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USAID Health Finance and Governance Activity

DECENTRALIZATION IN THE PUBLIC HEALTHCARE OF JORDAN – A SITUATIONAL ANALYSIS

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ACRONYMS

BOD	Board of Directors
GC	Governorate Council
HFG	USAID Jordan Health Finance and Governance
HCAC	Health Care Accreditation Council
HR	Human Resources
KPI	Key Performance Indicator
LD	Law on Decentralization
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MOI	Ministry of Interior
MMA	Ministry of Municipal Affairs
OGP	Open Government Initiative
RMS	Royal Medical Services
SDG	Sustainable Development Goals
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The purpose of this study is to assess the situation of decentralization in healthcare in Jordan; inform the activities of the USAID-funded Health Finance and Governance Activity (HFG) in health sector governance and gender mainstreaming; and provide a basis for discussing health decentralization. In Jordan, as in other countries, decentralization is part of a political process that spans sectors; thus, decentralization in the healthcare sector depends largely on broader national developments. Jordan has a concentrated (centralized) government system. Authority in the public health sector is highly concentrated at the top of each of multiple public healthcare finance and delivery systems—the Ministry of Health (MOH), Royal Medical Services (RMS), and universities. Also, although there is no one center of power in the healthcare system to decentralize, there are powerful technical arguments and opinions in support of re-centralization of splintered public health insurance schemes—through civil insurance, military insurance, and universities.

Various definitions tend to converge on the concept that decentralization is a process of transferring power and responsibility from a center to either other structures or peripheral structures of that same center (administrative decentralization). The degree of a system's decentralization is often measured on a scale ranging from a single decision-making and funding center (centralized) to decision and funding independence (privatized). In between these ultimate stages are others—de-concentration (administrative decentralization/delegation of authority), devolution (statutory transfer of power from center to local government), and decentralization (a term used to refer to the process of decentralization as a whole) reflecting various degrees of delegation of authority. Internationally, discussions on decentralization, including in healthcare, are most often in the context of local self-government that assumes responsibilities and authority from the national government.

The meaning of decentralization in Jordan would benefit from an official definition—a vision of what decentralization should look like in five, 10, and 15 years, and a measure(s) of success. A Law on Decentralization (LD) enacted in 2015 could be a step toward local self-government. The European Union's standards for local self-government requires elected bodies to have significant control over local affairs and management, have regulatory powers, and derive a major part of their income from local taxes and fees. By that international standard, the new legislation in Jordan has a more limited goal than achieving local self-government.

Elected Governorate Councils (GCs) in Jordan have no authority over healthcare; sole responsibility rests with the governor and the MOH. To that extent, the discussion of healthcare decentralization cannot be attributed to the LD, which is limited to a de-concentration of powers between the vertical structures of the MOH. The issues are the degree of authority, responsibility, and budget that the MOH is ready to delegate to its health directorates at the governorate level, and what type and how much authority it is willing to delegate to healthcare providers. Examples of authority and responsibility that could be delegated include budgeting and finance management; human resources management; procurement of drugs, supplies, and equipment; outsourcing of non-clinical services; opening and closing units; and so on.

Jordan has some very limited experience with de-concentration of authority within the MOH's vertical structures. The governorates' health directorates function under a delegation of authority and responsibility from the MOH. Also, the MOH in the past has experimented with a transfer of limited management authority to some of its hospitals.

Other countries' experiences with healthcare decentralization are overwhelmingly in the context of local self-government. A notable lesson from such experience is that the transfer of responsibility for healthcare services to local self-government has been hard to defend, even in cultures that have had strong local self-governance for millennia (e.g., EU Nordic countries). Transfers of authority to local self-government in many cases have created conditions for inequity with little to show in improved health outcomes/quality of care or increased efficiency. These outcomes have been largely due to localizing the financing function by shifting the burden for funding to local authorities, thus creating disparities between richer and poor regions unless adequate budget transfers earmarked for health were put in place to equalize differences.

Decentralization cannot accomplish the goals of efficient delivery of equitable care without ensuring accountability. In Jordan's health sector, accountability is very weak. Some of the factors contributing to this problem include weak use of performance indicators, the lack of gender-responsive indicators, lack of tools to measure accountability, and a shortage of useful and reliable data across the healthcare sector. These issues make accountability in the public healthcare system very challenging to achieve.

The laws on decentralization and their implementing regulations may help advance democratization in Jordan by introducing the citizenry to some of the basics of self-government through local elections and scope for the elected bodies. Viewed through the lens of practical legal analysis, however, the implications for the public healthcare sector from this process are much less apparent and warrant only very limited expectations.

INTRODUCTION

This document draws on the USAID Health Finance and Governance's (HFG) understanding of the realities of the health sector, prior studies of decentralization in Jordan, a review of current laws and recent international obligations, and published opinions on decentralization. International experience emerges occasionally as a source for the conceptual framework and lessons for Jordan.

Why and what to decentralize
International experience suggests that decentralization in healthcare is a function of broader democratization processes in societies, tied to national objectives for the transfer of authority, responsibility, strategic and operational decision making, accountability, and resource collection and/or management to lower levels of government, civil society, or the private sector. Thus, the transfer can include ownership of facilities and/or responsibility for management and funding of specific areas of healthcare—public health in whole or part; preventive care and diagnostics; and all or parts of curative care, such as primary care. The possible variations on what is transferrable are numerous, with no clear model to follow (European Observatory, 2007).

Decentralization in the context of Jordan
Decentralization in Jordan has a long history but has occurred slowly, and with political and legal limitations. His Majesty King Abdullah II has encouraged various forms of power sharing. The new legal base for decentralization from 2015—the Law on Decentralization (LD)—could be only the first step toward local self-government. The end goal, meaning, and utility of decentralization for healthcare, however, is not discernable from the law, which does not grant local elected authorities any responsibility for healthcare. This responsibility rests with the governor (an appointed position) and the Ministry of Health (MOH). The law does not establish locally generated sources of funds to support the needs of the elected bodies. The functions of these new locally elected bodies appear to be largely concerned with increasing popular support for the functions of the local executive bodies.

Local self-government and limitations to decentralization in healthcare
The documented experience of other countries with decentralization in healthcare has been inherently connected with the needs and authorities of local self-government. That experience does not present compelling arguments and evidence that decentralization leads to improved health outcomes and/or more efficient use of public resources while preserving or improving equity. Decentralization in the context of local self-government, however, enables increased involvement of citizens in healthcare governance. Although governments make choices related to health (financing, benefits, facilities, etc.), decentralization limits these choices due to the rules of budget formation, execution, and budget size (pooling of funds); and priorities at different levels of government (central and local). These and other limitations of choice may result in relative differences in health funding and consumption, thus impacting equity and efficiency, and compromising some of the benefits of self-government in the eyes of the citizenry. Careful design and skillful, gradual, well-executed, and measured implementation are essential to success.

Arguments for decentralization and recentralization
Internationally, the most common reasons for both decentralization and re-centralization in healthcare are political. The argument of "efficiency gains" is one of the more powerful and has been used by both proponents and opponents of decentralization. A more "traditional" argument in favor of decentralization in healthcare has been that of increased democracy and local decision making. Arguments favoring re-centralization include healthcare equity and efficiency. In Jordan, for instance,

many experts agree that centralizing multiple public insurance schemes into a single public insurer would be a way to gain efficiency. Ultimately, however, whether or how healthcare decentralization works depends largely on historical and cultural factors, capabilities for local self-government, holding elected and appointed officials accountable, regulating effectively, implementing the law with vigor, mastering the fiscal balance between the central and local levels, and putting in place well-designed and executed fiscal transfers/grants to ensure equalization of resources for health across regions. Ultimately, these elements should lead to some form of local self-government in the future. The question then becomes: Is Jordan ready for decentralization?

Experience with decentralization in Jordan's health system
Attempts have been made in the past to de-concentrate certain hospital management decisions from the MOH to the leadership of MOH-operated facilities. The example of the Prince Hamza hospital management autonomy pilot in Amman is the one usually mentioned in conversations on the topic of management (administrative) decentralization. This pilot was begun nine years ago and its results have not yet been assessed. The MOH has expressed interest in having the pilot evaluated by an international expert.

In Jordan, the health departments at the governorates reportedly had some limited responsibilities for planning, budgeting, and financial management until 2013, when the Government Finance Management Information System was introduced and many of these responsibilities were assumed by the central MOH (effectively a re-concentration of powers). The World Health Organization (WHO) is preparing to review the functions of the MOH in 2017; this review will likely include a review of the functions of the health directorates at the governorate level. One potential result from such a review could be recommendations regarding administrative decentralization within MOH vertical levels.

The legal framework
The broad legal basis for decentralization in Jordan is scattered across more than 70 laws, bylaws, and instructions. The LD and the Law on Municipalities of 2015 bestow a certain amount of authority for the protection of public health upon the governorates and municipalities. At the governorate level, the authority rests with the governor (the appointed executive body). The Law on Municipalities appears to grant slightly more authority for local decision making in health as well as powers to generate revenue from local sources. Thus, municipalities can participate in the development of health infrastructure (public hospitals and clinics) and decide whether to allow construction of health facilities based on their populations' needs for health services.

Gender and decentralization
The Law on Municipalities and the LD offer a legal basis for women to participate in community mobilization. The LD allocated a 10 percent quota for women in elected seats as well as one-third of appointed seats, thus ensuring a total of 15 percent of seats reserved for women on Governorates' Councils. The Law on Municipalities allocates 25 percent of Municipal Councils' seats for women. Women's rights groups have been vocal regarding their concerns about the effect of decentralization on the status of gender equality in Jordan. More specifically, the two main women's rights groups in Jordan are concerned about the guarantees for gender mainstreaming at the governorate and municipal levels, calling for providing capacity building for elected members on gender mainstreaming, gender-responsive budgeting at the governorate and municipal levels, and inclusion of gender focal points at the governorates.

Role of national government and other parties in healthcare decentralization
Researchers and practitioners of decentralization claim that national governments should focus on enabling—including brokering efforts of multiple stakeholders in healthcare to improve health and

prevent diseases—rather than managing facilities and/or resources. The example of the Republic of Georgia provides ample evidence—the government brokered a private sector effort to build and operate 100+ new hospitals between 2009 and 2013. Collaboration among stakeholders in healthcare, is difficult to achieve, however, as it is not only time consuming, but also complicated and often frustrating because the common objectives, risks, and benefits of keen interest to each stakeholder are often poorly defined and shifting, thus presenting constant risks to stakeholders.

The environment in Jordan provides examples illustrating this point. Multiple vertical public healthcare systems (the MOH, Royal Medical Services [RMS], universities) resist rationalization due to lack of a common vision of risk/rewards sharing in the name of a larger public benefit (such as the concept of a single public payer of health services operating more efficiently than separate insurers). They also are concerned with the delegation of management authority over healthcare delivery capacity. The three public healthcare systems offer a great potential platform for collaboration—the establishment of a single public payer/insurer for health services as a separate entity governed to serve the best interests of the public sector, including each of the three public schemes. Such a step could add substantial social and economic value through economies of scale, standardization of operations, and elimination of redundancies, including multiple insurance coverage.

There are questions in Jordan about whether universities and professional healthcare societies have a role to play in the process of decentralization. The research on international experience for the preparation of this document could not find evidence for such a possible role. However, there is no reason why universities and professional societies, to the extent of their respective technical capabilities, cannot contribute to discussions and research related to decentralization in healthcare in Jordan.

Subsidies and decentralization
The public healthcare system in Jordan is heavily subsidized, with those insured making small contributions for lavish benefits and coverage of family members. Maintenance of such benefits could be jeopardized if responsibility for either health financing or delivery is delegated one day to local self-government without making certain system adjustments. An example of a proper adjustment would be a single public insurer, one of whose objectives would be to dampen the regional disparities that could emerge due to the responsibility for deriving income from local sources and forming and executing budgets within the governorates in the context of future local self-government. Notably, the opinion of Jordanian experts and policymakers in healthcare gravitate toward the need for a single public payer/insurer.

Situational Review and Analysis

Historical Overview of Moves Toward Decentralization in Jordan

The First Draft of the Decentralization Law (January–November 2005)

In January 2005, His Majesty King Abdullah articulated the vision of decentralization as part of "political, economic, social and administrative reform."[1] The King stressed that economic, social, and administrative development go hand in hand with greater popular participation in public sector policy making and implementation, and effective social auditing of public sector performance. This vision was driven by "keenness to have people in their respective governorates participate in affairs related to

[1] His Majesty King Abdullah II's website, available at: http://www.kingabdullah.jo/press_room/speechpage.ph.

public facilities, investment priorities, expenditures on capital and service projects and in overseeing the performance of official bodies in all areas."[2]

The 2005 vision focused on the notion that public policies should be developed through a "bottom-up" process rather than imposed from the top down: "Political development should start at the grassroots level, and then move up to decision-making centers and not vice versa."[3] In that speech, however, His Majesty had proposed the creation of regions rather than governorates, promoting them as a "number of development areas or regions, each consisting of a number of governorates. Each will have a local council directly elected by its people, to work hand in hand with the elected municipal councils in the governorates to set priorities and draw up plans and programs related to their respective regions."[4]

The details of translating the King's vision were left to a Royal Commission. The Commission submitted its report and a draft decentralization law on November 23, 2005. However, the public opposed the idea of dividing the country into a few relatively large regions run by local councils; as a result, the proposed legislation had to be withdrawn.

The Second Attempt (2008–2009)
Although the "regions" idea proved politically unfavorable, His Majesty's concern with Jordan's "political development" and increased people's participation in public policy making remained as valid, consistent, and urgent as ever. In subsequent speeches on October 5, 2008 and May 3, 2009, he continued to underline the importance of bottom-up public policy formation and the need for subnational "political development."

The search for appropriate ways to address the King's concerns resumed in May 2009, when the Prime Minister set up an Inter-Ministerial Committee on Decentralization and its Technical Committee with the task of developing a "Decentralization Strategic Framework." This policy document aimed to guide the reform of the subnational system of governance and public administration, focusing on (but not limited to) the enhancement of the developmental role of governors and governorate-level administrations, and the need for appropriate forms of people's participation in public policy making and implementation at the governorate level.

The Third Attempt (2015–2017)
This period covers the period from the enactment of the decentralization and municipality laws and their respective implementing regulations until the local council elections in August 2017, and the formulation and communication to the public of the vision for decentralization in Jordan.

Overview of the Environment for Decentralization in Healthcare

General Overview, Institutional Leadership, and Relationship of National-local Administration

The division of powers in Jordan is between the national/central level (King, Parliament, Prime Minister, and line ministries), regional/governorate level (12 governorates), and municipal level (94 municipalities, including Amman).

The institutional leadership for local government is exercised by the Ministry of Interior (MOI) for the governorates and the Ministry of Municipal Affairs (MMA) for the municipalities. The MOI's main

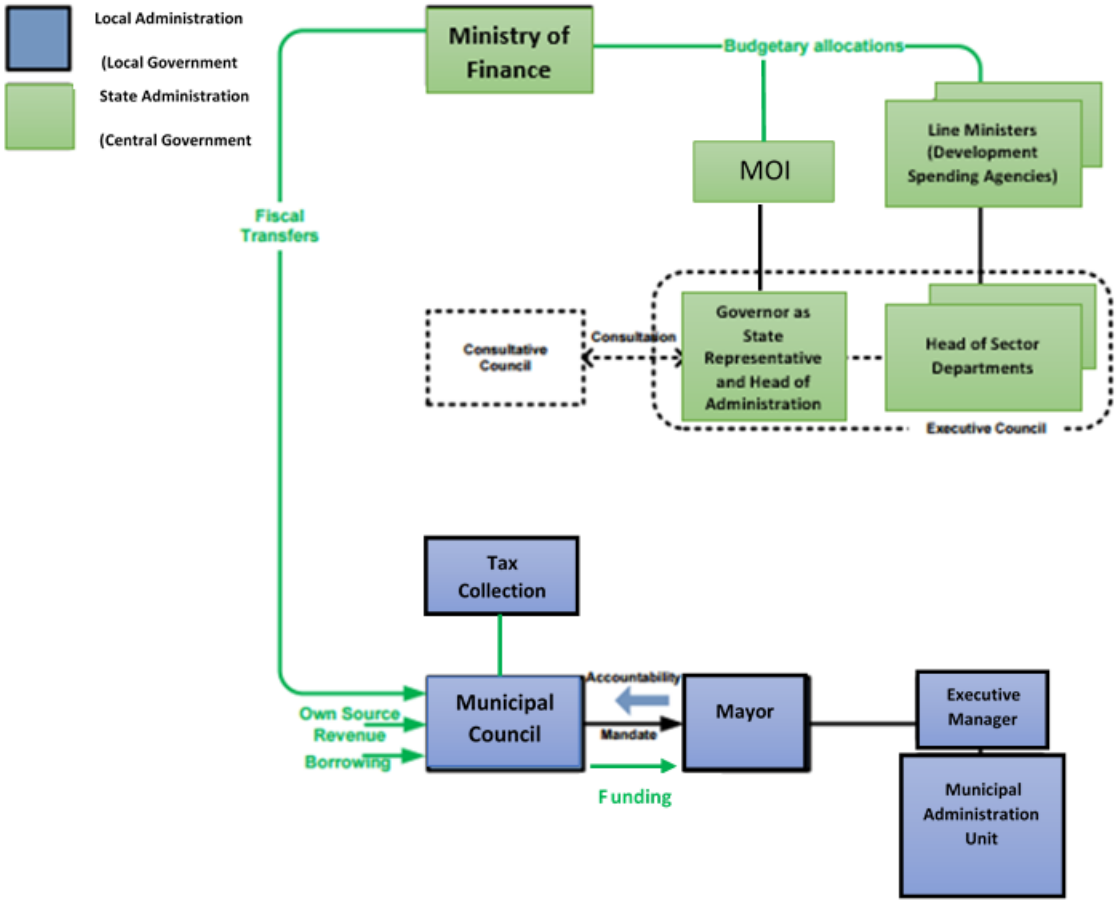
[2] Ibid.
[3] Ibid.
[4] Ibid.

functions are largely security and policing, whereas those of the MMA are overseeing and controlling development and resource use at the lowest level of government—the municipalities. Line ministries are represented at the government level through the respective governorate directorates, which in turn are under dual subordination to the governor (so-called "administrative subordination") and the line ministry (which officials call "technical subordination").

Figure 1 shows the responsibility for funding the local levels (governorates and municipalities). At the governorate level (boxes in green), the existing Consultative Council is made up of appointed (not directly or indirectly elected) members. Historically, these councils have not been effective popular participation channels because they have not drawn legitimacy from a direct popular vote. The members are not elected, very little policy making occurs at the governorate level, public programs and projects are reportedly decided and funded at the central level, and neither the governors nor the heads of the governorate-level sectoral administration (Mudiriyat) have much—if any—discretion in designing activities or allocating resources for the delivery of services and promotion of local development. With the newly elected Governorate Councils (GCs), the population of the governorate will gain a certain amount of participation in decision making regarding local affairs, which will strengthen democracy. However, this change will not amount to local self-government by international standards.

The municipalities (boxes in blue) are at the front line of the public services delivery process and are better positioned to capture a wide range of citizens' demands; however, their mandate is restricted to providing only a limited number of traditional urban management services, their general mandate for the welfare of their constituencies is not well understood and even less practiced, and no mechanism is in place to facilitate their interaction with line agencies and inform sectoral plans and programs about the needs and priorities emerging at the municipal level. They will remain subordinated to the MMA, and with a degree of autonomy not qualifying them as exercising genuine local self-government by international standards.

Figure 1. Diagram of Funding Responsibility and Relationships



The Issue of Decentralization as Reflected in the Strategies of the Health Sector

Currently, there are two strategic documents specific to the healthcare sector—the *National Health Strategy 2016–2020* and the *MOH Strategy 2013–2017*. The MOH Strategy has no targets related to decentralization. Also, it contains very few targets related to gender; however, this gap is being addressed by two government guiding documents: the *Jordan Vision 2025* and *Jordan's Voluntary National Report on the Implementation of the 2030 Agenda for Sustainable Development Goals*, which is the country's commitment toward the sustainable development goals (SDGs). WHO is supporting the development of the next MOH strategy. Goals related to healthcare governance and decentralization and gender should be included in the new strategy (see the Conclusions and Recommendations section below).

The *National Health Strategy for Jordan 2016–2020* makes several statements on decentralization, the most notable of which are as follows:

> *"In the end, it must be noted that our ambition in the coming years is that this strategy would contribute to strengthening the partnership between the health sectors, and would lead to the adoption of decentralization in decision-making because we believe that planning is a dynamic and constant process without any stops at any time."* (Preface to the National Health Strategy by His Excellency Minister of Health Dr. Ali Hiyasat)

> *"Studies and experiments have shown that decentralization (which means the transfer of power from the upper levels of government to the lower levels; from the center to the governorates) helps to solve a lot of financial, technical, social and administrative problems facing health institutions. Therefore, the role of the peripheral departments in the governorates of Jordan should be activated and delegation of powers to local levels (decentralized decisions) should be expanded. The decentralization project was partially implemented in 2000 in MOH hospitals. However, the current government has proposed a comprehensive law on decentralization and submitted it to the House of Representatives for consideration and approval."* (*National Health Strategy* Section 5.1, Health System Governance in Jordan)

The *National Health Strategy* views decentralization narrowly as the delegation of responsibilities along the MOH vertical structure. It relies on the LD to empower the expanded decentralization of healthcare providers, which is a far more important "decentralization" for the health system than the decentralization of authority between the MOH's central and governorate levels. To the extent the LD contains no provisions that would catalyze the de-concentration of provider management authority from the MOH to providers, it is crucial for provider management autonomy to become one of the core objectives in the upcoming *MOH Strategy*.

The *National Health Strategy* addresses gender gaps in the health sector; however, there is no evidence that the strategy or action plans provide responses to bridge such gaps. One exception is a pilot center in Tafileh, which set up a facility that focuses on women's health.

Overview of Administrative Decentralization in Healthcare

National Level:
The MOH and the RMS are the main centers of power in the public health sector, piloting more than 43 hospitals and many hundreds of primary healthcare facilities. They receive the lion's share of funding allocation from the national budget—in excess of 800 million Jordanian dinars (JD) in 2017. The MOH, RMS, and universities, such as the University of Jordan and Jordan University of Science and Technology, all finance and deliver healthcare to their own insureds/members and non-members. They operate in silos largely independent from one another. An estimated 90 percent of all insured for health in Jordan are members of these systems. A large charity care (Royal Courts) financing supports the health needs of uninsured Jordanians. Also, there are overlapping institutional mandates in healthcare, with fragmented and duplicative functions. The MOH, although formally the steward of the health sector, is largely recognized as responsible mainly for the system it funds and operates. Decentralization in such fragmented public healthcare presents additional challenges.

In Jordan, the healthcare delivery system covers the entire spectrum: highly concentrated at the MOH and RMS, with providers having no authority to manage resources; university- and donor-owned or operated programs, in which providers are somewhat autonomous; and the private sector programs, in which the state has regulatory but no operational or funding authority.

The RMS serves the military and remains a centralized system because of the intrinsic nature of a military system to be highly centralized so as to respond quickly to orders. Thus, the authority within the MOH system is the focus for potential de-concentration through transferring responsibilities along the vertical MOH national and local system. From a legal standpoint, however, the MOH has the same powers to de-concentrate as it had before the adoption of the LD.

Subnational Level:
There are healthcare directorates within the 12 governorates, but their organizational structure and functions have some variations. They have limited authority, generally related to monitoring the MOH, private providers, and public health in the regions, and collecting and passing information to the national level and the governor, which have responsibility for health. These directorates participate in the fulfillment of the public health law—in cases of medical emergencies, for instance. There is no public healthcare administration at the municipality level.

De-concentration of Authority from the MOH to the Health Directorates in the Governorates

As mentioned previously, the legal base for decentralization does not create a need or requirement for de-concentration of authority from the central MOH to the health directorates in the governorates. Thus, it is entirely up to the MOH to choose how to distribute authority between the center and periphery. Under the auspices of the former Minister of Health, Dr. Nayef Al Fayez, the MOH and WHO established a steering committee in 2009, tasked with preparing an assessment of health system administrative decentralization in Jordan. The assessment was a part of a WHO Eastern Mediterranean Regional Office (EMRO) initiative to assess decentralization in the health systems of 12 countries. The MOH committee held several meetings and discontinued its work after the production of the assessment. The assessment had two objectives—to present an overview of the situation regarding decentralization in Jordan's health sector and design strategies to plan and implement decentralization initiatives. It focused on the MOH. Thirty-two personnel from the central and middle management levels at MOH were visited to conduct checklist interviews regarding the forms, extent, and mechanisms undertaken to achieve decentralization, and what functions could be decentralized to a more local choice. The results of the assessment, most of which are likely still valid today, could provide some base for decision making regarding de-concentration along the MOH central/governorate vertical system. According to some former MOH officials who participated in the assessment process, WHO intended to contribute to the preparation of a decentralization strategy in the healthcare system.

Potential decisions for the delegation of authority and responsibility downstream merit considerations of efficiency, effectiveness, and legal and regulatory limitations. A rationale for decisions in favor of de-concentration needs to answer the following questions: What will change? What will work better, and why, if authority is delegated? Decisions must also consider any potential limitations in knowledge, skills, systems, and data in fulfilling a delegated mandate. The case against de-concentration is clearer for certain types of authority, such as the procurement of drugs and supplies, which is more efficient when centralized. As for other functions, such as human resources (HR) hiring and firing, the arguments in favor of de-concentration are stronger, provided there are no legal limitations to what types of HR decisions could be delegated. Also, there are some other functions for which there could be both pros and cons to de-concentration, such as construction of new facilities. The following matrix shows the resource requirements for different MOH resource drivers. It provides a guide to those areas with the largest potential economic impact when deciding which functions to keep concentrated and which to de-concentrate.

Table 1. Resource Allocation Matrix (source: National Health Accounts, 2013)

Resource Driver	Resource Demand / Consumption as Share of Total MOH and Capital Improvement Plan (CIP) Funds

Staff Salaries and Benefits	37.6%
Pharmaceuticals	6.92%
Supplies	2.5%
Operations	6.5%
Food and Housekeeping	5.4%
Treatment	33.4%
Training	0.4%
Medical and Non-Medical Equipment Procurement	2.4%
Construction	3.7%
Other	1.2%

Reportedly, at the governorate level there are no budgets for current expenditures, only capital ones. Not having data on what is expensed locally can be a problem even for administrative decentralization. It is critical to know where expenditures are made before decentralization. It is also the only way to be able to analyze the equity aspects of resource allocations.

Decentralization of Management Decision-making Authority from the MOH to Healthcare Providers

Overview of Development in Jordan

The MOH, with some support from USAID and on its own, has been conducting pilots in hospital management autonomy since 1998. Until now, the MOH has refrained from considering the autonomy of secondary and primary care providers. The following is a short account of the experiments with hospital management autonomy:

Experiment 1:
In 1998/99, the MOH, with support from the USAID-funded PHR Plus project, started a hospital management decentralization pilot at the El Karak (Karak) and Princes Raya (Irbid) hospitals. The pilot aimed at granting partial management autonomy to the hospital leadership. It sought to improve the execution of legal provisions and thus increase efficiency in such areas as personnel management, hiring and firing, employee transfers and performance evaluation, staff training, and increasing hospital directors' discretion to purchase supplies or services above the threshold of 200 JD. Executing planned interventions highlighted the need for legal and regulatory amendments to enable sustainable long-term change (such as changes in the Civil Service Code). According to many MOH officials, the pilot was a sound initiative intended to bring a great deal of positive change. The same officials expressed regrets that the results were not formally evaluated, and the experiment was unsustainable beyond the life of the PHR Plus project.

> "IN JORDAN THE GOVERNANCE OF MOH HOSPITALS IS HIGHLY CENTRALIZED. ALL SIGNIFICANT MANAGERIAL, BUDGETARY, AND PROCUREMENT MATTERS ARE ULTIMATELY DECIDED BY SENIOR-LEVEL EXECUTIVES LOCATED AT THE MOH HEADQUARTERS IN AMMAN. THIS HAS CREATED A SYSTEM IN WHICH THE NEEDS OF HOSPITALS AND THEIR PATIENTS FREQUENTLY CONFLICT WITH THE POLICIES OF THE CENTRAL MINISTRY. THIS HAS LED MANY TO SPECULATE THAT MOH HOSPITALS COULD BE MORE EFFICIENTLY OPERATED, AND THE LEVEL OF QUALITY OF PATIENT CARE ENHANCED, IF GREATER INDEPENDENCE WERE GRANTED TO THESE INSTITUTIONS. IN FACT, HOSPITAL DIRECTORS HAVE OVERWHELMINGLY STATED THAT GREATER INDEPENDENCE OVER PERSONNEL, FINANCIAL, AND PROCUREMENT MATTERS IS NECESSARY FOR ACHIEVING TARGETED MOH COST CONTAINMENT OBJECTIVES. A WELL-PLANNED, CAREFULLY DESIGNED POLICY CAN TAKE AS LONG AS 10 YEARS TO FULLY IMPLEMENT. "
>
> QUOTATION FROM TECHNICAL REPORT 44, IMPLEMENTING HOSPITAL AUTONOMY IN JORDAN: CHANGING MOH OPERATING PROCEDURES, PHR PLUS, ABT ASSOCIATES, MARCH 2000

Experiment 2:
The follow-on project of the USAID PHR Plus project began executing an ambitious plan of skills and systems building for management autonomy at all MOH hospitals in 2004–2005. The plan included the areas of quality management, financial and operations management, information systems, and others. Although the direction and intent of the program were well aimed, it is unclear why it was discontinued. Some officials pointed to an aversion to decision making and criticism at the time from some high-level government officials and parliamentarians indicating that increased management autonomy was tantamount to privatization.

Experiment 3:

Prince Hamza hospital in Amman was built in 2006 and given special status (and the privilege) to operate with management autonomy under bylaw No. 90 of 2008 issued by the Cabinet of Ministers based on of Art 114 of the Constitution of Jordan and Law No. 0 of 1952. The hospital was established as a juridical entity with its own bank account. The bylaws subordinate the hospital to the MOH but allow it to have its own budget, which is approved directly by the Cabinet of Ministers. Although the hospital is formally under the MOH, its management reports to a Board of Directors (BOD) chaired by the Minister of Health and oversees hospital management, approves the budget, and sets strategies, among other responsibilities.

Hospital management reported that the hospital can hire both long- and short-term staff, procure certain pharmaceuticals within higher thresholds (the director has the authority to procure pharmaceuticals worth 5,000 JD at one time), launch new services, and rapidly make various other decisions related to clinical and non-clinical operations. Many MOH officials and opinion leaders consider the pilot at Prince Hamza hospital either successful or at least manifesting a positive image and significant potential. However, some also doubt the scalability of a pilot with a BOD comprising so many high-level MOH officials, who may not be available to sit on other hospital boards (in case a roll-out is considered). With a governance structure consisting of the Minister of Health and other key health officials, the BOD reportedly enables accelerated decision making. However, a question remains as to what extent this amounts to decentralized management, and to what degree it is the same basic centralized decision model with the difference that the top decisionmakers may periodically move physically to the hospital's premises.

The pilot is affected by a flaw in the public budget system that may not be easy to overcome—MOH hospitals are not allowed to save the funds remaining in their budgets at the end of the fiscal year; rather, they are withdrawn by the Ministry of Finance (MoF). This situation influences the hospital's incentives for increasing its efficiency and ability to plan and execute long-term strategies beyond one year. An evaluation still needs to be conducted as to what authority and responsibility are actually de-concentrated—for example, in the hands of the hospital management vs. the MOH vs. the BOD—and the subsequent effect from such a de-concentration. The availability of reliable data and information to conduct the assessment is a challenge that may impede a more scientific approach to evaluating the results of the experiment and leave it dependent mostly on qualitative factors.

Some voices within the MOH have called for an assessment of the Prince Hamzah Hospital pilot. The assessment should provide information about the degree of the pilot's success and inform decisions on whether to roll out the pilot or first amend and strengthen it. Moreover, a gender audit of the operations within the hospital would offer valuable lessons for future similar pilots.

Decentralization accomplishes its goals when there is accountability that uses performance indicators and measures them to determine whether progress is being made as expected. Currently, accountability is limited in public hospitals, as are performance indicators, data, and monitoring and evaluation (M&E). The lack of useful data to measure performance across the public health system is hiding deficits—not only of resources but also of capabilities. The establishment of incentives for quality and efficiency in the system is needed, but one of the prerequisites should be useful and reliable data for analysis, which is currently unavailable.

Hospital Accreditation as an Aid to Hospital Management Autonomy

A Health Care Accreditation Council (HCAC) was established in 2007 to continuously improve the quality and safety of healthcare facilities, services, and programs through the development of globally accepted standards, capacity building, and granting accreditation certificates. Reputable international

accreditation agencies have authorized the HCAC to accredit hospitals and healthcare centers in Jordan. The *MOH Strategy* envisions that all MOH hospitals will be accredited within two years.

Healthcare facilities accreditation in Jordan is emerging as an approach to influencing quality and patient safety. One of the significant limitations in the process is monitoring clinical quality using data. Despite this limitation, the accreditation process is perhaps the most powerful driver for quality improvement in the public sector. It helps improve hospital management, and a legal requirement to maintain accreditation as a prerequisite to operating a hospital ensures the sustainability of accreditation. Public hospitals that have received accreditation are much better candidates for hospital management autonomy than those not yet accredited.

The Case for Provider Management Autonomy

Provider management autonomy—defined as a provider's authority to make all key decisions related to hospital operations, including budgets and financial management, at the facility level—is one of the essential prerequisites for setting up meaningful provider payment systems (PPS). Management freedom is what allows providers to spend resources where they deem most needed in response to the priorities and needs of the population they serve. Reportedly, with the exception of Prince Hamza hospital, there are no PPSs at MOH hospitals, as all expenses are paid centrally. Modern PPSs are recognized as the best drivers of efficiency and clinical quality across health sectors. National and private insurers across the globe invest significant resources in establishing and operating them. Provider autonomy is an essential prerequisite to PPSs, as are electronic financial data and data from medical encounters.

Many countries with public health systems similar to Jordan's that have implemented meaningful provider management autonomy struggled for decades to put such autonomy in place. Implementation is complicated regarding building various management systems and capacities as well as overcoming legal and regulatory limitations, particularly those embedded in the rigidity of national budget laws. To enable serious movement in the direction of quality and efficiency in public healthcare, a triad is needed, composed of provider management autonomy, data systems, and modern provider payment mechanisms. Judging from the experiences of other countries with health systems similar to Jordan's, the MOH is at least a decade away from reaching this triad if it designs and executes an orderly advance and implements its priorities.

Enablers for Decentralization in Healthcare

The Legal and Regulatory Framework:

The Constitution of Jordan of 1952 is the foundation of the country's legal/regulatory and governance system and framework. It does not address the area of healthcare, however. It vests the power of administrative division in the Council of Ministers (Art. 120) and the administration of municipal and local council affairs in municipal and local councils in accordance with special laws (Art. 121).

The enabling environment for decentralization was enhanced in 2015 with the enactment of the LD (No. 49, 2015). It opened the door for increased involvement of the population in local governance through elected GCs. The governor is not elected, but rather appointed by the Minister of Interior. He/she presides over the elected GC. Art. 3 of the LD provides the governor with the authority to "take the necessary measures to protect health." The limited authority of the GCs appears to define them more as providing popular support for the executive power (the governor and his/her executive council) and less as its effective counterweight and counterpart in local affairs. Unlike the governor, the GC has no authority over health issues.

Budgets to serve local development agendas are controlled by the governor. Because governorates do not have their own sources of revenue, they are dependent on transfers from the national government. The GC, although having declared legal and financial independence, does not seem to have a source of revenue other than national-level funding. In theory, it may be entitled to borrow money to self-finance, but it is unclear whether this option is practical. In contrast, municipalities are entitled to their own revenue sources and so may have somewhat greater independence from central authorities than the governorates in setting development priorities (including in health). The main focus of the LD is the GCs' composition, elections, and procedures, with less emphasis on functions, funding, and the relationships of different addressees of the law. Thus, the LD is gender sensitive, in that it reserves a percentage of the seats on the GCs for women (Article 6). Implementation of the LD requires the adoption of a number of bylaws, almost all of which are linked to the election process.

It is important to highlight that the LD should not be confused with a law on local self-government; thus, it is fair to say that it suffers from major flaws compared to international standards. One such standard requires that locally elected authorities have powers to regulate and manage a substantial share of public affairs in the interest of the local population, and that a significant share of the financial resources required to exercise these powers be derived from local taxes and charges (*European Charter of Local Self-Government,* Strasbourg, 15.X.1985).

In Jordan, the elected GC has no explicit authority over healthcare or any independent source of revenue. Indeed, such revenue may not be needed, as the GCs' duties as described in Article 8 of the LD are largely administrative, involving the support of various functions of the appointed executive power in running local affairs.

As mentioned above, the LD does not provide an additional base for decisions and/or action for decentralizing authority from the central MOH to the governorate health directorates. Thus, it is up to the MOH to decide within its existing purview and regulatory base what, if any, powers to delegate to the governorates. A layperson may see the LD as encouraging more delegation of power (decentralization of authority within the MOH's vertical structure); however, such a conclusion currently has no legal basis.

The Law on Municipalities, No. 41 of 2015, declares that municipalities have financial and administrative independence (Art. 3), backed by their own revenue sources (Art. 16–25). Article 5 provides the municipal council, an elected body, with the functions of protecting public health, contributing to the development of public health facilities, and participating in identifying areas where health facilities could be built. The mayor, also elected for four years (Art. 37 and Art. 32), presides over the elected council; the exception is the Mayor of Amman, who is appointed by the Council of Ministers (Art. 3). Municipal elections are triggered by a decision of the Council of Ministers (Art. 34). The law also requires a minimum female participation in local councils and that the MMA appoint a woman to the local council if one has not stood for election (Art. 33).

Compared to the LD, the Law on Municipalities appears to grant more responsibilities for healthcare to elected bodies. Also, these responsibilities are more concrete; thus, the law invites more genuine decentralization of health functions compared with the governorate level. However, municipalities' resources are limited, and an assessment of past implementation of the laws by international donors has revealed a gap between the large number of functions (nearly 40) and the number of services municipalities actually provide. It is yet to be seen how much of this gap will be bridged through implementation of the new Law on Municipalities. Its inability to deliver services in the future could damage the image of the law facilitating decentralization and dampen public expectations.

Public Health Law No. 47 of 2008 largely addresses the responsibilities of the MOH. It vests in the Minister of Health broad authority to combat the spread of disease in the country. It requires the MOH to coordinate with "relevant authorities," which presumably includes governors, when working to fulfill its functions and achieve its objectives. To the extent that no article of the law addresses the issue of de-concentration or concentration of authority along the MOH vertical administration structure, and provided that such provisions are not contained in other laws, it could be presumed that the MOH is free to determine the level of authority and decision making within its own structure.

De-concentration of MOH authority from the central to the local level would not be in the context of local self-government; thus, decisions and pros and cons remain dependent on considerations of administrative and managerial efficiency and effectiveness. Countries with well-functioning local self-government have laws dividing the roles and powers of local and central governments, and some have laws determining the fiscal balance between the two. Fiscal equalization transfers, revenue sharing, and allocation of funds are some of the ways in which fiscal rights and responsibilities can be shared within a thoughtful and well-implemented legal framework. These are the next steps for Jordan on the way to potentially expanding self-government in the future.

Annex 1 provides references to selected regulatory documents of some relevance to healthcare decentralization.

Data and Information Systems

A strong system of health sector governance depends on the presence of certain enabling factors, such as computer-based information systems, a strong healthcare data governance mechanism regulating the issues of ownership and access to data, a robust system for the collection and quality control of healthcare data, and a skillful analysis of useful and reliable data (information).

In Jordan, various elements of the health sector are responsible for the collection and use of healthcare data. Reportedly, more than 20 separate information systems operate in the public healthcare sector. Can any of these systems or their elements support delegated authority to the governorates and, if so, how?

His Majesty the King of Jordan has given the government tight deadlines to implement an e-government structure in only a few years. When implemented, this structure potentially could increase the health system's visibility and data-sharing options. The Public Health Law of 1999 does not contain provisions related to healthcare data and information systems. At present, little available information is available for decision making at the local level. Certain micro-level information is essential for an analysis of quality and cost of care useful for decision making, health sector planning, and monitoring at both national and local levels. Such information specifies the type of services delivered, as well as where, when, and at what price for which individuals.

There are several global commitments regarding the provision of data in the health sector. In 2016, Jordan introduced a new commitment under its open government initiative: "Develop healthcare services and automate the healthcare sector through electronic linkages." The purpose of this commitment was to "improve the sum of health services provided to citizens and improve access to information." The other commitment stems from the SDGs, in which Jordan commits to "mainstream gender in all national development plans in line with the SDGs, mapping of gender indicator gaps and establishment of a gender database." The SDG framework set up three working groups—on gender, healthcare, and decentralization.

Human Resources

Human resources with strong, relevant skills are key to decentralization. A recent regulation has mandated the retirement of government employees older than 60. This change has opened up opportunities for younger healthcare professionals to take on positions and responsibilities for the functions of the MOH, and also has increased women's representation in leadership. However, this mandate also has reportedly left the public health sector starved of its most experienced human resources, both for administration and healthcare delivery. The public health sector is in competition for cadres of health professionals from international players (mainly from the Gulf States) and the local private sector. This situation, coupled with difficult economic conditions and budget cuts in the public sector, make it challenging to offer competitive incentives to skilled professionals, particularly at the subnational level. A number of recent studies produced by USAID programs and the World Bank have highlighted the serious gaps in employment motivation, retention, incentives, and performance monitoring. These deficits affect the quality of care and thus the perception of the population as to the benefits of publicly funded and operated healthcare delivery.

Capacity Building

Another enabler related to human resources is building the capacity of the MOH governorate directorates to assume new or delegated functions and introduce performance indicators, including those that are gender specific, to measure progress and enforce accountability. Capacity building needs to be timely to be effective. Providing it far in advance of delegation of authority is largely a waste of resources because of the nature of adult learning—people often forget knowledge and skills shortly after building them unless they can use new skills immediately and continuously practice them. On the other hand, capacity building long after authority is transferred can lead to unsatisfactory performance and undermine public confidence in the benefits of decentralization, thus reinforcing its critics. It is critical to time capacity building either to immediately precede or coincide with the actual transfer of authority. Women's rights groups are currently advocating at the MOH for building capacity for gender-responsive budgeting to ensure effective budgeting and bridge gender gaps.

Enabling Population Feedback to Decision Making

Involving the population in providing feedback to decision making in healthcare is often indispensable to holding authorities accountable—without effective accountability, no form of decentralization is ultimately successful. Thus, involving the population enables decentralization by making local bodies responsive to local needs for services. To track the performance of local authorities and effectively hold them accountable, the population needs access to relevant information. As stated earlier, useful information for decision making in healthcare is scarce in Jordan.

A Snapshot from International Research and Experience with Decentralization

International experience generally does not support a strong causal relationship between decentralization of healthcare mandates and improved health outcomes, or a relationship between improved health outcomes and decentralization. The latter could be attributed to the complex networks with sophisticated relationships and linkages influencing each other in the healthcare sector, as well as decision making that needs to consider multiple tradeoffs with no perfect scenarios.

Decentralization is uniformly linked with shifts of power, authority, funding, and responsibility between levels of government. It is often considered one of the litmus tests for increased levels of democracy. At the health level, the dimensions are the ability to choose the provider and insurer; citizen participation

in running the system; and oversight, monitoring, and evaluation. A major concern about decentralization—again in the context of dividing roles and responsibilities between central and local governments—is maintenance of equity among regions in a decentralized model. Inequalities in distribution and access to healthcare often increase with decentralization, largely because of inequalities in financing due to funding local health systems entirely or partly from locally generated revenue sources. Another cause is poor or nonexistent mechanisms for transfers of funds earmarked for health from rich to poor regions via the national treasury system. An additional factor is the quality of local health system management, which often is a function of shortages in human, institutional, and technological capabilities.

The arguments for and against decentralization in healthcare can be equally strong. International research suggests no compelling cases either for or against it. The decision to decentralize is not so much an evidence-based decision as a political one. Ultimately, a decentralization strategy is based on the values, objectives, and preferences of the decisionmakers, which are necessarily context dependent.

What context, in what pattern, to what degree, at what pace, and in what sequence decentralization in healthcare should proceed are essential issues in any debate on the subject. International experience suggests that this task is massive, many different possible approaches are possible, the devil is in the details, and examining the details with knowledge requires relevant and reliable data.

Whether implicit or explicit, the ultimate goal of decentralization is political and often tied to shifts from a publicly dominated to a more private/market-oriented health system. Ultimately, decentralization is technically meaningful if it is part of a sound plan for addressing shortcomings in health system outcomes (efficiency and effectiveness); it is politically savvy if it backs a plan to influence the public's satisfaction when encountering the health system, using the benchmarks of satisfaction, responsiveness, accountability, and empowerment.

The degree of discretion in decision making at various levels is a critical topic for discussion in decentralization and should be part of any assessment of this process. Increasing the discretionary space for actors at lower levels in the system implies increased degrees of freedom to interpret and implement health policies and practices.

International experience suggests that incremental decentralization is more successful when it is smaller in scope and uses specific financial or managerial functions, and when solid training components are combined with shifts in the orientation of a central bureaucracy from control to facilitation and support (Rondinelli, 1983).

In the delegation of authority between stages of the healthcare system, the central government (usually represented by a national MOH) plays the role of the "principal," with both the authority and the right to delegate decisions and budgets to an agent(s); the agents usually are another level of government (e.g., self-government), nongovernmental organizations, or private sector entities. In some countries, growing evidence of the ineffectiveness, inefficiency, and inequity of publicly delivered health services has resulted in increasing criticism of the government's principal role in the health system. In such cases, the voices advocating privatizing functions that the government is fulfilling poorly become increasingly audible and meaningful.

Countries may both centralize and decentralize parts of their health sectors. An example is moving from multiple public or public and private payers to a single-payer or single public payer and back to multiple payers. Moving at the same time to centralize one part of the system while decentralizing another is not unusual in international experience.

The experience of other countries that have decentralized healthcare is mixed. Therefore, Jordan's efforts will be served best if informed by the potential risks of failure. These risks, however, are associated with delegating authority from central to local self-government. As Jordan does not have local self-government that assumes delegated functions from the center, the stakeholders may be aware only of the risks regarding potential future expansion of decentralization.

> "Decentralization is not a "magic bullet" capable of solving all structural and policy dilemmas at a single stroke. There is no set model, no perfect or permanent solution that all countries should seek to adopt. Rather, there are multiple models of decentralization, each developed to fit the particular context and circumstances of an individual country. Advocates who are certain they have created a "perfect" model should be avoided. Decentralization in practice is neither unitary nor consistent across any given country's health sector. Typically, health systems in which some areas are decentralized will have other areas that have been centrally controlled or may be recentralized. Thus the practical question for policy-makers is the mix of decentralization and recentralization strategies in a given system and the balance between those strategies."
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> Excerpt from Saltman, Richard B. and Karsten Vrangbæk. 2007. "Drawing Lessons for Policy-making." European Observatory on Health Systems and Policies Series.

Opinions on Decentralization from the Jordanian Media

As in any other country, the media in Jordan helps to translate political agendas and social trends to a language the public understands. The media increasingly has been interested in the issues surrounding decentralization, such as its scope and fundamental principles, its practical meaning for the regions (such as increased decision-making powers), and the need to measure progress toward decentralization with clear indicators. Some articles point to the controversial nature of the debates and actions surrounding decentralization, warning of the pros and cons of both sides of the question, and calling for more research and debate before decentralization is implemented. **Annex 2** provides excerpts from articles on decentralization published in some major media outlets in Jordan. Because decentralization is a relatively novel concept in Jordan, it is foreseeable that media messages may not be entirely accurate, sufficiently explained, or well understood. With more discussion over time, these concepts will crystalize and, with good communication, public knowledge on the subject will likely improve.

CONCLUSIONS AND RECOMMENDATIONS

Decentralization in Jordan is a slow and incremental process. Given its evolving legal framework and historic pace, it will likely take many more years of persistent incremental change to reach a level and strength of local self-governance commensurate with international standards. The pace of overall decentralization in Jordan undoubtedly strongly influences the pace of decentralization in the MOH-financed and -operated healthcare system. Without empowering elected local self-government bodies with responsibility for service delivery, including for healthcare, the only decentralization possible is administrative—through transfer of authority and responsibility from the central MOH to its directorates in the governorates. Such de-concentration has always been possible because it is essentially a matter of delegating responsibilities within the same institution.

Jordan has an almost 20-year history of limited pilots marked by decentralizing management decision making in the MOH-owned and -operated healthcare delivery system. The sole pilot of many still running is that at Prince Hamzah hospital. It is in its eighth year of implementation, which warrants an assessment, to be followed by a decision on next steps: modify and improve the pilot before expanding it; expand it to other hospitals as is; or modify it while expanding it to other hospitals. The option to terminate the pilot if it is determined to have been unsuccessful is the least desirable, as hospital management decentralization is essential for the betterment of the publicly funded health system. That option should be chosen only in the context of replacing one pilot with a better one.

For the MOH system to embrace modern management and strengthen its resilience and sustainability, it must put in place three system pillars: provider management autonomy for all types of providers, PPSs, and health information systems hosting reliable, gender-desegregated clinical and financial data. Through pilots like that at Prince Hamzah Hospital and the building of the Hakeem system—an electronic medical record and health data management system—Jordan has been building experience, showing that it takes many decades of hard work before any of the three systems can be put in place. Accreditation of healthcare providers also is important to support the building of these three pillars. At the same time, an efficient, sustainable, and well-governed healthcare system demands management autonomy for hospitals and secondary and primary care providers. Accreditation is not and cannot be a substitute for management autonomy but can be extremely helpful in establishing and stabilizing it. The issue of provider autonomy deserves an important place in the new MOH strategy.

The rules of the budget/treasury system are not flexible enough to enable robust provider management autonomy and may very well impede the advancement of modern healthcare PPSs. Other serious potential impediments include the lack of options for providers to save and transfer money from one budget year to the next, and the need to allocate those budgets broken into budget categories/line items when it is very difficult to move funds from one item to another.[5] Some countries have been unable to overcome the inflexibility of such budget systems. They have pursued temporary exemptions from national budget rules, created off-budget financing vehicles to finance public providers, or even privatized parts of healthcare delivery. A dialogue with the MOF should be initiated promptly on how to overcome

[5] Moving funds among budget programs/activities/articles is regulated by the Annual Budget Law No. 2 for fiscal year 2017. Thus, Article 8f of that law provides that appropriations may be transferred from one program to another, from one project to another, from one activity to another, from one article to another, or from one item to another within the same chapter, upon the approval of Directors General of the General Budget Department.

barriers within the budget and fiscal management system so as to move toward a sustainable and efficient public healthcare delivery system.

Shifting authority and responsibility for the sake of decentralizing decision making alone can be a political but not a technical argument for decentralization. Shifting authority—even that within the MOH and its regional directorates—should not result in the creation of extra steps in decision making without adding value. Instead, value can be added by shortening the lead times between the need for a decision and making the decision, or by making more informed decisions due to the physical proximity and interaction between MOH governorate directorates and local providers.

The MOH will benefit from a review of its functions at the central and governorate levels, with the objective of determining which functions warrant delegation to the governorate level and what prerequisites (such as capacity building and technology) are required to execute this process. Authorities should ask the question: will de-concentration improve health outcomes or increase the efficient use of public resources and, if so, what is the guiding issue and principle in justifying or rationalizing the delegation of authority? The results of such a review could help the country develop a vision for decentralization in the MOH, followed by a detailed roadmap with steps, targets, timelines, and responsible individuals, thus providing a tool that, if developed, would help achieve the vision. These efforts could support the inclusion of decentralization as one of the objectives of the *MOH Strategy* for 2018–2022. Gender issues should be given special attention and consideration in preparing the vision and roadmap. Specifically, gender gaps within the healthcare system need to be transformed by developing targets and goals to eliminate them. Moreover, indicators must be disaggregated by sex and localized as much as possible.

Jordan has a vibrant private healthcare sector that effectively exports quality services to hundreds of thousands of medical tourists; it also provides services to privately and publicly insured and uninsured Jordanians and refugees. The private sector reportedly satisfies customers by delivering quality care efficiently. It does so while operating under pressure from competition and expectations from stakeholders that it will not incur financial losses. The key to private sector success is a blend of competitive pressures and managing with autonomy to allocate resources where needed in response to patient needs and demand for services while optimizing it expenses. The MOH can learn from the experience of the private sector and adopt some of its management and operational practices.

The MOH should consider options for allowing private healthcare provider management companies to operate publicly owned hospitals and clinics. Many countries have used this option to achieve very good results in service quality improvement and the efficient use of resources. At a time when public-private partnerships are encouraged by the Government of Jordan, health budgets are being reduced, and deficits in the public sector are growing, this option should merit fair consideration.

Policymakers should be wary of the pitfalls in delegating authority without also delegating budgets and without accountability checks. Shallow decentralization can backfire—beneficiaries and supporters could lose faith if they do not find it meaningful—for example, if it brings only marginal improvement, improvement that is not measurable, or none at all. Currently, Jordanian law does not leave room for genuine decentralization, including in healthcare. Such decentralization happens only in the context of local self-government in which citizens and communities are not only invited to provide feedback for purposes of accountability, M&E, and learning but, more important, are empowered to respond to poor performance in local affairs by voting it out. Finally, one of the pillars of successful decentralization is how well citizens are informed of its definition and meaning, how they can benefit from it, and what role they can play in the process.

Summary Table of Recommendations (listed in order of their respective importance for a sustainable and resilient healthcare system)

	Recommendations	**Anticipated duration of implementation: * Short-term: 1–3 years Medium-term 3–5 years Long-term: 5–10 years**
1	Set indicators and targets for decentralization, autonomy for hospitals and other providers, and narrowing gender gaps.	Short-term
2	Set a strategy and plan for hospital management autonomy.	Long-term
3	Set a strategy and plan for secondary and primary care provider management autonomy.	Medium-term
4	Work with the MOF on modifying budget funding rules for publicly owned providers.	Short- to Medium-term
5	Pursue unification of public healthcare insurance schemes (civil insurance, military insurance, and university insurance) under a single public payer/insurer.	Short-term
6	Complete the deployment of the Hakeem health information system across providers in Jordan and begin providing useful data to the system.	Short- to Medium-term
7	Establish modern PPSs for public sector healthcare providers, preferably under a single public payer/insurer (meaningful PPSs will depend strongly on outcomes resulting from item #3).	Medium-term
8	Establish partnerships with the private sector, including for healthcare provider management.	Short-term
9	Determine which functions warrant delegation from the MOH to the healthcare directorates at the governorates; strongly consider allowing budget decentralization, along with authority and responsibility.	Short-term

* These estimates are based on a case in which the leadership of the system shares these opinions on technical issues and has a strong will to act in changing the system, in addition to good technical capabilities to implement them or willingness to acquire the necessary capabilities rapidly. Examples from health reforms in many countries demonstrate that when these features are not in place, the anticipated implementation period can last much longer.

ANNEXES

ANNEX 1

Law / Bylaw	Relevant Issues
Internal Bylaw for the Governorate Council (175/2016)	After elections, the governor calls for a meeting within 30 days. - The GC meets every two weeks. - GC meetings are public unless they agree otherwise. - Decisions are published online. - The council creates several committees, including **health, environment,** and **public works committees**. - The **health committee examines/studies the health services offered by the government and provides suggestions for improvement**.
Administrative Division By Law (No 46/2000)	It covers three main items: 1. Addresses the boundaries of governorates 2. Identifies the city center of each governorate 3. Lists the names of cities and villages that fall within a governorate district
Administrative Formation Law (No. 46/2000)	The governor is responsible for the following: - "works on providing the best services to citizens" (Art. 10/g) - "It is the responsibility of the Governor to ensure that public servants abide by the working hours" (Art. 14) - In coordination with other entities. . . the governor "ensures that health services are offered for all, by building health services and developing them" (Art. 24/g)
Financial Regulation of Municipal Council (No. 30/2017)	Article 13 offers the most explicit reference to delegation of authority. The regulation reads that in any other items uncovered in this regulation, the government financial regulation shall be implemented when: - For the annual capital budget, the governor acts as Minister of Finance or the relevant minister, whereas the finance director acts as a secretary general. This regulation discusses the process of planning and approving the governorate budget. The governorate budget should include only capital items and the administrative costs of the GCs. The regulation clearly shifts this process to feed into the 2019 annual budget.
Jordan Valley Authority Law (No. 63/2001)	Article 5 allows the Council of Ministers to delegate authorities and functions related to the implementation of projects to a local committee (regardless of any other legislation).

ANNEX 2

Selected Quotations on Decentralization from Articles Published on the Websites of Jordanian Media:

Amman net:
"The decentralization law allows the governorates' council to define their investment needs and the method of implementation through their internal tools, but the law doesn't give the freedom to take appropriate decisions and to achieve self-sufficiency. Some voices claims that this is a step to achieve full decentralization." (Author: Izzat Al Natour) 2.03.2017

Al Rai:
"Due to controversial debates on the political side of decentralization, His Majesty the King directed the government to adopt administrative decentralization at the governorate level." (Author: Abdel Karim Al Doghmi /politician and parliamentarian) 2.03.2017

Jordan – News:
Under the topic: Fundamental principles for decentralization success in Jordan:
"Legislations pertaining to decentralization should adhere to the following main principles: Local community participation in defining their priorities; Separating the elected authority who sets the plans and programs from the executive authorities which implement; Defining the roles and responsibilities at the three levels: central government, governorate, and municipality; Achieving regional equality and provision of conditional funding for programs and services in order to bridge the gaps; and Establishing efficient and sustainable administrative and financial systems." (Author; Dr. Omar AL Razzaz /currently Minister of Education and politico-economic analyst) 17. 02. 2016

Al Dustour newspaper:
Forum on Decentralization: Irbed Governorate
Statement of the Minister of Political and Parliamentarian affairs: "The decentralization law will increase the community participation in decision-making process. Decentralization is a new style of management and development where we can get rid of bureaucracies and constraints in decision making, and thus we can attract foreign and local investors outside the capital." (Yarmouk University website) 25.10. 2016

Al Madinah News
A report titled "Founding roadmap to implement decentralization" recommends implementing the legal framework for decentralization. The report calls for setting short-, mid-, and long-term objectives for implementing decentralization to be time bound and with clear performance indicators. The decentralization strategy should have good communication tools to raise awareness through advocacy and social media. Report from 28.02.2017

Al Rai Newspaper
From Centralization to Decentralization and Back

"The controversial relationship between centralization and decentralization is found in managing companies and organizations as well as at the local governance level. Reformists and change supporters call for centralization in the decentralized systems, whereas they call for decentralization in centralized systems.

"Others say that Jordan is not a large country that can decentralize authorities, and the local leaders are not capable of setting their priorities, nor to efficiently distribute and allocate resources. Their contradictory directions could harm the interests of other regions. This is a unique case in Jordan, where regions and governorates have wide differences in: environment, population density, and economic resources. The government should wait before applying decentralization. There is a serious need for more in-depth comprehensive studies and situational assessments." 15.02.2015

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