PROPOSAL FOR DECENTRALIZATION OF HEALTH SYSTEM IN MOROCCO

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EXECUTIVE SUMMARY

The Government of Morocco has initiated a process of decentralization involving the creation of a regional level of public administration and has charged each line ministry with preparing a plan for the creation of regional authorities for their respective organizations. At the same time, there are broad political pressures to decentralize to the provincial level. In administrative terms, regional decentralization implies “deconcentration” to a regional unit of the Ministry of Health. The more profound decentralization to the province would involve “devolution” to the local executive and legislative authorities. International experience suggests that the Ministry of Health should prepare to implement the most effective process of decentralization for each type. Indeed, the Ministry of Health has already commenced some key initiatives of deconcentration, including: transfer of hiring responsibility to the provinces for many positions; creation of regional bodies such the Observatoire Regional d'Epidemiologie, and regional blood banks; the implementation of capacity building projects (Progress, PAGSS,GTZ) in specific regions; and the simplification of budgetary line items in the recent "Global Budgeting" process.

This consultant’s report presents two options for consideration by the Ministry of Health of Morocco. Plan A is a limited proposal for deconcentration to the regional level. This responds to the current government process. Plan B is a proposal for devolution to the province level that might be appropriate if the government decides on this form of decentralization. These options are presented as part of the continuing dialogue within the Ministry of Health and the Government of Morocco. They reflect the professional judgments of the consultant and not necessarily those of the sponsoring institutions.

Decentralization should not be an end it itself but rather should be designed to achieve better equity, efficiency, quality and financial soundness of the health system. Both Plan A and Plan B are designed to attempt to achieve these objectives based on the consultant’s long-term assessment of international experiences. Decentralization can also be defined in terms of the “decision space” that is allowed to the local authorities. Decision space is defined as a range of choice (from limited to wide) over each of a series of important functions – financing, service organization, human resources, targeting, and governance. Designing an appropriate process of decentralization involves widening local choice over only some of the functions and adjusting the responsibilities of the central, regional and provincial authorities.

Plan A starts from the assumption that the new regional authority should have limited role and responsibilities so as not to add an additional inefficient and costly bottleneck between central and provincial authorities. Plan A also suggests that some deconcentration should involve increased responsibility at the provincial level. Specifically, the provinces should have more control over their budget proposals and increased flexibility over expenditures. It is also recommended that the allocations to each region and province be made by a process that uses a "needs based" transparent formula based largely on population as a target guide. The provinces should also have wider control over human resources and increased ability to coordinate local service organization and relations with civic society. In addition,

hospitals at the provincial level would be granted more control over budgets and human resources. The role of the regional authorities should be to facilitate coordination and planning among provinces, provide activities which are more cost-effective at the regional level (such as maintenance and, in some cases, warehousing) and technical assistance in key areas, such as the Observatoire. It should also coordinate with local authorities and take on some of the human resource tasks for regional staff (but not provincial staff). The central authorities would also change to provide more guidelines and criteria for local authorities to take into account in their decision-making, develop a more effective information system and analytical capacity to evaluate the performance of regional and provincial decisions and to hold local authorities accountable through management contracts. The center should also retain some control over procurement and logistics, especially to retain market power for drug purchases.

Plan B involves devolution of authority to local governments at the provincial level. It would develop a process to transfer funds to these authorities according to a needs-based formula based on population, disease patterns, vulnerability and rurality. Matching grants from the central authorities would be used to encourage local authorities to partially fund central priorities. Local authorities would be allowed to gain "waivers" from central norms for service organization to allow for local innovation and experimentation, and performance contracting would be used to monitor and evaluate the effectiveness of local choices. Provincial authorities would be allowed wider choice over hiring, firing and transfer of human resources, within a merit-based civil service system. Provincial authorities should also be allowed to create semi-autonomous governance entities separate from the provincial governmental administration.

These proposals would allow Morocco to develop a reasonable and controlled process of decentralization that has a good chance to achieve greater equity, efficiency, quality and financial soundness.

I. Introduction

The Moroccan health system is highly centralized in a model following the French administrative system. While there has been increasing capacity building at the lower levels, in particular, the provincial level, the administrative system with its strict classic budgetary process and its rigid public functionaries laws has significantly limited the range of choice for those at the periphery of the system. In addition, the process of democratization that has been quite successful in combining a democratically elected national assembly within a still active monarchy, also has significant limits on democratic accountability at the periphery of the system. There are legislative councils at the local levels -- regions, provinces and communes. While the communal assemblies are directly elected, the lower level assemblies indirectly elect those at the higher levels. There are also strong executive authorities at each level -- Wali, Governor, and Caïd -- who are appointed and accountable to the centralized Ministry of the Interior.

There however, appears to be recognition that such centralized authority is limiting progress in both improving the administration of the system and in promoting greater democratic accountability. This has led to an accelerating effort, begun in the 1990's, to decentralize power (initially through a 1993 law on Competence de Atribution), with a recent focus on the establishment of a regional authority, between the provinces and the central government. The regionalization law of 1997 established the regional legislative and executive authorities and defined their functions in broad terms (Loi No. 47-96). Recently the Ministry of Affaires General has been given the authority to develop a general “deconcentration” of the central ministries. (see below for definitions of "deconcentration" and "devolution") This has involved each ministry in a process of reviewing and proposing options for their own ministry deconcentration to the level of the regions. The process currently appears to be quite fluid with no clear boundaries and guidelines. Each ministry appears to be working on its own process with little integration or communication among the ministries. There has also been some progress in developing a general "Chart de deconcentration", however the Chart has not yet achieved consensus needed for approval and participants in the process describe it as "timid" and vague. It is expected that there will be a future process of integration and decisions made based on both a common set of rules and specific functions particular to each ministry.

In the Ministry of Health this internal process has involved the development of a five year Strategic Plan (1999-2004) and a series of seminars/workshops in the year 2000 in which the central Directors of Service, Provincial "delegates", Regional "coordinators", hospital directors, and directors of ambulatory services discussed and developed options for regional deconcentration. This internal process produced a synthesis report at Staddat 2.

An initial version of this consultant report was an attempt to build on this internal process and to introduce more systematic analysis, based in part on other international experience, to assist the Ministry to define its proposal for deconcentration to the regions. The initial report was reviewed by Ministry officials from the central level, several regional deleges and regional and provincial deleges and elected officials from SMD region at a seminar at Agadir in October 2001. The current version updates the report based on that seminar. The Agadir seminar

emphasized the need to decentralize the financing and human resource functions. In particular for financing it recommended establishing criteria for a needs based formula for allocating budgets to provinces, providing more local flexibility in management of budgets, developing interregional equity funds and subsidy funds. For human resources it recommended fixing budgetary posts at the provincial level, transferring routine functions, reinforcing local training capacity and developing local human resource management skills.

In addition there are other reform processes that suggest that a wider view needs also to be taken at this time. There is a general reform process within the Ministry, headed by a separate reform unit, which is also reviewing options for the creation of two social insurance schemes, which would change significantly the financing of the health system. The new Minister has also called for a more general review of the Charte de Sante. In addition, while the current process of general governmental reform is focused on deconcentration to the regions, this is seen as an initial step in a broader process of “devolution” toward the legislative and executive authorities at the province and commune levels embodied in a current effort to develop a "Charte Communale". This process is seen as driven not so much by the national administration but by the legislative and political processes and is less clear and predictable. In this context, this consultant report also focuses on options for the Ministry of Health for a more full decentralization of authority to these levels. Experience in Senegal, Philippines and Indonesia shows that if the political process moves toward devolution to these authorities and the ministry of health does not have a carefully developed plan and strategy for this process, the ministry can be overwhelmed by the wider process and lose control of essential resources and procedures. The result may be a major disruption and deterioration of the health system.

II. Why Decentralize?

The first reason that the Ministry of Health in Morocco is engaged in decentralization comes from outside the health system and is a broader initiative that the Ministry of Health is required to participate in. However, there are also good reasons for reforming the current health system and for decentralizing some parts of the system. The current public health system is under some stress. The public sector only accounts for 27 % of total health spending and total spending is low in relation to similar countries (4.5% of GDP CNS 2001). There is also a growing supply of private sector physicians, while the public sector employment of physicians has stagnated (Santé en Chiffres 1999). However, there are indications that utilization of services in the private sector has declined over the 1990s -- from 60% in 1991 to 50% in 1998 -- with a concomitant growth in the public sector (ENNVM 1998/9). This does not suggest that the population is fleeing the public sector in favor of the private sector. Nevertheless, there is a general perception and some evidence of low quality, significant inequalities, inefficiencies, low morale among the public work force, and health facilities remain high on the list of priority needs in the household survey (second priority). While there is evidence that salaries of health providers are sufficiently high to discourage illegal dual employment in public and private sectors, there are suggestions that provider productivity is not increasing with wages. At the central level some administrative processes -- especially in human resources,

information systems, and budgetary processes -- have clearly become bottlenecks where even routine administrative decisions can be delayed for months or even years. Local health officials are often also unwilling to take decisions that they have authority to take because of a lack of initiative and a bureaucratic culture, which discourages individual responsibility at lower levels.

It seems that this is an appropriate time to advance the process of using decentralization as a means of overcoming some of the continuing and emerging problems of the health system. In addition to the external processes pushing for deconcentration and devolution described in the Introduction, there is also the internal process of the *Chart de Santé* and the health reform proposals for insurance, as well as new technical initiatives including the creation of regional *Observatoire d'Epidémiologie*, and proposed immunization cold storage units and maintenance units at the regional levels. The new Minister also seems to be interested in promoting reforms and is said to have some political weight.

In this context, it is important to define clearly what decentralization is expected to achieve. There is an explicit expectation of various informants that decentralization can improve equity, efficiency, and quality and increase mobilization of financial resources at local level. These objectives are also often mentioned in many international processes of decentralization. However, it is important to review these expectations because it is not always clear that decentralization can achieve these objectives. We have several examples of countries, which initiated decentralization only to make the administration of resources worse and to create more problems than solutions. It is likely that we need to select the best types of decentralization in order to achieve the objectives. Therefore, it is important to design the process of decentralization so that it has a better chance of achieving these objectives and does not make the situation worse.

Equity: There is a wide variation in per capita spending for primary health care among the regions and provinces. The Comptes Nationaux de La Sante show that the range in per capita spending is from 1.83 dm in El Gharb-Charda to 68.58 dm in Oued Eddahab. Even excluding the low population areas, the range is still quite great -- 27.3 dm for Orientale, the highest for regions with similar population size. It may also be that the provinces with most vulnerable population are getting less than the richer provinces. Although information on the distribution of facilities was not analyzed for this report, it is likely that access to facilities is also unequally distributed among provinces and within provinces.

Decentralization might improve the distribution of finance if it involves changing the allocation mechanism to a transparent formula and away from the current historical budgeting which retains these historic inequities. However, it may also mean that richer provinces can add more resources to health than poorer can – increasing inequality. Decentralization can also improve the access of populations if local authorities have this as a major priority. However, it is probably important first for the financial resources to be assigned in a more equitable manner so that investment decisions can be made from the center.

Efficiency: Efficiency of the health system is difficult to measure and we have only indirect indicators that should be further analyzed. More detailed data collection should be initiated to establish a base line for monitoring improvements in efficiency.

Data on hospital and administration as % of total budgets, while not exorbitant, suggest that more efficient allocations can be made. There is quite a variation among the regions as the table in Annex ??? shows. For spending in non-hospital administration the variation is almost 10 percentage points (from 5.12% in Tara Alhoceima to 13.42% in Donkkula-Abda, with a mean of 9.08%). Excluding the unusual cases of Rabat and Casablanca (their CHU expenditures are not included in the data) and the Western Sahara regions (with low population and special issues), the spending on primary health care and on hospitals varies almost 20 percentage points. Hospital spending varies from 34.93% in Taza Alhoceima to 52.11% in Marrakech Tensift ElHaouz with a mean of 44%. This variation suggests considerable differences in both allocative efficiency (which should favor primary health care expenditures) and technical efficiency (which would seek lower administrative expenditures).

Decentralization could allow local managers to make more efficient use of resources if they can assign them with some flexibility. This objective is not likely to be achieved if the local authorities do not have significant control over human resource distribution, incentives, and flexibility in reassigning recurrent budget line items. It is also not likely unless there are explicit limits to allocations in inefficient costly services (such as restrictions on allocation to hospitals and administrative units). Contracting mechanisms might improve efficiency under certain conditions (see below). It is also possible to develop regulations requiring that expenditure on hospitals and administration be restricted to a minimum and maximum range (see below).

Quality: There is little information on current quality of service, although there is an impression that quality standards are not fully observed and that much could be done to improve quality. Quality improvements require a combination of central standards and accreditation or close supervision as well as local incentives for initiatives to constantly improve service. Decentralization therefore still means that central authorities need to define the standards and to monitor carefully the achievement of those standards. It also means that local authorities should be allowed to make choices that involve local priorities about quality assurance and local initiatives to take responsibility for demonstrating that quality has improved. Techniques of Total Quality Management require some local decision making authority to be effective. Decentralization might also improve the responsiveness to local health systems to local indications of patient satisfaction.

Mobilizing additional resources: One of the advantages of devolution to local governmental authorities is that granting them some role in decision-making may encourage them to contribute local resources to the health system. Since the local authorities now have control of some tax revenues this source of additional funding could be substantial. There are financing mechanisms such as earmarking and matching grants (see below in Plan B) that can be used to encourage localities to dedicate increased resources to the health sector. There are also mechanisms that could assure that poorer localities also have resources that can be dedicated to health so that inequalities among communities do not depend on community wealth or poverty.

Innovations and pilots. Decentralization may also provide the freedom for local authorities to develop innovative approaches and solutions to ongoing problems.

Allowing this flexibility may produce new approaches that central authorities have not considered but which may provide evidence of effective programs that other local authorities ought to consider as well or that the center should adopt as national policy. The initiatives in pilot projects Progress, PAGSS and GTZ provide some evidence of the utility of this approach.

III. Deconcentration, Devolution and "Decision Space"

There are two basic issues of design of decentralization. The first is to identify which institutions are to take on the new authority and responsibilities of decentralization. The basic choices are to:

- "deconcentrate" authority and responsibility to the regional and/or district offices of the Ministry of Health
- "devolve" authority and responsibility to the state, province and/or municipal governments
- "delegate" authority and responsibility to another semi-autonomous agency such as a separate board of health, health fund, or superintendence.

The second set of design issues is about how much choice should be allowed to local decision-makers. For this we have developed a "decision-space" map to define the options of ranges of choice (from narrow to wide) over different functions (finance, service delivery, human resources, targeting and governance).

The following table outlines the kinds of design choices that are available.

Box of Decision Space Functions

Decision Space Functions	Description of Functions
Financing and Expenditure Functions	
Revenue Sources	**Choices about where sources come from**: i.e. Will local authorities be allowed to assign own source revenue to health?
Allocations of Expenditures	**Choices about how to allocate funds:** i.e. Will local authorities be allowed to assign funds to different priority programs? Hospitals vs. primary care?
Fees	**Choices about local charges**: i.e. Will local authorities be allowed to set fees at all, and if so are they allowed to determine the levels and change them?
Service Organization Functions	
Hospital autonomy	Will local authorities grant hospitals autonomy and select the degree of autonomy allowed?
Insurance Plans	Will local authorities create, manage, and regulate local health insurance plans?
Payment Mechanisms	Will local authorities select different means of paying providers? E.g. per capita, salary or fee for service.
Required Programs and Services	To what degree will the central authority define what programs and services the local health facilities have to provide?
Service Standards	To what degree will the central authority define service standards, such as quality standards for facilities?
Vertical Programs and Supplies and Logistics	Are vertical programs continued under the control of central authorities or are they transferred to local control? Are drugs and other supplies provided by central authorities or do they become the responsibility of local authorities?
Human Resources Functions	
Salaries	Will local authorities be allowed to set different salary levels? Will they be

Decision Space Functions	Description of Functions
	allowed to determine bonuses?
Contracts	Will local authorities be allowed to contract short-term personnel and set contract terms and compensation levels?
Civil Service	Will local authorities be allowed to hire and fire the permanent staff without higher approvals? Will staff able to be transferred by local authorities?
Access Functions	
Access Rules	Will local authorities decide who has access to facilities and who is covered by insurance?
Governance Functions	
Governance Rules	Are local officials accountable to the electorate? Will local authorities have choices about: Size and composition of hospital boards? Size and composition of local health offices? Size, number, composition and rule of community participation?
Strategic Planning and Investments	
Planning and Investments	Are local officials responsible for strategic planning and investment decisions?

As can be seen by the decision space map, many functions are still in the narrow range of choice, meaning that the central authorities define these choices. However, there are a significant number in the moderate range of choice and for a few functions, the local authorities are granted a wide range of choice. The tendency is for allocation decisions, contracting and governance decisions to be wider than for service delivery organization, targeting and salaried civil service rules. In several cases, wide ranges of choice were initially allowed -- over allocations of expenditures and over human resources -- but these choices were later reduced. Wide choice over human resources has brought political backlash from the unions and professional associations. Wide choice over allocation of expenditures has led central authorities to impose earmarks and other restrictions.

Current Decision Space in Morocco

TJB note: The french version is missing the following paragraph which should be added!

The current administrative system is divided into 16 regions that group 2 to 8 of the 68 provinces (or urban prefectures). The Ministry of Health is represented at the Province level by a Provincial Delegate who is accountable to both the Ministry and its Directors of Service and to the Governor of the Province. The regional representative of the Ministry is called the Regional Coordinator and is appointed from among the Provincial Delegates of the region. He usually is the delegate from the dominant province -- the province mere -- and is accountable both to the Ministry of Health and to the Wali, the representative of the Ministry of Interior at the regional level. Currently the Regional Coordinator does not have an additional budget for the region unless he manages to persuade the local regional authorities or NGOs to grant him additional resources from their local budgets.

Current decision space is typical of highly centralized French system. However, even in this system there is some range of choice over some functions.

In financing there is some choice at provincial level over the limited non-personnel recurrent budget (around 16% of total MS budget). In a new budgeting process developed by the Ministry of Finance and Ministry of Health, greater choice may be

granted by collapsing some of the budget lines (a process called "Global Budgeting") and negotiating preformance contracts between provinces and the central ministry. Commune, regional and provincial assemblies (with Governor approval) also are allowed to allocate additional resources to health and this is not restricted – can be salaries, investment, other. Even NGOs can offer resources and personnel to MS facilities.

Some hospitals, 2 CHU (to be expanded to 4) and around 20 SEGMA have been given some autonomy and can charge for services but also get a large subventions from state (own source accounts only for 15%). However, hospitals have no choice in setting the fees for services.

Organization of Services follows norms and standards defined in detail by the central MS. As in most French systems these norms are strict and technically defined by the central Directions of Service. However, the Directions of Service not only have established strict norms but also are involved in many of the direct management of their service activities -- such as defining vaccination days, providing the logistics and supplies for the services, control of specific training activities. The central Directions of Service appear to intervene often in the local administration in vertical and uncoordinated ways. At the same time it is not clear that the central Directions of Service are able to monitor and evaluate the performance of the services. The information system does not currently reliably and quickly provide information needed for the Services to monitor provincial activities.

There has been some attempt to deconcentrate some central vertical programs. The Department of Epidemiology has created regional Observartoires which are functioning well in at least 5 regions. Some maintenance functions have been transferred to provincial and regional levels. There are other efforts to create regional blood banks and warehousing for cold chain immunizations and other pharmaceuticals.

Currently there is no local authority to define payment mechanisms although there is some discussion of allowing local authorities to define payments in contracts – e.g.; contracts for some supplies and equipment using standardized contracts as guides. Localities are not allowed to grant their hospitals more autonomy, nor create their own insurance systems.

Human resources. For the regular staff of the *Fonction Publique* there is really very little local choice. This staff is regulated by a single law that would have to be changed, but this can happen only if the appropriate political force is available. Its rigid rules limit the ability even of the central Ministry to hire, fire and pay personnel. This has tremendous consequences for the flexibility of the budget since personnel make up more than – 60% of the total budget and more than 75% of the recurrent budget.

The formal authority for hiring new personnel into the professional staff, assigning staff to vacant positions of responsibility, disciplining personnel, and transferring personnel from one province to another is the responsibility of the central authorities. These authorities do not have ability to change individual salaries, nor change the general salary rules which remain in the hands of other ministries (Finance, Affaires General). The law also identifies the staffing post with the individual so that transfers

and retirements mean the loss of the post and replacements must be negotiated at each year at the central level with the other ministries. The provincial authorities however have been delegated the to the Delege the choice over recruitment of all staff except three which are appointed by the Minister – the Delege, the Administrator (Chief du SIAAP?)and the Medical Director (Chief du SAE?) – and they can transfer all staff within the province. Currently provinces complain that the MS transfers staff too much and therefore seek to require that posts be immovable at the province level, unless the provincial *délégué* approves. The *Division de Ressourses Humaine*s processes around 1,500 transfers per year out of a total MS staff of 42,000. Recruitment varies year to year depending on the negotiation among ministries within a total government limit. Last year MS recruited around 1,000. Retirements are growing (around 450 last year) and the MS loses the post when someone retires. Disciplinary activities are initiated at the province level but reviewed at the central level. The centralized process of making routine human resource decisions has overwhelmed the central human resources office and delayed the formal approval of many routine decisions. The current Director of Human Resources describes the central routine system as "chaotic" and is planning to deconcentrate many of the routine processing of staff forms, maintenance of local data base and some disciplinary functions to the provincial level but he needs to establish order in the central system first.

The central Ministries have now been required to have an "*appel à candidature*" for all positions of responsibility which allows any public functionary to submit their candidature and for which there is a jury, which includes a representative of the *Ministère des Affaires Générales*. This process currently is highly centralized but could be regionalized or provincialized. Currently new recruits can be hired "according to title" (*sur titre*), which requires that the "oldest" qualified candidate is chosen, and a newly instituted competitive process (*concours*) which is also centralized. This process is to be completely phased in for all posts in 2002.

[tjb note: This paragraph is missing in the French version and should be added.]Decentralization of training has already been initiated with the creation of sixteen *Instituts de Formation aux Carrières de Santé* (IFCS), one in each region. There are some initiatives such as the development of local training capacity in maternal and child health in the Progress project which might be used to strengthen local capacity to take on this responsibility.

Local authorities of the region, province and commune can hire additional staff with their own resources if approved by the representative of the Ministry of Interior at those levels. These staff are covered by a different regulation (which is also be quite rigid). The CHU also have separate processes for hiring staff that is similar to that of the regional, provincial and communes.

Targeting and governance. Central authorities control access and targeting and are likely in the social insurance scheme to make changes in the current systems to regulate two different regimes of insurance. There does not seem to be choice of local governance forms. There is a significant interest in having the regions and provinces respond to civil society and to ONG in positive ways. There seems to be considerable freedom in this area for the provincial *délégués*.

Strategic Planning and Investments. Routine annual planning has been usually a centrally sponsored activity allowing some local choice within rather strict national guidelines, parameters, and criteria. However, an interesting initiative in regional coordination of strategic planning and investment has begun under the Progress project in the Souss Massa Draa region. This process has involved the Delege du Chief Lieux of the regon as Regional Coordinator and the creation of a Comite Regional de Coordination (which includes the provincial deleges and the prefecture de la region) and a Unite regional de gestion du project with specific responsibilities for developing the strategic plan.

IV. Expanding Decision Space – "Plan A"

This option works within the constraints of the current laws, or with only minor modifications that might be supported by the larger process of deconcentration of the public sector. It focuses on defining regional level choice, however, to define regional level also requires definition of changes in center and provincial choices. This option focuses on "deconcentration" to regional and provincial levels within the Ministry of Health and does not directly address the possibilities of "devolution" to local government authorities such as the regional and provincial councils. "Devolution" is addressed in Plan B below. It should be noted that the current budgetary and public functionary laws are significant constraints on what is possible even in deconcentration. The consultant suggests some internal policy changes and the possible use of "delegation of signature". In any case, these suggestions should be taken only as temporary solutions until the larger reform process makes significant changes in the laws.

We have established the following criteria for deciding how to allocate decisions and functions to the three levels:

- proposed changes should be to retain or expand choice at the province level, rather than take away current or potential capacities from the provinces.
- responsibilities that can efficiently be made at the central level vis-à-vis the provinces should also be retained there – rather than creating a potential bottleneck between province and central authorities.
- effort should be made to keep down the cost – especially the recurrent cost – of the new regional level.

The "internal" process of discussion within the ministry has led to some specific suggestions about functions that should be assumed by central, regional and provincial levels. The Strategic Plan sets out some general guidelines on central, regional and provincial level responsibilities (attributions), which are presented in the Annex 1. Following these general guidelines, the Ministry held several seminars/ workshops to debate the options for regionalization and have produced a synthesis document which outlines another set of functional responsibilities for each level and two options for organizational design (see Annex 1).

These documents have been used by the consultant as a basis for a more specific definition of the functions and organization at the central, regional and provincial levels. However, it should be noted that some of the functions that the "internal" process has assigned to the different levels are functions that currently under a

centralized system they already have -- such as the responsibility for managing resources, improving quality, coordination and planning which already exist in some form at all three levels now without new efforts at deconcentration. In addition there are some responsibilities that are not available under current regulations -- such as imposing equity of financial resources among regions that cannot be done under the current budgetary process. Since there is considerable overlap in the functions described by the internal process and this process has not developed clear distinctions among the functions at the different levels, this consultant will suggest some options in terms of "decision space" at the different levels. He will then suggests how the current functions would change in specific instances.

IV.A. Financial Decision Space

It is clear that for increased ability to make local decisions that can improve the efficiency of the management of the system, greater control over budgetary decisions needs to be deconcentrated to the regional and provincial levels -- especially to the provincial level. The SEGMA hospital experience suggests that the effectiveness of local management needs greater flexibility in control of the budget. Many other countries such as Colombia, Chile, Bolivia, Zambia, Philippines have experimented successfully with extending greater budgetary control to province and municipal level authorities (see Annex).

Expansion of decision space over budgets involves at least two areas:

- wider control of the planning and budgeting process -- allowing the provinces to have greater participation in the final decisions over their plans and budgets at the start of the year
- wider control of managing the budget after it has been approved -- allowing for more efficient choices and adjustments over the year

For budgetary decisions, it is unlikely that changes in the law should be expected in the near future. Plan B will propose significant changes in budgetary laws and regulations.

There is however a coordinated program with the Ministry of Finance to simplify and strengthen the current budgetary process by two initiatives: "Global Budgeting" and performance contracting. These initiatives are not yet fully developed and understood by the Ministry of Health but they should provide a new basis for wider local control, especially at the province level. The "Global Budgeting" process will collapse some of the budgetary categories so that local authorities can make wider choices within budget rubrics. It remains to be seen just how much new choice these changes will allow and this process should be monitored to encourage wider rubrics so that greater choice over key programs is allowed. The performance contracting effort attempts to develop indicators and establish an internal contract between provincial and central authorities over expected performance. This process can later be converted into a mechanism for allowing local choice over budgets if local authorities can demonstrate that they achieve their performance objectives.

In the process of planning and budgeting each year, it might be possible by internal policy within the Ministry to shift some additional responsibility from the central

ministry to the provinces. This internal policy would be a declaration by the minister and Directors of Service that they will limit their changes in proposed provincial plans and budgets and that any changes that the central authorities make in provincial plans and budgets will be reviewed by the provinces before they are negotiated with the Ministry of Finance. This process could be made more transparent.

If the Global budgeting process does not provide sufficient flexibility for provincial authorities for changes in the expenditures during the year, some additional mechanism should be sought to allow the provincial and regional authorities to manage their budgets more during the year -- simplifying the budgetary "chapters" and/or allowing local authorities to reassign a wide percentage of each "chapter" to another "chapter". There seems to be some interest in this change in the Ministry of Affaires General (see *Etude sur la Déconcentration Administrative*. 1998). Again in the absence of change in laws and regulations, the MS and the Directors of Service could agree informally to only decide to approve or veto the decisions made by the provinces and only use the veto in cases where regulations have not been followed.

A second alternative is to use a process called “delegation du signature” for some budgetary decisions – such as a portion of budgets that are now controlled by the Directors of Service (see below on financing mechanisms). This is however a cumbersome and temporary measure that should be used only if laws cannot be changed to provide formal authority. (see *Etude sur la Déconcentration Administrative.* 1998)

In any case, some legal mechanism or informal internal policy should be sought to allow greater budgetary control at the province and regional levels so that they can define their budgets more consistently at the planning stage, and so that they can adjust spending over the year.

In this process, it is not recommended that the regional authorities have control over the provincial budgets. While the regions could be required to equalize the budgets among their provinces, it is not clear how this could be done within the current budgetary structure and it is likely to retain inequities among regions. It is probably best to have the center define a transparent and consistent formula for equitable assignments rather than leaving that choice to the regional levels. Equalization of the budget among regions should be the task of the central authorities across all of Morocco. However, the regional authorities should have control of their own regional budgets that should be separate and specific for the new tasks that they are assuming (see below)

It might also be possible to allow more local choice over setting of tariffs in the hospitals. Again, other countries (Colombia) have experimented successfully with this flexibility. This flexibility is especially important in systems where there is competition among public and private providers -- which may come with the new proposals for social insurance. This flexibility for local choice of tariffs could be done by allowing hospitals to decide within a range set by the central authorities. Setting a range could maintain a rough equity while allowing managers to respond to local conditions. It could also restrict choice where there is no competitive market.

The relatively wide choice allowed to elected authorities of communes, provinces and regions to allocate their own resources to health is limited by the resources

available and by the local political processes but not by restrictions on decision space. The regional law appears to allow significant local control over this budget, however, apparently the Governor and Wali, both appointed by the Ministry of Interior, and have significant influence over the implementation of legislative choices. (Law of 1997) Plan B will suggest some changes in this area.

Even without decentralizing, it might be useful for the ministry to consider replacing the historically based budgeting process so as to assign resources based on a more equitable formula of population size and density and indicators of vulnerability or poverty. This process could be used for strategic planning decisions early in the budgetary process and could be introduced slowly in order to allow the provinces which would receive less resources than they have historically to reduce facilities and staff accordingly and those that would receive more than they have historically would have time to increase investments and personnel. This process may be possible simply with internal budgeting processes but probably will also require an agreement with the Ministry of Finance.

IV.B. Organization of Services

The expansion of decision space allowed under the current laws appears to be most possible for choices about organization of services. While it is important for the center to retain strong control of the norms and standards of the organization of services, they should get out of the business of managing specific activities. The provinces should be given more latitude in the day-to-day operation of programs and should not be subject to specific uncoordinated interventions from Directions of Service. The local level has more direct information on needs and conditions and should be able, within norms and standards, to make better operational decisions.

For this kind of choice it is important to push most of the choices to the provincial level where with small increase in training local staff can take on the tasks. Regional responsibility should come where there are major economies of scale (for instance for depots and maintenance) or where there is a scarcity of highly specialized trained personnel (Epidemiological surveillance). Costing studies should be done to determine the standards for establishing when there are economies of scale or when specialized technical personnel at the regional level is justifiable.

However, the role of monitoring and of assuring quality and for providing routine specialized technical assistance to the provinces should be retained at a higher level. Here there are two major choices:

- strengthen the regional role in monitoring, quality assurance and technical assistance by building up its technical capacity and by shifting many mid level technical experts from the central offices to the regional offices.
- retain this role at the central level and improve the monitoring information system and the capacity of the central offices to visit all provinces.

While this consultant prefers the first option, it is unlikely that technical personnel at the center will easily be transferred to the region, without a major initiative and additional funding for incentives. Therefore, the proposed regionalization here will keep a minor role in monitoring and technical assistance at the regional level and

retain most of this role at the central Directorates. However, over time, it is likely that increasing regional role in supervision and monitoring will be possible and that both the center and region should retain some responsibility in this area. If a management contracting system is developed -- see below -- then the role of supervising and monitoring will become more important making it more necessary to build regional capacity.

There does not seem to be the budgetary flexibility to allow local choice on payment mechanisms and on local contracting so this issue will be discussed in Plan B.

IV.C. Human Resources Decision Space

The central bureaucracy is over burdened with individual dossiers that require routine approvals that can easily be done at lower administrative levels. Granting local authorities the right to make these routine bureaucratic decisions, within the established rules and procedures of public functionaries laws and regulations, could easily solve this problem. The Ministry is already in the process of initiating this change. The regularizing and updating of the central human resources data base is a first step and once it is accomplished the data base should be decentralized to the provinces so that local authoities can perform these routine functions.

The second problem is to work with the Funcion Publique to develop a means of defining the budgetary posts in the provinces so that transfers do not mean the loss of a post. In order for this process to work, however some mechanism for determining the human resource needs in each province should be established. This process should accompany the development of a needs based formula for budgetary allocations described above. Without a transparent "needs based" means of determining human resource allocations, fixing the budgetary posts will only preserve historic inequalities and make more difficult the application of a needs based formula for budgetary allocations.

The internal process has proposed changes in the human resources area so that positions can be fixed in the province so that it is only through negotiation between provincial delegés that a person can be transferred. This option, while increasing provincial control, risks ending up with a very rigid system that will generate many motivational problems among the staff who want to move and among the chiefs who want to change personnel under their authority.

A better option would be to allow the provincial or regional staff to hold the "*concours*" and the "*appels de candidature*" for all provincial posts, including *postes de responsabilité*, and have clearly defined process rules to assure merit choices. In this case the central level should exercise veto power only if the rules are not fully followed. The candidates for these positions could come from anyone in the *fonction publique* and not just from the province or region. Similar rules could be defined for disciplinary actions at the provincial level to expand the local choice.

Except for the human resources decisions about the Regional Headquarters and the entities attached to this office -- such as the maintenance units or depots for vaccine -- there seems little reason to have the region involved in personnel decisions made by the provinces and authorized by the center. There should not be any

bureaucratic bottleneck at the regional level for human resources decisions made by the provinces. However, the region might assume a mediating and coordinating role among the provinces so that transfers within the region might be facilitated according to strategic planning objectives. For this purpose, the regions might be provided with the human resource data bases of the provinces within their purview.

IV.D. Governance and Targeting

In the internal process there has been no discussion of allowing the regions or provinces to choose their own forms of governance or to define different rules about access and targeting. It does not seem advisable to recommend a significant change in this area since it would likely require significant changes in laws.

However, it would be wise to encourage regional coordinators and provincial *délégués* to expand coordination and communication with the local authorities to prepare for possible future devolution and to develop skills of persuading stakeholders to fund health activities and to expand coordination with ONG.

IV.E. Strategic Planning and Investment

Currently strategic planning and investment decisions are fully centralized and there does not seem to be a legal means of transferring investment decisions to local authorities. This consultant suggests that these decisions remain at the central level in order to avoid inappropriate strategic planning and investments by local authorities. In many other systems local investment decisions have favored more expensive curative facilities rather than needed primary care facilities. Even in the US, central authorities attempt to control local investment in order to reduce cost escalation. German system is also one in which local authorities cannot make investment decisions.

There is room here for a significant coordinating and monitoring role for the Regions. The process of developing provincial strategic plans should be defined by the central authorities who should also define the broad national priorities. Provincial strategic plans should be developed in a coordinated process within Regions and lead by the regional authorities in a process based on that has been piloted in Souss Massa Draa. Provinces should then translate their strategic plans into provincial Operational Plans. The regions should also take initiatives to coordinate intersectoral and NGO activities at the regional level.

Changes in Decision Space for Deconcentration at Province Level "Plan A"

(for international comparison see Annex 1) [tjb note change in last row of this chart]

Functions	Range of Choice		
	Narrow	Moderate	Wide
Financing			
= Sources of revenue	X		
= Expenses	X →		
= Fees	X		
Organization of services			
= Hospital Autonomy	X		
= Insurance Plans	X		
= Payment mechanisms	X		
=Required Programs and norms	X		
= Vertical Programs and supply and logistic systems	X →		
Human Resources			
= Salaries	X		
= Contracts	X →		
= Civil Service	X →		
Access Rules	X		
Governance			
= Local accountability	X		
= Boards of hospitals	X		
= Health Offices	X		
= Community Participation	X →		
Strategic Planning and Investments			
Planning and Investment	X →		

Summary of Changes in Functions in Plan A

Changes in Functions at Province Level

Financing Functions

Increase provincial choice in planning and budget process – requiring review of all revisions made at the central level before negotiations with the Ministry of Finance

Increase provincial choice over non-salary and non-investment budget now controlled by Directions of Service, using informal policy or delegation of signature.

Organization of Services

Increase Coordination of hospital and SIAAP services and Provincial Planning

Operation of all programs within norms established by Directions of Service

Proportion of equipment and drug supply, and maintenance (see Central)

Human Resources

Staffing decisions (recruitment, appointment, transfer of staff within province and negotiate transfers between provinces, disciplinary actions) allowed by informal policy or delegated by signature from the central MS

Governance

Coordinate with NGOs and civil society

Increase coordination with *Conseil* and Governor to prepare for devolution

Strategic Planning and Investments

- Develop specific priorities for province
- Develop operational plans
- Coordinate strategic plans with other provinces under Regional coordination
- Define local investment priorities and plans within limits set by central level

Changes in Functions at Regional Level

Financing Functions

Planning and Budgeting for Regional Staff and Facilities (*dépôts, centres de maintenance, activités financées par le Conseil de la Région*)

Organization of Services

Economic scale activities – *dépôts* and *centre de maintenance*
Technically specialized activities – *Observatoire*
Technical assistance to Provinces in priority programs

Human Resources

Staffing decisions (recruitment, negotiate transfer of regional staff to and from other regions, disciplinary actions) only for regional staff

Coordinate and mediate transfers of staff among provinces within the region and maintain a regional human resource data bank.

Governance

Allow regional selection of autonomous hospital boards within criteria established by central MS
Increase coordination with *Conseil* and Wali to prepare for devolution

Coordinate intersectoral and NGO activities at the regional level

Strategic Planning and Investments

- Coordinate provincial strategic planning to develop a regional strategic plan and define intersectoral participation
- Coordinate provincial investment decisions within limits set by central level

Changes in Autonomous Hospitals

Financing Functions

Allow range of choice over tariffs.

Organization of Services

Allow some local purchasing of selected supplies and drugs.

Human Resources

No change in current decision space

Changes of Functions at Central level

Financing Functions

Review all changes of provincial plans/budgets with provincial authorities before negotiating with MF
Informal policy of allowing provinces to change budget line allocations for non-salary budgets now controlled by Divisions
Introduce formula based budgeting for allocations to provinces

Organization of Services

Define criteria for economy of scale and technically specialized services for region
Set norms for priority activities for provincial and regional activities and provide technical assistance and training in priority activities.
Purchase vaccines, high cost equipment, essential drugs and collective requests from provinces

Significant improvement in information system for monitoring and analyzing performance of provinces and regions

Significant improvement in analytical capacity for evaluating performance of system

Human Resources

Establish procedures for province and regional human resource decisions under informal policy or delegated signature.

Review human resource decisions made by informal policy or delegated signature to assure that procedures were respected – veto only in case of violation of procedures.

Governance

Establish criteria for selection of autonomous hospital boards by regions.

Strategic Planning and Investments

- Define national priorities for strategic and operational plans
- Define process by which regions are to coordinate provincial plans and intersectoral activities
- Set limits on local decisions for investments

IV.F. Structural and Process Changes (Plan A)

1. Create separate Regional Office

Conflict of Interest of Region and *Province Mère*

There is a continuing danger of increased inequality with the current structure of the region that allows the *délégué* of the *province mère* (usually) to be the regional coordinator. Creating a small separate regional office should reduce this problem. As noted above, the tasks of the region are quite limited since most of the expansion of choice is granted to the provincial level. The regional staff should be selected by concurs and priority should be given to those who would be transferred from the central MS.

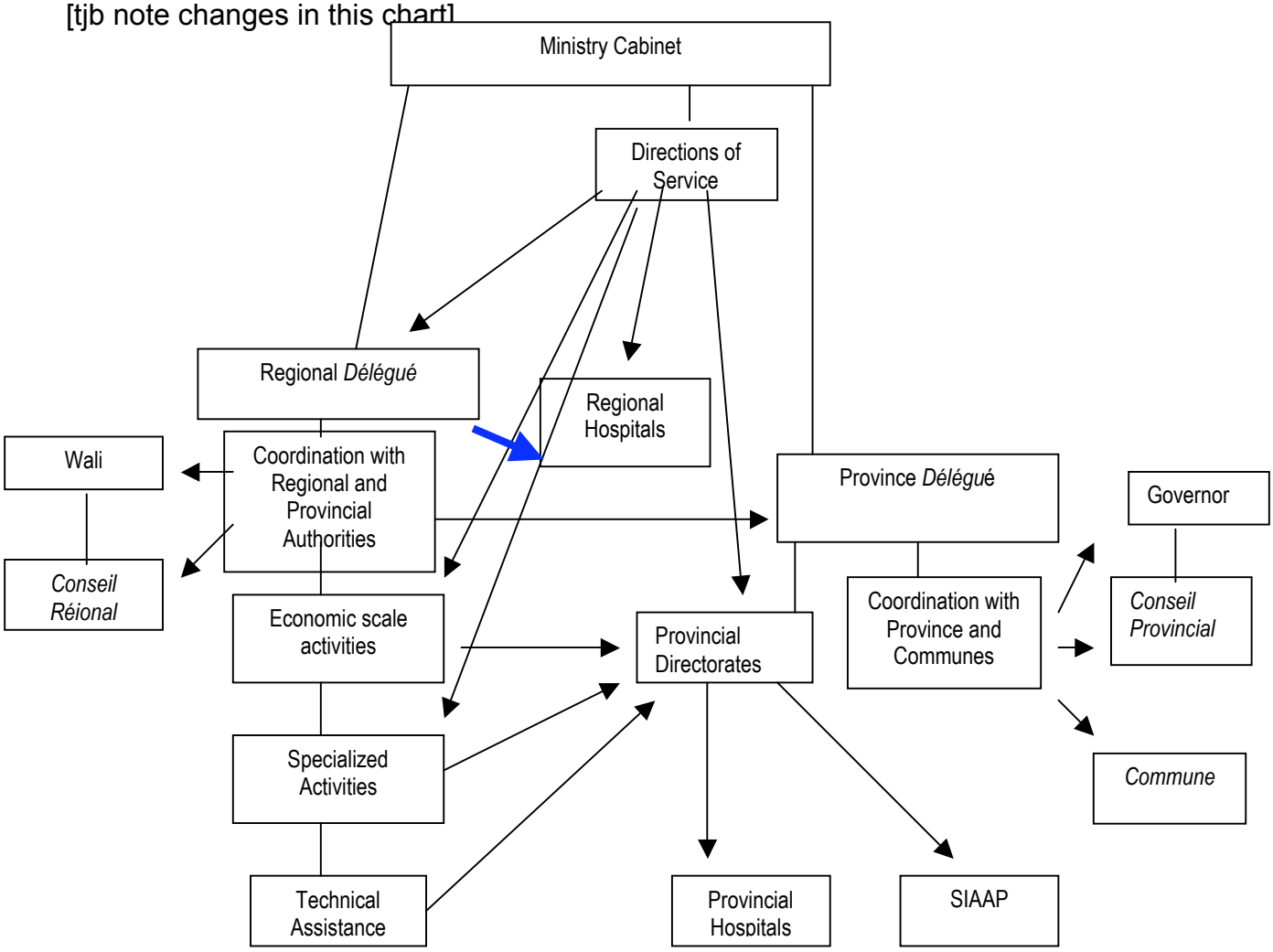
No Additional Costs of Regional Structure

The region should be formed from budgets that currently are assigned to central and provincial levels without adding costs, except for the investments in equipment and facilities for activities of economies of scale and for recurrent costs of transportation.

Organigram

The following chart is used only to suggest that some organizational relationships between the province and central authorities should be retained and that the regional authority should not become a bottleneck for them.

[tjb note changes in this chart]



2. Implement Management Agreements

The internal process has begun to develop new administrative procedures called "contracts for performance" between the administrative levels. This is an important innovation that has been tried with some success in England, Chile, Costa Rica and other countries. However, there are some conditions needed to make this process effective. Skills in developing and managing contracts are complex and require experience and training that currently does not exist in most public ministries. The performance criteria need to be wide enough to prevent the achievement of some objectives at the cost of reductions in other important activities. Performance measures need to be controlled by independent sources so as not to be manipulated to falsely show achievement of objectives. Finally, the contracting authority requires budgetary flexibility to grant additional incentives for achieving the objectives and for sanctions for failure to reach objectives.

The agreements should be based on negotiated performance objectives and specified performance indicators that would be established in negotiations between the center and the regions and provinces. The agreements should initially be targets and would be developed to teach authorities at both levels how to enter into contracts and to evaluate the utility of the performance indicators as motivators and indicators of achievement of objectives. In the initial stage there would be no formal financial incentives for achieving the performance targets, nor would there be formal sanctions for failing to achieve the performance targets. There would be non-financial incentives and sanctions, such as publicized recognition of achievements and failures.

As experience is gained with these management agreements, and if the budgetary law is changed (see below) then these processes could be transformed into actual contracts with formal financial incentives and sanctions. It is likely that such a process will require additional support from donors to be effectively put in operation.

A pilot effort might be initiated by Progress to develop a model contract and contracting process that could be replicated throughout the country after a thorough evaluation.

3. Economies of Scale and Special Requirements

The areas where regional authorities need to be developed require a careful analysis of economies of scale. Studies of the cost-effectiveness of regional compared to central or provincial laboratories, motor pools and other maintenance units, drug warehousing, should be completed before decisions are made to transfer these responsibilities to the regions. Similar studies of human resources for special technical skill areas need to be done before reassigning responsibilities and staff to the regional levels. The standard for assigning responsibilities to the regions should be cost effectiveness not a slavish adherence to a simple and formal model of regional responsibilities.

4. Improvement in Information Systems

The importance of rapid information system with key indicators of performance, expenses and utilization is even greater in a decentralized system than in a

centralized system. Choices that are made at the periphery need to be evaluated by central authorities so that adjustments in decision space and in funding by central authorities can be made if local decisions do not lead toward national objectives. The central level should develop a greater capacity to monitor quality of services through accreditation procedures and through surveys and specific quality monitoring indicators (such as internal hospital infection rates).

5. "Advocacy Group": Development of Strategy to Get Proposals Adopted

In order to achieve a decentralization process that is favorable to the objectives of the Ministry of Health, the Ministry should develop an "advocacy group" of technicians and officials with political responsibilities to develop strategies to adopt the decentralization proposals. Rather than simply reacting to the broader governmental initiatives, the Ministry might take a more proactive role to defend its interests in the process of decentralization.

There are various advocacy tools available, including a software package called Policy Maker that has been developed by Harvard School of Public Health to assist advocacy groups define their policy proposals, map the critical stakeholders in the system and assess their positions on the proposed policies and their power in relation to political decisions needed for the policies. It then assists the team to develop a set of strategies to improve the political feasibility of the proposed policy. The Advocacy group can be trained to use this tool as part of its activities.

V. Expanding Decision Space "Plan B"

While the process of reform and decentralization is not clearly defined, it is prudent to think of options that go beyond the restrictions of the current laws for two reasons: First, there are political pressures that may lead to broader changes that would increase the powers, budgets and authority of local authorities (leading to devolution in addition to deconcentration). Some are thinking that the process of regionalization is simply a first stage that will lead directly to devolution. It is important to prepare for the best way for the MS to adapt to this possible devolution. Second, in the context of changes in charts de deconcentration, *charte de santé*, charte communale and other general guides there is an opening for thinking about a more profound process of decentralization. Thirdly, it may help thinking about the current Plan A if the MS also has a vision of where it would like this process to lead in the coming years.

The following section contains this consultant's suggestions for thinking of a more significant decentralization than is possible under current laws. Plan B will require that the MS work with other Ministries and other governmental institutions to make changes in laws and regulations involving budgeting and human resources.

The first change would be to implement "devolution" to the provincial and regional governments -- transferring authority over health to the local government authorities -- both legislative and executive.

V.A. Financing Decisions

The current rigid "classic" budgetary system prevents local managers from making reasonable choices after the planning and budgetary processes are completed. It excludes them from the final negotiation with the Ministry of Finance but requires them to work within the strict budgetary items that are not related to program activities and are arbitrarily established by the final negotiations. With a large portion of the budget assigned to salaries, budgetary decisions are limited to a very small portion of the budget in any case. Furthermore, the process has been based on "historic" budgets -- with each year's budget based on the previous year adjusted for anticipated increases or decreases in the overall budget. Several other budgetary processes allow more flexibility during the year, and more choice for local authorities in the initial priority setting.

Experience in other countries shows that with appropriate financing mechanisms, a significant increase in the decision space can be allowed to local authorities. These mechanisms have led to increased equity of allocation of resources per capita and may have contributed to more efficient choices in the use of those resources (see Annex 1).

1. Formula based allocation to replace historical budgeting.

The central budget currently assigned by historical based budgeting could over time be changed to one based on a formula that includes population and indicators of health status, vulnerability, poverty or rurality. This process would make the assignments to provinces and regions more equal than they currently and can be adjusted to other health needs and priorities. It would be important to develop a process of shifting resources from those provinces which historically have had high allocations that were not justified by the formula so that these provinces have time to adjust to declines in their allocations. In addition, the provinces, which will receive higher allocations, will also need time to invest and increase their absorptive capacity. If it is not politically acceptable to reduce budgets to any currently favored province, a process can be implemented by which all increases in budgets are assigned to the provinces that should receive higher allocations by the formula. This process will take longer to achieve equity but without imposing politically difficult reductions.

2. Forced assignment of specified percentages of state budgets and/or budgets of regional, provincial and commune budgets.

Currently the regions, provinces and communes have no constraints on allocating their own source revenues. In some countries local authorities have been required to assign a minimum allocation or a minimum percentage of their revenues to the heath sector. It might be possible to require, for instance, that 20% of these revenues be assigned to health. Once the revenues are allocated to health, the local governments would be allowed to assign these revenues to any health activity that they want. An alternative that can be applied even in a deconcentrated system is to require that there be a limit to the percentage allocated to non-priority or inefficient activities. In Zambia for instance, they limit the allocations allowed to hospitals and administrative offices to a specific percentage range in the budget. According to the data presented in the introduction here; Morocco could establish targets using the mean allocations to hospitals and offices as the top limit for these allocations by local authorities.

3. Provincial Equity Fund

In some countries, such as Chile, the local governments are required to assign a percentage of their own source revenues from taxes, etc. to an equity fund, which would reassign those revenues to provinces according to a formula, which includes population size, and indicators of poverty and capacity to generate local revenues. This is a mechanism for equalizing provinces since there are significant differences in provincial ability to generate their own revenues.

4. Matching grants

The central government budget can also utilize separate funds in order to encourage provinces to provide more of their own revenues to health care activities. Matching grants are used in the US for Medicaid and other programs and have been introduced in Philippines and other countries. These grants require that the provinces assign a portion of their own resources to a well-defined activity in order to qualify for additional funds from the central government. This is an important mechanism to mobilize local resources without forcing the governments to assign them. Poorer provinces could be required to provide lower amounts of counterpart (say 10%) while wealthier provinces could be required to provide higher percentages (say 50%). This mechanism requires that the central government retain a budget that can be assigned as counterpart if the local provinces agree to the matching grant offers.

6. Implications of Health Insurance Proposals

The proposed two types of insurance will have significant implications for the funding of public service facilities in a decentralized system. The current plans are not sufficiently developed to offer clear guidance however the proposals suggest two things that need to be taken into account in the process of decentralization. First, some of the funding that currently is assigned directly to MS public facilities will be reassigned to insurance entities, which means that the central budgetary funds transferred to regions and provinces will decline. The MS public facilities may have to compete with other public providers and with private providers for these funds, which are likely to follow the patients' choice of facilities. Secondly, the MS public facilities are likely to have to become more competitive in order to retain and attract patients that will now have some choice over facilities that they will be able to choose. This means that provincial and regional authorities will have to work with lower levels of direct budgetary funding and will have to become more entrepreneurial in that they will function in a market where patients with insurance can choose other providers.

V.B. Organization of Services

"Waiver" Procedure.

One of the advantages of decentralization is to allow local authorities to experiment and innovate to discover better ways to achieve health system objectives. One means of allowing local authorities to innovate is to establish a formal process to grant “waivers” from established norms to allow provinces or regions to experiment

with alternative service organization. This procedure has been used with success in the US government Medicaid health system for the different States (like Oregon) to experiment with innovative financing and payment mechanisms. The MS would establish a procedure by which the provinces and regions could appeal for exemption from current norms and policies in order to test new approaches in their territory. This process is similar to establishing pilot programs except that it would come from local initiatives rather than central and donor driven initiatives. The criteria and processes for allowing "waivers" should not be so rigid as to prevent any innovations, nor should they be so wide as to allow experiments that are clearly not able to achieve objectives. Technical assistance from the center and from donors could be used to assist in the development of these innovations.

V.C. Payments and contracts

As discussed above, performance contracting among the levels could be developed over time if the appropriate skills in contracting are in place and if the authorities at each level are given the flexibility to use budgets as incentives and/or to withhold funding if performance targets are not met. Increased choice could also include allowing regional and provincial authorities to contract out services to private providers and to set the means of payments -- either freely or within a range established by the central authorities.

V.D. Human Resources

Human resources in a devolved system would be transferred from the public functionary system to a similar civil service system of the provinces. Even this system currently does not allow local managers much choice over hiring, firing, transfers, disciplinary actions and financial incentives and sanctions. In order to improve local management choice, it is necessary to allow to local authorities much greater role in these functions so that they can manage in ways likely to improve efficiency and quality of services. At the same time, this local choice needs to be made within constraints that protect staff from arbitrary decisions and that prevent local authorities from hiring and favoring staff that are friends, family or political associates. This requires a transparent merit system of recruitment and promotion, and a process to review complaints. The proposals in Plan A that apply to an internal process of deconcentration could be transferred to the local governmental authorities through a change in the laws of both public functionaries and human resources of provinces.

V.E. Governance

Devolution involves the local authorities directly in decisions about the allocation of resources and will increase the accountability of the health system to their priorities. The Ministry officials at the local level will have to work for two masters and will need to develop skills for working with these authorities.

In many systems, the local authorities are allowed to define how the local offices are run. They are allowed to select whether to have a provincial health office that

directly runs the service as a governmental unit. They may also select to establish a semi-autonomous health agency that will manage the health system but be separate from the local government. The advantages of semi-autonomous units are that they usually have more flexible control of budgets and human resources and may be less influenced by local politics. The disadvantage is that they usually require high levels of skilled personnel at the local level. Highly centralized bureaucratic systems like Morocco, France and others, usually do not allow this kind of choice and it seems advisable to first retain the familiar direct local government control, except perhaps in the larger cities such as Rabat, Casablanca, Marrakech, Fez where there are more skilled personnel and where local authorities might be given the choice to establish a semi-autonomous health agency.

V.F. Option of Delegation to Boards of Health

An alternative to devolution is the creation of Boards of Health at the provincial levels to which the central ministry could delegate authority. This option could involve the formal creation of Boards of Health headed by the provincial *délégué* from the Ministry with representatives of the local provincial government, and other notables from the provincial civil society and the professional associations. These extra official members should be elected from the communities and not appointed by the Ministry or they will not have local legitimacy. These boards have been created in many different countries, including the USA, Zambia, and Ghana. These boards of health could have the same decision space as that proposed for the devolved option.

Changes in Decision Space for Devolution at Province Level "Plan B"

(for international comparison see Annex 1)

Functions	Range of Choice		
	Narrow	Moderate	Wide
Financing			
= Sources of revenue	X →		
= Expenses	X →		
= Fees	X		
Organization of services			
= Hospital Autonomy	X		
= Insurance Plans	X		
= Payment mechanisms	X		
=Required Programs and norms	X		
= Vertical Programs and supply and logistic systems	X →		
Human Resources			
= Salaries	X		
= Contracts	X →		
= Civil Service	→ X		
Access Rules	X		
Governance			
= Local accountability	→ X		
= Boards of hospitals	X		
= Health Offices	X		
= Community Participation	→ X		
Total of decision space			

VI. Processes for Implementation – Next Steps

1.

2. Revised set of Proposals Disseminated to Divisions, Hospitals, Provinces, Donors

3. Study Tour in USA or Central Europe

4. Consultant visit to selected Provinces and regions to discuss proposals

5. Initiate development of a "needs based" formula for allocation of budgetary resources to provinces

6. Cost studies for criteria for selecting economies of scale activities for regional level

7. Pilot performance contracting initiative in a Progress province.

8. Tangiers Workshop similar to Agadir for additional training in decentralization options, skills and leadership and to gain additional review of proposals.

9. Round Table Discussion of Proposals – Including representatives of Ministry of Affaires General, Finance, Interior as well as donors

10. Revision of Proposals

11. Review proposals with highest authorities of MS and revise on basis of their choices

12. Establish a team of "policy advocacy" in the Ministry to assist highest authorities develop advocacy plan.

13. Training of policy advocacy team in policy feasibility analysis and strategy design – “Policy Maker”

ANNEXES

ANNEX 1
COMPARATIVE DECISION SPACE: CURRENT RANGES OF CHOICE

TABLE 3

Functions	Range of Choice		
	Narrow	Moderate	Wide
Financing			
Sources of Revenue		Colombia Chile Bolivia	
Expenditures		Colombia Chile Bolivia	
Income from Fees	Chile Bolivia	Colombia	
Service Organization			
Hospital Autonomy	Colombia Chile	Bolivia	
Insurance Plans	Colombia Chile Bolivia		
Payment Mechanisms		Colombia Chile Bolivia	
Required Programs & Norms	Colombia Chile Bolivia		
Vertical Programs, Supplies and Logistics		Colombia Chile Bolivia	
Human Resources:			
Salaries	Colombia Chile Bolivia		
Contracts		Colombia Bolivia	Chile
Civil Service	Colombia Chile Bolivia		
Access Rules	Colombia Chile Bolivia		
Governance			
Local Accountability			Colombia Chile Bolivia
Facility Boards	Colombia Bolivia	Chile	
Health Offices	Colombia Bolivia	Chile	
Community Participation	Bolivia		Colombia Chile
Total Decision Space:			
Colombia	8	5	2
Chile	7	5	3
Bolivia	9	5	1

As can be seen by the decision space map, many functions are still in the narrow range of choice, meaning that the central authorities define these choices. However,

there are a significant number in the moderate range of choice and for a few functions, the local authorities are granted a wide range of choice. The tendency is for allocation decisions, contracting and governance decisions to be wider than for service delivery organization, targeting and salaried civil service rules. In several cases, wide ranges of choice were initially allowed -- over allocations of expenditures and over human resources -- but these choices were later reduced. Wide choice over human resources has brought political backlash from the unions and professional associations. Wide choice over allocation of expenditures has led central authorities to impose earmarks and other restrictions.

Improvement in Equity of Funding under Devolution in Colombia

The following table shows how over three years the per capita expenditures became more equal among municipalities. The left hand column lists the deciles of municipalities according to their wealth -- with the poorest 10% of the municipalities being the first decile and the wealthiest being the 10th decile. The "central budget" funds are those provided by the central government budget and the "own" funds come from the local taxes, sales and fees. The table shows that in 1994 the central funds, which were still allocated according to historical budgeting, were extremely unequally distributed -- with the wealthiest getting 6 times more than the poorest. Local "own" revenues were also inequitably assigned -- with the wealthiest assigning 41 times more than the poorest. However, three years later the central government's formula driven allocations (based largely on population size) had almost achieved equity, with the wealthiest only 1.2 times more than the poorest. And the gap in allocation of "own" source revenues also declined from 41 to 11 times more than the poorest.

COLOMBIA: AVERAGE CENTRAL BUDGET AND OWN SOURCE REVENUES PER CAPITA BY INCOME DECILE

TABLE 7.

	1994		1995		1996		1997	
Deciles	Central Budget	Own	Central Budget	Own	Central Budget	Own	Central Budget	Own
1 poor	7.1	0.2	10.9	0.2	22.4	0.9	54.6	2.1
2	10.7	0.5	12.0	0.8	22.8	1.2	56.2	2.9
3	10.5	1.2	15.3	1.4	25.4	3.2	59.1	7.1
4	14.8	2.2	19.4	2.4	26.6	4.7	54.4	9.6
5	16.9	2.6	24.3	4.3	28.8	7.6	62.4	13.9
6	28.1	4.1	27.1	6.0	38.0	12.8	60.0	18.1
7	24.5	4.1	36.0	7.9	47.2	14.7	67.3	20.3
8	25.7	4.1	41.6	8.0	45.8	13.4	67.3	21.2
9	37.8	6.7	52.4	10.0	56.0	18.1	64.7	23.4
10 rich	43.4	8.3	58.7	14.0	52.7	21.2	64.6	25.0
Avg.	21.9	3.4	29.7	5.4	36.6	9.8	61.1	14.4
10th/1st	6.11	41.5	5.38	70.0	2.35	23.55	1.18	11.9

CURRENT ALLOCATIONS TO HOSPITALS AND ADMINISTRATIVE OFFICES

Regions	Administration	RSSB	Hospital Network	IFCS	**Total**
Chaouia Ouardigha	11,14%	41,77%	47,09%	0,00%	100%
Doukkala-Abda	13,42%	46,62%	39,96%	0,00%	100%
El Gharb-Chrarda	8,33%	43,08%	48,59%	0,00%	100%
Fès-Boulmane	8,14%	39,38%	50,74%	1,74%	100%
Grand Casablanca	10,65%	38,85%	48,61%	1,89%	100%
Guelmim-Smara	12,56%	55,93%	31,50%	0,00%	100%
Laayoune -Boujdour	10,09%	28,20%	61,71%	0,01%	100%
Marrakech-Tensift-ElHaouz	4,46%	41,86%	52,11%	1,56%	100%
Méknès-Tafilalet	12,79%	42,05%	44,12%	1,05%	100%
Orientale	6,26%	47,26%	46,11%	0,38%	100%
Oued Eddahab	11,47%	34,39%	54,14%	0,00%	100%
Rabat-Salé-Zemmour-Zair	12,84%	54,40%	27,29%	5,48%	100%
Souss-Massa-draa	6,27%	52,71%	39,50%	1,52%	100%
Tadla-Azilal	10,75%	54,32%	34,93%	0,00%	100%
Taza-Alhoceima	5,12%	58,76%	36,12%	0,00%	100%
Tanger-Tétouan	8,41%	41,77%	49,54%	0,28%	100%
Total	9,08%	45,67%	44,07%	1,17%	100%

Source: MOH, *Direction de la Planification et des Ressources Financières, Service de L'économie Sanitaire. 2001.*

ANNEX 2: LIST OF INTERVIEWS

[tjn note: Volcan can you add to this list people Ihave seen during Agadir Workshop, especially Meshaq, Cherradi, Falsa, Habibi.

Ministry of Health
Dr Cherradi, *Chef de la division de la santé scolaire et universitaire, DP*
Dr Jrondi*, Directeur de la DHSA*
Dr Darkaoui, *Chef de division des soins ambulatoires, DHSA*
Dr Belghiti, *Responsable UMER, DHSA*
M. Lagham, *Directeur de la DEM*
Dr Mahjour, *Directeur de la DELM*
M. Jalil Hazim, *Chef de division financière, DPRF*
Dr Braikat, *Chef du programme national d'immunisation, DP*
M. Belkadi, *Directeur de la DRH*
M. Idriss Zineddine, *Chef de service de l'Economie Sanitaire, DPRF*
Melle Asmaa El Alami F, *Cadre du service de l'Economie Sanitaire, DPRF*

Ministry of General Affairs
Mr. Ziani

USAID
M. Peter Kresge, General Development Officer
Mme Susan Wright, Population and Health Team Leader
M. Dawn Traut, Consultant
M. Taoufik Bakkali, Project Management Specialist

Progress
M. Volkan Cakir, Chief of Party, JSI
Mme Boutaïna El Omari, Technical Advisor, JSI

ANNEX 3: LIST OF REFERENCES

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