isolation as a separate entity. It is an integral part of a country's governance system.

Decentralization is very much context-specific. The contexts are:

- political;
- geographic;
- social and economic.

Though countries can effectively learn from the experiences of each other on decentralization, comparing decentralization “outcomes” between countries is not easy. This Regional Seminar is a continuation of:

- the Regional Meeting on Revitalizing PHC in 2008; and
- the Regional Meeting on Health Care Reform in 2009.

The primary intention of the seminar is to look at decentralization of health-care services within the context of health systems based on primary health care (PHC) and within the context of health-care reform. Certain important components of decentralized health care systems may be particularly examined in this connection. These include:

- referral systems to ensure effective back-up to health-care services in the community;
- the essential role of local governments in the management of health-care services;
- the indispensable role of the community health workforce at the grassroots level;
- policy direction, supervision and oversight from the centre;
- health policy reform; and
- human resources reform.

Decentralization in health needs to be made a part of the total government decentralization system. The capacity of local government is the prerequisite for successful decentralization. This capacity can be built through the processes that permit learning by doing on the ground. This capacity building requires institutional support from both local and central levels. Universities have an important role to play in building the management and planning capacities of the local governments. Also, it may be kept in mind that successful decentralization

depends on the strength at the centre. Decentralization will not successfully take place if the centre is weak. Various disease-specific programmes, even though initiated from the centre, should be implemented through decentralized health-care systems in an integrated fashion.

The role of stakeholders other than the local governments must also be clearly defined for their effective involvement. These stakeholders include:

- the private sector;
- NGOs;
- civil society and communities; and
- others.

This seminar is to provide an opportunity for sharing experiences among countries as to:

- what works;
- what does not work; and
- how to make such decentralization happen more efficiently and effectively.

This is just to re-emphasize that while sharing our experiences, it needs to be kept in mind that policy on decentralization is very context-specific – political, social and economic. Decentralization is a means to an end. It is an important process of national health services management. The process that has to be implemented within multidisciplinary and multisectoral environments. With the accumulated experiences of our countries, we should be optimistic that future endeavours in this area in the South-East Asia Region will be more promising. There has been considerable debate on the various issues involved. However, decentralization is an essential measure towards the achievement of equity and social justice in health. With our richness in the past experiences and lessons, the challenges in front of us should be squarely faced in forging forward.

We need to be very pragmatic in our approach in dealing with decentralization issues. And we have to use a systems approach in an integrated manner in tackling the issues involved. When it comes to action, we need to be adequately realistic and practical.

To be successful in providing health-care services to all people, especially in the countries with resource constraints, decentralization is a must. WHO will continue providing a platform for information exchange in this important area.

WHO will continue supporting countries that pursue decentralization within the context of health systems based on PHC and health-care reform.

I hope that the distinguished participants will find this seminar useful and worthwhile. When we go back home, we should have more ideas to pursue decentralization of health care services in our countries.

With these words, ladies and gentlemen, I wish the seminar all success.

Thank you.

Programme

Day 1: Tuesday, 6 July 2010

09.00-9.45	Inaugural Session <ul style="list-style-type: none"> • Welcome remarks by Dr Budihardja, Director-General of Community Health, Ministry of Health, Republic of Indonesia • Opening address by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia • Introduction of Participants by Dr Nani Nair • Nomination of Chair, Co-chair and Rapporteur • Announcements by Dr Ilsa Nelwan • Group photograph
10.15-10.45	Decentralization of Health Care Services in the South-East Asia Region – Perspectives and Challenges <i>Dr Poonam K. Singh, Deputy Regional Director, WHO-SEARO</i>
10.45-11.30	Health Care Services – decentralization in Java : Implications for Asia <i>Professor Peter Heywood, Australia</i>
11.30-12.30	Theme 1 : Role of MoH vis-à-vis local government in health care services Moderator :Dr Gado Tshering, Bhutan <i>Country experience:</i> <ul style="list-style-type: none"> • Functions decentralized to local government <i>Speaker: Professor P.K. Michael Tharakan, India</i> • Safeguarding decentralization in implementing minimum service standards for health <i>Speaker: Dr Budihardja, Indonesia</i> • Privatization as a means of decentralization <i>Speaker: H.E. Mr Ahmed Mujthaba, Maldives</i>

13.30-15.00	<p>Theme 2: Improving management capacity of local government through strengthening of District Health System (DHS)</p> <p>Moderator Dr A.E. Gnanajothy, Sri Lanka</p> <p><i>Country experience:</i></p> <ul style="list-style-type: none"> • Training in health management <i>Speaker: Dr Asjikin Iman Dahlan, Indonesia</i> • Strengthening of health information system <i>Speaker: Professor Ramji Dhakal, Nepal</i> • Partnership with civil society <i>Speaker: Mr Prayuth Sangsurin, Thailand</i>
15.00-15.30	Briefing for group discussion and other announcements
16.00-17.30	<p>Parallel group discussions</p> <ol style="list-style-type: none"> 1. Decentralization and centralization of government functions 2. Capacity building of health system with emphasis on DHS 3. Role of civil society in improving accountability of local government
Day 2 : Wednesday, 7 July 2010	
08.30-9.00	<p>Reflections of day 1</p> <p><i>Dr N. Kumara Rai</i></p>
9.00-11.00	<p>Theme 3: Improving quality of health care services –</p> <p><i>Referral system to improve quality of primary care</i> <i>Dr Athula Kahandaliyanage, WHO-SEARO</i></p> <p>Moderator: Dr Supachai Kunaratanapruk, Thailand</p> <p><i>Country experience:</i></p> <ul style="list-style-type: none"> • Improving referral care <i>Speaker: Dr Palitha Gunaratna Mahipala, Sri Lanka</i> • Community-based health care <i>Speaker: Dr Somchit Hanucharunkul, Thailand</i> • Improving programme management effectiveness <i>Speaker: Dr Swe Win, Myanmar</i>

11.30-12.30	<p>Theme 4: Vertical/semi-vertical health programmes in a decentralized setting</p> <p>Moderator: Dr AKM Abdus Samad Mia, Bangladesh</p> <p><i>Country experience:</i></p> <ul style="list-style-type: none"> • Effective vertical health programme in decentralized setting <i>Speaker: Dr Gado Tshering, Bhutan</i> • Managing tuberculosis programme through public-private partnership <i>Speaker: Dr Faruque Ahmed, Bangladesh</i>
13.30-15.30	<p>Parallel group discussions</p> <p>4. Improving quality of health care services</p> <p>5. Referral care system in decentralized health care</p> <p>6. Public-private partnership</p>
16.00-17.00	Preparation of presentations by all the groups
Day 3 : Thursday, 8 July 2010	
8.30-09.00	<p>Reflections of Day 2</p> <p><i>Dr Prakin Suchaxaya</i></p>
09.00-10.00	Group presentations and discussions (Groups 1, 2 and 3)
10.30-11.00	Group presentation and discussions (Groups 4, 5 and 6)
11.00 -13.00	Meeting of Drafting Group (Rapporteurs and WHO Secretariat)
14.00-15.30	<ul style="list-style-type: none"> • Presentation of draft recommendations by the Rapporteur • Discussion • Closure

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Annex

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