Analysing the Effectiveness of Decentralisation in Improving Health Services in Balochistan

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Abstract

This paper examines how decentralisation improves healthcare services in Balochistan. Pakistan undertook major reforms through the 18th Amendment to the Constitution and the implementation of the 7th National Finance Commission Award. The health sector is one of the key social sectors that provided the bedrock of the decentralisation argument in Pakistan. In adopting institutional capacity, decision, space, and accountability approaches, the paper explores the effectiveness of decentralisation on health service delivery in Balochistan. Using a qualitative approach, primary data was collected from a sample of 33 key decision-makers at various healthcare systems in Balochistan's four districts. The respondents' perspectives were explored in the Framework Method, using institutional capacities, decision space, and accountability approach on key health functions that include Planning, Budgetary Allocation and Financing, Implementation of Health Programmes and Service Delivery, Management, and Monitoring and Utilisation of Data. In all functions, the decision space is noted as "narrow" and "narrow-to-moderate" only, notwithstanding the implementation of decentralisation reforms some 12 years ago. The paper concludes that to enhance the impact of decentralisation in health service provision, bigger decision spaces for

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decision-makers at the district/local level may be accompanied by a consistent augmentation of capacities and accountability to support good decision-making at regional levels in the decentralised functions. Examining the health system among this synergic approach is crucial for exploring tangible policymaking in Balochistan, other provinces and regions in Pakistan, and other countries with similar governance structures.

Keywords: Decentralisation, Framework Approach, Decision Space, Accountability, Capacity, Balochistan.

Introduction

The primary aim of decentralisation is to empower sub-national and local governments to provide more effective and better representations and services to the people. In heterogeneous and diverse societies, decentralisation is preferable to a centralised service delivery mechanism. In the case of ethnically diverse cultures, and when there are no spill overs from one region to another, decentralisation is invariably preferred over centralisation for social services provisions.[1] However, this argument may not be appropriate for developing countries in which the mechanisms of political accountability are not well-developed, with prevalent corruption and the capture of regional/provincial governments by interest clusters and local elites. In such cases, decentralisation is less desirable than centralisation for service provisions. Fiscal resources that are disbursed to local/subnational governments from the central government may be siphoned off into luxury consumption by the local elite, instead of investing in improving the service to the local population.[2,3]

For these reasons, it is argued that decentralisation must be accompanied by measures that strengthen local accountability, minimise the risk of corruption, improve the transparency of regional/local governments, and ensure that local people participate in the political process. Scholars also point out the negative consequences of decentralisation,[4,5] highlighting major issues with decentralisation like local/regional governments' lack and inefficiency of human resources in implementing devolved social

[1] W. Oates, *Fiscal Federalism* (New York: Harcourt Brace Janovich, 1972).
[2] J. Manor, *The Political Economy of Democratic Decentralization* (The World Bank, 1991).
[3] D. Olowu, "Challenge of Multi-Level Governance in Developing Countries and Possible GIS Applications," *Habitat International* 27, no. 4 (2003): 501–22.
[4] B. Flynn, "Is Local Truly Better? Some Reflections on Sharing Environmental Policy between Local Governments and the EU," *European Environment* 10, no. 2 (2000): 75–84.
[5] D. Brinkerhoff and O. Azfar, "Decentralisation and Community Empowerment: Making Decentralisation Work: Democracy, Development, and Security*,"* (Lynne Rienner Publishers, Boulder, CO, 2010).

services[6] mismanagement and misallocation of resources in a decentralised setting.[7] Elite capture in economic and political sphere settings,[8] unhealthy competition and insufficient equity are encouraged among the sub-national/local governments,[9] creating issues of free riders and local-level corruption. According to Wallace Oates,[10]decentralisation carries risk, as the decentralised units/provinces may lack the ability and motivation to behave in the ways as the theory predicts.

While discussing the merits and demerits of decentralisation, it is typically claimed that coordination failure among the subnational governments – the inability to take advantage of economies of scale or internalise various forms of externalities – is to blame for the weak performance of decentralisation.[11] According to C Dick-Sagoe[12'13],[13]increasing the amount of money allocated to service delivery is crucial for achieving successful outcomes in the provision of social services. It requires a specific

[6] V. Tanzi, *Taxation in an Integrating World*, (Washington, DC: Brookings Institution Press, 1995).
[7] R. Reinikka and J. Svensson, "Local Capture: Evidence from a Central Government Transfer Program in Uganda," *The Quarterly Journal of Economics* 119, no. 2 (2004): 678–704.
[8] Bardhan. P. & Mookherjee. D. "Capture and Governance at Local and National Levels," *American Economic Review. 90 (2). 135–139.* (2000).
[9] M. S. De Vries, "The Rise and Fall of Decentralisation: A Comparative Analysis of Arguments and Practices in European Countries," *European Journal of Political Research* 38, no. 2 (2000): 193–224.
[10] Paul Smoke, "Rethinking Decentralization: Assessing Challenges to a Popular Public Sector Reform," *Public Administration and Development* 35, no. 2 (May 26, 2015): 97–112, https://doi.org/10.1002/pad.1703.
[11] Wallace E Oates, "An Essay on Fiscal Federalism," *Journal of Economic Literature* 37, no. 3 (September 1, 1999): 1120–49, https://doi.org/10.1257/jel.37.3.1120.
[12] C Dick-Sagoe, "Reducing Poverty through Decentralised Public Service Provision of District Assemblies in the Central Region, Ghana." in *7th African Union and Renaissance Conference* (Pretoria, South Africa, 2017).
[13] M. Sow and I. F. Razafimahefa, "Fiscal Decentralisation and the Efficiency of Public Service Delivery International Monetary Fund," (2015).

institutional environment, which Smoke[14] and Dick-Sagoe[15] identify as having strong local capacity, strong accountability at several levels of institutions, good governance, and effective and independence of local/provincial governments to make decentralisation more efficient and effective in achieving service delivery. When evaluated in terms of the outcomes of service delivery, it does not essentially result in an improvement in service quality. Enhancing local service delivery production is not sufficient, the quality of local service delivery is also highly important.

In Pakistan, the adoption of (fiscal) decentralisation was motivated, among other historical and political considerations, by the desire to give the provinces more financial and administrative latitude to handle not only health services but also other services like social welfare, education, agriculture, tourism, and local infrastructure. Decentralisation – both fiscal and administrative – was sought after in 2010 with the passage of the 18th Amendment, and the consensus on and implementation of the 7th NFC Award. Some stakeholders in the society, especially the regional political parties and smaller ethnic groups and provinces, enthusiastically welcomed these reforms towards decentralisation to provinces, given the political climate and the makeup of the federal structure of Pakistan. However, research suggests that decentralisation and fiscal federalism, as reform measures intended to enhance the provision of social services, might not be successful unless some essential requirements are considered and appropriately satisfied. In the following, based on the Framework Method, it is observed how, under the decision space framework, certain authorities are given to the local/subnational officials and political

[14] Smoke, P. "Rethinking decentralization: Assessing challenges to a popular public sector reform,' *Public Administration and Development*, *35*(2), 97-112. (2015).

[15] Dick-Sagoe, C, "Reducing poverty through decentralised public service provision of district assemblies in the Central Region, Ghana,' A paper presented at the 7th African Union and Renaissance Conference, South Africa 2017, 31st March to 1st April 2017, Pretoria, South Africa. (2017).

representatives to make decisions at the regional level to take initiatives to improve health services delivery. In addition, the level of "capacity" of the officials in the health sector plays a substantial role in effective policymaking and applying the policies and improvements of the "devolved" authorities after the decentralisation initiatives to provide better health services. To make the case that the complementary interactions or synergy of all three proportions will result in improving health outcomes following decentralisation in Balochistan, it is summarised with the 'decision space' and the other two crucial dimensions: 'accountability' and 'capacity'.

Focusing on Balochistan, the paper seeks to analyse how well decentralisation has improved the health system in the province. The main objective is to describe the circumstances that allow decentralisation to work well, based on the knowledge of decision-makers in the health sector. Evaluate the extent to which health sector decision-makers utilise their decision-making space about different health sector functions and examine how it interacts with aspects of accountability and capability. Examine the viewpoints of health sector decision-makers regarding governance modifications that could enhance service delivery under decentralisation. Examine how decentralisation can improve the functioning of the health system in different contexts. And finally make policy suggestions for Balochistan and other comparable provinces and countries to increase the advantages of decentralisation to enhance health service delivery.

Literature Review

For decentralisation to be effective and result-oriented, mainly in terms of social service provision, a ray of political, economic, and administrative conditions must be fulfilled. Literature on decentralisation is divided and inconclusive on the impacts of decentralisation on social service provision, mainly because decentralisation as a reform policy should not be seen in isolation. Myriad factors and conditions explain its success and

failure. Scholars like J. Rodden [16] and Razafimahefa[17] argue that the quality of governance and a robust accountability mechanism at the subnational level contribute immensely to the success of decentralisation, mainly on the quality and magnitude of services provision. The governance structure includes an enabling local framework, effective political accountability, the administrative capacity of institutions, a sound mechanism for accountability, and a large decision space for local officials to initiate and implement policies. Johannes[18] believes that decentralisation's efficacy, active political involvement, and participation of the local people are the salient fundamentals when it primarily aims to enhance the quality and quantity of public-funded services. Successful decentralisation requires delineating the officials' governance structure, roles, and responsibilities in each sector. However, Kolehmainen and Newbrander's[19] comprehensive review of decentralisation in 10 countries demonstrates that decentralisation is not so impactful in improving healthcare services as given the specialised human resource requirements, decentralised governments lack the capacity and financial wherewithal to provide quality healthcare services. The organisational structures, roles, and responsibilities between national and subnational governments for certain healthcare services invariably overlap and lead to confusion. The roles of g governments' conflict with each other, as the responsibilities of each tier of government are not delineated. The organisational structures and responsibilities often get disputed, potentially creating certain conflicts of interest.

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[16] Regmi, K., Decentralizing Health Services: A Global Perspective. (*Springer Science & Business Media, London.* 2013).

[17] Sow, M., & Razafimahefa, I. F. "Fiscal decentralisation and the efficiency of public service delivery international monetary fund", WP/15/59 IMF Working Paper Fiscal Affairs. (2015).

[18] Johannes Jütting et al., "What Makes Decentralisation in Developing Countries Pro-Poor," *The European Journal of Development Research* 17, no. 4 (December 1, 2005): 626–48, https://doi.org/10.1080/09578810500367649.

[19] Kolehmainen-Aitken R-L and Newbrander W, "Decentralising the management of health and family planning programs. Lessons from FPMD Series", Boston: *Management Sciences for Health.* (1997).

Thomas and Siddle[20] used a sample of 37 South African municipalities to conclude that decentralisation is too complex for under-capacitated subnational/local governments to handle self-governance, causing poor service provision and a democratic deficit. They find out that, South Africa's local governments are overburdened with constitutional and legal requirements they cannot meet. The Congo case shows that decentralisation reforms further worsen essential public services provisions. Greater predation, centralisation at the provincial level, unaccountable governments at the provincial level, and self-serving local elites were the results of Congo's decentralisation.[21] The decentralisation issues in Congo serve as an example of how deeper politics and governance reforms in Africa are often at odds. An exploratory and qualitative study was carried out by Michael *et al*.[22] on informants who were selected from five distant and poor districts of mainland Tanzania. Lucy *et al*,[23] also reached similar conclusions. Molina's[24] study on Colombia comes to the same conclusion about the inconsistency of decentralisation's effects on the health sector. He shows that the government's management of the health sector fails to keep up with other social sectors and healthcare performance. This has an immediate impact on the calibre of the workforce in the health sector, which is correlated with the politics of clientelism and favours. Gilson *et al* [25] present the

[20] Thomas A. Koelble and Andrew Siddle, "Institutional Complexity and Unanticipated Consequences: The Failure of Decentralization in South Africa," *Democratization* 21, no. 6 (September 19, 2014): 1117–33, https://doi.org/10.1080/13510347.2013.784270.

[21] Johannes Jütting et al., "What Makes Decentralisation in Developing Countries Pro-Poor?" *The European Journal of Development Research* 17, no. 4 (December 1, 2005): 626–48, https://doi.org/10.1080/09578810500367649.

[22] Michael A Munga et al., "The Decentralisation-Centralisation Dilemma: Recruitment and Distribution of Health Workers in Remote Districts of Tanzania," *BMC International Health and Human Rights* 9, no. 1 (December 30, 2009): 9, https://doi.org/10.1186/1472-698X-9-9.

[23] Lucy Gilson, Peter Kilima, and Marcel Tanner, "Local Government Decentralization and the Health Sector in Tanzania," *Public Administration and Development* 14, no. 5 (January 2, 1994): 451–77, https://doi.org/10.1002/pad.4230140503.

[24] Molina Gloria, "An Integrity Perspective on the Decentralization of the Health Sector in Colombia," *Advances in Qualitative Research in Ibero America* 10, no. 2 (2009).

[25] Gilson, Kilima, and Tanner, "BMC International Health..."

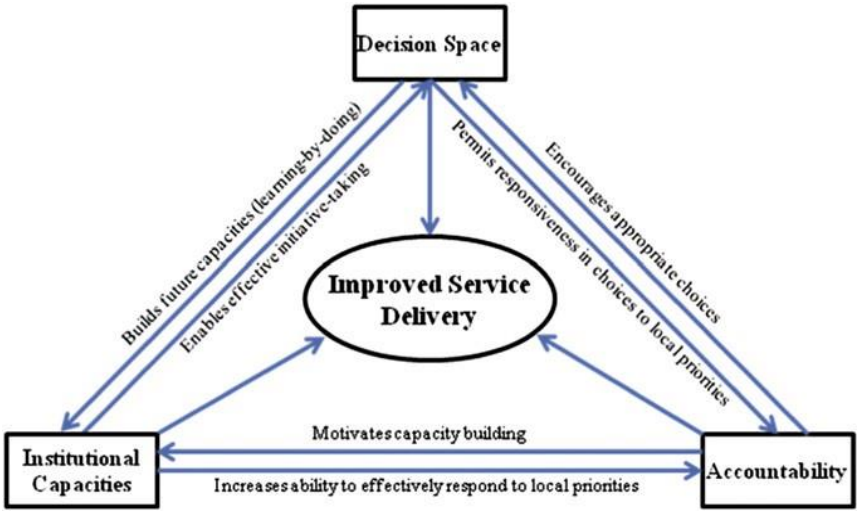
decentralisation pattern in the health sector from the managers' point of view to let people comprehend their viewpoints. They conclude that managers have little power to decide on critical issues like resource management, which might deal with issues like inefficiency and poor primary healthcare. Limited institutional capacity, conflicts between the needs for local discretion and central control, resource limitations and political and cultural influences over the operation of decentralisation are other problems impeding effective administration. Bossert and Mitchell[26] examine the relationships between three aspects of decentralisation: institutional capacities, accountability to local officials, and decentralised authority (also known as the "decision space"), using a sample of 91 health sector decision-makers from 17 districts in Pakistan. The four main health functions are budgeting, strategic and operational planning, human resources management, and service organisation/delivery. Three key conclusions are drawn from this work. First, despite Pakistan's provinces sharing comparable regulations and operating under a single decentralisation regime, district-level respondents indicate differing degrees of each component. Second, there are synergies between respondents' reported levels in one function and other functions when it comes to decentralisation's dimensions, including decision space and capacity. Third, there are connections between the various facets of decentralisation, especially when considering an all-encompassing measure of institutional capabilities. These results imply that Pakistan's decentralisation strategy should concentrate on fostering synergies between decentralisation's many elements to promote more accountability to locally nominated officials, increased use of the *de jure* decision space, and increased institutional capacity uniformity.

[26] Bossert, T. J., Mitchell, A. D., & Janjua, M. A, "Improving health system performance in a decentralized health system: capacity building in Pakistan", *Health Systems & Reform, 1*(4), 276-284. (2015).

Decision Space, Accountability and Capacity

In the emerging literature on decentralisation, a larger consensus has developed that decentralisation to augment and improve public health involves not only the questions of fiscal transfers to the second and third tiers of governments, but also those related to authority, accountability, and capacity. For many years, the health system's decentralisation has been on the public policy agenda, with both opponents and proponents debating its merits and demerits based on theoretical arguments and empirical evidence. In recent times, the literature on decentralisation has somewhat linked the success of decentralisation in health service delivery with a suitable degree of authority and discretion – which the literature terms the "Decision Space" that combines with suitable institutional capability, something called "Capacity" to make appropriate choices that are consistent with the performance of the public health sector. In addition, a third dimension, besides discretion and capacity, is the accountability of those choices that cater to public health needs and priorities. In other words, accountability to public representatives, officials, or the governance structure.

Figure 1: A conceptual framework based on the synergy and decentralisation of healthcare service provision



Source: *Bossert and Mitchell*[27]

As shown in Figure 1, it is an attempt to conceptualise the relationship among functional decision space, institutional capacity, and accountability to develop a framework of analysis. The framework makes clear that improving the health sector, like other social sectors, results in the fundamental goal of decentralisation. It demonstrates how decision space, institutional capability, and accountability work together to improve healthcare outcomes. The components of this framework can then be utilised to construct indicators of dimensions, which aid in the

[27] Bossert, T. J., Mitchell, A. D., & Janjua, M. A, "Improving health system…".

examination and assessment of their interrelationships and, ultimately, health outcomes.

This paper builds its analysis on the decision space, the institutional capacity, and the accountability dimensions of the health sector officials and staff at the provincial level focusing on four districts in Balochistan. The paper develops its analysis based on the framework presented in Figure 1. It assesses how much district-level officials' actual decision-making varies from the legally defined range of options available to them. It connects their decisions to related institutional resources and accountability dimensions. The paper focuses on relationships among the three dimensions of decentralisation (Fig. 1). Yet, given the data limitations, it is left to future studies to examine the relationships between those factors and performance-related outcomes. Decentralisation is a complex process, but the salient feature of decentralisation is the allocation of power and authority over certain decision-making from sophisticated – federal and provincial – to lower-provincial, divisional, district, or local-level administration.[28]

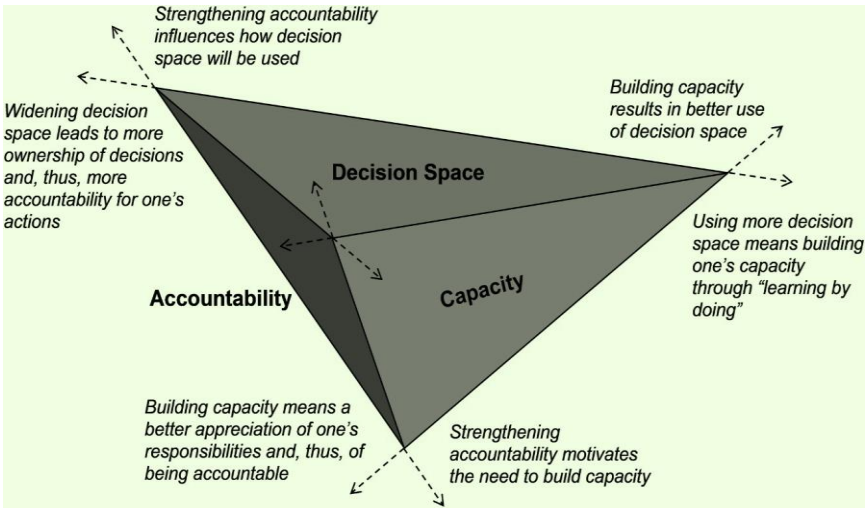
The Decision Space framework typically examines the underlying discretion, authority, and official functionaries obtain and, thereby, exercise for health services delivery. The decision space framework involves a multifaceted, complex process of determining the choices of various administrative functions and financial discretions the officials at the subnational and local level are provided and allowed to use by the central or provincial authorities. The *de jure* power or decision space is also integrated, and the power that in practice is exercised by the local authorities – the *de facto* power or decision

[28] K. Kostanjevec, Policy Failure of Croatian Decentralisation Policy (Doctoral dissertation, Central European University). (2014).

space. Some proponents of decentralisation argue in favour of higher local choices over a wider range of health services provision.

Decision space refers to the intricate process of determining the number of options for various functions and funds that local officials are permitted to employ from above (i.e., de jure decision space) as well as the powers that are used in practice (de facto informal decision space). Some proponents of decentralisation favour a high degree of local choice over a wide spectrum of publicly overseen services, including health services. Nevertheless, the opponents of decentralisation in the health sector argue that since the health sector involves a complicated process with myriad functions, maximum autonomy at the subnational/local level is bound to create a conflicting situation, compromising the objectives of the health system at the national level.

Figure 2: The synergy of decision space, Institutional capacity & accountability from the perspective of decentralisation and Health services.



Decision-making at the local level is the crux of decentralisation's argument to augment local authority and efficiency, reduce the level of bureaucracy, better match local needs, and increase the level of participation of local people in decision-making for all social services delivery, including health. Given these prospective benefits, decentralisation has been forcefully implemented in many countries to provide better social services including health.

Decision Space has been used as an effective framework to assess the impact of decentralisation on health services. Through this Framework, the amount of choice transferred to the local officials/representatives – that is, wider than moderate, or the least narrow – from the higher level and the decisions made at the lower level given the approved space, and the impacts of such decisions on the delivery of health services.

One could argue that the effectiveness of local health officials and the institutional capacity play a major role in determining how decentralisation affects the health sector capacity in terms of organisational structure and training, as well as a conducive environment that fosters the methodical capacity building of the sector with the necessary systems and processes, infrastructure, and procedures to support optimal decision-making and policy implementation in any conditions.[22] Thus, appropriate institutional and individual capacities to work out a given decision space are necessary for better health sector operations.

In addition to the value of developing capacity, the accountability factor is a necessary precondition for better healthcare services provision. Accountability can actively involve local or subnational government structures and local communities in decision-making, which can potentially lead to making the public involved in the decision-making process and reduce the risk of elite capture at the national level. Empirical evidence on decentralisation, however, continues to focus mainly on two fronts. Firstly, the variations at the local level in an array

of choices the officials at the local level make, given a common set of official rules may be significant determinants of differences in the initiatives, implementation, and effect on health sector performance and outcomes that result from decentralisation.[29] Secondly, if institutional capacity and accountability mechanisms are also vital determinants, a better and more nuanced analytic framework may be helpful to know the roles that institutional capacity and accountability mechanisms at the local/subnational level can play in making decentralisation effective in better health services provision. Yet the available empirical evidence on decentralisation's impact on health has insufficiently examined the synergy of these dimensions to make health services delivery more responsive and effective.[30]

Therefore, based on the analytical framework developed by Bossert, Mitchell, and Janjua, the paper examines and evaluates the decision-making space, accountability, and institutional capability of local and subnational officials focusing on four districts in Balochistan.

Methodology

To investigate the responsibilities, functions, and policy decisions that the decision-makers and authorities in the healthcare sector carry out at the province and district levels in Balochistan, the paper employs a conventional research methodology and conducts protracted, semi-structured questionnaire-based research. The decision space, accountability mechanism, and institutional capability variations that arise over four types of functions in the health sector are measured using standard research instruments: 1. Strategic planning and strategy, 2. Human resource management 3. Budget and finance, and 4. Service

[29] T. Bossert, "Decentralization in Zambia: Resource Allocation and District Performance," Health Policy and Planning 18, no. 4 (December 1, 2003): 357–69, https://doi.org/10.1093/heapol/czg044.

[30] M. Ahmed, "Political Economy of Elite Capture and Clientelism in Public Resource Distribution: Theory and Evidence from Balochistan, Pakistan," India Quarterly, 79(2), 223-243, ((2023). https://doi.org/10.1177/09749284231165115

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delivery. It assesses four types of health functions in each of the three dimensions that are discussed above.

First, building on the Decision Space dimension captures the extent to which the subnational level officials can make decisions to perform various health functions and provide healthcare services. We assume that the decision space available to the health officials depends on both the decisions that are delegated to the officials at the lower tier as well as the degree to which these officials are permitted to make a variety of decisions for health services delivery. Decision space may be broadened or narrowed, such as when decision-makers at the local level make decisions irrespective of what rules may dictate them or making certain choices that take advantage of, to a greater degree existing options. Second, institutional capacity is another dimension to assess the effectiveness of the local health officials performing service delivery.

Institutional capacity primarily focuses on personnel and organisational characteristics of the health systems at the confined level. The instruments employed attempt to evaluate resources that is the availability of funds, quality and scope of infrastructure, human resources, and systems and processes. The third dimension is the measurement of accountability, which is the downward accountability of choices made by decision-makers/health officials, who are accountable to elected representatives at the local/provincial level, as well as unelected officials at the upper tier(s). This nature of accountability is assessed by asking the health sector professionals and civil service respondents about their perceptions of the downward and upward accountability exercised by health officials.

A semi-structured survey-based questionnaire is developed by drawing from the concept of health sector tasks and the decision space approach while analysing the synergies between decision space, accountability, and capacity. The questionnaire provides latitude in investigating participants'

insights about their perceptions and personal experiences in dealing with health services post-decentralisation reforms.

It examines their decision-making flexibility, institutional capacity for implementing decisions and service delivery, and accountability mechanisms within designated health sector functions. These functions are distinct categories of duties where decision-makers and health officials make choices for the health sector. Thus, taking a cue from some relevant studies,[31'32'33] it initially identified six health functions

1. *Planning* - The planning function captures devising specific plans for local health services as a routine, involving all stakeholders in planning and implementing these plans.
2. *Allocation and Financing* – the allocation of budget from the provincial government or through other sources to support the health services provision at the local level and the utilising mechanism of the budget which is intended for health services provision.
3. *Health Services Delivery* – health services delivery following guidelines and protocol provided by the national/provincial government, implementation of services designed locally according to local needs and conditions considering quality standards.
4. *Management of Personnel and Staff* – hiring, firing, and retaining staff and professionals, training officials and staff to meet national standards, and supporting their career needs. Salary structure and benefits should be in line with national/provincial standard rates, etc.

[31] T. Bossert, "Decentralization in Zambia: Resource Allocation and District Performance," *Health Policy and Planning* 18, no. 4 (December 1, 2003): 357–69, https://doi.org/10.1093/heapol/czg044.
[32] Bossert, T. J., Mitchell, A. D., & Janjua, M. A, "Improving health system performance in a decentralized health system: capacity building in Pakistan," *Health Systems & Reform, 1*(4), 276-284. (2015).
[33] Ahmed, "Political Economy of Elite…"

5. *Management Medical Equipment* and *Facilities* – ensuring the types and quantity of health facilities at the local level where required, the maintenance and upgrading of such facilities, and the provision and supply of equipment and medicines to make the medical services fully functional and effective.
6. *Monitoring Health Indicators and Their Utilisation* – choosing the indicators to monitor the performance of health services at the local level, collecting these data accurately, executing data management professionally, and using the data collected about indicators to communicate the results at local levels.

The health functions discussed above are wide-ranging, with numerous sub-themes. Based on three dimensions and six health functions, it builds a comprehensive semi-structured questionnaire. It thoroughly reviewed the questionnaire while keeping in view the health sector management in Balochistan. Three-point ordinal scales are used to grade survey questions that are included in the analysis.

The **"narrow"** or low decision space, the low institutional capability, and the absence of accountability are represented by the score of **"1,"** whereas **"2"** captures or depicts a medium-level decision space, **"medium"** level institutional capability, and accountability, **"3"** symbolises a **"wide"** decision space with adequate institutional capacity and a strong accountability system. Through a methodical and cooperative process, it creates the alternatives and then arranges the answers along the scale.

Selection of Respondents

The study purposefully selected respondents who were duly contacted (through phone calls and WhatsApp messages) and those decision-makers who are serving in the Health Department and Planning and Development Department (in the case of Additional Chief Secretary) in different positions of authority. They primarily represent three types of implementers and decision-makers.

1. Provincially appointed ministers, secretaries, directors, and CEOs of the People's Primary Health Initiative (PPHI);
2. District health officers, also known as career officers or health officers, are Deputy Commissioners (DC), and Medical Supervenient (MS);
3. Career health professionals who oversee Basic Health Units (BHUs) and Regional Health Centres (RHCS) at the *tehsil* and local levels.

From Balochistan's three divisions, four districts were chosen (see Table 1). Two secretaries, one of whom was the health secretary, who was serving during the interview, and the other the former health secretary, are among the respondents. There were two politicians: a former Minister for the Planning and Development, Department, and a serving Health Minister. Professional health officials in the civil service made up the remaining respondents.

Table 1: Sampled Districts in Balochistan

Province	**Balochistan**		
Divisions	**Kalat**	**Makran**	**Quetta**
Districts	Lasbela	Kech	Quetta
		Gwadar	

Before conducting formal interviews, the respondents were requested, and upon their agreement, the questionnaire was sent to them through email/WhatsApp. The interviews were recorded with the consent of the respondents. The interviews were taken either in Urdu or Balochi. On average, the interviews lasted for an hour. Even though the qualitative research method did not allow us to obtain a statistically representative sample of the respondents, purposive selection of members was initiated to capitalise on the variation in the respondents' profiles about their

current roles, overall affiliations with the organisation, level of decision-making, and terrestrial locations where they are staffed or employed.

Table 2: Officials and Politicians who are interviewed			
Respondents	**N**	**Of service/politics (average years)**	**At current Post**
DCs (Deputy Commissioners)	4	24	2.5
DHOs (District Health Officers)	4	25	1.8
MS (Medical Superintendents)	4	20	9
Medical Officers (RHCs)	6	15	4.6
Medical Officers (BHCs)	8	14	6.4
Secretary	3	26	0.4
Minister	2	20	0.7
Director General	1	25	0.8
Chief Executive Office, PPHI	1	18	1.2
Total Respondents	33		

Framework Method

Following the studies conducted by Heath *et al*, [34] the study derives investigations on the "Framework Method," which considers a methodical approach to thematic investigation while comparing the perspectives of the respondents. It primarily applies a deductive approach in the study for robust analysis.

[34] Gemma Heath et al., "Paediatric 'Care Closer to Home,' Stakeholder Views and Barriers to Implementation," *Health & Place* 18, no. 5 (September 2012): 1068–73, https://doi.org/10.1016/j.healthplace.2012.05.003.

Thematic analysis centres on how decision space is used by health officials and decision-makers in various health functions. It also evaluates whether decision space is viewed as wide, moderate, or narrow within each identified health function, as well as the kinds of circumstances that make decentralisation beneficial for the healthcare sector in carrying out these functions. A condition is defined as any feature or procedure, as well as any combination of them that makes it possible to establish a decentralised health system that works effectively. In a similar vein, it identifies the impediments that negatively impact the health system. The paper summarises favourable and unfavourable circumstances based on the roles played by the health sector and the range of choices available to different decision-maker groups within these roles.

Table 3: The following is a summary of questions asked to respondents to examine decision-making in six functions to assess the scope and nature of decision space as narrow, moderate, or wide.

Follow-up questions related to capacities and accountability are also included. The questionnaire and Interview Guide are as follows:
Appendix A:

Is decision-making for this function made with sufficient latitude at the District level for better health service delivery?

Planning	***Investigation: Are the health Officials at the District Level?*** • Develop their own (bi) annual plans for health services. • Determine their priorities, which may vary from priorities set at the fed/provincial level. • Include local stakeholders in their planning process. • Implement and adopt what is stated in their plans.

Financing & Allocation of Budgeting	• What are the sources of funds needed to support health services? • Generate additional sources of financing to support such health services in the district. • Spend the allocated budget according to what is planned.
Planning	Investigation: Are the health Officials at the District Level? • Develop their own (bi) annual plans for health services. • Determine their priorities, which may vary from priorities set at the fed/provincial level. • Include local stakeholders in their planning process. • Implement and adopt what is stated in their plans.
Health Services Delivery/Programme Implementation	• Health services provision, as mandated by the Fed/Provincial govt. • Provide health services/Implement programme. Consider the local context. • Provide good quality and faithful local health services to the fed/provincial standards.
Administration/Management of facilities and Supply of Equipment and Medicine	• Place the suitable types and number of health facilities in the localities where they are needed. • Continue and upgrade these facilities? • Deliver suitable equipment and medicine, for these facilities to be fully functional.
Management of health Sector officials and Workforce	• Hire and fire the local health workforce according to health services delivery. • Compensate the locally hired health staff, and train them. • Manage and build the capacity of the local health staff and support their professional development.

Monitoring and Utilisation Data	• Choose the indicators for monitoring the health system's performance at district levels. • Collect such health indicators in a precise and timely way. • Accomplish monitoring and management of data professionally and electronically? • Use the data and local knowledge for policy formulation.

Results:

Planning

In Pakistan, after the 18th Amendment, health services have come under the complete control and domain of provinces. The "decision space" in the domain of strategic planning for decision-makers and policy planners is assessed as "**moderate.**" Elected representatives lead the provincial government with the authority to plan on their own. Yet, numerous experiences in Balochistan suggest that planning in the health sector is conducted by bureaucracy, the health department, and the relevant sections in the Planning and Development Department. Therefore, planning depends entirely on the ability of these two departments to make plans for health services provision and their implementation. To assist the health department in planning, but particularly in execution, the District Health Officers (DHOs) play a crucial role. The PPHI, which is responsible for primary healthcare services through offices at the district level, where a district support manager looks after the affairs of primary healthcare, also conducts the annual planning for health at the primary level, a mechanism through which the BHUs are provided with all technical support, equipment, and medicine.

When the planners and decision-makers possess the necessary ability to carry out strategic planning on a regular and appropriate basis and involve many stakeholders in the planning process, decision-making and planning can be improved with this **"moderate"** decision space that the health

officials can work out. A good accountability mechanism is imperative to develop good decision-making in planning, which requires the officials in the health department and health officials at district, divisional, and regional levels personnel and health officials to receive additional training and technical support to enhance their capacity in making plans at all levels and to review these plans and approve them at provincial levels to confirm their alignment with national aims. They may ensure strict examination of the implementation of these plans to guarantee the satisfactory provision of health services.

Thus, in the planning domain, we noticed that at the provincial level, the officials enjoy "**moderate**" decision space, while at the district level, the officials are restricted from making any decision beyond their mandates, as mentioned in the rule book. Officials at the district level have "**narrowed**" decision space in the **"planning"** sphere.

Financing and Allocation of Budgeting

Decision space, accountability, and institutional capacity for financing and budgeting were assessed to be from **"moderate"** to "**narrow**" because in Balochistan politicians, in particular, control was excercised in much of the province government's discretionary spending and finance decisions. For financing and budgeting decisions of the health sector, officials/representatives hardly take suggestions from the health representatives and civil experts dealing in the Health and Planning and Development Departments.

It is observed that district governments in somewhat urbanised districts (e.g., Turbat and Quetta) receive a larger portion of the funds allocated to the district headquarters' RHCs and hospitals. The province significantly allocates a lesser proportion to smaller districts, which is insufficient to provide labour-intensive health services both in urban centres and towns and in rural areas. It was observed that the district-level health sector is heavily dependent on payments from the provincial government due to a

high degree of "centralisation" in budgeting and financing. These insights from the interviews also support earlier research on Pakistan's other provinces (see Bossert and Mitchell[35]) which observed declining health spending by district governments over time, in addition to the prevalence of limited electoral goals influencing decisions about how to pay for healthcare in Balochistan. Financing and budgeting decisions may be made more effective when decision-makers can set priorities. For instance, they have the authority to give precedence to informed evidence and primary and preventive care services over politically motivated financial decisions made both at the district and provincial levels.

In addition, the accountability mechanisms mandate that health institutions run by the provincial government meet the minimal requirements set forth by the federal government. As a result, when it comes to financing and budgeting, health officials have "narrowed" the scope of their decision-making.

Health Services Delivery/Programme Implementation

Decision space for health services delivery or health-related implementation commands significant importance in assessing the overall role of decentralisation in the health sector. The Department of Health in Balochistan has the authority and jurisdiction to carry out health programmes and offer regular (primary and territory health) services, hence our assessment rates the delivery of health services as "**moderate**." The DHOs and the PPHI are authorised to offer services and implement health programmes. Nonetheless, inadequate programme execution and service delivery are the outcomes of a weak governance framework in the district and beyond where primary health care is offered. This covers functions like women's prenatal care and children's vaccine coverage. It was also noted that poor district and local governance coupled with a lack

[35] Bossert, T.J., Mitchell, A.D., Health sector decentralization and local decision-making: Decision space, institutional capacities, and accountability in Pakistan, Soc. Sci. Med, 72, 39–48, (2015). https://doi.org/10.1016/j.socscimed.2010.10.019.

of resources led by poorly trained and corrupt local health officials failed to meet the national goals for these kinds of initiatives. It is, therefore, resolved that decision space can be more effectively used when decision-makers and implementers possess the necessary capabilities to deliver health services while upholding national objectives that cater to local and regional needs, that are better suited to the cultural context, resulting in more successful district/local health service implementation. In addition, health officials at the local/district level can also perform their functions better if they can collaborate with other provinces of Pakistan.

The provinces may collaborate and constitute a functional service delivery network, which can help weaker provinces like Balochistan improve not only the human resource domain but also the infrastructure and institutional capacity. And to share resources like medicines when the health facilities of other provinces have stock, to allow health professionals to assist in health facilities in another province, in case that province lacks basic health staff. The accountability in such functions should be reinforced when the provincial-level decision-makers/planners maintain their responsibility to develop and implement the technical procedures to comply with all tiers of government mandated by the federal government. This includes the expansion and coverage of programmes on immunisation, Tuberculosis, and control of non-communicable diseases as well as the training of health staff at the district level and beyond, who run these programmes. The province should also encourage the acknowledgement and promotion of district government-implemented programmes that the district-level tier can adopt. This might create a kind of inter-district competition for the provision of health services and increase accountability. The province may also facilitate the grouping of districts that fall in the same region or division for constituting functional and efficient service delivery networks.

Table 4: Assessment of decision space, capacities & accountability mechanism for the health sector (b)

Health sector functions	Decision space at	Institutional and Personnel/Individual	Accountability mechanisms put

	the district level	Capacities	in place by the Provincial Government
Administration/ Management of facilities and Supply of Equipment and Medicine	Narrow	*Institutional:* • Willing, capacity, legal provision, and resource availability to purchase and supply equipment and medicine, and to partner with the private sector to enhance the delivery of health facilities. ***Personnel/Individual*** • The ability to manage public health facilities and provide healthcare services through management.	The provincial government penalises health officials in case it fails to provide healthcare services. ***Potential policy consideration*** Provincial-level procurement of selected equipment and supplies on behalf of the department at the district level to gain leverage to negotiate for the provision of these resources as augmentation to district-level
Management of health Sector Officials and Workers	Narrow	***Institutional:*** The department at the district level has adequate financial capacity & regulatory framework to: Hire & fire health staff needed to serve the local people. Provide health staff	Placement of provincially hired health staff to local health facilities, but condition to district level performance on: Establishment of support for the implemented health

		salary, benefits, and training, if required ***Personnel/Individual*** Deep recognition of the crucial role that district/local health officials and staff play at all governing levels.	officials/staff Pledge to eventually allocate the finances required to hire a health workforce on their own. The provincial level is to be officially responsible for supplying capacity-building staff at the district/level across the province. Implementation of a provincial policy that hinders health officials/staff at the district level from being partisan
Monitoring and Utilisation of Data	**Narrow**	*Institutional:* • Systematic ability to monitor and use data at the district level in a coordinated and integrated manner following decentralisation. *Personnel/Individual:*	Deployment of provincial-level data enumerators at the local level to validate data collected at the local level and speed up data transmission to the provincial level.

		• Basic information on health issues to recognise the significance of the indicators collected. • Skills and technical knowhow for evidence-based public health, • Skills in transforming data into policy action	Upholding of a provincial-level automated database, in which the district level is required to transmit data promptly. • Production & Publication of rankings of districts in completing selected health (targeted) outcomes

The Administration/Management of facilities and Supply of Equipment and Medicine

The decision-making space for general management and administration, as well as the accessibility of facilities, equipment, and medication supplies, is deemed to be "**narrowed**." In the meantime, the district administrations already possess the whole authority and managerial control over the medical facilities and apparatus they own. However, the respondents noted that local facilities and equipment were simply non-existent. Vaccines, medications, contraception, lab equipment, diagnostic kits, operating rooms, and so forth are among them. Decision-making space for these responsibilities may be enhanced in addition to equipment supplies, if health officials and decision-makers have the capacity and management abilities needed to successfully oversee and operate health facilities and programmes. The health officers and staff of the district and municipal governments hardly ever possess this capacity. To improve the efficiency of certain aspects of service delivery through Public-Private Partnerships (PPP), health officials at the local level must also strengthen and expand their capacity to engage the private sector. This is especially

important at the district headquarters level, where the private sector health structure is largely operational. Areas for such a collaboration include outsourcing the obligation and maintenance of expensive equipment, for instance, X-ray machines, ultrasound machines, or CT scanners. Both the government(s) and private entities can share the income from the equipment. Another area for partnership, for example, can be the provision of supply of medicines and other small equipment for Basic Health Units, Regional Health Centres, and other such hospitals through a delivery agreement with private providers, which not only curtails drug stocks but also allows the public sector to pay only for the medicines that are utilised. Strengthening accountability in providing such functions may be achieved when the provincial government strictly enforces licensing of health facilities to keep quality, but in the meantime providing and ensuring technical support to officials at the local level who are struggling for better health services provisions.

Management of Health Sector officials and Workforce

The evaluation of the domain of workforce management and health officials indicates a "**narrow**" decision space. At the provincial and local levels, the health department formally has complete control over the administration of its workforce and health officials. However, in practice, at the district level, the governments are unable to hire the minimum number of workers and health officials they require. There is lack of funding, lack of mandate, and lack of services and incentives to encourage health workers to assist in remote areas. Mandates and capabilities that local health officials must possess could include having the funds necessary to hire the number of health workers the community needs. It also means the ability to pay competitive wages and benefits. When the local health department has the regulatory approval to hire additional health workers as deemed required, their capacity may be further enhanced. These capabilities could be reinforced by accountability mechanisms. Such as the province's requirement that district-level officials who gain from staff placement programmes not only support the

staff equally — by offering free housing or conveyance allowance for posted health workers. It also implements a medium to a long-term plan that outlines the required budget alterations to hire the necessary workforce. Without these conditions, the district-level organisation might be forced to rely on the province for all its health worker's needs. Additional accountability measures could involve the province bearing some of the burden of increasing the local healthcare structure's capability for health workers in the province.

Monitoring and Utilisation of Data

Principally the local health system is not in charge of gathering health-related data and sending it to the province for consolidation, additional use, and evaluation. So, the decision space for data monitoring and utilisation is "**Narrow**." Based on experiences in Balochistan, it appears that even provincial-level decision-makers gather data according to tradition and merely out of compliance. And the Health Department is ill-equipped to use the data for any activities aimed at improving healthcare services.

When their ability to comprehend health-related issues and the provision of public health is enhanced, provincial-level decision-makers and health officials may expand their "decision space" for such functions. They ought to be aware of the significance of key health indicators and how to analyse and convert them into information that can help with wise decision-making. The Health Department may utilise its enumerators to verify the information provided by the experts and expedite the transfer of data to the federal level for use on a national and worldwide scale as part of the accountability procedures for such functions. The federal government might consider suggesting to the provinces that they have achieved certain health outcome benchmarks. It might keep an accurate computerised database that compiles all local health-related statistics, which is necessary for determining how well the nation's health services are performing.

Conclusions

Decentralisation efforts have long been a popular approach for reforming health policies in both rich and developing nations, including Pakistan. Proponents of decentralisation policy reforms frequently advocate for increased subnational and local decision-making authority to improve resource distribution and the quality-of-service provision. However, the opponents and critics of decentralisation argue that decentralisation of services in healthcare may create a conflicting situation for overall health, jeopardising the provision of uniform health services. They also show concern for the decentralised governments' implementation capacity and accountability.

This paper attempts to make a decentralisation effort for the health division and services provision in Balochistan (applicable elsewhere in Pakistan), focusing on the synergy of the 'decision space,' the 'institutional capacity,' and the 'accountability mechanism.' The findings present a wealth of potential evidence to enhance institutional capacity at the provincial, district, and local levels and reinforce accountability frameworks to foster sound decision-making in Pakistan's decentralised health system. The analysed respondents' interviews, using the Framework Method, enabled them to compare the viewpoints of district and provincial-level decision-making, which, for some functions, exhibit divergent opinions. For example, a few district-level decision-makers stated the lack of autonomy to develop and carry out their functions independently in the planning domain. However, the decision-makers at the provincial level expressed that the district-level officials cannot plan independently. Even if they do, the plans cannot be fully implemented independently, as they lack capacity and are inefficient.

Varying perspectives have been compared and then triangulated these views to obtain an overall evaluation of decision space for each function from a combination of several views. Accordingly, the analysis shows that decision spaces at district levels have been particularly **"narrow"** in

Balochistan despite decentralisation reforms through the 7th NFC Award and 18th Amendment. The results suggest that the 'narrow' or 'narrow-to-moderate' decision spaces observed at the district level are the results of both: The refusal of the province to grant the space to the district level; and inadequate capacity of the decision-makers and health officials at the district level to perform fully whatever the province post-decentralisation gives them. It is, thus, concluded that a truly comprehensive decision space at the district level can hardly be achieved if it is not accompanied and complemented by expanding institutional capacity and strengthening accountability mechanisms. The analysis shows how increasing each of these three dimensions can improve selected health outcomes in Balochistan. Through a qualitative approach, it is attempted to discover several specific policy considerations if the synergy of decision space, capacity, and accountability works well in increasing the healthcare services in Balochistan. Much research (for example, *Jalal et al*[36] and Sean *et al*[37]) on decentralisation has also come to a somewhat similar conclusion, showing that decentralisation only allows the decision space, but its effective use by decision-makers at lower levels of the system may be realised only when their institutional capacity is developed. An accountability mechanism is put in place, particularly for functions such as planning, priority setting, and building capacity, which can expand the

[36] Jalal Mohammed, Nicola North, and Toni Ashton, "Decentralisation; The Question of Management Capacity: A Response to Recent Commentaries," *International Journal of Health Policy and Management* 6, no. 1 (October 4, 2016): 61–63, https://doi.org/10.15171/ijhpm.2016.134.

[37] Sean Dougherty et al., "The Impact of Decentralisation on the Performance of Health Care Systems: A Non-Linear Relationship," *The European Journal of Health Economics* 23, no. 4 (June 17, 2022): 705–15, https://doi.org/10.1007/s10198-021-01390-1.

use of decision space, as reported in Tanzania by Ramadhani *et al*[38] and for Tanzania by Stephen.[39]

The paper analysed a list of required institutional and individual capacities to help improve the delivery of services and implementation of healthcare programmes. At individual levels, these include skills for strategic planning and management, priority setting, and evidence-based policymaking. At institutional levels, these required capacities are having a multi-stakeholder approach, partnership with the private sector, and facilitating cooperation among various district officials.[40,41] In a decentralised context, the responsibility for building decision-making capacities at the district level and for the health officials remains with the provincial-level decision-makers in Balochistan.

It was observed that notable growth in all health sector functions offered at the local level by the provincial-level healthcare system, can fulfil its obligation to provide the population with high-quality healthcare. Such lack of intervention from the provincial government indicates the lacklustre attitude of the latter toward the importance of district-level setup in implementing the true spirit of decentralisation. Such

[38] Ramadhani Kigume, Stephen Maluka, and Peter Kamuzora, "Decentralisation and Health Services Delivery in Tanzania: Analysis of Decision Space in Planning, Allocation, and Use of Financial Resources," *The International Journal of Health Planning and Management* 33, no. 2 (April 15, 2018), https://doi.org/10.1002/hpm.2511.

[39] Stephen Maluka et al., "Decentralized Health Care Priority-Setting in Tanzania: Evaluating against the Accountability for Reasonableness Framework," *Social Science & Medicine* 71, no. 4 (August 2010): 751–59, https://doi.org/10.1016/j.socscimed.2010.04.035.

[40] Aloysius Ssennyonjo et al., "Government Resource Contributions to the Private-Not-for-Profit Sector in Uganda: Evolution, Adaptations and Implications for Universal Health Coverage," *International Journal for Equity in Health* 17, no. 1 (December 5, 2018): 130, https://doi.org/10.1186/s12939-018-0843-8.

[41] M. Ahmed, "Analysing the Impacts of Decentralisation in Improving Health Services in Balochistan: A Decision Space, Institutional Capacity and Accountability Approach", Policy Brief, RASTA, Pakistan Institute of Development Economics, Islamabad.

phenomenon of decentralisation is documented in Kenya,[42] Indonesia,[43] Ghana and Guatemala.[44]

Although there are many facets to accountability, the study concentrated on the procedures the province might employ to hold third-tier health system personnel accountable. Meeting the targets and accountability are examples of our methods' financial, accounting, and resource allocation performance components. These insights stem from an increasing awareness that one should think more complexity-informed and move beyond linear causality. The typical challenges in the health sector in Balochistan may not come from undoing the decentralisation process or negating the federalism spirit of Pakistan, but potentially by focusing more on improving the capacity, accountability, and governance. In other words, widening decision space at lower levels is required to augment decentralisation impacts on the health sector. Yet, it must be accompanied by enhanced institutional and human capacity and strengthened accountability,[45] demonstrate how the availability, accessibility, and use of healthcare services are affected by the decentralisation of the health system.

It implies that increasing the capacity of health officials and decision-makers tasked with organising and carrying out health services delivery at

[42] Benjamin Tsofa et al., "How Does Decentralisation Affect Health Sector Planning and Financial Management? A Case Study of Early Effects of Devolution in Kilifi County, Kenya," *International Journal for Equity in Health* 16, no. 1 (December 15, 2017): 151, https://doi.org/10.1186/s12939-017-0649-0.

[43] Sekar Ayu Paramita et al., "Distribution Trends of <scp>Indonesia's</Scp> Health Care Resources in the Decentralization Era," *The International Journal of Health Planning and Management* 33, no. 2 (April 11, 2018), https://doi.org/10.1002/hpm.2506.

[44] T. J Bossert, D. M Bowser, and J. K Amenyah, "Is Decentralization Good for Logistics Systems? Evidence on Essential Medicine Logistics in Ghana and Guatemala," *Health Policy and Planning* 22, no. 2 (January 15, 2007): 73–82, https://doi.org/10.1093/heapol/czl041.

[45] Arianna Rotulo, Christina Paraskevopoulou, and Elias Kondilis, "The Effects of Health Sector Fiscal Decentralisation on Availability, Accessibility, and Utilisation of Healthcare Services: A Panel Data Analysis," *International Journal of Health Policy and Management*, (November 28, 2021), https://doi.org/10.34172/ijhpm.2021.163.

all levels within the province will be necessary in addition to providing a broad decision space at the subnational level to enhance and expand the delivery of health services. In addition, this should be accompanied by ensuring accountability of health officials and policymakers not only to the community and politicians but also to the overall system of governance for all relevant decisions they make. It is, therefore, suggested that for the effectiveness of health services delivery, numerous configurations of the decision space within the institutional capacity and robust accountability mechanism may be stringently implemented.

The findings of the paper conclude that the lack of administrative capacity, weak accountability, and narrow decision space at the district level adversely affect the impact of decentralisation on healthcare services. These results provide a way forward to augment the capacity and strengthen the accountability procedures to support and promote the decision space in the health sector at the district level. This investigation allowed us to compare federal, provincial, and district-level decision-making perspectives for functions like healthcare services.

The result suggests that different space scenarios – moderate and moderate-to-narrow –suggest that even the local officials do not have the adequate capacity to fully utilise the administrative and fiscal autonomy provided by the second tier (the provincial government) for better healthcare provision. It, therefore, implies that a wider decision space at the district level remains ineffective unless the administrative capacity is adequately enhanced, and a stringent accountability mechanism is implemented.

Therefore, given the entrenched and prevalence of rent-seeking power structure at the provincial level, it is likely that decentralisation in Balochistan will not be successful in providing services, particularly health services, given that politicians are at the core of decision-making. Decentralisation exacerbates or maintains corruption with a poor

institutional framework and a lack of accountability procedures. The insights from Balochistan suggest that the policy process needs to shift from linear causation of decentralisation and healthcare outcomes to much broader, complex thinking. Yet, the solution for better healthcare services in Balochistan does not come from "re-centralisation." Instead, focus more on the capacity and accountability of the overall governance structure at the provincial and local levels.

Since the provision of basic healthcare is significantly performed at the local level, the desired capacities of individuals/officials and institutions at the lower level need to be augmented. At the personnel level, the capacities involve skills building for strategic planning and management, evidenced-based policymaking, agenda setting and prioritisation, and creativity in service provision. At the institutional level, the required capacities involve efficiently utilising resources, generating resources from local sources, engaging, and partnering with the private sector, and enabling health officials and other stakeholders to improve the services. For accountability, the allocation and utilisation of funds, accounting for achieving the targets, and accountability of local politicians and representatives for services like healthcare should be in place. Thus, the efficacy of decentralisation in service delivery, including healthcare, depends on the synergy of these three critical dimensions, where the capacity of personnel and institutions complements the decision space at the local/district level, and the institutional mechanism of the governance structure. With this line of reasoning, one can acquire the complexity of considering decentralisation and produce tangible policy measures for better healthcare services in Balochistan.

Policy Recommendations

To expand the effectiveness of decentralisation in the obligation of providing healthcare services, it is advised to consider beyond mere linear causation and, instead, adopt a more complexity-informed strategy. Balochistan's health sector challenges cannot be solved by increasing

federalism, decentralisation, or centralisation of national authority over local administrations. For decentralisation to be implemented at all levels of government and tiers, a concerted effort should be made to push all health authorities to assume functions for making decisions that aim to improve the performance of health services and to develop greater information on the *de jure* decision space. Additionally, by building institutional capacity, efforts should be made to create synergistic effects, primarily focusing on the district administrative units with the least institutional capability. All healthcare programmes should include these kinds of interventions to enhance local capacity. Similarly, greater bureaucratic authority should be used to enforce accountability to elected officials and the governance structure overall. If the local accountability mechanism is considered a policy aim, then further work in a decentralised environment might be required to support regional decision-making with sensible configurations of the decision space that integrate the proportions of institutional capability and a healthy accountability mechanism. To improve the efficiency of some aspects of service delivery through public-private partnerships, the ability of local health officials to cooperate with the private sector must also be strengthened and expanded. This is because the private sector health structure is operational in most district headquarters in Balochistan. Potential areas of collaboration for this kind of arrangement encompass contracting out the supply of expensive equipment needed by hospitals.

When their ability to comprehend health-related issues and deliver public health improves, policymakers and health workers may also expand their decision space for such functions. They ought to know the significance of key health indicators and how to analyse them and convert them into statistics to support national wise decision-making. When local decision-makers can establish priorities, focusing on primary and preventive care services rather than politically motivated decisions at the provincial and district levels, decision-making in financing and budgeting may be improved. As part of the responsibility mechanisms for such functions, the

provincial health department may send out its data collectors locally to confirm the information provided by experts and expedite its transfer to the federal level for use on a national and international scale. To report to the public on the accomplishment of the provincial governments, the federal government may also think about publicising and admiring the province(s) for meeting particular health result targets. A reliable and robust computerised database that compiles all health-relevant statistics from the district and municipal levels must be maintained to assess the nation's healthcare situation accurately.■