Policy Brief

ANALYSING THE IMPACTS OF DECENTRALISATION IN IMPROVING HEALTH SERVICES IN BALOCHISTAN: A DECISION SPACE, INSTITUTIONAL CAPACITY AND ACCOUNTABILITY APPROACH

Manzoor Ahmed

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INTRODUCTION

In Pakistan, besides many historical and political factors, a key reason for adopting (fiscal) decentralisation was to empower provincial governments in terms of both financial and administrative functions to provide better health and other services. Decentralisation, both fiscal and administrative, was pursued through the 7th NFC award and the 18th Amendment in 2009 and 2010 respectively. Given the political atmosphere and nature of federal structure, initiatives towards decentralisation were passionately celebrated all by segments of society, and particularly by the regional political parties and minority ethnic groups. Yet decentralisation and fiscal federalism as reform policy aiming to improve the social services delivery may not be effective unless some of the critical conditions are taken into account and sufficiently satisfied.

The impact of decentralisation on the health sector largely depends upon the institutional capacity and individuals' performance (Scutchfield et al., 2004). Capacity not only in terms of training and organisational structure, but also an enabling atmosphere that nurtures systematic capacity building within the sector with required infrastructure and systems and processes, supporting optimum decision making and policy implementation at all times and circumstances. A suitable institutional and individual capacity to exercise a given decision space is crucial for the health sector performance. Another equally important condition for improving health service delivery is the accountability dimension.

Based on Framework Method and Decision Space Model (Bossert et al, 2015), we examine how the health officials and representatives make "decisions" at the provincial and district levels in Balochistan to implement health policies and provide health services, what is their level of "capacity" and what is the mechanism of accountability of the officials and representation for health services delivery. We combine the decision space with the two other dimensions - accountability and capacity – to argue that the complementary interactions or synergy of all three dimensions will lead to improved health outcomes after decentralisation in Balochistan.

DECISION SPACE, ACCOUNTABILITY AND CAPACITY

The success of decentralisation on health services delivery is linked with a suitable degree of authority and discretion, a "Decision Space", a sufficient "institutional capability" and a sound "accountability mechanism" for the choices catering to the public health needs and priorities.

We discuss and analyse the decision space, the accountability and the institutional capacity of h health officials in four districts to assess the actual decision-making space within the discretionary financial and administrative powers given to them after decentralisation. We focus on how the synergy of all three dimensions would drive the efficacy and effectiveness of decentralisation on health services delivery in the province.

We have conceptualised the relationship among functional decision space, institutional capacities and accountability of officials and staff in health departments in provincial level officials and in four districts in Balochistan after the implementation of the 7th NFC Award and the 18th Amendment in 2009 and 2010 respectively. It evaluates the degree of variation in actual decision-making exercised by district level officials within the legally defined range of choice granted to these officials, and relates those choices to affiliated institutional capacities and accountability mechanisms.

METHODOLOGY

We adopt a standard research design with a semi-structured questionnaire to explore the tasks or initiatives which the decision makers and officials in the healthcare sector perform at provincial and district level in Balochistan. Research instruments are used to measure variations that occur in decision space, accountability mechanism, and institutional capacity broadly over six types of functions in the health sector: 1. strategic planning and strategy; 2. budget and finance; 3. human resource management; and 4. service delivery. 5. management of officials and workforce; and 6. monitoring and Utilisation data

Survey questions scored on a three-point with ordinal scale. The score **"1"** represents **"narrow"** or low decision space, low institutional capacity and lack of accountability. While **"2"** captures a "**medium**" level decision space, medium level institutional capacity and accountability, "**3**" represents a "**wide**" decision space with sufficient institutional capacity and sound accountability mechanism. We developed the choices set and then ordered the answers along the scale through a collaborative and systematic procedure.

We purposively-selected respondents, serving in health and P&D departments in different positions of authority, representing three broad categories of decision-makers and implementer: 1. Ministers, secretaries, director general and CEO PPHI who serve at provincial level; 2. District Health Officers (DHOs), Medical Supervenient (MS) and Deputy Commissioners who serve as career officers or health officers at district level; 3. Career health officials who work at Tehsil and local level as head of Regional Health Centre and Basic Health Units.

We selected four districts from three divisions of Balochistan (table 1). Our respondents included three secretaries, –– both cadre civil service officers in grade 20 and two politicians The remaining respondents were professional civil service health officials.

Whereas the qualitative research approach did not permit to get a statistically representative sample of the respondents, purposive selection of participants was commenced with the underlying purpose to capitalise on the variation in the profiles of the respondents in terms of current roles and overall

affiliations with the organisation, degree of decision-making, and geographic locations where they are staffed or working.

FINDINGS

In the Planning function, we find "narrow" decision space that the health officials at districts can exercise, and "narrow-to-moderate" decision space for health officials and politicians at provincial level. Decision making in planning can be enhanced when planners and decision-makers not only have sufficient capacity for strategic planning and engaging numerous stakeholders in the planning procedure but also have a sound accountability mechanism to develop good decision-making and planning at all levels as well as stridently monitor the implementation of these plans to guarantee satisfactory provision of health services.

In *financing and budget allocation* function we assessed "moderate" to "narrow" space at the district level, and "moderate" at provincial level, as the flexibility in making financing and budgeting decisions in Balochistan is largely conducted by the provincial government, particularly the politicians, hardly taking any suggestion from the health officials and the civil services dealing in the health and P&D departments. We notice that districts in relatively-urbanised districts, like Quetta and Turbat, get a bigger share for allocation to RHCs and Hospitals located at district headquarters, while smaller districts get a lesser share from the provincial allocations, not sufficient to support labour-intensive health services. We notice that with a high degree of "centralisation" at provincial level in budgeting and financing, the health sector at district level relies significantly on payments from the provincial government.

The *health services delivery* is assessed as "narrow", since the health officials at district level do not have the required scope to implement health programmes and provide routine (both primary and tertiary health) services. District Health Officers and the PPHI have no authority to promulgate health programmes and provide services apart from the ones mandated by the provincial government. We found that weak governance, insufficient capacity at district and beyond where the primary health services are provided, result in weak services delivery and programme implementation. This includes the immunisation coverage to children, prenatal care to women etc.

Decision space for the overall *management and availability* of equipment and medicines is assessed as "*narrow*". Whereas, the district level officials already have full mandate and management control over health facilities and equipment that they have, yet the respondents reported sheer lack of availability of facilities and equipment at the local level, which include vaccines, medicines, contraceptives, machinery laboratory diagnostic kits, labour rooms operation theatre etc. Decision space for such functions in the healthcare sector can be improved if the decision-makers and health officials at the district or local level are better equipped with the required management skills and sufficient capacity for running health facilities and programmes. This sort of capacity is hardly possessed in fact by the district/local government health officials and staff members.

Our assessment of *health officials and workforce management* is "narrow". Formally the health department enjoys full control over the management of its health officials and workforce at both provincial and district level. The district level officials are unable to hire the minimum number of health officials and workers they need due to lack of mandate and their lack of resources to pay for their wages or the absence of facilities and incentives for health workers to serve in these far-flung areas. Required mandate and capacities for local level health officials may include having suitable

financial resources to hire workers and quantity of health workers which the local people then require, and to offer adequate salaries and benefits.

The decision space for *data monitoring and utilisation* is "narrowed", as the health setup at the district or local level is not primarily responsible for collecting health-related data at local levels and to transmit the same to the provincial government for consolidation and further consumption and assessment. We find that in Balochistan even the decision-makers at the provincial level perform data collection in a customary fashion and out of mere compliance. The department at the provincial level lacks capacities to utilise the data to initiate meaningful actions for better healthcare services.

Our findings offer numerous opportunities for increasing the institutional capacities not only at district/local but also at the provincial level, as well as strengthening the accountability mechanisms to encourage good decision-making after decentralisation. A wide decision space at district level is not enough to improve and expand health services delivery if it is not accompanied by building the capacity of health officials, and also to ensure their accountability to community, politicians and overall system of governance for all relevant decisions they make.

Based on these results we can conclude that decentralisation in Balochistan may not be effective in services delivery including health services, as the existing power structures persist in the province with rent-seeking tendencies. With weak institutional structure, decentralisation furthers or sustains corruption compounded by a lack of accountability measures as politicians become the centre of decision-making, and sustain and even promote.

POLICY RECOMMENDATIONS

The insights from Balochistan suggest that we should move just beyond linear causation, and to a more complexity-informed approach to make decentralisation more effective for health services delivery. The solution to the challenges in its health sector in Balochistan does not come from either more centralisation or more decentralisation or federalism to local governments per se. It instead potentially comes from concentrating on enhancing the institutional capacity and accountability regardless of the governance structure. In this policy brief we have explored opportunities for augmenting decision-making at district levels with a multi-steps approach and qualitatively analysed the decision space for each function. We also assessed the institutional capacity and accountability adjustments required to expand decision-making within each function. To optimise decentralisation for the health sector in Balochistan, better decision space at district levels is indeed required, but this needs to be accompanied by an expanded capacity and strong accountability.

It is important that in all tiers of government for implementing decentralisation, there should be a concerted effort to encourage greater knowledge of the *de jure* decision space and push all health officials to take responsibility for making decisions aiming for better performance of health services. Efforts should also be made to develop on synergistic effects by developing institutional capacity, focusing first the district administrative units facing least institutional capacity. Such interventions for local capacity building should be a component of all health-related programmes. Similarly, accountability to elected representatives and to the governance system as whole should be exercised at a higher bureaucratic level. If the accountability mechanism at local level is perceived as a policy objective, then more effort in decentralised contexts may be needed to encourage local decision making with balanced configurations of the decision space with the dimensions of institutional capacity and robust accountability mechanism.

Capacity for the health officials at the local level to engage the private sector also needs to be enhanced and expanded so that some aspects of service delivery can be made more efficient through public-private partnerships as in majority of districts in Balochistan the private sector health structure is functional. Areas for such a partnership include the outsourcing the provision and maintenance of expensive equipment required by the provincial hospitals,

The officials may also enhance their decision space for such functions when their capacities in understanding the health-related issues and provision of public health are increased. They should understand what the certain crucial health indicators mean and how they can be interpreted and to translate these data that can guide for effective decision-making. Decision-making in financing and budgeting may then be enhanced when local decision-makers have suitable degree of capacities for performing priority-setting, including an emphasis on primary and preventive care services, and evidence informed instead of politically-motivated funding decisions at the provincial and district level. The accountability mechanisms for such functions may include the health department at the provincial level to deploy its own data collectors at the local level and to validate the data being reported through experts, and also to accelerate the transmission of the data to the federal level for national and international use. Furthermore, the federal government of Pakistan may consider frequently publicising the provincial governments in terms of meeting selected targets of health outcomes in order to inform the population of the performance of the provincial governments. Similarly, it may maintain a reliable electronic database that pools all health-relevant indicators from district and local levels, which is essential for accurately assessing the state of health as a whole.

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