8

DECENTRALIZING HEALTH: LESSONS FROM INDONESIA, THE PHILIPPINES, AND VIETNAM

Samuel S. Lieberman, Joseph J. Capuno, and Hoang Van Minh

This chapter examines the decentralization experience of three East Asian countries from the perspective of how well they have addressed the special features and requirements of the health sector. These features include the substantial role of externalities, the high degree of specialization, the critical role of quality and timeliness, and the high level of knowledge required to participate in the health care system at all levels. These characteristics have important implications for the design of health policy in general, and especially for a decentralized system of service delivery and sector management. This chapter outlines the decentralization health policies and programs of Indonesia, the Philippines, and Vietnam, focusing on the period 1985–2003, spanning the years before and after significant decentralization began in these countries. The chapter also points to areas where reforms may facilitate more effective health care delivery.

The Health Care Context of Decentralization

Experience with decentralizing health in developing economies is limited, and the literature reveals no widely accepted, best-practice health policy framework. This is partly because decentralization in many low-income countries is a recent development, while affluent countries historically moved in a centralizing direction as constituent states came together to form federal unions.

Another constraining factor has been the top-down, centrist bias in the influential Health for All (HFA) paradigm, used to build dominating but difficult-to-manage and ineffective health ministries in many countries. HFA's main sponsor, the World Health Organization (WHO), has been traditionally uncomfortable with decentralization. The literature on government roles in health systems is relevant to the extent that privatization is a form of decentralization, but this literature misses the critical decentralization issue: the allocation of roles among levels of government. The literature also lacks a connection between options for decentralization and health financing. Meanwhile, most approaches that focus on health challenges—including the Millennium Development Goals of the United Nations and the World Bank–sponsored Poverty Reduction Strategy Papers in developing countries—assume a strong central role for ministries of health.

Nevertheless, a debate has developed around decentralization design issues, with contributors dividing into two camps. Proponents see decentralization, if handled well, leading to systematic citizen involvement in setting the goals, design, and financing for health policy, and in monitoring service provision and other functions. In this view, decentralization can also spur providers to obtain the skills, material support, and authority they need to offer high-quality services. Decentralization can further enable clients to secure information, financing, and bargaining power, and offer health ministries a chance to jettison impractical obligations and carve out a new role and image.

Detractors warn, however, that (badly designed) decentralization heightens vulnerability to near-term crises and longer-term risks. Typical start-up problems include staff opposition, leading to breakdown of deployment and other personnel mechanisms; mismatches between health care funding and spending requirements; ambiguity in responsibilities and premature delegation of functions, leading to deteriorating service quality; and disruptions in reporting, accountability, and quality control. Medium-term concerns include rising system costs. Specifically, downsizing administrative units may yield designs for key health functions that are neither technically efficient nor cost-effective because of diseconomies of scale. Such "transitional" problems may be difficult to correct.

Because of these risks, public health commentators have called for careful introduction and management of decentralization. Most analysts support WHO's recommendation that countries phase in devolution under central guidance, subject to stringent criteria, with health ministries continuing to take responsibility for specialized services, medical supplies, basic education and training, and other key functions (WHO 1995). This advice illustrates two recurring themes: that the overriding rationale for health decentralization is improved effectiveness and efficiency, and that the timing of the process is subject to ex ante design.

Such premises are usually not valid, since the impetus for decentralization is generally political. Improved health is only a second-order objective, with imperatives such as preserving national unity usually driving the process and shaping the decision to devolve to particular levels of government.

That was arguably the case in the Philippines, Vietnam, and Indonesia, which decentralized their health services starting in 1992, 1996, and 2001, respectively.[1] Evidence suggests that health ministries in these countries initially were not prepared to articulate and assume a new specialized role of system manager rather than main provider. Inconsistent policies further indicated that expediency rather than strategy guided official responses to transition problems.

At the same time, the faltering performance of the health systems in these countries before decentralization signaled a need for significant changes in health policy. In the Philippines, improvements in infant survival rates and other health status indicators in the 1980s were beginning to plateau, indicating decreasing returns from health expenditures that were higher than in other developing countries in terms of gross domestic product (GDP) (Solon et al. 1992).

In Vietnam, the collapse of the agricultural financing system and economic reform in the 1980s undermined funding for primary health care services and produced shortages of drugs and skills, deteriorating quality of care, and a decline by a half or more in use of government facilities. Funding gaps also led to higher user fees, which became a financial barrier and reduced access to care by the poor.

In Indonesia, the 1997 financial crisis brought funding cuts that confirmed the susceptibility of the government network to drug shortages and other breakdowns. But performance problems had existed earlier. The country did not sustain favorable trends in survival and nutrition rates from the 1980s in the 1990s, despite large-scale intervention. Use of public services also faltered. After rising to nearly a third, the share of people who sought outpatient care from public providers fell below 30 percent by 1995, and below 20 percent by 1998. Meanwhile, households in the top expenditure quintile were far more likely than the poor to use public facilities as inpatients, and nearly as likely as to use such facilities as outpatients.

Objectives of the Chapter

This chapter examines decentralization experiences in Indonesia, the Philippines, and Vietnam with an eye toward three sets of questions. First, how can developing countries design decentralization to provide an appropriate framework for a public health system, and what policies and instruments

promise to be effective in improving the efficiency and equity of a decentralized health system? Second, how should countries handle transition problems and other risks? Third, what lessons do the experiences of these three countries reveal?

In addressing these questions, the chapter examines the emerging role of central health ministries. Critical functions include monitoring and controlling communicable diseases, setting standards and assuring quality for devolved health services and pharmaceuticals, ensuring access of the poor to health services, and sustaining health financing.

The three countries have broad features that facilitate comparison. All have tropical or semitropical climates, and all are highly populated developing countries composed mostly of rural-based agricultural households, with significant numbers of poor. Each country also has a colonial history in which the struggle for independence led to a unitary form of government with a strong center. Communicable diseases are the main cause of morbidity and mortality in all these countries, although each is now experiencing an epidemiological transition that brings growth of noncommunicable, lifestyle-related diseases. Yet each country also possesses unique features that provide interesting contrasts to the other two. Unlike the Philippines and Indonesia, for example, Vietnam has adopted a market-oriented economic policy only recently while retaining socialist features in its government structure. Unlike Vietnam, Indonesia and the Philippines are archipelagos that are insulated to a degree from disease transmission across land borders.

The available data limit comparison between these countries. Official statistics on health, demographics, government finances, and other socioeconomic indicators vary in scope, detail, and quality. The same applies to secondary sources of information. Data constraints also add to the methodological challenges of tracing the impact of decentralization on health amid other socioeconomic factors, external conditions, and policy interventions. Thus, the analysis draws only broad conclusions and policy guidelines.

The analysis suggests that decentralization dividends so far have proved modest and concentrate in some areas of each country. Decentralization may have helped sustain overall improvements in health status and spurred local initiatives in health planning, service delivery, and financing. However, decentralized arrangements have not worked as well as hoped, especially regarding access to high-quality health services for the poor.

The Origins of Decentralization

The fact that these countries have experienced only modest health gains from decentralization reflects circumstances outside the control of policy makers. In particular, these countries introduced decentralization in less than favorable economic and political environments. For example, the 1997 Asian financial crisis underscored the direct link between macroeconomic performance and health expenditures. Before 1998, the Philippine economy—much like that of Indonesia and Vietnam—was growing steadily. Per capita income in the Philippines rose from US$2,310 in 1985 to US$3,870 in 1997. Following the outbreak of the crisis in late 1997, per capita income fell to US$3,730. The impact of the crisis in Indonesia was graver. Its per capita income declined from US$3,030 in 1997 to US$2,580 in 1998; by 2001 per capita income was US$2,900, still lower than before the crisis. Vietnam was less affected by the crisis, although per capita government health spending leveled off and may have fallen after the crisis.

In the Philippines, the crisis prompted the national government to invoke "an unmanageable public sector deficit"—a provision under the Local Government Code of 1991 that allows a 10 percent cut in the Internal Revenue Allotment (IRA) distributed to lower levels of government.[2] Because most local governments depended heavily on the IRA, the reduction further reduced local health spending, especially among provinces and municipalities, which had absorbed the bulk of devolved health functions.

Uneven regional growth aggravated the situation. In the Philippines, provinces in the Eastern Visayas and Northern Mindanao continued to lag behind other provinces, especially those in Metropolitan Manila and surrounding provinces. In Vietnam, the cities of Hanoi and Ho Chi Minh were developing faster than other areas, and similar unevenness existed in Indonesia. Utilization rates and other indicators of health access therefore varied widely across regions in all three countries.

Indonesia and the Philippines also implemented decentralization amid considerable uncertainty following political crises. After the fall of the Marcos

regime, the Philippines ratified a new Constitution in 1987 and further articulated strong decentralist provisions in the Local Government Code of 1991. In Indonesia, the overthrow of the Soeharto regime in 1998, and then de facto secession of the erstwhile province of East Timor in 2000, contributed to the clamor for decentralization. The Philippines experienced several military uprisings after 1986, the most recent in late 2003, and has had four presidents and nine secretaries of the Ministry of Health under the present Constitution. These frequent musical chairs in the health ministry have disrupted policy priorities and the ministry's momentum in adapting to a decentralized setting. Persistent rural insurgencies and kidnappings in areas such as Southern Mindanao have made it difficult for both the private sector to pursue investments and the public sector to reach out to the poor.

Weak governance in the Philippines, including corruption in key branches of government, has also led to loss of revenues and waste of limited resources. Mechanisms like Health Boards and other local consultative bodies have seldom been convened for counsel or feedback, contrary to the intent of the Local Government Code (World Bank 2000a). However, the proliferation of nongovernmental organizations (NGOs) and other civil society groups has been a major positive development. Many such organizations now work side by side with key national agencies in agrarian reform, health advocacy, local capacity building, livelihood projects, community mobilization, and governance reform.

A second set of reasons for the modest gains from decentralization in these three countries relates to weaknesses in policy itself. While external factors limited the potential benefits, better management by the central ministry of health, especially in critical health functions, would have helped. Experiences in the three countries suggest how to define and pursue an effective role for the central health ministry.

The next section analyzes the features and implementation of each country's decentralization policy. The following section examines the impact of decentralized health services on health status, service coverage, overall efficiency, and equity in these three countries. Ensuing sections examine intergovernmental fiscal challenges, personnel management, and service delivery under the decentralized health care systems in these three countries. The final section summarizes findings and draws lessons regarding the role of the central health ministry in managing the health sector.

Health Policy under Decentralization

Consistent with their respective constitutions, the three countries passed legislation that enabled, if not mandated, the decentralization of health services. Besides added administrative powers and responsibilities, local governments attained greater fiscal autonomy through higher shares of national government revenues and expanded taxation powers.

In Indonesia, the principal enabling legislative acts were Law 22 and Law 25 of 1999, while Regulation 25 of 1999 facilitated implementation. The Philippines promulgated decentralization through the Local Government Code of 1991, implemented the following year.

In Vietnam, the *doi moi* economic reforms that began in 1986 and the Public Administration Reform of 1995 shaped health decentralization, with implementation based largely on the 1996 and 2002 State Budget laws. The latter two measures brought fundamental changes in the preparation, approval, and execution of budgets for all government agencies, from the central to local levels. Since 2004, province-level People's Councils have had more authority to prioritize expenditures and determine sectoral allocations and transfers to lower tiers, and stronger means of mobilizing resources. Transfers from the center for stable periods of three years will promote local planning, while provinces must produce forward-looking expenditure plans in return.

Decree 10, another element in Vietnam's legal underpinning for decentralization, took effect in July 2002. When fully implemented, this decree will give managers of facilities much greater control over their budgets, and more (though still limited) discretion regarding pay and employment, user charges for nonbasic services, and domestic borrowing.

In each country, later laws further articulated, directly supported, or affected the decentralization of health services. In the Philippines, for example, these laws included the Magna Carta for Public Health Workers of 1992, the *Barangay* Health

Workers' Benefit and Incentives Act of 1995, and the National Health Insurance Act of 1995. In Vietnam, the Seventh Communist Party Congress passed a resolution to broaden the "scope of responsibilities and power of the sectors and localities," and passed the Grassroots Democracy Decree in 1999 (Communist Party of Vietnam 1993; Government of Vietnam 1999).

Main Design Features and Implementation

At first glance, the division of responsibility for critical health functions between the national and local governments in these countries broadly reflects efficiency principles. That is, local governments have assumed responsibility for health functions that are simple to administer or confer localized benefits. The central government or higher local governments have assumed responsibility for health functions with significant economies of scale or interjurisdictional spillovers. For example, basic, primary health care services are assigned to communes in Vietnam, including the network of village health workers, to villages in Indonesia, and to *barangays* (villages) in the Philippines. Primary-level health facilities are assigned to cities and municipalities in the Philippines and to districts in Vietnam. Secondary-level hospitals are assigned to provinces in the Philippines and Vietnam. Tertiary-level and specialty hospitals, on the other hand, are mainly the responsibility of the central government—that is, the central heath ministry—in all three countries.

Central governments continue to provide certain public goods such as health research and development, and merit goods such as maternal, child care, and family planning services. Local governments are often involved in and sometimes cofinance these programs. However, overall, the devolution of health functions and corrective measures reveal flaws.

Decentralization occurred gradually in Vietnam and not without setbacks. Local mobilization was seen as a key element in the country's impressive achievements by the mid-1980s in delivering primary health care. As mentioned, the combined province and commune share of government health outlays was already significant in the early 1990s. Thus, local officers had experience with decentralization when the 1996 State Budget Law assigned additional health tasks to provinces and districts (Fritzen 1999). The law established financial links underpinning a unitary system in which national authority is delegated to lower levels. At each level, budget preparation and implementation are the responsibility of the People's Council.

In contrast, implementation in the Philippines and Indonesia occurred in Big Bang fashion. The former completed the transfer of 45,896 health personnel, along with hospitals, clinics, and other facilities, in 1993, two years after passing the Local Government Code. Indonesia completed a similar transfer in 2001, less than two years after enacting Laws 22 and 25.

The Big Bang approach has its merits, but experiences in Indonesia and the Philippines reveal its disadvantages. In Indonesia, decentralization laws and rules and regulations do not provide enough detail on functional and operational responsibilities, resulting in confusion and divergence between provinces and districts. For instance, provinces are supposed to handle cross-district tasks, but no definitive finding tells them how to apply that rule. The laws and regulations governing decentralization are also often inconsistent with other laws, especially civil service rules. This inconsistency has limited the ability of local governments to right-size inherited health bureaucracies and anticipate personnel matters.

Moreover, administrative preparation was inadequate. For example, many local officials in the Philippines were unaware of the precise nature and extent of their new expenditure responsibilities and powers, and the central Department of Health (DOH) was slow to transform itself structurally and operationally.[3] Lack of personnel severely hampered the Local Government Assistance and Monitoring Service, created to troubleshoot transition problems, and the service lacked clout, as different DOH divisions managed public health programs as before. With DOH looking uncertain, many local governments seemed to adopt a wait-and-see strategy, apparently hoping that the agency would be blamed for the breakdown in the public health system and be forced to recentralize health functions.

In different degrees, these three countries also introduced local governance mechanisms to promote transparency, accountability, and participation as they devolved health services. This, of

course, complicated the transition, as local governments initially had to adopt these mechanisms on their own without much guidance or experience, leading to delays, perfunctory compliance, or failure to convene the mandated consultative bodies.

Health Dividends under Decentralization

On the whole, each country sustained favorable trends in overall health status after decentralization (see table 8.1). In the Philippines, gaps in health status across regions continued to close during the 1990s. Measured as the difference in infant mortality rates (IMR) between the poorest region (Eastern Visayas) and the richest region (Metropolitan Manila), the gap narrowed from 15 in 1980 to 9.8 in 1985. By 1990 the gap was almost zero, with the IMRs of Metropolitan Manila and Eastern Visayas 27.4 and 27.1, respectively. In 1995, the gap remained near zero, although the IMRs of Metropolitan Manila and Eastern Visayas improved to 21.3 and 21.6, respectively. Following the 1997 Asian financial crisis, however, the disparity widened. By 2000 the IMR of Metropolitan Manila was 19.4—worse than the 10.7 of Eastern Visayas.[4]

Each study country also experienced an epidemiological transition in the 1990s, in which the incidence of chronic, lifestyle-related diseases like cancer and heart diseases began to match—if not overtake—that of communicable diseases such as tuberculosis and malaria (Solon et al. 1999).

In Vietnam, disparities in survival rates between regions appear to have widened in the late 1990s, captured in the rising ratio of highest to lowest regional IMRs by region. After growing from 1.7 in 1989 to 2.3 in 1994, this ratio rose to 3.6 in 2002. This is not to imply that rates and underlying conditions were static. On the contrary, IMRs themselves fell by at least half in every region between roughly the early 1990s and 2003. However, the decline in these changes was extraordinary, dropping to a third or less of the early 1990s figure in the Mekong, Central Highlands, Southeast, and Central Coast regions.

Some Progress in Health Outputs and Access

The favorable trend in overall health status was arguably due partly to progress in health outputs and service coverage. In the Philippines, for example, the proportion of births attended by trained health workers, and of the population with access to clean water source and sanitation services, rose in the 1985–2000 period.

Similar developments in health status, outputs, and access indicators occurred in Indonesia over the same period. The 2002 Demographic Survey

TABLE 8.1 Selected Health Status Indicators

	Year						
Indicators	1980	1985	1990	1995	2000	2001	2002
Infant mortality rate (per 1,000 live births)							
Indonesia	79	70	60	46	35	33	1.9
Philippines	65	55	45	36	30	29	1.9
Vietnam	50	43	36	32/30	28/18	30/18	1.9
Under-5 mortality rate (per 1,000 live births)							
Indonesia	125	108	91	66	48	45	1.9
Philippines	81	74	66	51	40	38	1.9
Vietnam	70	60	50	43	34	38	1.9
Life expectancy at birth							
Indonesia	55	59	62	64	66	66.3	66.7
Philippines	61	63	66	68	69	69.5	69.8
Vietnam	60	63	65	67	69	69.4	69.7

Sources: World Bank 2002; WHO 2002.

and Health Survey pointed to a continuation or even an acceleration of favorable trends in fertility, contraceptive use, malnutrition, and trained maternal care. Some indicators worsened: immunization rates fell between 1997 and 2002–3 for children under age two, for example, while the prevalence of childhood illness remained the same as in 1997. In Vietnam, on the other hand, output and access measures all pointed in a positive direction between the mid-1990s and 2002. For example, the country reported a significant increase in childhood vaccination coverage, and in the proportions of women receiving prenatal care and giving birth attended by skilled health personnel (Committee for Population, Family, and Children 2003).

Health Expenditures

Decentralization may have more than sustained momentum in improving health status and even reversed worsening trends. Unfortunately, available data do not allow us to verify these two suppositions, nor do input measures such as health expenditures enable definitive conclusions.

According to the *World Development Report 2004,* annual health expenditures remained more or less a constant proportion of GDP throughout 1997–2001 in the three countries. The average annual proportion was 2.5 percent in Indonesia, 3.5 percent in the Philippines, and 4.9 percent in Vietnam. In per capita terms, however, total health spending fell in Indonesia from US$26 in 1997 to US$16 in 2001, and in the Philippines from US$41 in 1997 to US$30 in 2001 (World Bank 2004).[5] Asia's financial crisis led to a steep decline in 1998 in health spending in these two countries: 50 percent in Indonesia and 24 percent in the Philippines. Seemingly immune to the financial crisis, Vietnam's per capita health spending rose from US$16 in 1997 to US$21 in 2001.[6] In general, health expenditures as a percentage of GDP in these three countries were similar to those of most of their neighbors. For example, the average percentage share of health expenditures in GDP in Thailand and Malaysia was 3.7 and 3.2, respectively.

Meanwhile, the public sector share of total health expenditures in each of the three countries did not change much between 1997 and 2001. Indonesia's public sector accounted for roughly a fourth of total health expenditures. In Vietnam, the public sector share fell slightly from 31.5 percent in 1997 to 28.5 percent in 2001. In the Philippines, the public share rose from 43 percent in 1997 to 45 percent in 2001.

A closer look at public sector outlays reveals a shift in the financing burden from the central to local governments. Most local governments devoted health spending to hospital and personal care services, much like the pattern before devolution. This is understandable, as local governments absorbed many hospitals under decentralization. However, this orientation may be inappropriate given the high prevalence of communicable diseases and high relative cost of hospital-based interventions.

The Philippines certainly saw such a shift in financial burden. The annual share of local governments in public health expenditures climbed up from less than 5 percent before 1992 to 12.5 percent in 1993. By 2001, the local share reached 20.9 percent, exceeding the 16.6 percent share of the national government. Moreover, personal care services constitute the bulk of public expenditures for health in the Philippines, and, ominously, a growing portion of the health outlays of local governments as well (Solon et al. 1992).

In Indonesia, regional governments now account for most routine spending, while development spending at the regional level grew fourfold. However, central development outlays rose almost threefold, and nearly half of development expenditures still come from the central budget. Understandably, local governments continue to regard the Ministry of Health as a key supplier of financial resources as well as personnel, equipment, drugs, and vaccines.[7]

In Vietnam in the early 1990s, subnational governments, including those at the commune level, were already spending more on health than the central government (Knowles et al. 2003). Provincial spending accounted for 68 percent of government health expenditures in 1991 (not including revenues from user fees and donor support), while central spending accounted for 13 percent. However, five years later, after the country passed the Law on State Budget, provinces accounted for 53 percent and central units 26 percent of all government outlays. By 2000 the latter figure had fallen to 17 percent, while the province-level share (narrowly construed) had dropped to 44 percent.

However, the thrust of the 1996 legislation would seem to suggest including revenue from health insurance and user fees in the provincial total. In that case, provincially "controlled" outlays accounted for 76 percent of total government health spending, up from 70 percent in 1996. (Donor outlays are treated as a separate category influenced by particular agendas and criteria.)

In light of these financing and spending patterns, it is doubtful that decentralization has widened access by the poor to quality health care. A national client survey confirmed that Filipinos in general were more satisfied with private hospitals and clinics than with government health facilities. Filipinos also tended to rate traditional healers as more satisfactory than any public providers (World Bank 2001a). The low regard for public health services prevailed even among the poor, an indication that the public health system does not serve its target clients well.

A World Bank study of socioeconomic differences in health, nutrition, and population in selected developing countries corroborated these observations (see table 8.2). In the Philippines, children born in 1998 to the poorest families were twice as likely to die within a year as children born to the richest families. The infant mortality rate for the poorest families (48.8) was 1.7 times that of the richest families (28.8). The life chances of these unfortunate Filipinos did not seem to improve with age: under-five mortality rates were 79.8 and 29.2 for the poorest and richest families, respectively.

Vietnam also had disparities in health status across economic groups, resembling those in Indonesia before decentralization. Like their counterparts in the Philippines, the poorest families had infant and under-five mortality rates several times higher than those of the richest families. Discrepancies in health status between the poorest and richest households appeared to be worse in Indonesia than in Bangladesh, India, the Philippines, and Vietnam.

Perhaps because of the inferior quality of public health services, the poor—like well-off fellow Filipinos—continue to self-finance their access to private health services. Private sources, including direct out-of-pocket payments, accounted for an annual average share of 57 percent of total health expenditures in the Philippines from 1991–2001.

Local Initiatives in Health Services and Financing

Decentralization has given local authorities and other stakeholders greater leeway to adapt or even replace once-standard methods for delivering and financing health services. And these greater discretionary powers have led to numerous local innovations in health planning, service delivery, and financing. Most notably in the Philippines, there are the provincial health insurance programs of Bukidnon and Guimaras, as well as other "textbook" cases, such as the health card system of Paranaque City, the City in the Pink of Health program of Marikina City, and the Community Primary Hospital Program of Negros Oriental (Pineda 1998; Bautista et al. 1999; Quimpo 1996; and Legaspi 2001). Several of these programs have received formal recognition from government

TABLE 8.2 Health Status of the Poorest and Richest Population Groups in Selected East Asian Countries[a]

Country (year)	Infant mortality rate (per 1,000 live births)			Under-5 mortality rate (per 1,000 births)		
	Poorest	Richest	Poorest/ richest	Poorest	Richest	Poorest/ richest
Bangladesh (1996–7)	96.3	56.6	1.701	141.1	76.0	1.857
India (1992–3)	109.2	44.0	2.482	154.7	54.3	2.849
Indonesia (1997)	78.1	23.3	3.352	109.0	29.2	3.733
Nepal (1996)	96.3	63.9	1.507	156.3	82.7	1.890
Philippines (1998)	48.8	20.9	2.335	79.8	29.2	2.733
Vietnam (1997)	42.8	16.9	2.533	63.3	23.0	2.752

Source: www.worldbank.org/hnp.
a. Economic groups are based on asset (wealth) quintiles.

BOX 8.1 Local Innovations in Health Service Delivery in the Philippines

Charging User Fees for Health Services in Malalag, Davao del Sur

In December 1993, the local *Sangguniang Bayan* (municipal council) of Malalag, in the province of Davao del Sur, enacted the Malalag Revenue Code. This code established a socialized fee schedule for health services, among other provisions. The graduated payment scheme reflects users' annual family income: those earning ₱15,000, from ₱15,000 to ₱50,000, and more than ₱50,000 pay 25 percent, 50 percent, and 100 percent, respectively, of fixed service charges. The code also gave low-income families priority in receiving health services. Public consultations, hearings, and an information and education campaign overcame initial resistance to the scheme. Partly as a result, the local government earned about ₱1 million worth of fees on an outlay of ₱688,888. This enabled the government to provide additional health services, including surgical, medical, and dental services. With these improvements, the local clientele have become more demanding of the quality of health services and the performance of health personnel.

Transforming a Rural Health Center into a Community Clinic in Sebaste, Antique

Under Mayor Juanita de la Cruz, Sebaste in Antique—a remote sixth-class municipality—became a prime example of how to transform a basic rural health center into a full-service community clinic despite limited resources. With only ₱800,000 in IRA funds from the center, the government tapped foreign donors, local people, and former residents living abroad for support for its health goals while also appealing to the sense of mission of health personnel. After creating a trust fund, the government infused ₱3.085 million into the project from 1994 to 1998. By 1997, the community clinic employed 16 people, including two physicians, and remained open 24 hours a day, providing primary health care, laboratory and pharmacy services, and minor surgery. The clinic has reduced the cost of these services to the local clientele while also serving the medical needs of residents of neighboring municipalities.

Source: Galing 2001.

agencies and private bodies such as the Galing Pook Foundation (see box 8.1) and the Philippine Human Development Network.[8]

Vietnam has seen numerous instances of sponsored and spontaneous innovation at the province level. An example of the former was the health ministry's effort to encourage local responses to childhood diseases, including community-determined indicators (Fritzen 1999). Reactions to HIV/AIDS illustrate the spontaneous case. As in several other provinces, the epidemic spurred the Thanh Hoa government to pursue preventive activities such as harm reduction and 100 percent condom use. These initiatives resulted from strong commitment by the People's Committee. Besides ensuring the participation of the police (Department of Public Security), the committee allocated an annual budget to fight HIV/AIDS. The committee also organized a provincial Steering Committee on HIV/AIDS headed by the Department of Health, under an umbrella Steering Committee on HIV/AIDS, Drugs, and Prostitution Control chaired by the vice-chair of the People's Committee. District and communes adopted the same structures.

In Indonesia, Yogyakarta province showed how to use the country's still immature decentralized framework to introduce health sector reforms and elements of a health insurance system. The province used donor funds to secure technical assistance and conduct assessments, trials, benchmarking, workshops, training, and coordination meetings with districts, as well as advocacy events. The province established a board of trustees and new fund-holder institutions, as well as a benefit package and an insurance premium.

The province has created a plan for a quality council to accredit facilities and license practitioners based on local standards. Meanwhile, the province increased user fees under local control to reflect the actual unit costs of providing services. Task forces developed strategies for improving service quality based on consumer surveys; purchasing equipment; developing accountability

mechanisms based on focus groups and the complaint resolution system established during the financial crisis; and improving health workforce management, and submitted a tighter organization structure to the provincial government for consideration.

The province launched the new system in 2003 by paying the premium to enable the poor to use public facilities. The program became available to the nonpoor in 2004, competing with private providers in providing a benefit package. The approach in Yogyakarta gives districts a key role, as specified in Law 22, but also responds to the loss of economies of scale that may make health services ineffective and inefficient. The province encourages cross-district collaboration, especially in upgrading technical support, sharing medical and technical specialists and trainers, and organizing communicable disease control, quality assurance, and health education and advocacy. The Joint Health Council facilitates such activities, with task forces making recommendations. But the provincially staffed Technical Review Team plays the largest role by reviewing district proposals and providing feedback and guidance.

A number of other provinces are closely watching and applying this approach. Central agencies have not been deeply involved, although Yogyakarta sought their guidance on establishing standards for its regulatory framework.

Overall, the health impacts of decentralization are not easy to estimate. Few data indicate significant windfalls in health benefits linked to decentralization. The early phases were not incompatible with sustaining impressive overall improvements in health status, and decentralized governance opened the way to promising local initiatives in health planning, service delivery, and financing. However, much better results would seem to be within reach through policy adjustments.

Identifying appropriate policies—though not easy—is critical. In the Philippines, central agencies, often in partnership with NGOs, have documented, disseminated, and advocated best practices in local public services through the media, educational trips for local officials, and various training programs. Despite these initiatives, however, the speed of innovative practices has been limited, and the overall level and quality of local health services have barely improved. A lack of incentives rather than missing models—including political dividends and other signals—appears to be holding back needed policy interventions by local decision makers.

Health Care and Intergovernmental Fiscal Challenges

A country's intergovernmental fiscal system should meet the complex goals of its health system, as with other public services. The key to an effective fiscal system is "finance follows function." The intergovernmental fiscal system must also usually address horizontal as well as vertical equity, key relationships between levels of government and jurisdictions, and incentives for collaboration. Weaknesses in the design of each country's fiscal system have had important consequences for the delivery of health services.

In Vietnam, the budgeting and financing system formalized in the 1996 Budget Law revealed such challenges:

- Norms emerged during the 1990s to determine almost every kind of input into the system. For example, gaps between provinces in per capita health spending reflect a complex fund allocation based on population norms and allocations to and within sectors. These take into account differing geographical conditions between provinces but do not offset revenue and cost disadvantages and variations in need. The Ministry of Finance may also rely on other criteria during the budget negotiating process.
- Provinces have substantial discretion in allocating resources to districts and communes, and the methods they use vary considerably. Districts have little autonomy, and interdistrict variations are significantly greater than at the province level.
- The norm-based system relies on flows of accurate data. For example, user fees and insurance reimbursement rates reflect costs and expenditures in different settings. Besides the high cost of regularly updating such information, these figures are unlikely to capture variations linked to scale and quality as well as discretionary elements. What's more, because the steps to create fee schedules are cumbersome, time consuming, and costly, the schedules remain in effect for years; that in use today dates from 1995.

- Despite formal autonomy at lower levels of government, the norm-based system constrains flexibility. Civil service salaries have first call on funds and absorb most expenditures. Provinces with fewer local revenues have less flexibility.
- The norm-based process limits sectoral interventions. The Ministry of Health did not fully participate in budget discussions and lacked detailed information on expenditures by provinces and lower levels of government. The ministry also could not assess whether actual spending by lower levels was consistent with sectoral policies.
- Limited investment in local facilities, such as upgrades to community health centers, also affected quality of care, and more patients bypassed such facilities as a result.
- The Ministry of Health focused on allocating funds to national programs aiming at combating high-priority diseases such as tuberculosis. Some of these programs were particularly important to disadvantaged groups and implemented mainly through local governments. However, no mechanisms ensure that once national goals are met, those programs are discontinued.
- Reliance on norms has also discouraged creation of medium-term planning frameworks that facilitate recognition of tradeoffs and set priorities between and within sectors.

The December 2002 budget law, which took effect in January 2004, gives more discretion to subnational governments. Province-level People's Councils have more power and a greater obligation to prioritize health spending, determine allocations and transfers to lower tiers, implement policy, and mobilize resources. The fact that the central government establishes three-year transfers once it reaches agreement with provinces on expenditure plans may allow the Ministry of Health to influence allocations across functions and service levels.

In the Philippines, the primary fiscal vehicle supporting decentralization is the Internal Revenue Allotment (IRA), which transfers funds to local governments. As noted, most local governments depend heavily on this source, as do devolved health services. The central Department of Health (DOH) also created the Local Government Assistance and Monitoring Service to manage transition problems, and to provide financial assistance to local governments unable to maintain health services or meet their Magna Carta obligations because of inadequate resources. DOH also implemented a conditional matching grant program, the Comprehensive Health Care Agreements, intended to secure local funding for devolved functions and core public health programs. This reflected an important part of the country's strategy of using incentives and disincentives to achieve national objectives in a decentralized system.

However, the relationship between service delivery and financing arrangements entailed significant weaknesses. For example, devolution of public facilities led to fragmentation of the hospital referral system. Under the new regime, each hospital or clinic primarily serves the constituency of a local government. Several provinces therefore reduced budget appropriations to urban hospitals and channeled resources to less-well-off municipalities, in the process raising the average cost of urban services. Instead of cofinancing these facilities with the provinces, many cities opted to refurbish their own clinics or build enclave hospitals. Further, weak monitoring of local compliance with Comprehensive Health Care Agreements did not help ensure financing of the devolved services.

Ensuring Equity

In Vietnam, two factors have undermined the distribution of heath services to the poor. First, the central government has not targeted resource flows to poorer provinces, concentrating instead on the supply side by improving multitiered service delivery. The government has taken demand for services largely for granted and has not weighed it heavily in policy making, at least until recently.

Second, longstanding funding shortfalls continued through the decentralization process. Starting in 1989, hospitals in Vietnam were allowed to collect user fees and mark up drug prices, and the resulting revenues became, and still are, a sizable source of health financing. However, user fees were a disincentive to enhanced utilization by the poor. And with user fees only partially offsetting funding gaps, lower quality followed. All this led to reduced use of health services from the late 1980s, with demand often shifting to "private" providers ranging from retired government doctors to informal

drug vendors. These developments likely exacerbated variations in health indicators by region and income group, with poorer areas such as the northern uplands recently falling further behind.

Some cities and provinces reportedly reduced user fees charged to the poor and other groups. Recent findings show that distribution of central and local budget funding, official development assistance (ODA), and health insurance reimbursements among provinces benefit the poor disproportionately more than do other sources of province-level funding. However, only the ODA is strongly propoor. Neither central and local budget funding nor ODA relates significantly to province-level measures of health needs, household poverty rates, or the percentage of minorities. The distribution of public health expenditures among provinces is weakly propoor, thanks largely to the state budget and ODA (Knowles et al. 2003).

Decision 139, issued in October 2002, further requires each province to set up a Health Care Fund for the Poor to finance free health care for disadvantaged groups, with budgetary support from the central government. Decision 139 entails a major increase in health spending in Vietnam amounting to D 700 billion (some US$0.5 billion) per year. This program is starting slowly to allow the country to overcome difficulties in identifying the poor and channeling funds to poorer provinces. The program may improve health access in remote areas as it does not cover the indirect costs of care. Along with Decree 10, which gives hospital managers much greater control over their pay and employment, user charges, and use of surplus funds, Decision 139 represents a shift in that the Ministry of Health is moving from direct service provider to sectoral steward, directing central resources to the poor and other vulnerable groups based on clear definitions of eligibility. The directives also imply differentiation of government roles, with provincial health departments organizing delivery of care and Vietnam's insurance agency responsible for collecting contributions and purchasing services.

This change is important because while the main clients of devolved health services in all these countries are the rural poor, their access to quality health services is highly uneven owing to wide variation in local revenues and the flawed design of fiscal transfer programs. In the Philippines, for example, economic growth remains uneven across regions, and only cities have generally robust economies. Most provinces and municipalities rely heavily on fiscal transfers, principally the IRA. However, the IRA formula favors highly populated local governments and those with large land areas, and so does not ensure an overall propoor bias in health services. Studies have also shown that other fiscal transfers, including those administered by the central Department of Health, correlate only weakly with poverty, with poor regions appearing to have received lower DOH budget allocations in 1994 and 1997. On the other hand, one of the richest regions in the country receives a disproportionate amount of the DOH budget (Mercado 1999; Capuno 2002).

As in Vietnam, government hospitals in the Philippines may collect user fees and impose up to a 30 percent markup on drugs. However, cost-recovery rates remain low because of the inordinate volume of charity and subsidized patients. In the case of provinces, for instance, the combined share of hospital fees never reached 13 percent of total hospital outlays from 1992 to 2000. Municipalities fared better, with the share of fees in total hospital outlays rising from 9 percent in 1992 to 29 percent in 2000 (Capuno 2002). But because most hospitals were devolved to provinces, the unintended result of low cost-recovery rates is that many hospitals are poorly maintained, understaffed, and ill-equipped.

Vietnam and the Philippines instituted health insurance schemes in 1993 and 1995 that target the poor. Health insurance in Vietnam has become a significant financing source, more important than in the Philippines (Knowles et al. 2003). Nevertheless, in Vietnam coverage is still low and mainly includes civil servants and others employed in the formal sector. Decision 139 represents a potentially significant scaling up of the number of people with insurance.

Records from the Philippine Health Insurance Corporation (PHIC) show that among those enrolled in the national health insurance program, the number of paying members, from both the public and private sectors but excluding the insured indigent families, grew from about 5.57 million in 1999 to 7.62 million in 2001. This suggests that nearly four in eight Filipinos have social insurance coverage, but that the program is still far from achieving its target of universal coverage. However, since 2000, the PHIC has been aggressive in

enrolling indigent families under its Medicare para sa Masa (indigent program). As a consequence, the total number of indigent families enrolled has grown from 2,904 in 1997 to 1,762,116 in 2003. By June 2004, the total ballooned to 6,175,651 indigent families. Whereas in 2001 about 37.8 percent of these indigent members were concentrated in the richest regions, by 2003 the same regions accounted for only about 19.91 percent of the total membership. The fact that other regions have gained significance suggests that a wider set of poor households now enjoys coverage. However, this trend is likely to slow as more local governments must copay with the national government the insurance premium of poor constituents. Most local governments see this contribution as another unfunded mandate.

Health Care Personnel and Civil Service Management

Many local governments find it difficult to hire physicians, nurses, and medical technicians, who are in great demand in foreign markets. In the Philippines, for example, local governments in many areas where tuberculosis is epidemic have found it difficult to hire medical technologists and rural physicians. Indeed, staff anxiety and opposition were major problems during the transition to decentralization in Indonesia and the Philippines. Though usually temporary, staff discontent can affect the quality and quantity of personnel available under decentralization.

In the Philippines, health workers were perhaps the largest group opposing decentralization. Many initially feared loss of job security, "politicization" of their functions and positions, limited career prospects, and lower pay.[9]

To appease devolved workers, the central Department of Health pushed for the Magna Carta for Health Workers in 1992. Among other features, this law provides for higher compensation and extra benefits and allowances to all health workers, including those devolved to local governments, and requires the latter to pay the additional compensation. This unfunded mandate would have demoralized other staff and made some rural physicians the highest-paid local public employees, earning more than mayors, which they considered unacceptable.

As a stopgap measure, the Department of Health instituted the Doctor to the Barrios Program, which supplied temporary, contractual, and better-paid doctors to remote areas. In May 1993 the program began to deploy physicians to 271 municipalities lacking doctors, and by December 2003, 198 of these municipalities had received doctors. They receive an attractive package of salary and benefits for serving two years, and some also receive honoraria and material support, such as free board and lodging, from local governments. However, only about a third remain after their two-year tour of duty, discouraged by the lower pay and fewer privileges that accompany local employment. The number of applicants to the program is dwindling owing to a surge in foreign demand, and conflict areas remain underserved because of a lack of incentives.

To supplement the local health force, the *Barangay* Health Workers' Benefit and Incentives Act of 1995 provided for training volunteer workers and providing minimal incentives to convince them to join *barangay* health stations. These volunteers assist in clerical tasks and minor health procedures, such as weighing and measuring patients. However, these workers do not effectively cater to the health needs of the population.

In Indonesia, the central government established the contract doctor (PTT) scheme in the early 1990s to ensure a flow of doctors to remote locations. Doctors hired after completing their initial medical degree received substantial monetary incentives for practicing in more remote areas for three years, as a condition of advancement. Specialists also had to complete compulsory assignments for one to four years or two to three years as PTT staff.

Discontent grew over the obligatory nature of assignments, relatively low salaries, and poor administration of program benefits. In 1999, regulations were eased to permit alternatives such as teaching in a medical school, working as a PNS (civil servant) in designated areas, or working in private practice as a clinic employee in remote areas. Service requirements for very remote areas were reduced to two years, and new graduates could postpone mandatory service if they wanted to start specialist training. These changes did not satisfy the PTT lobby, and doctors continued to press to scrap the regulations.

PTT issues remained unresolved as decision makers launched decentralization. The Ministry of

Health has been exploring new ideas such as allowing medical personnel to serve in the military and the police. Districts, meanwhile, have stayed with the residual national system despite its flaws, as without central funds and guidance they might not have been able to integrate the numerous centrally assigned, locally based staff transferred overnight via Law 22. Moreover, few districts can turn down central offers to recruit and assign PTT doctors using central funds. Still, district officials are concerned that staffing policies that reflect local priorities and conditions have not been established, including options to "right-size" staffs within each district. This issue arises especially in districts obligated to handle staff oversupply left behind by flawed centralized-era policies.

Strong political and administrative leaders in some provinces have created master plans to reshape the bureaucracy to fit local conditions. These include using downsizing mechanisms such as redeployment of staff, early retirement, voluntary resignation with severance payments, and retraining to encourage entrepreneurship. However, implementation of these plans awaits full political commitment, facilitating legal steps, and an injection of cash. The inability to proceed highlights concerns voiced by district and province decision makers about dependence on central government for salary payments and methods for "right-sizing."

Vietnam confronted personnel issues under decentralization as well, as the distribution of health personnel did not occur exactly as planned. Enough doctors and other higher-level staff are generally available in cities, but numbers are inadequate in rural areas. Provinces with medical schools have about the right number of staff, but poorer provinces do not, especially newer ones with no secondary medical schools. One study showed only 1.7 doctors per commune in the North Highlands and the North Central Coast, while a commune in the Southeast Region averages 6.8 doctors (World Bank 2001b).

The number of health workers at the provincial level is generally adequate (in relation to Ministry of Health guidelines), although some provinces do not have enough specialists. But districts generally lack enough doctors who specialize in priority areas, such as obstetrics and gynecology and emergency surgery. Communes do not have enough doctors (nearly all at commune health centers are upgraded former assistant doctors), and often lack enough staff with other training as well, except in densely populated delta areas and near cities. For example, in 1997, 26 percent of communes lacked an obstetric-pediatric assistant doctor or a midwife. The Ministry of Health requires all communes to retain such an employee, reflecting the high priority accorded to local maternal and child care.

Average monthly salaries of health staff have remained essentially unchanged in real terms since 1994. In 1998, the average monthly salary of a government health worker was merely US$29, even though user fees supplement salaries somewhat. This low pay, compared with the education sector, has induced many health staff to seek additional sources of income, reducing the time, attention, and dedication they devote to their work (Dung et al. 2001).

Service Delivery Mechanisms

Health programs are prime examples of the need to design institutional arrangements carefully to ensure that parties in the service delivery process have the understanding, ability, and incentives to fulfill their roles. Coordination is invariably a crucial requirement of system effectiveness. While a country's central health ministry should take key responsibility for controlling communicable diseases, it cannot do this efficiently and effectively without the cooperation of local governments, as the latter are at the forefront of service delivery.

In the Philippines, programs to combat communicable disease depend on devolved health personnel and local counterpart funds, which are in short supply. Local governments see their participation as another unfunded mandate, and program coordination has suffered as a result. To elicit local support, the central Department of Health under the Comprehensive Health Care Agreements (CHCAs) matches each peso that a local government commits with a higher amount. However, the local government must first commit a minimum amount for its devolved health functions. This requirement has proved stringent, as many local governments initially lacked the resources to finance these functions, much less meet their contractual obligations for vertical programs. DOH also did not develop a monitoring and enforcement mechanism to track

compliance. Worse, many local officials believed that strict compliance with the program was not necessary, as DOH would always take the blame for public health failures (Esguerra 1997; Medalla 1996). Hence, only after two rounds of implementation, CHCAs were discontinued in 1997.

In the three study countries, integration between programs within provinces as well as across provinces remains poor. Subnational governments implement national programs separately, leading to overlap and overload of grassroots health facilities.

Vietnam partly solved this problem by giving provinces a greater role in setting goals, developing plans, and using funds for national targeted programs. This is appropriate given variations in disease profiles across regions, and is said to have raised immunization rates and lowered fatality rates.

Low Quality and Unsteady Supply of Drugs at the Local Level

The supply and quality of drugs at the local level have become a concern owing to limited funds, deficient drug management systems, and loopholes in procurement rules. In Indonesia, provinces have not been aware of or prone to intervene in drug supply, stocks, and use at the district level under decentralization. Districts have been able to plan for and purchase their own drugs based on standard procurement practice. However, compliance with quality assurance procedures has been poor, partly because responsibilities have not been clear and districts do not have the technical capacity to handle the task.

In the Philippines, each local government similarly manages its own system of drug procurement, inventory, dispensing, and financing. The quality of locally procured drugs is generally poor, the purchase price is often higher than in private pharmacies, stock shortages are frequent, and irrational drug use occurs. A principal reason is that local therapeutic committees are not constituted, not functioning, or not well trained in modern drug management. Local drug procurement is also corrupt in many places: bids are rigged, qualified bidders are "preidentified," and bidders connive. Moreover, the supply chain extends only to urban centers; poor outlying municipalities rely on itinerant drug peddlers who arrive infrequently.

To ensure drug quality in all public health facilities, the central health ministry in all three countries has adopted drug formularies and drawn up an essential drug list. In Indonesia and the Philippines, the central ministry even advocates and promotes generic drugs. However, these regulatory measures have not ensured the overall quality of drugs, owing to weak information campaigns and enforcement mechanisms. In the Philippines, for example, many local governments, with support even from their own health officials, routinely buy branded drugs because of their supposed proven efficacy. Further, the Bureau of Food and Drugs, which lacks laboratory and regulatory capacity, has not convinced doctors of the supposed equivalence of generic drugs (Lim and Pascual 2003). In Indonesia, hospitals buy drugs and unbranded products outside the essential drug list.

Unlike in the Philippines, in Vietnam and Indonesia state-owned enterprises dominate the drug supply, as they can assure quality more easily than a private drug market. In Vietnam, the state-owned VINAPHARM, which includes central and provincial trading and manufacturing enterprises, is responsible for supplying drugs countrywide. The Drug Administration Department within the Ministry of Health is responsible for overall drug management, supported by the Drug Quality Control Institute and the Drug Inspectorate. In each province a Drug Quality Control Department falls under the Provincial Health Bureau, while a Drug Testing Center and Inspection Department monitor drug quality in the local market.

In Indonesia, four state-owned enterprises produce generic drugs and vaccines. Regulatory functions, including enforcement, are the responsibility of the Directorate General of Food and Drug Control, a unit of the Ministry of Health. Quality assurance efforts include establishing the essential drug list; enforcing standards in the development, testing, registration, manufacture, and distribution of drugs; and overseeing health professionals. Working through 26 province-level branches, the directorate monitors drug quality and safety through follow-up visits and testing programs. The directorate bases inspection of manufacturers on criteria for good practice adopted in 1971.

State-owned enterprises impose their own inefficiencies on the market. In Indonesia, these units are protected by tariffs and limits on final-product

imports, constraints on foreign investment, and restrictions on registering new drugs, opening new pharmacies, and the nonpharmaceutical activities of retailers. Reforms adopted in the 1990s relaxed some restrictions on foreign drug companies, encouraged generic drug prescriptions in public health centers, and enforced good manufacturing practice. Hospitals could also keep drug revenues to secure supplies at the facility level.

However, inconsistencies and missteps weakened or negated these pre-2001 reforms, and the outcomes were unsatisfactory. Moreover, districts inherited a flawed and incomplete reform agenda, with impacts on government stewardship obligations. Since Law 22 has taken effect, deviation from established standards, patterns, and procedures has grown. For example, complaints about the physical appearance or expiration date of drugs are widespread, suggesting that longstanding quality assurance procedures are not being observed. Reporting of drug quality problems is not formalized, and procedures for addressing quality concerns are unclear and complicated by multiple sources of drugs and funding. Limited skills surely play a role as well, as many service units and district warehouses depend on unqualified staff. Nor can provinces step in, as they lack the authority to monitor, yet alone supervise, district drug procurement.

More generally, laws and regulations provide little detail on operating responsibilities and have brought confusion and divergence between provinces and districts. For instance, some procurement procedures have spurred small purchases from 15 or more suppliers. Districts usually reject pooled procurement despite possible cost savings.

Nor is there a definitive view on which drugs belong in categories defined by the Ministry of Health in pre-2001 preparations. Central involvement appears to be limited, and provinces reveal no common pattern of procurement. Some are not supplying any drugs, and plan to reduce future drug supply. Some still buy drugs to cover emergencies and temporary district shortfalls. Districts are using their own funds to buy drugs from all three classes of the essential drug list. Meanwhile, the drug supply and regulatory system in hospitals is different from that at the primary care level. Hospitals, which have long been allowed to procure and dispense drugs outside the essential drug list, are buying mainly branded drugs, funded through self-financing revolving funds and using spot buying methods. The change from central to district procurement may have also increased drug prices because of lower procurement volumes. This would likely widen variations in drug prices, reducing equity and lowering the availability of orphan drugs.

Vietnam represents an interesting comparator. As in Indonesia, deregulation of pharmaceutical production and distribution brought heightened activity among informal drug vendors and pharmacy shops and greater availability of drugs throughout the country. Consumer purchases of drugs, especially for self-medication, grew as well, from 2.1 annual contacts per capita with drug vendors and pharmacy shops in 1993 to 6.8 by 1998. However, the two countries differ in their experiences with drug prices. In Vietnam, deregulation brought a 30 percent fall in the real price of medicines in the 1993–98 period, while in Indonesia price reductions do not seem to have followed policy reforms.

Moreover, the risks facing Indonesia are comparable to those of Vietnam, where drug vendors account for roughly two-thirds of health service contacts, and antibiotic resistance has reached epidemic levels thanks to excessive and otherwise inappropriate use.[10] The resistance problem is compounded by the limited training of pharmacists and the low average education level of drug vendors and the public. Even when doctors prescribe drugs, compliance with appropriate treatment guidelines is low. Oversight of health providers is weak as well. Enforcement of the many regulations and decrees governing minimum quality standards and the protocols expected of health providers through regular inspections of health facilities is less than satisfactory.

In the Philippines, on the other hand, a few drug manufacturers and importers, which are mostly multinationals, dominate the upstream segment, while a single drugstore chain effectively controls the retail segment of the domestic drug industry. A parallel drug importation policy has not helped bring down the overall price of drugs because the government chose to maintain an import monopoly with capital of just ₱50 million—not enough to affect the multibillion-peso domestic drug trade.

Health Information Systems

Decentralization in Indonesia, the Philippines, and Vietnam has fragmented the health information

system and undermined coordination among various sectors, and thus effective and efficient control of communicable diseases. Subnational governments are unaware of their roles, and, more critically, lack the incentives and technical capacity to assume those roles. Subnational governments need support for activities from collecting health information to providing further inputs to performing overall health planning to actually implementing programs.

From 1992 to 1995, the Philippine Department of Health implemented the German-funded Health and Management Information System, whose main objective was to institutionalize a "need-responsive and cost-effective health information system" at the national and local levels. The initiative introduced software modules and processes to fortify the production and use of information. Besides developing district-level health indicators, the system supported innovations in community health care financing and service delivery. However, the initiative stopped short of a nationally integrated but locally operated health information system and was not sustained.

In Indonesia and the Philippines, the central health ministry relies on local governments to report information voluntarily. This has resulted in erratic or delayed submission and poor-quality data. The devolved staff members who were responsible for such data under the old regime now supply information on health expenditures and input indicators to provincial and lower-level elected officials, who are less concerned with outputs and outcome indicators.

In Indonesia, only 36 percent of health centers reported infectious disease surveillance data in 2002.[11] Those that do report do so irregularly or late. Thus, the limited data that flow through the system may not be reliable enough for use in planning, policy analysis, or evaluation.

In these countries, the central health ministry, lacking information, is less able to monitor the quality of laboratory services, hospitals, and other devolved services. This is worrisome as, for example, local health centers in the Philippines are responsible for both finding cases of tuberculosis, which requires sputum examination, and monitoring cases. Indonesia discontinued some programs such as those tracking leprosy because districts did not monitor the number of cases. Quality assurance systems for provincial hospitals in both the Philippines and Indonesia continue to rely heavily on input indicators such as the number of beds, floor area, and medical instruments, with only infrequent verification of such information by local governments.

In the Philippines, although the Department of Health deploys its own representative to provinces, cities, and municipalities to help monitor disease outbreaks and coordinate vertical programs, the flow of health information remains slow. DOH representatives must often double-up as service providers, as many local governments lack the needed personnel.

Performance Standards and Incentives

In the Philippines, efforts to improve the quality of health services have relied on both incentives, including awards and accreditation measures, and disincentives. One example of an approach that encourages local governments to upgrade their health services is the Sentrong Sigla accreditation. Aside from providing a mark of quality, this accreditation originally conveyed a ₱1 million grant to local health centers. Based mostly on input indicators of a health facility's "readiness to provide services," the program had certified some 48 percent of health centers, 14 percent of district and provincial hospitals, and 3 percent of *barangay* health stations by October 2003. Though these numbers are encouraging, they represent only a minority of the country's facilities. Moreover, most of the cash awardees are better-off municipalities that do not need the funds as urgently as localities that do not qualify (Lamberte 2003).

In the Philippines, the Department of Health issued Administrative Order no.100 in 2003, which established new guidelines to improve the Sentrong Sigla program. Instead of cash awards, the new guidelines specify a matching grant for new qualifiers, and also make certification a prerequisite for other DOH grants and the Capitation Fund program, recently introduced by the Philippine Health Insurance Corp. Under the latter program, an accredited local government can claim reimbursement for services extended to PHIC-insured indigent families in their localities. However, these accreditation schemes are voluntary.

Vietnam and Indonesia, in contrast, have adopted norm setting as their approach. Vietnam's Ministry of Health sets province-level norms, but

quality remains uneven because province and district health officials introduce norms and guidelines as well. The Ministry of Health has used decrees and circulars to define the quality of human resources and equipment and performance standards. The ministry also has issued more than 100 treatment guidelines, though a survey conducted in 20 district hospitals in 2000 on acute respiratory infections showed that compliance was 25 to 40 percent, probably reflecting weak support and supervision at the local level. Meanwhile, overuse and overprescription of injection drugs were common, with representatives of drug companies influencing physicians' prescriptions (Dung et al. 2001).

Indonesia established minimum health service standards by ministerial decree in 2003. Districts must deliver services according to local needs in 32 areas, including immunization, nutrition services, prevention of communicable diseases, and curative care. Such standards will help define the service levels that districts are accountable for delivering. Whether these standards will be requirements or targets needs further consideration, along with measures for dealing with districts that do not meet the standards.

Toward a New Role for Ministries of Health

Decentralization in Indonesia, the Philippines, and Vietnam may help sustain overall improvements in health that have occurred during the last two decades. Decentralization has appeared to spur local initiative in planning, delivering, and financing services. Users are now participating in planning in many regions, leading to more appropriate and better-targeted health services. Volunteers supplement limited local financial and technical resources. More important, perhaps, citizenship and trust in local government have deepened. The resulting efficiency gains and social capital support the decentralization of health services.

Still, experience in these three countries reveals that decentralization dividends have been modest for two reasons. First, these countries decentralized health services in less-than-favorable environments. Inequitable economic growth, population pressures that brought epidemiological changes, and political uncertainties have limited the potential gains from decentralization. Improvements in health status are therefore greater in well-off provinces, and service innovations have failed to spread beyond areas where the local economy is robust and the political situation relatively stable. In these provinces, local governments have had the resources to meet growing demand for health services.

Weakness in decentralization policy also contributed to lower-than-expected health payoffs. These include ambiguities in goals, lack of detailed design, inconsistency with other policies, and poorly thought-out implementation strategy. These follow from the fact that health was not the main—much less the sole—driver of decentralization. The Philippines, for example, included health services in its decentralization strategy only when resistance from the education lobby forced legislators to look at other national expenditures.

Inconsistent priorities have translated into inconsistencies in policies and poor design of policy instruments, especially the intergovernmental fiscal transfer system. Local governments are also typically unaware of the types and timing of national interventions—information that is crucial to their own budget and investment planning. With prior knowledge of available grants, technical assistance, and other support from national agencies, local governments can use information on local needs, and proximity and direct accountability to beneficiaries, more effectively.

In Indonesia, the slow and arduous emergence of a consensus on a health decentralization framework partly reflects a governmentwide determination to avoid service interruptions. But this focus has also allowed the central government to postpone difficult decisions over the role and scale of key central ministries.

The Indonesian Ministry of Health also tends to view the public as passive service recipients rather than discriminating customers, owners, and potential allies, and to present itself as a policing and standards-upholding authority rather than a technical agency. What's more, the government has not yet developed a clear concept of the role of provinces in the health system. Decision makers know that districts are typically too small to support cost-effective programs, but they have not designed institutional solutions to encourage joint service areas, or to make provinces agents of public health and related programs.

Policy weaknesses also stem from laws and regulations, introduced in Big Bang fashion, that lacked detail on functional and operational responsibilities and brought confusion and divergence between provinces and other local governments. The Ministry of Health also failed to coordinate with local governments and other actors in performing critical health functions.

In these countries, reactive responses to transition problems did not necessarily resolve fundamental design issues. For instance, in the Philippines, the Magna Carta for Public Health Workers—which provided supplemental funds to only a few local governments—temporarily appeased disgruntled health workers but upset local governments by imposing unfunded mandates. Similarly, the country "resolved" the mismatch between the distribution of the IRA and devolved expenditures after 1992 by providing grants to cities for hospitals they were already financing before 1991. Thus, compensating cities for their supposed "losses" due to the adjustments in the IRA was a politically necessary but costly way of ensuring adequate funding for the health functions devolved to provinces and municipalities (Capuno 2001).

However, efforts to correct these weaknesses could expand the gains from decentralizing health, even within a less-than-favorable environment. Toward that end, central health ministries must focus on specific tasks such as setting up quality assurance mechanisms for drug supplies, safeguarding access to medicines by the poor, and dismantling state monopolies on drugs. Responsibilities for communicable diseases include monitoring national and regional trends, supporting laboratory capacity and quality control and assurance, alerting provinces to outbreaks elsewhere, and advocating for emergency financing.

With the Stewardship of the Ministry of Health

These examples illustrate the contributions needed from central government during decentralization of health services. Above all, central agencies should concentrate on activities that go beyond the direct provision of preventive and curative services, focusing on core public health functions, responding to overall imperatives, and preventing potential failures.[12] These efforts include not only tasks related to pharmaceuticals and communicable diseases but also workforce training, recruitment, pay and benefits, and supervision.

Other core public health functions include ensuring that the poor have access to affordable care, overcoming micronutrient shortfalls, creating sustainable funding arrangements, acting as a source of ideas and best practices from the provinces, and providing technical assistance on a selective basis. As the steward, a Ministry of Health would build consensus on national health objectives and standards, and coordinate rather than require local governments and civil society groups to meet these goals. Instead of relying on sometimes heavy-handed regulation, the ministry should align incentives to elicit the cooperation and participation of all sectors. Rather than impose high standards, the ministry should perhaps promote them through advocacy and by strengthening local governance mechanisms.

The stewardship role also entails pushing for greater consistency among goals, programs, and policies of different national agencies to support local governments. Finally, stewardship includes more than content: it clearly entails leadership and a flexible, opportunistic mode of building partnerships and exploiting opportunities.

Central interventions are warranted partly because these functions may not convey the urgency or tangible appeal of disease-specific programs, and thus districts may neglect them. Subnational governments have little incentive to pursue core public health functions because they cannot fully capture the returns, and because some functions are difficult to perform well because of limited resources or lack of scale economies. The impacts of core public health functions are also hard to measure: gauging the effects of a strong disease surveillance and reporting system is difficult, while the direct distribution and use of drugs by infected patients has obvious benefits.

Has the Philippines Turned the Corner?

The central health ministries in all three countries have taken steps to fulfill this new role, but no definitive transformation into stewardship has yet occurred. Furthest along is the Philippines, whose Department of Health has examined whether decentralization has paid off as a health reform vehicle.

In 1999, under the Estrada administration, DOH formulated a comprehensive decentralization strategy called the Health Sector Reform Agenda (HSRA). The HSRA noted a slight resurgence of certain diseases and persistent inequities in service access. To counter these problems, DOH positioned itself as a health leader, enabler, and capacity builder, administering only certain services (Department of Health of the Philippines 1999b). As a leader, it would primarily be responsible for setting national health policy and regulations and strengthening regulatory agencies. As an enabler and a capacity builder, it would seek to promote innovations and standards in health services, especially at the local level. And as an administrator, it would confine itself to pushing hospitals toward fiscal autonomy, securing funds for priority public health programs, and promoting universal coverage under the National Health Insurance Program.

The novel aspects of this strategy are DOH reengineering and the convergence of all DOH interventions in each province under the HSRA framework. DOH reengineering meant streamlining operations, finances, and bureaucracy, and deploying 1,638 personnel from the central office to regional health offices, retained hospitals, and other DOH agencies. Under the convergence strategy, some provincial officials have drawn up health development plans and interlocal health zones, with the DOH providing technical input and other assistance. These zones bring together contiguous local governments around a district hospital to find ways of improving the hospital referral system, exploiting economies of scale, and containing spillovers.

In December 2004, for example, Capiz province devised a five-year development plan for enrolling indigent families in the National Health Insurance Program, upgrading selected hospitals, and adopting revolving drug funds and new drug management systems, with specific targets and activities at provincial and zone levels. With initial DOH support of ₱10 million, the Capiz plan is expected to yield gains from economies of scale in hospital operations, pooled procurement of drugs, and control of epidemics. Similar arrangements are expected in 2005 in other sites such as Pangasinan, Agusan del Sur, and Misamis Occidental.

As a dynamic process, decentralization in the Philippines will continue to require adjustment guided by HSRA. For example, the country can do more to prepare the intended beneficiaries, such as local governments and health care users, and diffuse political resistance. At the same time, the central Department of Health needs to extend its partnership with health NGOs and civil society organizations with whom it is already working. Local health finances must rest on a firmer footing, including through greater reliance on local funds. Carefully designed user charges would not only make service delivery more efficient but also make local health programs sustainable and help subsidize the health needs of the poor. But to justify higher user fees, local governments must improve service quality and require up-front financing for facility improvements, personnel training and hiring, and drugs and medical equipment. DOH matching grants could support enhanced services if local governments introduced new fee schedules. Grants would also make local public employment more attractive to health workers.

Waiting for Indonesia...

Indonesia has not clarified the health roles and responsibilities of central and lower governments after three years of decentralization. Nor has the country moved to emphasize core public health functions, or seen marked improvements in specific areas such as infectious disease control, pharmaceuticals, and human resources. Sectors besides health also have indeterminate policies, prompting advice to clarify assignments across levels of government and sectors (World Bank 2003a).

Two strands of thinking on decentralization are evident within the Ministry of Health. The first is distilled in a 2003 decree that lists 29 strategic issues related to core public health functions and adds key steps to address them, such as minimum service standards (MSS), partnerships with NGOs, and services for the poor. The decree points to accountability mechanisms and traditional command-and-control instruments to limit the risks of service disruption. The former include the use of MSS to elicit district commitment, including assistance in funding core public health functions. The Ministry of Health has been relatively assertive in exerting its authority in responding to infectious disease outbreaks such as severe acute respiratory system (SARS), and overseeing surveillance of and

programs to combat diseases of national importance and involving international obligations, such as tuberculosis and HIV. The Ministry of Health depends on central and donor funding to achieve these ends, though each is unreliable, and has looked for district support, seeing MSS as targets for district spending.[13] The decree assigns key responsibility to district chief executives, and states that efforts to attain MSS should rely entirely on district budgets, with central and provincial governments providing technical help, supervision, and oversight.

This approach is risky. Detailed, extensive MSS could undermine decentralization, and poorer districts could reject them because of limited fiscal capacity. Most MSS have been set at high levels, imposed on rather than owned by local governments, with the means of enforcement and penalties for noncompliance undisclosed. MSS would be better seen as medium-term goals rather than performance requirements that trigger funding and require enforcement. The Ministry of Health needs to develop ways of boosting district ownership of efforts to prevent and control infectious diseases.

The second strand of thinking within the Indonesian Ministry of Health takes a more benign and constructive view of decentralization. This approach is embodied in initiatives under way in Yogyakarta and three other provinces (Lampung, North Sumatera, and West Java), with twenty-one other provinces due to come on stream later. Ministry officials who support this approach are trying to use the momentum of decentralization as a catalyst for sector reform, with provinces playing an important mid-level role. However, the above-cited decree limits provinces to backstopping central and district-level initiatives.

The province-based approach remains new and under trial. It has already survived early bureaucratic and other challenges, but the Ministry of Health needs to carefully assess experiences, implications, and lessons emerging from the province-based framework and disseminate them to key stakeholders. The ministry can also help implement new and existing provincial programs, including interventions that widen and deepen the decentralized approach. The ministry can also support pilot work and research aimed at helping provinces respond to the diverse challenges of managing and developing the health workforce, such as by helping provinces rationalize staffing numbers. The ministry could also sponsor trials of approaches to attract doctors, especially specialists, to remote and undesirable locations. The ministry also needs to develop standards that provinces and districts can use to license service providers; work with professional associations to strengthen quality improvement efforts and establish partnerships for professional development; consult with consumer groups and hospitals on workforce quality; focus on trends in medical education; and fund and deploy special-purpose health teams.

Opportunities, imperatives, and stakeholder pressures could support the Ministry of Health's impetus toward devolution and health reform. Budget constraints may force the ministry to look to districts and provinces as sources of funds and jobs for the health workforce. Demands for better service quality and other public pressures have begun to register with local political leaders and within the national ministry. A medium-term scenario resembles that in the Philippines: contested decentralization followed by a faster pace and major adjustments, leading to consolidation and mid-course correction. The Filipino experience most relevant for Indonesia is arguably the change in outlook within the Department of Health regarding its role in a decentralized system.

Stewardship by Vietnam's Ministry of Health

The tempo of change in Vietnam is quickening, with several distinct drivers governing the pace. The first is the reappearance of deadly public health threats at the top of the policy agenda. Vietnam is clearly vulnerable to new and more virulent strains of diseases such as SARS, HIV/AIDS, and influenza, and reemerging diseases such as tuberculosis and dengue fever. Malaria remains a major public health problem in mountainous and ethnic minority areas.

Successive crises have spawned rapid-reaction structures and shown the importance of timely and well-targeted responses guided by updated disease surveillance data. The Ministry of Health appears to be developing expertise in explaining disease challenges and engaging the public and political leaders while soliciting various sorts of assistance. The ministry has also gained credibility and built stronger ties to decision makers at the provincial

level and in key central ministries, including the Ministry of Finance, the Ministry of Public Information, and the Ministry of Labor, Invalids and Social Affairs. These drivers of change could intersect if, as seems likely, the revised agenda on communicable diseases leads to requirements for more spending. This effort should involve a review of arrangements for funding disease control and the possibility of consolidating such outlays. A related issue is the need to avoid substituting for local expenditures; the ministry could make a case for requiring matching contributions from local governments.

The 2002 law requires some acceleration in efforts to adjust government roles. These efforts will entail significant shifts, and the experience and credibility accumulated in fighting SARS and other diseases could prove helpful.

In particular, the advent of provincially managed service delivery suggests the need for formal recognition backed by real authority and resources, with the Ministry of Health focusing on key stewardship functions. Implementation of the 2002 law will thus enable the ministry to get out from under second- and third-best aspects of the de facto health decentralization system that took hold in the 1990s:

- Provinces are supposed to provide updates on how they are allocating their recurrent budget. However, this requirement appears to be largely a formality. The Ministry of Health has little information on health budgets, and it is not clear to what extent, if at all, it can influence provincial spending of budgets already approved.
- The ministry lacks a clear role in formulating and assessing policy and determining central allocations to health; the ministries of Finance and Public Information are the key agencies in this process. Central recurrent health spending reflects projected revenue growth and recurrent expenditures.
- Such incremental budgeting is not sensitive to the goals and priorities set by the Ministry of Health.

The ministry can respond to the 2002 law partly by strengthening budgeting procedures as well as improving allocation. These efforts may include replacing allocation norms and hospital payment mechanisms with instruments based on the price of health care services. The ministry would like to prepare expenditure norms to support management, monitoring, supervision, and control functions, and explore the use of norms that reflect population needs and improve equity in service access and use.

The Ministry of Health also recognizes that it needs other policies with significant near-term impacts to address disparities in health outcomes and per capita health expenditures across provinces. Per capita spending in the richest seven provinces is over three times that in the poorest seven provinces. Central and donor transfers do not provide a counterweight, as the richest provinces receive the largest per capita amount, and because the resources involved are relatively small.

Endnotes

1. No consensus has developed on the starting point for health decentralization in Vietnam. This chapter treats the 1996 Law on State Budget as a path-breaking measure.
2. On December 27, 1997, then-President Ramos issued Administrative Order 372, which effected the withholding of the "amount equivalent to 10 percent of the IRA." Local governments challenged this order before the Supreme Court and won in June 2000.
3. This is a common observation by local officials interviewed for the *Rapid Field Appraisal of Decentralization* (Associates in Rural Development 1993a, 1993b, 1994).
4. The standard deviation in regional IMR also fell from 8.51 in 1980 to 4.84 in 1990, and then to 3.34 in 2000.
5. Figures from the Philippine National Health Accounts also show that total per capita health spending rose from US$20.82 in 1991 to US$29.79 in 2001. In real terms, however, the country recorded a per capita decline from US$12.15 in 1991 to US$8.84 in 2001.
6. Vietnam also achieved a hefty threefold nominal rise in total health expenditures over a five-year period, from US$0.68 billion in 1993 to US$2.17 billion in 1998 (Knowles et al. 2003).
7. This occurs through the JPS-BK (the health component of the social safety net); the fuel subsidy; and the DAK (a special-purpose grant) channels.
8. The Galing Pook Foundation presents awards to local governments for the best innovations in public service delivery. The Philippine Human Development Network uses the Human Development Index to identify and honor provinces that made the greatest strides in promoting health, wealth, and education.
9. Moreover, the Department of Health itself did not anticipate these issues, as the initial plan was to decentralize education first. Opposition from that sector led the government to consider decentralizing health instead (Diokno 2003).
10. Data from the 1998 Vietnam Living Standards Survey indicate that 93 percent of all drug vendor contacts entailed efforts to obtain medicines without a prescription, with little variation across economic groups.

11. A survey conducted by the National Family Planning Coordination Board in 2002 found that less than 10 percent of health centers followed the manual on preventing infections that may result from the use of contraceptives. The survey also discovered that counseling in the family planning program was poor, and that 20 percent of public facilities had never been supervised.
12. The Pan American Health Organization established 11 essential public health functions through international consensus. These have been field-tested and implemented in 43 countries of Latin America, the Caribbean, and Europe.
13. Central spending is limited and subject to strong competition from outside and inside the Ministry of Health. For example, during 2001 and 2002, the central budget was highly constrained, and the ministry's main funding initiative aimed not to control disease per se but to hire doctors to fill vacancies. The ministry allocated some funds for combating tuberculosis and HIV and a few other programs, leaving insufficient central resources for tackling other diseases.

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