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## Session 6H) SPF Roundtable: Reconciling Equity and Decentralization: Health

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It is significant that three round tables that have emerged from this important Conference -- in which the problems of health, education and income will be analyzed -- have received identical titles: Reconciling Decentralization and Equity. This fact confirms the importance of three areas in government policies (areas which, let us remember, the United Nations considers basic to measure the status of human development in its member countries); and b) that health, education and income are strategic fields to observe the relationships between decentralization and equity, but conflicts and expectations are strategic fields as well. In many countries of the world, the debate on decentralization has provoked tensions and crisis, especially when we are trying to distribute power from a historically privileged center towards an underprivileged and demanding periphery.

The topics of this table are clamoring for a specific analysis of the policies, strategies, programs, experiences and the effects that are taking place in all countries caused by the adoption of schematics of one or the other type. The debate is economic, ideological, political and technical, and sticking to it a priori is not possible

Even if decentralization seems to adjust itself better to the aspirations of the peoples so that they can achieve better services and an improvement in their quality of life, this same fact has loaded it with values that take many people involved to identify decentralization with equity and to identify centralized action with an action emanating from the Federal Executive Branch. We would have to add -- and the Latin American experience so confirms -- that the action of the State, decentralized or not, on health issues, is not the only form of external action that is arriving at the communities: non-government agencies and the churches have made out of health one of the best privileged topics to be involved in -- with very different purposes -- in the life of many social strata, specially among the poorest sectors in urban areas and among peasants and native Indians. The pressures, complementarities and transactions resulting from all of this is an input of the analysis which cannot be ignored.

The text presented by Dr. Lucas is a remarkable synthesis of this problem, and

even though it points out that the "changes in the health sector have gone in two diametrically opposite directions" (more centralized systems versus decentralized systems), his presentation is focused on the possible challenges and achievements of reforms with decentralization, this latter associated to "the promotion of equity in benefit of social justice" (p. 1). His analysis of the variables involved in health allow him to formulate a clear warning: "Decentralization of public health may make a useful contribution to efficiency, effectiveness and equity on health issues, but the benefits are not automatic. To promote equity, those responsible for the formulation of policies, planners and managers of decentralized medical services should consider seven important elements: the political will of the governments, the formulation of policies addressed to promote equity, the fair allotment of resources, mobilization of other sectors for intersectorial action, efficient and efficacious community participation, information systems and mechanisms of follow-up and evaluation" (p. 17).

I would like to underscore the importance of these seven points, because there is no doubt that their joint achievement, their convergence, depends on the successful development of the decentralization proposals of the health systems. The second of the seven elements points out explicitly to the formulation of policies destined to promote equity, but it is obvious that the principle of equity may be contained in all the other six issues and be a parameter of the social usefulness of each one of them. Actually, the achievement of equity might appear as an imperative which will guide the will of the governments, the allotment of resources and the harmonious development derived from intersectorial coordination. The demand for equity is an engine for the organized community and a goal to be achieved with the help of its active participation. On the issue of information, the author states clearly that "access to health information should be recognized as a human right" (p. 15). And finally, equity is not an eternal asset: it is necessary -- I am quoting Dr. Lucas – "to include mechanisms to objectively watch equity"; its follow-up and evaluation require specifically clear actors and it also requires "sensitive markers that may inform them of their performance" (p. 16).

For somebody whose work is focused on the indigenous areas, the text of Dr. Lucas has an additional attraction: a large part of its thoughts and of the examples chosen refer to the native populations of Africa and Latin America, with cultures, languages, forms of social organization and ideas of the health/disease process which are different from those of the Western culture in which the medical model which has been in a position of leadership was originated. This medical model has been the leader in the field of health planning since, at least, the middle of the XIX century. From my own standpoint, the author has not pointed out the economic, ideological and technical crisis that this model is undergoing, which confers to the physician and to the hospital the star roles in the process of health care, and also, that the decentralization policies obey -- in no meager measure -- the structural impossibility of maintaining a schematic of

high technological concentration as the core of health care. Today we know that, even though predominant, the biological and technological model is only one of the several currents of Western medical thought, and that a good part of the criticisms to the centralized schematic have emerged out of the inner contents of the official medical systems.

Dr. Lucas has stated, and justly so, that institutional intervention in health must face three important challenges: diversity, complexity and change" (p. 2). It is very significant that he is emphasizing the importance of the fact that geographical, ecological, environmental, economic, social, cultural, behavioral and demographic factors are imprinting the different proposals of decentralized models and he has left the topic of health and accessibility to health services as the last item. We are not trying to give this item a subordinate position, but according to my understanding, we are trying to show that the extension programs on the coverage of high quality health services should he confronted against the foreseeable effects that are produced by the other variables. Let its take a look at this situation on the light of the following examples:

1) Thousands of Indian communities (and institutional health services have been arriving in these communities during the last few decades) have the persistent idea that man is subject to the action of a set of supernatural, natural and interpersonal forces, and that wellbeing lies in searching for harmony among the forces in conflict. There is no long-lasting or final state of wellbeing. Health is not situated as an axis whose opposite pole is disease. But these ideas, transmitted by Western, or colonial or modern medical systems go against the ideas that uphold that there are two poles, balance and imbalance, which act in the setting of the supernatural, natural and social planes. These ideas clash between them and are in confrontation with the ideas of the biological model.

2) Another example, repeated all along Latin America is clearly showing medical policies and practices on care of pregnancy and childbirth, and particularly the behavior of the State towards traditional midwives. In Mexico, for many years, but above all between 1950 and up until the mid seventies, the medical sector upheld that traditional midwives who are working in rural areas would have to be "tolerated" (and even be supported) until they could be replaced by qualified medical staff. Today, the perspective is tending to undergo a substantial change in spite of the fact that the coverage extension programs have undergone remarkable advances since the end of the seventies. There are several factors involved in this change of perspective. 1) The impossibility of the medical model to reach full coverage, which leaves thousands of small communities without services, because the installation of a formal medical unit involves excessive costs. 2 ) The persistence of the midwife as an important local resource, that people can go to, both because of her knowledge and skill as well as because of the uncertainty of achieving effective institutional care. 3) The social and technical role of the midwife as a key interpreter of the habits and ideology of the group. The Directory of' Rural Midwives of 1994 registered 23,845 of these

traditional therapists. This is a significant figure if we consider that the number is triple the number of field physicians, and the fact that many peasant and Indian areas were not surveyed.

The importance given by Dr. Lucas to the social, cultural and demographic variables reveals the synergisms that the health area establishes with other areas of social praxis. However, I would like to add other reasons in addition to those already presented so as to evaluate the weight of these concurrent factors. Working experience in the Indian areas where medical services have arrived show that health care is performed in three areas that the population does not consider to be exclusive but complementary: that of academic medicine (institutions, scientific), traditional medicine performed by healers, midwives or herb-doctors, and domestic or home remedies medicine. A large number of cases cared for are left out of our perception and of the records of the official medical system because of the existence of traditional and domestic medicine. It is not only because they might eventually be treated successfully by the healer or by the housewife, but also because they respond to different epidemiological patterns, that the population recognizes or supposes to be alien to the field of action of the health center, of the rural medical unit or of the dispensary. These cases may not be included in the current systems of disease classification. In consequence, we are trying that not only will the institutional medical system be sensitive to cultural determinants, but also to the possibility of generating new recording instruments (for example, those of social and cultural epidemiology) to uptake the incidence of diseases such as fright, airs, or the evil eye, typical of the Indian peoples of Latin America. Achieving equity means also the reinforcing of local capacities to face disease, accidents, imbalance or death, and the development of new technologies for health which are adaptable to the situation.

I would like to stop for a moment and comment on the references made in the text to "the important influence of non-medical factors in health", and to "the need of mobilizing complementary intersectorial action" on issues such as agriculture, education, basic sanitation and the creation of jobs (p. 4), to which I would add communication and justice procurement. My intention is not to emphasize the impacts of non-medical factors that today, and we all know it, are determinants in the decrease of mortality and prolongation of life expectancy, or nutrition or the change in epidemiological profiles, but rather I would like to point out that the decentralization process on health cannot be fully undertaken without a similar policy in the other areas mentioned. In our countries, the experience of unilateral decentralization has made us see the obstacles for intersectorial agreement and coordination, and has contributed to fragment the forms of representation and of dialogue of the people with the State when generating so many participants in the dialogue (groups, associations, committees) as programs or projects are being generated and designed from the center (whether this center is located in the capital cities of the states or of the country). The following example may be illustrative of the problems that go together with decentralization when structures are generated without enough

back-up to operate, or when we decentralize unilaterally. In Mexico, the National Institute of Indian Affairs (INI) was born in 1948; it was inspired, for its goals, on the ideals of the Mexican Revolution, and for its methods, on social anthropology. The first Indian Coordinating Centers started operating in areas of high concentrations of indigenous population, called "shelter areas" by reason of their isolation, traditionality and reluctance to contact with the dominant halt-breed sectors. In these Indian "shelter areas", the Coordinating Centers acted as decentralized units, emphasizing local planning and postulating the need that "educational and health programs, technical innovations in agriculture, livestock breeding, traffic, political organization or any others (should) be implemented as a globality together, so that they can each support each other while going after balanced development" (AGUIRRE BELTRAN 1994: 11). INI acted in this way, as a designer and operator, "with bilingual schools staffed by Indian teachers and promoters, clinics for primary health care, technical advice (for livestock, agriculture, forestry or fishing), credit and financial aid" (ibid). The decadence of this schematic of global intervention, but which was questioned ideologically and was restricted to only one part of the Indian population, agrees with the unilateral, sectorial decentralization, which took the specialists to voice their opinion that their "comprehensive work" was being "replaced by specialized actions unilaterally implemented" (ibid: 12). The analysis of the advantages, and disadvantages of both experiences should be part of the baggage of the planner, since the historical dimension should not only be at stake for the formulation of the policies and for institutional design, but also to estimate the behavior of populations to which the institutional action (centralized or decentralized) is addressed.

Without a shadow of a doubt, the underlying philosophy of decentralization seems better adjusted to the aspirations of a society which is looking forward to, as is happening in Mexico, the fullest construction of democracy. The Indian peoples of my country have shown themselves to be in favor of the establishment of a new relationship with the State and with all the groups of national society. But, as Dr. Lucas has very rightly said, "the relationship between decentralization and equity is not automatic -- there may be injustices both on services undertaken at a centralized as well as at a decentralized level." (p. 11).

If we share all of this, one of the unavoidable tasks of the future processes of decentralization of the health systems will be to evaluate the contents and specific results of the health strategies promoted during the last twenty years. I am thinking, basically, of Primary Health Care, and of the reformulation of the SILOS tactics (Local Health Systems). Let us remember for example that the risk approach disseminated by the WHO is applied to "measuring the need for care of specific groups. It helps to determine health priorities and is also a tool to define the needs of reorganization of the health services. It is trying to improve care for everybody, but paying more attention to those who need it most. It is a non-equalitarian approach: it discriminates in favor of those who have a greater need

of care" (WHO, 1986: 9). I underlined the words.

The complexity of the different situations in the different countries which are facing the challenge of decentralizing with equity are confirmed in the case of the Indian population of Mexico. If, as the highest health authorities of health in Mexico have stated, "The analysis of the 542 municipalities of the country whose population is made up by 40% and more of inhabitants who speak one autochtonous language shows an incontrovertible reality: the Indian population of Mexico is living in remarkably more precarious conditions than the rest of national society" (SEPULVEDA et al. 1993:49). It is obvious that planning with equity should include compensatory schematics which will reduce the gap between the poorest sectors and the rest of national society. Hence the reference to the risk approach which is absolutely pertinent. But, at the same time, during the last few years, the Indian peoples are showing extremely high mobility, product of migration, which generates new and different scenarios that CHANGE will have to face, the last of the topics proposed in this presentation.

I do not want to close these comments without alluding, even in passing, to one of the most difficult problems that institutional health programs and others have (whether decentralized or not). I am referring to the crisis of representation that Dr. Lucas has so lucidly presented in his analysis of The Community Participation. This crisis of representation erodes the relationships on which, on the last instance, programs and projects rest upon. The fragile "provision of believable images" has become an exercise which, far from generating long lasting trust, is consumed in its immediacy. Hence the need to establish a new system of relationships for dialogue, planning and the application and evaluation of the impact of the programs. Hence also, that the discourse on equity should look for new pathways which will be viable only if the populations confirm, by themselves, the positive and healthy impact of the policies.

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