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Decentralisation of Primary Health Care in Brunei Darussalam during the Period of Economic Slowdown

1. Introduction

1.1 Background

This paper is aimed at introducing health sector reform in Brunei Darussalam with particular reference to decentralisation of primary health care (PHC) services (outpatient services) from the hospital to the health centres – a move which is more to promote and enhance PHC services than simply moving the general outpatient services of the hospital. Health sector reform is often taking place against the wider background of civil service review, and Brunei Darussalam is currently in the process of reorganizing and reorienting its Ministry of Health within this context. A Civil Service Review programme was initiated by the Government as an initial effort to improve the efficiency, effectiveness and quality of management in the Civil Service. It is an increasingly recognized view that the role of Ministry of Health in the future should change from management and delivery of services towards policy formulation, monitoring, co-ordination and regulation.

1.2 Health Sector Reform as an Integral Component of the Civil Service Review Programme

The initiative taken by the Ministry of Health to decentralise the primary health care services is in line with the spirit of Civil Service Review to review and reorganise the health care system delivery of the Ministry of Health. The move is also in line with the Brunei National Health Care Plan (2000 – 2010) that states explicitly placing greater emphasis on primary health care as one of the strategic goals. The decentralisation was in fact the first systematic review ever conducted by the Ministry of Health on the health system infrastructure. The rationale to streamline the health care delivery system in particular after the decentralisation of primary health care services from the Raja Isteri Pengiran Anak Saleha Hospital to the health centres in Brunei Darussalam can be considered in terms of their new roles.

The role of health centres include

i) to provide comprehensive, accessible, convenient and equitable primary health care services;

ii) to refer complicated cases that cannot be handled at the health centre setting to hospitals;

iii) and to promote family practice.

Whilst, the new role of Raja Isteri Pengiran Anak Saleha Hospital include:

i) as a National Referral Hospital

ii) Centre of Medical Training

iii) to improve efficient use of resources by reducing the number of medical procedures which do not need to be handled at the hospital environment.

With the decentralisation, greater autonomy is also given to the medical officers in charge of the health centres in the planning and the day to day management of the centres. In the next coming years, all the health centres will be staffed by more skilled personnel i.e. senior medical officers after the completion of the first cohort of Diploma Programme in Primary Health Care. The programme is jointly organised by three institutions namely Ministry of Health, University of Brunei Darussalam and St. George's Medical School, University of London.

1.3 Primary Health Care and Primary Care

The term primary health care (PHC) is used here as defined by World Health Organisation (WHO,1978) at the World Health Assembly, Alma Ata which is defined as

"*essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*"

The Alma Ata Declaration states that primary health care includes at least:

1. Education concerning prevailing health problems and the methods of preventing and controlling them;

2. Promotion of food supply and proper nutrition;

3. Adequate supply of safe water and basic sanitation;

4. Mother and child health care including family planning;

5. Immunisation against the major infectious diseases;

6. Prevention and control of locally endemic diseases;

7. Appropriate treatment of common diseases and injuries; and

8. The provision of essential drugs.

It is therefore the interest of the Ministry of Health to integrate and further promote/enhance the World Health Organisation concept of primary health care. This will mean having to provide all the primary health care doctors and dental services that will promote family practice from children, mothers / women and up to the elderly which will come under one roof.

It should be noted that primary health care is interpreted either as a set of services or an approach. When the term is used as an approach, the definition by WHO above applies. But when it is used to describe a set of services the term means first-level services, mostly delivered by health centres. What primary health care should ideally contain as stated by WHO are in fact present in the primary health care system of Brunei Darussalam but the extent of integration of the services varies from one health centre to another. It should also be recognised that the term primary medical care or primary care is used to describe first level of contact. In the context of Brunei Darussalam, the primary care level is the health centre at the sub-district level, the secondary care level is the district hospital and the tertiary level is the referral hospital at the capital.

2. Decentralisation and Health Sector Reform

2.1 Decentralisation

The concept of decentralization as defined by the field of public administration focuses on the ways by which a national political structure manages the distribution of authority and responsibility of health services. As a result the analysis leads toward recommendations as to how to shift responsibility and authority from the centre to the periphery of the administrative system.

Decentralization is one of the main components of health sector reform in a wide range of countries. It is widely recognized that management, planning, and policy functions in the health sector may be carried out more efficiently and effectively, if they are decentralized (Mills et al, 1990; Collins, 1994). Decentralisation is viewed favorably by the Ministry of Health as a tool to implement primary health care because it is essential in developing local support for PHC. In view of this, emphasis has been put to strengthen the district and community levels as this is the level closest to the community and support for PHC activities can be developed.

Decentralisation must not be seen as an end in itself but rather a means to achieve other objectives. In the health sector the main objectives of decentralisation include increasing equity (access and coverage), efficiency, quality and improved outcomes. Therefore, it is important to evaluate whether and how well decentralisation structures, mechanisms and processes achieve these objectives.

The paper attempts, as far as possible, to address the central question of whether decentralisation of primary health care services improve equity, efficiency, and quality of services. Therefore, some of the key issues of equity, efficiency, effectiveness and health outcomes are addressed in the paper.

In the context of our Health Sector Reform, the shifting of the responsibility and authority from the central based health care services in the referral hospital is never being transferred to the community level. Doctors in their designated catchment population will be able to plan, manage and be responsible for the health of individuals, families and people in their own community.

2.2 Health Status and Challenges

Brunei Darussalam faces continuing challenges to the health of its population. Lifestyle diseases have become increasingly of public health importance in Brunei Darussalam particularly in the last two decades. The health profile in the country reveals that the preventable communicable diseases traditionally associated with developing world have been decreasing sharply, while the non-communicable lifestyle related diseases – cancers, heart diseases and cerebrovascular diseases are increasing. **Figure 1** shows the ten year trend for the leading causes of death in Brunei Darussalam. In the year 2000, cancers continue to be the leading cause of death in the country. They cause 19.2 % of all deaths and are responsible for a large proportion of health care costs. Many types of cancers are related to lifestyle and are thus, to varying degrees, preventable. Heart disease is the second leading cause of death in the country, accounting for 15.4 % of the total. Cerebrovascular diseases are third largest cause of death in the country. These affect particularly adults in their thirties and forties, and thus have a disproportionate effect on families and on economic productivity.

The health challenges have two important implications for health sector reform. The first is that health services have a relatively limited impact on improving health. Overall health status is determined primarily by behavioural and lifestyle factors, socioeconomic status and environmental conditions. A wider intersectoral and country approach is required to address the main health determinants, as well as a strengthening of public health function within the health services. The second important implication is the need to drive health services to respond to these challenges by shifting funds from curative to preventive care, and from secondary and tertiary care to primary care. This project has been considered a milestone in the history of medical and health services in the country where it has started to move into the direction of redistribution of same resources from curative to the public health, preventive and primary care services.

2.3 The Evidence on Primary Health Care

There is strong evidence that a health system based on primary health care principles is safer, more effective in achieving good health outcomes, and more efficient in terms of containing total health costs (Starfield B, 1999). Research on the comparison of health policies of Norway and Sweden, in which the former places greater emphasis on primary health care, has suggested that the differences in policies between the two countries largely explain the lower per capita cost of the Norwegian system. This shows that a system which places greater emphasis on primary health care is more cost-effective. (Agdestein S; Roemer M, 1991).

2.4 The Impact of Economic Slow Down

The economic recession which started in 1997 has also affected Brunei Darussalam's economy to a certain large extent. Structural adjustment policies had been exercised, as a key feature, on the reduction in the size of the civil service. This has led to a review and tightening of public funding for operational and in particular development budget of the non-productive sectors. Greater emphasis has been placed on revenue driven and operational efficiency area of the public services. Under the Brunei Darussalam Seventh National Development Plan (1996-2000) five health centres were approved for construction. This is part of the proposal for the completion of a national network of primary health centres in the Brunei Muara District. The economic recession provided the impetus for a re-think about the Development Plan. The Ministry of Health was aware of the increasing problem of overcrowding faced by the primary care outpatient services at the Raja Isteri Pengiran Anak Saleha Hospital. Furthermore, there was an increased awareness for the primary health care services to be improved in line with the need to give priority on the prevention of diseases and health promotion programmes.

Despite the economic recession and set against the background of greater priority being given to primary health care, the chronic problem of overcrowding and the strong evidence that primary health care is cost effective, the Ministry of Health pursued the implementation of the Development Plan. The Ministry therefore decided to take the alternative of using temporary buildings to be used as health centres and completely decentralize the primary health care closer to the community as a short-term and immediate measure.

A study was then commissioned to reexamine the proposal and to reevaluate the number of health centres required in order to be able to decentralize the primary health care services from the national referral hospital to the periphery. The study was also conducted to identify the strategic locations of the main health centres and to determine human, financial and other resources required. An evaluation study was also conducted in order to determine the achievement of the decentralisation project in terms of indicators of health system performance such as equity, effectiveness, efficiency, quality and public acceptance.

3. Feasibility Study

3.1 Objectives

Before the decentralisation, the government institutions which provide general outpatient services in the Brunei Muara District were the Raja Isteri Pengiran Anak Saleha Hospital Outpatient Department, Pengiran Anak Puteri Hajah Rashidah Health Centre in Sungai Asam, Jubli Perak Health Centre in Sengkurong, Muara Port Clinic, Police Headquarters Clinic and International Airport Clinic. The decentralisation study of primary health care services for Brunei Muara District was first conducted in July 1999. The purpose of this study was to determine the number and locations of the new health centres to cater the whole population of Brunei Muara District. Before the decentralisation, 70% of the outpatient attendances was handled by the Raja Isteri Pengiran Anak Saleha Hospital. The hospital is also a national referral hospital for the country. Table 1 shows the general outpatient attendances at the Raja Isteri Pengiran Anak Saleha Hospital and the health centres in the Brunei Muara District for the year 1998. The study of the number of doctors required to staff the centres was also done as a critical factor in determining the feasibility of the project to proceed.

3.2 Data Requirement and Sources

The study was conducted for the whole of Brunei Muara Distict. The base year was 1998, while 1999 was the year chosen for the projection. There are three data sources required for this study as follows:-

1. 1991 Population Census (Department of Economic Planning and Development, Ministry of Finance);

2. Estimated mid-year 1998 population (Department of Economic Planning and Development, Ministry of Finance) and actual population of the kampongs and mukims for the year 1998 (Brunei Muara District Office, Ministry of Home Affairs); and

3. 1998 Raja Isteri Pengiran Anak Saleha Hospital Outpatient Department and existing health centres and clinics general outpatient attendances).

3.3 Methodology

Covering an area of 570 sq. km, Brunei Muara may be the smallest district in Brunei Darussalam, but it is the site of the capital, Bandar Seri Begawan and the seat of main government administration and commercial centre. The number and location for the new health centres were determined by considering the following main factors: -

1. Catchment population (based on ratio of one health centre to pre-determined population);

2. Population density and distribution;

3. Major projects which involved population movement such as housing development projects;

4. Accessibility by studying transportation and road networks;

5. Distance between each health centre and residential areas;

6. Government policies on national development plan;

7. Division by mukims / kampongs for ease of administration;

8. Cost of renting or renovating the proposed health centres; and

9. Requirement of human resources (doctors) for every health centres.

3.3.1 Catchment Population (based on ratio of one health centre to population)

The ratio of one health centre to the number of population proposed by the World Health Organization (WHO) is that 50,000 people to each health centre or 1:50,000. However, a number of possible ratios of one health centre to population was considered in the study. The ratio used also took into consideration the proposed number of health centres under the Seventh National Development Plan which was altogether 7 including the 2 existing ones before the decentralisation. The ratio determined was based on the mid 1998 population of Brunei Muara District which was 213,800. The possible ratios of health centre to population considered were 1:25,000, 1:30,000, 1:35,000 and 1:40,000. The number of health centres required for the ratios selected is as shown in **Table 2**. Considering the initial plan under the Seventh National Development Plan as well as the cost-effectiveness in determining the required number of health centre and in terms of the limited resources especially the small number of doctors, the ministry endorsed the ratio of 1:30,000. Therefore the number of the new health centres required to cater 213,800 population was five (5). This ratio was used in determining the catchment population in optimising the locations of the new health centres. Although the ratio used was 1:30,000, due to the uneven distribution of the population, this ratio is not strictly adhered to. The catchment population for one health centre to another ranges from 20,000 to 40,000 as shown in **Table 3**.

3.3.2 Population Distribution and Density

In Brunei Darussalam, each village or “kampong” has its head or “ketua” and a group of “kampongs” comprises a “mukim”, which is headed by a “penghulu”. Brunei Muara District comprises of 17 “mukims” with more than a hundred fifty “kampongs”. The 1991 population census and the projected mid 1998 population were used to estimate the number of people living in each “mukim” or administrative division. The number of people living in each “mukim” was then used to determine the distribution of the new health

centres. The study involved combining the population in one "mukim" with the other or nearby areas to finally determine the location for each health centre.

3.3.3 Major Projects Involving Population Movement such as Housing Development Projects

Another factor in determining the number and location of health centre is to consider the major government projects that involve population movement such as housing development projects. Such projects involve certain potential areas on-land as well in the water village. Those mukims which are part of these housing development projects were given greater attention in determining the locations of the health centres. Therefore, the mukims which potentially have high population density, must have a health centre. This led to the decision of locating health centres at the main areas of housing development projects like Rimba Health Centre, Berakas 'B' Health Centre and Muara Health Centre.

3.3.4 Accessibility by Studying Transportation and Road Networks

The accessibility of each health centre to every residential place was determined by studying the road network indicated by the Brunei Muara District map provided by the Survey Department. It was shown that road network in Brunei Muara District is very good and each health centre can be reached or accessed by people from any residential area.

3.3.5 Distance Between Each Health Centre and Residential Area

From the study, it was found that the distance between each health centre and the residential place for the designated catchment population does not exceed 15km and it is estimated around 15 minutes to reach each health centre by car. This is the maximum distance used by the Ministry of Health as a standard between each health centre and the residents for which it is meant to serve for the Brunei Muara District. This gives a figure of 100% of the population residing within 15km of a health centre which indicates a very good coverage and access. This also reflects the improvement of equity in terms of access to a health centre and coverage after the decentralisation.

3.3.6 National Development Plan

The study also considered government policies on National Development Plan. Under the Brunei Darussalam Seventh National Development Plan (1996-2000), 5 health centres and 2 health clinics have been approved for construction. The locations of the approved health centres are in Bandar Seri Begawan, Kg Lambak Kanan resettlement area, Muara town, Kg Rimba, Gadong and Gadong industralised areas. Whereas the locations for the health clinics which were approved include Kg Mentiri and Kg Bunot resettlement areas. Seven health centres are required to cater the population of Brunei Muara District based on the ratio of 1 health centre to

30,000 population, which means that 5 new health centres were required in addition to the two existing health centres.

3.3.7 Cost of Renting and Renovating the Health Centres

The cost of building 5 new centres was estimated at 20 million dollars. This was based on the cost of one health centre which is 4 million dollars (the cost of building the 2 existing health centres). As the financial difficulties faced in building five new health centres, the Ministry of Health decided to use, as far as possible, either existing government buildings, renting commercial buildings, and private housing. The study showed that even in the long term, renting commercial building / private housing is still much cheaper than building new health centres taking into consideration the cost of maintaining the buildings. Due to the pressing need to promote and enhance primary health care and reduce the overcrowding of the Raja Isteri Pengiran Anak Saleha Hospital, the cost of renting and renovating the existing government and private housing / commercial buildings was feasible to implement the project. Based on the present health centres, it takes about 15 – 20 years to recover the costs. **Table 4** shows the estimate costing for each health centre. After much consideration, it was decided that one government building (other than MOH building) and two Ministry of Health's own buildings were used and one commercial building and one private housing were rented for the project.

3.3.8 Requirement of Human Resources for Every Health Centre

Once the locations of the new health centres were determined, the number of required human resources such as doctors, nurses, and other technical workers as well as facilities and financial allocation were then determined for each health centre.

The allocation of the number of doctors were based on the 1998 average outpatient attendance where 37 patients were consulted by 1 doctor per day in the Raja Isteri Pengiran Anak Saleha Hospital and 51 patients were seen by each doctor per day in health clinics and health centres in the same year. Based on these ratios the average consultation time for each patient was calculated as 10.5 minutes at Raja Isteri Pengiran Anak Saleha Hospital and 7.6 minutes at health centres and clinics. Based on these figures, the ratio of 1 doctor to 50 patients was adopted in calculating the number of doctors required. The number of doctors required for Raja Isteri Pengiran Anak Saleha Hospital and each health centre based on the 1998 outpatient attendance rate is also shown in **Table 1**.

4. Implementation and Launching of Primary Health Care Centres in Brunei Muara District

4.1 Health Centres

On the 1st of June 2000, the decentralisation of Raja Isteri Pengiran Anak Saleha Hospital outpatient services took place in 2 existing and 5 new health centres namely Bandar Seri Begawan (functioning in Raja Isteri Pengiran Anak Saleha Hospital), Rimba Health Centre in Gadong, Muara, Berakas 'A' and Berakas 'B'. The distribution and locations of these health centres and the existing ones are as shown in **Figure 2**. Bandar Seri Begawan Health Centre was temporarily based in Raja Isteri Pengiran Anak Saleha Hospital until the first week of March 2001 when it was separated out in Ong Sum Ping. Altogether, there are seven health centres (plus the existing Pengiran Anak Puteri Hajah Rashidah Health Centre in Sungai Assam and Jubli Perak Health Centre in Sengkurong) are functioning in Brunei Muara District after decentralisation.

4.2 Cost

Major renovation work of one of the Ministry of Health's buildings (Anggerek Desa Flat) has taken place changing it to a new health centre set-up and now operating as Berakas 'A' Health Centre. The overall cost of renovating this building was only three quarter of a million dollars (B$750,000). Muara and Berakas 'B' Health Centres are using two commercial buildings which are rented at a cost of around nine thousand dollars and six thousand dollars respectively. Bandar Seri Begawan Health Centre is using one of the government condominiums in Ong Sum Ping and this building does not belong to the Ministry of Health. Lastly, the large unoccupied space available in Rimba Dialysis Centre is used for the outpatient services for Gadong Health Centre. The budget used for this project was taken from the Seventh National Development Plan budget.

4.3 Types of services provided

Primary Health Care services in the context of Brunei Darussalam is confined to providing three major services under one roof which are seen as necessary to be the basic care for the whole population. These services are general primary care services, mother and child health care services and dental services. Though the decentralisation was aimed at providing an integrated primary health care services which include the three core services, some of the health centres still do not provide all the three services. Berakas 'A' health centre for instance, does not have dental and MCH services. However, such services are available at the clinic near the centre. This is the step in trying to integrate and promote the primary health care services in the country as envisioned in our strategic plan.

4.4 Human Resource

The decentralisation programme is operating with the existing available number of staff especially doctors. This means that it was implemented using the same number of doctors as it was before the decentralisation. However it involved the reorganisation of human resources especially doctors and facilities required for each health centre. **Table 5** shows the distribution of doctors and other supporting staff for each health centre for

the decentralisation project. Apart from manpower allocation, requirement of equipments and other facilities was also considered. These include equipments such as nebulisers, consultation and treatment rooms and other important equipment.

After the decentralisation, a number of positive comments was given by the public and generally they are in the opinion that the services provided are pleasant in a more comfortable environment. They have also expressed the view that the services have improved in terms of accessibility.

5. Evaluation of Decentralisation of Primary Health Care Services

This is an extract from the evaluation study entitled “Statistical Evaluation of Primary Health Care Services in Brunei Muara District, Negara Brunei Darussalam” by Health Statistics Unit of Research and Development Section, Department of Policy and Planning, Ministry of Health. The ensuing report will present its study objectives, methodology used and highlights of the main findings.

The objectives of the study were to look at the distribution pattern of patient movements before and after launching decentralisation programme, determine the theoretical catchment population that each facility was serving and evaluate the primary health care services including the waiting times and. morbidity experience in each health facility. The methods applied were as follows - Two cross-sectional surveys on outpatient movements were undertaken ie before and after launching the programme. The surveys were carried out in all health centers and private clinics. At each outpatient service point, the patients were asked the Mukim and Kampong in which they were residing. The actual catchment population served by each service establishment was dertermined based on these rapid surveys. To augment the evaluation aspects of the primary health care services, the waiting time study which will reflect the client’s satisfaction with the clinic visit was conducted. It was completed on a sample of 4644 patients who attended the clinics during five working days period. The outpatient morbidity pattern by health centre was also studied based on specially designed new data collection system. The data processing was done with Microsoft Excel and Epi-info softwares.

5.1 Main Findings

+ The results revealed that 91 % of the patients from the designated Mukims attended their respective health centers according to the Ministry’s plan. This again showed 25 % increased effectiveness during the study period.

+ The daily attendance under the new health reform programme has increased by 22 %. This is probably because the health centres are being distributed in different communities allowing people to have more access to the health facilities.

+ Obviously, it was found that the outpatient attendances that used to be heavy in Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital were now shared by the new health centers.

+ During the study period, it was found that the daily number of patients seen by each doctor was decreased from 48 (before) to 36 (after). This fact showed 25 % reduction reflecting quality and technical efficiency of the services.

+ The rate of utilisation of health services by the people was illustrated by health centre area (Table 6). In Muara , Gadong and Berakas B health centre areas, the findings suggested a high utilisation rate of services by the people which is one of the indicators used by WHO in quality and equity assessment in primary health care. It was found that the rate was increased from 152 (before) to 159 (after) showing 5 % increased utilisation.

+ The overall population coverage of all seven health centers was found to be approximately 60 % whereas the remaining 40 % coverage was by private clinics combined (20 private clinics in Brunei Muara District) (Table 7). The population coverage of BSB and Gadong health centers were the lowest among the health centers because most of the private clinics were operating in these areas.

+ The waiting time study was conducted for 5 days in all health centers. Statistics revealed the favourable waiting times in the health centers compared with the previous figures i.e. before decentralisation. It was observed that it took 29-39 minutes to wait from time of registration to time of seeing doctors in all health centres which is found to be far less than the assumed target of not more than 45 minutes. There was a significant association between waiting time (registration to doctor’s consultation) and the health centres ($p < 0.001$). The findings demonstrated the achievement of the Ministry’s plan to reduce the waiting time of the patients and at the same time suggesting indirectly the client satisfaction with clinic visits. The doctor’s consultation time took only 4-5 minutes. The patient’s waiting time to get medicine varied from 1 to 5 minutes. Altogether total waiting time came up to 36-48 minutes among health centers.

+ The following table illustrates the achievement of the Ministry’s plan in terms of indicators of health system performance.

Measures of achievement before and after decentralisation

Measure	Before	After	Achievement
1. Daily Attendance	730	894	22% increased attendance
2. Daily number of patients seen by each doctor	48	36	25% decreased – reflecting quality and technical efficiency of services

3. Proportion of patients from the mukims going to designated health centers	73%	91%	25% increased effectiveness
4 Rate of services received by 1000 population per month	152	159	5 % increased utilization rate
5 Median waiting time (from registration to doctor's consultation)	59	37	37 % decreased in waiting time reflecting quality, technical efficiency and client satisfaction

+ The study also allowed to look at the outpatient morbidity pattern by health centre for the month of April 2001. Statistics showed that acute upper respiratory infection was the most common cause of outpatient morbidity in all health centers followed by diseases of skin, influenza, bronchitis, emphysema & asthma and conjunctivitis. Table (8) presents the estimated incidence rates (per 1000 catchment population) of above-mentioned common causes of morbidity by health centre. The findings revealed that the incidence rates were comparatively high in Muara, Sg Assam and Sengkurong Health Centres.

6. Conclusion

In order to strengthen health system management and performance by using available resources efficiently and effectively, the Ministry of Health has decentralised the hospital outpatient services of Raja Isteri Pengiran Anak Saleha Hospital to 5 new health centres making a total of 7 health centres in the Brunei Muara District. This was one of the efforts to improve and sustain the performance of primary health care sector. This reform will be built-up to improve the performance, equity, quality, efficiency, effectiveness, acceptance and sustainability of primary health care services and systems. The evaluation of the decentralisation programme illustrates the achievement of the ministry's plan in terms of indicators of health system performance. In view of the success implementation of the project, the Ministry of Health is planning to extend the decentralisation of primary health care services to other districts ie. Kuala Belait and Tutong.

This project has encouraged the Ministry of Health to plan for the integration of the existing primary health care services to a greater extent of not only covering the three core services of general primary care (outpatient services), mother and child health care services and dental services. The decentralisation project has also transformed the health care system into a clearer structure. With the decentralisation of primary health care services, this has paved the way for future reforms to take place. Some of the reforms which have been planned include:-

- Introduction of computer and telehealth / e-healty into the Brunei Health Care System;

- The health centres would function as “gate-keeper” and to become centre of excellence and also can provide appropriate and controlled referrals to secondary and tertiary care.

- Reformation of health care financing and considering an alternative form of compulsory health (social) contribution.

With all these new initiatives and reforms, it is the goal of the Ministry of Health, Brunei Darussalam to have a sustainable, efficient and effective services which would be affordable, accessible, equitable and with high quality to serve the people of Brunei Darussalam in the long term.

REFERENCES

World Health Organisation, *Geneva. Alma Ata 1978. Primary health Care*

Mills A et al, eds. *Health Systems Decentralisation. Concepts Issues and Country Experiences*. World Health Organisation, Geneva, 1990

Collins CD. *Management and Organisation of Developing Health Systems*. Oxford, Oxford University Press, 1994

Starfield B. *Primary Care: balancing health needs, services and technology.* New York, Oxford University Press, 1999

Agdestein S; Roemer M, World Health Forum; 1991; vol. 12 no.4; 428-431