THE QUEST FOR HEALTH CARE DECENTRALIZATION: REVISITING DECREE 159

K.M. Kassak, A. Mohammad Ali, Mitra Tauk, and A.M. Abdallah*

ABSTRACT. Many developing countries have at some point in their quest for health reform considered decentralization as a strategy. A search of Lebanese health policy texts revealed a call for some form of decentralization in the mid-eighties through Decree 159. This paper highlights the experience of health centers in Lebanon and discusses the importance of implementing an incremental decentralization of the system by highlighting the importance of ensuring political commitment as well as building the capacity of administrative and clinical staff as prerequisites for the implementation of a fully decentralized system.

INTRODUCTION

The primary reason behind calling for decentralizing health care is the strong belief that decentralization has potential for improving the quality of services provided, and allowing for better coverage, thus leading to increased equity in the delivery of care. However, the exact methods for achieving these benefits, in addition to the real impact of decentralization are not yet fully understood (Mliga, 2003; Bossert, 1998; Collins, 1994; Aitken, 1998). Moreover, testing the real impact of decentralization as one strategy of health reform in order to be able to attribute its benefits or losses cannot be performed except

* K.M. Kassak, Ph.D., Associate Professor, A. Mohammad Ali, MPH, Instructor, M. Tauk, RN, MPH, Research Assistant, and A.M. Abdallah, RN, MPH, Instructor, are teaching at the Department of Health Management and Policy, American University at Beirut. Dr. Kassak’s research interests are in health management and human resources development. Ms. Mohammad-Ali’s research interests are in health policy analysis, Mr. Abdallah’s research interests are in human resources and health management

Copyright © 2007 by PrAcademics Press
under ideal circumstances (Sheridan, Sidorukfrom, & Carefoote, 2001).

OVERVIEW

Over the past two decades, decentralization has been incorporated into the healthcare systems of several countries (Bossert, 1998; Lakshminarayanan, 2003; De Vries, 2000; Hutchinson, 2002). Decentralization involves the transfer of decision rights, responsibility and accountability from higher authorities located in the center to lower authorities located at the local level or at the periphery (Collins, 1994; Lakshminarayanan, 2003; Wangi, et al., 2002; Brinkerhoff & Leighton, 2002). Moreover, decentralization takes many different forms, which include deconcentration, delegation, devolution and privatization (Bossert, 1998; Aitken, 1998; Brinkerhoff & Leighton, 2002; Mills, 1994), although the latter has not been often recognized as a real form of decentralization (Bossert & Beauvais, 2002). These forms vary depending upon the level of empowerment given in terms of decision rights, financial administrative function and power over residual revenue, allegiance to beneficiaries (consumers) and responsiveness to market pressures, and the structure and mechanisms of accountability (Harding & Preker, 2003).

There are several reasons for promoting decentralization, including increasing service delivery effectiveness, efficiency of resource allocation, health worker motivation, financial lucidity, community participation and representation, in addition to equity and private sector participation (Hutchinson, 2002; Brinkerhoff & Leighton, 2002). Nonetheless, the success of decentralization in meeting these objectives depends on many dynamics and circumstances. It is believed that by expanding the power at the district level and by moving to a more horizontally structured system of health care, resistance to change may develop among those who are at risk of losing power from decentralization (Aitken, 1998). Initial losses in efficiency and increased liability may also occur as power is transferred to lower levels until administrators become accustomed to their new responsibilities (Bossert & Beauvais, 2002). Other reasons for practicing decentralization include increasing local ownership and accountability, strengthening integration of services at the local level, creating a realistic and integrated health service that
accommodates local preferences, controlling costs of targeted health programs and improving their implementation, and reducing discrimination that results in differences in healthcare delivery to rural and urban populations (Aitken, 1998; Hutchinson, 2002).

In choosing governance strategies, countries opted for decentralization based on the hypothetical benefits rather than the more tangible facts of real experiences of other countries (Smith, 1997). These experiences vary greatly worldwide. For example, in the state of Ceara in northeast Brazil, decentralization was correlated with improved performance in only 5 of 22 performance indicators used in the study. The main findings of this study showed that informal management and political influences appeared to be more imperative indicators when compared to decentralization, and that the effects of good management practices were found to be the cause of decentralization and not vice versa (Atkinson & Haran, 2004). On the other hand, in the Philippines, decentralization exacerbated inequities, decreased the effectiveness and efficiency of service delivery, and weakened local commitment to primary health concerns (Lakshminarayanan, 2003).

Furthermore, a mixed experience was observed in Ghana with improvements in some areas but deterioration in others. In the decentralization of sexual and reproductive services, deconcentration of budgets succeeded in improving financial flow while decision-making remained a centralized function. However, due to the lack of capacity for planning, supervision and training at the district and regional administrative levels, confusion of responsibilities and deterioration of services resulted (Mayhew, 2003).

In contrast, the traditional hierarchies in New Zealand were almost entirely replaced through the decentralization of decision making to integrated patient groupings. Managers reported greater liability and commitment to the clinical staff. Greater efficiencies, better accountability of doctors, innovation and team building, and improved performance and service quality were all achieved under decentralization (Malcolm & Barnett, 1995).

With these examples in mind, decentralization should not be viewed as an ideal situation to improve the health care system. In the absence of political commitment, appropriate planning and acknowledgment of the lessons learned by other countries,
decentralization of health care can be unsatisfactory at best if not damaging. In essence, one would then wonder if countries are instituting decentralization based on their hypothesized benefits or on empirical evidence.

THE SITUATION IN LEBANON

Primary health care started to be well recognized as the basic structure of health care in almost all countries—including Lebanon—after the introduction of the "Health-For-All" declaration (“Declaration of Alma-Ata,” 1978). To achieve that basic structure, Lebanon committed to providing primary care through centers of comprehensive services operated by the public sector including the Ministry of Public Health (MOPH) and Ministry of Social Affairs (MOSA), and several Non-Governmental Organizations (NGOs).

The first center for complete services was established in 1970 in a suburb of Beirut, the capital. Following this successful project, twelve other centers were launched in other regions between 1974 and 1979. In a later period, changes at the legislative level came to pass, including changes in the role of the ministry of health, but most importantly the push by the Lebanese government to set the integration of family planning into primary health care services in all health units as a top priority (Mrouweh & Kronfol, 1985).

However, as a consequence of the civil war, the public sector experienced severe resource loss and malfunction in its role as a financer, provider and regulator of health services. This resulted in the dominance of the private sector, with the emergence of several nongovernmental, private, charitable and sectarian health organizations (World Health Organization, 1983). A deteriorated public sector and a highly inefficient and unregulated private sector led to a malformed health system. This chaos triggered decision makers to reconsider the current practices of health services delivery at the PHC level, which led to the enactment of Decree 159 in 1983. The purpose of this decree was to establish serious cooperation between the government and the private sector, and advocate the need to restructure the health care system by adopting a decentralization strategy.

The decree stipulated that a health district should be established for approximately two hundred thousand residents, and that a center
should cover the care of thirty thousand residents. The decree also emphasized the importance of having a health council for every health district. This would enable a better system for monitoring the care delivered, and thus more control over the quality and effectiveness of care. The health council was to include representatives from all the general directorates concerned with health affairs, representatives of health services beneficiaries, and representatives from the medical field. This was hailed as an invitation from the central government to citizens to participate in the management of their health district affairs (Mrouweh & Kronfol, 1985).

Nevertheless, once more, the war created a setback of the full execution of the enacted policies, resulting in further depreciation in the public sector and large disparities in quality between private and public providers (The Research and Consultation Enterprise and the Lebanese Population Help Society, 1993). Furthermore, the administrative structure was hampered by the lack of computerization and informatics, outdated legal passages and decrees, and irrational and politically bound employment and contracting, resulting in a surplus of unqualified personnel. In addition, there was a tremendous need for the development and application of a performance appraisal system. The structure was also suffering from the high cost of rented buildings and furnishings and the need to simplify and minimize bureaucracy in administrative operations and to accelerate the flow in contracting (Research and Guidance Department, Council of Ministers, 1999).

In conclusion, the system in Lebanon before 1983 was centralized, however, after that period and as a result of many propositions to improve the structure and quality of health services, the Ministry pushed for a pseudo-decentralized system by passing Decree 159 in 1983. To evaluate the performance of that enactment, one has to examine the level of decentralization in decision-making and how that affects administrative efficiency at the local level (Mrouweh & Kronfol, 1985). Even though the concept in relation to PHC in the centers is to have a "centralized control and a decentralized implementation" (World Health Organization, 2001), it is not yet clear how much centers at the ground level are really decentralized and how much they are given the authority for decision-making at the administrative and financial levels. This triggers the
need to assess the exact level of decentralization before attempting to assess the quality of care in those centers.

METHODOLOGY

The aim of this study was to assess the level of decentralization of PHC in the Lebanese health care system and its implications on the quality of care at this level. The study used a case approach focusing on two commonly used centers under the jurisdiction of the Ministry of Social Affairs (MOSA) in the Greater Beirut area. First, the study assessed the scope of decentralization implemented at the public health sector in Lebanon, and more specifically the level of decentralization implemented by the MOSA in managing their PHC centers. Management functions investigated include: financing, human resources management, and material management. Next, several dimensions of quality of care in the centers were measured according to their conformity to the following set of standards:

- **Structural Components**
  - Structural safety and maintenance of buildings and medical equipment,
  - Housekeeping and hygiene practices,
  - Sterilization procedures,
  - Medication storage and dispensing, and
  - Confidentiality and maintenance of medical records

- **Quality of Clinical Process**
  - History taking,
  - Infection control measures, and
  - Counseling.

Selection of these dimensions was based on their relative importance in defining quality of services provided based on the literature and previous studies (Rafeh, 2001; Rosen, 2000; Sofaer, 1998; Zinn, 1998).
**Study Methods**

In order to assess the level of decentralization at the primary health care level and its implications on the quality of care at the two MOSA centers in Lebanon, a previously trained surveyor team visited the centers and used three survey methods to establish a baseline on the facilities' compliance with the surveyed standards.

The team first reviewed a random sample of 40 medical records per center. The contents of both administrative and clinical records were reviewed against a checklist that included optimal international standards. Documents examined in each facility included facilities policies and procedures, clinical practice guidelines, human resources development files in addition to the patient medical/clinical records.

The team also observed patient - physician interactions (all patients $N=280$), the staff while performing their jobs, and the physical facility and its surrounding environment. Furthermore, surveyors observed managers, medical teams, administrative staff, personnel and patients to verify and validate the information gained from other sources of data collection in this survey (records and interviews). As in the record review process, all observations were recorded on a pre-determined checklist, which verified whether specific encounters had occurred or not.

The third survey method used by the team was interviews with management staff (center directors). These interviews were important as they complemented information obtained from the record review process and the observation process, and were also used to verify information not adequately reported in the latter.

The data collection tools (interviews and checklists) were subjected to pilot testing prior to implementation. Interviewers and observers were trained by professionals to avoid any bias and leading answers. Data collection extended over a period of three months.

**Data Analysis**

In order to assess the quality of health services provided at the two MOSA centers, measured parameters for the components previously mentioned were compared against standards taken from previous research and established by international health care
agencies. Statistical data analysis was performed using the software SPSS version 11.5. It was done through calculation of expected percent episodes or percent cases meeting the expected outcome with 100% as the ideal standard.

RESULTS

Decentralization scope in managerial performance

Based on the data collected from the directors, it was evident that both centers work under a very strict centralized managerial system due to laws and regulations imposed by the MOSA. The current managerial system limits the center directors’ authorities and responsibilities in almost all key managerial areas. At the financing level, all operational financing is provided by MOSA. Directors do not have the authority to raise local funds to support some of their operational or health program expenses without receiving MOSA permission to do so. Budgets are first proposed by the center directors to MOSA, which is where most of the decisions regarding budgetary and programmatic structures are made, and adjustments are made by the Ministry depending on the availability of financial resources at the level of the Council of Ministers. The center directors only monitor and control the center expenditures against the set budget. Both centers face several financial issues due to the delays in the disbursement of funds needed to cover most of their operational expenses.

Under the human resources managerial function, all responsibilities related to human resources policies for recruitment and employee wages and benefits are centrally bound. The facility directors perform no human resource planning and do not have the authority to hire or fire. Accordingly, both centers reported that they do not follow any employee performance evaluation system, have no employee benefits and incentive system, have no promotion system in place, and have no wage review system. Employees at both centers are not subjected to any routine medical examinations before or during their employment. Staff development and in-service training are also determined at the MOSA level, whereby the directors’ responsibility in this area is restricted to nominating employees for available training programs posted or referred by MOSA.
Under material management, again the directors’ authority is very limited. The essential drug list used by both centers is established at the central level. Drug selection, procurement and distribution are centrally bound and the center is only responsible for storing and dispensing the available drugs. Neither center had written policies regarding drug inventory control system or procedures for discarding expired drugs. The same findings were reported when asked about all other medical supplies and equipment. All acquisitions are done at the central level with only maintenance performed at the local level. The centers also did not have any written policies regarding equipment and physical facility maintenance, and reported major delays in maintaining their equipment as a result of fund disbursement delays.

Quality of care

Structural Components

Observation of facilities and environment of both health centers revealed that they had no policies and procedures regarding hazard control, the ventilation system, handicap accommodation, or plans in case of emergency or fire. In addition, even though their machines were being maintained, both centers had no schedule for machine maintenance.

Furthermore, neither center had written policies or guidelines regarding proper cleaning methods. Interviews of housekeeping staff revealed that staff members at both centers did not receive any formal training on proper cleaning and sanitation methods.

In accordance with clinical safety and sterilization procedures, both centers have an autoclave for disinfection, but even though the directors reported that their staff members are trained in its use, the research team observed many violations performed by various staff members. Unfortunately, neither of the two centers had written protocols for infection control or for discarding medical wastes, and none of the staff were trained on infection control as reported by the directors and staff.

Upon examination of pharmaceutical services, analysis revealed that both centers possess a technique to store drugs but have no written protocols for disposal of expired drugs. During the observations, the research team found expired drugs that were
placed with valid drugs. The drug storage facilities at both centers were inadequate, as there was no proper ventilation system, no proper lighting, the area was open with no lock, and the space was small. When observing the drug distribution processes at both centers, it was found that patients using generic drugs (dispensed in plastic bags) did not receive any written instructions for mode of drug use or dosage. Inefficient use of resources was also observed.

Upon reviewing the medical records in the centers, results showed that there was a designated employee in-charge of the medical records. However, both centers did not have any written policies on records’ confidentiality and maintenance.

**Quality of Clinical Process**

The study examined the comprehensiveness of medical histories recorded by providers. The analysis involved all clients who were new to the center and not previously seen by the health care provider elsewhere. It was noted that 34% of all new clients were asked about prior medical illnesses, 18% were asked about previous surgeries, and only 10% were asked about past hospitalizations. A medication history was solicited in only 14% of encounters with new clients and only 7% were asked about their family’s medical history. A social history, which includes questions about smoking, alcohol and drug use in addition to questions about the client’s family and home environment, was solicited in only 12% of encounters with new clients.

Infection Control and hygiene practices were also assessed by the observers during the medical encounter. It was observed that in 17% of the encounters, the provider washed his/her hands both before and after examining the client as recommended for infection control. In 50% of the encounters, the physician washed his/her hands only once after examining the client. The more striking finding was that in 33% of the encounters, the physician did not wash his/her hands before or after examining the client. It was noted that 19% of pelvic exams and Pap smears were performed without the use of examining gloves by the physician.

Finally, some counseling was provided by the health care providers during the medical encounter. The results showed that 79% of all clients who were coming for their first visit to the center
received no counseling at all. Of those who returned for follow up, 72% also did not receive counseling.

**DISCUSSION AND CONCLUSION**

More than 20 years after the passing of Decree 159, the Lebanese PHC system remains centralized. Quality indicators showed major deficiencies in the delivery of health services, which at face value can be reconciled with effective performance improvement at the local periphery level, theoretically speaking. As a matter of fact, PHC center directors have no authority whatsoever in managing their functions and are fully dependent on the central government for their decision-making. Effectiveness of the PHC system should not be judged before assessing the implications of the system in place on the quality of care being provided. However, the current study has shown evidence that under centralization the quality of care provided was in general unsatisfactory although there were some positive elements.

In the twenty years following initial passage of Decree 159, documentation has shown evidence of the many problems faced in PHC centers, most important of which is the bureaucracy found in the system marked by the ever standing hierarchies. Directors, being left with no authority, had no motivation or incentive to improve the provision of services under their leadership. This was reflected in the inefficient use of resources, lack of training of staff, and complete absence of performance appraisal, which affected the quality of work performed by the employees. No written policies, procedures or protocols were found for any managerial responsibilities; all of this resulting in poor quality of care being delivered by the centers.

There is no question that the country’s public sector has not recovered from the recession created by the civil strife. The inherited structures and resources are some of the symptoms of that and possibly the root of the inability of the system to reform itself. That is why change has to come in strides. The first step toward reform is not complete decentralization but rather an incremental change achieved by gradual empowerment of center directors in regard to decision rights, responsibility and accountability.

In addition, policy makers must be made aware of the different forms of decentralization, and need to understand which aspects of management need to be decentralized. This would lead to a more
efficient system with improved quality. Ministry and other central officials need to widen their scope of managerial capacity and exercise some restraint in their tendency to over control. Again, it need not be revolutionary as in New Zealand (Malcolm & Barnett, 1995); the change could be accomplished with an evolutionary approach. The administration could initiate areas of empowerment in managerial functions such as human resources management. In that area for example, center directors are knowledgeable of the goals to be achieved in their centers, they know what it will take to get there and they know the capabilities of their staff and their need for capacity building. Parallel to that, managers must be further trained to be capable of carrying out more effective managerial processes. This is necessary but cannot be sufficient without appropriate venues allowing managers to practice acquired knowledge.

This highlights some of the basic requirements for improving the quality of care being provided, which can be summarized as follows:

- Developing and enforcing written policies and procedures to standardize managerial work processes;
- Training physicians and other medical personnel on infection control practices and health counseling;
- Revising the current system of staff appraisal to help in evaluating and motivating staff to improve performance; and
- Developing a monitoring and evaluation system, which would help the administration in quality assurance.

Further research in the area of governance is necessary to learn more about the potential impacts of decentralization on the management of PHC centers in the country. In addition, previous experiences of other countries as well as the perceptions of central and local managers in Lebanon need to be closely examined. Conceivably then can we revisit Decree 159 and make sure that the system is functioning accordingly.

REFERENCES


