Decentralizing Organizational Arrangements for Service Delivery

Introduction

The key assumption that underlined the study was that organizational and management reforms in the four sectors studied were pushed by the new public management-type reform agenda reviewed in Chapter 2. These reforms tend to ignore the specificities of sectors and the institutional contexts of poor countries often characterized by state dominance, weak market institutions, fiscal crisis, poor incentives and political sensitivities. This chapter will examine the nature and the extent of ‘the new management’ organizational reforms for service delivery across the four sectors, using evidence from the case study countries (Ghana, Zimbabwe, India and Sri Lanka) and reference countries where possible. The focus in this chapter is on internal management reforms rather than externally oriented market-type reforms, which are analyzed in Chapters 6–8. To put the reforms in context, the first section briefly reviews the pre-reform organizational arrangements for service delivery. The second section then outlines the types of organizational arrangements, and the third section examines the nature and extent of reforms in organizational arrangements. The fourth section reviews the available evidence on the performance of reformed organizational arrangements. The conclusion teases out cross-country and crosscutting issues in organizational arrangements and performance.

Pre-reform organizational arrangements

The context in which reforms were introduced in the four core countries was one of centralization and direct provision of public services by
the state, with minimal private sector participation and only lip service paid to improving performance. Sub-Saharan Africa and South Asian countries had similar levels of high and active state involvement in the four sectors of the economy, especially in the immediate post-independence period until reforms in the 1980s. They also shared a similar tradition of being Commonwealth countries with the organization of their public services more or less following the British tradition before reforms. Ministries, departments and agencies for service delivery were quite hierarchical in structure and consequently very bureaucratic in their operations.

In curative health, where formal systems were largely government funded and provided, the organizational arrangements for service delivery were found to be broadly similar (Mills et al., 2001). The depth of hierarchical structures and bureaucratic controls were more noticeable than in other sectors. This may be explained by the fact that historically there was a stronger state presence and direct role for government in curative health care provision than in other sectors in all the four core countries. As Mills et al. point out:

The Ministry of Health (MoH) was at the apex of a pyramid, with lower management levels below it, and a structure of services – at least in theory – consisting of peripheral outpatient facilities, local hospitals, general hospitals and central hospitals with referral and supervisory relationships between them. (Mills et al., 2001:3)

The lower management levels referred to above typically took the form of deconcentrated regional and district offices of the MoH and health facilities accountable through the hierarchy to the ministry. Large hospitals, especially teaching hospitals, existed outside the deconcentrated organizational structure, but had some delegated management authority from the MoH, as was the case in Ghana and Zimbabwe before reforms. Delegation of financial and other management powers to the lower units of the health system were limited; decision-making was centralized in the MoH and other government agencies. In India the relationship between the federal and state governments further complicated the issue of centralization (Mills et al., 2001:35).

Over-centralization was closely associated with vertical programmes and professional cadres. In India the federal government had significant authority over most priority services such as malaria and AIDS control (ibid.: 36). In the case of Ghana, for example, vertically organized programmes necessarily encouraged the development of separate,