

The decentralization of health care in developing countries: organizational options

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SUMMARY

The complex ways in which decentralization is practised in the field of government health services are examined. Organizationally, decentralization means a choice between different types of public institution, which vary in terms of: the *areas* over which they have jurisdiction, the *functions* delegated to local institutions; and the way decision-makers are recruited, so producing *institutions*. There is little agreement about the optimum size of areas, either in terms of population or territory. Areas cannot be delimited without consideration being given to the powers to be exercised at each level. The specification of functions always assumes certain things about who will exercise the delegated powers. The two issues cannot be separated. Five structures of decentralization are distinguished, each of which could in principle be created at regional, district and village/community level: the multi-purpose local authority, the single-purpose council, the hybrid council, the single purpose executive agency, the management board, field administration, health teams, and interdepartmental committees. Whatever the institutions used for decentralization, the choice of structures and the ensuing process of decision-making will be highly charged politically. © 1997 by John Wiley & Sons, Ltd.

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INTRODUCTION

While it is widely accepted that decentralization in government health service provision to sub-national levels is necessary to produce an optimum combination of top-down and bottom-up planning, it is surprising how rarely the precise kinds of organization needed are specified or even guidance given on the choices available.¹ This article is concerned with the complex ways in which decentralization is practised in the field of government health services.² The classification normally used in studies

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¹Decentralization in this article is restricted to the decision-making structures of the state, and avoids the confusing notion of decentralization as privatization or the withdrawal of the state from provision, leaving health care to be provided either by profit-making commercial concerns or not-for-profit NGOs (Collins and Green, 1994).

²The pressures for decentralization and the advocacy on its behalf will be familiar and need not be described here. On the decentralization of health care, see WHO, 1988a, 1991, 1992b; Oakley, 1989; Tarimo and Fowkes, 1989; Mills *et al.*, 1990; Reilly, 1990; McPake *et al.*, 1993; Thomason *et al.*, 1994; World Bank, 1994a; Hurley *et al.*, 1995; Shaw and Griffin, 1995.

of decentralization—devolution, deconcentration and areas agencies—is too broad, since much variation along the three dimensions is possible. The mechanisms identified by Mills (1994) to obtain some degree of accountability in health care—including devolution to special purpose area authorities, advisory bodies to field officers, and management boards, all with varying mixes of appointed and elected members—go some way towards refining the concept of decentralization. But devolution may be on a very small scale (village councils, say) or a large one (provincial and regional governments). The authority delegated to different levels will vary from one country to another. Special purpose area agencies can be on a wide range of scales and involve different types of recruitment, often used in combination. The concept of deconcentration encompasses officials of the Ministry of Health with widely varying levels of authority and status, such as District Medical Officers and village health workers. The analysis of decentralization needs to recognize the variations possible in each of the broad categories.

COMPONENTS OF DECENTRALIZATION

Organizationally, decentralization means a choice between different types of public institution that vary in terms of: the *areas* over which they have jurisdiction and how these are geographically delimited; the range of *functions* delegated to local institutions and the level of discretion allowed within each; and the way decision-makers are recruited, so producing *institutions* that are primarily political, primarily bureaucratic or some mixture of the two (Smith and Stanyer, 1976, pp. 58–65).

There are many institutional options available at the sub-national level.³ Institutions are created by the recruitment of office holders by two main methods: election and appointment. Appointment is either bureaucratic or political. However, the combinations that can be created from methods of recruitment, the allocation of functions, and the delimitation of areas leaves this typology needing further refinement. Five structures of decentralization can actually be distinguished, each of which could in principle be created at regional, district and village/community level. Furthermore, it is quite likely that there will be more than one form of decentralization at any given level, especially devolution alongside deconcentration (field administration) (Smith and Bryant, 1988; Mogedal *et al.*, 1995, p. 355).

The evidence available of how these different institutional arrangements perform is far from complete. It only allows the most tentative conclusions about the consequences of decentralizing health services to different organizations. Decentralization creates costs and benefits, which is why it is so important for reformers to study other countries to see where the risks lie as well as what opportunities can be created. It is easier to say what can happen rather than predict what will happen if a particular institutional form is introduced into a particular setting. And even then it is difficult to separate the effects of decentralization from other factors influencing health care performance and health outcomes (Newbrander *et al.*, 1991; Thomason *et al.*, 1991).

³For the purposes of this article only organizations with executive responsibilities are included in the analysis; advisory and consultative bodies, such as Colombia's neighbourhood committees of community participation (WHO, 1994, pp. 9–11), are ignored.

Devolution: the multi-purpose council

Devolution may take the form of a multi-purpose local authority whose deacon-makers are recruited by election or more traditional methods, such as chieftancy.⁴ This is the most familiar local government body. Elected representatives exercise devolved powers, including aspects of health care. In principle, such arrangements could be created for all tiers in the health service hierarchy. The devolved powers are likely to include taxation and other forms of revenue raising, such as fees and charges. Examples are provincial government in PNG, district councils in Tanzania and Botswana, the provinces and counties in China, and the Philippines Local Government Code of 1991 (Bloom *et al.*, 1991; Gilson *et al.*, 1994; Bloom and Gu, 1997).

The principle of the multi-functional political council can be experienced on a very small scale at village level and even neighbourhood, as in the case of parts of Indonesia where neighbourhood 'associations' have been set up with powers and resources, albeit limited, in community affairs such as the maintenance of roads and irrigation canals, the construction of water supplies, the observation of official ceremonies and aspects of primary health care such as the evaluation of the performance of volunteer health and nutrition workers (Halliman and Williams, 1983). At the other end of the scale, in a federal system the regional level of government will be highly politicized and include, as in Mexico, responsibility for health services (Gutierrez, 1990).

Some of the benefits of devolution are illustrated by Papua New Guinea where it strengthened coordination among health professionals who saw themselves as members of a team when before they had acted in isolated sections of the ministry. Deconcentration had encouraged 'departmentalism' and accountability upwards even within a single ministry. Under devolution resources (transport as well as finance) were shared, morale became stronger and cooperation improved. Consequently, access to health services and the coverage of disease control programmes benefited, leading to substantial improvements in the health of the population, notably a lowering of infant, childhood and maternal mortality, and increased life expectancy (Reilly, 1989).

Devolution can, however, create problems that need to be recognized and planned for. Senior ministerial officials often find it difficult to switch to being merely the technical advisers of provincial or district councils after having been in charge of health programmes. Devolution usually exists in parallel to a structure of deconcentration that shares responsibility for the provision of health services. Lines of accountability can become confused when there are two hierarchies of professional and managerial staff, as in Tanzania and Botswana, for example (Gilson *et al.*, 1994, p. 469; Mogedal *et al.*, 1995, p. 356).

The quality of elected leadership can vary greatly, which may adversely affect the quality of personnel, decision-making and, consequently, the health service

⁴Devolution may not be uniform across a single country, and the boundary between devolution and federalism may be thin. In PNG for example the decentralization programme did not 'define clearly, once and for all, the respective responsibilities of the levels of government. Instead, responsibilities were to vary depending on such factors as relative capacity and political strength'. It also involved a combination of 'pure' devolution (provinces exercising delegated powers under national legislation) and federalism (the exercise of powers under provincial legislation) (Regan, 1991, pp. 36–38).

available. This points to the importance of giving clients, patients and beneficiaries a role in selecting, assessing and disciplining incompetent, dishonest or lazy community health workers who are the relatives or supporters of local councillors.

However, conventional local government is not always good at encouraging other kinds of participation that can be beneficial to government health services, such as the mobilization of community groups in providing inputs or the involvement of client groups in the management of facilities (Reilly, 1990). The insertion of an intermediate tier of developed government can shift power upwards from local communities unless other arrangements for community participation are made, such as management boards for health facilities. Yet local governments may not be able to provide support and supervision to smaller areas. In China, for example, the counties (with populations of between 100 and 400 thousand) do not seem able to provide the administrative support, training, regulation and supervision to townships and villages that the communes and brigades did under collectivized agriculture (Deng *et al.*, 1997).

The devolution of revenue-raising powers can lead to inequities between individuals in different areas arising from the adoption of different revenue regimes (such as different charges for the same service) or inequities between communities arising from differences in socio-economic status, with health expenditures of authorities growing at different rates depending on their ability to generate income. China is a case in point (Collins and Green, 1994, pp. 466–469; Gu *et al.*, 1995; Bloom and Gu, 1997; Tang, 1997).

There is also a risk that devolved bodies, because of administrative incapacity and resource shortages, merely act as the agents of the central government, implementing its policies rather than initiating their own—as in PNG, for example (Regan, 1991). The logic of devolution also means that devolved governments may choose to spend on services other than health, again starving health of the resources that the centre thinks it requires (Newbrander *et al.*, 1991). Or they may emphasize aspects of health care (curative rather than preventive) that are not compatible with the centre's priorities.

There are, in effect, major contradictions for health care within devolution: between accountability and competing priorities; between the small scale needed for participation and the large scale needed for managerial effectiveness; and between accountability and equity (Cassels, 1995, p. 341).

Devolution: the single-purpose council

When local government is weak a preferred option for the decentralized administration of health provision may be a body composed of representatives of the people but with a single function. Examples are the regional and cantonal health associations in Alajuela, Costa Rica in the 1980s. These were statutory bodies, responsible for the organization of community health activities, including the administration of health centres and health education, whose members were democratically elected annually (Solano, 1988).

Such councils or committees are increasingly being set up at village level to plan and execute local projects. Examples include Cameroun's village-level health committees whose function is to analyse local problems, identify needs and priorities, and fund interventions using local resources (Isely and Sanwogou, 1983, p.48); Guatemala's health committees responsible for the selection, discipline and dismissal of community health workers (Behrhorst, 1984); and a rural health programme in one province of Indonesia in the 1970s where community participation was sought by the establishment of village health committees, which administered some of the revenue generated by a health insurance scheme to create income-generating activities, and selected volunteers for first aid, sanitation, preventive health and community development work (Rifkin, 1986a).

The main lesson from experience here is that the local health organization should ideally be strong enough to manage its own staff and not have to rely on support from outside. The community health workers employed by local bodies that do not have a strong health care administration have to rely on ministry staff for supervision, technical support and advice. This may not be forthcoming if ministry officials do not feel committed to a scheme that is not under their direct control. Primary health care involving community health workers, community volunteers, traditional birth attendants and the like has suffered from a lack of supervision by professionals as the cases of the Gambia, Ecuador and Nicaragua have shown (Walker and Cham, 1981; Heiby, 1982; Mangelsdorf *et al.*, 1988). When provincial and district teams have been motivated to provide support, performance has improved, as in the case of Zambia (Inambao *et al.*, 1987). Technical and managerial support for primary health care from both local community and the health administrators and professionals is needed (Vaughan *et al.*, 1984). There is a paradox here, however: when CHWs are recruited and perhaps remunerated by the local community but supervised by health professionals from the ministry, a divided accountability is created. Developmental work may be neglected and medical work given priority (Vaughan, 1980).

A further problem is that multi-sectoral decentralization seems to be necessary for the promotion of community participation. Rifkin's survey of over 200 primary health care projects found that programmes that sought to promote only health and health-related services actually limited community participation because health is not necessarily a top priority, lay people see little scope for their own involvement, and professional planners tend to define the problems and present communities with the solutions. Participation in which people bear responsibility rather than just reap benefits is effective when a range of community needs is being addressed (Rifkin, 1986b). This points to the need for multi-purpose devolution.

Single purpose councils can also be seen as a political threat to those in office under the local government system. This was found in a case study of political conflict between the community health worker and ward councillor in Luampungu, a ward of Sesheke District in the Western Province of Zambia in the early 1980s. The solution seemed to be the incorporation of health into a wider structure of decision-making at village level to legitimize the roles of new officials such as community health workers, as well as to generate resources for village-level health infrastructure and improve communications between organizations (Twumasi and Freund, 1985).

Devolution: the hybrid council

A hybrid multi-purpose council can be constituted by mixing types of recruitment, as in some district and village development councils that include health care in their portfolios and combine local representatives with government officials. In district-level development planning in developing countries we find mixtures of recruitment methods, including the appointment to district agencies of field officers and local members of the national legislature, as well as directly or indirectly elected councillors and other community or group representatives. Indonesia's Village Community Resistance Boards plan and implement village development including health with members drawn from local religious and professional groups such as teachers (WHO, 1994, p. 18).

The case of primary health care in Zambia confirms that in planning community participation local politics and interests need to be taken into account. The hybrid council is one way of doing this. Twumasi and Freund argue that the way to avoid destructive clashes with local political interests is to integrate primary health care into an effective local organization that claims the support of the local power elite, as well as the rest of the community. In Zambia, this was done through Village Development Councils bringing together traditional leaders, elected party officials, community health workers and other local notables such as the head teacher of the village school. The advantages of this scheme are that it neutralizes opposition by coopting local power-holders, minimizes the likelihood of the CHW being regarded as a political threat, provides a broader based forum than a specialized health committee to discuss resource matters, creates a channel of communication between the community and field officials in agriculture and education, as well as primary health, and brings about accountability, especially in financial management (Twumasi and Freund, 1985).

Delegation: executive agencies

A widely encountered organization, and one advocated by a WHO Study Group in 1992, is the district council consisting of a combination of local representatives, either directly or more likely indirectly elected, and health officials with managerial responsibilities in the area. Such district health councils are executive and political bodies in that they are responsible for determining health policy, approving a district health budget, financial accountability and the evaluation of health programmes. They are composed of elected representatives of the community, the district health officer, the senior district nurse, hospital directors, representatives of NGOs and departmental district heads from other sectors, such as education, agriculture, the social services and the district administrator (WHO, 1992a). Examples are found in Zimbabwe, Swaziland, the Sudan, Mexico and Nigeria (Gutierrez, 1990; Rahim *et al.*, 1992; WHO, 1994, pp. 29–33).

An analysis of Panama's village-level health committees, set up in 1970 to share in the planning, operation and evaluation of health programmes with Ministry of Health officials, identified several factors distinguishing successful from unsuccessful performance in improving preventive health care. First, success was found where

there was commitment to community health by the regional and district medical directors employed by the Ministry of Health who regarded participation as more than just a means of cutting costs. Second, the technical support constituted an integrated health team, which maximized contact with the community through its range of expertise. Third, there were active associations of health committees to pressure the government for improvements, lend money to individual committees, provide a link between new and existing committees and train committee officials. Fourth, local political leaders were supportive. Fifth, the health committee leadership was knowledgeable, able and experienced, and received assistance from health officials. Finally, communities with successful health committees were less socio-economically stratified than where there were inoperative committees.

Health reformers may not be able to do much about this last factor, but it is important to remember that in health care, as in all other areas of decentralization, the less inequality there is, the less people are forced into dependency relationships with more wealthy and powerful members of the community and the more willing people are to join popular organizations 'without fear of political and economic repercussions' (La Forgia, 1985, p. 60). Unfortunately, these conditions were not found in a majority of the districts sampled for assessment, where over 90 percent of health committees were inactive by 1983.

A combination of ministry officials and community representatives can also make the organization subordinate to ministerial planners, as in the case of Nicaragua's Popular Health Councils at local and regional levels in the 1980s. These carried out health planning and delivery functions, and were composed of representatives from 'popular organizations' such as women's associations, the federation of health workers, the association of agricultural workers and neighbourhood bodies. However, the membership was changed to include representatives from the Ministry of Health, with the effect of diluting the independence of community representatives in planning and evaluation (Donahue, 1986).

The importance of including a representative of patients on ad hoc agencies is shown by the Philippines' Municipal Health Boards where it was clear to observers that 'The consumer's experience and information would constitute a vital link in the planning and implementation aspects of the system and the programmes' (WHO, 1994, p. 34).

Delegation: management boards

A strong form of decentralization is found when representatives from client groups can form managing bodies for local health institutions such as hospitals or health centres. According to the World Bank, 'community involvement in the *management* of health facilities is emerging as an important aspect of district-based health systems in many African countries' (World Bank, 1994a, p. 120). Decentralization of this kind may combine the management of services with the organization of productive activity and the exercise of influence on planners and decision-makers responsible for the allocation of resources. It may also include accountability to the community or groups of beneficiaries from which the board members are drawn. The WHO sees this as a method for 'promoting greater responsiveness to consumer preferences'

(WHO, 1993, p. 51). Such boards can develop long-term plans, monitor the quality of care, appoint, pay and assess the staff, assess the adequacy of resources, recommend fee levels and criteria for exemptions, purchase drugs and equipment, develop channels of communication with users, and organize health education. It is also possible to insert some of the properties of market forces into the relationships between parts of the health care system. Hospitals and other community facilities can be allowed to sell their services to purchasers within the system—family doctors, for example, using government grants to purchase primary and secondary care for their patients—and manage their facilities with considerable autonomy (Lacey, 1997).

This form of decentralization is illustrated by community involvement in Senegal on the committees set up to manage health care facilities—health huts, posts and centres. The committees select community health workers, finance their training and salaries, manage receipts from fees, and purchase drugs (NDiaye, 1990).

Participation in the management of district health facilities through community management committees has been found to improve performance by strengthening the accountability of providers to clients. The involvement of diverse groups based on kinship, ethnicity or culture facilitates the expression of grievances and collaboration in problem solving. Participation encourages a sense of ownership of, and support for, ways of solving local health problems. Empathy and trust between health care providers and their clients are encouraged (World Bank, 1994b, pp. 121–122).

Self-managing bodies can also be a way of involving hitherto excluded sections of the community in decision-making and implementation, empowering them by increasing their knowledge and status. This was clearly seen in the Berawan village of Long Jegan in Sarawak in which women formed a health committee to manage a kindergarten and children's feeding programme, having first identified child health as their top priority. An increase in the capabilities and self-reliance of village women resulted as organizational skills developed. Their prestige in the community grew as their pre-existing capabilities in child-care were recognized and acknowledged (Wong and Chen, 1991).

Experience also suggests that discussions of health costs by managing committees not only contributes to a more cost-conscious level of provision and utilization of health care, but also encourages efforts to find health-promoting alternatives such as water supplies and diets (Kasongo Project Team, 1984).

Deconcentration: field administration

The bureaucratic hierarchy in a Ministry of Health may extend from regional and district levels down to small communities in both urban and rural areas, with the employment of health workers responsible for health education, environmental health and primary care. Front-line health workers forming an extension of the formal health organization are usually referred to as village health workers, whereas those who are paid for by, and accountable to, the local community are usually called community health workers (Vaughan, 1980). VHWs are usually appointed by the professional field officer at district level and assigned to a village or group of villages. The job may involve being an animator as well as medic, with particular

reference to the organization of village health committees. VHWs are often given the task of mobilizing community representation and decision-making, so contributing to the capacity at village level for the exercise of decentralized powers. This is a badly needed role when the social organization of the village is weak.

An example is found in Nepal where village and ward health workers are an extension of the district administration providing outreach clinics, antenatal care, immunization, child growth monitoring, family planning, health education and demographic record keeping (Chaulagai, 1993).

The benefits of decentralization within a national ministry are shown by Indonesia's Comprehensive Health Improvement Programme, which was partially effective in promoting deconcentration to the provincial and local levels in the Ministry of Health, a highly centralized bureaucracy extending downwards to 27 provinces divided into 300 regencies. The programme aimed to develop the skills of field staff in the collection, management and analysis of epidemiological studies.

The main lesson to be derived from this programme is that if the technical, managerial and planning capability of field offices is improved the negotiating strength of the lower levels in the bureaucratic hierarchy will be increased. The power relationship between field offices and ministerial headquarters is thus altered. This enables the field staff to demonstrate that their decisions are more appropriate for their area than decisions taken centrally. Field offices are also able to gain support for health projects from local government. The allocation of resources then reflects the special conditions and problems of different areas, thereby achieving one of the objectives of decentralization. Better information at the periphery is, however, only a necessary and not a sufficient condition of decentralization. The Indonesian case also shows that administrative structures and budgetary controls are even more important determinants. Without changes here centralized decision-making will remain to some extent arbitrary, inflexible and inefficient in the use of resources (Bossert *et al.*, 1991).

Deconcentration also enables ministry officials to provide the support needed by other decentralized institutions. For example, village health committees may need to be supported by field personnel if the level of social organization in the village is low. This was found in Cameroun where village society had been disorganized by government economic and education policies, centralization, loss of leadership, ethnic disunity, and poor communications (Isely and Sanwogou, 1983, p. 53).

However, the professionalism of the staff of the formal ministerial hierarchy inhibits flexibility, assumes health policy can only be made by experts who have a monopoly of health knowledge, and limits the role of local people to implementation (at the most) (WHO, 1991). Thus responsiveness to local needs can be a problem for deconcentrated personnel. In the Indonesian case mentioned earlier, the extent to which provincial and local officials were able to secure variations in national policies to suit their areas was constrained. Vertical rather than horizontal accountability meant that central policy-makers still failed to change many national targets, continued to make decisions that seemed arbitrary to provincial officials, ignored provincial arguments and proposals, and persisted with inefficient and inflexible administrative procedures. Even when provincial policy initiatives were taken up centrally it did not always allow for a flexible response to provincial priorities (Bossert *et al.*, 1991). Similar problems have been experienced in Zimbabwe and Thailand (Nitayarumphong, 1990, p. 251; Woelk, 1994, p. 1033).

Deconcentration: health teams

Authority decentralized to health officials of central ministries is frequently exercised collectively through health teams at regional or district level (Tarimo, 1991, p. 82). In Botswana, for example, regional health teams consists of the regional medical officer, the regional public health nurse and the regional health inspector (Maganu, 1990). The district health management teams set up in Ghana in 1978 to provide horizontal links between separate divisions within the Ministry of Health, each with its own staff, interventions, management systems, communications, transport and in-service training, have worked well, despite fears on the part of technical divisions of loss of control and therefore programme coverage and effectiveness (Cassels and Janovsky, 1992).

However, intrasectoral coordination may be inhibited (as in parts of Colombia) by managers having different levels of delegation, institutional jealousies and lack of commitment resulting from unstable employment (WHO, 1994, p. 1; see also Harpham and Pepperall, 1994).

Deconcentration: interdepartmental committees

The importance of inter-sectoral and inter-departmental coordination and collaboration is widely acknowledged when the health status of the population is a function of so many socio-economic variables and therefore the decisions of different government agencies. The health sector alone cannot improve the health of the population. Education, water supply, sanitation, nutrition and even inequalities of income need to be tackled as well (Muhondwa, 1986; Tarimo and Fowkes, 1989). Intersectoral committees can facilitate the sharing of resources and information. They can disseminate information about the objectives of PHC and promote activities in non-health sectors that will benefit the health of communities. Even at the village level, coordination between sectors, as well as collaboration with non-governmental health provision, can be neglected. Hence the importance of formal mechanisms to bring together officials from different central agencies whose activities have implications for health promotion and disease prevention (Vaughan *et al.*, 1984; WHO, 1988b, p. 47; Tarimo, 1991, pp. 69–70).

However, experience in Botswana suggests that intersectoral collaboration is best served by having local health personnel under a local authority (district and town councils), compared with development committees and extension teams of officials from central departments with different levels of delegation that impedes decision-making (Maganu, 1990, p. 54).

A similar lesson is drawn from the experience of district development teams in PNG from 1991 to 1993. Fifteen of the 19 provinces created district offices under District Administrators with teams of officials from the provincial ministries including health staff. The quality of health services deteriorated because of the absence of accountability to elected representatives at district level. Noting a similarity between the problems of district administration with those experienced when provincial devolution was introduced, Campos-Outcalt *et al.* identified the absence of an elected assembly at one level and not the other as a key difference. The

district administrations operated free from both provincial and district oversight, increasing the opportunities for financial abuse and patronage (Campos-Outcalt *et al.*, 1995, p. 1097).

THE PRIMACY OF POLITICS

Whatever the institutions used for decentralization, the ensuing process of decision-making will be highly charged politically. The choice of representative government as a means of delivering health services locally builds constitutional politics into the decision-making process, especially the recruitment of office-holders and the choice of policy priorities. In PNG, for example, decentralization was found to be associated with increased politicization. Devolution opens up opportunities for corruption and political patronage though these are by no means the exclusive preserve of local government, being found in other forms of decentralization.

Power politics will be present whatever the organizational form chosen. As in Senegal, health committees can fall prey to political party factions, which lead to health problems taking second place to 'personal quarrels' (NDiaye, 1990, p. 112). This is a risk with whatever method of recruitment to office is used. India's Community Health Volunteers were selected by doctors in the primary health centres from among candidates nominated by the 'community'.⁵ This did not prevent party politicians and elected representatives intervening in, politicizing and, in some cases, controlling the selection (backed by sanctions against doctors such as threats of transfer) in order to penetrate village life, reinforce a local client's obligations, or secure the dominance of a political faction (Jobert, 1985, pp. 15–16).

All forms of participation are capable of intensifying social and political conflict. Participation is widely recognized as a problem in poor countries because of political inequality and dependency, illiteracy, poverty, poor communications, physical insecurity, professional and bureaucratic hostility, political centralization and tokenism. 'Communities' are not socially homogenous and the greater the inequality the more difficult participation is likely to be. Programmes aimed at strengthening the position of the poor may exacerbate conflicts with local and national elites, which may have to be coopted before a programme can run successfully.

Community leaders do not always act to the benefit of all. The early phases of committee management of health centres in Kisantu, Zaire between 1979 and 1981, found members seeking privileges and recognition from participation. Only later did they get down to managing health care delivery (Lamboray and Laing, 1984). Government planners and community workers do not necessarily share the same goals (Rifkin, 1986a).

Without doubt, the most serious mistake any reformer can make is to assume decentralization to be a managerial exercise devoid of political cause and consequence.

⁵i.e. those who attended an information meeting convened by the doctor, those who came forward after a 'summary call for applications', or those put forward by village heads and a few local leaders.

REFERENCES

- Behrnhorst, C. (1984). 'Health in the Guatamalan highlands', *World Health Forum*, **5**.
- Bloom, G. H. and Gu, X. (1997). 'Introduction to health sector reform in China', *IDS Bulletin*, **28**, no. 1.
- Bloom, G. H. *et al.* (1991). 'Health programme planning for consolidation and quality', *World Health Forum*, **12**.
- Bossert, J. T. *et al.* (1991). "'Bottom up" planning in Indonesia: decentralization in the Ministry of Health', *Health Policy and Planning*, **6**, no. 1.
- Campos-Outcalt, D. *et al.* (1995). 'Decentralization of health services in Western Highlands Province, Papua New Guinea: an attempt to administer health service at the subdistrict level', *Social Science and Medicine*, **40**, no. 8.
- Cassels, A. (1995). 'Health sector reform: key issues in less developed countries', *Journal of International Development*, **7**, no. 3.
- Cassels, A. and Janovsky, K. (1992). 'A time of change: health policy, planning and organization in Ghana', *Health Policy and Planning*, **7**, no. 2.
- Chaulagai, C. N. (1993). 'Urban community health volunteers', *World Health Forum*, **14**.
- Collins, C. and Green, A. (1994). 'Decentralization and primary health care: some negative implications in developing countries', *International Journal of Health Services*, **24**, no. 3.
- Deng, W. *et al.* (1997). 'Village health services in rural China', *IDA Bulletin*, **28**, no. 1.
- Donahue, J. M. (1986). 'Planning for primary health care in Nicaragua: a study in revolutionary process', *Social Science and Medicine*, **23**, no. 2.
- Gilson, L. *et al.* (1994). 'Local government decentralization and the health sector in Tanzania', *Public Administration and Development*, **14**, no. 5.
- Gu, X. *et al.* (1995). 'The financing and organization of health services in poor rural China: a case study of Donglan country', *International Journal of Health Planning and Management*, **10**, no. 4.
- Gutierrez, R. A. (1990). 'Implementing decentralization of local services: a case-study from Mexico', in Mills, A. *et al.*, *Health System Decentralization. Concepts, Issues and Country Experience*, World Health Organization, Geneva.
- Halliman, A. and Williams, G. (1983). 'Can people move bureaucratic mountains? Developing primary health care in rural Indonesia', *Social Science and Medicine*, **17**, no. 19.
- Harpham, T. and Pepperall, J. (1994). 'Decentralizing urban health activities in developing countries', *Development in Practice*, **4**, no. 2.
- Heiby, J. R. (1982). 'Some lessons from Nicaragua', *World Health Forum*, **3**, no. 1.
- Hurley, J. *et al.* (1995). 'Geographically decentralized planning and management in health care: some informational issues and their implications for efficiency', *Social Science and Medicine*, **41**, no. 1.
- Inambao, A. W. *et al.* (1987). 'Revitalising primary health care', *World Health Forum*, **8**, 200–203.
- Isely, R. B. and Sanwogou, L. L. (1983). 'The itinerant health worker: an experiment in rural health care delivery', *African Journal of Medicine and Medical Science*, **21**, no. 1.
- Jobert, B. (1985). 'Populism and health policy: the case of community health volunteers in India', *Social Science and Medicine*, **20**, no. 1.
- Kasongo Project Team (1984). 'Primary health care for less than a dollar a year', *World Health Forum*, **5**, 211–215.
- Lacey, R. (1997). 'Internal markets in the public sector: the case of the British National Health Service', *Public Administration and Development*, **17**, no. 1.
- Lamboray, J.-L. and Laing, C. (1984). 'Partners for better health', *World Health Forum*, **5**, 30–34.
- La Forgia, G. M. (1985). 'Fifteen years of community organization for health in Panama: an assessment of current progress and problems', *Social Science and Medicine*, **21**, no. 1.
- Maganu, E. T. (1990). 'Decentralization of health services in Botswana', in Mills, A. *et al.*, *Health System Decentralization. Concepts, Issues and Country Experience*, WHO, Geneva.
- Mangelsdorf, K. L. *et al.* (1988). 'Primary health care and public policy', *World Health Forum*, **9**, 509–513.
- McPake, B. *et al.* (1993). 'Community financing of health care in Africa: an evaluation of the Bamako Initiative', *Social Science and Medicine*, **36**, no. 11.

- Mills, A. (1994). 'Decentralization and accountability in the health sector from an international perspective: what are the choices?', *Public Administration and Development*, **14**, no. 3.
- Mills, A. *et al.* (eds) (1990). *Health System Decentralization. Concepts, Issues and Country Experience*, World Health Organization, Geneva.
- Mogedal, S. *et al.* (1995). 'Health sector reform and organizational issues at the local level: lessons from selected African countries', *Journal of International Development*, **7**, no. 3.
- Muhondwa, E. P. Y. (1986). 'Rural development and primary health care in less developed countries', *Social Science and Medicine*, **22**, no. 11.
- NDiaye, J.-M. (1990). 'Decentralization of health services in Senegal', in Mills, A. *et al.* (eds), *Health System Decentralization. Concepts, Issues and Country Experience*, WHO, Geneva.
- Newbrander, W. C. *et al.* (1991). 'Performance of the health system under decentralization', in Thomason, J. *et al.* (eds), *Decentralization in a Developing Country. The Experience of Papua New Guinea and its Health Service*, Pacific Research Monographs, No. 25, Australian National University, Canberra.
- Nitayarumphong, S. (1990). 'Evolution of primary health care in Thailand: what policies worked?', *Health Policy and Planning*, **5**, no. 3.
- Oakley, P. (1989). *Community Involvement in Health Development: An Examination of the Critical Issues*, World Health Organization, Geneva.
- Rahim, I. M. A. *et al.* (1992). 'Smaller health areas for a better service', *World Health Forum*, **13**, 31–37.
- Regan, A. J. (1991). 'The legal framework for decentralization of health functions', in Thomason, J. *et al.* (eds), *Decentralization in a Developing Country*.
- Reilly, Q. (1989). 'More power to the people', *World Health Forum*, **10**, 473–476.
- Reilly, Q. (1990). 'Experience of decentralization in Papua New Guinea' in Mills, A. *et al.* (eds), *Health System Decentralization. Concepts, Issues and Country Experience*, WHO, Geneva.
- Rifkin, S. B. (1986a). 'Health planning and community participation', *World Health Forum*, **7**, 156–162.
- Rifkin, S. B. (1986b). 'Lessons from community participation in health programmes', *Health Policy and Planning*, **1**, no. 3.
- Shaw, R. P. and Griffin, C. C. (1995). *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*, World Bank, Washington DC.
- Smith, B. C. and Stanyer, J. (1976). *Administering Britain*. Martin Robertson, Oxford.
- Smith, D. L. and Bryant, J. H. (1988). 'Building the infrastructure for primary health care: an overview of vertical and integrated approaches', *Social Science and Medicine*, **26**, no. 9.
- Solano, E. C. (1988). 'The open road to health', *World Health Forum*, **9**, 461–463.
- Tang, S. (1997). 'The changing role of township health centres', *IDS Bulletin*, **28**, no. 1.
- Tarimo, E. (1991). *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care*, WHO, Geneva.
- Tarimo, E. and Fowkes, F. G. R. (1989). 'Strengthening the backbone of primary health care', *World Health Forum*, **10**, 74–79.
- Thomason, J. A. *et al.* (1991). 'Decentralization of health services in Papua New Guinea: a critical review', in Thomason, J. *et al.* (eds), *Decentralization in a Developing Country*.
- Thomason, J. A. *et al.* (1994). 'User charges for rural health services in Papua New Guinea', *Social Science and Medicine*, **38**, no. 8.
- Twumasi, P. A. and Freund, P. J. (1985). 'Local politicization of primary health care as an instrument for development: a case study of community health workers in Zambia', *Social Science and Medicine*, **20**, no. 10.
- Vaughan, P. (1980). 'Barefoot or professional? Community health workers in the Third World', *Journal of Tropical Medicine and Hygiene*, **83**, no. 1.
- Vaughan, P. *et al.* (1984). 'The importance of decentralized management', *World Health Forum*, **5**, no. 1.
- Walker, G. J. A. and Cham, M. K. (1981). 'The need for an integrated approach to the provision of essential health care services: a study from the Gambia', *Journal of Tropical Medicine and Hygiene*, **84**, 203–208.

- Woelk, G. B. (1994). 'Primary health care in Zimbabwe: can it survive? An exploration of the political and historical developments affecting the implementation of PHC', *Social Science and Medicine*, **39**, no. 8.
- Wong, M. L. and Chen, P. C. Y. (1991). 'Self reliance in health among village women', *World Health Forum*, **12**, 43–48.
- World Bank (1994a). *Better Health in Africa. Experience and Lessons Learned*, World Bank, Washington DC.
- World Bank (1994b). *Philippines. Devolution and Health Services: Managing Risks and Opportunities*, Report No. 12343-PH, Country Department, Population and Human Resources Operation Division, East Asia and Pacific Region Office.
- World Health Organization (1988a). *Strengthening Ministries of Health for Primary Health Care*, Technical Report No. 766, WHO, Geneva.
- WHO (1988b). *The Challenge of Implementation: District Health Systems for Primary Health Care*, WHO, Geneva.
- WHO (1991). *Community Involvement in Health Development: Challenging Health Services*. Technical Report No. 809, WHO, Geneva.
- WHO (1992a). *The Hospital in Rural and Urban Districts*, Technical Report No. 819, WHO, Geneva.
- WHO (1992b). *The Role of Health Centres in the Development of Urban Health Systems*, Technical Report No. 827, WHO, Geneva.
- WHO (1993). *Evaluation of Recent Changes in the Financing of Health Services*, Technical Report No. 829, WHO, Geneva.
- WHO (1994). *Health Development Structures in District Health Systems. The Hidden Resources*, WHO, Geneva.