Author’s response to reviews

Title: Optimizing decentralization for the health sector by exploring the synergy of decision space, capacity, and accountability: Insights from the Philippines

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[*The responses detailed below are also provided in Table form in our cover letter. We invite the reviewers to refer to our cover letter instead for an easier reading of our point-by-point responses.]

Reviewer 1: Mario R Festin

1. Page 4. Lines 5 to 7. I would suggest that the usual interaction between central and regional or subregional level be described if the recommendation that certain accountabilities need to be enforced by the central office.

* We sincerely thank Dr. Festin for pointing this out. To address this concern, we have revised the relevant paragraph. Please see page 4, lines 13-19. While we hope that we could elaborate more, in many instances the Journal’s space limitations also mean that we have to be brief in some of the explanations that we make in this manuscript.

2. Page 4. Lines 12 to 17, so which is the direction that the government is pursuing, reversing devolution and fostering centralization OR strengthening devolution by a federal system of government? Is it clear among the local and national leaders?

* We recognize the importance of current debates in the Philippines about whether or not to decentralize the health sector. There continues to be an ambivalence on this issue, and so relevant references about the contrasting views are included in the Introduction (please see page 4, lines 20-24, and line 26).
3. Page 4. Lines 25 to 28. Is devolution complete for all components? Would there be some components or issues that are still from the central office? Since you looked at different levels, how do these interact, and influence decision making? For specific components, where does the decision making take place - at the provincial level or city level?

* Indeed, across all functions, we report on the continuing involvement of the DOH in how decision-making is performed by the local governments, and these have been well described for each function in the Results section (pages 14-25). The observations have also been highlighted in the Discussion and linked to the experience in other countries (please see page 27, line 17 onwards).

4. Since health is not the only government program that was devolved, has there been any problem with the devolution of other programs such as education, agriculture, etc.? It may show that the local government unit may have different strengths for the various components that were devolved.

* The analysis of experiences of devolution in other sectors such as in education or agriculture and linking the lessons to our manuscript is potentially of interest. However, this is beyond the scope of our current research, and will also lead to us exceeding the word limit of the Journal. Nevertheless, we recommend such an endeavor for further studies in the Conclusion section (page 29, lines 7-9).

5. Page 5. Lines 9 to 11 - Citation 34. And citation 22. What did these say? Citation 34 is not yet available.

* Unfortunately, due to space limitations of the Journal, we are unable to expound further on the content and conclusions of these publications, and these publications are not the only articles cited in this paragraph (page 5, lines 14-18). Thus, we rely on citing these articles in order to direct the readers to look into these references if they would like to know more. Moreover, we are also pleased to report that Citation 34 (now Citation 35) is now available. Please see https://doi.org/10.1371/journal.pone.0206809

6. Page 6. Lines 17 to 20, and lines 20 to 26. The sentences can be rephrased better to be clearer.
* We split one long sentence in this paragraph and hope that this revision helps in clarifying the sentences (see page 6, lines 24-28, and page 7, lines 1-2).

7. Page 8. Lines 13 o 26. How were the interview subjects chosen? Was it through purposive or convenience sampling? Was the health profile of the geographic region where the interview subject considered in the choosing?

* In the initial draft, we stated that sampling was purposive. We maintain this in the revised version (see page 8, line 17), but also include an explanation that sampling was purposive in order to maximize the variation in the profiles and backgrounds of the decision-makers (see page 8, lines 24-27, and page 9, line 1). We have also added a new Table 1 in order to clearly show the profiles of the participants (see Table 1 on page 9).

8. Page 10 Lines 1 to 23. These 6 functions are described related to the local level context. How many of the respondents of the survey interviews actually work at the local level? Three respondents were noted to be former ministers. How were their responses used in the analyses of responses?

* We do refer again here to the new Table 1 (page 9) to show the different levels where these decision-makers were coming from. Consistent with the standards of Qualitative Research (i.e. COREQ Guidelines, Reference 45) and following the Framework Method (as explained in the Methods, page 10, lines 13-17), we analyzed all interview transcripts in their entirety (which lasted 28.8 hours in total). The reason for including central and regional decision-makers was also to triangulate with what local decision-makers were expressing during the interviews.

9. Page 10, Line 25 ++ - The descriptions of wide, and narrow and then moderate seem very subjective and may have problems of consistency and reliability. Would you be able to provide criteria and how the categorization was done? Was observer variability considered? How were these grading levels standardized to minimize bias and these other problems?

* The reviewer’s concern is similar to the comment from Reviewer 2 who developed the decision space framework (see response to Comment no. 3 under Reviewer 2 below). We hope that the new Table 2 (see page 13), as well as the new Supplementary Material (please refer to Supplementary Material) are adequate to address concerns related to the assessment of decision space.
10. Page 12. Table 1. We are only given the decision space assessment, without a proper description of what was the basis for such assessment. I think this would need a better description because the columns on needed capacities and accountability mechanisms are probably dependent on this description.

* Thanks again for pointing this out. We hope that the previous comment above (i.e. our response to comment 9) is able to address this concern of the reviewer.

11. Page 12, Table 1. The illustrative notes reflect somehow what the interview subject believes that they should do, and probably not what they are actually doing. How much assessment of the validity of the responses was done - on whether what they said was actually what was happening?

* We revised Table 3 (see page 16) and Table 4 (see page 22) to take up this concern from the reviewer and to be able to show what is “currently in place but may still be enhanced” and “potential policy considerations” particularly for accountability. We hope that this distinction is adequate to address this concern. However, we are not able to do this for capacities (see response to Comment no. 6 under Reviewer 2 below).

12. Page 13. Lines 3ff. A moderate to narrow category may suggest that maybe more categories may be needed, or better criteria to delineate the various categories may be needed. Would not the decision space for budget and financing be based not on how much resources they have but whether the person is able to use the allotted budget fully and dependent on their needs? Increased capacity would be dependent on how much they are able to identify additional resources for income such as PHIC or PCSO. Accountability mechanisms would be dependent on the Commission on Audit requirements. It may also be that budget allocations are not equitable but are highly dependent on the income category of the local government unit, and likewise the existing health systems. Like hospitals and accredited health professionals would tend to stay in urban areas while the non PHIC accredited providers would most likely be in the remote rural areas, thus denying these areas of the potential for more income from PHIC.

* We appreciate the perspectives of the reviewer when it comes to budgeting and financing. All the results presented here come from the perspectives of the 27 decision-makers with long experiences in decision-making under a devolved Philippine health system. We can only report and analyze the themes that emerged from our interviews. Nonetheless, the
perspectives raised here complement what we have written for budgeting and financing, where we also now include the citation of relevant studies about the Philippines in order to support the observations (see page 18, lines 11-20).

13. Page 14. Program implementation and service delivery. The assessment is a bit vague because the central unit DOH is tasked to have the national policy development, and program implementation and service delivery would usually be in the lower levels. Are we giving them a grade of moderate because they are not able to design policies and programs, when their primary function is to implement programs and deliver services. It is mentioned that a higher rating may be achieved if there is some capacity for innovation and modification. But what if the existing program is able to achieve goals and meet or even exceed targets even without modification. What would the assessment grade be? Was the assessment made on the process but how much weight was given on the outcomes or status of the main health outcome indicators? There seems to be a preference over innovating but in some instances, it may not be needed.

* This perspective is also consistent with what is articulated in the manuscript for program implementation and service delivery. The reviewer may see the results for this function (see page 19, lines 25-28, and page 20, lines 2-5) and also the illustrative quotes with explanations for this function in the Supplementary Material.

14. Page 15. It may be that the assessment for facilities and equipment may have to be separated from that of supplies. All levels of health programs would also express the need for better and newer facilities and equipment. Lines 15 to 22 say good and interesting suggestions for improving capacity but it may need to be based on more than one citations of successful experiences using such mechanisms rather than just theoretical suggestions. If there are good and successful examples of public and private partnerships in some of the interviewed local government units, it would be helpful if these are cited. If such suggestions are provided, the role of the PHIC to support the financing of patients in the public sector to allow access to pay for service facilities should be enhanced. For supplies, it was always believed that a centralized procurement of large volumes of drugs and vaccines by the central government may facilitate getting them at a lower price due to volume negotiations. (Lines 26 ff on page 15). Does this really work? Also do the local governments get what they need and ask for or are they being given drugs that they hardly use and just expire in the warehouses. Is there also evidence or experience from a regional procurement system which may be adapted in some regions?
Thanks for this suggestion to separate management of supplies. However, we already report on six health sector functions. The addition of another one will unfortunately exceed already the limited space allowed by the Journal. Moreover, we really intended to combine supplies with facilities and equipment because, as gathered from our interviews, health facilities only become functional if these have adequate equipment and supplies. Thus, we wish to consider these as part of one function.

In response to the other comments, we wish to reiterate that the results come from the themes that emerged from our interviews with 27 decision-makers using the Framework Method. We can only report on the experiences that were expressed during the interviews. While we cannot publish all the transcripts of the interviews in their entirety, we hope that the new Supplementary Material is adequate to explain how the results reported for this function were obtained.

15. Page 17. Should not table 1 and 2 be combined into a single table? The note about the basis for the decision space assessment applies to table 2 as well.

Thanks again for this suggestion. We decided to split the table into two tables for easier graphic design and also to benefit the readers. Having one table will result in a very long table which might be difficult to read.

16. Page 18. Line 3. Moderate to narrow again appears. So maybe a four point scale would be better? There may need to be some notes not only on deployment and hiring but on retention including those of the higher skilled professionals. There was a time that there were no doctors and nurses and they had to seek highly profitable opportunities abroad. This also led to a massive increase in nursing schools which graduated tens of thousands of nurses who after some years lost their opportunities to work abroad because the market closed down. But there also needs to be a check on the clinical competency training of these hundreds of professionals (physicians, nurses and midwives). There is also the issue of continuing professional education for these providers, that some coordination needs to be done. Some of the public health professionals are required to attend numerous seminars and workshops that require them to be out of their service areas, leaving no one in their rural or urban poor clinics.

We are unable to modify the assessment of the decision space into a four-point scale as our methods are qualitative and not quantitative. The decision space framework (developed by Reviewer 2) is based on a three-point scale: wide, moderate, narrow. It might be interesting to examine how this framework could be modified as suggested, but this needs to be explored in further studies, particularly in quantitative studies.
We also appreciate the other comments related to the health workforce. As indicated above, we are limited to report on the perspectives that were expressed by the decision-makers that we have interviewed.

17. Page 19. The classification of moderate needs to be supported well. I have heard many stories that the health professionals in the various service delivery areas also prepare their data reports, in addition to their nearly 24 hour on call duty as providers. I appreciate the note about the need to validate these data. These individual health service delivery points are supposed to provide important and accurate data, but they are also required to reach certain targets. How sure are we of the veracity and validity of the reports if such are required. The other issue is how soon the data is submitted to the central data management office so that these may be collated analyzed and used for decision making and policy development. It used to be that the lag time from submission to publication of data was from three to five years. With the internet and digital technology, there may be better ways of gathering and collating data, at least for the key and important indicators.

* For this comment, we wish to invite the reviewer to refer to the new Supplementary Material with the illustrative quotes and explanations for health workforce management.

18. Page 20. It would be interesting to note if there have been previous attempts at evaluating the devolution program using scientific methods. There have been attempts to cancel devolution to go back to the centralized system, but evaluation studies have also been made to look at increasing quality and improving systems. These reports may not have been published in scientific journals (but hopefully they are) but for sure the Secretaries of Health may have them. Also there are some hospitals that were devolved but some have been retained in the DOH system. Were some of the administrators or practitioners in these two types of hospitals considered in the interview survey?

* We agree that previous studies on devolution in the Philippines have to be properly referred to. We have ensured this in the revised manuscript. In this revision, we have cited relevant studies about the Philippines, namely:

References 3, 5, 6, 7, 8, 23, 35, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59.

19. Page 20. Line 15 to 16. The bases for wide decision space may have been set at a pretty high or near ideal level, that it would not have been possible to meet it despite much efforts. Lines 20 to 22 looks at the synergy been the different component functions that can actually
support improvement in systems and in quality, but was this approach in the analyses considered for this paper? Maybe if we consider that some specific programs in the past in the Philippines were highly successful such as the child immunization program (before the fiasco on the Dengue vaccine and the HPV vaccine. I would understand that the present survey or interview were on the existing staff and programs. It may also be helpful if some examples of wide decision space in other countries were cited.

* Thank you for this comment. Our assessment of decision space is consistent with how this framework was designed and applied in previous studies. We hope that the revisions in this paper, together with the new Supplementary Material, clearly explain why an assessment of wide decision space cannot be made for the functions we have reported for the Philippines. We have also cited many studies that have used the decision space approach as developed by Bossert (see page 5, lines 14-18) and drew from the lessons from those studies in our analysis and drafting of this manuscript.

20. Page 23. Lines 3 to 8. If a major recommendation from the paper analyses was to enhance synergy between the various components, maybe a more detailed example of how it came to be in Pakistan would be helpful. As such, a proposed model of synergy for the Philippines may be mentioned at some point.

* Again, due to limitations in space, we cannot make a more detailed explanation of the Pakistan studies. However, we have cited the Pakistan studies whenever needed (citations 24 and 25) and we invite the readers to refer to these papers for more information.

21. Figure 1. A proper label is necessary. Since this is an expanded version of a previous model, would it be helpful to identify at which points or areas the expansion took place?

* We do have a caption for Figure 1, although it was provided within the main text (consistent with journal guidelines) and not on the figure itself (see on page 7, lines 26-27). We have also provided an explanation on how Figure 1 expands on the figure which Bossert first developed (see on page 7, lines 10-14).
Reviewer 2: Thomas J Bossert

1. This professionally accomplished manuscript does a fine job of reviewing the basic arguments and literature about decentralization and explains the author's choice to use Bossert's "decision space" approach… In an innovative contribution, the authors present a dynamic model of the three dimensions to enhance the synergy and show mutually reinforcing interactions among the dimensions.

* We sincerely thank Prof. Bossert for his feedback and for recognizing the work we have exerted in reviewing the relevant literature on decision space, capacity, and accountability, and in presenting a dynamic way of visualizing the synergy between these three dimensions.

2. However, unfortunately, this contribution does not seem to have been effectively applied in their study.

* We hope that by the modifications described below, the conceptual synergy of decision space, capacity, and accountability in the context of decentralization in the Philippines has been more effectively applied in our study.

3. They use a well-designed qualitative methodology of interviews of 27 key informants using accepted methods of collecting and analyzing interview data… The interviews resulted in 6 decentralized functions - many of which are compatible with the functions of other studies of decision space… The reporting on each function however does not inspire confidence in the finding. The authors need to explain more about how they determined the "narrow", "moderate", or "wide" decision space - just an assertion without explanation is not enough. It would be good to establish a criteria for each type of decision space and explain how it was applied (see the chart in Bossert 1998).

* We apologize if we have not been very clear in describing the method for assessing decision space as wide, moderate, or narrow. Unlike a quantitative approach, the qualitative approach means that our assessment relied on the common themes that emerged during our analysis of the transcripts of the interviews (which in total lasted 28.8 hours). In order to better demonstrate how decision space was assessed, we have done the following:

i. Revisions in the Methods section (see page 11, lines 25-28, and page 12)

ii. Addition of a new Table 2 summarizing the guide questions that were instrumental in assessing decision space (see page 13)
iii. The new Supplementary Material that is able to present more quotations together with brief explanations on the assessment of decision spaces.

4. Furthermore, the assertions about capacity and accountability for each function appear to be summaries of the author's judgement about the interviews and are only supported with single quotations from officials only for three of the functions. It is not clear why they did this for only half of the functions. Even in these functions, it is not clear how representative those views are among the interviewees (something that I think is important and often ignored in qualitative studies).

* It may have been missed in the first draft, but we actually provided one illustrative quote for each of the six functions in two tables. In this revision, we maintained these two tables (Table 3 on page 16, Table 4 on page 22), but moved the quotes closer to the function (i.e. in the second column). As also mentioned above, the new Supplementary Material now also provides more quotes, which should convey how the views expressed by decision-makers support the assessments that we make.

5. Some of the observations should also be supported by references to other literature about the Philippines system (the lack of references in this section contrasts greatly with the excellent use of references in the rest of the manuscript).

* We agree that this aspect has to be strengthened. Consequently, we have cited relevant studies about the Philippines for each function. Please refer to:

i. Planning (page 14, lines 12-18)

ii. Financing and Budget Allocation (page 18, lines 11-20)

iii. Program Implementation and Service Delivery (page 19, lines 11-13, and lines 18-20)

iv. Management of Facilities, Equipment, and Supplies (page 21, lines 18-21)

v. Health Workforce Management (page 24, lines 6-7 and12-14, and page 25, lines 2-4)

vi. Data Monitoring and Utilization (page 25, line 27 to page 26, line 1).
6. The section on findings drifts too quickly from reporting about decision space, capacity and accountability to making recommendations, which in part seems due to collapsing the interview responses from questions about what is the current situation to what the interviewees think produce better performance.

* This is an important point which the reviewer raises. In the revised version of the manuscript, we classified the results for accountability mechanisms into “currently in place but may be enhanced” and “potential policy considerations” (see Table 3 on page 16, and Table 4 on page 22). However, we are not able to do the same for capacities as this dimension would refer to the capacities that decision-makers currently possess and desire to possess—something which could have been obtained if we did a quantitative survey of several individuals instead. Nevertheless, given our methods, we are able to distinguish between desired individual and institutional capacities, and this we have also provided in the new Tables 3 and 4.

7. It would be good to have the interview guide in an annex to see if it allowed the interviewees to make this kind of distinction and to explain more about how they judge the need for more capacity and better accountability.

* We hope that the outline of the guide questions in the new Table 2 (page 13) (related to response to Comment no. 3 above) would be adequate to address this concern. In this revised manuscript, we also refer to an example of the full questionnaire (see caption of Table 2 on page 13), which is available as an annex in an earlier article (if interested, kindly see in https://doi.org/10.1371/journal.pone.0206809).