An evaluation of three decades of health system decentralisation in Oman

Nahida Raouf Allawati[1], Nazar Mohamed[2] and Waleed Al Nadabi[1]

[1]Policy and Health Systems Unit, Ministry of Health, Sultanate of Oman (Correspondence to Nahida Allawati: dr.nahida@hotmail.com). [2]Human Resource Planning.

Abstract

Background: In 1990, the Omani Ministry of Health initiated a decentralisation of its health system, transferring authority to the regional health administrations, in line with the global drive to improve the efficiency, equity, accessibility, and quality of health service delivery.

Aim: To evaluate health system decentralisation in Oman over the past 30 years, including its strengths, weaknesses and areas for improvement.

Methods: We reviewed reports, ministerial decrees, legislations and other documents relating to the health system decentralisation policy in Oman and interviewed 35 key informants among those responsible for its implementation. This review was guided by the health systems framework of the World Health Organization, which focuses on leadership, governance, finance, service delivery, workforce, information, and medical products.

Results: Respondents expressed varying levels of satisfaction with the decentralisation across the health system. They said decentralisation has helped improve service quality, timing of procedures, resource management, and responsiveness to community needs. They highlighted the need to evaluate the current model and improve it, expand delegation of authority, strengthen legal and accountability frameworks, invest in leadership development, restructure in accordance with the decentralisation principles, and improve communication and use of technology.

Conclusion: Our findings show that decentralisation has helped improve health care at the hospital level in Oman, particularly service delivery and governance. Strengthening leadership skills of health workers and managers, clarifying roles, and improving accountability would help make the system more responsive and more efficient.

Keywords: decentralization, delegation, health system, health system framework, health sector, Oman

Citation: Allawati NR, Mohamed N, Al Nadabi W. An evaluation of three decades of health system decentralisation in Oman. East Mediterr Health J. 2026;32(1):12–18. https://doi.org/10.26719/2026.32.1.12.

Received: 10/11/2024; Accepted: 22/09/2025

Copyright © Authors 2026; Licensee: World Health Organization. EMHJ is an open-access journal. This paper is available under the Creative Commons Attribution Non-Commercial ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Introduction

Since the 1980s, many countries have adopted decentralisation reforms in their health sector, significantly impacting health system governance (*1*,*2*). Decentralisation is often driven by economic growth or community engagement, it rarely begins in the health sector alone (*3*).

Decentralisation is the transfer of power from the central to local authorities, in 4 common forms: delegation (organisational), de-concentration (administrative), devolution (political) and privatisation (*4*–*9*). The roles of decentralised health units are determined by the form of decentralisation adopted, and these may include legislation, policymaking, resource allocation, management, and intersectoral collaboration (*3*). Decentralisation grants decision-making authority at the local level, particularly in finance, human resources, service delivery, and governance (*10*–*13*). Following WHO recommendations and the Alma Ata Declaration, many countries initiated decentralisation of their health systems to address the limitations of centrally governed systems, especially in underserved rural areas (*1*).

The primary goal of health system decentralisation is to improve the efficiency, equity, accessibility, responsiveness, and quality of service delivery. The advantages include better alignment of health services with local preferences, improved programme implementation, reduced duplication, decreased inequalities between urban and rural areas, and enhanced community engagement (*5*,*14*,*15*). However, decentralisation has potential downsides, such as service fragmentation, weakened central health authorities, inequity, political manipulation in favour of interests of some stakeholders, and diminished public sector control (*15*).

Decentralisation does not guarantee better health outcomes or efficiency without critical considerations, including manager capacity building, accountability systems, clear legal frameworks, community involvement in design, resource allocation, and consistent monitoring. Success in achieving equity, efficiency and resilience in health systems varies, and in many cases, decentralisation reform affects or is affected by pre-existing centralised structures. It is therefore important that decision-makers and planners understand and are equipped

with strategies to maximise the positive and minimise the negative impact of decentralisation on a range of measures in different settings.

Health system decentralisation in Oman

In Oman, the Ministry of Health (MoH) was established in 1970 to build a modern, universally accessible, free health service system. Initially focused on infrastructure development, the ministry later expanded its scope to include public health programmes (*16*). Decentralisation began in 1990 with the formation of local health administrations. By 1993, directorates-general were established in 10 regions, accompanied by the gradual delegation of financial, administrative and decision-making authority (*16*). In 1999, Wilayat Health Committees, chaired by local governors, were introduced to support the multisectoral and community-based health initiatives. Over time, regional hospitals gained autonomy, and detailed regional plans were incorporated into the 5 year plans of the ministry beginning from 1996, with Wilayat-level plans added in 2001 (*16*). This decentralisation has improved service delivery and service responsiveness but it requires continuous evaluation to balance national policies with local needs.

Objectives of this study

This study was conducted to document experiences and achievements of the health system decentralisation policy in the Sultanate of Oman over the past 3 decades, evaluate its strengths and weaknesses, and offer recommendations for improvement. Decentralisation is one of the strategic directives in the "Oman 2040 Vision" document: "Comprehensive Geographic Development Through Decentralization and The Development of Limited Urban Hubs; and The Sustainable Use of Lands" (*17*). It was mentioned as one of the health priority goals: "A decentralized health care system operating with quality, transparency, fairness, and accountability."

Methodology

This descriptive study was conducted from January to April 2021, using the MoH organisational structure endorsed in 2015 to determine the study population, which includes the central and governorate level directors-general (or central and governorate level health administrators), hospital directors and experts (key informants). We collected, reviewed and analysed all reports, ministerial decrees, legislations and other documents related to the implementation of the decentralisation policy since its inception in 1990. Information from the review was used to design the study tools, including the structured questionnaire and key informant interview questions.

Four sets of questionnaires were developed, each targeting a specific group: governorate directors-general (*11*), central directors-general (*16*), hospital directors (*8*), and experts and key figures (*9*), who had held leadership roles in the ministry during early implementation of the decentralisation policy. The questionnaires were mostly similar, with little modifications to reflect the specific context and role of each target group. They were based on the WHO health systems building blocks (*18*): leadership and governance; health financing; service delivery; health workforce; health information systems; and medical products, vaccines, and technologies.

Each questionnaire was divided into 3 parts. The first part assessed the level of authority and delegation granted to the directors-general and satisfaction with that level of authority across the 6 health systems building blocks. The second part explored the perceptions of participants about the adequacy of the policy. The third part explored the perceptions of participants about the outcomes of the policy, suggested improvements and potential challenges of expanding the decentralisation in Oman. The open-ended format enabled a wide range of responses.

Copies of the questionnaires were sent by e-mail to all the participants, which they filled and returned by email. The response rate was 97%; only one director-general could not complete it due to his preoccupation with the COVID-19 response.

Four governorates were purposively selected for the interviews for geographic and operational diversity, while ensuring data saturation, given the homogeneity in governance structures across the 11 governorates. However, the perspectives of all 11 governorates were represented in the analysis of the data. There were 35 participants: 15 central directors-general, 4 governorate directors-general, 8 hospital directors, and 9 experts.

Key informant interviews were held with all the 35 participants to validate their questionnaire responses and explore areas not covered by the questionnaire.

Due to COVID-19 restrictions, all interviews were conducted online via Zoom by 2 team members. All the interviews were recorded and subsequently transcribed for analysis. Verbal consent was obtained from all the participants.

Data analysis

All the quantitative data were entered into an Excel sheet and presented as charts, including the participants' perceived satisfaction with the level of delegation across the 6 health systems building blocks. It was hypothesised that greater delegation would be associated with higher levels of satisfaction.

The qualitative data were analysed thematically and manually. The answers were coded and classified according to the domain of the study and the target group; repetitions in each domain and target group were monitored; relationships between different parts of the different domains of the study, and based on the target group, were observed, monitored and recorded; and intersections between the different domains and the different target groups were monitored. Although some data may resemble outputs from the Social Network Analysis (SNA), our study did not use SNA methodology. Some of the results were generated through quantitative analysis of structured survey data, reflecting individual

perceptions of authority and satisfaction across health system domains. No relationship mapping or network-based analysis (such as centrality or clustering) was conducted.

Results

Level of authority and delegation

Hospital managers reported the highest levels of authority and delegation (79%), followed by governorate directors-general (61%), while central directors-general reported the lowest levels (53%) (Figure 1). Sixty-eight percent of hospital managers, 66% of central directors-general, and 48% of governorate directors-general expressed satisfaction with the levels of authority and delegation.

Among the central directors-general, across the 6 health system pillars, the highest was health workforce (2.9 of 4) (Figure 2), followed by governance and service delivery. The lowest satisfaction was in financing and medical products. Central directors-general were most satisfied with their authority in governance, followed by service delivery and medical products, while they were least satisfied with health information, after finance and health workforce.

Among the governorate directors-general, the highest score was health information, followed by governance, health workforce and service delivery (Figures 3). The lowest scores were observed in financing and medical products. Governorate directors-general were most satisfied with their authority in health information, governance and service delivery, and least satisfied in finance and medical products.

The highest score in the level of power and delegation among hospital directors was in service delivery, followed by governance, while the lowest were in medical products and finance (Figure 4). Hospital directors were most satisfied with governance, followed by service delivery and health information, and least satisfied with health workforce, medical products and finance.

The level of authority was not always linked with higher levels of satisfaction. For example, central directors-general held the highest level of authority in health workforce (2.9) and a corresponding satisfaction level of 2.7. Their satisfaction was higher with medical products (2.9) despite a lower authority level of 2.3. Similarly, governorate directors-general reported authority level 3.3 and satisfaction level 2.7 for information. However, in finance, where they had the same authority level, their satisfaction dropped significantly to 1.8. These findings suggest that the optimal level of authority required to achieve satisfaction may vary across different health system domains and hierarchical levels.

Perspectives about decentralisation

The directors-general agreed on the utmost need to implement decentralisation as a system in principle. One of them commented:

> *"In the past, the authority granted to the directors-general was greater and more comprehensive. In recent years, much of the authority has been withdrawn or codified"* [which has hindered progress].

One expert said:

> *"The powers exist, but hesitant leadership undermines decentralisation—some directors-general lack confidence even when authority is granted."*

All the participants agreed on the importance of reviewing the authority and mandate for the directors-general, establishing a clear system for evaluation and

Figure 1 Satisfaction with level of authority and delegation

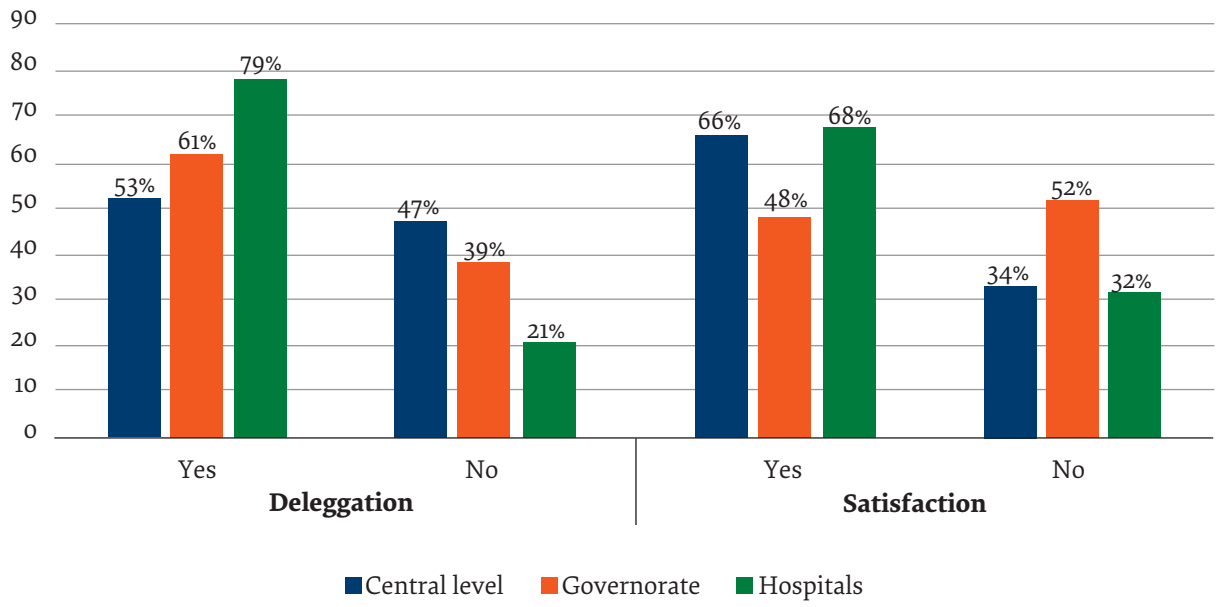


Figure 2 Satisfaction with level of authority and delegation (central directors-general)

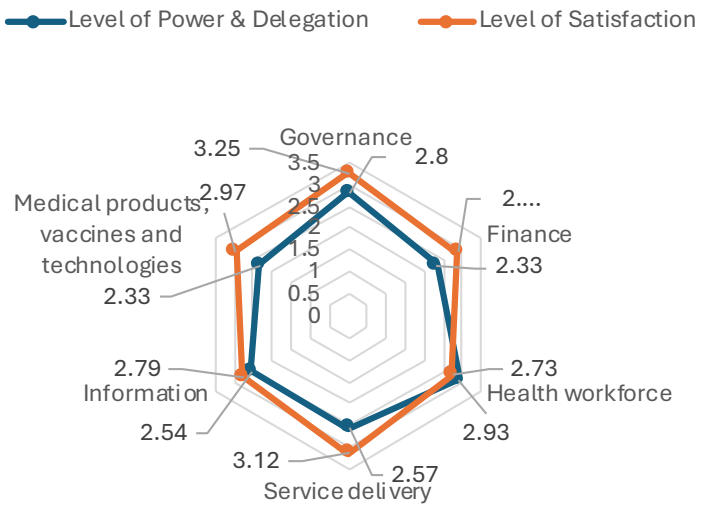


Figure 3 Satisfaction with level of authority and delegation (governorate directors-general)

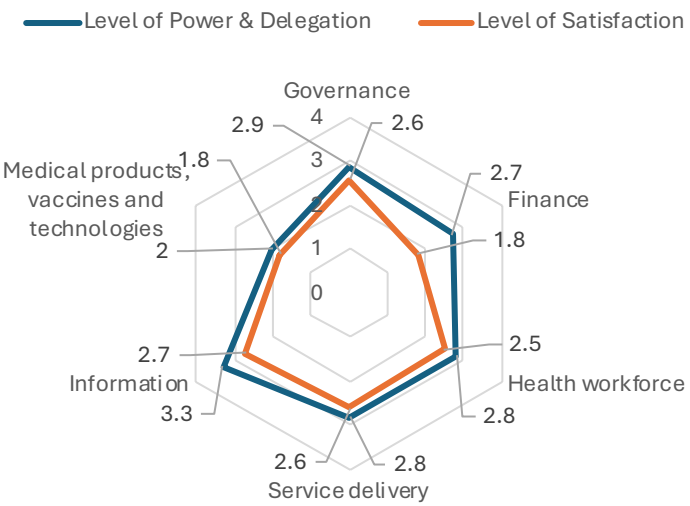
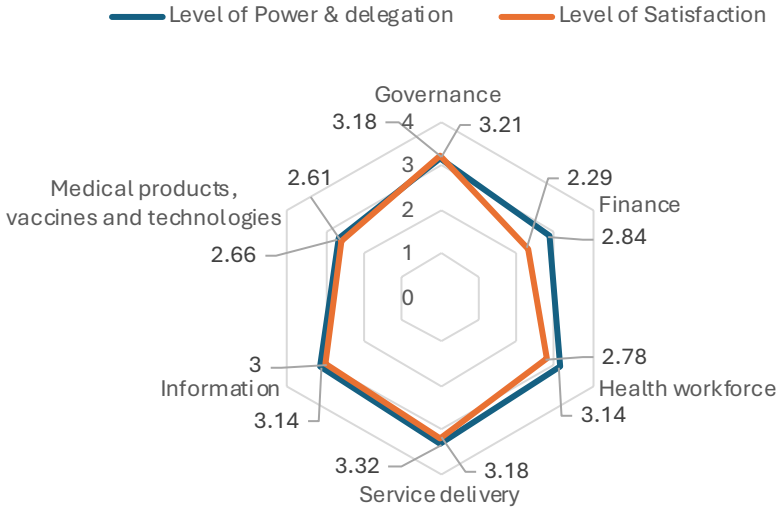


Figure 4 Satisfaction with level of authority and delegation (hospital directors)



accountability, and preparing the directors-general for their positions through strong leadership training.

Most of the directors-general agreed with the concept of "autonomous hospitals," however, they highlighted the necessity of:

> *"Defining the powers of the hospital director and the governorate directors-general and of clarifying their roles and the coordination mechanisms between them".*

Recommendations for improving decentralisation

Participants said decentralization in Oman has led to improved service quality, faster procedures, better resource management, and greater responsiveness to community needs. They said it has promoted fairness in service distribution, strengthened community engagement and encouraged leadership and innovation. To enhance the system, participants recommended evaluating the current model, expanding delegated powers, strengthening legal and accountability frameworks, investing in leadership development, restructuring in line with the principles of decentralisation, and improving communication and use of technology. Hospital directors noted the need for greater autonomy in staffing, procurement and partnerships.

The challenges to further decentralisation mentioned were lack of system and personnel readiness, unclear roles, deficient policy, and limited resources. Participants noted the need to clarify purpose, provide stronger oversight and adopt a phased approach to expansion to ensure smooth implementation.

Discussion

This study revealed various perceptions among central and governorate directors-general and hospital directors regarding the levels of authority and delegation and their satisfaction across key health system functions. Hospital directors reported the highest levels of delegation and satisfaction, while central and governorate directors-general reported lower levels, particularly in financing and medical products. This variation reflects the different responsibilities of each group. Hospital and governorate directors handle daily operational challenges requiring immediate decisions, whereas central directors-general focus on policy formulation and oversight of national programmes.

Satisfaction generally correlated with perceived authority, although notable gaps were identified in health information and workforce management. Given that leadership and governance are pivotal in shaping the overall impact on the health system (*19*), investing in this pillar is of paramount importance. Such investment is crucial for enhancing the effectiveness of governance structures and for ensuring that authority is perceived consistently across different levels of the health system.

Policy-setting powers at the directorate level were limited, mostly requiring senior management approval or coordination with other directorates. Participants described overlapping mandates and unclear delineation of authority across directorates, consistent with other studies that noted gaps in responsibility and accountability mechanisms (*10*).

Most of the directors-general reported limited authority over the health information system (HIS), specifically the Al-Shifa programme, because any changes require approval from a central committee so as to maintain national standardisation. This limitation made some directors-general to develop parallel data management systems. Studies have noted that decentralisation can negatively impact information management systems (*10*).

Governorate directors-general expressed satisfaction with their authority to transfer and reassign personnel but noted unclear powers when transferring employees to other central directorates. The lack of clear guidance for determining human resource needs across departments hindered decision-making. Studies have shown that centralized human resource processes can cause bureaucratic delays, while decentralisation carries its own risks, including a decline in employment conditions and abuse (*10*,*19*).

Participants said decentralisation is essential, although some of them reported a recent restriction on delegated authority. They perceived the effectiveness of decentralisation to depend on individual leadership capacity and institutional support. There was a consensus on the need for clearer definition of roles—particularly between directors-general and hospital directors—and stronger leadership capacity development.

Overall, participants said decentralisation has improved service quality, efficiency and responsiveness while fostering innovation and community involvement. However, they noted the need for further reforms, including expanding authority, enhancing legal and accountability structures, and improving coordination and digital systems.

Key challenges to further decentralisation were limited readiness, ambiguous roles coupled with weak coordination, resource constraints, and a need for clear, phased implementation supported by oversight and policy clarity.

Study limitations

The exclusion of primary health care and private sector providers in this study limits its insights into grassroots-level challenges. Future studies should integrate these stakeholders to better assess the risks of systemic fragmentation. Involving a broader range of stakeholders across all system levels would provide a more

comprehensive and more representative understanding of authority structures within the health system.

Conclusion

This study highlights significant variations in perceptions regarding decentralisation in the Omani health system, with hospital directors reporting greater delegation and satisfaction than their central and governorate counterparts. Limited policy-setting authority, overlapping roles and centralised control over key functions such as health information and workforce management emerged as major challenges. Although decentralisation has led to notable improvements in service quality, responsiveness and operational efficiency, its effectiveness remains constrained by unclear roles, limited resources and inconsistent delegation practices.

To advance meaningful decentralisation, it is essential to strengthen the governance structures, clarify authority at all levels and invest in leadership development. These findings provide valuable information and lessons for health policy in Oman and other countries with similar health system seeking to implement or refine their decentralisation strategy. A well-planned, phased approach—supported by transparent accountability mechanisms and capacity building—can help ensure that decentralisation translates into improved equity, efficiency and responsiveness in health service delivery. Subsequent policy development should adopt a more nuanced approach that leverages the strengths of both centralisation and decentralisation.

Funding: None.

Conflict of interests: None declared.

Évaluation de trois décennies de décentralisation du système de santé à Oman

Résumé

Contexte : En 1990, le ministère de la Santé d'Oman a entrepris une décentralisation de son système de santé, transférant l'autorité aux administrations sanitaires régionales, conformément à l'orientation mondiale visant à améliorer l'efficacité, l'équité, l'accessibilité et la qualité de la prestation de services de santé.

Objectif : Évaluer la décentralisation du système de santé à Oman au cours des 30 dernières années, en examinant ses forces, ses faiblesses, ainsi que les domaines à améliorer.

Méthodes : Nous avons passé en revue des rapports, des décrets ministériels, des législations et d'autres documents relatifs à la politique de décentralisation du système de santé à Oman et avons interrogé 35 informateurs clés parmi les responsables de sa mise en œuvre. Cette démarche a été guidée par le cadre des systèmes de santé de l'OMS, en mettant l'accent sur le leadership, la gouvernance, le financement, la prestation de services, les ressources humaines, l'information et les produits médicaux.

Résultats : Les personnes interrogées ont exprimé des niveaux de satisfaction variés concernant la décentralisation du système de santé. Elles ont indiqué que ce processus a contribué à améliorer la qualité des services, les délais des procédures, la gestion des ressources et la réactivité aux besoins des communautés. Ces personnes ont souligné la nécessité d'évaluer le modèle actuel et de le renforcer, d'élargir la délégation de l'autorité, de consolider les cadres juridiques et de responsabilisation, d'investir dans le développement du leadership, de procéder à une restructuration conforme aux principes de la décentralisation, et d'améliorer la communication ainsi que l'utilisation des technologies.

Conclusion : Nos résultats montrent que la décentralisation a contribué à améliorer les soins de santé au niveau hospitalier à Oman, en particulier la prestation de services et la gouvernance. La consolidation des capacités de leadership des agents de santé et des cadres, la définition claire des rôles et le renforcement de la responsabilisation contribueraient à rendre le système plus réactif et plus efficace.

تقييم لامركزية النظام الصحي على مدى ثلاثة عقود في سلطنة عُمان

ناهدة رؤوف اللواتي، نزار محمد، وليد الندابي

الخلاصة

الخلفية: في عام 1990، شرعت وزارة الصحة العمانية في تطبيق اللامركزية في نظامها الصحي، ونقل السلطة إلى الإدارات الصحية الإقليمية، بما يتماشى مع التوجه العالمي نحو تحسين كفاءة الخدمات الصحية وإنصافها إتاحتها بجودة عالية.

الأهداف: هدفت هذه الدراسة إلى تقييم لامركزية النظام الصحي في سلطنة عُمان على مدار الثلاثين عامًا الماضية، بما في ذلك نقاط القوة والضعف والمجالات التي تحتاج إلى التحسين.

طرق البحث: استعرضنا التقارير والمراسيم الوزارية والتشريعات والوثائق الأخرى المتعلقة بالسياسة اللامركزية للنظام الصحي في سلطنة عُمان، وأجرينا مقابلات مع 35 من المسؤولين عن تنفيذها ممن يمثلون مصادر للمعلومات الرئيسية، واسترشدنا بإطار "النُّظم الصحية لمنظمة الصحة

العالمية"، مع التركيز على القيادة، والحوكمة، والشؤون المالية، وتقديم الخدمات، والقوى العاملة، والمعلومات، والمنتجات الطبية.

النتائج: أعرب المجيبون عن مستويات متفاوتة من الرضا عن اللامركزية في النظام الصحي بأكمله. وأوضحوا أن اللامركزية ساعدت على تحسين نوعية الخدمات، وتوقيت اتخاذ الإجراءات، وإدارة الموارد، والاستجابة لاحتياجات المجتمع. وأبرزوا الحاجة إلى تقييم النموذج الحالي وتحسينه، وتوسيع نطاق تفويض السلطة، وتعزيز الأطر القانونية وأطر المساءلة، والاستثمار في تطوير القيادة، وإعادة الهيكلة وفقًا لمبادئ اللامركزية، وتحسين الاتصالات واستخدام التكنولوجيا.

الاستنتاج: تشير نتائجنا إلى أن الإدماج قد ساعد على تحسين الرعاية الصحية على مستوى المستشفيات في سلطنة عُمان، لا سيما تقديم الخدمات والحوكمة. ومن شأن تعزيز المهارات القيادية للعاملين الصحيين والمديرين، وشرح الأدوار، وتحسين المساءلة، أن يزيد استجابةَ النظام وكفاءته.

References

1. Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. Health Policy Plann 2019;34(8):605–617. https://DOI.org/10.1093/heapol/czz055.
2. Kigume R, Maluka S. Decentralisation and health services delivery in 4 districts in Tanzania: how and why does the use of decision space vary across districts? Int J Health Policy Manag. 2019;8(2):90–100. doi:10.15171/ijhpm.2018.97.
3. The World Bank. Financing health services in developing countries: An agenda for reform. Washington DC: World Bank, 1987. https://documents1.worldbank.org/curated/en/468091468137379607/pdf/multi-page.pdf.
4. Rondinelli DA, Nellis JR, Cheema GS. Decentralization in developing countries. Staff Working Paper 581. Washington DC: World Bank, 1983. https://documents1.worldbank.org/curated/en/868391468740679709/pdf/multiopage.pdf.
5. European Observatory on Health Systems and Policies Series. Decentralization in health care strategies and outcomes. Edited by Richard B. Saltman, Vaida Bankauskaite and Karsten Vrangbæk, 2007. https://eurohealthobservatory.who.int/publications/m/decentralization-in-health-care-strategies-and-outcomes.
6. Rondinelli DA. Government decentralization in comparative perspective: Theory and practice in developing countries. Int Rev Adm Sci. 1981;47(2):133-145. DOI:10.1177/002085238004700205.
7. Mills A, Vaughan JP, Smith DL, Tabibzadeh I. Health system decentralization: concepts, issues and country experience. Geneva: World Health Organization, 1990. https://iris.who.int/handle/10665/39053.
8. Peckham S, Exworthy M, Greener I, Powell M. Decentralizing health services: More local accountability or just more central control? Public Money Manag. 2005;25(4):221-228. DOI:10.1080/09540962.2005.10600097.
9. Mills A. Decentralization and accountability in the health sector from an international perspective: What are the choices? Public Adm Dev. 1994;14(3):281-292. DOI:10.1002/pad.4230140305.
10. Bossert TJ, Beauvais JC. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. Health Policy Plann. 2002;17(1):14-31. DOI: 10.1093/heapol/17.1.14.
11. Bossert T. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Soc Sci Med. 1998;47(10):1513-1527. DOI: 10.1016/s0277-9536(98)00234-2.
12. Bossert T, Chitah MB, Bowser D. Decentralization in Zambia: resource allocation and district performance. Health Policy Plann. 2003;18(4):357-369, DOI: 10.1093/heapol/czg044.
13. Bossert TJ, Bowser DM, Amenyah JK. Is decentralization good for logistics systems? Evidence on essential medicine logistics in Ghana and Guatemala. Health Policy Plann. 2007;22(2):73-82. DOI:10.1093/heapol/czl041.
14. Sumah AM, Baatiema L, Abimbola S. The impacts of decentralization on health-related equity: a systematic review of the evidence. Health Policy 2016;120: 1183–1192. DOI: 10.1016/j.healthpol.2016.09.003.
15. Collins C, Green A. Decentralization and primary health care: some negative implications in developing countries. Inter J Health Serv. 1994;24 :459–475, DOI: 10.2190/G1XJ-PX06-1LVD-2FXQ.
16. Alshishtawy MM. Four decades of progress: Evolution of the health system in Oman. Sultan Qaboos Univer Med J. 2010;10(1):12-22. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074664/pdf/squmj-10-1-12.pdf/?tool=EBI.
17. Government of Oman. Oman 2040 Vision. https://www.oman2040.om/assets/books/oman2040-en/index.html#p=1.
18. World Health Organization. Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization, 2007. http://www.who.int/healthsystems/strategy/everybodys_business.pdf.
19. Sapkota S, Dhakal A, Rushton S, van Teijlingen E, Marahatta SB, Balen J, Lee ACK. The impact of decentralisation on health systems: a systematic review of reviews. BMJ Glob Health 2023;8:e013317. DOI:10.1136/bmjgh-2023-013317.