



## Decentralisation in Asian Health Sectors: Friend or Foe?

by Hiroko Uchimura and Johannes Jütting

- ◆ Decentralising health services – the transfer of power and responsibility from the central to the local level – should help the poor if local resources, accountability and governance are in good shape.
- ◆ The process in China and India had negative effects because local governments remained under-funded and health was not seen as their priority. Contrary to this, ...
- ◆ ... decentralisation in Indonesia and the Philippines produced better health outcomes because they reformed healthcare funding. This is key to successful pro-poor decentralisation.

### Questioning “pro-poor” decentralisation

Can Asians decentralisation trend help countries achieve the MDGs, half of which concern health? How does it affect health system performance and outcomes? What kind of decentralisation delivers efficient, accountable and participatory systems that improve the poor's access high-quality services?

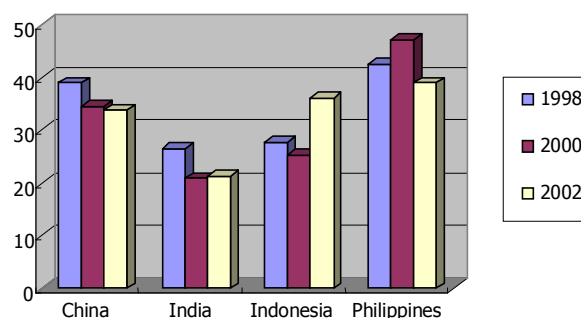
More than a decade ago, China, India, Indonesia and the Philippines began ambitious decentralisation that included the health sector. Advocates of decentralising health services say incorporating local data in decision-making, altering patterns of authority and holding officials and health workers accountable improves performance, outputs and outcomes such as mortality rates, and thus benefits the poor. Critics doubt this. Hence there is a need for empirical country analysis to be able to draw lessons under which conditions health decentralisation leads to pro-poor outcomes.

### Country reviews find mixed effects

Government expenditure on health care in China, India, Indonesia and the Philippines declined or stagnated after decentralisation began. The percentage of government health spending as part of total health expenditure fell in China and India and stagnated in Indonesia and the Philippines between 1998 and 2002.

Figure 1. **Government Health Expenditure**

Government health expenditure as % of total health expenditure



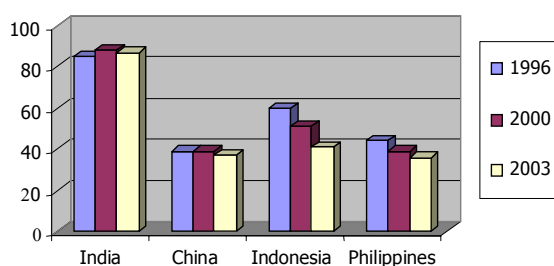
Source: World Health Report, WHO.

The fall in China and India can mostly be explained by three factors. First, fiscal decentralisation shifts the burden to local governments without properly funding their new responsibilities. After China reformed its inter-governmental transfer system in 1994, social service spending remained decentralised, but revenues were recentralised. A complicated transfer system to equalise revenue and expenditure across provinces is barely functioning and is increasing the health funding gap between poorer and richer provinces.

Secondly, local governments have no incentive to invest in health as they do in infrastructure and private sector development. Thirdly, the impact of different types of health services varied. More autonomy for hospitals in China, for example, led to buying more expensive equipment and drugs to generate local revenue, leading to greatly increased medical costs and an under-supply of those services with inter-jurisdictional spill-over such as immunisation. This also happened in the Philippines and Indonesia where vaccination coverage dropped significantly after decentralisation.

Figure 2. **Health Outcomes**

**Under-5 mortality rate per 1000**



Source: *World Development Report*, World Bank; *World Health Report*, WHO.

In Indonesia and the Philippines, which did not reduce health spending, outcomes have improved with decentralisation. The under-5 mortality rate has sharply fallen, while it was stable or slightly worse in China and India. The difference may be because the already high out-of-pocket (OOP) expenditure, mostly paid by the patient at the point of delivery, in China and India has steadily risen, probably due to less government health spending. In Indonesia and the Philippines, the OOP share remained stable or fell slightly, also due to early investment in healthcare funding reform. So improving the healthcare financing system towards more pre-payment and less OOP is a key to successful decentralisation.

## Lessons learnt

Decentralisation can be important in substantially changing developing countries' health sectors. There is no single recipe, but major indications of what works and what does not can be identified.

The process and the policy context are crucial. The key is less choosing a big bang approach (the Philippines and Indonesia) over a gradual one (China and India) than ensuring that these changes are accompanied by reform of healthcare funding. Many countries are now rethinking their policy here and moving away from high OOP payments towards pre-payment through insurance or tax-funded healthcare provision. The real challenge, however, is to combine health sector financing reforms with the decentralisation process in such a way, that OOP payments are reduced and access to health care services improves.

When central government incentives are missing or enforcement does not work well as in China, local governments are less interested in providing services, including healthcare. Local authorities generally have little interest in public services, especially those with inter-jurisdictional spill-over. Giving local governments incentives to invest in health leads to better outputs and outcomes. Mapping resources to expenditure is an important tool for this but not the only one. Setting up a transfer system to redistribute funding is important to boost poorer regions' fiscal capacity. To make this function, responsibilities at the various levels of government and health institutions must be clearly defined and enforced.

Decentralisation is a long-term process, so setting up an evidence-based process for continuous change is essential. Establishment of a high-quality data collection system along with an evaluation culture is a prerequisite. This should be an integrated participative process.

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OECD Development Centre  
2, rue André-Pascal,  
75775 Paris Cedex 16, France  
Tel.: +33-(0)1 45.24.82.00  
Fax: +33-(0)1 44 30 61 49

E-mail: [dev.contact@oecd.org](mailto:dev.contact@oecd.org)