Decentralization and Health: Case Studies of Kenya, Pakistan, and the Philippines

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Decentralization and Health: Case Studies of Kenya, Pakistan, and the Philippines
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The information presented is the product of a two-month internship at the World Health Organization in Geneva, Switzerland as part of the Duke Program in Global Policy and Governance. The work presented here was conducted in the division of Health Systems Governance in order to determine how countries meet (or do not meet) and health metrics in a decentralized context, taking note of important factors that contributed to or hindered success.

Decentralization
Decentralization, defined by the World Bank (2001) as, “the transfer of authority and responsibility for public functions from the central government to intermediate and local governments or quasi-independent government organizations and/or the private sector,” is a movement that has gained much traction in recent history. For many countries undergoing decentralization, a major driver has been a desire to increase the role and participation of local governments in the decision-making space. In doing this, it is hoped to create governance structures that are more accountable and responsive to the people. For health, decentralization has been touted as a potential way to improve responsiveness to local needs, improve service delivery, and improve equity. In light of these goals, many countries as part of their political decentralization have also opted to decentralize healthcare.

Country Quick Facts

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<tbody>
<tr>
<td>Kenya</td>
<td>Poverty Level: 5.0% of population lives on less than US$1 per day</td>
<td>Population under 15 (2012): 42.37% (high dependent population)</td>
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<td>Fertility Rate (2012): 4 births per woman</td>
<td>Malnutrition (2012): 36.7%</td>
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<td>High burden of communicable diseases, with Malaria as the main cause of death and diarrhea: 29.3% of deaths, 24.2% of all deaths</td>
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<td>Maternal and neonatal mortality: 63.0 per 100,000 live births</td>
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<td>In 2013, 4.6% of the GDP was spent on health; 5.9% of GDP on education</td>
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<tr>
<td>Pakistan</td>
<td>Poverty Level: 6.4% of population lives on less than US$1 per day</td>
<td>Population under 15 (2012): 35.1% (high dependent population)</td>
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<td>Fertility Rate (2012): 4 births per woman</td>
<td>Malnutrition (2012): 37.5%</td>
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<td>High burden of communicable diseases, with Malaria as the main cause of death and diarrhea: 35.8% of deaths, 24.2% of all deaths</td>
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<td>Maternal and neonatal mortality: 49.0 per 100,000 live births</td>
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Kenya

Reason for Decentralization: 2010 Constitution
Legal and Policy Frameworks: Article 43 of the 2010 Constitution, Vision 2030

Progress:
- Creation of Kenya Health Sector Strategic Plans (KHSSP) with five-year plans set to run until 2030
- Alignment between health sector planning and budgeting 2015-2016: still lack of integration due to weak Ministry of Health stewardship, the rapidly changing planning and budgeting environment, lack of reliable data, and poor participation of key stakeholders.
- Key challenge: overlap between legal responsibilities of the national and county governments

The Philippines

Reason for Decentralization: establishment of the Fifth Republic (1987) after the People’s Power revolution of 1986 in which dictator Ferdinand Marcos was thrown from power

Progress:
- Fiscal decentralization and financial autonomy of local government units remains problematic
- Inequities in health status and high out-of-pocket payments

Pakistan

Reason for Decentralization: 18th Constitutional Amendment of the 2010 Constitution
Legal and Policy Frameworks: Implementation Commission, National Finance Commission Award

Progress:
- Abolition of the Ministry of Health in 2011 resulted in re-establishment in 2013
- New financing award has improved equity of financing between provinces and the federal government and provinces

Lessons Learned
1. Influence of international commitments: Alma Ata Declaration (1978) and commitment to primary health care
   - Kenya: Alma Ata—further emphasis on health and national blueprints for health were created
   - The Philippines: adoption of primary health care focus in 1979
   - Pakistan: post-Alma Ata environment lead to a boom in first level, public care facilities
2. Decision to decentralize is often political, and is not necessarily driven by health needs
   - Kenya: the major impetus for the new constitution and decentralization were grievances about the distribution of health services.
   - The Philippines: decentralization came with the installation of the Fifth Republic in 1987 after the People’s Power Revolution that ended the dictatorship of Ferdinand Marcos.
   - Pakistan: adoption of the 18th Constitutional Amendment and a shift from a heavily centralized system to a predominantly decentralized federation.
3. Need for communication and networks for communication with engagement of key stakeholders
   - Kenya: Sector Wide Approach (SWAP), Joint Program of Work and Funding was developed to ensure that SWAP was properly implemented, Intergovernmental Relations Act 2012
   - The Philippines: Sectoral and Management Coordination Team that helped with the development, monitoring, and coordination of policies and guidelines of FOHR/FOHR One for Health; Internal Management and Support Team for coordination and administration of the DOH finances and logistics.
   - Pakistan: the 18th Amendment strengthened the Council of Common Interests, which is a forum in which provincial and federal interests can be address
4. National plans with set objectives and goals help ensure success of programs
   - Kenya: national health plans have been set as the Kenyan Health Sector Strategic Plans, the Kenya Health Policy Framework 2014-2030, Article 43 of the 2010 Constitution.
   - The Philippines: 2013 National Development Budget
   - Pakistan: re-establishment of a Ministry of National Health Services Regulation and Coordination (MNHSRC)
5. Finances and resources that are equitably shared to carry out national plans
   - Kenya: author have estimated that without better financing the current health plan may not be able to meet its targets.
   - The Philippines: health spending has increased nearly 15% from 2000-2012.
   - Pakistan: creation of a new formula to improve the equity of health financing amongst provinces and to increase overall financing

Conclusions
Kenya, the Philippines, and Pakistan represent three countries that have changed their health systems due to political forces. With political pressure as the driving force, each country has implemented changes to their healthcare system as part of their commitment to improving the health of their population in a decentralized context. Understanding the broader context under which health systems are created is important even at the clinical level because in understanding what shapes health, we can better act to create structures and systems that support health.