Public choice and decentralised healthcare service delivery in Lesotho: Assessing improvement and efficiency in service delivery

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Abstract: Providing efficient decentralised local public services such as healthcare in hard to reach and remote areas has been the recent concern of public finance experts. Thus public finance theory, the public choice, has been devoted to explain the link between decentralised local public service delivery and efficiency. The theory argues that efficient delivery of decentralised local public service is achieved through the proximity advantage of local management boards, which enables them (that is the local management boards) to provide services tailored to the needs of their respective local communities. Using the public choice’s decentralised local service provision, this study adopted a qualitative design, and accidentally selected and interviewed 40 health service users (HUs) and 10 Health professions (HP) in the rural areas of Lesotho. The results show improvement and efficiency in healthcare service accessibility, utilisation and affordability in the study communities. Again, it emerged that decentralised healthcare delivery helped healthcare service providers to gain an in-depth knowledge of the healthcare needs of the local people, thereby enabling them to adjust services to the healthcare needs of the community through innovative healthcare delivery strategies, like mobile healthcare delivery service and the mobilisation of trained assistant nurses deployed to serve in remote and hard-to-reach communities. Results further

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PUBLIC INTEREST STATEMENT
Lesotho decentralised her healthcare system with the aim to improve the efficiency and quality of healthcare service delivery in the country, especially in the hard-to-reach and remote rural areas. This study assesses the views of healthcare users and professionals to ascertain if healthcare service delivery in rural areas has met the efficiency and quality targets. The results prove that healthcare services have improved, however, significant areas of healthcare delivery need improvement in Lesotho.
show that these innovative healthcare strategies meet the health needs and preferences of the local people. The study recommends local and central governments to prioritize and scale up decentralised healthcare delivery across the country, particularly in vulnerable and poor communities, in addition to the provision of state-of-the-art healthcare facilities and intensified human resource training for the healthcare sector.

Subjects: Development Policy; Rural Development; Economics and Development

Keywords: Public choice; health service; efficient health service; health service utilisation; decentralisation; local governments

1. Introduction
The revolution in public administration is concerned with the achievement of efficiency, economy and effectiveness in public service delivery. Arguably, this revolution aims to improve the quality of service provision to meet the needs and preferences of local people (Shah, 2006). This revolution challenges public administrators to be result-oriented, productive and make judicious use of scarce public resources to achieve optimum outcome for the benefit of all in society. To achieve this, Public Economics argues that public administrators, who manage public services, should ignore political influence and increase local participation in decisions on local service provision. The reason being that increased participation of local people in service provision ensures that local service delivery meets the needs and aspirations of the local people, who are the ultimate beneficiaries of such public services (Dick-Sagoe, 2016; Dick-Sagoe & Andraz, 2020; Ostrom & Ostrom, 1971). Efficiency in public service provision means that public administrators will follow the right processes by doing things the right way. In other words, public administrators perform in the best possible manner with least use of resources, time, and efforts. This can be seen in increased responsiveness to local needs in fast and cheaper means, which increases local people’s satisfaction and trust because they see that local administrators act in their best interest.

The public choice theory has contributed immensely to the revolutionary debate on economy, efficiency and effectiveness of public administration (Brennan & Buchanan, 1980; Ostrom & Ostrom, 1971). The theory, public choice, seeks citizens’ freedom and strongly argues for an end to state monopoly in the delivery of public goods and services (Ostrom & Ostrom, 1971). This theory, forwards the institutional pluralism idea which satisfy the needs and priorities of local people (Batley & Larbi, 2004; Gruening, 2001). Public choice theorists question the neutrality and rationality of bureaucracy (Gruening, 2001; Ostrom & Ostrom, 1971) and contend that bureaucrats are self-aggrandising and manipulate public resources for their parochial interest, at the expense of the public interest.

Efficiency in the public sector, according to the public choice theory, is shifted from the bureaucratic structures of traditional public administration to the behaviour of the individual, which is considered rational (Gruening, 2001). This individual actor (also referred to as an economic man), attempts to increase net benefits in the consumption of public goods. Simply put, the rational man wants to pay less for service and wants service to come fast to save time. Efficiency here is achieved by saving the time of a common man through service provision, which should be provided faster than previously done. Public administrators’ role within this framework is to develop decentralised, small scale service systems at different levels of government (Chattopadhyay, 2013; Oates, 1972). This is believed to produce a mixture of economics and politics, which offer an innovative way of restructuring the service delivery system. Restructuring service delivery leads to a democratic administration, which is valued as an efficient form of administration (Ostrom & Ostrom, 1971). Democratic administration results are democratic decision making and decentralisation, where citizens play a critical role in the decisions and policies that advance their lives.
Through the 2016 National Health Policy, the government of Lesotho decentralised health services in the country to achieve efficiency, effectiveness and economy in healthcare delivery (Ministry of Health, 2016). According to the Lesotho Review (2018), decentralized health service in Lesotho is a priority, as the country is marked by many isolated rural areas dominantly populated by the majority of the people. The goal of the healthcare sector is to achieve effective, affordable, accessible and full coverage of healthcare for all citizens by 2030 (Lesotho Review, 2018). In addition, the National Health Strategic Plan (NHSP 2017–2022) aims to ensure safe, affordable and effective healthcare, as well as increased access to quality essential healthcare services for all people living in Lesotho. To ensure that decentralised healthcare delivery in Lesotho achieves its stated objectives, monitoring and evaluation studies at every four years of implementation are essential. The availability of accurate information from monitoring and evaluation studies are important to track the progress, challenges and weakness of the decentralised healthcare system in Lesotho. However, there is a dearth of literature studies on the effectiveness of the decentralised healthcare service delivery in Lesotho, especially in the rural areas. This is problematic, as decentralised healthcare services have been in operation for over four years. This warrants a study to assess the efficiency of decentralised healthcare services in Lesotho, mainly from the perspective of service users and providers.

This study also become relevant, as it contributes to one of the unexplored areas of decentralisation and healthcare service delivery performance in Africa, as identified by Zon, Pavlova, Drabo and Groot in 2017. They further argue that most African countries, including Lesotho, embarked on decentralisation reforms, while a review of these reforms remains largely absent. Wickremasinghe et al. (2016) and Cobos Muñoz et al. (2016) attempted to fill this gap, however, focusing on low income countries made their study not Africa specific. Studies done by Zon et al. (2017) is very close to this study as they focus on decentralised healthcare systems of Sub-Saharan African countries. This study is unique as it focuses on a country specific case in Africa, which is Lesotho. This country specific case, as presented in this study further becomes relevant as the lessons and experiences from healthcare decentralisation in Lesotho are essential to carry out studies, which compares healthcare service levels before and after decentralisation in Lesotho. The subsequent sections of the paper are as follows: theoretical framework, methodology, results, discussion and conclusion.

1.1. Public-choice theory of decentralisation and efficient service delivery

The public choice theory of decentralisation bases its argument on efficiency and effectiveness in local service delivery. To test this efficiency in decentralised service provision, a comparison is made between the central and the local governments (Oates, 1972). Lockwood (2006) assumes that both central and local governments are benevolent, as they all seek to maximise citizens’ welfare. Lockwood further assumes that all communities will have uniform public programmes. Based on these assumptions, Lockwood coined two terms: the political economy and the standard approaches. This study focuses on the standard model since it describes the service provision functions of governments. The standard model gave birth to the decentralisation hypothesis. The central argument supporting efficient public service provision here is seen using these scenarios (Lockwood, 2006; Oates, 1972):

- If localities are equal and no spill-over effects of service provision are reported, then both decentralised and centralised service deliveries are successful.
- If the areas are unequal and there is no spill-over effects of service provision are reported, decentralisation is more successful.
- Central provision is effective if similar positions are reported (equal and unequal localities) with spill-over effect on service provision.

Efficiency in decentralized public service provision refers to economic efficiency, which is concerned with the use of public resources to achieve optimum outcomes. This addresses
policymakers’ biggest task of reconciling rising demands in service provision with limited public funds (Lockwood, 2006). Economic efficiency refers to the choices made by a society, which maximises the results of public service delivery, measured in quality healthcare outcomes. In essence, efficiency is concerned with the relationship between the use of scarce resources (capital cost, labour cost, equipment, etc.), calculated in the form of expenditure, and their intermediate production (e.g., shortened waiting times) or outcomes of service (e.g., quality of life) (Lockwood, 2006).

On the contrary, the political economy model explains the government’s actions. The model takes into consideration the actions of a government from structural and political perspectives. This political economy approach ensures the achievement of two key decentralisation bedrocks: efficiency and accountability, through the preference matching advantage (allocative efficiency) and accountability. According to Besley and Coate (2003), the advantage of the political economy approach, over the standard approach, is that it nullifies the advantages of spill-over effects from the provision of public service in favour of the central government. The authors argue that the central government adopt a strategic choice of the delegate by voters to deal with the provision of public service in heterogeneous districts, which leads to less preference matching efficiency for centralised forms of government (Besley & Coate, 2003).

From these public-choice theory explanations, it can be said that the theory seeks to empower local people, especially the poor, in the provision of public services by their local governments. The proponents of public choice theory (see Tiebout, 1956; Musgrave, 1959) suggest decentralisation on economic priorities, such as lowering the welfare state and cutting public spending. The democratic nature of local government structure allows public officials to offer social accountability to the local people. Studies on local accountability show that public officials and local politicians have provided public goods that meet the needs of the poor (Dick-Sagoe & Asare-Nuamah, 2020; Hindricks & Lockwood, 2006; Lockwood, 2006).

Increased public participation increases efficiency in providing the right balance of public goods that meet local people’s needs. In this case, limited public resources are spent on products that represent local preferences and needs, thereby improving efficiency. While it is noteworthy that decentralisation has more significant benefits for increased public service provision, it has, however, not improved the quality and equity of public services in developing countries, especially in Africa (Crook, 2003; Dickovick & Riedl, 2010; Fox et al., 2011). Nevertheless, this paper believes that decentralised healthcare delivery will improve healthcare services through the information advantage of localities through demand and supply for local healthcare services. Hence, we expect to see an improved healthcare delivery, from the perspective of both health professionals and users (patients) in Lesotho.

2. Methodology

2.1. Study approach
This study adopted a qualitative research approach, supported by social constructionism (Bryman, 2012). Being a theory of knowledge, social constructionism believes in developing an understanding of the world through an examination of jointly constructed understanding. Through this, there is a shared assumption about social reality. The implication from a social constructionist point of view is that everything we find self-evident and believe to be objective truth is socially constructed in facts and can thus change as society changes (Vinney, 2019). This supports Guba and Lincoln (1990) argument that there is a distinction between the human world, and the natural and physical world. Similarly, Patton (2002) notes that individuals in the human world construct their world and give it meanings, based on their interaction and interpretation. The adopted approach, therefore, enabled the study to construct the experiences and perception of decentralised healthcare service delivery from the viewpoint of healthcare users and service providers in Lesotho.
2.2. The study context and decentralised healthcare services

The study was conducted in rural communities in Lesotho. Lesotho consist of highland and lowland areas and has a total population of 2,109,197, where three-quarter of this total population live in rural areas (World Bank, 2015) and is characterised by a widening inequality (Gini Index of 0.52) and high unemployment.

The study visited public clinics and hospitals in the villages located within both highland and lowland areas. The choice of village public healthcare centre was necessitated by the fact that the majority of the poor, three quarter, are living in rural areas and income distribution favours the urban areas (World Bank, 2015).

Decentralised healthcare service delivery was introduced in the year 2011 to deal with maternal and child mortality, as a result of lack of adequate staff and staff unpreparedness, as well as dilapidated rural healthcare buildings, supply shortages of healthcare centres (Nseera et al., 2015; World Bank, 2018c) and high out-of-pocket expenditure for households that use private healthcare services (World Bank, 2018c). In addition, statistics show that more than 30 percent of rural deliveries take place at home, using unsafe practices, due to lack of adequate healthcare facilities in the rural areas and high cost of healthcare services (Nseera et al., 2015; World Bank, 2018c). Decentralised healthcare service became the obvious option to deal with these problems together with the biased distribution of healthcare workers, particularly doctors and nurses, in favour of the urban areas (Nseera et al., 2015; World Bank, 2018c). Healthcare service decentralisation was meant to reverse the poor result that negatively affected the Lesotho government’s ability to deliver healthcare services (World Bank, 2018c), characterised by dilapidated healthcare buildings, lack of healthcare equipment and lack of adequate and inadequate healthcare staff in rural healthcare centres. Therefore, decentralised healthcare service is believed to enhance safe delivery, and increase child immunization, increase postnatal care. In addition, it is to ensure relocating doctors to underserved rural areas.

A plan to decentralise healthcare in Lesotho started in 2011 with the devolution of healthcare service delivery from the Ministry of Health and Social Welfare to the 10 districts under the management of District Health Management Teams, which is under the authority of the Ministry of Local Government and Chieftaincy Affairs (Government of Lesotho, 2013; WHO, 2014)

2.3. Participants and sampling procedure

Sixty (60) participants were selected for the study. Fifty (50) of them were service users (hereafter referred to as SU) of decentralized healthcare delivery services while the remaining were health professions (also referred to as HP). The participants were purposively selected for an interview, which was conducted in Sesotho language, the official language of the Basotho people. In the case of patients, the study reached a point of saturation as no new information emerged after the 50th interview. Similarly, the interviews of the health professionals also reached the point of saturation after the 10th interview was conducted. The selection of the participants was made as follows. The non-probabilistic purposive sampling procedure was employed, where participants were not given equal chances to be selected for the study.

Purposively the study used 10 out of the 106 public healthcare facilities in Lesotho. These 10 public healthcare facilities, fairly representing both low and highlands communities were used for a collaborative study jointly sponsored and undertaken by the United Nations International Children’s Emergency Fund (UNICEF), the World Bank Group and the Government of Lesotho on healthcare expenditure in the country (Government of Lesotho, 2017, p. 19). These 10 healthcare facilities were Mtsiakhe, Makoanyane, Leribe, Machabeng, Motebong, Botha-Botha, Mafeteng, Mokhotlong, Berea and Quthing. By the distribution, 5 healthcare users were interviewed in each of the 10 healthcare facilities and 1 healthcare professional from each of the 10 healthcare facilities.

The demographic distribution shows that 20 percent of the participants were males while 80 percent were females. Of the service users, 70 percent lived less than 5 kilometres from the healthcare
facility. With respect to the health professionals, 60 percent have been stationed in the community for over 4 years, which implies they have a better knowledge of service performance and conditions after the implementation of the decentralized healthcare delivery. Again, 60 percent of the service users have up to basic education while all the service providers have tertiary educational qualification.

2.4. Data collection instrument and procedure
The field data collection exercise lasted from November 2019 to January 2020. The study used a semi-structured interview guide, which allowed to probe for further information during the field data collection. The interview guide consisted of questions of what and how of the changes and experiences observed in health service delivery, and the effects of the implementation of decentralised healthcare on access and utilisation of healthcare services in the study area. For instance, participants were asked “has the implementation of decentralised healthcare service delivery improved access and utilisation of health services, if yes, how?” Questions pertaining to the challenges encountered in the implementation of decentralised healthcare service delivery were also asked. For example, participants were asked “what are the challenges encountered in this healthcare facility with the implementation of decentralised healthcare service delivery?” Prior to the interviews, the instrument was piloted, which helped to eliminate ambiguous questions and improved the standard of the instrument. This also helped to ensure the content validity of the data used for the study.

The study sought oral and/or written informed consent from patients and healthcare facility (clinic/hospital) administrators where the study was conducted. Ethical clearance was sought from the ethics committee of the National University of Lesotho to collect data and also to publish the paper. Participants’ confidentiality and anonymity were also protected in all aspects of this study. In this case, the names of the respondents were never used in the study. Participants were also given the freedom to take part in interviews or leave the interview process at any point. Face-to-face interviews (Creswell & Plano Clark, 2018; Kusi, 2012) were conducted and all interviews were conducted based on the preference of the participants. Interviews done using Sesotho language lasted for an average of 50 minutes and were recorded, based on participants’ approval.

3. Data analysis
As a qualitative study, thematic analysis of data was employed by following Braun and Clarke (2014) stages of thematic analysis. Prior to the analysis, the recorded interviews were transcribed from Sesotho to English and the transcripts were shared with the participants for validation (Creswell & Plano Clark, 2018). The researchers perused the transcript consistently to identify themes and draw patterns. Theme and pattern identification paid particular attention to similarities and differences in views of the respondents as well as the frequency of the views expressed. The views of the respondents were reported in verbatim quotes to give emphasis to how the participants expressed their real-world of decentralized healthcare delivery in Lesotho. For reference to the participants, pseudocodes were used. For instance, SU1 to SU 50 were ascribed to service users and HP 1 to HP 10 were used for health professionals.

4. Results
According to the public choice theory, efficient service delivery is achieved under the following: economy (cost-effectiveness), effectiveness (meeting the preferences of the local people) and efficiency, which makes government responsive to the needs of the people by providing tailor made services. Achieving these serve the best interest of the local people, thereby making them satisfied with service delivery. The study operationalized all these constructs from increased accessibility, utilisation and affordability of healthcare service.

4.1. Improvement in healthcare service delivery
Service users (SU) attested to the fact that health services have improved considerably. Upon further interrogation, the following views were recorded to support the claim that healthcare service delivery has improved. A service user reported that “the clinic has improved its time
management. Previously, we had to wait for a long time before we will be attended to. However, currently we hardly face the same situation, as healthcare services are rendered with minimal delay” (SU 1). These were corroborated by SU 8, 30, 46, and 48. Another improvement is the implementation of ambulance services. SU17 hinted that “we now enjoy ambulance services, which have increased access to healthcare in the community.” A respondent further expressed that “now when a child is sick, even in the middle of the night, s/he is taken to the clinic during that time since the healthcare facility is near instead of travelling to the hospitals in town. We are enjoying the benefits of decentralised healthcare service delivery. The clinic can provide immediate service needed by members of the community and nearby villages. We are at peace and there is hygiene in the village now” (SU 3).

Aside the improvement in services and conditions of health facilities, the participants also reported affordable services. For instance, SU 13 indicated that “the services are better than in the past and people now access cheaper service compared to the past where many people in the community could not afford healthcare service delivery. The participants also commented on the proximity advantage that comes with decentralized healthcare service delivery. According to SU 7 “people died in the past because health facilities were far from here and there were no ambulance services. Since this community now has a health facility, we do not travel for a long distance to access healthcare services. We can also access services at any time of the day.”

There has also been a significant improvement in the human resource capacity of healthcare facilities. A service user (SU23) hinted that “at first, only one nurse served as both a consultation officer and Pharmacist, which delayed service delivery.” According to SU 33, “previously, there was only one qualified nurse without a medical doctor. As such, most of the patients were transferred to other hospitals in town. However, now we see and encounter many health professionals when we visit the facility.” This was corroborated by a health professional who noted that “the number of health professionals has increased than before. We also have a human resource with diverse health service specialities” (HP 9). Health users now enjoy specialised healthcare services. For instance, SU 3 noted, which was later confirmed by SU 14, 19, 39 and 44 that “there was no medicine for certain health problems like diabetes and high blood pressure. Patients with such conditions were not served in the local clinic and had to go to big hospitals.” Notwithstanding the reported improvement, SU 36 hinted of “no improvement in healthcare service delivery.”

From the health professionals’ perspective, the provision of decentralised healthcare services has improved healthcare in the community. HP 1, indicated that “healthcare services in this facility have improved considerably. People no longer have to wait for too long in a queue to access healthcare. Currently, we have introduced a new service for HIV/AIDS testing and counselling based on our understanding of the healthcare needs of the community. This service was previously not available” Other health professionals (HP 2, 3, 6, 7, 8, 9) also confirmed these improvements. HP 3 emphasised the essence of the introduction of the HIV/AIDS service. To HP 3, “people need to know their status because sometimes patients report sicknesses like flu and others, whereas it is something else.” There were comments on the improvement in healthcare, due to the increased human resource capacity of healthcare facilities. For example, HP 9 indicated that “healthcare service has improved, due to the increased number of healthcare workers.” Further, HP 5 and 10 concurred that “currently, there are different departments in the clinic, which demonstrates our ability to deal with different diseases and conditions. These have improved the quality of healthcare delivery services because there are nurses for diverse health conditions and every personnel is responsible for his or her work.”

Another improvement reported from the perspective of a health professional was access to electricity supply needed by healthcare facilities to perform their tasks. HP 1 and HP 4 note that
“the health facility did not have electricity in the past, but electricity supply has now been provided, which has made it possible to store some of the medications that require refrigerating. We no longer operate in darkness, especially at night. These improvements have helped us to serve our patients better.” The healthcare services have also improved because we have increased our coverage to the most remote and hard to reach areas in our community. This has increased the number of people we serve, as the healthcare facilities are now closer to the people. Also, we are able to reach children for vaccination against diseases like measles and polio. This is done based on the fact that the healthcare centre administrators have realised that many children are not brought to the healthcare centre on specific dates assigned for a vaccine for various reasons, such as:

- Some children stay with their grandparents, who are too old and weak to travel to the nearby healthcare centre for immunization.
- Some parents are lazy and careless to visit the healthcare facility for immunisation
- Sometimes, the immunization announcement fails to reach the community members early.

Providing essential healthcare service requires efficient transportation. According to a health professional (HP 1, 4, 7, 8 and 10), “access to transport increases the services we provide to patients.” HP 1 and 4 explained that “since we received a vehicle from the Lesotho Millennium Development Authority (LMDA), we are able to quickly transfer emergency patients. We now boast of transporting health professionals to remote villages, to offer services such as polio and measles vaccinations and other required healthcare needs. This has enabled us to know the healthcare needs of our communities and serve them better”

4.2. Improvement in healthcare accessibility and utilisation

This section ascertained whether the availability of the healthcare facility has improved accessibility and utilisation of healthcare service delivery. All the service users were affirmative, which implied that the availability of the healthcare service has improved accessibility and utilisation of healthcare facilities. Most of the female service users reported accessibility and utilisation of healthcare facilities, especially maternal services. SU 12 emphasised that “the majority of us use the maternity services of the clinic. Now, almost all pregnant women would prefer to go to the clinic, unlike the past when we had to travel long distance for maternity services and so, many pregnant women stayed and delivered their babies at home” A male service user “indicated that apart from our wives being cared for at the clinic during pregnancy, we also go to the centre anytime we suffer from sicknesses and diseases. We no longer stay at home or buy medicines for treatment without visiting the health facility for proper treatment (SU 19)”.

Healthcare service accessibility and utilisation have “improved a lot and saved many lives. It is a long story, there were a lot of pregnant ladies and pregnant young girls in the community who hardly visits clinics because they were ashamed of their untimely and unplanned pregnancies and without the community healthcare facilities, such people run the risk of making unsafe abortions while some give birth through the assistance of the traditional birth attendants who mostly use unsafe methods. The presence of the local healthcare facility has solved these problems because if a lady is pregnant but has not visited the healthcare facility, the local people report such cases to the clinic and the clinic will send the nurses to go to the house and ensure that the pregnant lady follows the right procedure and access the health services (SU 10, 28, 49).”

All the service users attested to the fact that there have been an increase in access and use of healthcare centres. SU 44 expressed that “people who are severely ill can access the healthcare services, which has reduced the burden of transporting patients on horseback to far bus stops where they will pick a bus that will take them to hospital.” Another service user (SU 9) also stated that “now that there is a community healthcare facility, those found ill or under serious health conditions that need to be transferred to a big hospital are easily transported by the local healthcare facility’s own vehicle without incurring any transport cost.”
To the service user (SU 17), “providing a healthcare facility in this community has improved healthcare accessibility and utilisation for the community members because death rate has decreased in the community. People with HIV and AIDS are now able to get medication at the right time. Some members of the community are selected to serve as assistant nurses who provide services to the community on behalf of the healthcare facility where necessary.” The health professionals equally reported improved access and use of healthcare facilities. For instance, HP6 stressed that “we receive many patients and provide diverse healthcare services to many people in this healthcare facility. If this facility was not available, people would have resorted to home treatment or travel longer distances to access and use healthcare facilities in the city.”

4.3. Benefits of the healthcare facility to the community
All the service users responded positively that they have benefitted immensely from the proximity of a community healthcare. For example, service user (SU 23) indicated that “healthcare services are close to us so we do not spend much time and money to access healthcare services.” Service user 33 also concurred that “healthcare service is closer to the people and it takes just a short time to go to the clinic.” Another service user expressed that “the local healthcare facility has come to the rescue of those who could not travel for long distances to seek medical care (SU 9).” The health facility has also increased employment for the youth. Service users 8, 13, 22, 35, 46 and 50 noted that “the community has benefited from this community healthcare facility because some of the community members are hired to clean the clinic and its yard, hence providing employment for some community members.”

Furthermore, the presence of the healthcare facility has benefitted the community because “the healthcare facility gives immediate service when people are sick, unlike when there was no clinic and sick people had to wait for days to travel to other areas for healthcare services. Patients now receive immediate help and this reduces complications and sicknesses that may arise when there was no clinic (SU 21).” Again, the clinic staff “joins the community gatherings such as sports programmes and other entertainments to assist in accidents that may occur”. The clinic also “provides services for HIV/AIDS patients, who would otherwise resort to big hospitals, which has a long list of patients who need such services” (SU 6). The participants agreed that indeed the presence of the community healthcare facility has improved the health and well-being of the community members. It also emerged that the members of the community received education on hygiene and sanitation from the healthcare professionals, which helps to boost a clean environment in the community.

4.4. Waiting time to seek medical attention at the healthcare facility
All the participants affirmed that there has been a reduction in the waiting time of patients who access the health facilities. According to SU 18, “it does not take a lot of time to seek medical attention at the healthcare facility” Another service user hinted that “it takes me less than one hour to seek medical attention. At first, if I had to visit a health centre, I assume that my day is gone because I had to spend several hours before I can access healthcare services (SU 27).” The decrease in waiting time, according to health professionals, is associated with the improved health facilities coupled with increased human resource capacity of the health facilities. Nevertheless, some health users lamented that although there has been a reduction in waiting time, they still experience delays when they visit health facilities. Thus, the establishment of the community healthcare facility has shortened the time people stay in healthcare centres to access healthcare services.

4.5. Frequency of seeking medical care
The establishment of community healthcare facilities has increased the frequency of seeking medical attention. According to a service user “I regularly visit the healthcare facility to seek medical attention (SU 17).” SU 19 also concurred that “I have increased the number of times I visit the community health facility. At first, I used to use local drugs or buy from the drugstore when I am sick, but now I prefer to visit the healthcare facility for proper treatment” The rise in the
frequency of accessing healthcare facilities is borne out of the proximity of the healthcare facility to the community.

Special healthcare needs may also account for the increased frequency of patients seeking healthcare services. A Service user (SU 16) reported that “periodically, I seek healthcare services because I am on a monthly high blood pressure medication. Again, I visit the healthcare facility regularly for a regular check-up, due to the problem of high blood pressure and in my situation, the presence of the local healthcare facility has reduced the cost of transport I used to incur to see a medical doctor in the city.” However, service user 9 indicated that “I do not see the need to frequently visit the healthcare facility. I only go to the clinic when I am sick” The healthcare professionals also narrated that visit to the healthcare facility among the community members has increased and this continues to increase on daily bases, which to them is an indication of the trust the people have in their services.

4.6. Availability of adequate healthcare facilities and equipment

The service users were generally not impressed with the healthcare facilities and equipment at the healthcare facilities. One narrated that “the community healthcare facilities are not well resourced in terms of technology and equipment like those in the big towns and cities” (SU 1). Service users (SU 20 and 41) further explained that, “they have only one vehicle and that limit their ability in that when the vehicle transports patients to the hospital, there is no other vehicle for the staff to use to travel to villages to attend and provide healthcare services to patients who cannot afford to walk to the healthcare facility by themselves, like the old aged and people who are severely ill.” A health professional also argued that “since we have just one vehicle, once it has gone somewhere, we have no standby vehicle to attend to emergencies (HP 8).”

Other participants also complained of shortage of beds. For instance, service user 13 narrated that “the healthcare facility does not have adequate healthcare facilities and equipment because there is a shortage of bed for patients who need to sleep there and pregnant women are not able to deliver here because of lack of bed.” A health professional (HP 1) also reported that “as the number of users of community healthcare facilities keeps increasing, it will be prudent to increase the number of health professionals at the community healthcare facilities.” Nevertheless, it came to light that the community healthcare facilities are not in the status of hospitals and therefore cannot have all the facilities available in a hospital-status healthcare facility. On the contrary, service user (SU 24) narrated that “the community healthcare facilities have adequate facilities that meet their requirements. They are just local level healthcare facilities and not hospitals”

4.7. Performance of the healthcare staff

The participants were positive regarding the performance of the healthcare staff. A participant expressed that “amidst the logistics challenges the healthcare professionals are facing, they are doing their best, as they provide the required healthcare services to the community.” (S 12). This view was also supported by service users 13, 16, 20, 27 and 34. Service user 2 equally expressed that “the health professionals are doing their work to the best of their ability.”

Other service users also expressed themselves that indirectly showed their satisfaction with the performance of the healthcare staff. For instance, SU 5 indicated that “I am not in a position to rate them because there are no other local healthcare facilities here to compare with but overall, I have no complaint about the healthcare service delivery and performance of the healthcare providers.” Similarly, SU 8 hinted that “I cannot estimate the performance of this clinic because as a patient, I can see that we are treated differently. However, what I can say is that the nurses are doing their best to perform well.” The health professionals were rather not in a position to rate their own performance since they claim that their service is patronised by the communities, who were in a better position to rate or comment on their performance. However, most of the health professionals were quick to add that although they are doing their best, their performance is mostly hindered by lack of adequate logistics.
5. Discussion
This study sheds interesting insights pertaining to accessibility and utilisation of healthcare service delivery under the implementation of the famous decentralised healthcare service system by the government of Lesotho. The findings from the study support the arguments of the standard approach to decentralization, which served as the theoretical framework for this study.

As argued by the proponents of proximity advantage, local administrators are in a better position to offer improved and quality services that meet the needs of their constituents, due to their closeness with the people (see Chattopadhyay, 2013; Oates, 1972). Indeed, the findings showed that with a decentralised system of healthcare delivery, health professionals are able to offer quick, improved and better services that suit the healthcare needs of their communities.

| Local Innovation | Affordable services (less money paid for service) | Tailor-made services | Fast service provision (less waiting time) | Responsiveness to local needs | End to monopoly | Proximity (large service coverage) |
|------------------|---------------------------------------------------|----------------------|------------------------------------------|--------------------------------|----------------|----------------------------------|
| SU 1, 8, 48, 30, 46 | √                                                  |                      |                                          |                                |                |                                  |
| SU 17            | √                                                  |                      |                                          |                                |                |                                  |
| SU 3             | √                                                  |                      |                                          |                                |                |                                  |
| SU 13            | √                                                  | √                    |                                          |                                |                |                                  |
| SU 7             | √                                                  |                      |                                          |                                |                |                                  |
| SU 23            | √                                                  | √                    |                                          |                                |                |                                  |
| SU 33            | √                                                  |                      |                                          |                                |                |                                  |
| HP 9             | √                                                  |                      |                                          |                                |                |                                  |
| SU 3, 14, 19, 39, 44 | √                                            |                      |                                          |                                |                |                                  |
| HP 1, 2, 3, 6, 7, 8, 9 | √                                                |                      |                                          |                                |                |                                  |
| HP 5, 10         | √                                                  |                      |                                          |                                |                |                                  |
| HP 1, 4          | √                                                  | √                    |                                          |                                |                |                                  |
| HP 1, 4, 7, 8, 10 | √                                                  | √                    |                                          |                                |                |                                  |
| ALL SUs          | √                                                  |                      |                                          |                                |                |                                  |
| SU 10, 19, 28, 49 | √                                                  | √                    |                                          |                                |                |                                  |
| SU 9, 44         | √                                                  | √                    |                                          |                                |                |                                  |
| SU 17            | √                                                  | √                    |                                          |                                |                |                                  |
| HP 6             | √                                                  |                      |                                          |                                |                |                                  |
| SU 9, 23         | √                                                  |                      |                                          |                                |                |                                  |
| SU 6, 21         | √                                                  |                      |                                          |                                |                |                                  |
| SU 18            | √                                                  |                      |                                          |                                |                |                                  |
| SU 27            | √                                                  |                      |                                          |                                |                |                                  |
| SU 17, 19        | √                                                  |                      |                                          |                                |                |                                  |
| SU 16            | √                                                  |                      |                                          |                                |                |                                  |

Source: Authors’ construct, 2021
through improved accessibility and the use of healthcare facilities. This is largely due to the in-depth knowledge that health professionals gain from working closely with and within local communities (Chattopadhyay, 2013). With this, health professionals are able to identify and prioritise the healthcare needs of communities and map out strategies to address them in an effective and efficient manner. Table 1 provides field evidence of this as the majority of the participants commented that the presence of the decentralised healthcare service has reduced the waiting times for service delivery, has made local administrators more responsive to local health needs and has increased the number of patients who seek medical attention on daily basis at the healthcare facilities. Again the same table proves that local administrators of the healthcare facilities have become innovative, falling on so many strategies to improve and increase their response to the healthcare needs of the local people.

Existing studies have pointed out that increasing the number of healthcare facilities in rural communities have increased access and use of healthcare services, thereby improving the health and wellbeing of the local people (Crook, 2003; Crook & Sverrisson, 2001). This corroborates with the World Bank and the World Health Organization, who recommend and emphasise the critical need for governments, especially in developing economies like Lesotho, to bring healthcare services closer to the people (World Bank, 2003, 2006, 2018a, 2018b). The aim is to improve the health status of citizens, which is critical to economic productivity and efficient human productivity (World Bank, 2015).

With increasing global health challenges and the ripping effects on vulnerable communities, the need to intensify healthcare services is the utmost priority (Zhang et al., 2020). For instance, the COVID19 has seriously exposed the leakages and deficiencies in healthcare delivery in developed economies, where there are better and improved access to quality healthcare (Alemanno, 2020). There is a pressing need for governments in Africa, including that of Lesotho, to prioritise and intensify decentralised healthcare services that deliver both quality and improved services (WHO, 2020). Kingdom of Lesotho (2005) indicates that quality healthcare implies reduced waiting time, access to technology-oriented healthcare, the availability of competent trained health professional, and affordability of healthcare services.

Nevertheless, a large body of literature reveals numerous challenges in the practice of decentralisation in Africa (Crook, 2003; Dick-Sagoe & Andraz, 2020). For instance, a study in Ghana, Kenya, Ivory Coast, Tanzania and Nigeria reported that decentralised services by local authorities are burdened with poor accountability and power capture, with a ripping effect on responsiveness of local authorities to meet the need of local people, including poverty alleviation (Crook, 2003). This confirms the findings of this study, as the participants reported that decentralised healthcare services are confronted with challenges, mainly logistics and human resource, which affects the essence of decentralised healthcare system, which are to improve access and use of quality healthcare services. According to the WHO (2020) quality trained health professionals and technology-oriented healthcare facilities enhance quality healthcare delivery. It is therefore imperative for the government of Lesotho to prioritise personal, logistics and equipment, including electricity (World Bank, 2013), as an essential priority in her healthcare decentralisation agenda. Without that, the full benefits of the decentralised healthcare system will not be realised.

6. Conclusion
This paper has proved, with evidence from the experiences of healthcare facility users and professionals, that decentralised healthcare has the potential to improve the efficiency of healthcare service delivery at the local level in Lesotho. This study has provided a link between decentralised service provision and the public choice theory using qualitative approaches. In the literature, the study has demonstrated how the theory of public choice links with efficiency in decentralised healthcare provision, supporting the demonstration with empirical data on decentralised healthcare service delivery in Lesotho. The study argues that making healthcare accessible, closer to communities at an affordable, and in some cases, at no cost at all, meets the
healthcare needs of the poor in the marginalised communities. Meeting the healthcare needs of community members was shown in intense utilisation and accessibility to decentralised healthcare service.

Further, the modern public finance theory concerns itself, among others, with the impact decentralisation has on public services in terms of efficiency and equity. Efficiency comes in here because local managerial boards, being close to the local people, may be able to uproot inefficiencies. Again, the local people will encourage efficient delivery of locally governed healthcare service (Levaggi & Smith, 2003). On equity, local management of decentralised healthcare service can spread evenly limited resources equitably. Again, service users attempt to increase net benefits in the consumption of local public good. Simply, the rational man wants to pay less for service and wants service to come fast and save time. Efficiency here is addressed by saving the time of a common man through service provision, which should be provided faster than previously done.

From the premise above, this study proved that decentralised healthcare service delivery in the selected communities in Lesotho, has efficiently improved considerably. This can be seen from the fact that service users have increased the net benefit from the consumption of healthcare services within their localities. In most cases, healthcare services have been sent to the doorstep of the local people through intensive local innovation. For example, having realized the challenges poor people face in immunizing their children, the healthcare professionals (HP) from time to time, move from door to door within the community and immunize their children at no cost. Again, the adoption of mobile clinic and the deployment of nurses in hard to reach and remote communities to provide medical care are examples of the many responsive strategies adopted by the local health professionals. This is a true application of local innovation which comes with decentralised healthcare service provision. These local innovations, seen in this case, come through a complete understanding of local people’s needs and preferences and making constant efforts to meet such needs. Again innovation and local competition in healthcare delivery has compelled management of decentralised healthcare facilities to recruit more skilled and specialist staff to handle specialised healthcare needs and have acquired equipment which aid in general and specialised healthcare service delivery. These demonstrate efficient use of scarce resources at the local level.

From these analyses, one can see a reflection of Tiebout’s voting with feet in play here. Where many healthcare facilities with different specialization and cost offer service users the chance to move and enjoy healthcare services which provide the best mix of services at an affordable cost.

Further, service users spend less time at the healthcare facilities when they seek medical treatment. Again, services are mostly rendered at no cost and where there is a cost involved, they are made to pay a part, which service users consider being pocket friendly. Walking and travelling distance to the healthcare facility has also reduced considerably, thus helping the poor and the marginalized to access healthcare services at regular times, thereby reducing the challenges in transporting sick people to nearby healthcare facilities.

Several provisions of public services create competition, which leads to improvement in public service quality at the local level. This competition reduces cost of service provision as service providers seek innovative strategies to reduce their operational cost. Again, competition and innovation in service provision will force service providers to look for several alternative ways and strategies to survive on the market. This study has proved that this has happened for healthcare service delivery. Healthcare service providers have adopted to quick delivery of services to satisfy service users (patients), they have become more responsive to the health needs of the local people by setting up mobile health delivery services for social gatherings and other sporting activities where the risk of people getting injured or falling into other health-related problems are high. Again, the mobile health service delivery concept has been adopted for baby immunization in hard to reach remote communities.
Special trained assistant nurses have been deployed in hard to reach and remote communities for purposes of safe delivery and immunization of babies, prenatal and antenatal healthcare services and education, such as the importance of breastfeeding in hard to reach remote communities. Healthcare facilities have been fitted with suggestion boxes for patients to drop their comments and suggestions to improve healthcare service provision. One service user (patient) commented that he was very happy when a senior healthcare professional rebuked and forced a nurse to render an apology to him after the nurse abused him and the case was reported to the senior staff.

The study also observed that healthcare providers, because of competition, were expanding the healthcare services by employing many healthcare professionals with different specializations, so that they can expand healthcare service delivery at the local level. All these innovations have been put in place to meet the needs and preferences of service users. This was reflected in the comments offered by a health service user, who expressed happiness with the healthcare service provision. All these indicate allocative efficiency in local healthcare service delivery, where healthcare expenses and priorities are made to reflect the preferences and the needs of the community (patients).

7. Recommendation

Local government officials, together with the local authorities, should make it a priority to improve the available healthcare facilities and equipment. This will further improve healthcare delivery in the local areas. In addition, policymakers are to periodically monitor the progress and challenges of decentralised healthcare facilities. This will offer valuable insights and information needed to improve decentralised healthcare service delivery. Healthcare professionals must build strong bonds with the members of the community to enable them to gain their trust, which is critical to understanding their healthcare needs and offer services tailored to those needs. It is also critical for practitioners and local communities to ensure the efficient use of the existing resources, owing to the scarcity of resources that bedevil governments in developing countries.

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