



Decentralization and Governance in Health

With almost all countries developing or implementing some form of decentralization, health initiatives targeting control of specific diseases, as well as projects that work on broader health systems restructuring, will be influenced by these decentralization efforts. It is important to assess the degree and types of decentralization and to formulate strategies for promoting more effective decentralization, or at the least learning to cope with and manage within decentralized systems. This paper presents some of the basic governance issues related to decentralization and some examples of how projects and donor policies have contributed to more effective decentralization processes.

Decentralization is basically about who makes decisions over what specific issues and how much choice they are able to make about these issues. If governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them, then decentralization is a specific case of governance (see Brinkerhoff and Bossert 2008). It specifies the arena – national, provincial or state, district or county, or municipality – that is addressed by interest groups from civil society, where the political processes over specific policymaking is made. It determines who participates in those decisions and who is responsible for implementing those policies. In Health System 20/20's health governance model that frames the linkages among the state, providers, and clients/citizens, decentralization specifies where the responsibilities of the state lie. Since responsibilities for different issues are often shared among all levels of government, it is important to understand the specific allocations of decision-making power and responsibility at each level in order to develop appropriate strategies for strengthening the governance capacities at those levels.

The purpose of this paper is to clarify the concepts of decentralization by introducing a framework of analysis that defines decentralization in terms of the decision space that public officials at different administrative levels of the state have, their capacities, and their accountability. Finally we discuss how USAID projects can attempt to improve the performance of decentralized systems.



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WHY IS DECENTRALIZATION AN IMPORTANT ISSUE?

Many countries around the world have begun to decentralize their general public administration in ways that directly affect their health systems. Often responsibilities and authority, once vested in the ministry of health, are transferred to the elected governments at state, province, county, and municipal levels. In other cases, highly centralized health systems grant greater decision-making authority to their own regional and district offices.

Governments decentralize for a variety of reasons. Sometimes the process is initiated for political reasons to encourage greater democratic processes and to guard against future authoritarians consolidating power in the center, as was the case, for instance, of the administration of Corazon Aquino in the Philippines. Often, advocates for decentralization argue that decentralization can improve the accountability and responsiveness of local officials to preferences of the local population and, with better knowledge about the local conditions, can produce better policies for addressing specific local needs. Others have demonstrated that decentralization can improve the equity of allocations to localities (Bossert, Larrañaga, et al. 2003). These advantages may have positive effects on health system objectives.

On the other side, many have found that decentralization is not the panacea claimed by its supporters. Some studies have noted that decentralizing health systems has failed to alleviate drug shortages or increase efficiency of resource utilization. Others have found that decentralization actually disrupts health systems, leading to fragmentation, inadequate funding, disruption of centralized logistics and information systems, and a breakdown of relatively successful vertical programs such as family planning and immunization (Jeppsson and Okuonzi 2000, World Bank 2000, Khaleghian 2004, Homedes and Ugalde 2005, Newell et al. 2005, Phommasack et al. 2005, Soerojo and Wilson 2001). A recent analysis of 140 low- and middle-income countries highlights the potential problem of decentralization for achieving high rates of immunization. While low-income countries with devolution of fiscal authority had higher immunization rates than more centralized political regimes, the opposite occurred among middle-income countries (Khaleghian 2004).

KEY ISSUES OF DECENTRALIZATION AND GOVERNANCE

Decentralization is a structural change in governance that changes who makes decisions and how much choice they have over different functional issues of health systems. The effectiveness of decentralization will be strongly influenced by the actual range of choice allowed to local decision makers as well as their capacities to make good decisions, the funding available for implementing programs, the local administrative capacity for implementation, and the degree of accountability they have to both national government and to their local populations.

In the Health Systems 20/20 governance model of linkages among state, providers, and clients/citizens,



illustrated in Figure I, decentralization disaggregates the state category, allowing for a local set of officials to be more directly accountable to their local clients/citizens and to have more direct influence over local providers. However, of course, the relationships are more complicated. The national governments rather than local governments may be more responsive to the needs and desires of the local population, especially the poor, if the local government is captured by local elites. And the national government might have better access to knowledge and expertise of those who know more about what kinds of services will be most effective in addressing health needs. We will address some of these issues below.

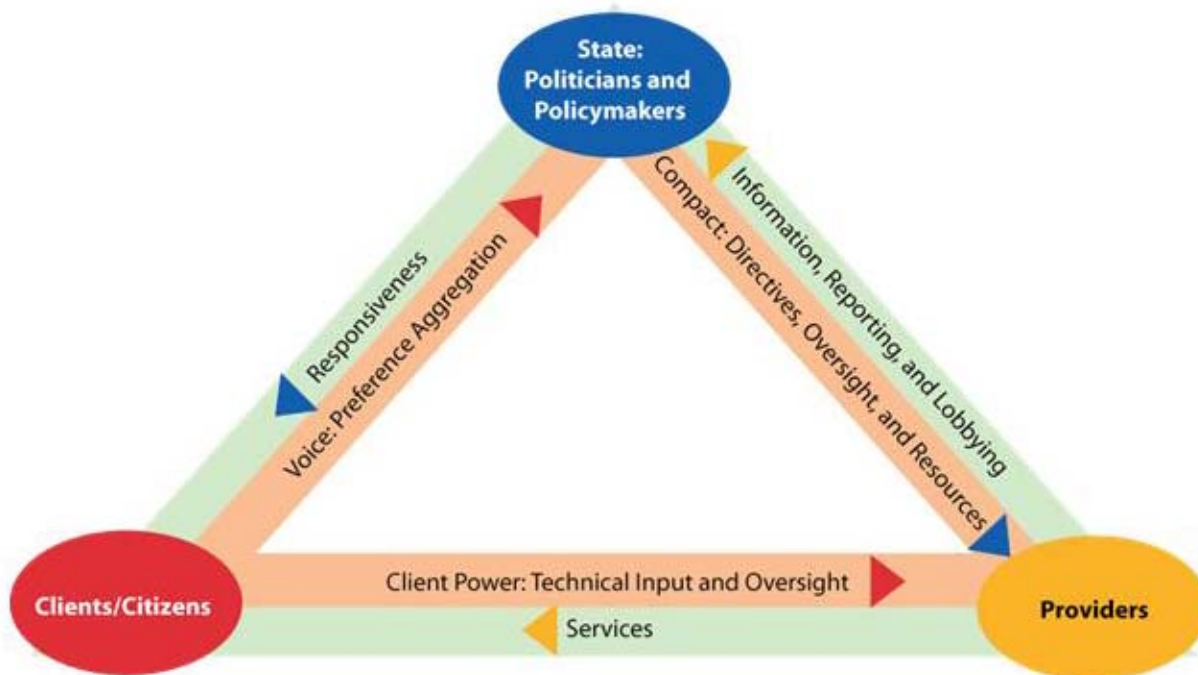
WHO GETS HOW MUCH CHOICE OVER WHAT?

It is important to know who in the state is making decisions, especially if we want those officials to be more accountable. The standard definitions of decentralization make useful distinctions among the officials who are in regional or district offices of the ministry of health, which is called **deconcentration**; local government officials of states, provinces, municipalities, **devolution**; or officials of

semiautonomous agencies like a central board of health, accrediting agency, and the like, **delegation** (Cheema et al., 1983, Mills et al, 1990). There are significant differences in the potential decision-making authority and the accountability implied in these categories. Deconcentration usually allows significant control by the national ministries since they usually are responsible for the career paths of local decision makers and they specify the norms of service for these officials. Many countries, including Costa Rica, Zambia, and some states in India, deconcentrate some decision-making authority to the provincial or district administrative offices of the ministry of health.

Devolution, while often increasing the range of choice allowed, also introduces competition with other sectors for local resources since local officials usually are responsible for education, water and sanitation, and other local services that compete for local budgets. Devolution introduces other stakeholders into the decisionmaking over local health system activities, which often changes health system priorities. The Philippines, Chile, Colombia, and many others have devolved some decision-making authority to local elected governments.

FIGURE I. HEALTH GOVERNANCE FRAMEWORK



Source: Adapted from World Bank 2004, 2007

Delegation is often a means of sharing responsibility in ways that introduce new mixes of stakeholders and new administrative structures to implement policy decisions made by national government actors. For example, the ministries of health delegated some operational decision-making authority to a central board of health in Zambia and Ghana. Table I offers a summary.

In addition, it is useful to know at what administrative level these officials are located (e.g., region, state, county, district, or municipality), and how many layers there are between the central authorities and the smallest administrative units. In the Philippines, for example, devolution of authority has involved providing local authorities with block grants relatively unencumbered with earmarking or central-level directives. Under Ghana's delegation, by contrast, fiscal decisions continue to be overseen by a semiautonomous Central Board of Health that imposes relatively more rules and provides relatively less local decision-making leeway (e.g., formula-based budget allocation) than in the Philippines. And in Zambia's deconcentration, district-level authority to develop and manage budgets is conditional upon

central-level approval in most regards, such as purchasing decisions and work plan development (Bossert and Beauvais 2002).

Next, it is important (and not often clearly defined) to know how much choice these officials have over what specific functions of the health system – something we call "decision space" (Bossert 1998). Decision space can be defined as the range of effective choice that is allowed by the central authorities to be exercised by local authorities. This range can be both officially granted and/or informally assumed. Official regulations and policies that determine the administrative form of decentralization – deconcentration, devolution, and delegation – relate to official decision space. Idiosyncratic and personal interpretation of rules as well as negotiations and give-and-take of authority between levels of the system often results in an informal decision space that may be more or less than the formal sanctioned range of choice allowed. Both elements combined define the specific "rules of the game" faced by decentralized units. Decision space may be negotiated and cause friction between levels, with local authorities challenging the degree of decision space

TABLE I. DECENTRALIZATION AND GOVERNANCE: KEY QUESTIONS AND CONCEPTS

Key Questions	Key Concepts
Who gets more decision making power?	Deconcentration - local offices of national ministries Devolution - local elected officials Delegation - semi-autonomous agencies
How much decision-making power over what kinds of functions?	"Decision space" - narrow, moderate, or wide choice over different functions such as: <ul style="list-style-type: none"> ● Budgets ● Human resources ● Service delivery
What kinds of capacities do local authorities have?	Capacities are a function of - <ul style="list-style-type: none"> ● Local staffing, skills, experience and training ● Evidence-based decision-making ability ● Levels of corruption and patronage
What is the accountability of local authorities?	Besides the degree of decentralization (deconcentration, devolution, or delegation) accountability is influenced by - <ul style="list-style-type: none"> ● Extent of civil society participation ● Transparency of policy and administrative processes

Source: Author

conferred on them by the central authorities. It can be mapped for various functions or expressed across a range of narrow, moderate, or wide.

Table 2 shows examples of decision space for three Latin American countries that have a reputation for being highly decentralized. It is pertinent to note that many functions remain relatively centralized ("narrow" decision space) even in these countries that had a reputation for being the most decentralized in Latin America.

There are a number of advantages to adopting the decision space approach to analyzing decentralization. It accounts for decentralization that exists both on paper and in practice. Its framework permits a much more nuanced analysis than is possible under the administratively oriented classifications of decentralization. Rather than seeing decentralization as a single transfer of a bundle of authorities and responsibilities, decision space accommodates function-specific analyses over which local officials have a defined range of discretion. For

example, different degrees of decision space may exist depending on the various functions and activities over which local authorities will have increased choice. A greater or lesser degree of decision space along one dimension, such as human resources, may not imply commensurate decision space along other dimensions (e.g., budgeting). Ultimately, the decision space approach provides a framework to indicate how much choice decision makers at each level have over the providers of services as well as what the local population can reasonably hold them accountable for.

DECENTRALIZATION AND FUNDING

Decentralization often involves a significant shift in control of funds and the local contribution of funds. Complex mechanisms of transferring funds from the central government to local authorities often restrict local decisions over these funds through earmarking expenditures for specific activities, but in some instances these intergovernmental transfers are in untied block

TABLE 2: DECENTRALIZATION AND DECISION SPACE IN CHILE, COLOMBIA AND BOLIVIA

Functions	Range of Choice		
	Narrow	Moderate	Wide
Financing Sources of Revenue Expenditures Income from Fees	Chile	Colombia, Chile Colombia, Bolivia Colombia, Bolivia	Bolivia Chile
Service Organization Hospital Autonomy Insurance Plans Payment Mechanisms Required Programs & Norms	Colombia, Chile Colombia, Chile, Bolivia Colombia, Chile	Bolivia Colombia, Bolivia Bolivia	Chile
Human Resources: Salaries Contracts Civil Service	Colombia, Bolivia Colombia, Bolivia	Colombia, Bolivia	Chile Chile Chile
Access Rules	Colombia, Chile	Bolivia	
Governance Local Government Facility Boards Health Offices Community Participation	Chile Colombia, Bolivia Colombia, Bolivia Bolivia	Chile Chile	Colombia, Bolivia Colombia, Chile
Total Decision Space: Colombia Chile Bolivia	8 6 6	5 4 6	2 5 3

Source: Bossert (2000a).

grants over which local authorities can make relatively unrestricted choices. In addition, local governments often assume a larger responsibility for funding their services by assigning local revenues from taxes and other sources. These local sources often make the difference between effective and under-funded services. However, in other cases, the local sources may be diverted to programs that are not priorities of USAID or of the national government.

In some cases, donors provide funding directly to local governments. This may allow funding in areas that are priorities for USAID 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. In Bangladesh, for instance, the number of project management units established to coordinate donor funding once exceeded 100 (Peters and Chao 1998). In Kenya and Zambia, donor-supported (and donor-accountable) family planning project units resulted in duplication of policies and programs, some of which were not compatible with each other. In Ghana, the unwillingness of some donors to participate in the sector-wide approach (SWAp) pooled funding mechanism undercut incentives to budget and plan holistically. The Ghanaian Ministry of Health, for instance, did not include a line item for condoms knowing that funding for this commodity would continue outside of SWAps (Mayhew 2002).

LOCAL AND CENTRAL CAPACITIES AND DECISION MAKING

One of the often-mentioned problems with decentralization is the lack of sufficient capacity at the local level to make appropriate decisions and to implement them without strong direction and supervision from the top. These capacity gaps come in a variety of forms: lack of sufficient staff in critical administrative positions, lack of appropriate education, training, and experience to develop needed technical and managerial skills, and evidence of high levels of corruption, patronage, and favoritism. Few systematic studies document these weaknesses, and often the preconceived opinions of central authorities (who have an interest in showing failures of decentralization) are not supported when careful studies are made. For instance, in Andhra Pradesh,

India, state officials resisted decentralization using this argument. However, when studies were made of the local capacities, they found significant levels of skills and training that were sufficient for allowing greater decision-making capacity (Berman et al. 2003).

In other cases, capacity gaps are real and contribute to serious implementation problems for projects and national programs, especially those requiring high degrees of information sharing between different levels of the system. Radical devolution of authority to local municipalities in Senegal was not accompanied by central-level guidance on funding and operating the health system. With the breakdown of communication between local authorities and the Ministry of Health, the local authorities seldom followed national priorities and often did not provide even minimum funding for health services (Berman and Bossert 2000). In both the Philippines and Uganda, malaria control programs under decentralization have suffered from a disconnect between data and planning and inability to use financial resources due to capacity deficiencies at the local level (Espino et al. 2004, Kivumbi et al. 2004). These kinds of problems associated with decentralization are not uncommon.

In a decentralized system, central capacities also need to be developed. Traditional central functions such as the use of information systems for monitoring and evaluation may be even more important than in a centralized system. Without a direct command structure, the central authorities first need to ensure that their information systems are providing information about the decisions that are being made at local levels and their performance. Without appropriate information, the central authorities cannot monitor and evaluate the initiatives taken at the local levels. They need to identify failures to reach national priorities as well as identify innovations that might merit being disseminated for others to adopt. In order for the central level to hold the periphery units accountable, without direct authority that comes within a line ministry, they need to develop alternative mechanisms of stewardship, administrative and technical oversight, and the development and enforcement of regulations. The role of setting standards and norms becomes one of the major means by which the center can restrict local choice in order to ensure quality of health providers and at least minimum adherence to national priority programs.

In their stewardship role, central authorities also need to develop skills and mechanisms for encouraging local decision makers to adopt policies and programs that are national priorities. Establishing the capacities to provide technical assistance to local governments in a collaborative and diplomatic manner is an important shift from the usual authority that a centralized ministry often enjoys.

CORRUPTION

Corruption is defined as the use of public office for private gains. It can undermine both the effectiveness of public services to achieve health objectives and reduce the ability of clients and citizens to hold officials accountable (Lewis 2006). Health systems offer many venues where actors have the opportunity to pursue potential corrupt practices, from national to local elected officials who make policy decisions and administrative officials who control budgets and procurements, to facility managers and individual providers (Savodoff 2007). There are many types of corruption: absenteeism, purchasing of staff positions, kickbacks for procurement, falsification of invoices, and payments to elected officials for policy decisions. All of these forms have potential to undermine the effectiveness of health systems to achieve their goals, reduce the capacity of accountability mechanisms to hold officials accountable, and reduce the legitimacy of the government in the eyes of the public.

By allowing for more decisions to be made by local officials, especially over procurement and local policies, decentralization potentially increases the opportunities for corruption, especially in systems in which the enforcement capacity of the central authorities is weak. There is little evidence, however, that decentralization increases overall corruption, or that decentralization of corruption results in less-effective governance. There have been arguments that suggest that local-level corruption may often be at a smaller scale and may only affect some jurisdictions and not others, while centralized corruption, involving larger sums of money, may have a more devastating impact on effectiveness of health systems. Others suggest that local-level corruption is likely at least to recycle funds within a country, while central-level officials are more likely to have access to external bank accounts, and therefore may contribute less to the national economy. Local-level corruption is not benign, though, and risks undermining the legitimacy

of local government officials and reducing public adherence needed to enforce regulations and laws.

In any case, the remedy for decentralized corruption is likely to be similar to activities suggested for reducing corruption in general. Positive measures include adequate (competitive) pay for officials, more rigorous auditing, merit-based systems of human resources, and increasing local-level accountability through community oversight (Lewis 2006). Anti-corruption interventions would likely be more effective if an integrated approach to addressing corruption at both the central and local levels were implemented.

ACCOUNTABILITY

In democratic political systems, there are four key actors that clients and citizens can hold accountable for providing for their needs and preferences about the health system: national elected politicians, national officials (usually civil servants) in health administration institutions (ministries of health, health insurance institutions, education institutions training health professionals), local elected politicians, and local health administration officials. Decentralization shifts the burden of accountability from the national to the local officials. However, the means of accountability for elected officials may be different from those that apply to administrative officials. The major mechanism for holding elected officials accountable is elections. Other means include public protests, media reporting, and – in cases of malfeasance or corruption – investigations and prosecutions. Non-elected officials may be held accountable by being removed or transferred by elected officials, or through oversight by health commissions, hospital boards, legislative hearings, and/or judicial institutions. Beyond these so-called agencies of restraint, non-governmental organization (NGO) watchdogs and the media can enable civil society to bring voice into the policy-making process and into public administration.

Local health officials are subject to two principal forms of accountability: horizontal accountability to local government officials or to local civil society organizations such as facility health committees, and vertical accountability to higher administrative officials such as the ministry of health. These linkages have implications for the governance model we have used in the Health Systems 20/20 project, which focuses

on the long and short routes of accountability between clients/citizens and the state (see World Bank 2004). Horizontal accountability shortens the route of accountability for some health system performance by increasing the responsibility of local officials, while it does not remove the vertical accountability of the central government, which should also be held responsible for health system performance.

One of the principal arguments for decentralization since de Tocqueville and, subsequently, public choice and fiscal decentralization theorists (Tiebout 1956), is that local officials will be more responsive and accountable to the preferences and needs of the local population than will distant bureaucrats in capital cities. This logic is implicit in the general governance model of the Health Systems 20/20 project in that service users/citizens are more able to hold the state accountable if the government officials are local and can hear their complaints, or can be voted out of office if they are not responsive to citizens'/clients' preferences (in Hirschman's famous term: citizens can exercise voice more directly). Centralized authorities are likely to be less responsive to the specific preferences of local populations since they are accountable to a wider set of patients and interests. A second set of fiscal decentralization arguments is about competition among different jurisdictions to attract resident voters, labor, and capital investments. In this argument, local politicians make choices to provide services that will attract more investment and satisfy the preferences of local voters to whom they are accountable.

An example of this kind of accountability has been the transfer of authority to local elected officials in the Panchayat Raj institutions (PRIs) in some Indian states to validate attendance of health professionals in their health facilities. In many parts of India, absenteeism is a significant problem. This authority allowed officials to dock pay for professionals who were not at their posts.

This benign vision of local accountability, however, is challenged by the possibility that local officials may be captured by local elites or specific political or economic interests, or that local officials may take advantage of lack of central control to engage in widespread corruption. The responsiveness of local officials to the preferences and needs of the local population depends on a variety of conditions,

including the effectiveness of democratic processes at local levels, the salience of health issues in the population, the strength and role of civil society and NGO organizations, and the transparency and level of corruption in local decisionmaking. This accountability is also affected by the actual decision space that local officials exercise. If local officials do not have much discretion over budgets and human resources, even if officials intend to be responsive to local preferences, they may not be able to do anything significant to achieve those objectives.

Two examples of these problems can be drawn from India. In Uttar Pradesh, local officials are recognized to be corrupt and use patronage to maintain their control. In West Bengal, although the state structure is devolved with significantly wide decision space for local officials, the Communist Party-Marxist controls most of the officials through party discipline, which limits local responsiveness. In addition, even in the cases of local accountability for attendance, local officials were said to require favors from the health providers, in return for certifications for attendance, regardless of actual attendance.

There is an additional concern with local accountability if local preferences are at significant odds with national priorities. Many local officials and their electorate favor investing in a local hospital and curative care rather than attending to national priorities for prevention and for cost-effective activities to reduce incidence of preventable diseases (Bossert 2000b).

These experiences suggest that significant efforts need to be made to ensure that local accountability is responsive both to the local preferences of a majority of the local population and to reasonable needs as defined by national priorities. Decentralization of health systems may need to balance the degree of decision space with the conditions for real local accountability to make this accountability effective in achieving health sector goals.

BEST PRACTICES IN DECENTRALIZATION AND GOVERNANCE IN HEALTH

Best practices in decentralization require assessing the effectiveness of decentralization in achieving broad health sector objectives of health status improvement, patient and citizen satisfaction

with the system, and financial risk protection in a way that improves equity, efficiency, and quality of the health system (Roberts et al. 2004). These are the ends toward which we hope that decentralization and good governance can be the means. In addition, we would also like to evaluate the effectiveness of decentralization of the health system in improving governance in the health sector, specifically:

- Improving policy-making processes among different stakeholders,
- Increasing participation and accountability to local populations,
- Enhancing transparency and reducing corruption.

Unfortunately, there are few definitive studies that can provide strong evidence of the positive or negative effects of decentralization (Robinson 2007). Some of the reasons are: i) decentralization is often one component of a larger reform package, and thus it can be difficult to isolate the effects of decentralization; and ii) decentralization is undertaken for a variety of reasons, some of which are unrelated to decentralization's contribution to improved health service delivery (see Brinkerhoff and Leighton 2002). Further, the success of decentralization may depend on the balance of decision space between central and local authorities – requiring a complex analysis that few studies have undertaken. Finally, decentralization might improve some measures of governance performance, such as more accountability to local patient preferences, while at the same time reducing other measures – good technical choices for more effective policies.

A few studies illustrate some "best practices" related to decentralization for specific objectives in the health sector. For instance, Chile and Colombia demonstrate an effective process of decentralization that achieved greater equity of allocation of both national and local health funding (Bossert, Larrañaga, et. al. 2003). By changing allocations from historical budgets to a population-based formula, both systems reduced the centralized system's inequities, in the Colombian case, from six times more per capita spending for wealthy municipalities to almost equal allocations from the national budget. Surprisingly, the gap between rich and poor municipalities' funding from local sources also declined, from a difference of 42 times to 12 times. It appears that even poor communities significantly increased their health spending when their local elected officials had more responsibility for health decisions.

Other studies reveal that even with relatively well designed processes of decentralization, such as in Uganda, where local governments have taken on broad responsibilities and have been responsive to local preferences while retaining national priorities in allocations of funding to the health sector, there has been no real improvement in health services available to the population (Onyach-Olaa 2003, Golooba-Mutebi 2005). The former Ugandan health minister, who presided over the decentralization effort, now feels that a more centralized approach is called for.

However, we would like more information about what choices about decentralization would lead to better outcomes. Is it better to have devolution than deconcentration? Is wider decision space better than narrow decision space? Do we have to wait until capacity is built before expanding decision space? What conditions make local accountability more effective? There are no definitive studies to answer these questions. However, in the following section we review the issues and make some recommendations.

DEVOLUTION OR DECONCENTRATION?

It is likely that devolution to local elected officials is a more effective structure for improving governance than deconcentration, at least if local elections are fair, competitive, and do not exclude important constituents. Even if local elected officials make poor technical choices about health policy, their involvement will likely give them experience and over time officials and electorate may learn to invest more in health and make better choices about government programs. Robert Putnam's study of social capital and the structure of society in Italy found that over time elected officials were drawn from more professional ranks and made better technical choices (Putnam 1993). More recently, it has been found that during the first years of decentralization, local elected officials tend to allocate local resources to flashy public works programs that are politically visible; they later learn that investments in social programs are needed to maintain power (Ruiz and Guissani 1996, Bossert and Beauvais 2002).

However, it should also be noted that the context matters, and if elections are corrupt or if the decision space is too limited for local choice, deconcentration might be a better option. For example, local elections in Upper Pradesh in India have been notoriously corrupt and do not lead to

better local performance. A comparative study of five countries found that deconcentration in some countries has given local officials more decision space than devolution in other countries. With more local choice, local administrators may be able to be more responsive to local needs and preferences (Bossert and Beauvais 2002).

WHAT DEGREE OF DECISION SPACE?

The degree of decision space allowed to local authorities defines the balance between central and local choice. Since decision space is a relatively new concept, there are no clear studies linking the degree of decision space to better performance. Experts who consider democratic participation the most effective form of governance generally argue that wider decision space is to be preferred in order to allow these officials to be more responsive to local needs and preferences. However, there is no clear evidence that local elected officials make better choices than national officials about health issues. The historical experience with federalism in the United States tends to show that there is an ebb and flow of authority between the federal, state, and local governments; and that there may not be a "right" balance among the levels of government to achieve the optimal outcomes for health system improvements.

The studies of decision space in selected countries in Latin America, Africa, and Asia suggest that the tendency among nations that have decentralized is to allow moderate decision space over financing, community participation, and contracting while limiting local choice over norms and standards, logistics and information systems, human resources, and targeting beneficiaries (Bossert, Larrañaga, et al. 2003), Bossert and Beauvais 2002, Bossert, Chitah, et al. 2003). It is not clear that these systems have improved performance of these functions by this mix of decision space: however, for some of the functions there is a logic that might be useful for guiding policy. It may be useful to allow local governments to take more financial responsibility for their health care systems. As shown above in the study of Colombia and Chile, local authorities can provide more resources for health over time and reduce the gap between rich and poor municipalities. However, allowing local authorities to define community participation might exclude significant underserved groups, so there should be some limits that require

local participation of these groups. Local control of contracting also might open the door to local corruption in the absence of some degree of capacity for managing contracts, so some limits that require auditing, community oversight, and transparency would be needed, as well as requiring local administrative officials to have contracting skills.

As for norms and standards of service operations, it is likely that the technical requirements for quality will be better served by national decisionmaking, with oversight carried out by a combination of national and local entities. National standards that ensure some minimum uniformity for quality metrics among the different providers will lead to better performance, as well as provide a uniform basis for accountability judgments.

WAIT FOR LOCAL CAPACITIES TO DEVELOP?

It has often been argued that decentralization should wait until there is sufficient local capacity to make appropriate decisions and to implement them. It is likely that there is a minimum of local technical skills that is needed in areas of public health, finance, and management. A recent study of decentralization of primary care in Uganda found that local governments at the lowest levels (parishes and villages) had less capability to take on decision-making responsibilities and were less-effective performers than districts and municipalities (Onyach-Olaa 2003).

However, it is also likely that without incentives of sufficient decision space, the higher-level skills will not be developed and individuals with those skills will not be interested in taking on the leadership roles. Some demand for these skills is probably required to make decentralization effective and to keep managers and elected officials motivated and interested in improving performance in the sector.

WHAT CONDITIONS ARE NEEDED FOR EFFECTIVE ACCOUNTABILITY?

There are several cases that suggest that accountability to local authorities requires an effective and supportive central administration, strong civil society organizations, and strong local technical capacities (Tendler 1997, Mehrotra 2006). This potent combination has led to strong HIV/AIDS programs at local levels in Brazil (Gómez 2006, Nunn 2007).

However, if local authorities are corrupt, captured by non-responsive elites, or if the system is dominated by clientelism and patronage, then it is unlikely that accountability to local authorities will lead to the effective achievement of health system objectives.

WHAT USAID PROJECTS CAN DO ABOUT DECENTRALIZATION

What are some specific activities that USAID projects could include to strengthen governance in a decentralized system so that it will contribute to national and international objectives for health system improvement? We make recommendations for three types of USAID projects (or components of projects) based on the degree to which governance improvement is an explicit objective of the project:

- Projects whose major purpose is focused on a specific set of diseases (such as HIV/AIDS, malaria, and tuberculosis) or a specific population (such as maternal, neonatal, and child health),
- Projects focused on logistics system improvement,
- Projects designed to address health system development in general or broad policy change.

An initial principle for project support is the old medical prohibition: "First, do no harm." There are many ways donor projects can undermine decentralization processes and projects should be designed and implemented to avoid weakening the effectiveness of ongoing decentralization. Projects that recentralize authority for national or international purposes without allowing some room for local decisionmaking weaken, rather than strengthen, local decision space, capacity, and accountability. Many vertical programs designed to demonstrate rapid results, such as some HIV/AIDS programs, may take decision-making powers and resources away from local authorities. Other projects that support local civil society organizations to implement activities that local governments have a mandate to provide, often bypass local governments, undermining their legitimacy and access to resources (Romeo 2003, Manor 2003).

Second, governance improvements within health projects can be pursued through a variety of avenues. Brinkerhoff and Bossert (2008) offer programming options for USAID projects to promote good governance. These options identify activities within the policy, public administration, and civil society arenas

that can help to improve responsiveness, leadership, voice, checks and balances, accountability, transparency, evidenced-based decisionmaking, efficiency, and effectiveness. A selection of these options could be included in projects designed to address governance improvements at central and/or subnational levels. To support decentralization, it is likely that an integrated governance improvement approach that attempts to address issues at both central and local levels holds a higher probability of success.

DISEASE OR POPULATION TARGETED PROJECTS

In some contexts of decentralization, the only effective project will be to bypass local authorities in order to implement a program that can have demonstrable results. The historic debates about vertical/centralized versus decentralized/horizontal projects are perhaps best cast as ones in which context conditions should determine the right approach. In country situations where decentralization has transferred significant budgetary and human resource control to local governments, and where local governments lack significant capacity as well as real accountability, USAID programs focused on disease-specific or population-targeted objectives may need to develop an approach which works directly with interested local governments. Several projects involving contraceptive self-reliance (a goal of most USAID family planning programs designed to reduce dependence on donor supplies of contraceptives) have depended on working directly with local governments to develop programs that the central government has supported. A key to their success has been the involvement of national coordinating committees that include stakeholders at all levels of the system and initiative at the local level. In Colombia, for instance, a lack of executive-level enthusiasm for being involved in family planning was offset by a strong and active civil society, which helped push forward a contraceptive self-reliance strategy at the local level (Brune 2005). In the Philippines, the USAID Local Enhancement and Development for Health (LEAD) project effectively gained provincial and municipal support for modern contraceptives in contrast to the national government policy favoring natural methods and refusing to allow national funding for modern methods. This project targeted interested provincial and municipal governments through a competitive process to gain project resources in a series of staged competitions.

A second strategy is to develop programs with NGOs and other civil society organizations to build their capacities to lobby local authorities, be they elected officials or health administrators. This strategy involves support for disease- or population-targeted activities but also training in advocacy, conflict resolution, and negotiation as well as citizen report cards and surveys on disease-specific services. This strategy, however, runs the risk of undermining the legitimacy of local elected governments if the local government is not involved in public/private partnerships (Manor 2003).

A third strategy is to build local capacities of district or municipal authorities involved in implementation of the project. For example, some recent research suggests that district offices in Pakistan exhibit greater and lesser degrees of decentralization across a variety of functions (e.g., human resources planning, organization of services, financial management). That is, not only do levels of decision space and capacities vary from one function to the next, but a high (or low) degree of decision space within one function is not always matched with a similar capacity level. There is also preliminary evidence that decision space and capacities are associated with improved performance. For example, a study found higher decision space and capacity in human resources management to be associated with better staffing outcomes, such as percentage of posts filled and availability of personnel at facilities (Bossert, Mitchell, and Janjua 2007). The Pakistan Infant, Maternal and Neonatal Health Project (PAIMAN) is using this information to inform interventions designed to reduce maternal, neonatal, and child mortality. Based on this assessment, the project will work with district officials to ensure that capacities are commensurate with decision space in each function and monitor service outcomes.

These three strategies can be complementary or sequential, and may depend on the willingness or interest of the local governments to address these specific USAID priorities. In the first strategy, local authorities need either to share the interest in the disease or population priority or, at minimum, find the project resources attractive enough to compete for them. The second strategy requires some basic willingness of both NGOs and local government to work together for the same priorities. The third strategy also requires local interest and willingness to engage in capacity-building programs.

PROJECTS WITH LOGISTICS SYSTEM COMPONENTS

Logistics systems are often seen as requiring highly centralized control to be effective. These systems have significant requirements for uniform practices – for example, inventory rules, single formats for information reporting – and it is often seen as easier for technical assistance to address problems at the center than it would be to work at multiple and dispersed local sites.

While central-level support and technical assistance are undoubtedly crucial, there is evidence that not all aspects need to remain centralized. A recent study of decentralization of logistics systems for the DELIVER project showed that some functions in logistics may be better managed if local authorities have more decision space, such as planning and budgeting and procurement (under the model of national bidding to set prices), while others should remain centralized, for example, information systems and warehousing norms (Bossert et al. 2007). Applying these findings to logistics system reforms should strengthen local governance by building capacity in these functions while also improving the effectiveness of the whole system to avoid stock-outs. Improved services are likely to enhance the legitimacy of local governments and may bring more electoral support to officials able to claim responsibility for these improvements.

PROJECTS DESIGNED TO ADDRESS SYSTEM DEVELOPMENT IN GENERAL OR POLICY CHANGE

Projects with broader scope of system development and change can begin to address the design as well as the implementation of decentralization. USAID projects in El Salvador, Zambia, and other countries in the 1990s and recent projects in Benin, Guinea, Peru, Philippines, and Rwanda give significant support to broad health reform efforts. As project evaluations of more disease-specific programs begin to demonstrate the need to address system issues, it is likely that more attention can be devoted to questions of what is the best design of decentralization in order to achieve broad health goals.

It is likely that an approach that focuses on supporting or initiating a decentralization policy that is specifically tailored to the system conditions and political realities of each country will be necessary. A first step should be to assess the current characteristics of the system, identifying the levels of decision space, capacities, and accountability through carefully designed operations research. Some of the tools for this analysis are being developed and applied in the PAIMAN project in Pakistan and could be modified for other countries. The PAIMAN surveys ask local health administrators specific questions about the degree of choice they have been able to exercise over different system functions, their capacities to make and implement decisions, and their accountability to local elected officials (Bossert, Mitchell, and Janjua 2007). This tool has been modified and is currently being implemented in two states in India for the World Bank.

Using situation analysis, first a core group of key stakeholders and later a broader public consultation should review the potential options, borrowing lessons from other similar countries, to design an appropriate balance of local and central decision space in relation to the current and likely future capacities and degree of local accountability. Some of the studies mentioned above can be used to bring in lessons learned that can be considered in the local context. In Pakistan we learned that there was great variation in decision space and capacities among different districts. We prepared a specific capacity-building strategy for each district and an advocacy program to adjust decision space to allow more choice as capacity developed. In India, different strategies are being developed for Uttar Pradesh and Orissa, taking into account their different levels of capacity and accountability. As noted in previous sections, it is likely that local authorities can be granted more decision space over some functions and less for other functions, but the mix will depend on local conditions.

Effective decentralization is likely to require sufficient funding to assist in the design and especially in the implementation of decentralization. The lessons of hasty and inadequately prepared decentralization in Senegal and Philippines suggest that sufficient time to prepare local authorities and to develop information and coordination mechanisms is important. Developing

local capacities to implement health programs as well as ensure that mechanisms of accountability reflect preferences of the population, rather than those of partisan elites, will also be important.

CONCLUSION

Decentralization poses a special governance challenge that involves changes in who makes decisions and how much choice these officials will have over different functions. The amount of choice should be related to the capacities that different levels of government have and to the accountability that health officials have to both national and local elected officials. The process of decentralization requires attention to the new relationship between the state, providers, and client/citizens as well as new rules of civil society, politics, policy, and public administration. Decentralization shifts some of the focus of these relationships and rules to local governments, making them a more important operational venue for all of the elements of governance.

USAID health projects will increase the chances of achieving their specific health objectives as well as contributing to sustainable health governance if they develop strategies that encourage local governments to take on a greater role in making decisions and implementing disease-specific programs. This can be done through competitive grants that interested local governments apply for; advocacy activities with NGOs and public/private partnerships at local levels; and capacity building for local officials in decisionmaking and implementation for the priority programs.

Projects designed to improve logistics systems can also be oriented toward increasing local decisionmaking in some functions (planning, forecasting, and procurement) while retaining uniform central norms for other functions (information systems, warehousing).

System strengthening and wider reform projects can attempt to address changes in decision space, capacity, and accountability by first assessing the current degree of decentralization, capacity, and accountability as a starting point for developing broader interventions and as a baseline for monitoring and evaluating the success of reforms.

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