

DECENTRALIZATION AND HEALTH IN THE PHILIPPINES AND INDONESIA: AN INTERIM REPORT

Setting the Scene

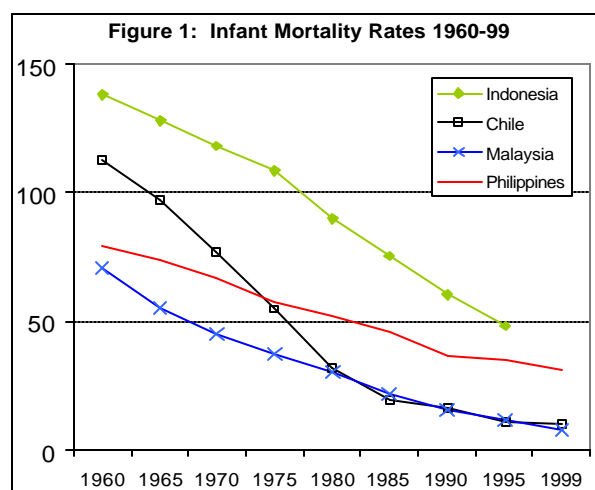
Recent decades have seen significant improvements in health indicators in many East Asian countries. The infant mortality rate (IMR), a useful overall health indicator, fell from 40 per 1000 live births in 1990 to 35 in 1999 for the East Asia region as a whole (Table 1). Yet progress on health in the region has tended to lag that on other development indicators, and to disappoint in several ways. For example, while reduction in East Asian income poverty in the 1990s was faster than in all other developing regions, that in the IMR, at about 1.5 percent a year, was less than half the 3-4 percent a year average pace in Latin America, Europe and Central Asia or the High Income countries. At this pace the region would fail to meet its Millennium Development Goal (MDG) of reducing infant mortality by two thirds between 1990 and 2015.

There is also a lot of diversity in health outcomes within the region. Low-income countries like Myanmar, Lao PDR, and Cambodia continue to face high child and maternal mortality risks (Table 1). These countries are still in a phase where health gains are tied to improved nutritional intake, housing, safe water, sanitation coverage other basic public health interventions. Here progress towards meeting health MDGs will tend to depend on broad factors like the rate and pattern of economic growth and the scale of public health initiatives (Mohs, 1985; PAHO, 1999).

A second group includes countries like the Philippines and Indonesia, which are the focus of this paper, which have made good progress on health indicators in the past, but where improvements over the last decade have been less impressive, especially in comparative terms. In the Philippines, for example, the annual rate of decline in the IMR slowed to 1-2 percent a year in the 1990s, from 3-4 percent in the 1980s (Figure 1). In both countries IMR levels are well above MDG targets and women still continue to face serious reproductive risks.

These countries are of particular interest because, broadly speaking, they have already experienced the major health benefits associated with higher standards of living and broad public health measures, and are now in a second phase, where future advances increasingly depend on more complex factors such as the availability of life-saving medical technologies and the incentives governing health provider and consumer behavior (Rosero-Bixby, 1991; Rosano, et. al., 2000; Bahr, et.al., 1993). An IMR of 50 per 1000 can be taken as a rough and somewhat arbitrary dividing line between these two phases of health development. The Philippines crossed the IMR50 threshold sometime in the early 1980s, but, as noted above, the pace of

decline has slowed in the last decade. Indonesia is estimated to have crossed the IMR50 line in the mid 1990s, but may not have advanced much further in view of the shocks and reversals experienced by the overall economy, the poor, and the health system in the late 1990s. Yet international experience shows that developing countries that successfully address the more complex issues of health service delivery in this second phase of development are able to maintain rapid rates of advance in health outcomes. Chile and Malaysia, for example, have achieved 5-7 percent annual rates of decline in infant mortality over the last two decades, after crossing the 50 per 1000 boundary, rates that are as high or even higher than before (Figure 1).



The Philippines and Indonesia are also of interest because they are tackling demanding health care challenges at a time when governments in both countries are undertaking a far-reaching process of *decentralization*, with substantial authority, resources, and responsibilities being devolved from central agencies to sub-national units. In principle decentralization can be a powerful instrument in improving health service delivery, but it can also pose significant risks and challenges that need to be carefully addressed if the potential benefits are to be realized. This paper tries to provide an interim progress report on the recent experience of the Philippines and Indonesia in implementing decentralization in health services, focusing on the problems that have come up, attempted solutions, and emerging lessons. Given the gathering momentum of decentralization in East Asia, the experience of these two countries should be of interest to policy makers throughout the region. Nevertheless, since both countries are still in the midst of the decentralization process, any conclusions that can be drawn at this stage are of necessity partial and tentative in nature, and will need to be revisited as more experience is gained.

Table 1: Millennium Development Goal Indicators for Health Care for Selected East Asian Countries

| Indicator 14. Infant mortality rate (per 1,000 live births) | | | | | | | | | |
|--|--|-------|-----------|---------|----------|---------|-------------|----------|---------|
| year | East Asia | China | Indonesia | Lao PDR | Malaysia | Myanmar | Philippines | Cambodia | Vietnam |
| 1990 | 40 | 33 | 60 | 108 | 16 | 94 | 37 | 122 | 40 |
| 1995 | 38 | 34 | 46 | 104 | 12 | 83 | 35 | 108 | 37 |
| 1999 | 35 | 30 | 42 | 93 | 8 | 77 | 31 | 100 | 37 |
| 2015 Target | 13 | 11 | 20 | 36 | 5 | 31 | 12 | 41 | 13 |
| Indicator 15. Proportion of 1-year-old children immunized against measles (%) | | | | | | | | | |
| year | East Asia | China | Indonesia | Lao PDR | Malaysia | Myanmar | Philippines | Cambodia | Vietnam |
| 1990 | 92 | 98 | 86 | 32 | 70 | 68 | 85 | 90 | 85 |
| 1995 | 91 | 93 | 92 | 68 | 81 | 82 | 86 | 75 | 96 |
| 1999 | 83 | 85 | 71 | 71 | 88 | 85 | .. | 63 | 93 |
| 2015 Target | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Goal 5: Improve maternal health | | | | | | | | | |
| Indicator 16. Maternal mortality ratio, reported (per 100,000 live births) | | | | | | | | | |
| year | East Asia | China | Indonesia | Lao PDR | Malaysia | Myanmar | Philippines | Cambodia | Vietnam |
| 1990-99 | .. | 55 | 450 | 650 | 39 | 230 | 170 | 470 | 160 |
| 2015 Target | Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. | | | | | | | | |
| Indicator 17. Proportion of births attended by skilled health personnel (%) | | | | | | | | | |
| year | East Asia | China | Indonesia | Lao PDR | Malaysia | Myanmar | Philippines | Cambodia | Vietnam |
| 1990 | .. | .. | 47 | .. | .. | 94 | .. | 47 | 95 |
| 1995 | .. | .. | 47 | .. | .. | .. | .. | 43 | .. |
| 1997 | .. | .. | 43 | .. | .. | .. | .. | .. | 77 |
| 2015 Target | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 |
| Goal 6: Combat HIV/AIDS, malaria and other diseases | | | | | | | | | |
| Indicator 18. HIV prevalence among 15-to-24-year-old women (%) | | | | | | | | | |
| year | East Asia | China | Indonesia | Lao PDR | Malaysia | Myanmar | Philippines | Cambodia | Vietnam |
| 1997 | .. | 0.0 | 0.0 | 0.1 | 0.1 | 1.7 | 0.1 | 3.5 | 0.1 |
| 2015 Target | Have halted by 2015, and begun to reverse, the spread of HIV/AIDS. | | | | | | | | |

Decentralization and Health Care: Potential Pluses and Minuses

Perhaps the most important potential advantage of decentralization for health service delivery is allowing a closer flow of information and interaction between health service providers and consumers, leading to health services that are more differentiated and better targeted to varying local needs. When successful, decentralization should lead to more systematic involvement of citizens in decisions regarding health policy goals, design, and financing, and in monitoring service provision. To achieve this outcome, clients need to have access to the information, financial means, and bargaining power required to elicit appropriate responses from health care providers at the decentralized level. These providers in turn need to be faced with the appropriate incentives, and have access to the skills, supervision, material support, and discretionary authority needed to offer high quality services. If these conditions are fulfilled, decentralization should provide the basis for sustainable financing as well as continuing health advance.

On the other hand, the far-reaching reorganization of government that decentralization represents can be highly disruptive in the short run. These effects include opposition by health care staff that fears loss of status, benefits and authority as a result of being transferred to lower levels of government, breakdowns in staff deployment and other personnel mechanisms. Other short run effects include withdrawal of support previously earmarked for the poor, lapses in reporting, accountability, and quality control procedures, all potentially leading to a deterioration in service delivery and quality.

Looking beyond the immediate horizon, there is a substantial risk that downsizing of administrative units could result in operational levels for key health functions that are neither technically efficient nor cost effective. This could be due to a failure of lower level units to invest and capture externalities linked to public health spending, or to hire staff with expert skills, putting technical oversight in doubt. Scale reductions can raise unit costs and threaten program sustainability with respect to communicable disease control, regulation, financing, health education, personnel, procurement, and training activities. Smaller units may also have less capacity to develop and finance initiatives targeted at the poor.

The Philippines—Almost There

Initial conditions and the reform

Before the present effort to decentralize, the Philippines and Indonesia had followed similar health development strategies based on government-funded, publicly managed, multi-tier delivery systems. The Philippine version was based on rural health units (RHUs) which provided maternal and child care, general outpatient and dental care, family planning and nutrition advice, control of specific diseases, health education, and environmental sanitation. By 1981 there were roughly 2000 RHUs in place, each headed by a municipal health officer and staffed by a public health nurse, a sanitary inspector, and 4-5 public health midwives. Each RHU was responsible for 3-4 barangay health stations (BHS) set up to serve surrounding villages, each BHS staffed by a trained midwife and several locally recruited volunteer health workers.

By the mid 1990s, the Indonesian adaptation of the same approach consisted of 7,100 health centers (puskesmas) which provided primary health care through outpatient clinics and through roughly 23,000 sub centers, over 4,000 mobile clinics, and 19,000 village maternity rooms (polindes). Health centers had 13-15 employees including a doctor, 46 nurses and midwives, and various paramedical workers. Patients were referred to 285 district hospitals, and more than 50 centers of excellence and specialized facilities run by MOH. Health centers also served as the hub for surveillance and other communicable disease control activities. Puskesmas staff was tasked with supporting more than 240,000 posyandus, monthly village gatherings in which community volunteers promoted maternal and child health and nutrition

There was recognition in each country that the payoffs to this approach had been less than expected. For example, a 1984 Bank review analysis found the Philippine system to be excessively centralized, with fragmentation and duplication between central and field units, and weak linkages between rural programs and centrally run disease specific campaigns. Some adjustments were made in response, but

a comprehensive 1993 review pointed to worrisome features of the health scene, e.g., sizable mortality differentials and trend reversals in some regions; poor nutritional status in low income households; slow fertility decline; and low levels of consumer satisfaction with government facilities (Herrin, et. al., 1993).

Other countries with similar approaches have been able to overcome such problems. In the 1970s, for example, Malaysia took decisive steps to refocus and upgrade its version of the publicly run, primary care system. However, successive attempts at reform in the Philippines were far less successful than what was achieved in Malaysia where policy makers were able to bring to bear ample resources and strong policy instruments. Accordingly, decision makers in the Philippines turned to an alternative framework and process in order to strengthen health policy. After extensive debate, policy makers opted to make health one of the first sectors to be decentralized per the provisions of the 1987 Constitution. This was intentional--decentralization was seen as a way of achieving significant reform.

Implementation began in January 1993 with the transfer of funding, facilities, and staff to some 1600 Local Government Units (LGUs), as specified in the 1991 Local Government Code. Primary health care services, more than 600 hospitals, other health facilities and approximately 46,000 health personnel were devolved. The main funding source for each LGU was an Internal Revenue Allotment (IRA) from the center. These arrangements were immediately challenged by stakeholders and politicians at different levels, with implementation put on hold until 1995, when the Congress debated and rejected a proposed return to the pre-reform system, while recognizing the need for various adjustments to the initial plan.

Evaluation and lessons

The Philippines Department of Health (DOH) recently issued a "Health System Reforms Agenda" (HSRA) which provides an assessment of the last decade's experience of decentralization in the health sector. The report is doubtful whether decentralization has had overall positive effects so far. It finds only slight improvements in health status, a resurgence of certain diseases, and persistent inequities in service access. There is little evidence that the all important provider-client equation has improved dramatically or that the risks of "downsizing" to an inefficiently small scale have been fully mitigated. However, the situation has not remained static either. While decentralization did bring disruptions, it has also led to institutional innovations that hold promise of delivering better results going forward. In this regard the HSRA represents a thoughtful consolidation of a decade of reforms and a renewal of purpose. Indeed, HSRA itself is an indication of what has been achieved. Its focus, timing, and tone, notably the determination voiced to reach the public with concrete results, are quite different from the 1992 LGC-based "design." A review of the problems addressed in the last decade and the current agenda will help put these institutional gains in context.

Personnel issues. Decentralization immediately entailed a host of personnel policy difficulties. The 1993 Magna Carta of Public Health Workers Act gave centrally employed health workers a comprehensive and generous package of benefits and guarantees, in order to win their acceptance to being devolved to Local Government Units. However, the associated costs constituted an unfunded mandate, which disturbed LGU decision makers and deepened the gap between reassigned DOH and locally hired staff. These problems led to a follow up 1995 Barangay Health Workers' Benefit and Incentives Act, which partly defused tensions by making some local workers eligible for civil service status and providing some education, insurance, training, legal representation, and loan benefits. Nevertheless, there are still personnel issues to attend to. Locally hired health staff increasingly consists of relatively low-skilled health employees, such as midwives and barangay nutrition workers.

Size of national program. The size and composition of funding retained for the central DOH program remains contentious. The size of the DOH budget has fluctuated sharply, falling 30% to 7.3 billion pesos in 1993, then rising to 12.9 billion pesos in 1998, before falling again to 10.7 billion pesos in 2000 (Capuno, 2002a; Esguerra, 1997). Central funding is directed to programs, mostly facility maintenance and operations, in particular hospitals, and various disease and problem specific services. Implementation of these programs, e.g., family health, nutrition and welfare, communicable disease control, and environmental health, required DOH to develop partnerships with LGUs, each of which had its own spending priorities. Comprehensive Health Care Agreements (CHCAs) between LGUs and the Department

of Health were introduced in 1993 to facilitate such partnerships. These contracts allow LGUs to augment their resources while enabling DOH to channel support to priority programs. Finally, DOH's budget was substantially restructured in 2000 as part of the re-engineering exercise efforts and the adoption of HSRA. In 2000, the largest budget allocation went to regional operations (57 percent) followed by disease prevention and control programs (41 percent).

Local health programs. Average LGU spending and the LGU share in overall health outlays have grown thanks to increases in internal revenue allotments from the center. However, local spending has not kept up with the "cost of devolved health functions" (CDHF), which is calculated from the 1992 budgets for services which were later devolved. Many chief executives blamed this shortfall on IRA funding increases (and estimates of CDHF) not keeping up with the true financing requirements for service delivery. There was some validity in this position since the CDHF did not capture important aspects of devolved services, e.g., costs of repairing or upgrading many transferred facilities, and increased outlays on drugs and personnel to respond to rising public expectations and demands. There were also budget requirements for the Magna Carta benefits, which were essentially additional compensation for public health workers. Another financing issue relates to the capacity and willingness of LGUs to participate in an innovative health insurance scheme for the poor (see below).

Health insurance and the poor. The 1991 devolution package did not address health insurance issues, including providing coverage for the very poor. Instead, this was taken up in the National Health Insurance Act of 1995, and the 1996 Philippine Health Insurance Corporation (PHIC or PhilHealth) and National Health Insurance Program (NHIP). A year and a half later, Executive Order 277 set a goal of covering the poorest 25 percent of the population within 5 years. Two months later, PhilHealth began working with LGUs to enroll indigents in what became the Medicare para sa Masa (MpM). PhilHealth uses MpM to partner with LGUs to enroll their indigent populations with premiums partially subsidized by both LGUs and the national government. However these steps have not led to much of a gain in the coverage of poor households. MpM had enrolled only 80,000 indigent families by late 2001, just 15 percent of the target group. The reasons for this slow start are now better understood and are starting to be solved (Almario and Weber, 2002). More regions than just the very poorest are now included in the program. The initial benefit package also only provided for inpatient hospital care, which was not the highest priority for many poor families. Alternative benefit packages are now being piloted. The number of accredited service delivery facilities in areas where MpM members live is also being increased. One continuing difficulty is that LGUs are reluctant to co-finance required premium subsidies. Since LGUs fund some local health facilities, co-financing premium subsidies are like a double burden. The solution involves shifting current supply-side subsidies to the demand side (see below).

Looking Forward

As noted, these issues and DOH's broader concerns about the pace of health advance are addressed in its "Health System Reforms Agenda" (HSRA) of 2000. The HSRA has been included in the revised Medium Term Philippine Development Plan (MTPDP) approved by President Arroyo, and involves reforms in five interrelated policy areas:

- Disciplining DOH's retained budget by providing fiscal and managerial autonomy to government hospitals, including changing the way hospitals are governed and financed to improve quality of care, cost effectiveness of operations, and dependence on budget subsidies.
- Promoting the development of local health systems through networking and cost sharing among municipal and provincial health facilities, backed by cooperation and cost sharing among LGUs in the health catchment area.
- Building DOH's capacity to exercise technical leadership in disease prevention and control, enhancing the effectiveness of local public health delivery systems, and sustaining funding for priority public health programs.

- Developing awareness of the rationale for health regulations while upgrading implementation capacity.
- Expanding the coverage of the NHIP in order to use risk pooling to reduce the financial burden to individual families and provide the NHIP greater leverage to ensure value for money in benefit spending.

What is striking about HSRA is not only its content and tone, but also its realistic plans for implementation. The implementation strategy notes the importance of delivering recognizable, concrete benefits to the public and acknowledges that resource, time, and political constraints stand in the way of attaining broad coverage immediately. Accordingly, implementation is to concentrate on sites chosen to create maximum demonstration effects, hopefully inspiring nearby areas to seek the same coverage (Capuno, 2002a). Ten provinces and two cities are targeted for “convergence implementation” between 2001 and 2004.¹ Implementation in the convergence sites is being handled by DOH’s Bureau of Local Health Development (BLHD). In this regard, an attractive feature is the encouragement given to LGU “collusion.” BLHD provides a location where all LGUs in a province can meet to compare experiences, assess their collective and individual health needs, share ideas, and commit resources. The BLHD then provides the requisite technical assistance, including the monitoring of commitments or compliance to the agreement. The process should make it easier to elicit counterpart funding from LGUs. The convergence approach is well suited to deal with spillover effects, ranging from epidemics and environmental hazards to cross border use of facilities, and to encourage cost sharing, including co-financing of facilities.

Has the Philippines turned the corner, in the sense of assembling a workable package of incentives and controls for continuing IMR decline? The present paper is not an in-depth evaluation of Philippine health decentralization - this is being explored in the rich literature, which is developing - but it does suggest that the needed policy elements are now coming together and that a breakthrough is imminent. The publication of the HSRA signals that the DOH itself is finally using decentralization to establish a new and distinctive role and public image. Nevertheless, there are several areas still requiring close attention from DOH and other stakeholders:

- Even more can be done to build broad support for reform and, more importantly, to prepare the intended beneficiaries, e.g., LGUs and health care users. A professionally executed advocacy plan would help defuse political resistance to policy reform. At the same time, DOH needs to extend its partnership with the various health NGOs and various civil society organizations with whom it is already working.
- LGU health finances must be put on a firmer footing, including greater reliance on locally generated funds. LGUs must be encouraged to increase their at present relatively limited use of service fees. User charges would not only improve service delivery efficiency, but would contribute to the sustainability of local health programs and generate funds for subsidizing the health needs of the poor. There will be political costs to this step, which DOH can help with. And with higher user fees, LGUs will have to improve service quality, requiring up-front finance for facility improvements, personnel training or hiring, and drugs and medical equipment. DOH matching grants could help support enhanced services, provided LGUs introduce new fee schedules. Grants can also make local government employment more attractive to health workers. When adopted in adjacent LGUs or convergence zones, grants can reduce the political costs of fee increases. LGUs also need to tap private funding sources--involving civil society organizations more broadly in health planning may be helpful in this regard. LGUs can also be given improved access to donor funds, commercial credits and bond markets.

¹ The 12 convergence sites are Pangasinan, Baguio City, Nueva Vizcaya, Bulacan, Pasay City, Palawan, Capiz, Negros Oriental, Southern Leyte, Misamis Occidental, Agusan del Sur, and South Cotabatoe.

Indonesia—Waiting for a Coalition to Emerge

Initial Conditions and the Reform

As in the Philippines, there was longstanding dissatisfaction in Indonesia with the performance of the public delivery system. For example, nutrition and maternal mortality indicators registered only modest gains in the 1990s, despite large-scale interventions. Low utilization of public services drew attention as well. After rising as the system expanded, visit rates began to decrease in the early to mid 1990s, falling by a third by 1998. Various remedial policies were introduced: policy makers bolstered the administrative guidance and control mechanisms used to manage widely dispersed personnel, and turned to incentives-based measures as well, e.g., informal user charges were tolerated, while government staff were permitted to provide services privately when off duty. None of these steps proved fully effective, however. For example, instructions regarding standard practices were often in conflict with incentives; contradictory signals may well have lowered the work intensity and commitment of staff in their public responsibilities.

When decentralization appeared on the horizon, the reaction from the Indonesian Ministry of Health (MOH) was prompt and positive, much like that of DOH in the Philippines. The key statutes, Laws 22 and 25, were passed in 1999, and went into effect along with many accompanying operational guidelines on January 1, 2001. During 2000 MOH began to clarify its own role and tasks in a decentralized regime, as well as those of provinces and districts. High priority was given to developing a sectoral vision and translating it into a policy agenda. To carry out these responsibilities, MOH looked to various initiatives including:

A Decentralization Unit (DU) set up within MOH to tackle problem solving, coordination, and analytical functions. The aim was to facilitate health decentralization and reform, including monitoring implementation by region and level, and advising on existing and proposed legislation and operational guidelines.

Resource transfer mechanisms, e.g., National Health Grants, to help support health operations in poor regions.

Conversion of Directorates General (DGs) within MOH into specialized agencies, tasked with disseminating recommended standards and practices and assisting provinces and districts in upgrading and sustaining important technical functions.

Province-focused interventions aimed at building cross-district capacity and instruments including Joint Health Councils (JHCs), made up of district chief executives and civil society representatives, and seen as ways of getting greater attention and resources for health.

MOH recognized that there were risks attached to such measures, for example, staff resistance, and competition with the Decentralization Unit from established DGs. Provincial initiatives were dependent on policy and technical leadership at the national level, and vulnerable to pressures to replicate quickly. It was feared that cautiously led DGs would create divisions within MOH over direction and pace. Nevertheless, these measures came with some built-in, self-correcting capacity. For instance, a well-led, strongly backed DU was seen as likely to win over recalcitrant DGs. Likewise, astute JHC leadership and peer pressures were expected to prevail over unenthusiastic districts, possibly by drawing on National Health Grants

Early directions

The first fifteen months of implementation produced mixed results. Most disappointing has been the performance of the DU, which was slow to emerge as a trail blazing and problem solving team. Several crucial tasks were not taken on as a result, for example failing to make a strong case for Health Grants to the Ministries of Finance (MOF) and Planning (Bappenas). There were delays in establishing liaison with province-based bodies, including the JHCs or equivalent entities whose role was to advance health through cooperative efforts among districts. Instead of tackling these and other matters, the DU took months to establish and staff itself. There was a long dispute within MOH over where this unit should be placed and

what its Terms of Reference should cover. The compromise version was a toned down, coordination unit with little clout.

Some progress was reported as regards restructuring and reorienting the main technical DGs. For example, the DG for Communicable Disease Control has focused increasingly on monitoring national and regional trends, and alerting provinces and the public about outbreaks. Generally though, the technical DGs have focused on adjustments within MOH, and have yet to adequately engage the district and province-level teams, which should be the audience for their technical inputs.

Lastly, some promising results are emerging from the province level initiatives, which are underway, with WB and ADB financing. District and province-level commitment is palpable, and innovative planning and review mechanisms are taking hold. However, MOH has not been proactive in pulling together experiences, or initiating new efforts.

An assessment

The slow development of a health decentralization framework is attributable in part to the government-wide determination to avoid service interruptions during 2001. (Focusing on prevention of service deterioration also allowed GOI to postpone difficult decisions over the role and scale of key central ministries.) As noted, MOH was aware of service disruption risks and took preemptive steps in 1999 and 2000. In addressing service problems, however, MOH has tended to present itself as a policing and standards-upholding authority rather than a technical agency. This may suggest that there remains considerable ambivalence concerning decentralization, as seen, for example, in the limited backing given to the DU. In addition, a clear concept of the role of provinces in the health system has not yet been developed. Decision makers know well that districts are typically too small to support cost effective program volumes and scale. It was largely for that reason that the central ministry backed the provincial health initiatives, which several donors are helping to fund. However, at other times policy makers have seemed reluctant to acknowledge the province as the natural unit for public health and related programs.

This hesitation may be due to central officials being preoccupied with preserving as much as possible of their commanding position within the health system. In this zero sum view, local governments, especially at the province level, are seen as rival claimants rather than legitimate actors and possible coalition partners who now have their own ownership rights and obligations in the health sector, with valid concerns and inputs. This interpretation, though unfair as regard senior MOH staff, may reflect the attitudes of middle and lower echelon employees.

A second explanation looks to lack of preparation and resolve in addressing employee-related issues. Policy makers recognize the extent of overstaffing and low productivity performance, but feel unequal to the task of reforming the government health work force. Officials are apprehensive, for instance, about tampering with the often-lucrative private service provision that health staff engage in. There are worries about union reactions and awareness of the standoff in the Philippines over benefits for central staff. MOH officials also fear offering too attractive a benefits package to transferred employees, knowing that the resources may be reallocated from other health uses. What is surprising is that MOH is not exploiting some special features of its health work force, notably the extensive use of contract doctors, dentists, and midwives that provides a margin of flexibility in downsizing staff numbers. In addition, the fact that many government health workers provide health services on private account may make a transition out of public employment easier to handle. MOH could draw on these features to work out an effective transition approach.

Finally, MOH's persistent ambivalence reflects a longstanding tendency to view the public as passive service recipients not discriminating customers, owners and stakeholders, potential allies and sources of inputs, and so forth. This had begun to change with the Healthy Indonesia 2010 (HI2010) initiative, which was launched in 1999. This initiative saw health as a responsibility shared with individuals, families, community groups, other ministries, and the private sector; and suggested that HI2010 would work only as an inclusive national movement based on a well prepared communications strategy. Unfortunately, this recognition of the importance of individual responsibility and choice did not engender any follow up within MOH. For example, senior officials at times seem unaware of what consumers feel about the health services they use and the benefits they receive, their preferences and

perceived needs, and their image and impressions of MOH itself. MOH policy makers could also become more familiar with ways of working with different segments of the public.

The tempo and direction of health decentralization in Indonesia are not easy to forecast. Although MOH has not projected itself as a champion of devolution and health reform, there are fiscal and political imperatives and stakeholder pressures, which may encourage changes in thinking. Like it or not, budget cuts are forcing MOH to look to districts and provinces as sources of funds and employment for the health work force. Similarly, demands for better service quality and other pressures from the public have begun to register with local level political leaders and within MOH Jakarta. A possible scenario may resemble what took place in the Philippines, i.e., an initial two to three years of contested decentralization followed by a quickening of the pace and major adjustments, leading to an HSRA-like consolidation and mid-course correction.

Conclusion

The Philippines and Indonesia each still have some distance to cover to reach the MDGs in health, with progress in both countries linked to the sort of decentralized health system which is established. The conditions, which are conducive to health advance within decentralized settings, are quite stringent. They require an equation between health service customers and providers, which calls forth high quality responses from the latter, and close attention to the health responsibilities and scale of activity assigned to different government levels.

Of the two countries, the Philippines is closest to putting these demanding conditions into place. The approach laid out in HSRA, refined and supplemented in some respects, has all the needed ingredients and should provide an effective framework. Moreover, Philippine experiences with health devolution should be helpful as Indonesia moves ahead with its own version of decentralization. For example, experience-tested policy instruments such as CHCA, CDHF, the indigent scheme, and convergence zones all seem applicable. However, the Philippine experience, which is most relevant for Indonesia, is arguably the ongoing change in the outlook and role of DOH in a decentralized system in which there are several other key players.

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