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DECENTRALIZATION AND HEALTH SYSTEMS CHANGE: A Framework for Analysis

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INTRODUCTION

The relationship between decentralization and change in the health sector is complex.

- Decentralization is a term which is used to refer to a wide range of organisational structures and processes, each of which may affect health systems differently.

- Health systems performance is an equally complex concept, which has many different aspects, each of which can be influenced by decentralization in different ways.

- The relationship between specific forms of decentralization and aspects of health systems performance may be indirect or obscure, and be complicated by the fact that decentralization is only one of many sets of factors affecting the functioning of health systems.

The proposed framework for analysis can be used to systematically review the development and implementation of decentralization policies in one or more countries, and to examine concurrent changes in the health system that may, at least in part, be ascribed to decentralization. The framework considers the background to decentralization and the process of policy formulation; strategies and means of policy implementation; the form that decentralization takes; changes in organisational processes and systems in the health sector under decentralization; and trends in the distribution, quality and efficiency of health services as decentralization proceeds.

To accommodate the many different variants of decentralization, the framework must be sufficiently flexible. At the same time, a certain amount of rigour is needed in the application of the framework, if it is to facilitate the search for common patterns between different countries and to support a meaningful approach to countries learning from one another. To assess the possible relevance of the approaches pursued in one country to another, it is necessary to know not only ***what*** systems have been put in place and to what extent objectives are being achieved but ***why*** and ***how***. Much of the information sought will be qualitative and impressionistic rather than quantitative and factual.

The framework does not offer or use a particular typology of decentralization. However, to guide the analyst, the most common current ways of delegating authority are briefly presented as possible *streams* of decentralization, involving local government, different levels and institutions within the ministry of health, social insurance funds, and various provider

institutions in the public and the private sector. These *streams* usually go on concurrently. They may have been started at different times, for different reasons and by different actors. They may complement or contradict one another. They take different shape and form within and between countries. Explicitly or implicitly, they are all part of a country's decentralization policy.

Observed changes in health systems performance may be due to decentralization, but many other political and economic factors are likely to affect change as well. The impact of these factors will need to be considered at all stages of the analysis. Although the framework seeks to establish the nature of the relationship between decentralization and selected aspects of health systems performance, it will be important to keep looking for additional or alternative explanations of changes that are taking place in the health system. An overview table is presented on the following page and outlines the different components of the analysis.

In trying to untangle the effects of decentralization from those of other reforms and developments, it is useful to work backwards from changes in equity, efficiency and quality through to the background to decentralization, constantly referring to the larger context and enabling conditions within and outside the health sector. For example, to what extent can observed changes in the trends regarding equity, efficiency and quality be attributed to changes in organisational processes and systems in the health system? to what extent can the changes in organisational processes be attributed to the implementation of decentralization policy? in what way has the translation of policy into action been influenced by particular strategies of implementation?

Recognizing the difficulty of establishing direct ***causal*** links between different forms of decentralization and changes in the health system, the framework for analysis facilitates the search for ***plausible*** links between its different components and other important events. Equally, acknowledging the difficulty of arriving at ***universal*** conclusions, the framework underscores the need for examining the ***specific*** conditions under which certain forms of decentralization achieve the desired effect before drawing overly optimistic conclusions about the transferability of lessons from one country to the next.

The framework may be used to analyse the situation in countries at different stages of decentralization. Where decentralization has been in place for some time, it is reasonable to expect certain changes in the way the health system functions. For countries with mature decentralization, all five components of the framework will therefore be used. For countries that have only just formulated their policies, and determined the means for implementation, or where implementation has begun only recently, it is arguably not appropriate to look for change beyond organisational structures and processes. In these situations, the analyst will refer to only the first two or three components of the framework. However, the remaining

DECENTRALIZATION AND HEALTH SYSTEMS CHANGE
FRAMEWORK FOR ANALYSIS: OVERVIEW

Context
Other critical events
Enabling and inhibiting factors

Component 1
Background: Rationale & Policy Formulation

1.1 Overall government framework
1.2 Main features of decentralization policy: responsibility and authority delegated to
- *local government*
- *lower levels within MOH*
- *provider institutions*
- *social insurance fund*

1.3 The policy formulation process

Component 2
Strategies, Means and Cost of Implementation

2.1 Small-scale experimentation & full-scale implementation
2.2 The regulatory framework
2.3 Approaches to capacity building
2.4 Restructuring
2.5 Cost of implementation

Component 3
Form of Decentralization

3.1 New and restructured levels and institutions
3.2 Key functions and linkages
3.3 Responsibility and authority
3.4 Accountability

Component 4
Health Systems Change: Organisational Processes and Systems

4.1 Health policy development
4.2 Needs assessment and information
4.3 Planning and resource allocation
4.4 Financing and financial management
4.5 Human resources planning and management
4.6 Intersectoral coordination
4.7 Public participation

Component 5
Health Systems Change: Equity, Efficiency and Quality of Services

5.1 Total financial resources available to the public sector
5.2 Overall pattern of resource allocation
5.3. Expenditure/output ratio
5.4 Distribution of human resources
5.5 Utilization
5.6 Availability and range of services
5.7 Changes in support systems
5.8 Availability of essential drugs

comparing structure & functions now and at the outset

comparing processes & systems now and at the outset

comparing equity, efficiency & quality now and at the outset

components may be used to consider variables to be monitored for prospective study of the effects of decentralization. The questions raised in different components of the framework cannot be comprehensive or universally relevant. They cover common issues which have been selected to allow comparison and to stimulate further specific questions.

This framework is designed for ***rapid*** rather than exhaustive assessment, particularly when studying the effects of decentralization on equity, efficiency and quality. It is to help primarily with ***retrospective*** analysis, and for this purpose must rely on information likely to be available now. Key variables have been chosen with these criteria in mind.

COMPONENT 1
BACKGROUND: RATIONALE AND POLICY FORMULATION

1.1 The overall government framework
* structural adjustment
* role of the state and the public/private mix
* civil service reform
* democratization

1.2 Main features of decentralization policy
* local government
* lower levels within ministry of health
* provider institutions
* social insurance funds

1.3 The policy formulation process
* rationale and objectives
* analysis of options
* stakeholders and consensus building
* adoption

In order to understand the form which decentralization takes in any particular situation, it is necessary to know something about its background. This helps to see decentralization as a dynamic process, rather than simply as a particular form of organisational structure. Understanding the broader context of decentralization and the process of policy formulation will shed light on the prospects for implementation and for achieving policy objectives.

1.1 The overall government policy framework

The first step in the analysis is to review the overall context within which the move towards decentralization has emerged.

What is the general economic situation of the country? Is it undergoing a process of structural adjustment? Is there serious underfinancing of the social sector? What are the prospects for economic growth? What is the general thrust of government policy with regard to the role of the state? Is there a drive toward increasing the role of the

private sector? Are there efforts as part of a civil service reform programme to decrease the size of the civil service and improve its quality? How important is equity as an explicit concern of government? Is this concern reflected in the way the state allocates resources and regulates the private sector?

In many countries around the world, democratically elected governments are taking the first steps after years of single party systems and authoritarian regimes. Public participation and greater decentralization are usually integral parts of the democratization process.

How prominent are international and bilateral agencies in advocating and financing various reforms that feature decentralization as a key component?

1.2 Main features of decentralization policy

In this section, the focus is on statements of the formal policy, as indicated by the relevant policy documents. This may or may not be the actual form which decentralization takes. Decentralization policy is likely to be closely related to the explicit objectives of decentralization.

As indicated in the introduction, most decentralization policy is multidimensional, composed of several different *streams*. The intention is to obtain an overview of all the initiatives going on at present whereby authority to set local priorities and to allocate resources is granted, and significant responsibilities are delegated from central authorities to provinces, districts and/or other institutions.

The most common *streams* are outlined below. Within each stream, there will be considerable variation between different countries as to exactly what form this takes. Other distinct *streams* may exist and should be added to complete the composite picture.

Decentralization to local government
This involves the delegation of authority to a local government that is usually substantially independent of the national level with respect to a defined set of functions

Decentralization to lower levels within the Ministry of Health
Within the health sector, authority may be delegated to different bodies at different levels, health authorities at the provincial and/or district level, health management teams, health management boards.

Decentralization to and within provider institutions
Large provider institutions, most frequently large national referral and teaching hospitals, may be provided with global budgets and considerable authority to manage their institutions and staff and to raise additional funds. In addition to hospitals, groups of providers and health centres may be fund holders.

Decentralization to social insurance funds
A wide variety of arrangements exist under which insurance funds act with considerably autonomy at the local level.

1.3 The policy formulation process

A brief analysis of the policy process is an essential part of this exercise. This entails exploring the rationale for decentralization, the positions of different stakeholders, the approaches to reviewing options and to achieving consensus, and the steps involved in actually adopting a particular policy or policy *stream*.

The form which decentralization takes depends to a large extent on the reasons why it was introduced. This is a complex issue since it is often intended to achieve a number of different objectives, which are not necessarily consistent in terms of the form of decentralization required to achieve them.

Policies usually have explicit and implicit objectives. Explicit objectives are those which are officially stated by policy-makers and form the rhetoric of decentralization, while implicit objectives are those which influence the decisions of policy makers but are not explicitly stated. Both explicit and implicit objectives may be political, economic or organisational in nature. Political objectives include democracy, popular participation, accountability, central-local communication, retaining the support of electorates, and so forth. Economic objectives are concerned with reducing public expenditure, increasing the revenue base and stimulating local production or employment. Organisational objectives are usually about increases in efficiency, coordination, flexibility, responsiveness and other factors affecting the quality of service provision.

Some objectives fall into more than one category. For example, popular participation can have economic and organisational benefits as well as being a political objective. Similarly, increased efficiency in the use of resources is both an economic and organisational objective, and in the long run may be politically beneficial. In other cases, however, there is a clear distinction, and sometime a conflict, between the different categories. It is not easy, for example, to design a system of decentralization which results in significant reductions in public expenditure and improvements in the quality of service provision. In other cases, political objectives may dictate decentralization to an increased number of districts and a reduction in the influence of regional authorities. Managerial purposes, on the other hand, might be better served by a strong regional level to support districts.

What are the objectives of the different actors involved? What are the expected outcomes of decentralization? Is decentralization seen as a political end in itself that needs no further justification, or are there distinct and clear expectations of benefits? If so, who is expected to benefit and how?

Donors can be an important driving force in health sector reform. What has been the position of major donors with regard to decentralization? Have any agencies advocated a particular *stream* or form of decentralization? Have any conditionalities regarding decentralization been part of the aid package?

The financial cost and the time requirements of decentralizing are substantial. Were these costs explicitly considered? How were costs and expected benefits analyzed?

The formal steps in the policy process are well known; agenda setting, analysis of options, adopting and implementing options. It is useful to keep in mind, however, that these are not sequential steps in a rational process.

What process of consultation took place? How were different positions reconciled? Were there identifiable groups of *winners* and *losers* in the policy process? Stakeholder analysis is a useful tool for exploring these questions and can be used for this part of the analysis.

COMPONENT 2
STRATEGIES, MEANS AND COST OF IMPLEMENTATION

2.1 Small scale experimentation and full scale implementation
- * piloting and experimentation
- * phasing
- * immediate full scale implementation

2.2 The regulatory framework
- * legal
- * administrative
- * contractual arrangements

2.3 Approaches to capacity building
- * training of staff at different levels and institutions
- * systems development
- * technical support

2.4 Restructuring
- * restructuring existing levels and institutions
- * creating new levels and institutions
- * abolishing existing levels and institutions

2.5 Cost of implementation
- * investment costs
- * recurrent costs
- * time and level of effort

The second component in the framework considers the different strategies that are used to enable policy implementation, and the costs that are incurred in putting in place a functioning decentralized system. In practice, there is often a gap between policy formulation and implementation, for a variety of political, economic and organisational reasons. Several common strategies and options for facilitating implementation are briefly outlined. The list is by no means exhaustive, and other means to ensure translation of policies into action may be added.

2.1 Small-scale experimentation and full-scale implementation

Has there been a process of piloting and experimentation before adoption of the final policy? Were issues of country-wide implementation considered in the design and evaluation of these small-scale pilot projects?

Piloting and experimentation may be used for both technical and tactical reasons. Pilot projects usually serve to test the feasibility and effectiveness of decentralization on a small scale, without the commitment of a large amount of resources and without the political risks accompanying full-scale implementation. Technical reasons are essentially to try out one or more models of decentralizing responsibilities in order to test the effectiveness of such an arrangement. Tactical reasons are primarily to build consensus and gain commitment of important stakeholders to adopting or implementing a particular decentralization policy. The most common problem in piloting is lack of consideration for the conditions and resources required for replication and system-wide implementation.

Has implementation taken place in a phased manner in order to build up the required capacity? in order to allow adaptation and learning during a gradual process of implementation?

Was decentralization implemented at once throughout the entire country? Often, the reasons for proceeding in this way are of a political nature. Where this has been done, how were risks and potential gains assessed?

2.2 The regulatory framework

Decentralization can be sanctioned through a range of legal, political and administrative channels. The main possibilities are constitutional law, ordinary law, policy decrees, formal administrative regulations and informal administrative instructions. To this list of possibilities must be added the contractual systems used in the transfer of responsibilities from the public to the private sector and, increasingly, the contractual or internal market arrangements used within the public sector itself. The arrangement chosen will influence the permanence or stability of any form of decentralization, since some policy instruments can be changed more easily than others. For example, it is more difficult to change policies which are enshrined in legislation, especially constitutional legislation, than those based merely on administrative decisions.

What laws and decrees have been issued to govern the different streams of decentralization? Often, laws concerning different aspects of decentralization, such as local government, health insurance and hospital governance, are developed and proposed by separate groups. This may result, sometimes unintentionally, in conflicting rather than complementary systems. How have these conflicts been resolved?

What administrative regulations have been developed to influence provider behaviour in government and non-governmental institutions? In what way are contracts used to decentralize specific functions to public and private institutions? Performance-linked contracts with NGOs are emerging as a means of delegating some responsibility and authority while keeping a tight reign through greater emphasis on accountability.

2.3 Approaches to capacity building

This is often discussed but can be difficult to achieve. The term covers two important areas: the capacity of staff to undertake their new responsibilities, and the development of management and support systems, for example financial management systems, to respond to the new requirements. Staff and systems development are required at both central and peripheral levels.

Training of district planning officers and district health management team has been one of the most popular capacity building activities. What has been the balance between problem-solving participatory approaches and more directive specific skills training? Has the training been relevant to the situation in which the new planners and managers need to function? How much attention has been given to reorienting staff at the central level? What have been the results of reorientation and training?

Training alone is not enough, however. Effective decentralization is management-intensive. Size and qualifications of the establishment required may change considerably. Have the right people been posted to the decentralized levels and institutions? Have staff at central institutions been reduced? Have the required new skills in policy formulation, regulation and monitoring been imparted? How has this been done? Was any resistance encountered by professional interest groups? How was this addressed?

Have management systems been reformed to reflect changes in functions at different levels and in different situations? Have new operating procedures, protocols or guidelines been developed?

2.4 Restructuring

Existing organisations need to be restructured to support new functions to be performed in different parts of the system under decentralization. New institutional structures may also be created, for example, a decentralization secretariat within the Office of the President or the Ministry of Local Government, or a reform implementation team within the Ministry of Health.

What have been the main features of restructuring at the levels and institutions concerned? Have vertical or categorical programmes been reorganised? What has been the reaction of professional groups and other stakeholders to reorganisation? What new bodies have been created? Are they temporary or permanent? Are they part of an existing government ministry or outside the government?

An important point to consider is whether the purpose of the restructuring has been clear, and whether new functions at different levels were clearly defined, new lines of communication and accountability understood. The fit between organisational structures and policy objectives needs to be carefully examined. Are districts expected to deliver health care in an integrated fashion while vertical programmes continue to command staff loyalties and obtain earmarked funds?

Is there an intermediate level between the district and the centre? How have the functions of this level changed? Has this level been abolished or greatly weakened? Who will perform the functions previously carried out at this level? Often, under politically motivated efforts to decentralization there is a tendency to abolish intermediate levels, only to find that the centre is unable to take over some essential support functions. A managerial perspective is likely to render a different strategy.

2.5 Cost of implementation

Effective decentralization is not a cost-neutral endeavour. It is important to identify those costs that can be directly associated with decentralization efforts. There are new investments required for capacity building and restructuring to support decentralization as well as increases in the overall cost of running the health care system. It is important to capture not only the financial costs, but also the time dimension of introducing and managing change.

Investment costs will include, for example, time and money put into training, management systems development, and the development of new procedures and

manuals. Construction of new and upgrading of existing buildings (health facilities as well as offices), together with medical and office equipment and vehicles are costly items, often associated with decentralization efforts, as is additional staff housing.

Recurrent costs will cover items, such as salaries and incentives for additional personnel, increased communications, expanded information systems and additional administrative costs.

COMPONENT 3
THE FORM OF DECENTRALIZATION

3.1	New and restructured levels and institutions
3.2	Key functions and linkages
3.3	Responsibility and authority delegated
3.4	Accountability

In this part of the analysis, the particular form decentralization takes is explored. It is the ***actual form***, as opposed to the form intended according to official documents, that is to be assessed. Given the variety of *streams* within decentralization policy, it will be necessary to consider the same set of questions for each *stream.*

The focus of Component 3 is on structures that are actually in place, on the key functions that are being performed at present and on the linkages between different levels and institutions. Responsibilities assigned and authority actually granted are also considered. The section also explores the accountability of newly decentralized units.

A critical aspect is the analysis of the composite picture, and the combined effect of different parts of decentralization policy that may or may not be coordinated. In many countries, the picture which emerges is one of confusion and conflict, at least at the initial stages of decentralization. This is so, at least partly, because different *streams* of decentralization are owned by different groups and stakeholders, with different values and objectives.

Some illustrative questions for each sub-section are outlined below.

3.1 New and restructured levels and institutions

What new administrative levels (region, province, district, village) and institutions (district development committee, regional or district health authority, regional or district health board, hospital boards) have actually been created?

Have any levels or institutions been abolished or downgraded?

What are the main features of the new structures, including any reorganisation at national/central level? A comparison of old and new organisational charts should be made.

3.2 Key functions and linkages

What key functions are actually performed by the new or restructured levels and institutions? Is the newly decentralized level or institution responsible just for the health sector or for a range of sectors?

Within the health sector, are all health services covered or only specific aspects of the service delivery system, such as public health services, family planning, environmental health, personal health services, primary health care? Are all services and all health facilities, including hospitals, within a given geographical area decentralized? Are there different arrangements for urban and for rural areas? Is the responsibility of the decentralized unit limited to specific groups of users, such as state employees or members of cooperatives?

What linkages have been established between different levels and institutions? What mechanisms for information and communication are in place? How well are these functioning?

3.3 Responsibility and authority

Delegation of responsibilities without granting the corresponding authority is not uncommon. In this sub-section, the main responsibilities actually delegated are to be considered together changes in authority that have taken place.

What responsibilities have actually been assigned to newly decentralized units? What authority to perform new functions and carry out responsibilities has actually been granted? Allocation of resources within a block grant? performance-linked contract with a global budget? decisions on capital development? the right to contract for support services? To purchase specialist services within the public and the private sector?

Is the decentralized unit authorized to hire and fire? To transfer staff? To set salary levels? Are particular professional groups excluded from this arrangement?

Since Component 4 deals extensively with questions about organisational process and systems for the areas of responsibility most commonly delegated in decentralized systems, it is sufficient to simply list specific areas of responsibility actually delegated and to state with what authority these responsibilities are carried out.

3.4 Accountability

Decentralized units may be accountable to a widely different range of actors. The list includes accountability to the electorate, to higher levels of government, or to specifically composed governing or management boards. Members of boards may be appointed, elected or a combination of the two.

In working through the questions outlined above, it is important to describe not only the actual situation that has been reached in the process of decentralization. It is the ***comparison*** between

- what was in place before the decentralization study under investigation was pronounced,
- what was intended according to official policy statements and documents, and
- what is actually in place and functioning now,

which will provide the basis for further analysis proposed in Components 4 and 5.

COMPONENT 4
HEALTH SYSTEMS CHANGE: ORGANISATIONAL PROCESSES AND SYSTEMS

4.1	Health policy development
4.2	Needs assessment and information
4.3	Planning and resource allocation
4.4	Financing and financial management
4.5	Human resources planning and management
4.6	Intersectoral coordination
4.7	Public participation

The concern here is with changes in organisational processes and systems in the health sector which, it is assumed, will in turn affect the distribution, quality and efficiency of services. The organisational processes to be examined are those concerned with health policy formulation and with different aspects of health planning and management. Increased popular participation and improved coordination are frequently central to the rationale for decentralization. The analysis, therefore, also looks at the degree to which the form of decentralization changes the scope or extent of public participation in health care, and the effect of decentralization on coordination between the health sector and others.

Organisational processes can change for a wide variety of reasons – many unrelated to decentralization. While it is necessary to be aware of these other influences, it is important to try and trace links between the form of decentralization and its effect on health systems functioning. For example, the process of health planning and budgeting may have been influenced by many factors including training programmes, donor-funded vertical programmes, the production of planning guidelines, cuts in government health spending, and so forth. Our concern, however, is with changes in the process that may be attributable to decentralization.

The specific questions to be asked will vary according to the form of decentralization and the circumstances of the country concerned. Some illustrative questions in relation to selected organisational processes are set out below. It is difficult to treat each process in isolation. Most of the issues discussed below are inter-related.

4.1 Health policy development

Has decentralization changed the process of policy analysis and formulation? What aspects of policy are made at different levels of the system? Has the relative influence of the individuals and organisations involved in the process of policy formulation changed? What *de facto* policy changes can be observed? How and by whom were these initiated? How and by whom is the implementation of policy monitored?

The difficulty, of course, is not only to decide which changes in policy are related to decentralization but, more fundamentally, what actually constitutes health policy. It is most useful to determine which issues are perceived to be a priority; to assess how the health policy agenda has changed over time; and to review the means by which specific issues are addressed. This approach is likely to be more fruitful than an analysis of formal policy documents, which tend to avoid controversial issues in favour of bland statements of good intent.

4.2 Needs assessment and information

What mechanisms at each level are in place for assessing health needs? Who participates? What methods and tools are used? How often are changing needs reviewed? How does local needs assessment influence the form or content of service provision? How does needs assessment influence decisions to contract out service provision to missions, NGOs, private providers? What is the relationship between local needs assessment and the implementation of national priority programmes?

The responsiveness of the system to health needs is an important component of quality, which will be discussed further under the next component.

Has the process of collection, analysis and use of management information changed under decentralization? Have changes in responsibility for planning and resource allocation resulted in more use of information at a local level?

Changes in the way information is collected and used and the perceived importance of information systems are likely to be related to changes in authority to make resource allocation decisions.

4.3 Planning and resource allocation

Who is now in charge and at which level? To what extent has decentralization affected the role of health professionals versus generalist managers, civil servants or politicians? Has the responsibility to prepare plans been backed with the decentralization of the necessary authority and resources? How much freedom do local managers have to vire between line items and programmes?

If power to prepare plans has been decentralized to local authorities, do they have the capacity to fulfil their responsibilities? What are the professional concerns and political interests of those given the responsibility to plan? How have any changes affected the nature and range of resource allocation decisions made at different levels and by different institutions? Has the centre developed an formula for distributing resources equitably?

If a district development committee or a health management board have taken over responsibilities for health planning, what has this actually meant in practice? Who is now involved? What professional and political interests are represented on the committee/board? What kinds of resource allocation decisions does the committee/board make? What decisions does it leave to health professionals?

A particular concern is that in circumstances in which local government control increases, health may not be afforded the same priority as in the past. This may occur either as a conscious decision to allocate a greater proportion of funds to other sectors, or merely because local government is short of cash for running its own operations. Have funds, particularly for public health activities, been earmarked and protected by separate bank accounts?

There is increasing interest in transferring responsibility from the public to the private sector. At the local level a district health authority might be given authority to contract out maintenance and repair of vehicles or at a national level the MOH may be allowed to contract out responsibility for procurement and distribution of drugs. How well are districts and local institutions managing this process? How have the different parties reacted to new processes whereby district health boards and/or

provider institutions have been given the authority to purchase specialist and other services?

4.4 Financing and financial management

What changes in responsibility for health financing have occurred as a result of decentralization? What has happened in those countries where local government is required to assume some responsibility for health care financing? Have local authorities been able to meet their commitments?

Have the absolute amounts of financial resources increased? Has the number of different sources of funding increased? What strategies are used to raise revenues locally?

Is income from user fees and other new sources of financing allocated by different actors than the regular tax-based budget from central and local levels? How are the two (or more) different systems of resource allocation reconciled?

How have responsibilities for financial management at each level changed under decentralization? Do accounting procedures make it possible to monitor expenditure or variation in costs? Who now uses this information and for what purposes?

Are NGOs, missions and other private providers free to set their own prices? What mechanisms exist for controlling prices for private health care?

4.5 Human resources planning and management

Has the employment status of staff changed? Are district staff still employed by the Ministry of Health or are they transferred to local government? To what extent are local managers free to decide on the numbers and mix of staff they need? By what means does the centre exert control over personnel planning? To what extent and for which cadres of staff do local managers control the processes of posting and transfer? What sanctions or incentives are available to managers trying to improve performance? Do districts and autonomous health institutions set their own salary and incentive scales? Are richer districts and institutions able to attract better qualified staff?

The control of staff is both an important and controversial issue in implementing decentralization. If staff remain responsible to a higher level in the system, or to their parent ministry, district authorities have limited means of exerting their authority. On the other hand, health service staff often think of local government service as being inferior to central government and Ministries of Health are reluctant to lose control of their technical cadres. In the absence of other incentives, district level staff will be reluctant to join local government if there is no clear promotion path to regional or national level posts.

4.6 Intersectoral coordination

Advocates of decentralization to local government argue that such a move greatly improves intersectoral coordination and opens the way for innovative intersectoral action, particularly with agriculture, education and environmental sectors.

In what way do different streams of decentralization change the way different sectoral agencies cooperate and coordinate? What form does this coordination take in practice? To what extent has decentralization strengthened advocacy for health development? Have other sectors begun to show greater concern about the health impact of their activities?

4.7 Public participation

What channels for public participation have been created at each level in the process of decentralization? How responsive are they to the user? How much influence do representative bodies have? What is their legal status? What interest groups within the community do they represent? What form does popular involvement take? Which processes are influenced by public participation? What kind of decisions are made as a result of public intervention?

The issue of popular involvement is central to decentralization and needs to be assessed in relation to each of the processes discussed in this section.

COMPONENT 5
HEALTH SYSTEMS CHANGE: EQUITY, EFFICIENCY AND QUALITY OF SERVICES

5.1	Total financial resources available to the public sector
5.2	Overall pattern of resource allocation
5.3	Expenditure/output ratios
5.4.	Distribution of human resources
5.5	Utilization
5.6	Availability and range of services
5.7	Changes in support systems
5.8	Availability of essential drugs

The last component of the analysis examines the effect of changes in the way the health system operates on the way it actually performs -- assessed in terms of equity, efficiency and quality of health services. Towards this end, a number of indicators are identified that can be expected to change as a result of the organisational changes considered in the previous section.

The analysis requires two separate steps. The first is to examine changes in the selected indicators over time. The second is to interpret these changes, and to assess to what extent any observed changes may be plausibly linked to decentralization. This entails obtaining a fairly comprehensive picture of critical events and relevant contextual factors which may provide a better explanation for the change than decentralization.

The indicators listed below were selected because they are important indicators of performance in their own right, and because it is anticipated that the required information can be *relatively* easily obtained from routine information systems. In some countries, however, some difficulties in obtaining accurate data of a number of years have to be

expected. It is also recognized that in many countries, information for the private sector is incomplete at best. Most of the analysis will, therefore, be restricted to the public sector.

5.1 Total financial resources available to the public sector by type and amount

Has there been a change in

- the total amount
- the amount by source
- the number and type of sources

The most common sources of finance to be considered are central and local taxes, insurance, various forms of user fees and external aid.

5.2 Overall pattern of resource allocation

Public sector

In the health national budget, has there been a change in the allocation of resources

- between primary, secondary and tertiary care
- between capital and recurrent
- within recurrent, allocation between salaries, drugs and other operating costs
- between urban and rural areas
- between districts

Where the national contribution to districts is disbursed as a block grant to local government, what proportion of the budget in districts goes to health? Is there a wide variation between districts?

Where the national contribution to the district health budget is disbursed in the form of a global budget, has there been a change in the allocation of resources

- between primary, secondary and tertiary care
- between capital and recurrent
- within recurrent, allocation between salaries, drugs and other operating costs
- between urban and rural areas

Does the resource allocation pattern vary widely between districts?

How are locally raised funds allocated (by source: local tax; insurance; user fees)

- what proportion allocated to capital and recurrent?
- within recurrent, allocation between salaries, drugs and other operating costs
- between different levels of care
- between different types of programmes

Private sector

What is the proportion of total health sector expenditure going to the private sector?

5.3 Expenditure/output ratio

Where data is available, cost per units of output will permit an analysis of trends in efficiency. Where data is hard to obtain, acceptable proxy measures to be used are total recurrent costs (or recurrent budget estimates) over selected service outputs.

Possible service outputs for which data is usually available both by district, by facility and in aggregate nationally, are

- outpatient attendances at hospitals and health centres
- antenatal clinic attendances
- number of children fully immunized

During the initial phases of decentralization, expenditures often increase and performance tends to decrease. Measuring the ratio of expenditure to output at a particular time may paint a misleading picture. To capture the full impact of decentralization on cost and performance, it will be particularly important to analyse trends over an extended period of time.

5.4 Distribution of human resources

Has there been a change in the distribution of health staff?

It will be useful to consider staff changes for several different types of health providers, including doctors and nurses. Additionally, changes in the posting of administrators and accountants to decentralized levels and institutions should be explored.

Distribution of government staff should be analyzed

- between primary, secondary and tertiary care
- between districts
- between urban and rural

Where data is available, shifts of staff from government to the private sector and general growth of private sector staff, should be analysed.

5.5 Utilization

It is desirable to disaggregate data at least by sex and age, so as to obtain a more detailed pattern of utilization by different sections of the population. Where possible, utilization at both public and private facilities should be considered.

An approximate indication of access to care can be obtained by comparing utilization

- between districts (taking into account population)
- between urban and rural areas
- between primary and other facilities
- between those living in close proximity to a health facility and others in the theoretical catchment area.

Variation in these trends between different parts of the country should also be considered in the analysis.

5.6 Availability and range of services

Has there been a change in the range of services available in

- health centres
- district hospitals
- in tertiary hospitals

Are services available on a daily basis?

Has there been a change in the hours of operation of

- health centres
- district hospitals
- tertiary hospitals

5.7 Changes in support systems

Appropriate supervision of personnel linked with continuing education is an important component of good management, and helps to maintain and improve clinical standards. It can be achieved in various ways, for example, through direct visits to health facilities, the institution of regular meetings of staff from different health facilities in the district, a programme of continuing education and on-the-job training. The development of written clinical protocols can also be an indicator of moves towards getting standardised good quality care. Another change to look for is innovation in transport management, for example, through log book analysis, preventive maintenance, and training and incentives systems for drivers.

What are the records of supervisory visits to health facilities? Visits from central to district levels of management? What clinical management protocols are available to health facilities? Have there been changes since decentralization? Are more vehicles on the road and functioning than before?

5.8 Availability of essential drugs

It may be difficult to obtain this information over a period of years in order to assess trends, but can provide a powerful indicator of quality of care.

How often and for how long have selected primary care institutions been out of selected essential drugs, eg aspirin, chloroquine, common antibiotic?