Decentralisation of Health Care Delivery in Nigeria: Issues in Governance and Citizens' Participation in Local Health Care

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Abstract

Issues of citizens' participation in democracy continue to be a recurring decimal in governance discourse. This is more so as it is widely believed that promoting the main tenets of democracy and increasing people's participation will engender development. The inference from this is that, since development is about people, when people are part of the decisions that affect their lives, then, they would be able to make meaningful contributions to issues that concern their own development. It is therefore argued that popular participation is in essence the empowerment of the people to involve themselves in creating structures and in designing policies and programmes that serve the interests of all and contribute optimally to the development process. Decentralisation emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralised planning and be more responsive to market forces as well as local needs. In relation to the health sector, decentralisation is concerned with changing the way health systems are organised to produce effective service delivery. The point has been made that decentralisation could be useful in supporting and developing health services and bring it closer to people. This paper therefore examines the process of decentralisation and how it impacts on primary health care (PHC) service delivery in Nigeria.

Key words: *Citizens' participation, Decentralisation, Governance, Healthcare, Service delivery.*

Introduction

A feature of modern state administration is the need for closer contact between the individual, citizen and officialdom (Smith, 1985). In other word, it is imperative for state administration to maintain a closer interaction with the citizens. This is more so as citizens require accountability and responsiveness on the part of those who govern them.

The importance of reducing the concentration of decision-making at the central level has been receiving increasing recognition, especially as it concerns public

service delivery. World Health Organization (1981) observes that in most developing countries, the diversity of natural conditions economic potential, social and cultural structures and even of values and beliefs, demands flexibility in the mechanisms to achieve nationally agreed goals and adaptability in the definition of the goals themselves. An over-centralised political and administrative system, where decision-makers and officials legislate and prescribe for a whole variety of situations, often without knowledge of local circumstances and conditions may not be effective. Hence citizens' participation becomes *sui generis* for effectiveness and efficiency in service delivery. This position as it relates with the health sector suggests that decentralisation may be appropriate in achieving the objective of efficient health care delivery since decisions on health care planning and implementation will not flow from top-down but will incorporate stakeholders even at the grassroots and community level.

Decentralisation is concerned with changing the way health systems are organized to produce effective service delivery. The argument is that decentralisation could be useful in supporting and developing health services and bringing it closer to the people. It is intended to promote accountability and participation of local population, make health service providers accountable to the local community, and boost the responsiveness of the providers to the local demand for services. Decentralisation is therefore expected to improve the efficiency, equity, and quality of health service delivery and management (Tidemand, 2010).

This paper examines the process of decentralisation and how it impacts on primary health care (PHC) service delivery in Nigeria. The three tier health service and the nature of health care delivery system in Nigeria put the responsibility for PHC delivery at the doorstep of the local government. Though it is not easily implemented as it seems as a result of contradictions inherent in the nature of inter-governmental arrangement itself, which oftentimes constraints local government to act independently of the higher level of government.

The bane of the third tier of government is imbalance between responsibilities assigned local government and revenue available to local government. The third tier of government often complains that the available resources cannot match with responsibilities assigned to them, especially with regards to primary education and primary health care service delivery (Anyanwu, as cited by Abdulwaheed & Samihah, 2012, p.49).

Local governments in Nigeria often are confronted with the challenge of accessing resources to implement programmes and projects at the local level. Many times, resources of local governments are expended on other purposes for which they are meant while projects at the local government levels suffer and may be abandoned for lack of fund for their implementation.

The point has been made however, that if properly designed and implemented, decentralisation has significant potential for widening political representation and for targeting resources in favour of the poor (Bardhan & Mookherjee, 2006). The paper therefore argues that effective delivery of health care services especially the PHC will depend greatly on the extent to which people participate and feel part of the process.

Decentralisation: Conceptual and Theoretical Discourse

Decentralisation is a multi-level concept and usually difficult to conceptualise. This has led to various views and perspectives on the concept. Crawford and Hartman (2008) observe that though decentralisation is very prevalent, its form and extent vary greatly across countries. Different scholars view it through a variety of diverse, often inconsistent, sometimes overtly contradictory, analytic lenses (Bankauskaite & Saltman, 2007). The term decentralisation is used to describe a wide variety of power transfer arrangements and accountability systems. Public administration theory conceptualises decentralisation as the transfer of authority in public planning, management and decision-making from the national to sub-national levels (Kawonga, 2005). Decentralisation is conceptualised as the transfer or delegation of legal and political authority to plan, make decisions and manage public functions from the central government and its agencies to field organisations of those agencies, subordinate units of government, semi-autonomous public corporations, area-wide or regional development authorities; functional authorities, autonomous local governments, or non-governmental organizations (Rondinelli, 1981). To Crawford and Hartmann (2008: 13) "decentralisation is perceived as bringing government closer to the people, leading to greater political participation at the local level, with citizens more able to make claims on local government and to subject it to greater scrutiny. In turn, it is anticipated that local government will be more knowledgeable about and more responsive to the needs of local populations, inclusive of the majority poor. This practice enables the people (especially at the local level) to participate in their own development efforts. Central governments are often blamed for being too far from the realities of people. Thus, transferring various forms of authority and functions to sub-national units of government for

timely adaptation to locally specific conditions is considered to be an effective solution to today's compounded problems (Saito, 2008).

However, decentralisation whether it is local administrative or political actors, entails the creating of a realm of local autonomy defined by inclusive local processes and local authorities empowered with decisions and resources to deliver welfare services in meaningful ways to the local population (Abdulwaheed & Samihah, 2012). The focus is the way power and authority are given to the local authorities to take decisions that will bring development to the local populace. Olowu (2001: 2) observes that decentralization is a relative, complex, instrumental and multidimensional process. It is relative in that it describes the distribution of state resources (responsibility, finance, personnel or discretionary authority) between various institutional actors within the state and/or society against some normative mode in space or time. It is complex in that it incorporates and is impacted upon by political, economic, institutional and cultural factors.

Arguments for decentralisation have been based on widely differing criteria, ranging from expected improvements in allocative efficiency, welfare, and equity (Smoke, 2003), to increased participation, accountability, and responsiveness on the part of local authorities (Talpur, 2000; Mills, 1994; Smith, 1985). A leading rationale for decentralisation according to Robinson (2003) is that it can generate financial efficiency and quality gains by devolving resources and decision-making powers to local governments for the delivery of services. In the same vein, Jimenez and Smith (2005) argue that sub national governments have access to better information about local circumstances than central authorities, and therefore can use this information to tailor services and spending patterns to citizen's needs. In contrast, centralised government structures face significant informational and political constraints that are likely to prevent them from providing an efficient level of a local public good or service.

Decentralisation often involves the need for extensive reform of inter-governmental relations. This reform process most times challenges entrenched practices, vested interests, powerful actors, the inertia of existing institutions, and a lack of will for change.

From the local perspective up, decentralisation is challenged by the many ways in which the central government may circumvent and undermine local authority. From the national perspective, decentralisation is sometimes seen as a way to

undermine the authority and efficacy of national-level government, which must make tough decisions that benefit the entire country (sometimes at the expense of local actors) (Sisk, 2001). Whatever way one perceives it, the challenges of decentralisation are always inherent and require sometimes political intervention to resolve them.

Decentralisation emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralised planning of economics and be more responsive to market forces as well as local needs and characteristics (UNFPA, 2000). As observed by Akinboye and Quadri (2013), decentralisation is not a new phenomenon or something foreign to the African continent, most of the African states have sought to decentralise their state structures since independence (also in Olowu, 2000).Wamwangi and Kundishora (2003) have equally observed that:(a) The purpose of decentralisation should be to devolve power and responsibility to lower echelons, promote local democracy and good governance, with the ultimate objective of improving the quality of life of the people; (b) Decentralisation should be to local government structure, which are representative of, and accountable to, all sectors of the local population, including marginalised and disadvantaged groups; (c) Decentralisation should be to levels of local government structures, which enable effective community participation in local governance, (d) Decentralisation should involve the transfer to local government institutions those powers and functions necessary to enable them: i) provide services for the local population efficiently and effectively; ii) provide a conducive environment for local economic development; iii) develop and manage local resources in a sustainable member, (e) Decentralisation should include the provision of access to the resources needed to execute the above powers and functions efficiently and effectively, including financial and manpower resources, (f) Financial resources should be available to local authorities in a manner which is reliable, adequate, predictable, transparent, accountable, sustainable and equitable, (g) The basic components of a decentralised system of local government should be enshrined in the constitution.

In summary, decentralisation of authority and power is justified by the argument of efficiency and effectiveness, responsibility and accountability, as well as providing opportunity for people to participate in decision-making-process since power is no longer concentrated in a central/national government but distributed widely between the national and sub-national and subordinates units of governments.

Health Policy and Health System in Nigeria

Decentralisation of the health system is concerned with strengthening health system performance to deliver better quality and equitable health services that will respond to the needs of the local populace. Conceptually, it involves a change in power relation between the national (or central) government level and other actors in the health system, including statutory local government entities, other sub-national levels of government administration, private enterprises and non-governmental organisations.

Health policy is an important vehicle for influencing the health of individuals, families, and communities. Most health care policy initiatives are designed to address one or more of three concerns; cost, access, and quality (Smart, 1999).

With the global declaration in 1978 of PHC as the key to the attainment of *Health for All* and its reaffirmation by the African Health Ministers in 1985, Nigeria adopted the Three-Phase Health Development Scenario (TPHS) as a strategy for national health systems (NPHCDA, 2001).

The Three-Phase Health Scenario recommended three-tier levels for health care delivery with PHC forming the primary level and central focus. This influenced the development of Nigeria's maiden health policy, which was launched in 1988.

The overall goal of the policy was the attainment of enhanced standards of health by all Nigerians in order to promote a healthy and productive life (African Development Bank, 2002). A health system based on PHC was adopted as the means of achieving the goal.

The policy identified PHC as the cornerstone of the national health system and recommended four main strategies for its implementation.

(a) The promotion of community participation.
(b) The involvement of health-related sectors in the planning and management of the services.
(c) Strengthening of functional integration at all levels of the health system, and ;
(d) Strengthening of the managerial process for health development.

The policy prescribed a functionally integrated three-tier structure for the nation's health service.

The Federal government is to be responsible for: (a) the development of national policies; (b) the strategies to promote primary health care; and (c) the provision of tertiary care.

The State Government is to be responsible for:(a) technical assistance, logistic support and supervision of the Local Government Areas; (b) secondary care in the form of General Hospitals and;(c) training institutions especially for levels below that of the doctor, including primary health care workers.

The Local Government is to be responsible for: (a) the development and maintenance of primary care; (b) the training of community-based health workers such as the village health workers and the traditional birth attendants.

Each of the 774 LGAs in the country is responsible for operating the health facilities within its area, including the provision of basic out-patient, community health, hygiene and sanitation services. The State Ministry of Health coordinates activities and provides technical support.

The state provides at least, a general hospital in every local government to serve as the apex of the local government health care system. Each local government health committee must select one of its village health committee chairmen to represent it on the management committee of the General Hospital.

It is to be noted that, problems that cannot be solved at the level of the General Hospital will be referred to the Tertiary system under the jurisdiction of the federal government. The plan is for the federal government to provide a tertiary facility in each state to serve as the apex of the health system in the state. In order to complete the management system designed for the National Health Service that ensures its ownership by the community, a village health committee chairman is on the Board of the Teaching Hospital in the State.

This arrangement in health care delivery shows the state of decentralised health care delivery system in the country with the optimism of promoting effective service delivery. According to Olowu and Wunsch (1996):

> The decentralisation it was hoped, would strengthen local level participation in local affairs, and would stimulate more local revenue. It was also hoped greater accountability and decentralisation would improve efficiency and effectiveness at the local level by shortening long and circuitous administrative channels and by encouraging greater

> flexibility and responsiveness to particular local conditions and needs (Olowu & Wunsch, 1997, 70).

It is clear from the arrangement that the local government which is the lowest on the hierarchy is the first point of entry into the health system with primary health care located at that level.

Structure of Health Service Delivery at the Local Government

Health service delivery in each LGA is the responsibility of the Health and Social Welfare Counselor (ADB, 2002).

There are two levels of care at the LGA: the village and the ward/district. At the village level are the health centers. The process of implementation began from the bottom, by developing village health services. Village communities are mobilised to discuss and agree on their health problems, and the strategies and activities to tackle them.

With technical assistance from the federal, state and local governments, villages are encouraged to form village health committees. These committees selected individual and traditional birth attendants for training as village health workers to provide the integrated preventive, curative and midwifery services at the village level.

The service provided by the village health team is supervised by community health workers based in the community and the health centers. The village health committee has full authority over the village health services. Problems that cannot be solved at the village level are referred to the Health Center.

The local government provides a health center in every ward/district manned by the team of community health workers. The services provided at the health center are under the authority of the ward/district health committee consisting of the chairmen of all the village health committees in the ward. The health center is the highest level of health care facility under the jurisdiction of the local government and in the nation's primary health care system. Problems that cannot be solved there will be referred to the secondary health care system- the General Hospital, under the jurisdiction of the state government.

Health Governance in Nigeria: Real Issues in Decentralization of Health Service Delivery

A governance debate needs first to be based on the realisation that health cannot be addressed without a real involvement of people and their organizations at all levels (Xhafa, 2007). This invariably involves effective participation of stakeholders (including community people) in health decision-making. Participation gives the people the opportunity to share in the responsibilities that determine their health outcome. The participation of the people at the community level thus becomes an imperative if the principle of popular participation at the local level is to be enhanced.

The process of community oriented approach focuses on the population health needs as determined by them and not by the health officials alone. Community themselves are seen as part of the decisions that inform the nature of health care delivery. Conceived this way, health decision making commences from the bottom-up through the community people, and not to be seen as the sole responsibility of health bureaucrats.

Community's efforts at determining their health needs have implications for community participation in health care delivery. One of the reputed benefits of community participation is the belief that resources will be more often directed to the so-called 'felt needs' of those in the community, and that health activities will be carried out more appropriately when the community is given greater control (Zakus & Lysack, 1998). Identification of health needs within the community may come as a result of felt needs which the community people identified themselves and rely on health professionals to solve. Again, it may be the result of health education by the professionals who thus help the community to convert a real health need to a felt health need (Ekunwe, 1996). When community people participate at identifying their health needs and programmes arising from this, it can be taken for granted that they would likely see to the successful implementation of such health programmes. Mansuri and Rao (2012) rightly note that the two major modalities for inducing local participation are community development and decentralisation of resources and authority to local governments. Efforts of community to affect decision-making on development programmes including health and education will be meaningless not only if resources for adequate funding for implementation are hard to come by, but also if the local government lacks the authority to coordinate activities and take responsibility for success or failure of programmes and projects within its jurisdiction.

Related to the issue of peoples' participation in health care delivery is the financing of health care and the role of the community.

Health care financing refers to the strategies for paying for health care expenditures and these are for services and goods whose primary aim is to promote health. It is one of the major factors that drives health care delivery generally and PHC in particular (Nigerian Health Review, 2007). The sources of finance of the health sector as well as the mechanisms used to allocate those resources within the health systems directly affect poor people's access to health services, and thus the final health outcome (Sida in Nigerian Health Review, 2007, p.73).

The revised National Health Policy of 2004 provides a comprehensive strategy of health care financing in the country which includes Government Funding, Donor Funding, Health Insurance and Out of Pocket payments (OOPs) also known as User fees. The National Health Policy of 2016 has described the health financing functions as revenue generation, revenue pooling and purchasing (National Health Policy, 2016).

Specifically for PHC financing, the federal government provides budgetary allocation to PHC Department of the Federal Ministry of Health (FMOH) and NPHCDA. Also, there are budgetary allocations to various PHC activities in the country, such as malaria control programme, immunisation programme, HIV/AIDS amongst several others. Financing of day-to-day health facility functioning is largely provided by local governments (Nigerian Health Review, 2007).

Other sources of funding for PHC include, Donor Financing, the Mandatory or Social Health Insurance (SHI), Voluntary Health Insurance, Community Based Health Insurance, Drug Revolving Fund (DRF) and Out-of Pocket payments (OOP) or User fee.

Government funding takes the largest share of health care financing in the country. Where this is largely effective, health care financing and consequently health care service provisions is likely to meet the basic health demands of the people to a large extent. Paradoxically government provisioning for health care services in the country has been on the decline. Health financing challenges include gross under-funding of health, inadequate public health funding, low external funding, with the little external funding not being in tandem with national

priorities, incomplete and unreliable data on health financing, allocative and technical inefficiencies in health spending, very limited coverage with risk pooling mechanisms and poor private sector investments in health (National Health Policy, 2016). These challenges percolate to local governments manifesting in the decline revenue accruable to them and thereby impact on the responsibility of local government to deliver essential primary health care services at the local level.

The diagram below shows how revenue to local governments in the federation fluctuates year-in-year-out.

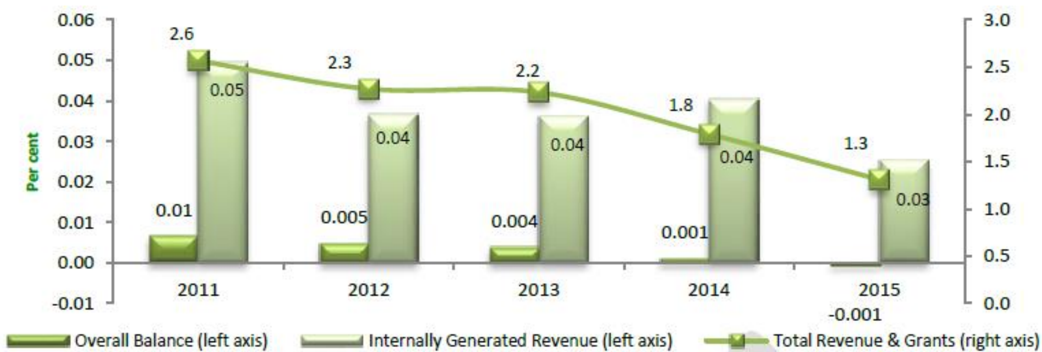

Diagram 1: Local Governments' Revenue & Overall Balance, 2011 – 2015 (Per cent of GDP)
Source: *Central Bank of Nigeria Annual Report 2015*

The CBN provisional data on local governments' fiscal operations reveals a declining trend in the revenue accruable to local governments. Consistently from 2012 till 2015, there is a decrease in percentage in internally generated revenue and total revenue plus grants in the above diagram. This would have implications for local governments' service delivery including health care.

Item	Local Governments' Revenue				Share in Overall GDP	
	2014		2015		2014	2015
	Amount (₦' Billion)	Share (%)	Amount (₦' Billion)	Share (%)	%	%
Federation Account	1,125.1	69.7	822.9	66.1	1.26	0.9
Excess Crude	13.6	0.8	2.8	0.2	0.02	0.003
NNPC refund to LGs	26.8	1.7	0.0	0.0	0.0	0.0
Exchange Gain	1.1	0.1	44.2	3.5	0.001	0.05
SURE-P	76.5	4.7	0.0	0.0	0.1	0.0
VAT	266.9	16.5	261.7	21.0	0.3	0.3
Internally Generated Revenue	36.5	2.3	24.0	1.9	0.04	0.03
State Allocations	4.1	0.3	6.9	0.6	0.005	0.01
Grants and Others 1/	11.1	0.7	9.5	0.8	0.01	0.01
Non-oil excess revenue	47.5	2.9	0.0	0.0	0.1	0.0
Additional Funds from NNPC 2/	5.6	0.0	73.7	5.9	0.01	0.08
Total	1,614.8	100.0	1,245.6	100.0	1.8	1.3

Source: *Central Bank of Nigeria Annual Report 2015.*

Specifically for years 2014 and 2015, it was observed that, the estimated total revenue of local governments, at ₦1,245.6 billion, represented a decrease of 22.9 per cent below the level in 2014. The revenue comprised allocations from the Federation Account, ₦822.9 billion (66.1%); and the VAT Pool Account, ₦261.7 billion (21.0%). Other sources included Exchange Gain, ₦44.2 billion (3.5%); Excess Crude, ₦2.8 billion (0.2%), and Additional Revenue from the NNPC16, N73.7 billion (5.9%); while Grants/"others" and State allocations amounted to N9.5 billion (0.8%) and ₦6.9 billion (0.6%), respectively. In addition, IGR accounted for ₦24.0 billion (1.9%), indicating a decrease of 34.2 per cent below the level in 2014.

Local health care system functions and competes with other sectors within this financial arrangement. Its appreciation depends on the premium the government places on health care development which is also determined by the extent to which government is willing to commit resources for its provisioning. Nigeria's spending on health places it at the bottom third of the ranking of countries in sub-Saharan Africa (HMCAN, 2016).

Community health care financing invariably becomes part of the process to augment the limited resources expenditure on health.

Community financing for health is a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social-economic or ethnic population group) finance or co-finance the current

and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health (Ojo, 2006, p. 215-216). However, direct payment / user fees also known as Out-of-pocket Payments (OOPs) is very common in developing countries although there has been calls for its removal in response to evidence of its regressive impact and its role in enhancing social exclusion particularly in primary care level (Nigerian Health Review, 2007).

The Bamako Initiative (BI) of 1988 introduced a strategy of health care financing where community operates the 'Drug Revolving Fund'. The main purposes of the initiative are to secure community funding of recurrent costs, enhance essential drug supply system and strengthen community participation and control (Oliveira-Cruz, Hanson and Mills, 2003). A study by this researcher conducted in four communities in Lagos State reveals that, most efforts of the communities at resources mobilization for health care are carried out by the community organizations in the four communities. One of the interviewees at the communities avers:

> Committee members raise money among themselves to buy drugs although we follow orders from the nurses as to what type of drugs to buy, this we sell and the profit saved for other future use, but you see we are finding it difficult now to even raise money to buy the drugs because of the economic situation which is affecting most of us or how do you ask someone that cannot feed himself and the family to come and contribute money for drugs? (FGD, Ilado, 2008).

Evidence from this qualitative study shows that community members are not positively disposed to making financial commitments towards health care development. Furthermore, 'Drug Revolving Funds' are either not in existence anymore or not been run effectively in some of the communities studied and this affects availability of drugs in most health facilities. This resonates with the reports of the survey carried out by NPHCDA in 2001 which states that there has not been an improvement. The NPHCDA health facility survey of 202 LGAs measured the availability of essential drugs list and drug revolving fund system. The reports indicate that drug supply is inadequate in public sector PHC facilities (Nigerian Health Review, 2007). It is possible to argue that the exclusion of communities from core decision-making also affects their participation in health care financing in the communities. The general argument for decentralizing health care is that greater local participation in health policy and local accountability can

lead to improved quantity (including coverage) and quality of service (Saavedra, 2010).

As earlier observed, within the three tier structure, the local government is responsible for the provision of PHC services; the state government takes the responsibility of secondary health care, while the federal government handles the tertiary health care. The delegation of PHC to local governments was intended to bring decision-making and services closer to where people lived and worked, thereby permitting the delivery of health care to be adapted and fine-tuned to local needs (Nigerian Health Review 2007). PHC is the first level of contact of the people with the nation's health care system, and it is at the grassroots level that this contact is made. By extension, the people at this level are to take responsibility for their health by taking part in the planning and management of the health system.

Within the system of health care administration and health care financing, local government is constrained in its function as the provider of basic PHC services in the country.

Financing of day-to-day health facility functioning for example is largely provided by local government. The federal and state governments are expected to provide logistical and financial assistance to the LGAs, primarily for programmes of national importance such as the National Programme of Immunization, or controlling the spread of HIV/AIDS (Nigerian Health Review, 2007).

Local governments get 20% of statutory allocation from the federation account. They are expected to generate revenue internally to meet their assigned responsibilities. In these areas, local governments are confronted with daunting challenges that constrain them in performing. The 20% statutory allocation to local governments is channelled through the state governments. It is no gainsaying that the experience of local governments in this respect has been tales of woes as state governments oftentimes divert local governments' allocation for other purposes.

Furthermore, the nature of inter - governmental arrangement which specify areas of operations amongst the three tiers of government is dysfunctional. Opinions have been expressed concerning the nature of the relationship between the three tiers of government as it relates to their roles and responsibilities in health care

delivery. According to the Appraisal Report of African Development Bank (2002),

> The organisational structure of the Nigerian health care system suffers from lack of specificity and ambiguities in the definition of roles and responsibilities of the three tiers of the system, the Federal, State and Local Government levels. Even when roles are clearly assigned there are instances where some tiers of Government take on responsibilities that are clearly not within their mandate (ADB, 2002, p. 18).

Lack of effective coordination of various institutions responsible for the provision of health care services is one of the factors responsible for the crisis of health care delivery in the country. Nwakoby (1999) is of the view that the institutional and functional divisions of the three tiers of government are not mutually exclusive, they are to complement each other with a view to realising the objectives of the National Health Policy.

The poor definition of roles and responsibilities of actors in the health sector has contributed to the confusion and haphazard implementation of PHC policy in the country. Furthermore, the local government which is assigned the responsibility of PHC has been described as the 'weakest and poorest' tier of government. Unfortunately, the community peoples are entwined in this state of confusion. It therefore becomes difficult for them to take part effectively in the process of health care delivery at the local level.

The whole argument of people participating in the decision-making at the local government revolves around the notion of 'responsible governance' where rulers are made accountable and responsible to the ruled. Issues of transparency, accountability, justice amongst other are perceived to be inclusive of the process of governance when people participate especially in the decision that affects their lives. As regards decision-making on health care delivery, community people are stakeholders and actors in the process.Health constitutes a strong platform for democratic participation and people's empowerment. Developments in the health sector in the country have shown a decline of the community participation in PHC planning and management. The consequence is the poor performance of the health care system and its failure to solve the basic health problems in the country.

Conclusion

Decentralisation has emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralised

planning of economics and be more responsive to market forces as well as local needs and characteristics.

One of the reasons advanced for decentralisation is that it can generate financial efficiency and quality gains by devolving resources and decision-making powers to local governments for the delivery of services. The general argument for decentralising health care however is the potential for improved service quality and coverage. Reforms in the health sector in most developing countries have promoted decentralisation as a means of achieving objectives such as improved efficiency, better responsiveness to local conditions and local accountability to community priorities especially in the provision of health care services. However, not all the potential benefits of health care decentralisation have been realised. Among the problems is the lack of clear delineation of tasks and management structures between and within different levels of the health system. This has often been neglected at the design stage of decentralisation. The division of authority for budgetary management is also important but in many countries, although recurrent budgets have been devolved to districts, development budget remain with the Ministry of Health. Thus budgetary decentralisation remains limited. This may constrain the ability of local system to improve the efficiency and effectiveness of service provision through improved resource allocation as decentralisation without delegation of appropriate financial and administrative powers does not work. It is therefore recommended that decentralisation policy should also include effective coordinating mechanisms of all processes of health care delivery systems in order to enhance efficient service delivery. Community participation in health care delivery through the engagement of community organisations and community people in health care planning and implementation should be enhanced to make citizens feel part of health development programmes in their localities.

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