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 sphere. 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 Implementation and Progress

<table>
<thead>
<tr>
<th>Country</th>
<th>Reason for Decentralization</th>
<th>Legal and Policy Frameworks</th>
<th>Progress</th>
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<td>Kenya</td>
<td>2010 Constitution</td>
<td>Article 43 of the 2010 Constitution, Vision 2030</td>
<td>Creation of Kenya Health Sector Strategic Plans (KHSSP) with five-year plans set to run until 2030</td>
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<tr>
<td>Pakistan</td>
<td>18th Constitutional Amendment of the 2010 Constitution</td>
<td>Implementation Commission, National Finance Commission Award</td>
<td>Fiscal decentralization and financial autonomy of local government units remains problematic</td>
</tr>
</tbody>
</table>

Lessons Learned

1. Influence of international commitments: Alma Ata Declaration (1978) and commitment to primary health care
   - The Philippines: adoption of primary health care focus in 1977
   - 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 DOH.

4. National plans with set objectives and goals help ensure success of programs
   - Kenya: national health plans have been set as the Kenya Health Sector Strategic Plans, the Kenya Health Policy Framework 2014-2030, Article 43 of the 2010 Constitution.
   - The Philippines: FOURmula One for Health: Internal Management and Support Team for coordination and administration of the DOH finances and logistics.
   - Pakistan: re-establishment of a Ministry of National Health Services Regulation and Coordination (MNSRC)

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 150% 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 in 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.