Regmi, Primary Health Care 2013, S6
DOI: 10.4172/2167-1079.S6-001

Primary Health Care: Open Access

Editorial Open Access

Health Sector Reform-Decentralisation: What would be the 'Next Move'?

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Making health services universal through bringing services closer to the heart of people is an ongoing public policy debate in the 21st century. People now live longer and get services quicker; nevertheless there are still many fundamental challenges in the health systems across the world. During the 1990s Mills et al. [1] published a book on decentralisation of health services examining case studies from ten selected nations, and highlighted things which worked and which did not based on their empirical findings. However, we fundamentally failed to gather substantial evidences to measure the effects of reform on performance due to lack of data, fragmented implementation and unreliable measurements framework [1,2]. One repeatedly used term amongst the proponents of health sector reform is 'decentralisation', as people often view it as a 'power' and 'politics' game between, among and within governments, external development partners, local authorities and civil societies. It is itself an ill-defined term that brings complex and contested meaning, and is often interchanged with the broader aspects of socio-economic development. In Bossert's [3] point of view, decentralisation is a form of reform mechanism in which central government's authorities and responsibilities will transfer to the local units of government or any defined statutory body retains some policy-making and monitoring work at the centre assuming that the state is a more powerful and well-resourced actor within the governance system [4]. Several authors put forward their views of decentralisation as a process of 'negotiation' between central and local government, rather than a 'transformation' process. It is, therefore, important to define the roles of central and local government who does what, who has what, who gains and who loses, etc., otherwise this may bring some tensions between these two tiers in terms of defining, demarcation and promising of service outcomes.

In line with this, there are different schools of thought going on to ascertain whose 'cake it belongs to'. One most promising thought is to ask the local government or local authority to come up with their 'to-do list', including what they can and cannot do, and all those 'nots' should be the role of central governments. Some anecdotal evidence suggests that the success of any decentralised government would determine to a degree how the local government would maximise the to-do list by minimising the 'nots' list in the long run. In other words, this is the process of increasing the level of local governments' 'comfort zone' by enhancing their current capabilities and capacities.

Peckham et al. [5] highlights that health services at the local level should be planned, prioritised, and polished adequately with resources to be able to develop a long-term strategy to bring lasting change to the people's health, investing in the areas of governance and incentives at the local level, development of health workforce model to deliver public health interventions, keeping people at the centre of healthcare policy, and developing capacity and capability at the institutional levels. There are several divides which exist in the view of decentralisation: Osborne et al. [6] claim that decentralised services are more flexible, responsive, effective and innovative 'good ideas bubble up' and institutions generate greater morale, more commitments and greater productivity, while in practice, such a simplistic view is deceptive and things may not happen like this pragmatically. In addition, substantial evidences have not been proved yet. Peckham [7] warns that there is very limited evidence to support assertions that reform/decentralisation works well. His predispositions are: large centralised governments are wasteful, and small organisations are better to deliver public services as they are closer to people. But Sheaff et al. [8] disagree with this view they instead argue that delivering public services through private contracts makes for better outcomes, as it would reduce costs and better utilise resources. I however argue that this is a very much tested hypothesis in the real world, particularly in many parts of the developing world where privatisation is viewed as the 'enemy' and often looked at from the profitable angle which should not always be the case.

Bossert [2] adds that even within the decentralised model, some form of centralisation is needed to work this as a complementary process; second, considering decentralisation as an independent variable is the wrong approach. Another important challenge that we face is the tools to measure the decentralised process. There are different measurement frameworks: a) Rondinelli's [9] four-fold typology, measuring the extent of shifting or distributing power and authority from the centre to the local level e.g. de-concentration, delegation, devolution, privatisation. One can argue that the first three dimensions relate to the welfare motive of transfer of authority and responsibility (autonomy) whilst the last one (privatisation) is the motive of financial reward; b) Burns et al. [10] proposed five dimensions of measurements localisation, flexibility, devolved, organisational, democratisation and public involvements. This framework is very much a dispersion of central authority but one critical argument about this framework is that physical desperation of operation and shifts of power and authority may not work in different settings; c) Hambleton et al. [11] four dimensions were based on geographical, power, managerial and political; d) Pollitt et al. [12] framework for measuring decentralisation uses the attributes of politics, competition and internal mechanism. Similarly Bossert's [2] principal agent theory, also called the 'decision-space' of measuring framework, has been widely used and tested in many parts of the developing world. He argued that the amount of choice transferred to local levels, and how much discretion the local officials/authorities would have to use these choices, brings key measuring performance. It is interesting to note that though this is an effective approach as it links to the dimension of central and local paradigms and represents local views, these are very much 'labels' and a vertical approach that makes it difficult to analyse multiple principals if there are of different administrative tiers. One critical argument about this framework is that this approach assumes that decentralisation gives local people more power to raise resources in planning and delivering appropriate services, which is not often the case [13,14]. Recently, Peckham et al. [15] developed an arrow framework using the configuration of inputs, process and outputs, ranging from the dimension of global to individual care 'direction of movements'. Though this is an interesting and useful

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Received January 15, 2013; **Accepted** January 17, 2013; **Published** January 19, 2013

Citation: Regmi K (2013) Health Sector Reform-Decentralisation: What would be the 'Next Move'? Primary Health Care S6: e001. doi:10.4172/2167-1079.S6-001

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framework, it does not really capture the meaning of decentralisation at greater 'breadth and depth'. One common critique across all these frameworks is the lack of insight into the examination of social context e.g. these do not take a wide view across peoples and programmes [16].

Therefore it is equally important to develop a framework that captures the meaning and remit of decentralisation's more holistic perspectives looking at the level of redistribution of tasks, competencies and other resources over all tiers of government. Exworthy and Peckham [17] suggest that making services access an interaction with organisational and personal factors, patients' choices and measuring their degree of fitness accessibility, affordability, availability, physical accessibility and accommodation of appropriate services tailored to people's needs and care would be paramount [18]. Similarly, Greener et al. [4] suggest the appropriate location of central roles, defining a clear demarcation of the roles moved/transferred and determining some form of the established role of people-focused healthcare systems with the principle of 'greater integration and regulation' would be some key attributes to measure the comprehensive and system approach to measure the success of the decentralisation [19,20]. That reminds me Bossert's [2] overarching questions might have relevance to this debate of measuring health sector reform for example, does decentralisation work? And if it does, what works for whom in what forms, and what mechanisms and processes of decentralisation are most effective? It is therefore important to make the 'next move' towards assessing of evidence-informed (conceptually clear and methodologically robust) outcomes of health sector reform triangulating the nature of relationship movement of 'space with power' between the tiers of governments examining the context, mechanism and outcomes, drawing from the examples of global initiatives on health systems [16].

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This article was originally published in a special issue, **Primary Health Care Reform** handled by Editor(s). Dr. Krishna Regmi, University of Bedfordshire, United Kingdom