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Some Lessons from Indonesia,
the Philippines and Vietnam**

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HEALTH DECENTRALIZATION IN EAST ASIA: SOME LESSONS FROM INDONESIA, THE PHILIPPINES, AND VIETNAM

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ABSTRACT

This paper examines decentralization experiences in Indonesia, the Philippines and Vietnam during the last 18 years (1985-2003). The analysis suggests that decentralization dividends so far have been modest and concentrated in some areas in the country. This is partly due to the limited potential gains that can be realized under the less than favorable macroeconomic and political context in which decentralization was introduced. More importantly, however, current arrangements within the health sector have not worked well as hoped, including ensuring access for the poor to quality health services. To improve the gains, a stewardship role for the MOH is suggested. In this role, the MOH would focus on critical health functions, namely: communicable disease surveillance and control; standard setting and quality assurance for devolved health services; and pharmaceuticals; ensuring access of the poor to health services; and, sustaining health financing.

BACKGROUND

1. This paper examines the decentralization experience of three East Asian countries from the perspective of how well the special features and requirements of the health sector have been addressed so far. These special aspects include the substantial role of externalities in the performance of the sector; the high degree of specialization entailed in some dimensions of service delivery the critical role of quality and timeliness in effective service delivery; and, the high knowledge input required for participation in the health care system at all levels. These characteristics have important implications for the design of health policy in general and especially for policies in support of a decentralized system of sector management and service delivery. In this review, the decentralization health policies and programs of Indonesia, the Philippines and Vietnam will be outlined, with attention directed to the period, 1985-2003, spanning the years before and after significant decentralization began in these countries; and pointing to areas in which reforms may facilitate more effective health care delivery.

The Health Care Context of Decentralization

2. The literature on health decentralization in developing economies indicates that relevant experience is limited, and there is no widely-accepted, best-practice health policy framework for decentralized settings. This is partly because decentralization in many low incomes countries is a recent development, while institutional change in affluent countries historically, was often in a *centralizing* direction as constituent states came together forming federal unions.

3. Another constraining factor has been the top down, centrist bias in the influential Health For All (HFA) health development paradigm used to build dominating but ineffective, difficult to manage health ministries (MOHs) in many countries. HFA's main sponsor, the World Health Organization (WHO) was traditionally uncomfortable with decentralization. The current health systems literature on government roles, especially vis a vis the private sector is relevant to the extent that privatization is a form of decentralization. But this literature misses the critical decentralization issue, i.e., the allocation of roles within Government. Analogous issues arise in the non-connection thus far between decentralization options and the health financing literature. Meanwhile, most health problem-focused approaches and the MDG-PRSP streams of thinking assume a strong central MOH.

4. Nevertheless, a debate has developed relating to how design issues are resolved, with contributors dividing into two camps. Proponents see decentralization leading, if handled well, to i) systematic involvement of citizens in decisions regarding health policy goals, design, and financing, and in monitoring service provision, and performance of other functions; ii) providers obtaining the incentives, skills, supervision, material support, and discretionary authority needed to offer high quality services; and iii) clients securing the information, financial means, and bargaining power required to elicit appropriate responses. Decentralization also offers MOHs a chance to jettison impractical obligations and carve out a new role and image.

5. Detractors, however, warn that (badly designed) decentralization brings heightened vulnerability to near term crises and longer term risks. For example, the following start-up problems are cited as typical: staff opposition leading to breakdown of deployment and other

personnel mechanisms; mismatches between funding and spending requirements; ambiguity over responsibilities and premature delegation of functions leading to deterioration in service quality; and disruptions in reporting and associated accountability and quality control arrangements. Medium term concerns include rising system costs. Specifically, the “downsizing” of administrative units may result in designs for key health functions and activities that are neither technically efficient nor cost effective because of diseconomies of scale. Such “transitional” problems may be difficult to correct.

6. Because of these risks, public health commentators have called for careful management and introduction of decentralization. Most support WHO’s recommendation that devolution be phased in under central guidance, subject to stringent criteria, with health ministries continuing to take responsibility for specialized health services, medical supplies, basic education and training, and other key functions (WHO, 1995). This advice illustrates two recurrent themes in the literature, i.e., assumptions that the overriding rationale for health decentralization is improved effectiveness and efficiency in service delivery, and that the process is subject to ex ante design as to timing.

7. Such premises are usually not valid, since the impetus to decentralization is generally political. Improved health is only a second-order objective, and with imperatives such as preserving national unity usually driving the process timetable and shaping the decision to devolve to particular local government levels.

8. Arguably, this was the case in the Philippines, Vietnam and Indonesia, which decentralized their health services starting in 1993, 1996¹ and 2001 respectively. Evidence suggests that health ministries in these countries initially were not prepared to articulate and assume in a decentralized health system a new specialized, role of system manager, not main provider. Inconsistent policies further indicated that expediency rather than strategy guided official responses to transition problems.

9. At the same time, faltering health system performance prior to decentralization in these countries signaled a need for significant changes in health policy. In the Philippines, improvements in infant survival rates and other health status indicators in the 1980s were beginning to plateau, an indication of decreasing returns to health expenditures that in terms of GDP, were higher than in other developing countries (Solon, et.al., 1992).

10. In Vietnam, the collapse of the agricultural financing system and economic reform in the 1980s undermined funding for primary health care services and resulted in drug and skill shortages, deteriorating quality of care, and a decline by a half or more in utilization of government facilities. Public sector funding gaps also led to increased user fees that became a financial barrier and reduced access to care by the poor.

11. In Indonesia, the 1997 financial crisis brought funding cuts that confirmed the susceptibility of the government network to drug shortages and other breakdowns. But performance problems existed earlier. Favorable trends in survival and nutrition rates in the 1980s were not sustained in the 1990s despite large-scale interventions. Utilization of public

¹ There has been no consensus on the starting point of health decentralization in Vietnam. This paper treats the 1996 Law on State Budget as a path breaking measures.

services also faltered. After rising to nearly a third, the share of those who sought outpatient care from public providers had fallen below 30 percent by 1995, and below 20 percent by 1998. Meanwhile, households in the top expenditure quintile were far more likely than the poor to use public facilities as inpatients and nearly as likely as outpatients.

Objectives

12. This paper examines decentralization experiences in Indonesia, the Philippines and Vietnam with an eye to three sets of questions. First, how can decentralization be designed to provide an appropriate framework for a public health system in developing countries? What policies and instruments promise to be effective in improving the efficiency and equity of a decentralized health system? Second, how should transition problems and other risks be handled? Third, what lessons can be drawn from the experiences of these three countries?

13. In examining these questions, the emerging role of the central health ministry is assessed. Critical health functions include communicable disease surveillance and control; standard setting and quality assurance for devolved health services; and pharmaceuticals; ensuring access of the poor to health services; and, sustaining health financing.

14. Broadly, the three countries have features that facilitate comparison. Located in the Southeast Asian region, they share the same tropical or semi tropical climates and comprise mostly agricultural, rural-based households. All are highly populated developing countries with significant numbers of poor. Each also had a colonial history in which the struggle for independence led to a unitary form of government with a strong center. In all of these countries, communicable diseases are the main cause of morbidity and mortality, although each is now experiencing epidemiological transition with the increasing prevalence of non-communicable, lifestyle-related diseases. Nonetheless, each country possesses unique features that provide interesting contrasts to the other two. Unlike the Philippines and Indonesia, for example, Vietnam has only recently adopted a market-oriented economic policy while retaining the socialist features of its government structure. Unlike Vietnam, Indonesia like the Philippines is an archipelago that is insulated to a degree from disease transmission across land borders.

15. However, comparison between, countries is limited by available data. Official statistics on health, demographics, government finances and other socioeconomic indicators are of varied scope, detail and quality. The same applies to secondary sources. Data constraints also add to the main methodological problem involved, which is to trace and isolate the sole effect of decentralization on health, amidst other socioeconomic factors, external conditions and policy interventions that impinged on health during the same period. Thus, only broad conclusions and guidelines for policy are drawn from the analysis.

16. The analysis suggests that decentralization dividends so far have been modest and concentrated in some areas in the country. Decentralization may have helped to sustain overall improvements in health status and spurred local initiatives in health planning, service delivery and financing. However, current arrangements have not worked as well as hoped, including ensuring access for the poor to quality health services.

Contextual Circumstances

17. The modest gains to decentralization can be traced to first, contextual circumstances outside of the control of policy makers. In particular, decentralization was introduced in less than favorable economic and political environments. For example, the 1997 Asian financial crisis underscored the direct link between macroeconomic performance and health expenditures. Prior to 1998, the Philippine economy, much like that of Indonesia and Vietnam, was growing steadily. Income per capita in the Philippines rose from US\$2310 in 1985 to US\$3870 in 1997. Following the outbreak of the crisis in late 1997, its income per capita fell to US\$3730. The impact of the crisis in Indonesia was graver. Its per capita income declined from US\$3030 in 1997 to US\$2580 in 1998; by 2001, per capita income was US\$2900, still lower than before the crisis. Vietnam was less affected by the crisis, although per capita government health spending leveled off and may have fallen after the crisis.

18. The Philippines illustrated the immediate consequence of the crisis. The national government invoked “an unmanageable public sector deficit”, a provision under the Local Government Code of 1991 to cut 10 percent of the Internal Revenue Allotment (IRA) due in 1997.² As most local governments were heavily dependent on the IRA, the reduction further reduced overall local health spending, especially of the provinces and municipalities, which absorbed the bulk of the devolved health functions.

19. Uneven regional growth aggravated the situation. In the Philippines, the provinces in the Eastern Visayas and Northern Mindanao continued to lag behind other provinces, especially those in Metro Manila and its surrounding provinces. In Vietnam, the cities of Hanoi and Ho Chi Minh were developing faster than other places in the country. Similar unevenness existed in Indonesia. Thus, wide variations across regions occurred in utilization rates and other health access indicators in all three countries.

20. Moreover, decentralization in Indonesia and the Philippines, was implemented amidst considerable uncertainty following political crises. Following the fall of the Marcos regime, the Philippines ratified a new constitution in 1987 with strong decentralist provisions that were further articulated in the Local Government Code of 1991. In Indonesia, the overthrow of the Suharto regime in 1998 and then de facto secession of the erstwhile province of East Timor in 2000 contributed to the clamor for decentralization. The Philippines had several military uprisings after 1986, the most recent in late 2003. Under the present constitution it has had four presidents. With the frequent musical chair in politics, policy priorities including health are altered and new DOH secretaries³ are appointed, thus disrupting DOH’s momentum to adapt itself to a decentralized set up. Furthermore, persistent rural insurgency problems, kidnappings and the worsening peace and order situation in selected areas (e.g., Southern Mindanao) made it difficult both for the private sector to pursue investments and for the public sector to reach out to the poor in these troubled areas.

² On December 27, 1997, then President Ramos issued Administrative Order 372 which effected the withholding of the “amount equivalent to 10 percent of the IRA”. The local governments have challenged this AO before the Supreme Court and won in June 2000.

³ There had been nine DOH secretaries serving four Presidents from 1986 to 2003.

21. Weak governance in the Philippines was also seen in the corruption permeating all branches of government, leading to loss in revenues and wastes of limited resources (World Bank 2000). Mechanisms like Health Boards and other local consultative bodies were seldom convened for counsel or feedback, contrary to the intent of the LGC of 1991 (Rood 1998). However, the proliferation of non-government organizations and other civil society groups was a major positive governance-related development in the Philippines. Many such organizations now work side by side with key national government agencies in the areas of agrarian reform, health advocacy, local capacity building, livelihood projects, community mobilization and governance reform.

Health and Decentralization Policies

22. A second set of reasons for the modest gains to decentralization to which we pay primary attention pertains to weaknesses in policy itself. While the potential benefits were effectively limited by external factors, actual gains may have been enhanced by appropriate management by the central MOH, especially in critical health functions. Experiences of the three countries suggest how such a role may be defined and pursued.

23. The rest of the paper is organized as follows: Section II summarizes the impacts of current health services decentralization on health status, service coverage, overall efficiency, and equity. Section III provides an analysis of the features and implementation of each country's decentralization policy. Section IV identifies the policies, programs, institutional arrangements and processes as implemented and how these design elements interacted with socioeconomic, demographic and political factors to condition the impact of decentralization on health. Finally, Section V summarizes findings and draws lessons regarding the sector management role for the central health ministry.

HEALTH DIVIDENDS

Sustaining Improvements in Overall Health Status

24. On the whole, the favorable trends in the overall health status established in each country were sustained after decentralization (see Table 1). One indicator is infant mortality rate (IMR), which in the case of the Philippines fell from 65 in 1980 to 45 in 1990, and continued its downward trend in a decentralized setting to 36 in 1995 and then to 29 in 2001. A similar IMR trend can be seen in Vietnam, from 36 in 1990, to 32 in 1995, a year before the Law on State Budget was enacted, and then to 32 in 2001. The just released 2002 Demographic and Health Survey points to a more rapid IMR decline in Vietnam, from a figure of 36 deaths per thousand births during the 1988-1992 interval, to 29.6 for 1993-1997 and 18.2 during the 1998-2002 interval. Indonesia's IMR also fell, from 79 in 1980 to 60 in 1990 and 35 in 2000, just before it decentralized in 2001. Similar trends can be observed for each country over the same period for the under-5 mortality rate and life expectancy at birth.

Table 1: Selected Health Status Indicators

Indicators	Year*						
	1980	1985	1990	1995	2000	2001	2002
Infant Mortality Rate (per 1,000 live births)							
Indonesia	79	70	60	46	35	33	
Philippines	65	55	45	36	30	29	
Vietnam	50	43	36	32/30*	28/18*	30/18*	
Under-5 Mortality Rate (per 1,000 live births)							
Indonesia	125	108	91	66	48	45	
Philippines	81	74	66	51	40	38	
Vietnam	70	60	50	43	34	38	
Life Expectancy at Birth							
Indonesia	55	59	62	64	66	66.3	66.7
Philippines	61	63	66	68	69	69.5	69.8
Vietnam	60	63	65	67	69	69.4	69.7

* Health decentralization started in 1993 in the Philippines, in 1996 in Vietnam and 2001 in Indonesia. Sources: World Bank, World Health Organization 2002; DHS 2003*

25. There was a further reduction in health status gaps across regions in the Philippines during the 1990s. Measured as the difference in the IMRs of the poorest region (Eastern Visayas) and the richest region (Metro Manila), the gap declined from 15 in 1980 to 9.8 in 1985. By 1990, the gap is almost zero, since the respective IMRs of Metro Manila and Eastern Visayas were 27.4 and 27.1. In 1995, the gap was also near zero, although the IMRs of Metro Manila and Eastern Visayas both improved to 21.3 and 21.6, respectively. Following the 1997 Asian financial crisis, however, the disparity again widened. By 2000, Metro Manila's IMR was 19.4, worse than the Eastern Visayas' 10.7.⁴ Each study country is also experiencing an epidemiological transition in the 1990s, in which the incidence of chronic, lifestyle-related diseases like cancer and heart diseases starts to match, if not overtake, that of communicable diseases like TB and malaria. (Solon, et.al.).

26. As regards Vietnam, it appears that disparities in survival rates grew wider between regions in the late 1990s. This is captured in the rising trend in the ratio of highest to lowest IMRs by region. After increasing from 1.7 in 1989 to 2.3 in 1994, this ratio rose to 3.6 in 2002. This is not to imply that rates and underlying conditions were static in some regions. On the contrary, IMR fell by at least half in every region between roughly the early 1990s and 2003. However, the decrease was extraordinary, dropping to a third or less of the early 1990s figure in the Mekong, Central Highlands, Southeast, and Central Coast regions (Myers, et. al. 2001; DHS 2003).

Some Progress in Health Outputs and Access

27. Arguably, the favorable trend in overall health status was partly due to the progress made in health outputs and service coverage. In the Philippines, for example, the proportions,

⁴ The standard deviation in regional IMR also fell from 8.51 in 1980 to 4.84 in 1990 and then to 3.34 in 2000.

respectively, of births attended by trained health personnel and of the population with access to water source or sanitation services rose in the 1985-2000 interval.

28. Similar developments in the same status, outputs, and access indicators occurred in Indonesia over the same period. The 2003 Demographic Survey and Health Survey pointed to a continuation or even acceleration of past, favorable trends in fertility, contraceptive use, malnutrition and trained maternal care. Positive directions were reversed, though, in some dimensions. For instance, immunization rates fell between 1997 and 2002-2003 for children under age two, while prevalence of childhood illness remained as in 1997.

29. In Vietnam, on the other hand, output and access measures all pointed in a positive direction between the mid 1990s and 2002. For example, significant increases were reported for childhood vaccination coverage, the proportions of women receiving antenatal care and giving birth attended by skilled health personnel (Committee for Population, Family, and Children, 2003).

Health Expenditures

30. Decentralization may have more than sustained the momentum in health status improvements. Or it may have reversed a worsening trend. Unfortunately, these two suppositions cannot be verified conclusively with available data. Nor can definitive conclusion be drawn from input measures such as data on health expenditures⁵ in Indonesia, the Philippines and Vietnam.

31. Based on data contained in the *World Development Report 2004*, the annual total health expenditures throughout the period 1997-2001 in the three countries were more or less a constant proportion of their GDPs. The average annual proportion during the period was 2.5 percent in Indonesia, 3.5 percent in the Philippines, and 4.9 percent in Vietnam. In per capita terms, however, total health spending fell in Indonesia from US\$26 in 1997 to US\$16 in 2001 and in the Philippines from US\$41 in 1997 to US\$30 in 2001⁶. Asia's financial crisis led to a steep decline in 1998 in health spending in these two countries: the reduction was 50 percent in Indonesia and 24 percent in the Philippines. Seemingly immune to the financial crisis, Vietnam's health spending per capita rose from US\$16 in 1997 to US\$21 in 2001.⁷ In general, health expenditures as a percentage of GDP in these three countries were similar to most of their ASEAN neighbors. For example, the average percentage share of health expenditures in the GDP in Thailand and Malaysia were 3.7 and 3.2 respectively.

32. With only limited health resources each year to meet the demands of growing populations, countries should strive for greater efficiency in their health expenditures. In this regard, there is little evidence that decentralization helped to reduce the longstanding bias towards hospitals and curative care in the three health systems. For example, the public sector

⁵Except for the figures in contained in Table 3, all other figures are originally specified in local currency and are converted here using the end-period exchange rate found in ADB's *Key Indicators 2002*.

⁶ Figures from the Philippine National Health Accounts (PNHA) also show that the total health spending per capita rose from US\$20.82 in 1991 to US\$29.79 in 2001. In real terms, however, there was a decline from US\$12.15 in 1991 to US\$8.84 in 2001.

⁷ Vietnam too achieved a hefty three-fold rise in nominal terms in its total health expenditures over a five-year period: from US\$0.68 billion in 1993 to US\$2.17 billion in 1998. [Knowles et al 2003].

share in total health expenditures in each of the three countries did not change much between 1997 and 2001. In particular, Indonesia's public sector still accounts for roughly a fourth of total health expenditures. In Vietnam, the share of the public sector decreased slightly from 31.5 percent in 1997 to 28.5 percent in 2001. In the Philippines, the share rose from 43 percent in 1997 to 45 percent in 2001.

33. A closer look at public sector outlays reveals that there has been a shift in the financing burden from the central to local governments. Most local government health spending went to hospital or personal care services much like the pattern before devolution. This is understandable, since local governments absorbed many hospitals under decentralization. However, this orientation may be inappropriate given the high prevalence of communicable diseases and the high relative cost of hospital-based interventions.

34. This shift in financial burden was certainly the case in the Philippines. Based on the National Health Accounts, the annual share of local governments in the total public health expenditures climbed up from less than 5 percent before 1992 to 12.5 percent in 1993. By 2001, its share reached 20.9 percent, which finally exceeded the 16.6-percent share of the national government. Moreover, it is noted personal care services constitute the bulk of public expenditures for health in the Philippines and, ominously, an increasing portion of the health outlays of local governments as well (Solon et al. 1999).

35. In Indonesia, most routine spending is now from regional government budgets, while development spending at the regional level grew fourfold. However, central development outlays rose almost threefold, and nearly half of development expenditures still comes from the central budget. Understandably, the Ministry of Health (MOH) continues to be regarded as a key supplier of financial resources, as well as personnel, equipment, drugs, and vaccines.⁸

36. In Vietnam in the early 1990s, provincial governments, including the commune-level, were already spending more on health than the central government (Knowles et al. 2003). Provincial spending accounted for 68 percent of government health expenditure in 1991. This figure did not reflect user fee revenues and donor support. Central level spending made up 13 percent of the total. However, five years later when the Law on State Budget was passed, provinces accounted for 53 percent and central units 26 percent of all government outlays. By 2000, the latter figure had fallen to 17 percent while the province-level share, narrowly construed had dropped to 44 percent. However, it would seem to be more appropriate per the thrust of the 1996 legislation, to include within the provincial total revenue from health insurance and user fees. When this is done, provincially "controlled" outlays made up 76 percent of total government health spending, up from 70 percent in 1996. Donor outlays are treated as a separate category influenced by particular agendas and decision making criteria.

37. Given this flawed approaches, it is doubtful that decentralization has widened access for the poor to quality health care. A national client survey (World Bank 2001) re-confirmed that Filipinos in general were more satisfied with private hospitals or clinics than with government health facilities. Filipinos also tended to rate traditional healers as more satisfactory than any

⁸ Via the JPS-BK, fuel subsidy, and DAK channels.

public providers. The low regard for public health services prevailed even among the poor, an indication that the public health system does not serve well its target clients.

38. These observations are corroborated by a World Bank study on the socioeconomic differences in health, nutrition and population in selected developing countries (see Table 2). In the Philippines, children born in 1998 to the poorest families were twice as likely to die within a year after birth than those born to the richest families. This is evident in an IMR for the poorest families, 48.8, that was 1.7 times the 28.8 IMR of the richest families. And the chances of these unfortunate Filipinos did not seem to improve with age: the under 5-mortality rates were 79.8 and 29.2 for the poorest and richest families, respectively.

39. The disparities in health status across economic groups were observed in Vietnam. These were similar to those in Indonesia prior to decentralization, and like their counterparts in the Philippines, the poorest families in Vietnam had IMRs and U5MRs several multiplied than higher, the richest families in the country. The discrepancy in health status between the poorest and richest households appeared to be worse in Indonesia than in Vietnam, Philippines, India, and Bangladesh.

Table 2: Relative Health Status of the Poorest and Richest Population Groups in Selected Asian Countries*

Country (Year)	Infant Mortality Rate (per 1,000 live births)			Under-5 Mortality Rate (per 1,000 births)		
	Poorest	Richest	Poorest/ Richest	Poorest	Richest	Poorest/ Richest
Bangladesh (1996/7)	96.3	56.6	1.701	141.1	76.0	1.857
India (1992/3)	109.2	44.0	2.482	154.7	54.3	2.849
Indonesia (1997)	78.1	23.3	3.352	109.0	29.2	3.733
Nepal (1996)	96.3	63.9	1.507	156.3	82.7	1.890
Philippines (1998)	48.8	20.9	2.335	79.8	29.2	2.733
Vietnam (1997)	42.8	16.9	2.533	63.3	23.0	2.752

Source: www.worldbank.org/hnp. *Economic groups are based in asset (wealth) quintiles.

40. Perhaps due to the inferior quality of public health services, the poor together with their well-off fellow Filipinos continue to self-finance their access to private health services. Private sources, including direct out-of-pocket expenses, accounted for annual average share of 57 percent in total health expenditures in the Philippines for the period 1991-2001.

Local Initiatives in Health Services and Financing

41. Decentralization has given greater leeway to local authorities and other stakeholders to adapt or even replace once standard service delivery and financing modalities. And these greater discretionary powers have in fact led to numerous local innovations in health planning, service delivery and financing under decentralization. Most notable among these in the Philippines are the provincial health insurance programs of Bukidnon and Guimaras (Pineda 1998, Bautista, Yap and Soriano 1999). Others became textbook cases like the Health Card System of Paranaque City, the City in the Pink of Health of Marikina City, and the Community Primary Hospital Program of Negros Oriental (Quimpo 1996, Legaspi 2001). Several have been awarded and

recognized formally by government agencies and private sector-led award-giving bodies like the Galing Pook Foundation (see Box 1) and the Philippine Human Development Network.⁹

42. In Vietnam, there are numerous instances of sponsored and spontaneous innovation at the province level. An example of the former was MOH's effort to encourage local level responses to childhood diseases, including community determined monitoring indicators (Fritzen, 2000). Reactions to HIV/AIDS illustrate the spontaneous case. As in several other provinces, the epidemic spurred the Thanh Hoa provincial government to pursue preventive activities such as harm reduction and 100 percent condom use. These initiatives were the result of strong commitment from the People's Committee. Besides ensuring the participation of the police (Department of Public Security), it allocated an annual budget to fight HIV/AIDS. The People's Committee organized a provincial Steering Committee on HIV/AIDS headed by DOH, under an umbrella Steering Committee on HIV/AIDS, Drugs and Prostitution Control, chaired by the Vice-Chairperson of the People's Committee. District and communes adopted the same structures.

43. In Indonesia, Yogyakarta province demonstrated how the country's still immature decentralized framework can be used to introduce health sector reforms, and the elements of a health insurance system. Donor funds (WB) were used to secure technical assistance, and conduct assessments, trials, instrument development, benchmarking, workshops, training, coordination meetings with the districts, and advocacy events. A board of trustees and new fund holder institution were set up, and a benefit package and premium agreed.

⁹ The Galing Pook Foundation bestows the *Galing Pook* Awards to selected local government units whose innovations in public service delivery are adjudged best in the year. The Philippine Human Development Network uses the Human Development Index to identify and honor the provinces that made the greatest strides in promoting health, wealth and education.

Box 1: Charging User Fees for Health Services in Malalag, Davao del Sur

In December 1993, the local Sangguniang Bayan of Malalag, Davao de Sur enacted the Malalag Revenue Code to formally adopt, among others, a socialized fee schedule for health services. The graduated payment scheme is based on the user's annual family income. Those with family income of PhP15,000, between PhP15,000-PhP50,000 or greater than PhP50,000 were charged 25 percent, 50 percent or 100 percent, respectively, of the fixed service charges. However, low-income families were given priorities in the provision of health services. Initial resistance to the scheme was eventually overcome with public consultations and hearings and as well as with the information and education campaign conducted for the purpose. Partly as consequence of the program, the LGU was able to earn about PhP1 million worth of fees for an outlay of PhP688,888. Moreover, additional health services including more frequent surgical, medical and dental missions were provided as more financial resources became available. With these improvements, the local clientele have become more demanding of the quality of local health services and of the performance of the local health personnel.

Transforming a Rural Health Center into a Community Clinic in Sebaste, Antique

A sixth class, remote municipality, Sebaste in Antique, under the then Mayor Juanita de la Cruz, became a prime example in how to transform the usual rural health center into a community clinic despite limited resources. With only PhP800,000 in IRA, the municipal government clearly had to mobilize other sources of funds to realize its health goal. It tapped foreign donors, local population, and former residents now living abroad for support, and likewise appealed to the sense of mission of the health personnel. Soon, a trust fund was created for the purpose. From 1994 to 1998, the LGU was able to infuse PhP3.085 million into the project. By 1997, the community clinic employed 16 personnel, including 2 physicians, was operating 24 hours a day, extending primary health care services, laboratory, pharmacy, and minor surgery. It has reduced access cost of the local clientele. Moreover, it also served the medical needs of the residents of neighboring municipalities.

Source: Galing Pook Foundation [2001]. Kaban Galing. The Philippine Case Bank on Innovation and Exemplary Practices in Local Governance.

44. Moreover, a plan is ready for a quality council to accredit facilities and license practitioners based on standards developed locally. In the meantime, User fees were increased under local government regulation to reflect actual unit cost for providing services. Task forces developed strategies to improve service quality, drawing on consumer satisfaction surveys; purchase equipment; develop accountability mechanisms using communication forums Focus Group Discussions, and the complaint resolution system established during the financial crisis; and improve health workforce management. A tighter organization structure was submitted to the provincial government for consideration.

45. The new system was launched in 2003, with the government paying for the premium for the poor in public facilities. Starting in 2004, the program will be available for the non poor and public facilities will compete with private providers in providing the benefit package. The approach in Yogyakarta gives districts a key role, as specified in Law 22, but also responds to the loss of economies of scale due to downsizing to district operations that may result in technically ineffective and inefficient health functions. Cross district collaboration is encouraged, with districts working together to upgrade technical support activities, share use of medical and technical specialists and trainers, and organize joint communicable disease control, quality assurance, and health education and advocacy. The Joint Health Council (JHC) provides a means to organize such shared activities, with Task Forces making recommendations on various technical topics. But it is the provincially staffed Technical Review Team (TRT) that has

the largest role in the technical strategy, through review of district proposals and the feedback and guidance offered.

46. This approach is being watched closely and being applied in a number of other provinces. Central agencies have not been deeply involved although Yogyakarta sought central guidance on standards for establishing its regulatory framework.

47. In summary, the health impacts of decentralization resist easy estimation. To date there are little conclusive indications in the available data of significant windfalls in health benefits linked to decentralization. What can be said is that the early phases were not incompatible with sustaining impressive overall improvements in health status. Moreover, decentralized governance opened the way to some promising local initiatives in health planning, service delivery and financing. However, much better results would seem to be within reach through appropriate policy adjustments.

48. The identification of appropriate policies, though not easy, cannot be overemphasized. In the Philippines, central government agencies, often in partnership with NGOs, documented, disseminated, and advocated the so-called “best practices” in local public services through the media, periodic exposure or educational trips of local officials, and the various training programs it administers. Despite these initiatives, however, there has been limited implementation and the overall level and quality of local health services has barely improved. It appears then, that it is not a lack of models to imitate that limits the wider adoption of such innovative practices—it would seem to be a lack of appropriate incentives, including creditable political payoffs and other signals to institute policy interventions that effect the desired changes.

DECENTRALIZATION POLICIES IN CONTEXT

Legal Basis

49. Consistent with their respective Constitutions, the three countries passed legislation that enabled, if not mandated, the decentralization of health services (see Table 3). In addition to increased administrative powers and responsibilities, local governments under these laws further attained local fiscal autonomy with their increased shares in national government revenues and their expanded taxation powers.

Table 3: Principal Laws that enabled Decentralization

Country	Enabling Laws
Indonesia	Law 22, Law 25, Regulation 25 (enacted in 1999 and implemented in 2001)
The Philippines	Local Government Code of 1991 (implemented in 1992; actual devolution of health services in 1993)
Vietnam	Law on State Budget 1996, Law on State Budget 2002, Decree 10

50. In Indonesia, the principal enabling legislative acts were Law 22 and Law 25. Further, Regulation 25 (1999) facilitated implementation of decentralization. Decentralization in the Philippines was promulgated in the Local Government Code enacted in 1991 and implemented the following year.

51. Health decentralization in Vietnam was shaped by the Doi Moi economic reforms that started in 1986, and by the 1995 Public Administration Reform, with substantial implementation based on the 1996 and 2002 State Budget laws. The latter two measures brought fundamental changes in the preparation, approval, and execution of budgets for all government agencies, from the central to local levels.

52. Starting from 2004, under the 2002 Law on State Budget, province-level People's Councils in Vietnam have enhanced powers and obligations. People's Councils were given greater authority to prioritize expenditures and determine sectoral allocations and transfers to lower tiers, and stronger means to mobilize resources. Local planning will be promoted through the agreement of transfers from the center to provinces for stable periods of three years, in return for which provinces will have to produce forward-looking expenditure plans.

53. Decree 10, another element in the legal underpinning of decentralization in Vietnam, went into effect in July 2002. Decree 10 has a facility level focus. When fully implemented, it would give managers much greater control over their budgets and greater though still constrained discretion regarding pay and employment issues, user charges for non-basic services and domestic borrowing.

54. In each country, subsequent laws directly supported, further articulated, or affected the implementation of decentralization of health services. In the Philippines, these laws included the Magna Carta for Public Health Workers of 1992, the Barangay Health Workers' Benefit and Incentives Act of 1995 and the National Health Insurance Act of 1995. In Vietnam too, the Seventh Communist Party Congress passed a resolution to broaden the "scope of responsibilities and power of the sectors and localities" (The Communist Party of Vietnam, 1993). Consistent with this declaration, the Congress passed the Grassroots Democracy Decree in 1999 (Government of Vietnam, 1999).

Main Design Features and Implementation

55. At first glance, the division of responsibilities over critical health functions between the national government (or central health ministry) and local governments, as shown in Table 4, broadly conforms with efficiency principles. That is, local governments assumed responsibilities over health functions that are simple to administer or confer localized benefits. Further, the central government or higher level local governments assumed responsibility over health functions that exhibit significant economies of scale or inter-jurisdictional spillovers. For example, basic, primary health care services are assigned to the commune in Vietnam (including the network of village health workers), to the village in Indonesia and to the barangays in the Philippines. Further, primary-level health facilities are assigned to cities and municipalities in the Philippines and to the districts in Vietnam. Secondary-level hospitals are assigned to provinces in the Philippines and in Vietnam. Tertiary-level and specialty hospitals, on the other hand, are mainly the responsibility of the central government (i.e., central health ministry) in all three countries.

56. In addition, the central government under the new regime continues to provide certain public goods like health research and development or merit goods like various components of

Maternal and Child Care Services and Family Planning Services. Often local governments are involved in, and sometimes co-finance, implementation of these programs. However, there are flaws in the devolution of health functions and in the corrective measures adopted. These will be discussed in Section III.

57. Implementation of decentralization in Vietnam occurred gradually and was not without setbacks. Local level mobilization was considered a key element in the country's impressive achievements by the mid 1980s in delivering primary health care. And as mentioned, the combined province and commune level share of government health outlays was already significant in the early 1990s. Thus, local officers had had experience with decentralization when additional health tasks were assigned to provinces and districts via the 1996 State Budget Law (Fritzen, 1999). The 1996 Law established the current system of financial linkages between government levels. – 61 (now 64) provinces, more than 600 districts and nearly 11000 communes, wards and district towns. These arrangements underpinned decentralized services within a unitary system in which national authority is delegated to lower government levels. At each level, budget preparation, and implementation are the responsibility of the People's Council.

58. In contrast, implementation in the Philippines and Indonesia occurred in “Big Bang” fashion. In the former, the transfer of 45,896 health personnel, along with hospitals, clinics, and other facilities, was completed in 1993, two years after passing the Local Government Code. Indonesia did the same in 2001, less than two years after enacting Laws 22 and 25.

59. The “big bang” approach has its merits but there are disadvantages entailed as now appear in Indonesia and the Philippines. For one, the laws and the implementing rules and regulations that were adopted provided insufficient detail on functional and operational responsibilities, resulting in confusion and divergence between provinces and districts in Indonesia. For instance, the tasks to be handled by districts or provinces are supposed to depend on the portion considered as a cross district activity, but there has been no definitive finding on how to apply such rules.

60. Also, decentralization laws and regulations are frequently inconsistent with laws, especially those concerning civil service rules. This limited the ability of local governments to right-size inherited health bureaucracies, and anticipate personnel matters. The latter included local compensation lower than national pay scales, limited prospects for promotion, and “arbitrary” changes in job description.

61. Moreover, administrative preparation was inadequate. For example, many local officials in the Philippines were unaware of the precise nature and extent of their additional expenditure responsibilities and their new powers.¹⁰ Likewise, the DOH was slow to transform itself structurally and operationally. The Local Government Assistance and Monitoring Service (LGAMS) unit created to troubleshoot transition problems was severely hampered by lack of personnel. Moreover, it did not have sufficient clout, since public health programs are managed under different DOH divisions. With the DOH looking uncertain, many local governments seemed to adopt a “wait and see” strategy, apparently in the hope that the DOH would be blamed for the breakdown in the public health system and be forced to re-centralize the health functions.

¹⁰ This is clear from the *Rapid Field Appraisals of Decentralization* [ARD 1993-1994].

62. Also, local governance mechanisms that should promote transparency, accountability or participation were introduced at the same time as the health services were devolved. This complicated the transition as local governments were initially largely left on their own to adopt these mechanisms. This led to delays in adoption, perfunctory compliance or non-convening of the mandated local consultative bodies.

POLICIES, PROGRAMS, INSTITUTIONAL ARRANGEMENTS AND PROCESSES

Intergovernmental Fiscal Issues

63. The intergovernmental fiscal system (IGFS) should meet complex goals in the health system, similar to other services. The key to effective IGFS design is “finance follows function”. In addition, issues of horizontal as well as vertical equity, principal agent relationships between levels of government and jurisdictions and incentives for collaboration between levels and jurisdictions also are usually addressed in the IGFS. Weaknesses in the design of each country’s IGFS had important consequences for health services delivery.

64. In Vietnam, implementation issues regarding decentralization relate directly to the budgeting and financing system formalized in the 1996 Budget Law. The issues include:

- Norms emerged during the 1990s as critical policy levers used to determine almost every kind of input into the system. For example, gaps between provinces in per capita spending on health reflect the fund allocation based on population norms and allocations to and within sectors guided by a complex set of expenditure norms. These take account of differing geographical conditions between provinces, but not enough to offset revenue and cost disadvantages and different need factors. In addition to official norms other criteria may be used by MOF during the budget negotiating process.
- Provinces had substantial discretion over resource allocation to districts and communes and the actual methods used to allocate state budget healthcare resources varied considerably. Districts had little autonomy and inter-district variations were significantly greater than that at the province level.
- One critical weakness of the norm-based system is its reliance on flows of accurate data such as user fees and insurance reimbursement rates from up-to-date information on costs and expenditure structures and trends in facilities in different operational settings. Besides the high costs of regularly updating such standard costs, these figures are unlikely to capture cost variations linked to scale and quality, and unacknowledged discretionary elements which enter in applications of norms. As the steps are cumbersome, time consuming, and costly to repeat, fee schedules remain in effect for years though out of date—the schedule in use today dates from 1995.
- Also, the norm-based system constrained flexibility despite formal autonomy at lower levels of government. Civil service salaries were a first call on funds and absorbed most expenditures. Flexibility decreases in provinces with lower local revenues.
- The norm-based process limited sectoral interventions. MOH did not fully participate in budget discussions and did not have detailed information on expenditures by provinces and lower levels of government. MOH also could not assess whether actual spending by lower levels of Government were consistent with sectoral policies.

- Quality of care was also affected by limited investment in lower level facilities, for instance, to upgrade selected CHCs – with implications including increased bypassing by patients.
- MOH focused on allocations to National Programs. These aimed at ensuring that adequate amounts were spent on high priority diseases, e.g., controlling TB. Some of these programs were particularly important to disadvantaged groups and are mainly implemented through local governments. No mechanism existed to ensure that once National Program objectives were achieved those programs are discontinued.
- Reliance on norms also discouraged development of medium term planning frameworks that facilitate recognition of trade-offs and setting priorities between and within sectors.

65. The December 2002 budget law that went into effect in January 2004, gives increased discretion in sector matters to sub-national governments as part of fiscal decentralization. Enhanced powers and obligations were assigned to province-level People's Councils to prioritize spending, determine sector allocations and transfers to lower tiers, and policy implementation. People's Councils were also given stronger authority and means to mobilize resources. There is provision for three year transfers once agreement is reached with provinces regarding their expenditure plans--this may lead to new ways for MOH to influence spending allocations across functions and service levels.

66. The primary fiscal vehicle for supporting decentralization in the Philippines is the Internal Revenue Allotment (IRA) transfers to local governments. As noted earlier, most local government are heavily dependent on this source, and consequently, so are devolved health services. In addition, the DOH created the LGAMS to manage transition problems the latter identified, and to provide financial assistance to LGUs unable to maintain local health services levels or to meet their Magna Carta obligations because of inadequate IRAs and other resources. Also, it facilitated the implementation of the initial DOH conditional matching grant program, the Comprehensive Health Care Agreement (CHCA), intended to secure local funding for the devolved functions and core public health programs. This reflected an important part of the Philippine strategy of using of incentives and disincentives to achieve national policy objectives in a decentralized system.

67. However, there were significant weaknesses in the relationship between the service delivery function and financing arrangements. For example, devolution of public facilities in the Philippines led to fragmentation of the hospital referral system. Under the new regime, each hospital or clinic facility serves primarily, the constituency of the local government unit (LGU) to which it is assigned. Thus, several provinces reduced budget appropriations to hospitals located in cities and re-channeled resources to less well-off component municipalities, but in the process increased the average cost of hospital services in the city. Instead of co-financing these facilities with the provinces, however, many cities opted to refurbish their own clinics or build enclave hospitals.

Equity

68. In Vietnam, two factors negatively affected the distribution of health services to the poor. First, central government resource flows were not well targeted to poorer provinces. Policy has

operated mainly on the supply-side, through improvements to the multi-tiered service delivery arrangements. Demand for services was largely taken for granted, and demand side considerations did not weigh heavily in policy development, at least until recently.

69. Second longstanding, funding shortfalls continued through the decentralization process. These shortfalls were partly recouped by charging patients. Starting in 1989, hospitals in Vietnam were allowed to collect user fees and mark up drug prices. The resulting revenues became, and still constitute, a sizable source of health financing. However, user fees were a disincentive to enhanced utilization by the poor. And with user fees only partially offsetting funding gaps, slippages in community mobilization and lower quality levels in health services followed. All of this led to reduced utilization from the late 1980s, with demand often shifting to “private” providers ranging from retired government doctors to informal drug vendors. These developments likely exacerbated pre-existing variations in health indicators by region and income group, with poorer areas, e.g., the northern uplands, recently falling further behind.

70. Reportedly, selected cities and provinces reduced user fees charged to the poor and other selected groups. Recent findings show that the distributions of state budget funding (both central and local), ODA and health insurance reimbursements among provinces are more pro-poor than other sources of province-level funding. Only the distribution of ODA is strongly pro-poor (i.e., received disproportionately by the poor). Neither state budget funding (central or local) nor ODA is significantly related to province-level measures of health needs, to household poverty rates or to the percentage of a province’s population belonging to ethnic minority groups. The overall distribution of public health expenditure among provinces is weakly pro-poor (i.e. more equally distributed than per capita income), thanks largely to the pro-poor distributions of the state budget and ODA (Knowles et al, 2003).

71. Further, Decision 139, issued in October 2002, requires each province, with special budgetary support from central government, to set up a Health Care Fund for the Poor (HCFP) to finance free health care for the poor and other disadvantaged groups. At an additional cost of VND 700 billion (some US\$0.5 billion) per year, Decision 139 entails a major increase in health spending in Vietnam and one that could be tightly targeted on the poor. This program is starting up slowly allowing difficulties in identifying the poor and channeling funds to poorer provinces to be overcome. Moreover, this program may not be helpful in improving the health access of the poor living in remote areas as the indirect costs of care, which are not covered by the HCFP, are also their burden. Another 2002 policy, Decree 10 gives hospital managers much greater control over their budgets as well as greater discretion regarding pay and employment, user charges, and use of surplus funds. With Decision 139, this is a paradigm shift marked by changes in MOH’s role. The key change is from direct service provider to sectoral steward, directing central resources at the poor and other vulnerable groups on the basis of clear definitions of eligibility. Differentiation of government roles is also implied, with provincial health departments organizing delivery of care and Vietnam’s insurance agency assuming responsibility for collecting contributions and *purchasing* services.

72. While the main clients of the devolved health services are the rural poor, their access to quality health services is highly uneven because of the wide differences in the revenues of local governments and the flawed designs of central fiscal transfer programs. In the Philippines, for example, growth remains uneven across regions and only cities have generally robust economies.

Thus, most provinces and municipalities rely heavily on central fiscal transfers, principally the IRA. The IRA formula favors the highly populated LGUs and those with large land areas, however, these factors do not help ensure an overall pro-poor bias in health services. Further, studies have shown that other central fiscal transfers, including those administered by the Department of Health, are only weakly correlated with poverty (Mercado 1999). Specifically, Region I, Region X, Region XI and Region XII, which are the regions with high poverty incidence, appears to have lower DOH budget allocations in 1994 and 1997. On the other hand, Region VII, which is among the richest in the country, receives a disproportionate amount of the DOH budget (Capuno 2002).

73. As in Vietnam, government hospitals in the Philippines are allowed to collect user fees and impose up to 30 percent mark up on drugs. However, cost-recovery rates in these hospitals remain low because of the inordinate volume of charity patients or subsidized patients. In the case of provinces, for instance, the combined share of hospital fees in the total hospital outlays never reached 13 percent in any year from 1992-2000. In this aspect the municipalities fared better: from 9 percent in 1992 to 29 percent in 2000 (Capuno 2002). But since most hospitals were devolved to the provinces, the unintended consequence of low cost-recovery rates is that many hospitals are poorly maintained, understaffed or ill-equipped.

74. Vietnam and the Philippines instituted health insurance schemes in 1993 and 1995, respectively, that target the poor. Health insurance in Vietnam has become a significant financing source (Knowles et al 2003), more important than in the Philippines. Nevertheless, in Vietnam coverage is still low and mainly includes civil servants and others employed in the formal sector scheme. Decision 139 represents a potentially significant scaling up of the number with insurance.

75. Records from the Philippine Health Insurance Corporation (PHIC) show that the number of paying members, excluding the members of insured indigent families, enrolled under the NHIP increased from about 5.57 million in 1999 to 7.62 million in 2001. This suggests nearly one in ten Filipinos has social insurance coverage, but still far from the targeted universal coverage. Moreover, the intended pro-poor bias of the NHIP is not yet fully manifest. The total number of indigent families enrolled in 2002 under the PHIC's Medicare para sa Masa (i.e., indigent program) constituted less than ten percent of the eligible indigent population, although the numbers rose from 47,304 in 1998 to 538,071 in 2001. With the PHIC's new recruitment strategy in 2003, the number of indigent members has risen to 1,493,212, representing a total of 7,466,060 beneficiaries under the Medicare para sa Masa program. Whereas in 2001 about 37.8 percent of these indigent members were concentrated in the richest regions in the country, namely NCR, Central Luzon and Southern Tagalog, by 2003 the same regions only account for about 19.91 percent of the total membership. Other regions, notably Ilocos Region and Northern Mindanao, have gained relative significance in this aspect, suggesting that more and a wider set of poor households now enjoy insurance coverage. However, this trend in enrollment under Medicare para sa Masa program is likely to slow down as more and more LGUs will be required to co-pay with the national government the insurance premium of their poor constituents. For most LGUs, the required counterpart contribution is seen as an additional unfunded mandate.

Personnel and Civil Service Management Issues

76. Many local governments find it difficult to hire physicians, nurses and medical technicians, who also are in great demand in foreign markets. In the Philippines, for example, local governments in many endemic TB areas have found it difficult to hire medical technologists and rural physicians. Indeed, staff anxiety and opposition were major problems during the transition to decentralization in Indonesia and the Philippines. Though usually temporary, staff discontent can have real effects on the quality and quantity of local health personnel available under decentralization.

77. In the Philippines, health workers were biggest group opposing decentralization. Many initially feared for their security of tenure, the “politicization” of their functions and positions, limited career prospects, and lower pay scales.¹¹

78. To appease the devolved workers, DOH pushed for the enactment of the Magna Carta for Health Workers in 1992. Among other features, this law provides for higher compensation and extra benefits and allowances to all health workers including those devolved to local governments. The law also required LGUs to pay the additional compensation of the devolved health workers. This posed problems for LGUs : this is additional “unfunded mandate” would demoralize other staff if only health personnel delivered benefits. Also, the additional compensation would make some rural physicians the highest paid local government employees, earning more than the local chief executive (which is unacceptable to mayors).

79. As a stopgap measure, the DOH instituted the Doctor to the Barrios (DTTB) Program that supplied temporary, contractual and better-paid MDs to remote LGUs. The DTTB program was initiated in May 1993 to deploy physicians to 271 doctor-less municipalities in the country. By December 2003, 198 of these municipalities were provided with doctors under the program. Serving for two years, a DTTB doctor receives an attractive package of salary and benefits. Some of these doctors also received from LGUs additional honoraria and material support, such as free board and lodging. However, only about a third of the DTTB doctors choose to stay with the local governments after their two-year tour of duty. Most who leave undertake residencies, while others are discouraged by the lower remuneration and other privileges under local government employment. Further, there is now a dwindling number of applicants to the program owing to a surge in foreign demand for local medical graduates, and conflict areas remain underserved because of lack of compensating incentives.

80. To supplement the local health labor force, however, volunteers were trained and provided minimal incentives to be health workers at the barangay health stations under the Barangay Health Workers’ Benefit and Incentives Act of 1995. These volunteer health workers assist in clerical tasks and minor health procedures such as weighing and measuring patients. Besides these functions, however, these health workers do not effectively cater to the health needs of the population.

¹¹ Moreover, the DOH itself did not anticipate these issues since the initial plan was to decentralize education first. It was opposition from the strong that led to DOH was considered instead (Diokno 2003).

81. In the early 1990s, the contract doctor (PTT) scheme was set up in Indonesia to assure flows of doctors to remote and difficult locations. Doctors were hired after completing their initial medical degree, with substantial monetary incentives for three years but required to practice in more remote areas as a condition of advancement. Specialists also had to complete compulsory assignments as PNS employees for 1-4 years or for 2-3 years as PTT staff.

82. Over time, discontent increased over the obligatory nature of assignments, relatively low salaries and poor administration of program benefits. In 1999, regulations were eased to permit alternatives such as teaching in a medical school, working as a PNS in designated areas, or private practice as a clinic employee in remote areas. Service requirements for *very* remote areas were reduced to 2 years and new graduates could postpone mandatory service if they wanted to start specialist training. These changes did not satisfy the PTT lobby, and doctors continued to press to scrap the regulations.

83. PTT issues remained unresolved up to 2001, and have not been revamped by decision makers since decentralization was launched. MOH has been exploring new concepts of medical personnel policy including service in the military, police. For their, districts have stayed with the residual national system despite its flaws. This is understandable in that without MOH funds and guidance, local governments may not have coped with the integration of the large numbers of centrally assigned, locally based staff transferred overnight via Law 22. Moreover, few districts can turn down central level offers to recruit and assign PTT doctors using central funds, which can be ‘topped-up’ by regions. Still, there is ambivalence in district circles. Officials are concerned that staff-related policies that reflect local priorities and conditions have not been established including developing options to “right size” the staffing position within each district. This issue arises especially in districts obligated to handle staffing oversupply left behind by flawed centralized era policies.

84. Strong political and administrative leadership in some provinces have created master plans to reshape the bureaucracy to fit local conditions. These include downsizing using mechanisms such as non structural or functional positions, redeployment of staff, early retirement, voluntary resignation with severance payment, and retraining to encourage entrepreneurship. However, implementing these plans awaits full commitment politically, facilitating legal steps, and an injection of cash. This inability to proceed highlights concerns voiced by district and province level decision makers about dependence on central government for salary payments, and ‘right-sizing’ methodologies.

85. In Vietnam, personnel issues were confronted under decentralization as well. The distribution of health personnel around the country is not exactly as planned. More doctors and other higher-level staff are available in the cities, where there are generally enough to fit the plan, while in the rural areas the numbers are inadequate. In provinces with a medical school there are approximately enough staff, but not in poorer provinces, especially the newer ones with no secondary medical schools of their own. One study showed that there are only 1.7 doctors per commune in the North Highlands and the North Central Coast, while a commune in the Southeast Region has an average of 6.8 doctors. (World Bank 2001b).

86. There are generally adequate (in relation to Ministry of Health guidelines) numbers of health workers at the provincial level, although some provinces do not have enough specialists.

But at the district level, there are generally not enough doctors with specialization in priority areas, such as obstetrics and gynecology or emergency surgery. And at the commune level, there are not enough doctors (nearly all of those at the commune health center level are the upgraded former assistant doctors) and often not enough staff with other training either, except in the densely populated delta areas and near the cities. For example, in 1997, 26 percent of communes lacked an obstetric-pediatric assistant doctor or a midwife. Ministry of Health policy requires that one of these in all communes owing to the high priority accorded to local level maternal and child care.

87. Average monthly salaries of health staff essentially remained essentially unchanged in real terms since 1994. In 1998, the average monthly salary of a government health worker was merely US\$29. Health worker salaries are still low even though they are supplemented to some extent from user fees. This low remuneration, compared to those in the education sector, induced many health staff to seek additional sources of income; this reduces their time, attention, and dedication to their work (Dung et al. 2002).

Institutional Arrangements and Processes

88. These “rules of the game” establish both the formal and informal relationships and incentives that have critical consequences for the performance of the sector. As an important, but often neglected part of the design process, these institutional arrangements have had a major impact on the performance of the health sector under decentralization.

Service Delivery Mechanisms and Processes

89. Vertical health programs are prime examples of the need to design institutional arrangements carefully to ensure that parties in the service delivery process have appropriate understanding, abilities and incentives to fulfill their roles. Invariably coordination is a crucial requirement of systems effectiveness. While the main responsibility for the control of communicable diseases should be the central health ministry's, it cannot discharge its function efficiently and effectively without the cooperation of local government units (LGUs) since the latter are at the forefront of service delivery. In the Philippines, implementation of these programs requires the participation of devolved health personnel and local counterpart funds – which are in short supply. This participation is increasingly seen as another “unfunded mandate” imposed to local governments in the Philippines and program coordination has suffered as a consequence. Further, DOH used the CHCAs to elicit LGU support for vertical programs. Under CHCAs, the DOH commits to match with a higher amount each peso that the LGU commits to spend on the vertical programs. A primary condition however must be satisfied: the LGU first commits a minimum amount for its devolved health functions. This proved to be a stringent requirement since many LGUs initially lacked resources to finance their devolved functions, much less meet their contractual obligations for the vertical programs. DOH also did not develop a monitoring and enforcement mechanism to tract compliance. Worse, many local officials believed that strict compliance with the CHCA was not necessary in order to receive in-kind assistance from the DOH, since DOH will always take the blame for failures in the vertical or public health programs. (Esguerra 1997; Medalla 1996).

90. In addition, integration among programs within provinces as well as across provinces is still poor. National programs are implemented separately -- leading to overlap and overload of the grass root health facilities implementing units.

91. Vietnam partly solved the problem by assigning greater roles to provinces in setting goals, developing plans, and using funds for NTPs. This is appropriate given variations in disease profiles across regions and is said to have led to increased immunization rates and improvements in case fatality rate.

Low Quality and Unsteady Supply of Drugs at the Local Level

92. The supply and quality of drugs at the local level has become a concern due to limited funds, deficient drug management systems and loopholes in procurement rules. In Indonesia, under decentralization provinces were not aware of and not prone to intervene in drug supply, stocks and usage at the district level. Districts were allowed to plan for and procure their own drugs based on standard procurement practice. However, compliance with quality assurance (QA) procedures was poor, partly because responsibilities for drug QA were not clear and districts do not have the technical capacity to handle the task.

93. In the Philippines, also, each local government manages its own system of drug procurement, inventory, dispensing and financing. However, the quality of locally procured drugs is generally poor, the purchase price is often higher than in private pharmacies, stock outs are frequent and irrational drug use occurs. A principal reason for these is that local therapeutic committees are either not constituted, non-functional or not well-trained in modern drug management systems. Also, local drug procurement in many places is corrupted: bids are rigged, qualified bidders are “pre-identified” and bidders connive. Moreover, the supply chain extends only up to urban centers; the poor-outlying municipalities are only infrequently served by itinerant drug peddlers.

94. To ensure drug quality in all public health facilities, the central health ministries in the three countries all adopted drug formularies, and drew up Essential Drug Lists (EDL). In the case of Indonesia and the Philippines, the central health ministries even advocate and promote generic drugs. However, these regulatory measures have not ensured the overall quality of drugs due to deficient information campaigns and weak enforcement mechanisms. In the Philippines, for example, many local governments, with support even from their own health officials, routinely buy branded drugs because of their supposed proven efficacy. Further, the limited laboratory and regulatory capacity of the Bureau of Food and Drugs did not help convince doctors about the supposed bio-equivalence of generic drugs (Lim and Pascual 2002). In Indonesia also, hospitals buy drugs outside the EDL and branded products.

95. Unlike the Philippines, drug supply in Vietnam and Indonesia is dominated by state-owned enterprises, which can make quality assurance for drugs easier than in a private-sector dominated drug market. In Vietnam, the state-owned VINAPHARM is responsible for supplying drugs country wide. Its members are central and province level trading and manufacturing enterprises. Within MOH, the Drug Administration Department is responsible for overall drug management in Vietnam, supported by the Drug Quality Control Institute and the Drug

Inspectorate. In each province, there is a Drug Quality Control Department that falls under the Provincial Health Bureau (PHB) and a PHB-managed Drug Testing Center and Inspection Department to monitor drug quality in the local market.

96. In Indonesia, four State Owned Companies (SOEs) produced generic drugs and vaccines. Regulatory functions, including enforcement, were the responsibility of the Directorate General of Food and Drug Control, a unit of MOH. Quality assurance efforts operated through establishing EDL as a norm; enforcement of standards in the development, testing, registration, manufacture, and distribution of drugs, and oversight of health professionals. Working through 26 province-level branches, the DDC and PPOM monitored drug quality and safety through follow up visits and testing programs. Inspection of manufacturers was based on Good Manufacturing Practice (GMP) criteria adopted in 1971.

97. SOEs imposed their own inefficiencies in the market. In Indonesia, these units are protected by tariffs and limits on final product imports, constraints on foreign investment, restrictions on registering new drugs, opening new pharmacies, and the non-pharmaceutical activities of retailers. Reforms adopted in the 1990s relaxed some restrictions on foreign drug companies, encouraged generic drug prescription in public health centers, and enforcement of GMP. In addition, hospitals were allowed to keep drug revenues to secure drug supply at the facility level.

98. However, inconsistencies and missteps weakened or negated pre-2001 reform initiatives, and the outcomes were unsatisfactory. Moreover, districts inherited a flawed and incomplete reform agenda, with impacts on government stewardship obligations as well. After Law 22 took effect, deviation increased from once established standards, patterns, and procedures. For example, there are many complaints about the physical appearance and/or the expiration date of drugs, suggesting that longstanding quality assurance (QA) procedures are not being observed. Reporting of quality problems with drugs is not formalized, and procedures for addressing quality concerns, and responsibilities to resolve problems are unclear and complicated by multiple drug and funding sources. Limited skills surely play a role as well—many service units and district warehouses depend on unqualified staff. Nor can provinces step in—they lack the authority to monitor yet alone supervise district drug procurement.

99. More generally, laws and regulations provide little detail on operational responsibilities and functions, and have brought confusion and divergence between provinces and districts.¹² For instance, some tendering procedures have resulted in awards to 15 or more suppliers, with purchases comprising small quantities, from a potentially wide range of sources. Districts usually reject pooled procurement at the province level despite possible cost savings.

100. Nor is there a definitive view on which drugs belong in categories defined by MOH in pre 2001 preparations. Central involvement appears to be limited to a part of the CDC program. No common pattern of procurement is found in the provinces. Some are not supplying any drugs, and plan to reduce future drug supply. Some still buy drugs for buffer stocks to handle emergencies and temporary district shortfalls. Districts are using their own funds to buy drugs from all 3 classes of EDL. Meanwhile, the drug supply and regulatory system in hospitals is

¹²This discussion draws on Barraclough and Hudyono (2002) and fields notes from Bank supervision visits.

different from that at the primary care level. Hospitals, which have long been permitted to procure and dispense drugs outside EDL, are buying mainly branded drugs, funded through self-financing revolving funds and using spot buying methods.

101. There are also concerns that the change from central to district procurement has increased drug prices because of lower district procurement volumes. This would likely widen drug price dispersion, reducing equity and lowering the availability of orphan drugs.

102. In this regard, Vietnam represents an interesting comparator. As in Indonesia, deregulation of pharmaceutical production and distribution brought the heightened activity of informal drug vendors and pharmacy shops and improved availability of drugs primarily throughout the country. Consumer purchases of drugs, especially for self-medication, increased as well--from 2.1 annual service contacts per capita with drug vendors and pharmacy shops in 1993, the number had increased to 6.8 annual contacts per capita by 1998. An important difference in the two countries' experiences relates to prices. In Vietnam, deregulation was accompanied by a 30 percent fall in the real price of medicines in the 1993-98 period, while in Indonesia, policy reforms were apparently not followed by price reductions.

103. Moreover, the risks facing Indonesia are comparable to those of Vietnam where drug vendors account for roughly two thirds of health service contacts, and thanks to excessive and otherwise inappropriate use, antibiotic resistance has reached epidemic levels.¹³ The resistance problem is compounded by limited training of pharmacists, and the low average education level of drug vendors and the public. Even when doctors prescribe drugs, there is low compliance by patients with appropriate treatment guidelines. Oversight of health providers was weak as well. Enforcement of the many regulations and decrees governing minimum quality standards and the protocols expected of health providers through regular inspections of health facilities was less than satisfactory.

104. In the Philippines, on the other hand, a few drug manufacturers and importers, which are mostly multinationals, dominate the upstream segment, while a single drug store chain effectively controls the retail segment of the domestic drug industry. A parallel drug importation policy also has not helped to bring down the overall price of drugs because, again, the government chose to maintain an import monopoly with capital of 50 million pesos only, which is not enough to affect the multi-billion domestic drug trade.

Health Information Systems

105. While the main responsibility over the control of communicable diseases should be the central health ministry's, it cannot discharge its function efficiently and effectively without the cooperation of LGUs since the latter are at the forefront of service delivery. LGU support is needed from collecting health information to providing further inputs to overall health planning to actual implementation of programs. However, decentralization in Indonesia, the Philippines and Vietnam led to the fragmentation of the health information system and poor coordination

¹³ Most drug vendor contacts represent purchases of drugs without a prescription. The VLSS 1998 data indicate that 93 percent of all drug vendor contacts were for obtaining medicines without a prescription, with not much variation across economic groups.

among the various sectors, leading to less than effective or efficient control of communicable diseases. The main reason for this is that the LGUs are unaware of their roles and, more critically, they lack the incentives and the technical capacity to assume these roles.

106. In 1992 to 1995, the Philippine DOH implemented on a wide scale the German-funded Health and Management Information System whose main objective was to institutionalize a “need-responsive and cost-effective health information system” at the national and local levels. Different software modules was introduced along with and processes to fortify information production and utilization. Besides developing district level health indicators, the system supported innovations in community health care financing and service delivery. However, the initiative was not sustained and stopped short of a nationally-integrated but locally-operated health information system.

107. In Indonesia and the Philippines, the central health ministry relied on LGUs to report health information voluntarily. This resulted in erratic or delayed submission and poor quality of data. The devolved CDC staff members who were responsible for such data under the old regime now have to supply mainly information on health expenditures or input indicators to provincial or lower-level elected officials less concerned with outputs or outcome indicators.

108. In Indonesia, only 36 percent of health centers reported infectious disease surveillance data in 2002.¹⁴ With those currently reporting doing so irregularly and/or late. Thus, the limited data that flow through the system may not be reliable enough for use in planning, policy analysis, or evaluation at different government levels.

109. With inadequate information, the central health ministry is less able to monitor the quality of laboratory services, hospitals and other devolved services. This is worrisome since, for example, in the Philippines both TB case finding, which requires sputum examination, and case holding are done at the local health centers. In Indonesia, some programs like leprosy were discontinued because there was no district uptake. Quality assurance systems for provincial hospitals in both the Philippines and Indonesia continue to rely heavily on input indicators like number of beds, floor area and medical instruments, and with only infrequent verification of such information provided by local governments.

110. In the Philippines, although the DOH deploys its own representative to provinces, cities and municipalities to help monitor disease outbreaks and to coordinate the implementation of vertical programs, the flow of health information remains slow. Often, the DOH-representatives are forced to double up as service providers since many local governments lack the requisite health personnel.

Performance standards and Incentives

111. Efforts to improve health service quality in the Philippines have relied on incentives including awards and accreditation measures, and disincentives. One approach encourages local

¹⁴ A survey conducted by BKKBN in 2002 found less than 10 percent of health centers followed the manual on prevention of infections that may result from the use of contraceptives. It also discovered that the quality of counseling in the family planning program was poor and that 20 percent of public facilities had never been supervised.

governments to upgrade the quality of their health services. The Sentrong Sigla accreditation, besides a mark of quality, originally conveyed a one-million peso grant to accredited local health center. Based mostly on input indicators to assess the health facility's "readiness to provide services", about 48 percent of health centers, 14 percent of district and provincial hospitals, and 3 percent of barangay health stations had been certified by October 2003. Though the numbers are encouraging, they represent only a minority of all facilities in the country. Moreover, most of the cash awardees are the better off municipalities, that need the growth less than those who are unable to qualify (Lamberte et al 2003).

112. In the Philippines, to improve the Sentrong Sigla Program, DOH issued Administrative Order No. 100 in 2003. This measure establishes new guidelines for the certification programs. Instead of cash awards, the new guidelines specify a matching grant for the new qualifiers, besides making the certification a prerequisite for other DOH grants and for the Capitation Fund program recently introduced by the Philippine Health Insurance Corporation. Under the Capitation Fund Program, the accredited LGU can claim reimbursement for services extended to PHIC-insured indigent families in their localities. Since these accreditation schemes are voluntary, they do not ensure that quality standards are met in all public health centers.

113. Norm setting, on the other hand, was the approach adopted in Vietnam and Indonesia. Vietnam's MOH sets province-level norms, but quality remains uneven as province and district-level health officials introduce norms and guidelines as well. MOH has used decrees and circulars to define quality of human resources and equipment, and standards of performances. It also has issued more than 100 treatment guidelines, though a survey conducted in 20 district hospitals in 2000 on Acute Respiratory Infection showed that compliance with guidelines was 25-40 percent, probably reflecting weak support and supervision at the local level. Meanwhile, overuse and over-prescription of injection drugs in treatment of were common. It was also observed that medical representative from various companies have influenced on physician's prescriptions (Dung PH et al., 2001).

114. Minimum health service standards (MSS) were set in Indonesia by ministerial decree in 2003. MSS were defined for 32 areas for which districts are required to deliver services according to local needs. Immunization, nutrition services, prevention of communicable diseases, and curative care were the main dimensions covered. Such standards could help in defining the service levels that districts are accountable for delivering. How these standards are to be interpreted, e.g., as a requirement, or as an indicative target for holding local government accountable, needs to be considered further, along with the implications of districts not meeting the standards.

TOWARD A NEW ROLE FOR MOH—SOME LESSONS

115. Decentralization in Indonesia, the Philippines and Vietnam may help to sustain the overall improvements in health that have occurred during the last two decades. It appears that decentralization spurred local initiative in service planning, delivery, and financing. In many places, planning is now undertaken with the participation of service users, leading to more appropriate or better targeted health services. Volunteers provide their time and finances to supplement limited local financial and technical resources. More importantly, perhaps,

citizenship and trust in local government has deepened. The efficiency gains and the social capital developed thus support the decentralization of health services.

116. Still, experience in the three countries indicates that decentralization dividends have been modest. As mentioned, there were two reasons for this. First, decentralization of health services in these countries was undertaken in less than favorable environments. Inequitable in-country growth, growing population pressure that also induced epidemiological changes, and political uncertainties together effectively limit the potential gains from decentralization. Thus, improvements in health status are greater in well-off provinces and service innovations failed to spread beyond areas in which the local economy is robust and the political situation relatively stable. In these provinces, local governments had the resources to meet the growing demands for their services.

117. Besides external factors, however, weakness in decentralization policy contributed to the lower-than expected health payoffs. These included ambiguities in objectives, insufficiently detailed design features, inconsistency with other policies, and poorly thought-out implementation strategy. These follow from the fact that health was not the main, much less the sole, consideration for decentralization in these countries. In the Philippines, for example, health services were included only when resistance from the education lobby forced legislators to look at other national government expenditure functions.

118. Inconsistent priorities translated into inconsistencies in policies and poor design of instruments, especially in the IGFS. Further, local governments are typically unaware of the types and timing of national government interventions, information that is crucial to their own budget and investment planning. With prior knowledge about available grants, technical assistance and other forms of support from the national government agencies, local governments are able to use more effectively their information about local needs or proximity and direct accountability to the target beneficiaries.

119. In Indonesia, the slow and arduous emergence of a consensus on a health decentralization framework is attributable in part to a government-wide determination to avoid service interruptions. This focus on prevention of service deterioration also allowed GOI to postpone difficult decisions over the role and scale of key central ministries.

120. MOH also tends to view the public as passive service recipients not as discriminating customers, owners, and potential allies, and to present itself as a policing and standards-upholding authority rather than a technical agency. In addition, a clear concept of the role of provinces in the health system has not yet developed. Decision makers know that districts are typically too small to support cost effective program volumes and scale, but have not designed institutional solutions to encourage joint service areas, or to make provinces agents for public health and related programs.

121. Policy weaknesses also stemmed from laws and regulations, introduced in big-bang fashion, that provided insufficient detail on functional and operational responsibilities, and brought confusion and divergence between provinces and other local government units. There was also inadequate coordination between MOH and local governments and other actors in the performance of critical health functions.

122. Further, reactive management of transition problems did not necessarily resolve fundamental design issues. For instance, in the Philippines, the Magna Carta for Public Health Workers, even with the supplemental funds the DOH provided under this law to a few LGUs, temporarily appeased disgruntled devolved health workers, but upset local governments with additional unfunded mandates. Similarly, the mismatch in the distribution of the IRA and the devolved expenditure functions across LGUs in the Philippines was “resolved” by de-facto adjustment in the IRA formula to provide additional grants to cities for the hospitals that they were already financing before the decentralization. This was politically necessary, but a costly way of ensuring adequate funding for the devolved functions (Capuno 2001).

123. However, these weaknesses, if corrected, would enable the gains from decentralization of health services to be expanded, even within limits set by a less than favorable environment. The “opportunities” thus delineated require MOH to focus on specific activities and tasks. For example, interventions in respect of pharmaceuticals entail setting up sustainable and effective quality assurance mechanisms in respect of drug supplies, safeguarding access of the poor to medicines and dismantling state monopoly. Responsibilities in respect of communicable diseases include monitoring national and regional trends, backed by support for laboratory capacity, and quality control and assurance; alerting provinces about outbreaks elsewhere, and advocacy for emergency financing.

With the stewardship of MOH

124. The examples cited above illustrate the contributions to health services delivery needed from central government policy during decentralization. Above all, central agencies should concentrate on activities that go beyond the direct provision of preventive and curative services. Attention should focus on core public health functions¹⁵ (CPHFs) that arise from overall health system imperatives and potential failures rather than those tied to specific diseases. These include the pharmaceuticals and communicable disease tasks mentioned above, along with health work force training, recruitment, pay and benefits, and supervision.

125. Other key CPHFs need be kept in view as well, e.g., assuring that the poor have access to affordable care, overcoming micronutrient shortfalls, creating sustainable funding arrangements, and acting as a source of ideas and best practices garnered from the provinces, and technical assistance on a selective basis. As the steward, the MOH would lead in building a consensus toward a set of national health objectives and standards, and coordinate rather than mandate local governments and civil society groups towards these objectives. Instead of relying on sometimes heavy-handed regulation, it would align incentives to elicit the cooperation and participation of all concerned sectors. Rather than impose high standards, it should perhaps only promote these through advocacy and by strengthening local governance mechanisms.

126. The stewardship role also entails pushing for greater consistency of objectives, programs and policies of different national government agencies in favor of the local governments. Finally, it is more than content that defines stewardship—there is clearly a leadership element and a

¹⁵ The Pan American Health Organization (PAHO) developed 11 essential public health functions through international consensus that have been field tested and implemented in 43 countries of Latin America, the Caribbean, and Europe (PAHO 2003).

mandate to be proactive—at best, stewardship is characterized by a flexible, opportunistic operating mode involving building partnerships, seeing and exploiting opportunities.

127. Central agency interventions are warranted partly because these functions may not have the urgency or tangible appeal of disease specific programs and may thus be neglected by districts. Also, sub-national governments have little incentive to carry out CPHFs because they cannot capture returns in full, with some CPHFs difficult to perform well because of limited resources or a lack of scale economies. A contributing factor is that CPHF impacts on health are hard to measure—it is difficult to gauge the effects of a strong disease surveillance and reporting system on slowing tuberculosis, while the direct distribution and use of anti-TB drugs by infected patients have obvious benefits.

Has the Philippines turned the corner?

128. Some steps towards this new role are recognizable in MOH statements and actions in the three countries. But no definitive transformation into a stewardship mode has yet occurred. Farthest along is the Philippines whose DOH has looked back at whether decentralization had paid off as a health reform vehicle.

129. In 1999 under the Estrada Administration, DOH formulated a comprehensive decentralization strategy called the Health Sector Reform Agenda (HSRA). The HSRA note slight improvements in resurgence of certain diseases, and persistent inequities in service access. To counter these problems, the DOH adopted a strategy that positioned itself more as leader in health, enabler and capacity builder, and administrator only of specific services (Department of Health Strategic Plan: 2000-2010). As a leader, it would be the primary institution responsible for setting national health policy and regulations, and strengthening the responsible regulatory agencies. As enabler and capacity builder, it would seek to promote innovations and standards in health service delivery, especially at the local level. And as an administrator, it would confine itself to specific health functions such as administering national hospitals towards fiscal autonomy, securing funds for priority public health programs, and pushing for universal coverage under the National Health Insurance Program.

130. The novel parts of the strategy are DOH-reengineering and the convergence of all DOH interventions in each province under the HSRA framework. DOH re-engineering meant streamlining of operations, finances and bureaucracy, leading to the redeployment of 1,638 personnel from the central office to the regional health offices, retained hospitals and other attached agencies of the DOH. In selected sites, the convergence approach enables the local officials, with the DOH providing technical inputs and other assistance, to draw up health development plans for their province and respective inter-local health zones (ILHZ). The ILHZ is a grouping of contiguous local governments within a province and usually around a district hospital that is meant to foster cooperation among its members to improve the hospital referral system, exploit possible of economies of scale, and contain spillovers.

131. In December 2004, for example, the Province of Capiz came up with a five-year development plan for enrolling indigent families with PHIC, upgrading of selected hospitals, adopting revolving drug funds and new drug management systems, with specific targets and activities both at the provincial and zone levels. With initial DOH support of PhP10 million the

Capiz plan is expected to yield gains from economies of scale in hospital operations, pooled procurement of drugs, and the effective control of epidemics and other spillovers. Similar arrangements are expected in 2005 in other convergent sites such as Pangasinan, Agusan del Sur and Misamis Occidental.

132. As a dynamic process, decentralization in the Philippines will continue to require adjustment guided by the piloting of the HSRA. For example, more can be done to build support for reform and prepare the intended beneficiaries, e.g., LGUs and health care users, and diffuse possible political resistance to policy reform. At the same time, DOH needs to extend its partnership with the various health NGOs and civil society organizations with whom it is already working. LGU health finances must be put on a firmer footing, including greater reliance on locally generated funds. Carefully designed user charges would not only improve service delivery efficiency, but would contribute to the sustainability of local health programs and generate funds for subsidizing the health needs of the poor. But to justify higher user fees, LGUs will be forced to improve service quality, requiring up-front finance for facility improvements, personnel training or hiring, and drugs and medical equipment. DOH matching grants could help support enhanced services provided LGUs introduce new fee schedules. Grants can also make local government employment more attractive to health workers.

Waiting for Indonesia...

133. As discussed above, central and lower government health roles and responsibilities in Indonesia have not been clarified sufficiently after three years of decentralization. Nor has there been an overall change towards a CPHF-based approach, or marked improvements in some specific policy areas, e.g., infectious disease control, pharmaceuticals, and human resources. The indeterminate policy scene is seen in other sectors besides health, leading to advice to clarify principles of functional assignment across government levels and sectors (World Bank 2003a).¹⁶

134. Currently, there are two strands of thinking within MOH on decentralization matters. The first is distilled in a 2003 decree that lists 29 strategic issues related to the core public health functions, and adds key steps to address issues such as Minimum Service Standards (MSS), partnership with NGOs, and services for the poor. Policy is seen as a means of limiting risks of service disruption, e.g., through accountability mechanisms and/or traditional command and control instruments. The former includes use of MSS to elicit the appropriate degree and quality of district commitment, including assistance in funding CPHFs. MOH has been relatively assertive in exerting its authority in responding to infectious disease outbreaks such as SARS, and handling oversight of surveillance and program execution for diseases, e.g., TB and HIV, of national importance and involving international obligations. To this end, MOH has depended on central or donor funding, though each is unreliable,¹⁷ and has looked for district support. In this

¹⁶ The Bank's view is that GOI should change: (i) Law 22/1999 and its implementing regulations to specify which *functions* in the decentralized sectors, rather than entire sectors, are the obligation of local government; (ii) sectoral laws and regulations to eliminate conflicts with Law 22/1999; and (iii) central regulations and decrees that maintain functions already assigned to regional governments through Law 22/1999.

¹⁷ Central spending is limited and subject to strong competition from outside and within MOH. For example, during 2001 and 2002, the central budget was highly constrained, and MOH's main funding initiative was not for disease control per se but to hire doctors to fill vacancies. Some funds were allocated for the TB, HIV, and a few other programs, leaving insufficient central resources for other diseases.

context, MSS are interpreted as targets for district spending. The decree assigns responsibility to district chief executives, and states that financing attainment of MSS should rely entirely on district budgets, with central and provincial governments providing technical facilitation, supervision, and oversight.

135. This approach is risky. Detailed, extensive MSS could undermine decentralization, and be rejected due to limited fiscal capacity in poorer districts. And most MSS have been set at high initial levels, imposed, not owned by local governments, while enforcement means and penalties for non-compliance have remained undisclosed. It would be better for MSS be interpreted as normative, medium term goals and not as performance requirements that trigger subsequent funding levels and require enforcement. Accordingly, different means are needed to increase district ownership of infectious disease prevention and control (Annex 1).

136. The second strand of MOH thinking has a more benign and more constructive view of decentralization. This approach is embodied in province-based initiatives underway in Yogyakarta and three other provinces (Lampung, North Sumatera, and West Java). Twenty-one others are due to come on stream later. MOH officials who support this approach are trying to use the momentum of decentralization as a catalyst for sector reform, with provinces playing an important mid-level role in a decentralized system. By contrast, the point of view reflected in the above-cited decree limits the province's contribution to backstopping central and district-level initiatives.

137. The province based approach remains new and under trial. It has already survived early bureaucratic and other challenges, but has yet to be assessed as regards impacts on health. Thus, there is much that MOH can do to ensure that experiences, implications, and lessons emerging from the province-based framework are being assessed carefully and disseminated to key stakeholders. MOH can also facilitate implementation in ongoing and new provincial programs, including interventions that widen and deepen the approach. And what central units learn in the process can then be disseminated to other regions. In addition, MOH can support pilot work or research aimed at helping provinces to respond to the diverse challenges of health workforce management and development including assisting provinces in rationalizing staffing numbers. In addition, MOH could support trials of approaches to attract doctors, especially specialists to remote or undesirable locations. Also MOH needs to lead work in developing standards that can be used by the provinces and districts to license service providers; working with professional associations to strengthen quality improvement activities and to establish partnerships in programs for professional development; consulting with consumer groups and hospital and other bodies on work force quality issues; drawing attention to trends in the quality of medical and other health worker education and its determinants; and funding and deploying special purpose health teams.

138. There are opportunities, imperatives, and stakeholder pressures that could support MOH's impetus towards devolution and health reform. Budget constraints may force MOH to look to districts and provinces as sources of funds and employment for the health work force. Similarly, demands for better service quality and other pressures from the public have begun to register with local level political leaders and within MOH. A medium term scenario resembles that in the Philippines, i.e., contested decentralization followed by a faster pace and major adjustments, leading to an HSRA-like, consolidation and mid-course correction. The Philippine

experience most relevant for Indonesia is arguably the change in outlook in DOH and its role amidst other players in a decentralized system.

Stewardship by Vietnam's MOH

139. Finally, the tempo of change in Vietnam is quickening with several distinct “drivers” governing the pace. The first of these is the reappearance of deadly public health threats at the top of the policy agenda. Vietnam is clearly vulnerable to new or more virulent strains of diseases such as SARS, HIV/AIDS, and influenza, and reemerging diseases such as tuberculosis and dengue fever. Malaria remains a major public health problem in the mountainous and ethnic minority areas of the country.

140. Successive crises have brought the creation of rapid reaction structures and shown the importance of timely and well targeted responses guided by updated disease surveillance data. MOH appears to be developing expertise in explaining disease challenges and engaging the public and political leaders while soliciting understanding and various sorts of assistance. MOH has also gained credibility and built stronger ties to decision makers at the provincial level and in key central ministries, e.g., MOF, MPI, and MOLISA.

141. These current drivers of change could intersect if as seems likely the revised agenda on communicable diseases leads to increased spending requirements--this should involve a review of current arrangements for funding disease control and the possibility of consolidating these outlays. A related issue is the need to avoid substitution for local government's own expenditure--there is a case for requiring matching financial contributions from local governments.

142. The 2002 Law requires some acceleration and then the completion of adjustments in government roles that have been occurring. Nevertheless, significant shifts are involved, and the experience and credibility accumulated in fighting SARS and other diseases could prove helpful.

143. In particular, the advent of provincially managed service delivery suggests that formal recognition backed by real authority and resources be given to a redistribution of responsibilities with MOH focusing on key “stewardship” functions. In this way, implementation of the 2002 Law will also enable MOH get out from under various second and third best aspects of the de facto health decentralization system that took hold in the 1990s. These include:

- Provinces are supposed to provide updates on how they are allocating their aggregate recurrent budget. However, this appears to be largely a formality. MOH has little information on health budgets, and it is not clear to what extent if at all, MOF can influence provincial spending on health from budgets already approved.
- MOH lacks a clear role in policy formulation and assessment overall, and in determining central resource allocations to health--MOF and MPI are the key agencies in this process. Central recurrent health spending is determined by projected growth of total revenue and recurrent expenditures and the share of health in aggregate recurrent expenditures.
- Such incremental budgeting is not sensitive to MOH-set goals and priorities.

144. Part of the MOH response to the 2002 Law is to strengthen budgeting procedures as well as improve allocation. This may include replacing allocation norms and hospital payment mechanisms with allocation instruments based on prices of health care services. MOH would like to prepare expenditure norms to support management, monitoring, supervision and control functions, and explore use of norms which reflect population needs, and serve as means of improving equity in service access and use.

145. MOH also recognizes that it needs other policies, with large and near term impacts, to address prevailing disparities in health outcomes and in per capita government health expenditures across provinces. Per capita spending in the richest seven provinces is nearly three times that in the poorest quintile--central and donor transfers do not operate as counter weight as the richest provinces receive the largest amount per capita, and because of the relatively small amounts of resources involved.

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