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DRAFT NOTE ON

Health Sector Decentralisation

The views expressed in this paper are those of the author(s) and do not necessarily reflect the view or policies of the Ministry of Foreign Affairs of Denmark

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1. INTRODUCTION

1.1 Background to study

The Danish public sector strategy "Effective and Accountable Public Sector Management – Strategic Priorities" is centred on three components: (1) anti-corruption, (2) local governance and service delivery and (3) public finance management. A key rationale of the strategy is to strengthen Danida competency and capacity within the three focus areas of the strategy. E-learning courses exist for anti-corruption and public finance management, while local governance and service delivery resource material remains scattered.

In order to improve the quality of Danish support to decentralisation reforms and approaches for improved local governance and service delivery it has been decided to develop a set of learning materials on decentralisation reforms.

The learning material is synthesized in an overall "Source Material on Decentralisation and Improved Service Delivery" while separate issue papers have been developed on:

1. Political Economy of Decentralisation,
2. Fiscal Decentralisation and Sector Funding
3. Draft Note on Health Sector Decentralisation
4. Draft Note on Environment Sector Decentralisation
5. Draft Note on Water Sector Decentralisation

The objective of this particular paper is to review international literature and Danida experiences with regards to decentralisation of the health sector. The paper should be read after familiarisation with the basic concepts in the overall "Good Practice Paper for Support to Decentralisation Reforms".

Below we initially explore the peculiarities of the health sector reform and the role of decentralisation within such reforms and subsequently what we know about contribution of decentralisation to better health service delivery. The chapter concludes with identifying specific criteria for a successful decentralisation of the health sector.

1.2 Health Sector System Reform

It is increasingly recognised that previous development programmes that focused on single disease programmes and single interventions were ineffective because of wider health system weaknesses. Consequently, Danida development assistance is increasingly emphasizing broader health sector support for improving national health systems[1]: A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It includes efforts to

[1] See: Ministry of Foreign Affairs, Danida 2009 – the subsequent discussion of the six elements of a "strong health system" is from the same paper.

influence determinants of health as well as more direct health-improving activities. A strong health system has six elements (see box 1): health services, health workforce, health information, medical products and technologies, health financing, and leadership and governance. All these elements must function well to ensure that quality health service reaches the entire population with promotive, preventive, curative and rehabilitative health services.

Box 1: The six building blocks of a health system

1. Good health services are those that deliver effective, safe, quality personal and non-personal health interventions.;
2. A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances;
3. Production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status;
4. Equitable access to and use of essential medical products, vaccines and technologies of assured quality;
5. A good health financing system raises adequate funds for health, and protects from financial catastrophe or impoverishment. It provides incentives for providers and users to be efficient;
6. Leadership and governance involves ensuring strategic policy frameworks, effective oversight, coalition-building, regulation, attention to system-design and accountability.

Source: WHO (2007) *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. WHO'S Framework for Action,* WHO. (Slightly abbreviated)

Health reforms are concerned with decentralisation as only one among many means to achieve more effective and efficient health systems. Health reforms commonly include changes in health financing and changes in health system organization and management. Changes in financing may involve cost recovery and user charges for publicly provided services, community-based financing schemes, insurance schemes (social and private), and changes in public expenditure and allocation. Changes in organization and management may entail decentralization (authority, responsibilities, and functions) and changes in the ownership of service provision and delivery (privatization or a public-private mix)[2].

Health sector reforms are thus complex and comprehensive. The focus of this paper is on one particular possible sub-set of such reforms: the decentralisation of health sector services.

1.3 Rationale for Decentralisation

What has been learned to date about impact of decentralisation on health services? This section will briefly review main literature.

Decentralisation of health services is undertaken with the assumption that it will improve health service delivery. One assumption is that local communities have better knowledge of local needs and conditions and can make better decisions if they are granted the authority to manage resources and organize and supply health services. Decentralization is intended to promote accountability and participation of the local

[2] Mattias Lundberg and Limin Wang: Health Sector Reforms" – Chapter 2 in World Bank PSIA Guidance on Sector-Specific Policy Reforms http://go.worldbank.org/7M9RU88L10

population, make health service providers accountable to the local community, and boost the responsiveness of the providers to the local demand for services. Decentralization is therefore expected to improve the efficiency, equity, and quality of health service delivery and management.

Decentralization has been widely implemented in Latin America since the 1980s, in Africa since the 1990s, and elsewhere (China, Eastern Europe and Central Asia) more recently. While some global studies conclude that fiscal decentralisation in general improves health outcomes[3], it is indicated that the objectives of decentralisation only rarely are realized[4]. However, many of the studies that have attempted to assess decentralisation specifically on health services suffer from significant methodological problems because they fail to recognise that decentralisation reforms cannot be generalised into one broad category but in reality refer to a wide range of different types of reforms[5].

Many country level studies are cautious in their assessments but do conclude that decentralisation reforms under certain conditions will lead to improved service delivery. Studies of the experience of health sector decentralisation in rural China and India (Tang and Bloom 2000 and Uchimura and Jütting 2006), Uganda (Kyaddondo and Whyte 2003, Hutchinsoon et al 2005), Tanzania (Semali et al 2005) and Nigeria (Khemani 2004) found that reforms for various reasons had limited or no positive impact on health services. The studies point to missing critical factors such as decentralisation without proper human resource management or financing arrangements, lack of effective local accountability within local government structures, lack of information to citizens and poor inter and intra sectoral coordination as critical factors for explaining the limited or occasional even negative impact of decentralisation on health services. One of the more systematic approaches to assess the impact of decentralisation on health services explored the relationship between decentralisation, various governance practices and health service outcomes in Ceará, Brazil (Atkinson and Haran 2004). This approach found that to a large extent good management practices led to successful decentralization rather than vice versa. The literature on health decentralisation thus confirms the broader review of decentralisation literature that it is not so much decentralisation itself but how decentralization is designed and implemented that will make a difference in equity, efficiency quality and financial soundness.

1.4 Overview of the paper

The paper is subsequently structured into the following chapters that each discuss what are common arrangements but also what can be considered as "good practices" with regards to each of the "five pillars of effective decentralisation":

[3] David Robalino, Oscar Picazo and Anders Voetberg: Does fiscal decentralisation improve health outcomes? Evidence from a cross-country analysis, World Bank Policy Research working Paper 2565 March 2001, The study concludes in summary: "Greater fiscal decentralisation is consistently associated with lower mortality rates – and its positive effects on infant mortality are greater in environments that promote political rights".

[4] See summary discussion by Lundberg, Mathias and Limin Wang: Health Sector Reform – chapter in Poverty and Social Impact analysis guidelines of the World Bank.

[5] For more detailed discussion see the general Good Practice Paper for Support to Decentralisation Reforms.

1. Assignment of functions: discussion of practices and lessons regarding transfer of health services to local governments;
2. Finances: discussion of practices and lessons regarding financing of decentralised health services;
3. Human Resource Management – practices ad lessons regarding decentralisation of health staff;
4. Local Accountability Structures – practices and lessons regarding how health services can be made more locally responsive by decentralisation;
5. Central institutions for reform coordination and oversight – practices and lessons regarding how health sector decentralisation can be coordinated and managed centrally.

The paper closes with a brief concluding chapter. The paper should be read subsequent to the general Good Practice Paper for Support to Decentralisation Reforms that provides a general overview of key concepts just as broader and more theoretical discussions of e.g. expenditure assignments are discussed there. In this paper the focus is on specific health sector issues.

2. FUNCTIONAL ASSIGNMENTS

2.1 Decentralisation as part of wider health and reforms

Throughout developing countries health sector decentralisation has for the last two-three decades been implemented on a broad scale[6]. This is partly explained by the progression of general decentralisation reforms but also to a large degree by specific health sector reform initiatives. The movement of health reforms with a weight on decentralisation was initiated by the emphasis on Primary Health strategies as adopted at Alma Ata in 1978[7] and further promoted e.g. by the World Bank in subsequent years[8].

As earlier mentioned, health reforms are concerned with decentralisation as only one among many means to achieve more effective and efficient health systems contributing to better health.

2.2 Main Modalities for Health Sector Decentralisation

Decentralisation of health services have taken place through all three main categories of (administrative) decentralisation discussed in the general paper including:

Deconcentration: transfer of authority and responsibility from central agencies to field offices of those agencies at a variety of levels regional, provincial, state, and/or local. This is a limited form of decentralisation that only marginally may increase local responsiveness of health services and also still retain health staff within the overall central civil service. Deconcentrated units (e.g. "district administrations") may

[6] See Mills (ed) 1990, Bossert et al 2002, Litvack et al 1998.
[7] WHO 1978: The Alma Ata conference on primary health care, WHO Cron 32: 409-430.
[8] World Development Report 1993: Investing In Health.

however have some local autonomy for health planning and budgeting within a framework provided by the central ministry.

Delegation: transfer of authority and responsibility from central agencies to organizations not directly under the control of those agencies. In the health sector this typically include semi-autonomous entities such as health boards, hospitals as well as arrangements whereby non-governmental organizations undertake certain service provisions on behalf of the central government (such as implementation of primary health care campaigns).

Devolution whereby authority, responsibility and resources are transferred from central government agencies to local governments. Local governments will have multiple functions, legislative and revenue raising powers and be responsible to a locally elected council. Devolution is therefore a form of decentralisation that holds the greatest potential benefits in terms of increasing local responsiveness of health planning and cross sectoral integration. However it is also a form of decentralisation that poses some of the greatest challenges as further discussed below.

Privatisation is also occasionally discussed as a modality of (health sector) decentralisation[9]. Privatisation involves the transfers of government functions to voluntary organisations or to private profit making or non-profit making enterprises. Many developing countries have for long depended on voluntary organisations – typically religious organisations – to provide a substantive part of what otherwise is considered as public health services. The interplay between the private sector and public sector is in most countries a key factor for successful health service delivery that also needs to be considered in design of a possible decentralisation programme of public health services.

In practice we find that the different forms of decentralisation co-exist in the same country. Table 1 below illustrates the basic types of decentralisation in selected countries. From the table it can be seen that some countries have undertaken health sector reform primarily based on delegation, deconcentration or devolution, and some countries have adopted several forms of decentralisation simultaneously. This may be mutually supportive but often it is the result of conflicting approaches that may lead to policy confusion, conflicts and tensions. In Ghana for instance there has for long been unresolved disputes between advocates for health sector reforms based on delegation and advocates for decentralisation by devolution to the elected District Assemblies. Even in a country like Uganda where decentralisation by devolution is rather well established in legislation and spelled out in the Constitution we find conflicts with sector policies. In in the health sector it has been argued that the desirable health facility hierarchy poorly fits with the overall local government architecture and a new level of sub-district planning is required for the planning of health services.

[9] It can be debated whether "privatisation" rightly should be categorised as a form of decentralisation or if the term decentralisation better be reserved for use of re-originations of the public sector. However privatisation is often discussed as a form of decentralisation in American literature including some World Bank literature, but also in e.g. the WHO review of health sector experiences edited by Anne Mills (Mills 1990).

Table 1: Types of health sector decentralisation in selected countries

Country **(Population)**	**Basic Type of decentralisation**	**Legal basis / year initiated**	**Levels**
Ghana (23.8 million)	**Delegation** to autonomous Ghana Health Service (GHS) and to semi-autonomous budget management centres. However also attempts of **devolving** functions to District Assemblies.	1996 Ghana Health Service and Hospital Act. However increasing tension with Local Government Legislation that in principle assume health services to be devolved (LG Act 1993), - the extent of effective delegation is de facto limited and health remains largely central directed as integral within civil service.	10 Regional Health Administrations, 110 District Health Administrations and related "sub-districts" – but 138 elected local governments – with boundaries different from health districts.
Zambia (12.9 million)	**Deconcentration** to Regions and Districts and **delegation** to central Board of Health.	1993 Health Sector Reform programme. Decentralisation programme for **devolution** planned to be implemented	Four regional directorates; 72 District Health Boards and District Health Management teams.
Uganda (32.7 million)	**Devolved** to elected District (Municipal and City) Councils.	1997 Local Government Act with various amendments.	Districts are the main local government unit but are composed of administrative layers at county, parish and village level. In addition the sub-counties are fully-fledged local governments. The health sector also operates with sub-district units that are not matched by similar local government structures.
Philippines (92.2 million)	**Devolved** to local governments.	1991 Local Government Code.	77 provinces; 60 autonomous cities, 1548 municipalities; 42000 Barangays.
Tanzania (40 million)	In principle **devolved** to local governments	1999 LG Amendments,	21 regions (deconcentrated),

	However, in practice significant central government control of staff and finances.	1997 Regional Act.	114 (higher) local Governments: districts, municipalities etc and more than 10,000 Village local Governments.

Source: Bossert and Beauvais 2002 and updated by authors based on available country and sector legislation[10].

2.3 Decentralisation of health sector functions to Local Governments

This section provides an overview and some tools for analysis of the challenges of decentralisation of health functions to local governments. This is followed by discussion of a set of the most common critical issues for health sector functional assignments.

2.3.1 General reflections

Shah (1994) WB suggests that a particular function is well suited for decentralisation if it fulfils certain conditions[11]:

- Local demands for the service differ across localities;
- There are no substantial economies of scale associated with the service;
- There is no significant spill-over of costs or benefits from the service;
- The service is amendable to at least partial local financing through taxes or user fees or other charges;
- Local governments have the capacity to deliver the service;
- The service is not meant to provide substantial redistribution of income or wealth.

A distinction can be made between "own" and delegated expenditure responsibilities – for the latter the actual decisions on budgeting and financing are carried out at the central level while the local government merely act as an agent. It should be noted that in reality many health functions often are only delegated to local governments include: health staff salaries and the implementation of various "vertical" health programmes (malaria control programmes, vaccination campaigns etc) where LGs have limited or no power to determine the number of staff recruited, their remunerations or the basic intervention modalities for the vertical programmes.

The typical functions decentralised to "district" level are frequently related to "Primary Health Care" and include according to international surveys[12]:

[10] Population data from 2009 United Nations Department of Economic and Social Affairs Population Division (2009)
[11] Shah 1994 The Reform of intergovernmental fiscal relations in developing and emerging market economies, Policy and Research Series no 23,World Bank. For a very analytical and practical discussion re roads and health see M. Andrews and L. Schroeder in Public Administration and Development 200 (Vol. 23, number 1).
[12] J. P. Vaughan: Lessons from (Health Decentralisation) Experiences, WHO 1990. The assignment of functions varies asubstantially across countresis. For a review of Danish system see Strandberg-Larsen, Mikkel Bernt Nielsen, Signild vallgårda, Allan Krasnik and Kirsten Vrangbæk 2007.

1) Organisation and running of the district hospital (but obviously not regional and national hospitals);
2) Implementation of community based health programs;
3) Management and control of local health budgets;
4) Coordination and supervision of all government, non-governmental and private health services within the district;
5) Promotion of active working links with government departments;
6) Promotion of community participation in local health planning;
7) Preparation of annual health plans;
8) Raising of additional local funds for capital projects;
9) Some in-service training of health workers;
10) Supervision and control of community health workers in the district;
11) Collection and compilation of routine health information and forwarding it to regional authorities and ministries of health.

National level responsibilities would typically include overall policy settings just as technically more complex services are provided at national or "regional" levels. However, in practice there are often substantive ambiguity in the assignment of functions (e.g. the specific division of responsibilities for management of district health staff may not entirely be decentralised but shared with central government) – a problem that leads to duplication, risk of underfunded mandates and lack of coordination.

A useful tool has been developed to assess the extent to which health sector functions are clearly assigned different actors (see annex 2). This analytical tool provides guidance for assessment of decentralisation in eight distinctive clusters of health functions/key issues:

1. Public health surveillance and response;
2. Financial resources;
3. Personnel;
4. Drugs, vaccines, and supplies;
5. Equipment and transport;
6. Capital construction and maintenance;
7. Health and management information;
8. Health communications.

2.3.2 Critical Issues

The devolution of health functions to local governments is faced with similar challenges as other sectors. In particular the challenges relating to matching functions with finances, and matching devolved functions with existing and likely future capacities as discussed in the general "Good Practice paper for Support to Decentralisation".

1. Relationship between the health sector service hierarchy and general public sector/local government hierarchy: this may for instance involve a hierarchy of national hospitals, regional hospitals, district hospitals, sub-district, county, sub-county, parish and village facilities that in various ways is sought linked to a similar – but frequently differently organised – system of local governments.

In Uganda for instance, it was in the late 1990s considered important to introduce a sub-district level of health planning (typically four in every district). However, it was technically unfeasible and too costly to devolve as far down as the sub-county level (typically 20 in each district) although the sub-county was the general level of decentralision preferred below district level.

2. Essential equipment and drug procurement – are rarely fully devolved: WHO concluded in an analysis of existing practices that the recent trend towards decentralizing responsibility for procurement can be positive, in that local authorities should have the strongest interest in maintaining a consistently effective drug supply system. However, without procedures to maintain economically viable procurement quantities, drug prices may increase dramatically. Moreover, without mechanisms to monitor local performance and to ensure adherence to good procurement practice, public health objectives may not be met and scarce funds may be wasted on inappropriate purchases. Contracting out parts of the procurement/distribution function may improve efficiency and reduce costs. But this will only be the case if public health systems can properly monitor and manage such contracts. In many countries the necessary experience and information systems for this are lacking. In some countries initial decentralization of drug procurement was followed by pooled procurement by hospitals or cooperatives[13]. In e.g. Philippines there is evidence of decentralised drug procurement has led to increased corruption and wastage[14].

3. Capital investments – it is a common feature in many LDCs that health infrastructure investments are made without corresponding investments in staff and other recurrent expenses. Local Governments can in certain situations have strong incentives for increasing capital investments in the health sector because they expect central government subsequently to allocate staff and recurrent expenses. Thus until local governments have a clear responsibility for providing recurrent funds and staff from own resources, it is risky (yet common) to devolve responsibilities for health infrastructure planning.

4. Curative versus preventive services; just like local political influences may lead to undesirable high levels of capital investments there is also a risk of decentralised health planning to focus on curative rather than preventive services. A common approach for minimizing such risks is to earmark funding for preventive services.

3. FINANCE

Fiscal decentralisation lies at the core of decentralisation programmes. A rich amount of literature provides guidance on the building blocks for successful fiscal

[13] WHO 1999: Operational Principles for Good Pharmaceutical Procurement - adapted from: Chapter 13: Managing procurement. Management Sciences for Health (MSH) in collaboration with the World Health Organization, Action Programme on Essential Drugs.* *Managing drug supply*, second edition. Edited by J.D. Quick, J. Rankin, R. Laing, R. O'Connor, H.V. Hogerzeil, M.N.G. Dukes and A. Garnett. Hartford, CT: Kumarian Press; 1997

[14] http://pcij.org/stories/2005/health.html

decentralisation[15]. This section will briefly discuss the specific health sector issues related to these building blocks with emphasis on three issues:

1) Costing of services;
2) Funding modalities; and
3) Use of formula based allocations.

3.1 Costing of services

Once it has been established what assignments the decentralised units should undertake, some form of exercise will normally be undertaken to determine how the service can be financed and in particular the costs of the services. This can be undertaken in various ways. Sometimes it is done in a very scientific manner whereby the cost of each of the agreed decentralised functions is calculated in great detail and where location specific (administrative) costs also are included. This is the ideal "textbook" approach and occasionally applied also in developing countries. A recent example can for instance be found in Indonesia[16].

However, in practice there is often a significant discrepancy between the desired levels of health financing and what in reality can be afforded. This is most apparent in Sub-Saharan Africa where the gap between official estimates for necessary health spending for reaching the MDGs (estimated at up to 35 USD per capita – see below) and the current levels are most glaring. WHO data indicates that per capita public spending remained lower than USD 10 on average in East, Middle and West Africa and South and Central Asia- and as low as USD4 in Burundi, USD 3 in Ethiopia and USD1 in the DR Congo[17].

Box 2: Estimating the Costs of Reaching Health MDGs

Various attempts have been made to estimate what it would cost to achieve the health MDGs. Such estimates are fraught with difficulty, partly because of the fact that health outcomes are determined by a wide range of factors. Income growth, for example, is a highly effective way of accelerating progress towards the MDGs, but it is difficult to disentangle the effects of this with those of other factors such as health spending. It needs to be recognised that the links between health spending and outcomes are uncertain and, at best, weak.
The traditional approach to costing has been to use a bottom up approach to identify and cost the services considered necessary to deliver the MDG targets. The 1993 World Development Report identified a publicly funded basic package costing some $12 per capita which, if implemented, would significantly reduce the burden of diseases.
More recently, increasingly sophisticated approaches have also tried to capture the synergies between different interventions, to make allowances for the health systems strengthening activities needed to make sustained progress towards the MDGs, and also to capture some of the costs associated with government stewardship of the sector. Using such an approach, the Commission on Macroeconomics and Health estimated that, in broad terms, low income

[15] For a brief overview see the General Good Practice Paper and for details see the Fiscal Decentralisation and Sector Funding Paper.
[16] Oxford Policy Management, GTZ, Health Department Republic of Indonesia 2009: District Based Normative Costing Model - see brief summary of approach as attached as annex 1.
[17] Mark Pearson 2007: Funding flows for health: what might the future hold? HLSP Institute, Technical Approach Paper April 2007, www.hlspinstitute.org

countries needed to spend around $35 per head of public spending to achieve the health MDGs.
Subsequent work, carried out using a similar methodology by the Millennium Project and involving more detailed work at country level, has shown that the figure could be as high as $48 in countries where HIV prevalence is highest. New approaches (such as marginal budgeting for bottlenecks, elasticity analysis and maquette for multisectoral analysis) have recently been tested. Each has its pros and cons, but in all cases the availability of data poses major limitations.
Extravagant spending targets, often implying huge increases from current levels of spending, have led many to believe that somehow health is entitled to such levels of resources, irrespective of other development needs faced by countries. In doing so they overlook that spending in other sectors may actually be a better way of improving health outcomes than spending in the health sector.
Source: Mark Pearson 2007: Funding flows for health: what might the future hold? HLSP Institute, Technical Approach Paper April 2007, www.hlspinstitute.org

Since the gap between the affordable and desirable level of funding in many cases is so significant, in practice the costing of decentralised health services is often pragmatic whereby it is attempted to ensure that at least the funds previously spent on a centralised health service are transferred to the decentralised services as part of a reform[18].

During a decentralisation reform process where the overall fiscal envelope is unchanged this may be the only realistic approach. However, even this goal may not be achieved and decentralisation reforms are under such circumstances where "unfunded mandates" are passed from central government to local governments most likely to fail.

3.2 Funding Modalities

Funding for decentralised health service delivery can broadly be categorised as:

1) Discretionary Local Government Funds such as locally collected taxes and non-earmarked central government grants ("block grants");
2) Earmarked sector funding (health sector grants etc); and
3) Out of Pocket.

This section will focus on the first two modalities that are most directly relevant for a discussion of health sector decentralisation while the discussion of out of pocket payments is a major topic on its own and may be implemented under both centralised and decentralised health service systems[19].

Most poor countries rely on taxes that most advantageously can be collected through central institutions such as VAT, customs and duties. The local taxes are often low yielding and local government finances will therefore depend on a system of intergovernmental fiscal transfers to close the gap between the often expensive functions assigned to local governments and the often low yielding taxes.

[18] See for instance Tidemand et al 2008: "Study on the Intergovernmental Fiscal Transfer System in Malawi".
[19] See e.g. Gottret, Pablo; George Schieber and Hugh R. Waters 2008: Good Practices in Health Financing: Lessons from Reforms in Low and Middle-Income Countries, World Bank

The design of specific grant elements within a fiscal transfer system will depend on the specific objective that the grant is to fulfil. A vast literature is established which discusses the characteristics of a good fiscal grant transfer system, and the issue is comprehensively dealt with in the Paper on Fiscal Decentralisation.

Conditional – unconditional grants

In order to ensure that local governments adhere to certain specific national policies and objectives, it may be appropriate to design specific conditional grants to cater for each of these objectives – the grant will thus be earmarked for specific purposes. In Tanzania for instance, the following earmarked health sector grants were allocated to the local governments in fiscal year 2009/2010:

1) Recurrent Grant: that covers the salaries for health staff and basic allocation of other charges;
2) Health Services: in principal a general block grant for health service provision: drugs, equipment, transport and some minor infrastructure rehabilitation;
3) Health Infrastructure Grant: for major health infrastructure rehabilitation and construction of new facilities;
4) A new grant for non-medical HIV/AIDS intervention.

Importantly each of these grants are also "internally earmarked", e.g. the general recurrent grant is essentially tied to payment of salaries of staff, where staff numbers and their salary scale is centrally determined. The health service grant stipulates certain maximum and minim amounts to be paid on drugs, transport, and allowances rehabilitation..

An unconditional grant on the other hand is a kind of broad budget support to the local governments. The advantage is that such a financing modality can take advantage of all the assumed advantages of decentralised planning and budgeting. Nevertheless in many countries, the fiscal transfers are dominated by conditional grants. If own source revenue is limited, the local government budget process may risk to be entirely dominated by central government earmarking of finances. If the use of conditional grants is exaggerated, the accountability tends to be more upward than downward. A real danger of completely centralising the local government budgets will occur and thus leave little rationale for maintaining a comprehensive democratic local government planning and budget system. Importantly local governments should at least be able to adjust services in accordance to local priorities.

On the other hand it is often argued that the health sector will be generally underfunded unless funding is provided in an earmarked manner (as apparently was the case in the early stages of decentralisation reforms in Uganda). There are also some dangers related to local government (or community) use of discretionary funding on health services. In several of the general development block grants

schemes[20] it is found that local governments (or communities) tend to prioritise construction of new health units even when existing health units are receiving insufficient recurrent financing (staff, drugs, maintenance). However such weaknesses may best be addressed through strengthening of local integrated health planning systems that properly balance capital investments and recurrent budget allocations.

It is important to note that the right balance between conditional and unconditional financing of health sector services depend on a large number of country specific issues – not least the capacities of the decentralised health service administration. It is therefore important to monitor the relative merits of various modalities and ensure that such experiences are fed into a qualified policy dialogue.

Earmarked funding: sector funding – from project finance to LG grants

In several cases, donors provide funding directly to local governments through various project specific modalities rather than as integrated through government budgets. This may allow funding in areas that are priorities for donors but not for the national government. Tensions between differing priorities can have adverse consequences for the country's health sector, such as duplication of efforts, and fragmented, inequitable, or unplanned funding[21].

For development partners it may not be possible or desirable to shift project financing into full budget support. However, an option that increasingly is adopted is for donors to work with national governments to formulate specifically designed intergovernmental fiscal transfers (LG grants) that will support the same type of objectives previously supported through projects. This will ensure that funds are integrated into the overall budget process, allocated and transferred to local governments in a transparent manner and ease local planning and reporting requirements. Aid modalities can then relatively easy shift from project mode to sector budget support mode. Several of the health sector conditional grants in many of the poor and aid dependent countries have been developed in this manner.

Various Global Health Partnerships (GHP) are rapidly expanding but constitute a risk for both wider health sector reforms and decentralisation reforms. As stated in GHP "While the increase in funding volume is a much-needed addendum to ongoing support to improve health outcomes, it poses major difficulties in terms of distortion of national health priorities and budgets. It overstrains fragile government administrations and it makes major public sector reforms like decentralization more difficult to pursue"[22].

3.3 Formula for Health Sector Grants

It is a common good practice to share available funds across local governments according to a transparent formula. The general objectives and principles for formula

[20] General LG development block grants include e.g. LGDP in Uganda, LGCDG in Tanzania, as examples of community funds with similar expenditure patterns (i.e. significant expenditures on new facilities while existing facilities are poorly staffed) see e.g. TASAF, NUSAF etc.

[21] For examples see USAID 2008: Decentralisation and Governance in Health.

[22] Ministry of Foreign Affairs, Danida 2009 op. cit page 28.

based grant allocation are discussed in the local government Fiscal Decentralisation paper.

An example of a "good practice" but also rather common[23] formula for a health sector grant is outlined below:

1) Population: 70% - this is the most fundamental measure of "needs" – to ensure that funds are allocated to serve people (rather than e.g. hospitals);
2) Number of poor residents: 10% - to ensure that poorer districts are provided with additional funds in order to enable them to catch up with others. The provision also assumes that more wealthy local governments will be able to generate more local revenue and therefore equalize;
3) District medical vehicle route: 10% - to cater for the fact that services are more costly to provide in localities where the population is more thinly spread. In some countries "land area" is used as a factor, but in Tanzania it was realised that some local governments had large rather unpopulated tracts of land and that total land area didn't provide a true picture of the different costs of health service provision. However the Ministry of Health had over the years established an agreed "mileage allowance" for each district in the country based on the actual distribution of population and health units;
4) Under-five mortality: 10% - as a basic health indicator – to ensure that those local governments that have the biggest health problems also are allocated more funding. However, health statistics are poor in many countries and many types of health data cannot be segregated at local government level (for all local governments) thus there is a limited choice of available data for use.

Importantly the formula adhere to the following principles:

1) Simplicity and transparency: Mechanism should be simple and transparent;
2) Data reliability – allocation factors should to the extent possible be based on reliable data;
3) Focus on service delivery: Transfer formulas should focus on the demand (clients or outputs) rather than the supply (inputs and infrastructure) of local government services (e.g. allocate funds according to number of children/students rather than number of teachers);
4) Avoid equal shares: Excessive reliance on the "equal shares" principle as a major allocation factor should be avoided (since it favours fragmentation of local government system and allocative inefficiencies).

A good formula should also provide incentives for local governments to adhere to good governance principles or improved service delivery. This is challenging to measure in a fair and transparent manner. In the health sector this has to date mainly been applied at facility level (rather than local government level) and linked to utilisation and quality of care indicators (see chapter on human resource management and discussion of "pay for performance P4P").

A major challenge for introduction of formula based grant systems is how in practice to progress from the previous (possible very unequal) allocations towards the newly

[23] This particular formulation is from Tanzania but very similar formulae are found in Malawi and Uganda.

agreed formula based arrangement. In the health sector this would in practice most often present itself as a challenge in the form of historical allocations based on the geographical distribution of health facilities and future largely population based allocations. Such transitions need to be gradual in order not to disrupt existing service provision, but on the other hand phasing in of agreed formula would also be the only way of rectifying previous historical biases.

4. HUMAN RESOURCE MANAGEMENT

4.1 Main models for decentralised HRM

Health sector staff has been decentralised in four main ways[24]:

• Retained in a uniform national civil service: Health workers are seconded or transferred to decentralized units (e.g. districts) under centrally defined civil service terms (e.g. Papua New Guinea and the Philippines)

• Decentralisation of the national civil service: Health workers are transferred to decentralized units, with civil service processes also decentralized to newly created local-level public service commissions (e.g. Uganda)

• Mixed model: Old employees are seconded to decentralized units under the national civil service with centrally defined terms. New hires are employed directly by the decentralized units under locally defined terms (e.g. Jamaica)

• Remove health workers from the national civil service: All public sector health workers become employees of a "national health service" with its own terms and conditions of service (e.g. Ghana), or transferred staff are "de-linked" from it with local terms and conditions of work (e.g. Zambia).

Successful decentralisation of human resources intends to achieve the following objectives:

- Hold staff to account to locally elected bodies;
- Allocate staff where need is greatest;
- Manage its financial resources;
- Attract and retain skilled staff.

The following table identifies the various employer functions that contribute to these objectives.[25]

[24] Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders by Riitta-Liisa Kolehmainen-Aitken in Human Resources for Health 2004, 2:5, This article is available from: http://www.human-resources-health.com/content/2/1/5

[25] Seminar presentation by Evans 2004, World Bank.

Table 2: Impact of Devolving the Employer Function

Impact on administrative Autonomy: Ability to:				
Dimensions of the employer Function:	Hold staff accountable	Allocate staff	Manage financial resources	Attract & retain skilled staff
Budget Transparency . Paying staff from its own budget	√		√	
Budget & Establishment Control . Controlling overall staff number . Controlling staff nos in local facilities . Authority to dismiss surplus staff		√ √	√ √	
Recruitment . Recognition as the formal employer . Authority to hire Ind. Merit-based recruitment mechanism	√ √ √	 √		
Career Management . Transfers within local government . Horizontal mobility . Promotion	 √	√ √		 √ √
Performance Management . Directing & supervising activities & tasks . Conducting evaluations . Ability to discipline/fire	√ √ √			 √
Pay Policy . Setting local hardship/remote allowances . Setting overall wage rates		√	 √	√ √

Decentralisation of human resource management is rarely implemented in full. Even when a fully-fledged separate local government service is created it is typical that the central government retains control over e.g. staff salaries and regulate the total number of employees etc.

4.2 General Experiences for Health Sector Decentralisation of Staff

The health sector features prominently in the literature on staff decentralisation. There are probably several reasons for this. The foremost is the fact that the health sector next to education has the largest number of staff working in decentralised systems including local governments. The literature confirms the significant risks related to poorly managed staff decentralisation including:

- Bias in selection of staff according to local preferences without due consideration of professional competencies and rather, an emphasis on e.g. ethnicity or relationship with a specific politicians;
- Stronger local political pressure on local government staff – including pressure on them to undertake illegal payments to councillors or other financial mismanagement;

- Limitations on career prospect for the higher level cadres, as possibilities for promotion within a specific local government are limited;
- Excessive local recruitment drives and/or non-payment of staff salaries or pension contributions, which leads to accumulated debts that ultimately may have to be carried out by the central government.

A fairly recent synthesis of the literature[26] concludes that decentralisation often had problematic impact on staff motivation and often has taken place without adequate attention to professional human management at both central and local government level. The paper concludes with recommendations regarding three key concerns that national authorities and international agencies should give prompt attention to; (1) defining the essential human resource policy, planning and management skills for national human resource managers who work in decentralized countries, and developing training programs to equip them with such skills; (2) supporting research that focuses on improving the knowledge base of how different modes of decentralization impact on staffing equity; and (3) identifying factors that most critically influence health worker motivation and performance under decentralization, and documenting the most cost-effective best practices to improve them.

In summary it can be argued that weaknesses in decentralised human resource management to a large extent is the result of similar weaknesses in the central institutions responsible for managing the reforms and result of the general limited attention to human resource management issues in public sector reforms generally.

4.3 Staff motivation in Decentralised Context

Most of the discussion on staff motivation has focused on pay although non-pay motivating factors also have been analysed.

4.3.1 Pay for staff motivation

Vujicic (2009) provides an excellent introduction to alternative, performance related payment (PRP) schemes in the health sector. The paper explains the complexities of various payment schemes and discusses research findings on how they affect health workforce performance, particularly absenteeism, productivity and quality of care. The author notes the need to distinguish performance related pay with contracting out arrangements, which can often contain flexible hiring arrangements and elements of performance-based financing. Other points highlighted in the paper include:

1) PRP introduces a risk of unnecessary provision which can lead to cost escalation. It can encourage health workers to demonstrate increased productivity by carrying out procedures that are not based on patient need.
2) Individual performance related pay is not common in developing countries.
3) Sometimes, group financial bonuses are given at a facility level, which can be passed on to individuals (often under contracting out arrangements). Little

[26] Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders by Riitta-Liisa Kolehmainen-Aitken in Human Resources for Health 2004, 2:5, This article is available from: http://www.human-resources-health.com/content/2/1/5

research has been done on how facility level financial incentives impact on individual health worker performance.
4) Research on PRP has tended to focus on service delivery impact, rather than workforce productivity.
5) Increasing wages alone does not improve performance. Salary increases are more effective when linked to performance.
6) Individual PRP systems are burdensome to monitor and costly.
7) Group based PRP systems are easier to administer but dilute the incentives for high-performers and allow poor-performers to benefit. A combination of individual and groups schemes may work well.
8) There has been little research on the impact of group PRP on individual performance.

The paper also suggests that the following components are needed to implement an effective PRP system:

1) A supportive legal framework;
2) Government flexibility;
3) Adequate management skills at all levels;
4) Adequate monitoring capacity;
5) Appropriate, carefully targeted incentives.

Box 3: Pay for Performance Initiative in Rwanda

This World Bank study evaluates the implementation of the „Pay for Performance" (P4P) initiative in the Rwandan health sector. P4P is designed to improve worker productivity through the provision of bonuses to providers for improvements in utilization and quality of care indicators. The authors find that P4P can affect health care firstly by incentivizing providers to put more effort into specific activities, and secondly by increasing the amount of resources available to finance the delivery of services. In particular, the study finds that P4P had a large and significant positive impact on institutional deliveries and preventive care visits by young children, and improved quality of prenatal care. No effect was found on the number of prenatal care visits or on immunization rates. P4P had the greatest effect on those services that had the highest payment rates and needed the lowest provider effort. The authors conclude that P4P financial performance incentives can improve both the use of and the quality of health services.
Basinga, P. et al., 2010, 'Paying Primary Health Care Centers for Performance in Rwanda', World Bank Policy Research Working Paper no. 5190, Washington D.C.

4.3.2 Non Pay Incentives

Possible alternatives to pay related performance enhancement systems include merit-related promotion as a less burdensome way of linking performance with pay, or performance related financing of teams or facilities rather than individuals. A recent study (Therkildsen and Tidemand 2007) provided evidence of impact of several non-pay incentives on organisational performance in a number of organisations in East Africa including: improved organisational leadership, realistic work planning, job delegation and improved personnel management. Judith Tendler (1998) concluded in a similar way regarding the performance and motivation of Brazilian health workers.

A general challenge for health sector practitioners is that pay and to some extent also non-pay motivating factors for health staff largely is the domain of the ministry responsible for public service (or similar institution) or local government institutions where it often will be very difficult to introduce specific benefits just for health staff.

In Danida health projects it has occasionally been attempted to address issues within the health sector only but also as part of wider public service reform programmes as when the health sector programme supported an initiate for Strategic Accelerated Salary Reform (SASE) within the broader public service reform. A main lesson from that exercise was that close follow up and continuous dialogue from the development partner and health sector is required for such reforms to be effective. In Tanzania the SASE scheme for health staff turned out to be ineffective because original intentions of targeting local (rather than head quarter) staff and linking SASE with performance appraisals were never implemented.

5. LOCAL ACCOUNTABILITY ARRANGEMENTS

This section discusses two main issues related to local accountability arrangements within decentralised health systems. Firstly the accountability issues related to situations where several forms of decentralisation are implemented simultaneously, and secondly accountability issues related to local government systems[27].

5.1 Different Routes of Accountability

The World Development Report of 2004 emphasised the importance of effective accountability mechanisms for improved service delivery to the poor. The report argued essentially for two ways to enhance accountability (1) by devolution of functions, finance and staff as discussed above and (2) by creation of a "short route" of service provider/public servant accountability to the public/clients. The latter can be promoted by the introduction of user groups at the service delivery level such as, health committees etc that will strengthen the "voice" of citizen in influencing the quality of service delivery.

Concurrent decentralisation through various modalities e.g. devolution and user groups may create complimentary and mutually enforcing systems that enhance the voice of (poor) citizens. Citizens may for instance influence the planning and delivery of health services through their local government while also participating in the local health unit committee in a mutually benefitting manner. However, often will different simultaneous forms of decentralisation also lead to uncoordinated and wasteful service delivery. The current arrangements in Kenya are for instance a well-documented case[28] whereby at least five parallel systems are in place for planning and delivery of services such as health. Lines of accountability are then confused and practical arrangements for service delivery uncoordinated. This is often hampered by

[27] For an in-depth discussion of the concept of accountability and analytical tools for understanding accountability issues it is recommended to use the http://www.gsdrc.org/go/topic-guides/voice-and-accountability

[28] The Danish Embassy in Kenya has recently supported a number of analytical reports available from their website: http://www.ambnairobi.um.dk . See also Dege Consult 2007 – www.dege.dk.

unclear assignment of services delivery mandates and interventions by central government in local government decision-making.

		Decision-makers located at	
		Central level	Local level
Decision-makers accountable to	Central body	**Centralisation** The Ministry of Health HQ centrally deploys health staff of different administrative units in a country. Budgets and accounts are made centrally **Delegation:** A relative autonomous central health board or health service commission manage staff deployments nationally. Executive agency with delegated powers under Ministry of Health. Budget and spending powers can be substantially decentralised.	**Deconcentration** Health field officer is granted discretion by the HQ regarding the assignment of responsibilities and duty stations to subordinate staffs. Budgets will be developed locally within strict central control and approved by central government.
	Local body	**"Delegation** with participation" A relative autonomous local /district health board or health service commission manage staff deployments locally. Budgets and accounting may be under substantive local scrutiny.	**Devolution** An elected local government is given the responsibility for the recruitment, deployment and discipline of local staff. The local government will have varying degree of local spending and taxing powers. Budget may include some central government scrutiny or even approval. **User Participation -** a health committee formed around a clinic is given responsibility for managing the clinic – including some discretion on recruitment of support staff and certain aspects of general staff welfare. Budgets and accounts are approved locally but with oversight from central and local governments.

5.2 Local Accountability in Local Governments

The general issues related to accountability of local governments were discussed in the Good Practice Paper and included issues related to:

- Local government elections (the extent to which councils are fully elected through free and fair elections);
- Modalities for more direct measures such as direct reporting by local governments to citizens on local government budgets, accounts and audits, access for citizens to be involved in planning, budgeting and project

implementation, possibilities to control performance, etc. that enhance the demand side of decentralisation reforms;[29]
- Control of corruption including use of Public Expenditure Tracking Studies (PETS).

For health sector specialists it is always a dilemma whether local accountability is to be strengthened by working through local government institutional arrangements or by establishing parallel modalities within the local government system. While the first option in theory is the most evident, in practice health sector programmes have often established additional health committees within the local government system (in addition to existing health committees), separate planning systems, separate financial management systems etc. In general the relative impact of such arrangements are poorly documented.

It is common that conflicts arise between what technical staff consider most rational and what are politically popular solutions. The emphasis that local communities and politicians frequently attach to e.g. health infrastructures and curative services conflict often with technically informed analyses that may put relative more emphasis on recurrent costs implications of infrastructure development and recommend more emphasis on preventive services. Such conflicts frequently lead health experts to resist decentralisation although more effort could be put into strengthening local capacities for health planning among that also brought local politicians on board .

6. Central institutions for reform coordination and oversight

6.1 Policy Coordination

To undertake a decentralisation reform of an otherwise centralised public administration requires fundamental changes of the strategies and systems of the central ministries as well as the establishment of relevant central supporting institutions. A decentralised health system with substantive functions assigned to local governments will normally require a more complex sector and donor dialogue than prior to decentralisation where the dialogue mainly was between donors and Ministry of Health. Under a decentralised health system it will be necessary to expand the dialogue and possibly ensure that new institutionalised procedures are in place for

- Working an established ministry of Local Government (MoLG) or Ministry of Internal Affairs responsible for local governments;
- Possibly working with Associations of local governments;
- Support relevant political oversight institutions (for instance a local government Public Accounts Committee);
- New permanent institutional arrangements for local government finance for dialogue with the Ministry of Finance;
- Institutional arrangements for local government human resource management that may include all of the above institutions in addition to the Ministry responsible for public service, public service commissions.

[29] For a discussion of recent experiences and approaches see www.gsdrc.org/go/topic-guides/voice-and-accountability/creating-participatory-spaces#dec

A key challenge for the sector is how to reorient itself institutionally once decentralisation is the declared policy. This is not easy as there are often low capacities within the Ministry of Local Government on health issues are frustrating such efforts.

6.2 Technical Oversight of Local Governments

The health sector is a technically complex sector that requires close interaction between its various levels of service provision and planning. Decentralised systems require adequate modalities for central government oversight and support. Typically this may include supervision by the office of the auditor general and the ministry responsible for local governments or similar institutions, but will also require sector specific arrangements. A key challenge is to build such arrangements into the wider central – local government reform. Some countries like Tanzania have intermediate deconcentrated regional structures that may serve such purposes.. A recommended practice is to ”piggy back” on existing systems rather than build new health sector specific arrangements except where it is really necessary. Specific health sector planning and service delivery issues may require sector specific support, but e.g. support and oversight of local government finances and local government personnel management may more successfully be integrated into generic approaches implemented by e.g. the ministries responsible for finance and public service. Some countries have also introduced performance based grant systems where health sector specific issues may be included. Further research is required for better understanding modalities for general local government oversight in the health sector as well as specific issues related to decentralised health care supervision[30].

7. SUMMARY CONCLUSIONS AND RECOMMENDATIONS

Decentralisation of health services is a common feature of global health sector reforms. While decentralisation can take many forms, there is an increasing trend towards some form of devolution (decentralising to local governments) in many countries. This form of decentralisation is the most radical with the most significant potential benefits but also with the greatest challenges to the sector.

The impact of decentralisation is not clear in terms of impact for all countries and depends on the specific features of decentralisation. However, five general key issues can be identified as critical for successful decentralisation of health services:

1) Pillar one: a clear and appropriate assignment of functions to the decentralised units. Although one cannot make generalisation regarding what functions are best suited for devolution, it is possible from the literature to assess what commonly are decentralised function. These broadly relate top decentralised planning and provision of primary health care services. There is broad consensus that a good practice is to have the functions assigned as clearly as possible. A tool for assessing the extent to which this is the case specifically for

[30] Xavier Bosch-Capblanch and Paul Garner 2008: Systematic Review of Primary health care supervision in developing countries, Liverpool School of Tropical Medicine, Liverpool, UK, Tropical Medicine and International Health, volume 13, issue 3, 2008.

the assignments of health sector functions is attached as Annex 2. The analysis also concludes that certain key functions frequently are undertaken in a problematic way if not very carefully analysed in a decentralisation process: this includes in particular drug procurement, infrastructure development and personal management.

2) Pillar two: appropriate financing modalities for decentralised health services: this includes appropriate costing of services and provision of financing modalities. Trade-offs have to be made between sector earmarking and more discretionary financing of local governments that in principle will allow for locally more suitable health systems. A key challenge for the health sector in many parts of the poorer developing countries (including most of Sub-Saharan Africa) is the significant gap between the theoretical amount of funds required to reach the MDGs and the current actual allocations. Effective use of additional (donor funded) health resources can only be achieved if capacity of a decentralised systems is built. Health sector funding is often earmarked at local level. There is a need for country specific documentation of the relative impact of non-earmarked and earmarked funding. The various global health funds frequently constitute challenges for integration of development funding into local government grant systems.

3) Pillar three: Human Resource Management – the health sector is particular sensitive to the impact of decentralisation on local human resource management as the health sector is "staff intensive". Local human resource management is frequently problematic and efforts for building such systems are urgently required. This can however, not be separated from building the wider capacity of human resource management in local governments. It is to a large extent an ignored aspect of decentralisation reforms and it is important that development partners ensure that it receives adequate attention.

4) Pillar four: Local Accountability Structures – different forms of decentralisation lead to different forms for local accountability. It is important to avoid duplication and overlaps that leads to unclear lines of accountability. There is some evidence that decentralisation by devolution not necessary leads to greater community involvement in the health sector. Supporting institutions such as community committees to ensure the voice of local people – care should be taken to relate these to the local government accountability structures.

5) Pillar five: Central institutions for reform coordination and oversight – when the health sector is decentralized by devolution there is a need for working with a much wider group of central institutions than in more traditionally centrally managed health sector programmes. Decentralisation of health sector functions for e.g. primary health care do not imply that central government no longer has a responsibility, but that the role of the central government is to be refined. The role of central government institutions for technical support and oversight to local governments under a decentralised system is often overlooked and require further attention.

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Key Resources on the web about health sector decentralisation

International Health Systems Program Department of Global Health and Population Harvard School of Public Health:
http://www.hsph.harvard.edu/ihsg/publications.html#2

Management Sciences for Health (MSH) http://www.msh.org/ includes a range of useful publications as well as a "Health Managers Tool Kit" http://erc.msh.org/toolkit/ - that also includes a "decentralisation mapping tool" (http://erc.msh.org/mainpage.cfm?file=95.10.htm&language=english&module=toolkit)

World Bank – health Sector reforms and Poverty and Social Impact Analysis
http://go.worldbank.org/WFLJX0XKY0

World Bank Health Sector Issues in Administrative and Civil Service Reforms
http://go.worldbank.org/53EU7N10C0

World Bank – Social Accountability Sourcebook
http://www.worldbank.org/socialaccountability_sourcebook/

World Health Organisation http://www.who.int/en/ includes a range of useful publications. Part of their site is dedicated to discussion of issues related to decentralised heath service delivery:
http://www.who.int/management/district/en/

SDC website on health sector decentralisation issues:
http://www.sdc-health.ch/priorities_in_health/good_governance/health_sector_reforms

USAID Health Systems 20/20 website http://www.healthsystems2020.org/ includes a wealth of documentation including a range of articles related to health sector decentralisation:
http://www.healthsystems2020.org/content/search/?search_query=decentralization&searchButton.x=15&searchButton.y=16

Annex 1: District Based Normative Costing Model (Indonesia)

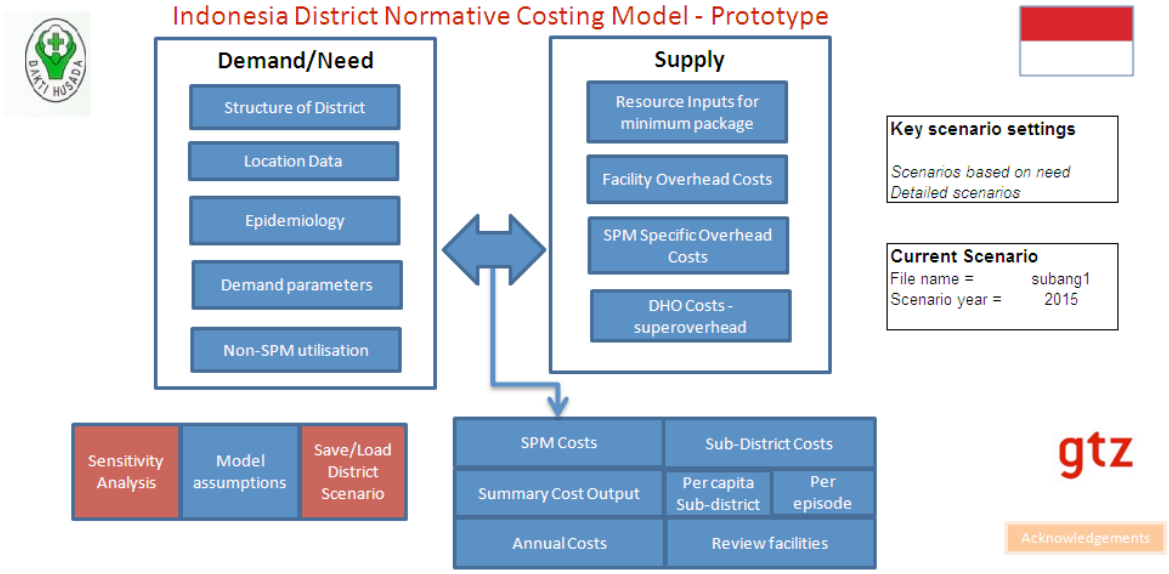
Oxford Policy Management, GTZ, Health Department Republic of Indonesia (Final Report April 2009): District Based Normative Costing Model

The objective of the district based normative model is to provide realistic, dynamic costing of the SPM (Standard Pelayanan Minimal) services that are part of the government's commitment to health of the population of Indonesia, by estimating the normative cost SPM conditions – 29 Services for Phase 1, calculating the actual cost of activities undertaken by Puskesmas and District Hospital, including SPM and Non SPM services for Phase 2, identifying cost determinants of Puskesmas and Hospitals in district level for both SPM and Non SPM services for Phase 2 and using the estimates and actual costs for purpose of budgeting and resource allocation.

The model is designed to be used to simulate the costs of providing services in a district based on key characteristics of that district. As such it takes account of the structure of health services in the district, geographic location and specific disease characteristics of the area.

Whilst the objective of the model is to cost the SPM it is clear that services that are not part of the SPM make a significant and probably increasing contribution to the workload of facilities. Since many resources within the system are shared between services (SPM and non-SPM) the apportionment of these overheads to SPM services is partly dependent on the provision of non-SPM services. Furthermore facilities have a maximum workload beyond which they cease to be economically and clinically effective requiring further capital investment, again a function of both SPM and non-SPM activity. For both these reasons it was felt important to ensure that that some measure of non SPM activity was included for the workload modelling even though the model does not provide a detailed cost of these activities.

Figure 1: Main menu



The model is divided into two main parts. The first part Demand/Need provides an estimation of workload either based on need for services or demand. The second part, Supply, provides information on the direct and overhead costs of providing service. Combining the cost components with workload provide a series of simulation of costs both for a chosen scenario year and over time. All parts of the model can be accessed from a main menu (Figure 1).

Annex 2: Decentralisation Management Tool

A useful decentralisation management tool has been developed for policymakers and managers that identifies those health management functions for which responsibility and management authority are most ambiguous.
It is an excel based system available on the web:

http://erc.msh.org/mainpage.cfm?file=95.10.htm&language=english&module=toolkit

Description:

Decentralization changes the way health systems and organizations are managed, but the new roles are rarely spelled out in sufficient detail. The Decentralization Mapping Tool (DMT) is designed to assess (1) the way responsibility and authority are distributed among management levels and (2) the extent to which responsibility for and authority over management functions have already been decentralized.
The DMT can be used to:

- assess whether health managers at different levels currently share the same perception of how responsibility and authority are allocated;
- examine managers' perceptions at different points in time to see whether management roles become clearer and whether the distribution of management responsibility and authority shifts in the desired direction over time;
- compare health managers' current perception of their responsibility and authority with the country's decentralization design.

The DMT instrument consists of a set of worksheet matrices in Excel. The data collection sheet lists all functions that are critical for managing a health system or an organization that are potentially affected by decentralization. These functional areas are health service delivery

- public health surveillance and response
- financial resources
- personnel
- drugs, vaccines, and supplies
- equipment and transport
- capital construction and maintenance
- health and management information systems
- health communications

There is a data analysis sheet for each of the nine functional areas plus a summary sheet to show the overall "picture" of the health system.

The DMT is applied through guided interviews with multidisciplinary teams composed of managers working at the same level (national, district, etc.). The team is asked about which management level is perceived to be responsible or have authority for each function or sub-function listed, and the team's consensus answer is recorded.

Findings are presented graphically as color-coded pie charts so that users can see quickly where there is high consensus, as well as where no consensus exists.

Developed by:
Health Reform and Financing Unit of Management Sciences for Health (MSH), 2004. (The DMT is based on the Decentralized Planning Tool developed by MSH, 1999-2000.)

Intended Users:
Health sector reformers, health planners and managers, health system researchers and representatives of donors and collaborating agencies.

Application:
The DMT was field-tested in the Dominican Republic, Ecuador, Guyana, and Jamaica. A modified version of the DMT was used in Nicaragua to collect data for restructuring the Ministry of Health.

Advantages:
The DMT allows policy-makers and high-level managers to identify and target for action the most critical management areas where roles are confused. Health systems and organizations benefit from the clearer definition of roles and responsibilities, reduced conflict, and better "fit" with the original decentralization design.
The DMT is a very flexible tool. It can also be used to compare perceptions of different groups of stakeholders, for example.

Limitations:
Requires familiarity with Excel.

Recommendations for Users:
Each guided interview takes approximately 1.5 to 2 hours, depending on how long the team requires to reach consensus. One day for data entry and analysis is needed after every 2-3 guided interviews.

Availability:
The DMT instrument and an accompanying User's Guide are available in English and Spanish.

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