

Is decentralization the key to achieving equity in healthcare in developing countries?

By Obrey Alexis

Abstract

This article explores the concept of decentralization and whether equity in health care in developing countries can ever be achieved. In answering this question, the article looks at, concept of decentralization and different forms of it, equity and decentralization, health system reforms, decentralization and participation, decentralization can improve accountability of lower level government and the political domination of power as it relates to decentralization. The article argues that decentralization is difficult as governments are afraid to dissolve power to local communities for fear of loss of control.

Introduction

The subject of decentralization draws an interest of development thinkers as it is closely associated with the reform of health systems across boundaries. At the same time the subject of decentralization solicits controversial views concerning its merits for health. Regardless of the various underlying motives for decentralization, its effects on health need to be assessed in relation to the ultimate goals which is to improve health status of population, to increase equity and efficient use of resources. Although the main focus of this paper is to examine the effect of decentralization on equity as it relates to developing countries, it is necessary to mention that equity is not the only objective pursued by decentralization. Often, decentralization is part of the wider reforms in health which are undertaken by governments in the will to design health systems in a way that will maximise use of the scarce resources to meet ever increasing demand. In other words, decentralization could be perceived as a tool for change.

Decentralization is a striking policy issue, and has drawn substantial attention from a number of researchers, policy makers and policy analysts. Decentralization plays a significant role in both developed and developing countries, because it tackles and to a large extent addresses the issue of effectiveness and efficiency in producing and providing services. However, it has been acknowledged by authors that decentralization is a recent phenomenon and for this reason the analysis of its experiences cannot offer any universal answers and, moreover, prescriptions.

Concept of Decentralization and different forms of Decentralization

Many writers have written about decentralization policy and so far have shared a relatively concise definition of decentralization. According to them decentralization, in general term, is the transfer of authority and power in public planning, management and decision making from higher to lower levels of government or from national to subnational levels (Rondinelli, 1981; Collins and Green, 1994; Mills, 1994). This definition is actually formulated in a very broad sense. Therefore Collins and Green (1994) further clarify that it is necessary to distinguish the process of changing power relationship and responsibilities from the centre to the periphery within a specific government sector with similar processes. It has been advised that decentralization should start in priority areas such as health and education. (World Bank, 1997). In this paper though health sector will be the focus of this article.

There are four commonly identified forms, in which decentralization takes place. They are 1. Deconcentration; 2. Devolution; 3. Delegation; and 4. Privatization (Mills, 1994). According to Mills, deconcentration happens most commonly, and can be used to recognise health services, particularly services provided at local level. Deconcentration, therefore, often involves gradual phasing in the reassignment of revenue authorities and of expenditure authorities from central to lower levels within the health sector. This process is carried out in ways that are compatible and consistent with previously identified needs and responsibilities. Devolution is often related to the creation or strengthening of subnational levels of government, which are called local government and are given a defined set of functions. Delegation and privatization, on the other hand, are engaged in the transfer of functions to organizations outside the central government structure. In delegation, some large referral and teaching hospitals are now operating under the management of an agency, which has status established by law and responsibilities akin to a nationalized company or parastatal. On the other hand, privatization involves the transfer of government functions to the voluntary or private sector. In this last form of decentralization, it is intended to open greater room to public voices and choices. The interest in non government organizations (NGOs) and private sector's role of service delivery has grown rapidly over the last decades in almost all developing countries.

Decentralization and Equity

One of the objectives of decentralization is to enhance equity. The equity objective is rather implicit than explicit in the statements of decentralization principles. The situation preceding decentralization, namely centralization has been perceived as a barrier for addressing specific needs of population groups. Thus decentralization through delegation of responsibility, authority

and resources to the community and to the intermediate levels would secure greater responsiveness to local needs (WHO, 1978). As advocated by World Bank (1993), decentralization should enable greater participation of people in development, planning, administration, more equitable distribution of benefits of economic growth to increase the productivity and income of all segments of society and to raise the living standards of the poor.

In the health sector it meant increasing allocative and technical efficiency, local revenue-raising, community participation and encouraging self-reliance. However mechanics of decentralization is not confined to that simple sequence of activities but constitutes from complex set of policies, procedures and actors which closely interact with each other. The results represent controversial and varying outcomes on equity. In order to examine the impact of decentralization on equity it is necessary to de-construct the meaning of decentralization and to relate it to the different dimensions of equity.

The most common definition of decentralization is transfer of power, activities or functions from national to sub-national levels. In the case of health, responsibilities and tasks are usually transferred from the central bodies, namely Ministries of Health to the district health authorities.

Decentralization can create barriers to equity in different ways. Firstly, it can create inequity in health need planning as each community or region can come up with their own set of needs and priorities, which can then affect the local allocation of resources. For example, the retraining of health staff may get more weight in this community whereas upgrading of building and medical equipment for health facilities are priorities in another community. Similarly, dealing with malnutrition in this area and coping with tuberculosis in another area does not mean that malnutrition in the second area is not severe. These inevitably lead to differences and disparities of service standard across the regions and communities. It is suggested that the standards in basic services need to be set up and taken care of by both centre and periphery governments (Collins and Green, 1994).

Secondly, another controversial policy of decentralization in developing countries is privatization. In public health sector, lower levels are also allowed to charge user fee in order to recover partly the cost for health care. It has been clear that user fees, and thus privatization are not favourable to the poor especially ultra poor, who can hardly afford food, let alone pay for the health care (Gilson, 1989). What should be then the measures for central government as well as local government to take in order to mitigate the adverse impact on the poor? Taxation and

health insurance are considered the best attempt in providing equitable care and access but there is still a huge need on research studies around these policies.

Furthermore, decentralization involves revenue generating authorities where local governments are authorized to raise revenue locally, but they have to make sure they fulfill the previously identified needs and responsibilities. The gap between revenue and expenditure may be granted by Central Government. For the rich areas, local authorities can mobilize substantial resources to improve local activities and ease the resource pressure on central government. However, this task places a burden for poor areas and communities. Several types of community financing have been experienced and encouraged but it has been proved that these have placed another barrier to achieve equity, even within a community, let alone between communities (Abel-Smith, 1994). In these local resource-mobilizing schemes, there have been several measures to help the poor such as, service levying exemption, free health insurance or voluntary health insurance. However, the population of poor people in such areas is often 50-70%, and naturally can only cover a few. With decentralization the situation of the poor can be exacerbated. As has been suggested previously, central government should direct more resources on poor areas. Abel-Smith also highlights that the success of different financing mechanism at local level depends heavily on the nature of each community as well as the political commitment of local leaders.

Health System Reforms

It is commonly believed and recognized that the health system in developing countries needs to be changed for the better. It is a fact that in many countries the health system has undergone intensive reform. There have been many reasons as to why there is a need for change. As Frenk (1994) has pointed out, health system reform stems firstly from economic, political and ideological reasons. Economic crises in developing countries, scarcity of resources, the changing of political and ideological regimes have led to macro economic reform, which inevitably inspires sectoral reform including health sector reform as well. Secondly, the health system itself appears ineffective in facing the complexities posed by epidemiological transition. The health sector of developing countries is weak, stagnant, ineffective and inefficient in providing services, let alone coping with newly emerging challenges and new health needs. The disease pattern has changed, the constituents for health improvements have changed; these induced health systems have changed in order for it to be more responsive to new demands. In practice, reforms are the concern for all governments at present, though they have different emphasis in different countries, they share a common goal which is to improve the quality of basic services within very limited institutional capacity and resources (Cassels, 1994).

Gilson and Mills (1995) have summarized that health reform is a package of policy measures affecting the organizations, funding and management of the health system. Obviously, there is no universal package of approaches for undertaking these reforms as each country is in such a different political, social and economic circumstance that requires different ways to tackle the problems. Health reforms, however, can be characterized by a set of main elements:

1. Identifying and responding to major health problems
2. Organisational and management changes, including decentralization
3. Health financing strategies
4. Improving quality of care

Health reform is a process of both institutional change and policy change. This article argues that decentralization is the backbone that structures the whole process.

The four elements of health system reform are not implemented separately but are many facets of the whole process; they support and complement one another. Therefore the relationship between decentralization and other elements of health system reform needs to be examined in a context of the whole process. Decentralization can create a catalytic and an enabling environment for implementing other health system reforms.

Decentralization and Participation

Casells (1995) has pointed out, in health, decentralization means the transfer of more responsibilities for the management, policy making and provision of health care to local level or to agencies within the health sector. This assumes that lower level government is closer to people, hence they have been given power so that the work they do and the result of their work will be more responsive to the local people's needs. Therefore many writers (Green, 1992; Mills, 1994) have argued that decentralization, in whatever form it takes should work towards common goals. The decision making should be brought closer to field-level service providers, so that their participation will be enhanced, voices will be heard and therefore the government and people will become more responsive to each other.

It is made explicit in decentralization policies that the objective is to decrease the dependency of local districts and regions from central government and to transfer funds and to rely more on local revenue-raising to finance health services. However, districts have highly unequal ability to raise sufficient revenues resulting from poor tax base in rural areas in developing countries.

Although local governments have authority to levy taxes, these are usually land and property taxes which are hard to raise. One of the results as evidenced in Zambia was that the districts with relatively wealthy population would have been able to exert greater drawing power to attract key staff, thus exacerbating the equity that the reforms were designed to address (Cassells, 1995).

Decentralization can improve Accountability of Lower Level Government

Decentralization often involves the assignment of expenditures and revenue authorities to local level government in accordance with previously identified needs (Mills, 1994). This assignment is also accompanied by clear-cut responsibilities given to each government level. These steps are the real changes in management, organisation and financing of the sector, where there used to be a highly centralized management system. A World Bank study in Vietnam has revealed that in a highly centralized management system, where all decision and planning are made at the central level and where the lower level just play the role of administrator or policy implementers, the quality of the services were often poor. The officials at the lower level often think that they are not responsible for failures occurring locally but the accuse either the finance sector for not providing enough resources for them to fulfill the task or accuse the central ministerial level for their imposed, dogmatic policy and guidelines, which the local officials consider as the root causes of the failures of policy implementation (World Bank, 1996). The study has further pointed out that in practise the local leaders often have to modify the imposed policy unofficially in order to meet the local needs.

The reason for organisational and management reform in health is to improve the capacity of each level, to enable them to work more effectively and spend resources efficiently. With decentralization, local communities are given clear responsibilities, which inspire them to be more concerned about their staff, about the way to get the work done and to fulfill the targets satisfactorily within the limitation of the budget they have. They are allowed to work flexibly and creatively to utilize and mobilize all potential resources available in their locality. Furthermore they are placed in a position where they must be accountable to the higher level of government, from whom they are assigned the work. In addition, it is commonly believed that at the lower level there is a greater potential for multisectorial collaboration, which is important for implementing primary health care programmes and contributing to health improvement at the locality (Green, 1992). The World Bank has also concluded from its various studies that public goods and services should be provided by the lowest level of government who can fully capture the costs and benefits (World Bank, 1997). It can, therefore, be argued that decentralization can

improve accountability of lower level government, and consequently can help to improve the effectiveness and quality of health services.

Decentralization and Government's capacity to regulate, coordinate and monitor

Decentralization can help to strengthen the central state by freeing it focus on its core functions (World Bank, 1997). The Ministry of Health is facing new challenges of monitoring and coordinating over all the work at national level. They, therefore, should be able to develop their own essential capacity to meet the new demand of the work, i.e. that is able to set up an effective information and feedback system in order to provide support and fill in the gap wherever it is needed. Ministry of Health should also create a strong institutional framework to facilitate and support the effective functioning of different parties in the common process, which now include the public, private and voluntary sectors. Because of the introduction of decentralization and health reforms, government responsibilities are often seen as being scaled down. However it can be argued exactly that, these responsibilities are not being scaled down but changed to be more focused and relevant. The role of the ministry is now more professional, more complicated, and more demanding.

Another critical role of health ministries within the sector is to provide adequate technical support to lower level authorities in identifying the local needs and planning of services through the locally appropriate approach. Decentralization process, if it is to be implemented successfully, requires efforts and capacity strengthening of both facets, both central and lower levels.

Weaknesses of Decentralization

All of the above are goals of decentralization and therefore decentralization is critical to the health sector reforms. According to Collins and Green (1994) arguing that decentralization is a means to achieve a number of ends and should not be viewed as an end in itself. A number of countries have implemented a decentralization process and some of them, such as South Korea, Indonesia, Malaysia, Mexico, China and Vietnam were considered successful (World Bank, 1996). However, like any development process, decentralization can also create some hindrances, which policy makers and planners should pay attention to.

Rondinelli et al (1983), Green (1994) and World Bank (1997) have identified a number of pitfalls of decentralization, such as developing countries that lack capacity strengthening abilities for both local and central government, can lead to negative impacts, decentralization may also lead to local government vulnerability resulting from control by locally dominant groups or it can lead to the monopolizing of local political leaders. Perhaps the most severe weakness is that decentralization can lead to disparities across regions and communities as well as ignorance of equity in health services.

Political Domination and Power Relations

It is necessary to mention that the whole idea of decentralization is not apolitical. The origins of decentralization are usually but does not always come from the centre to promote ideology of certain groups, often political parties who disbelieve in the effectiveness of centralization or who adopt decentralization as component of the package aimed at promoting pluralism and self-reliance. As in some Eastern African countries, decentralization could be effectively used by dominant political parties to retain their control over local authorities (Rondinelli et al 1983). The local elite may exert considerable influence on local politicians thus diverting equity orientation to local policies for their own benefit. It is hard for the poor who are less articulate to claim for local resources to be spent on services identified by them as priority.

On the balance, the formation of local health committees could be considered as an effective mechanism for mediating needs of ordinary people. It may enable communities to acquire greater control over the disposal of centrally allocated funds, the type of services available, and the health personnel who provide them (Standing, 1997). Gilson and Mills (1994) have said that participation of people in design and management can have a positive impact on equity by ensuring greater accountability of health workers to the local population and reinforcing solidarity and collective decision-making at the village level.

But the existence of the local health committees itself would not necessarily guarantee the fulfilment of equity objectives. Standing (1997) reminds us that the issues like composition of those committees, their capacity to act effectively and whether they truly represent the poor and vulnerable have to be verified.

Conclusion

The debate of decentralization in health raises a range of issues that characterise health system reforms in developing countries of the world. Without being specific to each country, the health system reforms most often comprise decentralization, diversification of funding and institutional changes. Therefore the effects of decentralization on equity, efficiency, access and quality are hard to isolate from the effects of other reforms .

The effects of decentralization on equity can be both positive and negative. The positive ones include increased participation by less powerful groups in decision-making over the design of services and resources allocation, improved access and utilisation of services by the poor, reduction of disparities in the provision of health facilities and their use among various geographical regions, improved quality of health services and responsiveness to local preferences in health planning.

But those gains, obviously, could not be attributed to only decentralization. When countries adopt decentralization in hope to mitigate their health problems the factors that make it such an attractive policy are usually the same ones that make it difficult to implement. These factors comprise strong institutional and managerial capacity, political leadership and popular support, availability of financial and human resources.

If governments are committed to the goal of achieving the best health for the population at an affordable cost, they need to undertake conscious steps to improve performance of its civil service, strengthen human resources, better coordinated activities between sectors with wide effects on health, to undertake measures for cost-effective use of resources and to increase stake of communities and user groups in matters affecting their health.

References

Abel-Smith, B. (1994). *Introduction to Health Policy, Planning and Financing*. London, Longman.

Cassels, A. (1994). Health sector reform: Key issues on less developed. *Journal of International Development*, 7, 329-368.

Collins, C. and Green, A. (1994). Decentralization and primary health care: some negative implications in developing countries. *International Journal of Health Service*, 24 (3), 459-469.

Frenk, J. (1994). Dimensions of health system reform. *Health Policy and Planning*, 27, 19-34.

Gilson, L. (1989). What is the future of equity in health policy? *Health Policy and Planning*, 4, 323-327.

Gilson, L. and Mills, A. (1995). Health sector reform in sub-Saharan Africa. *Health Policy and Planning*, 32, 215-243.

Green, A. (1992). *An introduction to Health Planning in Developing Countries*. Oxford, Oxford University Press.

Mills, A. (1994). Decentralization and accountability in the health sector from an international perspective: what are the choices? *Public Administration and Development*, 14, 281-292.

Rondinelli, D. A. (1981). Government decentralization in comparative theory and practice in developing countries. *International Review of Administrative Science*, 47 (2), 133-147.

Rondinelli, D. A. et al (1983). *Decentralization in developing countries*. Staff Working Paper 581, Washington D.C., World Bank.

Standing, H. (1997). Gender, vulnerability and equity in health sector reform programmes: a review. *Health Policy and Planning*, 12 (1), 1-18.

World Bank (1993). *World Development Report. Issues in Health*. Washington D.C., World Bank.

World Bank (1996). *Decentralization in service provision for rural area of Vietnam*. Washington D.C., World Bank.

World Bank (1997). *The State in a Changing World. World Development Report*, Washington D.C., World Bank.

World Health Organization (1978). *Primary Health Care*. Geneva, World Health Organisation.