DECENTRALIZATION AND RECENTRALIZATION: EFFECTS ON THE HEALTH SYSTEMS IN LAO PDR

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Abstract. In Lao PDR, lack of skilled manpower and financial resources in the central government, plus the policy urging local authorities to be self-sufficient and self-reliant caused the central government to decentralize all sectors to the provincial level in 1987. After 1987, the provinces took over all responsibilities such as planning, financing and provision of health services, only informing the Ministry of Health (MOH) about their activities. Because of economic differences between the 18 provinces, health services became unequal between the richer and poorer provinces. Some provinces generated high revenues, leading to over spending. The decentralized system had some negative impacts on the health service. The technical and planning functions managed from the ministry level became separated from management and financial decision making at the local level, and the ministry lost influence on the direction of health policy. Salaries from the local government were often delayed. Because health budgets were not allocated centrally by the Ministry of Health, there were no mechanisms by which health resources could be distributed preferentially to poorer areas with greater need. However, donors continued to support health programs through the Ministry of Health, sending drugs, vaccines, and other supplies to the provinces. The implementation of decentralization faced many difficulties due to the lack of experienced staff and insufficient training required for practicing decentralization. Similar problems in other sectors, such as agriculture, education, and communication, caused the central government to retake control from the provinces in 1992. During the recentralization period, utilization of health facilities increased. The Ministry of Health set rules and established regulations to strengthen the health system. A cost-recovery system was introduced to obtain additional funds, and conditions in the provinces gradually improved. The unique situation of decentralization followed by recentralization provides an excellent opportunity for study. We reviewed documents relating to these periods and interviewed officials at all levels who were concerned with the process.

INTRODUCTION

Lao PDR (the Lao People's Democratic Republic) is a landlocked country in the center of Southeast Asia, bordering on Vietnam, Thailand, Cambodia, China, and Myanmar. It has one of the lowest levels of health sector financing in the world (The World Bank, 1990). In 1995-1996, reported life expectancy at birth (both sexes) was 52.2 years, and the infant mortality rate was 102 per thousand live births. Reported maternal mortality rate in 1990 was 650 per 100,000 live births (UNDR, 1995-1996). Lao PDR is divided administratively into three levels: central government, 18 provinces including Vientiane Municipality, with a total of 135 districts.

When the Lao People's Democratic Republic (Lao PDR) was established in 1975 , all administration was centralized. All health services were provided by the government, with no private sector. Ministries were allocated resources, formulated national plans, and developed and managed budgets for their respective sectors. Provincial and district authorities merely implemented plans and administered budgets received from central ministries.

Beginning in 1985, the government implemented a series of integrated reforms intended to improve productivity in all public sectors, in-

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cluding health. Among these was the New Economic Mechanism (NEM) designed to stimulate economic development (MoH, Lao PDR, 1993). After 1987, the central government delegated to provincial authorities responsibility for revenue generation, collection and management, public administration, and provision of public services. Under the NEM, market mechanisms were introduced, some drug factories and pharmacies were privatized, and physicians were permitted to practice privately after official working hours.

Difficulties in implementation caused the central government to retake control from the provincials in 1992, under Decree 73/PM of the Prime Minister's Council. The Minister of Health (MOH) again became responsible for formulating strategies, planning, regulating, and revitalizing the entire health system.

We believe that no other nation has undergone a similar series of changes. This study was designed to understand the effects of decentralization and recentralization on the health care system. To do this, we have studied differences in organizational processes over this period in seven of the eighteen provinces of Lao PDR. Special attention has been given to the sources, flow and use of funds; arrangements for income from cost recovery; the process of planning and budgeting; and policies concerning the health services staff. We have also studied ultilization rates by province, district, and health center. The study covers a ten year period: five years of decentralization (1987 to 1991) and five years after recentralization (1992 to 1996).

MATERIALS AND METHODS

For the descriptive study, information was obtained and analyzed by a team consisting of the eight authors. Seven provinces, selected to represent different economic levels and regions of the country, were studied: Luang Namtha, in the northern area, relatively poor; Luangprabang in the northern area, relatively rich; Vientiane, in the central area, average; Bolikhamsay, in the central area, average; Khammuane, in the central area, relatively rich; Champasack, in the southern area, relatively rich; and Saravane, in the southern area, relatively poor. At least two team members went to each province.

Interviews at the offices of the MOH, Ministry of Finance, provincial governors, provincial health departments, and district health offices provided qualitative information during semi-structured interviews using written questionnaires. Some quantitative data, such as the ultilization of outpatient and maternal and child health services (Fig 2 and Table 4) were collected from records of health facilities. Data obtained from records at central, provincial, and district levels dealt with the sources and amounts of public health expenditure per capita, and the number of medical doctors, medical assistants, and nurses per capita, by district. National level data were obtained from central government sources and from international agencies, as indicated.

RESULTS

Financing

Period of decentralization (1987 to 1991). Before 1987, provinces were required to send funds to the central government, which returned a portion to the provinces according to their needs. With the NEM, each province retained its own revenue, which was used to operate public services, including the health system, according to their own plans. Salaries and routine operating costs of the health services at provincial and district levels had to be met by the respective local government sector, although the cost of drugs at district level was subsidized by the provincial government. Very often salaries of the staff were delayed for many months. Local governments could not afford maintenance of buildings, vehicles or equipment. No funds were available to control disease outbreaks, and the MOH was called on for emergency support.

In interviews, provincial governors reported that provinces having high revenues could regularly distribute salaries to their staffs, whereas in provinces with low income generation, salaries were paid only every 3 or 6 months. District hospital officials in poorer provinces said that their workers got 30 kg of rice per month as salaries, but no money. Officials of provincial health departments in some poorer provinces said that the salaries of their staff came from the central government, but were not paid on time.

There was a steady decline in health as a proportion of total government expenditures

during this period (Table 1). Government health expenditures as a proportion of GDP also declined. As there was no effective means by which wealthier provinces could subsidize poorer provinces, disparities between provinces increased. Those provinces which were poor in terms of human and material resources were unable to meet the costs of the public services, whist rich provinces could earn and retain profits.

External donor assistance for health remained more or less stable during this period. The decline in 1989 due to withdrawal of support from the Soviet Union was made up from multilateral sources in later years (Fig 1).

No data are available concerning household payments for health services during this period. However, the reduction in government support to the health sector required individuals to subsidize their own health care to a large extent.

Period of recentralization (1992 to 1996). After recentralization, provinces were once again required to send their revenue to the central government, which resumed control of finances and budgeting for all sectors including public health. The MoH determined budgets and provided money to the provinces. The level of financing improved, especially in the poorer provinces and the quality of service gradually increased. Provincial governors told us that staff salaries were now paid on time. Salaries became equal in all provinces and districts for equivalent workers in urban and rural areas.

Of public sector spending, about half was financed by the government and half by external aid. Even during the period of recentralization, only about 22% of total health sector spending came from government sources (Table 2).

In 1992-1993 about half of all health expenditures took place in the private sector. Household health care spending was investigated as part of the Lao Expenditure and Consumption Survey in nearly 3,000 households during 1992-1993. Most household expenditures were in the private sector, primarily for purchase of drugs.

In 1992 and 1993, the MoH introduced a

Table 1
Gross domestic product, total central government expenditure, and central government health expenditure, in US$ (x1,000) equivalent[a], Lao PDR, 1987 to 1991.

	1987	1988	1989	1990	1991
(1) Gross domestic product	380,840	413,480	774,436	1,025,033	1,036,528
(2) Total government expenditure	55,240	59,020	136,436	239,083	215,828
(3) Government health expenditure	3,000	4,460	3,563	3,466	2,885
(4) Total government expenditure as% of GDP	14.5	12.7	17.6	23.3	20.8
(5) Government health expenditure as% of Total	5.4	7.5	2.6	1.4	1.3
(6) Government health expenditure as% of GDP	0.7	9.0	0.4	0.3	0.2

Sources: Lao MoH (1993), World Bank (1990a)
[a]At current exchange rates

Table 2
Estimated total health sector expenditure, in Kip[a], by source, Lao PDR, 1992-1993.

Source expenditure	Expenditure (million Kip)	Percent of total	Average per person (Kip)
Government	6,108	22	1,404
External aid	6,568	24	1,468
Household	14,973	54	3,434
Total	27,649	100	6,303

Sources : Lao PDR 1993; Lao PDR/NSC, 1993; MoH, 1993; Vinard, 1993
[a]Exchange rate at the time was appropriately 700 kip to one US$.

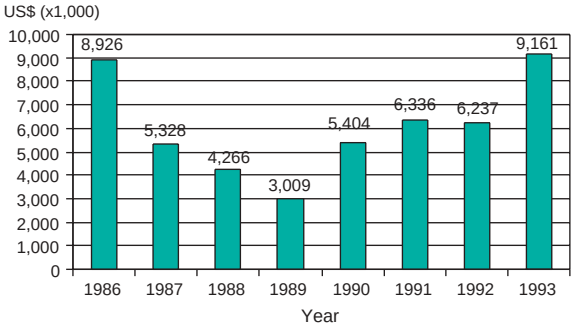

Fig 1–External health aid expenditure 1968 - 1993 (US$ x1,000).

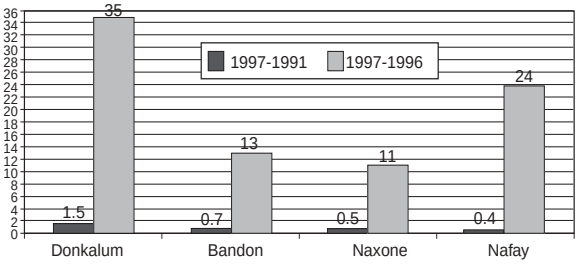

Fig 2–Recorded utilization rate per 10,000 population in 4 rural health centers, Pakngum district, rural district of Vientiane Municipality, 1987 to 1991 and 1992 to 1996.

Table 3
Health personnel in central, provincial, and district governments, by category, Lao PDR, 1985, 1989, and 1993.

Category	1985	1989	1993
Physician	556	1,247	1,405
Medical assistant	2,346	3,566	2,963
Nurse	6,660	8,271	5,602
Total	9,562	13,084	9,970

Source : MoH 1993

cost recovery program in the public sector. Tuberculosis patients, monks, and those unable to pay (about 25% of all patients) were exempted. Charges were instituted for laboratory tests, x-rays, dental services, and private beds in public hospitals. Hospitals were to keep 80% of these payments and send 20% to the province (if provincial) or district. Institutions could keep 100% of charges for drugs. The purpose of cost recovery was to obtain funds for the purchase of drugs. Little data are available about the funds generated by cost recovery, but in some larger hospitals the amount appears to be substantial. Rural health centers have started revolving funds for the purchase of drugs.

Planning and management

Period of decentralization (1987 to 1991). During the period of decentralization, the provinces set up their own rules and regulations, but policies were not clearly started. Provincial health departments followed the directions given by provincial administrators who were not trained in health matters. Policies for districts were established by the provinces. Provincial health department officials said that rules, regulations, and decision making on issues pertaining to health depend on the provincial governors. Provincial health budgets did not distinguish between curative and preventive services, nor between the single provincial hospital and community health centers. The MoH had no mechanism for monitoring provincial activities. Insufficient budgets led to fewer working hours by physicians.

Period of recentralization (1992-1996). Each year the MoH organized a conference with all provincial health directors to summarize achievements during the previous year and make plans for the following one and for five years. The MoH was responsible for formulating national health plans. They informed us that they sent their department heads to supervise work in the provinces and provide technical support for management and administration.

In 1995, the MoH was reorganized into six new departments to facilitate the operation of the health sector. These are: administration, curatives, preventives, food and drugs, manpower development, and research. A similar structure was also created in each provincial health department.

Human resources

Period of decentralization (1987 to 1991). During this period the staff of the MoH decreased by about 50% and the number of local staff increased (Table 3). The total number of health workers grew by almost 40% during decentralization. Some of this increase was due to return of Lao medical students from socialist countries (15%), increased recruiting of provincial auxiliary nursing and medical assistant schools (about 300 to 450 persons per year). The decline to previous levels after recentralization was ex-

Table 4
Annual number of outpatient (OPD) and MCH consultations in 3 selected provincial hospitals and their respective district hospitals, 1987 to 1991 and 1992 to 1996.

Province	1987 to 1991		1992 to 1996	
	OPD	MCH	OPD	MCH
Luang Namtha (P)	3,763	171	8,975	278
Muangsing (D)	3,498	54	6,993	168
Bolikhamxay (P)	14,120	1.128	16,528	1,640
Bolikhan (D)	2,906	232	3,206	366
Thabok (D)	5,951	541	6,998	3,371
Luang Prabang (P)	14,022	4,828	28,528	6,699

Source : Provincial data (D), district hospital; (P) provincial hospital
MCH = Maternal and Child services, OPD = Outpatient

plained by: closure of many provincial auxiliary nursing schools and reductions in medical assistant schools and encouragement of early retirement among the staff. Although total staff increased, performance was poor. Some persons were transferred from the central to the provincial governments. Management skills were insufficient, morale was low, and productivity declined. Many persons were sent to unfamiliar areas to perform tasks for which they were not trained. Provincial governors said that decentralization gave them the power to deploy, promote, reward, blame or punish health workers based on their performance. Once decided, the province just informed the MoH.

Period of recentralization (1992-1996). A school of public health was established within the Ministry to improve the managerial skills of senior district and provincial health staff. The MoH also took over the training of health workers and nominated district and provincial managers. In-service training for laboratory and emergency technicians was expended. The timeliness of salary payments and staff morale improved. Market reforms continued, and physicians were permitted to open small private clinics while continuing with their government service. Several dozen staff members were sent overseas for certificate or degree courses in donor countries.

According to MoH officials, development of personnel, promotions, rewards, and discipline were done only after agreement between province and MoH. Regarding local administrative matters, the province proposed and MoH approved.

Utilization

Period of decentralization (1987 to 1991). In general, utilization rates of all categories of government health facilities were very low, especially during decentralization. Fig 2 shows that for four health centers in Vientiane during this time very few patients attended community health centers because no drugs were available and there was little equipment. Utilization of hospital services in other provinces was also low during Decentralization and increased during Recentralization (Table 4).

Period of recentralization (1992 to 1996). Although still low, utilization rates have improved over the period of recentralization (Fig 2 and Table 4). Fig 2 records utilization rate per 10,000 population in 4 rural health centers, Pakngum district, rural district of Vientaine Municipality, 1987 to 1991 and 1992 to 1996.

Market reforms

Period of decentralization (1987 to 1991). Limited private practice of medicine was permitted by retired physicians and others after official working hours. Provincial hospitals officials had not yet introduced any cost recovery system. Approximately three drug import companies were opened as joint ventures with the government and private investors.

Period of Recentralization (1992 to 1996). Interviews with provincial health officials revealed that the MoH had established different decrees to facilitate operation of health services, such as the introduction of a cost-recovery system and licencing of drug stores. In 1990, there were

893 private pharmacies in Lao PDR. By 1992, there were 1,480 pharmacies, increasing to more than 2,000 by 1999. More than 300 private clinics have opened. In Vientiane, there are 3 private polyclinics with up to 10 beds. Four private drug manufactures and more than 10 drug and medical equipment importers have started business since 1992.

DISCUSSION

It was only 12 years after the establishment of the Lao People's Democratic Republic that a general policy of decentralization was implemented. During those 12 years the government faced many challenges. At the time of liberation there were fewer than one hundred physicians in the country and most citizens had no access to medical care. With few resources, the government was under pressure to create facilities and train health personnel of all ranks.

Global trends toward market economies were reflected in the policies of the government in Lao PDR as well as in neighboring countries. Health services were not immune from these demands. Although still in a state of development, the health sector was required to conform to the NEM and make major changes in its structure and functions.

Many other changes occurred concurrently with decentralization, both within the health sector and in the entire Laotian economy, so that it is impossible to isolate the specific factors responsible for the decline in health services. However, the reduction in productivity by the staff and increase in dissatisfaction by the public might have been avoided by adequate financial planning and proper training in management techniques. The technical and planning functions managed from the ministry level became separated from political and financial decision making at the local level, and the ministry lost influence in the direction of health policy. Although the government intended to decentralize to district level, in fact power could only devolve to provinces because of the lack of financial planning and management at district level.

The process of recentralization was also complex. Responsibility for finance, planning, and management reverted to the MoH. Other changes such as privatization and market reform continued to expand. Because of these other factors, recentralization per se could not claim credit for all of the accompanying improvements.

Although unique, the Laotian history of decentralization and recentralization is an interesting model from which lessons may be applied to other countries facing similar problems. Where local health systems are inadequate and unprepared, decentralization may lead to poor functioning. Therefore, arrangements must be made well in advance to build capacity so that devolution of power and delegation of responsibility can occur smoothly. In poorer provinces, equity will suffer unless careful preparations are made to balance resources with wealthier areas. If it is decided that recentralizations is advisable, equally deliberate steps must be taken at an early stage. In Lao PDR, the MoH played an important role during the recentralization period in setting rules and establishing regulations to strengthen the health system. We conclude that in this case, recentralization was a necessary but not sufficient condition for improving equity and quality in the health sector. However, market reforms were continued and extended, and other factors have changed since the decision was made to adopt the NEM, so that Lao PDR did not return to the conditions of 1987. As conditions change in the future, the Laotian government may once again decide to decentralize certain functions, in which case its current experience will provide a good guide for successful changes.

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