SURE Rapid Response

What role can the regional tier play in facilitating health services delivery?

April 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key Messages

- The regional tier arrangement is expected to bring about an impact on health services delivery similar to that expected out of decentralization as they both provide for re-allocation of responsibilities and moving resources like power and decision-making much nearer the end users.

- With the regional tier in addition allows for further sharing of resources between cooperating districts which leads to technical efficiency, that is, better cost consciousness, not having to duplicate services and creating a situation of increasing returns to scale for either or any of the districts

Who requested this rapid response?

This document was prepared in response to a specific question from a Senior Health policymaker in Uganda.

! This rapid response includes:

- Summary of research findings, based on one or more documents on this topic
- Relevance for low and middle income countries

X Not included:

- Recommendations
- Cost assessments
- Results from qualitative studies
- Examples or detailed descriptions of implementation

What is the SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

Background

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research on the topic. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Many countries in a bid to improve public systems and service delivery have embarked on reforms that ensure or promote more efficiency and participation of stakeholders. Just like decentralization, a reform through the regional tier approach would transfer fiscal, administrative, ownership, and political authority for health service delivery from the central body that is the Ministry of Health to alternate (usually lower) institutions or levels of political administration. In the case of the regional tier, there would in addition, be two or more districts coming together, and cooperating in several areas which if done well would mean that the two are complementary of each other. One of these areas of cooperation as spelt out in article 178 of Uganda's constitution is health and health services [1]. There are expected benefits from such an arrangement that moves resources like power and decision-making nearer to the people or the end users of public services, and yet also allows for cooperation between two or several of the lower level administrations.

There is a paucity of rigorous studies that have appraised the regional tier system and its effects on the health system. However an estimation of what role the regional tier can play in facilitating health service delivery can be made by looking at the impact of decentralization. It is noted though that the effects of these reforms are difficult to estimate because this requires major research effort to gather relevant data in a systematic manner and over a while [2]. In fact a study was done to evaluate four nations that had exhibited significant experience with decentralization. It involved a set of case studies that analyzed the decentralized health systems of Ghana, Zambia, Uganda, and the Philippines using the public administration and principal-agent frameworks, and it found that sufficient evidence does not exist to assess the impact of decentralization [3].

That not withstanding, it is expected and suggested that the re-allocation of responsibilities of such a policy on health service delivery would lead to improved efficiency and quality of services. There are however shortcomings of the policy too. This paper will look at the impact of decentralization and analyse the additional effect the regional tier system would cause, in an attempt to approximate the effect of the latter.

Summary of findings

Allocative efficiency is expected to increase because local decision-makers have access to better information on local circumstances than central authorities would, and they use this to tailor services and spending patterns to local needs and preferences. A study commissioned by the World Bank found that decentralization implemented in Bolivia helped to improve consistency of public services with local preferences and quality and access of social services [4]. In the regional tier system it would in addition allow for comparisons to be made within and across the different districts working together.

Technical efficiency: this is expected to improve through greater cost consciousness at the lower or more local level [5]. It would also be expected with the regional tier, to come with the fact that there are services that may be shared between the two or more districts coming together and so not having to duplicate services and moreover, creating a situation of increasing returns to scale for either district, whereby the output or benefit serving several districts increases by more than the input proportional change.

Quality of service improves because the public's participation is encouraged which provides input on local decision-making processes and holds local decision-makers accountable for their actions [5]. In addition, with the regional tier, when it comes to being accountable, problems of compromise due to local patronage and influence may be reduced considerably as there is a wider area one is accountable to and one's position may be based in one of the several districts not necessarily theirs. The lack of some skills for given positions may be avoided too as the participation and contribution of several districts provides a bigger pool to recruit from.

It is also expected that such reforms like decentralization and the regional tier create space for learning and innovation through wider involvement of stakeholders, community participation and the adaptation of public services to local circumstances [2]. The one-size-fits-all phenomenon that is seen with centralised systems is avoided with decisions and programs being tailored to the needs of the local communities. A study done in Porto Alegre, Brazil, found that services were better organised and delivered in a more equitable manner due to participatory budgeting [6].

A study done in West Bengal, India and another in Bangladesh, found that advancing poverty alleviation goals may be very difficult without decentralized management [7, 8]. This matched the findings in another study done in Albania, which found that reforms like decentralization had a positive impact on targeting of social assistance to those in need of it and what Foster and Rosenzweig concluded, that in India democratic decentralization led to improved allocation for pro-poor local services [5].

Huther and Shah, and Enikolopov and Zhuravskaya in their studies using data that was collected over time for a large number of countries found that decentralization contributed to improved delivery of public goods provision [2]. A similar study using data on a cross-section of industrial and developing countries found that decentralization leads to increased spending on public infrastructure [9]. This is to the larger benefit of the lower level individuals.

However there have been negative and inconclusive impacts observed as well. In Argentina, it was found that poorer provinces were less successful in program development and implementation, and service delivery [10]. It would be of very little benefit if under the regional tier arrangement, two or more poor districts came together. Furthermore this study noted that decentralization generated substantial inequality in public spending in these poor areas. Another assessment done in Uganda did not find any positive impacts of decentralization on efficiency and equity of local public service provision, while in rural China, it was noted that decentralization resulted in lower level of public services in poorer regions [11, 12].
Several studies observed mixed or inconclusive impacts of decentralisation. Azfar et al. noted that in the cases of the Philippines and Uganda, while local governments do appear to be aware of local preferences, their response is often inadequate as they are constrained by procedural, financing and governance bureaucracies and inefficiencies [13]. Such red-tape is in fact expected to be worse in the regional tier arrangement as decisions have to be passed by authorities of more than one district who may have their districts as priority and not the partnership. An assessment based on data from 140 countries found that decentralization improved the coverage of immunisation in low income countries but had opposite effects in middle income countries [14].

Conclusion

This paper has used the effects of the decentralization policy to approximate the impact of a regional tier system on health services delivery and the health system in general. Although studies have shown that the evidence available is not enough to assess this impact of decentralization, it gives an insight into what a policymaker should expect. These reforms, if

implemented well lead to more efficient and probably more equitable health service delivery that is pro-poor. They are however compromised by governance and organizational bureaucracies which might be in fact more pronounced in the regional tier arrangement.

References

1. *The Constitution Of The Republic Of Uganda* 1995(2005 amended).
2. Health Nutrition and Population. *Decentalization*. Health Systems; Available from: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20190818~menuPK:438810~pagePK:148956~piPK:216618~theSitePK:376793,00.html.
3. Bossert T. and J. Beauvais, *Decentralization ofhealth systems in Ghana, Zambia, Uganda, and the Phillipine: a comparative analysis of decision space.* Health Policy and Planning, 2002. **17**(1): p. 14-31.
4. Alderman H, *Social Assistance in Albania: Decentralization and Targeted Transfers*, in *LSMS Working Paper no. 134*, World Bank, Editor. 1998: Washington D.C.
5. ANWAR SHAH, THERESA THOMPSON, and HENG-FU ZOU, *The impact of decentralisation on service delivery, corruption, fiscal management and growth In developing and emerging market economies: a synthesis of empirical evidence*, in *CESifo DICE Report 1/2004*, The World Bank: Washington D. C.
6. Santos B. D. S, *Participatory Budgeting in Porto Alegre:Toward A Redistributive Democracy.* Politics and Society, 1998. **26**: p. 4.
7. Bardhan P and D. Mookherjee, *Poverty Alleviation Effort of West Bengal Panchayats. http://econ.bu.edu/dilipm/wkpap.htm/epwsumm.pdf.* 2003.
8. Galasso E. and M. Ravallion, *Decentralised Targeting of an Anti-Poverty Program. Development Research Group Working Paper.World Bank,Washington D.C.* 2001.
9. Estache A. and S. Sinha, *Does Decentralization Increase Spending on Public Infrastructure?* The World Bank Policy Research Working Paper 1457, 1995.
10. Galasso E. and M. Ravallion, *Reaching Poor Areas in a Federal System.* Policy Research Working Paper #1901.World Bank, Washington DC., 1998.
11. Azfar O. and J. Livingston, *Federalist Disciplines or Local Capture? An Empirical Analysis of Decentralization in Uganda.* IRIS, University of Maryland, 2002.
12. West L. and C. Wong, *Fiscal Decentralization and Growth Regional Disparities in Rural China: Some Evidence in the Provision of Social Services.* . Oxford Review of Economic Policy, 1995. **11**(4): p. 70 - 84.
13. Azfar O., S. Kahkonen, and P. Meagher, *Conditions for Effective Decentralised Governance: A Synthesis of Research Findings.* IRIS working paper # 256, University of Maryland., 2001.
14. Khaleghian P, *Decentralization and Public Services: The Case of Immunization.* Policy Research Working Paper 2989.World Bank,Washington, DC., 2003.

This summary was prepared by

Dr. Rhona Mijumbi, Supporting Use of Research Evidence for Policy (SURE Project), Office of the Principal, College of Health Sciences, Makerere University, New Mulago Hospital Complex, Administration Building, 2nd Floor, P.O Box 7072, Kampala, Uganda

Conflicts of interest

None known.

This Rapid Response should be cited as

Rhona Mijumbi, *MPH, MSc*. **What role can the regional tier play in facilitating health services delivery?** A SURE Rapid Response. April, 2011**.**

For more information contact

Dr. Rhona Mijumbi, mijumbi@yahoo.com

Regional East African Community Health Policy Initiative

The **Regional East African Community Health-Policy Initiative (REACH)** links health researchers with policy-makers and other vital research-users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States.

www.eac.int/health

The **Evidence-Informed Policy Network (EVIPNet)** promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.

www.evipnet.org