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BACKGROUND PAPER

RECONCILING DECENTRALISATION AND EQUITY: HEALTH

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Changes in the health sector have moved in two diametrically opposed directions. On the one hand, there are strong movements of increasing centralisation both. At the national level, mounting challenges on health services are prompting governments to be more assertive in defining national goals and targets as well as the strategies for achieving them. On the other hand, there is increasing realisation that centrally managed health services tend to be too remote and are not sufficiently flexible to adapt to local situations. International co-operation in health is being fostered by various considerations: fear of the spread of infectious diseases, compassion for populations that are afflicted by epidemics, and the mutual benefit from co-ordinated regional and global action.

This century has witnessed tremendous improvement in the health of people throughout the world. Great advances in medical technology and clinical services have made possible treatments and cures that would have been regarded as miraculous a few decades ago. The eradication of smallpox is a unique achievement; poliomyelitis has been eliminated from the Western Hemisphere and the rest of the world is engaged in a programme aimed at global eradication of the infection. Combinations of environmental action, behavioural modification and specific interventions with vaccines and drugs have controlled other traditional diseases.

The rapid advances in health technologies, the increasing demands and expectations of populations and the escalating costs of health care are challenging governments both in developed and developing countries. Governments are responding to these dramatic changes and the associated challenges by undertaking reforms of the health sector. In order to meet the needs and demands of their populations, they are redesigning mechanisms for delivering care and paying for the services. (World Bank, 1993). One important consideration in making these reforms is to promote equity in the interest of social justice.

The decentralisation of the planning and management of health services is a common feature of these reforms. It has become increasingly clear that governments cannot efficiently manage the delivery of health care from their central offices. Central Ministries of Health can set national goals and targets, whilst devolving the responsibility for detailed management of the services to peripheral authorities -- provincial, state, municipal and local governments. The exact details of decentralisation vary from country to country.

In spite of the enormous differences between the health services in affluent, industrialised countries and the least developing countries, issues of common interest with regard to equity can be usefully examined. Even though specific technical details may not be directly comparable, experience gained in some countries may generate useful lessons that are applicable in other countries. Usually in technological transfers, the flow of information is largely from the developed to developing countries. However, developed countries have learnt

from and adopted innovative, cost-effective strategies for health care delivery that were generated in developing countries e.g. ambulatory care of tuberculosis patients, community based care of psychiatric patients. (Dawson et al, 1966; Jegede, 1981; Lambo, 1965)

This paper reviews decentralisation within the health sector; it examines the factors that are stimulating this trend; and it critically examines the expected gains and the attendant problems associated with particular reference to the issue of equity. It will focus on the following issues:

- Why decentralise?
- Models of decentralisation
- Making decentralisation work
- Promoting equity in decentralised health services.

Why decentralise?

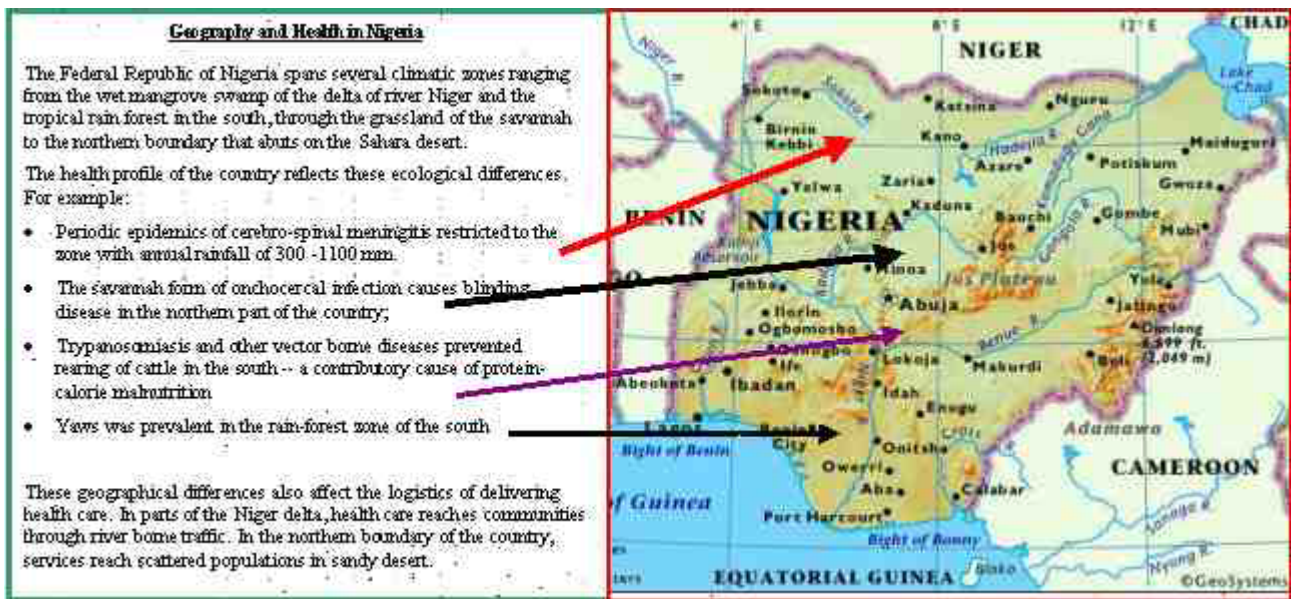
There are many clear arguments in favour of decentralising health services. In federal states, the devolution of health care to peripheral authorities is part of the overall political settlement about the allocation of power between the central and regional governments. But apart from the political considerations and even in countries with unitary governments, there are good reasons for transferring aspects of policy-making and planning and decision-making about health matters from the central governments to peripheral authorities. Decentralisation facilitates the design of the most effective mechanisms for coping with three important challenges to the health system: **diversity, complexity and change**.

Diversity

A common feature of the health scene in most countries is great diversity in the epidemiological pattern of diseases and in the health status of various communities and groups. A variety of factors account for the diversity in the health status and trends:

- Geographical, ecological and environmental factors
- Economic, social, behavioural and cultural factors;
- Demographic profiles; and
- Health services -- quality, accessibility.

Geographical, ecological and environmental factors affect the pattern and distribution of health and disease through their direct physical effects on people but also through the indirect effects on the agents and vectors of infectious diseases. These differences are particularly marked in large countries, which span several climatic zones, or in situations where there are marked differences in altitude. Box 1 illustrates some of the effects of geography on the health profile in different parts of Nigeria.



In addition to the differences resulting from natural ecological variations, some human activities especially large-scale development projects have significant health consequences. Modifications of local ecology (artificial lakes, irrigation schemes and other agro-engineering projects), pollution of soil, water and air from industrial plants and similar activities may have a profound effect on local patterns of disease and thereby contribute to the diversity in health status of people in different parts of the country.

Social and Cultural variations also affect the pattern of health and disease. Furthermore, for it to function optimally, the delivery of health care must be adapted to suit local cultures.

Variations in occupations, age of marriage and family patterns, religious beliefs and practices, food habits, the use of alcohol, tobacco and other life style features also account for some of the variations in health status. In a country like Nigeria, the 200 language groups represent great cultural diversity among the various ethnic groups. In the Americas and in Australasia, there is the special case of indigenous populations, who are excluded to varying degrees from the main stream of development and services; in their "reservations", they often represent nations within nations and their health profiles often reflect the degree of marginalisation.

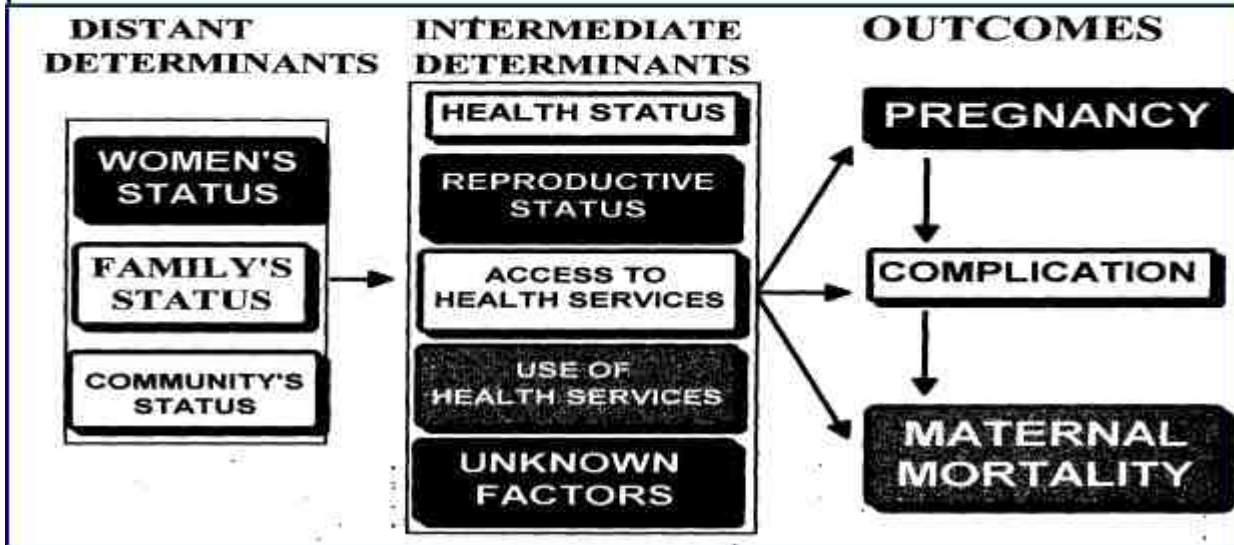
Demographic variations: Some of the diversity in health profiles of communities reflects differences in the age and sex distribution of the populations. Developed countries have undergone demographic transition with the falling birth rates and the longer expectation of life, the proportion of the elderly has increased steadily in recent decades, creating increased demands on medical and social services. The health services have to respond to this demographic transition and especially the modified pattern of health needs in the ageing populations. Similar demographic changes are occurring in developing countries.

In some countries, selective internal migrations distort demographic profiles e.g. mass emigration of adult males from rural communities to work in industrial urban areas of their countries or in neighbouring states. In other places, elderly retired persons migrate to warmer areas of the country e.g. Florida in the USA and Bournemouth in the UK.

Complexity

The Prevention of Maternal Mortality

- Half a million or more women die each year from complications of pregnancy and childbirth;
 - The clinical causes of the deaths are well known and are amenable to treatment;
 - These deaths occur against the background of intermediate and remote causes as illustrated in the diagram below;
 - The prevention of maternal mortality must ultimately address all these issues but the interventions have to be designed to suit the local circumstances and ranked in an appropriate order of priority;
 - In countries with very high maternal mortality rates, the highest priority should be assigned to improving emergency obstetric care; other interventions will include reduction of exposure to high risk and unwanted pregnancies by the provision of family planning services, safe abortion, training and supervision of traditional birth attendants and improvement of other aspects of maternal health services.
- (McCarthy, J & Maine, D, 1992; McCarthy, 1997).



Technical and scientific advances have vastly increased the complexity of health care. The widening scope of prophylactic, diagnostic and therapeutic options demands an increasing range of specific programmes with the associated need for specialist personnel, new categories of support staff, high technology equipment and infrastructure. Box 2 illustrates the complex interaction of medical and non-medical factors that are involved in perpetuating the high maternal mortality rates occurring in the developing world. It also offers clues as to the package of interventions that are required to reduce maternal mortality. (McCarthy & Maine, 1992). In addition to strictly medical interventions, there is now greater awareness of the important influence of non-medical factors on health. Thus, in addition to the direct inputs from the health sector, there is need to mobilise complementary inter-sectoral action, for example:

- Agriculture (food security and nutrition),
- Education (especially women's education),
- Waterworks and sanitation; and
- Labour and industry. (workers' health, pollution).

The complex interaction of medical and non-medical factors in the dynamics of health and disease calls for critical analysis as the basis of designing and managing health programmes. Rather than merely delivering standardised, pre-packaged, stereotyped interventions, regional and local health authorities should undertake critical analyses of local needs and opportunities as the basis for planning their health services.

Change

The delivery of health care must constantly respond to changes that are occurring in the health situation in local areas and must also assess and take advantage of new scientific knowledge and technologies. With the control of traditional health problems -- common childhood diseases and communicable diseases -- the health profile in developed countries and in the more

advanced developing countries is dominated by chronic diseases -- cancers, cardiovascular diseases, diabetes, etc. The less developed countries present a mixed picture with the persistence of infectious diseases compounded by malnutrition and the emergence of chronic diseases especially among the urban elite. (Frenk et al., 1989) There is however, the constant threat of the emergence of new infections and the recrudescence of old diseases that were previously controlled as shown by the recent examples of HIV/AIDS and tuberculosis. (Institute of Medicine, 1992). In addition to this epidemiological transition that slowly evolves over a relatively long period, more rapid changes occur in the form of epidemics and other acute problems e.g. natural disasters (floods, drought, etc). These changes do not occur uniformly nor at the same pace in different parts of the country. Monitoring of health trends in local communities generates useful information that can guide health officials responding appropriately to changes in local circumstances.

Models of decentralisation

Although the idea of decentralisation of health services has gained favour in recent years, there is no consensus on the ideal pattern for allocating functions between the various levels of government. Some of the variations relate to the type of government (federal or unitary); but other factors-- size of country, political systems and other variables influence decisions about decentralisation. (See examples from European countries: Diderichsen, 1999; Koivusalo, 1999; Pollock, 1999; Leys, 1999; Reverte-Cejudo, D. & Sánchez-Bayle, M, 1999) and in Canada (Armstrong & Armstrong, 1999). A simple model for the analysis in this paper considers the management of health services at three levels:

- Primary health care through community level services and local referral hospitals;
- Provincial or state level co-ordinating services in defined geographical parts of the country; and
- Ministry of Health, central government.

This section will briefly review the functions that can be decentralised to provincial and local governments as well as their relationships with each other and with the central government.

Primary Health Care

The responsibility for community health care is usually devolved to local or municipal governments. In developed countries, primary health care is physician based with support of nurses and other para-medical staff; the aim is to provide comprehensive health care and associated social services through community based facilities and referral hospitals.

In developing countries, the package of services that are delivered at this level were formerly labelled as "Basic Health Services" but were further refined into the eight elements of primary health care as defined at the Alma Ata Conference. (WHO, 1978). (Table 1). The usual pattern is a network of community based services with appropriate back up from referral hospitals that deal with difficult problems that cannot be effectively handled at health centres and other community based facilities. In the least developed countries, nurses and other non-physician staff play a large role at the primary health care level. The degree of the involvement of the private sector, both for profit as well as the not-for-profit (non-governmental organisations) influences the functions of the public sector. Regardless of the specificities of the primary health care services, two common issues are worth noting:

- To what extent has the local government the authority to define local policy and strategies for health care? and
- To what degree are the communities involved in decision-making?

There are sharply divergent views among key international agencies about the question of the autonomy of local authorities in shaping the health services. The World Health Organisation (WHO) with its concept of primary health care is at one end of the spectrum of ideas on this issue. As proposed by WHO, integrated health care at the district level should involve all health care providers, both public and private, and all health systems -- modern and traditional, orthodox and non-orthodox. The model defines the district as the smallest planning unit for health care, involving community based services through health centres and other institutions providing ambulatory care as well as the referral hospital. (WHO, 1987) WHO's model is inclusive and involves collaboration of all stakeholders: the public sector represented by the local government, the private sector, both for profit and the not for profit, and credible representatives of civil society. The hope is that the consensus that emerges from the interaction of these stakeholders would lead to the development of realistic health programmes that are culturally sensitive, sustainable and capable of growth and expansion as the community develops.

Table 1: Elements of Primary Health Care

Element	Comment
1. Education	Concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition	Food should be adequate, affordable and balanced in nutrients
3. Adequate supply of safe water and basic sanitation	A safe and adequate supply and clean disposal of wastes
4. Maternal and child health care including family planning	Special attention to the needs of underserved groups within the population.
5. Immunisation against the major infectious diseases	Ensure universal coverage of immunisation programmes.
6. Prevention and control of locally endemic diseases	Use appropriate measures including control of vectors and animal reservoirs.
7. Appropriate treatment of common diseases and injuries	Curative services for common ailments and injuries; and including mental health.
8. Provision of essential drugs	Ensure that the most vital drugs are available and affordable.

Some critics felt that WHO's approach was too broad and therefore unrealistic. They proposed instead "Selective Primary Health Care" a strategy that aims at delivering a limited number of interventions of proven efficacy and cost-effectiveness e.g. immunisation and mass chemotherapy of some endemic infections. (Walsh & Warren, 1979; Warren, 1988). Rather than grant the local authorities the right to define local priorities and strategies, they would be required to conform to a centrally determined national programme, which is made up of a limited list of well-defined, cost-effective interventions. There is some danger that selective primary health care would merely recreate vertical programmes in which practitioners in the field would be required to implement pre-packaged interventions blindly. An acceptable compromise would be to use UNICEF's GOBI-FFF(1) and the World Bank's clinical and public health packages as building blocks of primary health care.

Provincial or state level

In federal states, health services are usually devolved to provincial authorities, which serve an

intermediate role between the central government and the local health authorities. The Provincial authorities develop regional policies and programme in the context of the overall national policy and plans. They support, supervise and co-ordinate the local health services and they provide services such as specialist hospitals that cannot be replicated in individual local government areas. Again the question is to what extent the provincial authorities are able to undertake independent action in designing the services and how they relate to the private sector and the civil society in drawing up their strategies and plans.

Central Government

In a decentralised health service, the central government retains certain key functions, which may include:

- setting national goals and targets;
- provision of highly specialised services including research,
- national disease surveillance;
- emergency response to natural disasters and major epidemics
- establishment of standards,
- international relations,
- registration of drugs and
- accreditation of training programmes.

Formal protocols define the official relationships of the various health authorities but ideally, the interactions should represent mutual support towards the achievement of the common goal.

Making decentralisation work

Decentralisation is a common feature of the reform process that many countries are currently undertaking. Other elements in the reform package would include a variety of structural changes, new mechanisms for financing health care, redefined relationships with the private sector and other policy changes. There is also much variation in the structure of decentralised services but regardless of the specific details, certain important issues need to be addressed:

- Autonomy
- Financial resources
- Professional and technical capacity
- Information system
- Other health related sectors
- Relationship with other health care providers

Autonomy

There is much variation in the degree of autonomy enjoyed by devolved services. In federal states, constitutional authority may provide provincial governments with high degrees of autonomy than is given to regional health authorities in unitary states. Provincial and local health authorities in unitary states may have the responsibility of implementing services under the direction of the central government with little authority to make changes in the programmes.

Financial resources

Decentralisation of health services is generally accompanied by resource flows from the central government to peripheral authorities. The subvention from the central government may

represent the bulk of the resources available to the local health authority. Some authorities supplement central funds with revenue derived from local taxes and user fees. In general, local authorities that can raise funds through taxation and/or retain revenue derived from user fees tend to have more autonomy in making decisions and fine tuning health policies to suit local needs.

Information systems

Up to date information is an essential tool for the management of health services for identifying needs, designing services, and for monitoring performance as well as changes in health status. Ideally, the data should be disaggregated by the standard demographic indicators -- age, sex, marital status, but also by variables that may be relevant locally e.g. ethnic group, race, religion, etc.

Professional and technical capacity

Local professional and technical capacity is an important issue in decentralised health systems. In order for the devolved services to function efficiently, the peripheral health authorities must have appropriate capacity for planning, implementing and monitoring services. In particular, they must be able to gather and analyse relevant data as the basis for planning and monitoring.

Such expertise is often available in long established local authorities of developed countries but many developing countries are in the process of building such capacity. In any event, even in the most advanced countries, the resources of regional authorities and of the central government are sometimes required to fill the gaps in local capacity.

Other health related sectors

The well-known effects of socio-economic and environmental factors on health dictate the need for inter-sectoral action. National policies in such sectors as education, agriculture, welfare and environment are translated into action through provincial and local authorities. Decentralisation of these health related sectors would facilitate interaction with their colleagues in the health sector.

Table 3 shows the powers that were devolved to the recently created regional assemblies in the United Kingdom.

Powers	Scotland	Wales
Health	Yes	Yes
Education and training	Yes	Yes
Local government, social work and housing	Yes	Yes
Economic development and transport	Yes	Yes
Law and home affairs	Yes	No
Environment	Yes	Yes
Agriculture, fisheries and forestry	Yes	Yes
Sports and arts	Yes	Yes
Research and statistics	Yes	No

(From Pollock, 1999)

The central government at Westminster retains other powers including defence and national

security, fiscal economy and monetary system, social security, primary legislation for Wales, etc.

Relationships with other health care providers

In addition to the public sector, other providers are involved in health care. This includes private both for profit as well as not for profit agencies. In developing countries, traditional healers still play a prominent role. In developed countries, there is also increasing role of alternative medicine practitioners. Local health services relate vertically to regional and central authorities, which provide support for supplementing local capacity both for dealing with emergencies as well as for long term interventions. They must relate horizontally with other local health authorities especially those that serve neighbouring areas. By sharing information, they can reinforce their programmes by learning from each other and they can also achieve economies of scale by sharing resources.

Promoting equity in decentralised health services

"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."

Alma Ata Declaration, WHO (1978)

The meaning of equity

Although equity in health is intuitively understood to reflect a sense of fairness and justice, the term is used to refer to related but non-identical concepts The various specific definitions cover three main issues:

- Health status;
- Allocation of resources; and
- Access to and utilisation of services.

Health status: Inequalities in health status is a common phenomenon and is regarded as prima facie evidence of inequities in the health care system. (Murray, 1999). Significant inequalities in health status are found even in the most affluent developed countries, with long traditions of national health services that are designed to provide universal coverage. For example, the National Health Service was established in the United Kingdom 50 years ago but significant inequalities in health status persist in the regions of the country (Table 2) (Black et al. 1999; Pollock, 1999). A consistent finding is the strong association of poor health status as defined by such indicators as the expectation of life, the incidence of acute diseases and injuries, and the prevalence of chronic diseases and disabilities with poverty and other indicators of social deprivation. (Kennedy et al., 1996; Whitehead, 1999). The sub-group that has the highest level of health status represents what can be achieved.

Table 2: Some indicators of poverty and ill health in the United Kingdom

Nation	Gross Domestic Product (£/head) 1995	Unemployment %	Death rates per 100,000				
			All Causes	Lung Cancer		Breast Cancer	Cervical Cancer
				Male	Female		
England	10,324	6.9	1,041	77	42	61	6.5
Wales	8,440	8.4	1,096	74	39	61	6.8
Scotland	9,873	8.5	1,212	103	64	63	7.3
Northern Ireland	8,410	7.5	1,142	81	40	59	3.3

(From Pollock, 1999)

Allocation of resources: Equity is also examined in terms of the allocation of resources to different sections of the population. On moral and ethical grounds, the objective of allocative equity is for public resources to be shared out in a fair manner. (Taipale, 1999). The simplest formula would be a uniform per capita allocation. However, if large differences in health status already exist, an equal allocation would tend to perpetuate the inequalities. Other workers stress the re-distributive function of the state in allocating resources from the more affluent sector of society to meet the needs of lower income individuals and families the so-called "vertical equity."

Access and utilisation: Another view of equity is that everyone should have an equal opportunity of receiving care. This so-called "horizontal equity" proposes that individuals in like situations should be treated in like manner. Operationally, the aim is to ensure equal access. Access is often defined in terms of the availability of services and its geographical coverage but experience has shown that the potential access i.e. the services are within geographical range, does not necessarily correspond to real access as measured by the utilisation of services. Marked disparities are often found in the geographical distribution of health facilities: between regions, between urban and rural areas, between rural areas and within urban areas. (Phillips, 1990). The differential ratios of persons per facility -- hospital beds, nurses, and doctors -- are used to measure the disparities. The distribution of health centres and other institutions in relation to the population -- how far people have to travel to reach such facilities -- are also used to indicate the uneven distribution of resources. In some developed countries, the distribution of such basic facilities is still relevant (Knapp et al., 1999) but the availability of specialised services may be more appropriate. (Adam et al. 1998).

The relationship between decentralisation and equity is not automatic; inequities can occur in decentralised as in centrally managed services. Extreme cases of inequity have occurred in decentralised systems as for example during the apartheid era in South Africa when the white elite had access to the most modern, high quality health care, comparable to the situation in the most affluent developed countries. On the other hand, the decentralised services in the homelands were of much poorer quality than was found even in the least developed countries. (Reid & Giddy, 1998).

Optimisation of equity in decentralised services requires conscious attention to a number of important issues:

1. Political commitment
2. Policy formulation
3. Allocation of resources
4. Inter-sectoral action
5. Community involvement
6. Information system
7. Monitoring of equity

Political Commitment

The political commitment of the government is the essential basis for promoting equity in health. The objective of equity in health fits well with the political philosophy in welfare states that have the clear goal of providing universal coverage of comprehensive health care for the entire population "from the womb to the tomb". In such countries, the question is not whether the state should embrace equity in health but how to achieve this goal in practice. The situation is more difficult where the political outlook is dominated by free market ideas, individual entrepreneurship and market forces. Box 3 illustrates the differing response of two British governments to the problem of inequalities in health status.

Inequalities in Health Status: The British example

Within the past two decades, British authorities commissioned two major studies on inequalities in health:

1. **The Black report** "Twenty years ago the secretary of state for social services of the last Labour government appointed Sir Douglas Black to chair a working group to review information on inequalities in health and suggest policy and research that should follow from this review." Published in 1980, this report drew attention to inequalities of health in the United Kingdom and its determinants. The authors of the report made far-reaching recommendations with a strong emphasis on the alleviation of poverty. "The report ... received a cold reception from the new Conservative government." (George Davey Smith, Jeremy N Morris & Mary Shaw, *BMJ* 1998;317:1465-1466 (28 November)
2. **The Acheson Report**: "The 1998 Acheson report echoes the findings of the 1980 Black report: that the gap in inequalities in health has been steadily increasing and that differences in material deprivation are a major cause of the increase." The Acheson group argues for policies that "increase the income of the poorest." The current Labour government under Tony Blair is using the recommendations of the Acheson report in guiding its social and economic reforms.

Department of Health and Social Security. Inequalities in health: report of a research working group London: DHSS, 1980 (Black report).

Report of the independent inquiry into inequalities in health. London: Stationery Office, 1998

Political commitment is also required to correct the inequities that result from discrimination on the basis of gender, race, ethnic group and religion. Inequalities in health status reflect the marginalisation of disadvantaged groups. The probability of dying between age 16 and 60 is twice as high among black Americans as among their white counterparts. (Murray, 1990) (See Table 4). More recent analysis of data from the United States of America shows wide disparities in mortality and longevity by gender, race, wealth and geographical location. (Murray et al. 1998).

Table 4: Probability of dying between age 15 and 60 (per cent)

GROUP	MALES	FEMALES
White Americans	16	9
Black Americans	30.3	16
Japanese	11	5.6

The plight of indigenous populations in the Americas and Australasia is a special case. There is much variation in the commitment of the national governments to promoting equal socio-economic and political status to the indigenous populations. In extreme cases, erosion of their human rights borders on genocide.

Health workers in Australia have been much concerned about the poor health outcomes among

the aborigines. They are undertaking studies and analyses aimed at improving the situation (Gracey, 1998; Leeder, 1998; Mooney & Wiseman, 1998; Morgan & Allen, 1998; Rousham & Gracey, 1998)

"Mortality rates from all causes in Maoris in New Zealand and Native Americans have fallen substantially since the early 1970s. Comparable mortality rates for Australian Aboriginals and Torres Strait Islanders in 1990-1994 were at or above the rates observed 20 years ago in Maoris and Native Americans, being 1.9 times the rate in Maoris, 2.4 times the rate in Native Americans, and 3.2 times the rate for all Australians" (Ring & Firman, 1998)

2. Policy Formulation

In weighing policy options, a good guideline would be to examine critically the expected impact of the selected option on equity and to put in place mechanisms for measuring its impact on health. The formulation of health policies has to contend with a variety of pressures including the increasing demands of populations for more services, the desire to achieve maximal improvement in health of the populations served and the need to contain costs. Reforms of the health sector aim at improving efficiency, effectiveness, cost-effectiveness and equity. It is not always easy to reconcile these goals. For example, the delivery of care to the populations in remote areas is relatively expensive and less cost effective than services to dense urban areas. However, in the interest of equity, health services should reach the underserved populations even in remote settings.

The impact of macro-economic policies on health also deserves attention. For example, under pressure from the international finance agencies, some developing countries undertook structural adjustment programmes and markedly reduced public investment in health and other social sectors. UNICEF and other agencies drew attention to negative impact of SAP on the health of children.

There is increasing recognition of the role of health policy and health systems research in identifying and solving problems on the planning and operation of health services. A Global Forum for Health Research, a new independent entity, focuses specifically on promoting health research with particular reference to the problems that affect the poor. One of the initiatives of the Forum is the Alliance for Health Policy and Systems Research. (WHO, 1996; Global Forum, 1999).

3. Allocation of resources

One aspect of equity is that the government should allocate financial resources fairly to the entire population. On the basis of the constitution and from political agreements, governments use formulae to calculate the allocation of grants to provincial and local governments. A simple demographic formula that allocates funds simply on population size may need to be adjusted to take note of special needs of particular regions; otherwise, the uniform allocation may tend to perpetuate inequalities. Another source of inequity is the degree to which each authority can raise additional funds through taxation and by retaining user fees. Again, the fact that the more affluent areas are able to raise much larger funds than the poorer areas may tend to widen the gap in the quantity and quality of health care.

The imposition of user fees is a contentious issue. The advocates of this policy claim that it is a progressive measure that promotes equity. Their analyses suggest that the public sector can derive additional revenue from clients who are willing and are able to pay. The additional income can be used to improve the quality of services and to subsidise poor people who are exempted from payment (World Bank, 1994; Shaw & Griffin, 1995). Noting the sharp decline

in the utilisation of services when user fees are introduced, other workers regard user fees as a regressive policy that further widens the gap between the rich and the poor (Ekwempu et al., 1990).

Within the health budget, there is the difficult task of allocating resources to the needs of the various groups within the community. With finite resources, even the most affluent nations have to accept limits to the services that the public sector can provide. Hence rationing is an inevitable feature of health planning. In the interests of equity and social justice, if economies have to be made, the burden should be fairly shared among various sectors of the community. Quantitative estimates of burden of disease and of the cost-effectiveness of various interventions help to rationalise the selection of priorities. (Murray, 1994 a, b, c; Hyder, 1998). But a point is reached at which hard choices cannot be made solely on the basis of objective measurements. At this stage, the debate must include philosophical and ethical considerations about the value of human life. (Morrow & Bryant, 1995).

4. Inter-sectoral action

The profound effects of socio-economic circumstances on health have been widely recognised. Social stratification as variously defined is also a prominent risk factor for ill health, reflecting the combined effects of income, education and culture. The association between poverty and poor health is a consistent finding. "The poor die young". In developed countries, not only are they are higher risk from the diseases of the poor but they also suffer more from the life style health problems that are prominent in affluent communities -- cancer, coronary heart disease, etc. Furthermore, in many countries, with the increasing emphasis on free market economy, the gap between rich and poor is widening. Improved quantity and quality of health care is necessary but not sufficient to correct and prevent inequities in health status associated with poverty and social deprivation.

Discrimination against females is a global phenomenon but it varies in its intensity in different parts of the world. It extends through the entire life cycle, ranging from selective abortion of females, discrimination in quality of health care for infants and children, access to education and salary differentials based on gender. Discriminatory practices have direct and indirect effects on the health of women. It is often an underlying or aggravating factor in the frequency, severity and outcome of some specific health problems. For example, poverty is a common cause of malnutrition in women in some parts of the world; not only does it predispose them to anaemia and other health problems but it also limits their access to health care. A common finding is the association between female education and various health indicators for themselves and their children. (Cleland & Van Ginneken, 1989, Harrison, 1997)

A three pronged approach is required to deal with the inequalities of health status:

- Policies and programmes to alleviate poverty and social deprivation;
- Ensuring that people have the basic requirements for maintaining good health -- food, safe and adequate water supply, sanitation, and housing; and
- Access to affordable health care.

The health sector must provide the leadership for mobilising intersectoral action to achieve these three objectives.

5. Community involvement

Decentralised health services need to devise mechanisms for obtaining informed opinions from the whole community through credible representatives of civil society. The involvement of communities in decisions that affect their health care is widely recommended, it does not often work effectively in practice. Even in developed countries, the communities are often unable to

participate effectively in decision making because:

- authorities may not consult them;
- they lack relevant information; and
- the civil society may not be well organised.

Lack of consultation: Health officials often make key decisions about health care with minimal consultation of the public. Decisions about priorities for allocation of resources are often handed down without informed participation of the client communities.

Lack of information: The public often lack information that would enable them to make informed judgements about health care issues. Often this is because the technical information and their significance are not presented in language that would inform the lay public. On occasions, there is deliberate suppression of information by government officials e.g. there is a tendency to cover up information about outbreaks of infectious diseases -- cholera, "mad cow disease" (B.S.E.), poisoning by dioxin, etc. Some governments invoke the Official Secrets Acts and claims about sovereign rights and national security to justify their suppression of health information. Access to health information should be recognised as a human right. (Lucas, 1992)

Lack of effective organisation of the civil society: Even in developed countries where the lay public is relatively sophisticated, the civil society is poorly organised with regard to health issues. Much of what goes for public opinion about health is stage managed by vociferous single-issue lobbyists and by sensational reports in the tabloid press. In modern societies, a variety of special groups maintain watching briefs on specific issues of interest to them -- cruelty to animals or to children, protection of the environment, of wildlife, of birds, etc. Such groups collect and disseminate information, they lobby governments and engage in advocacy. Health care does not usually attract such strong lobbies from the lay public. The public response tends to be ad hoc and episodic rather than being well considered and systematic. Furthermore, there is usually no effective leadership and representation of the civil society to provide credible representation of the public. When consultations take place, the powerful elite, the politically influential and other privilege groups tend to dominate the debate drowning the soft voices of the poor, the disadvantaged and marginalised groups.

6. Information systems

Health authorities must ensure that the management information system includes data that can be used to design services that are equitable and to monitor performance and outcomes. The data needs include measures of inequalities in health status and inequities in access to health care. The data collecting instruments must be designed to take note of groups and sub-groups that are at risk of poor health status or whose access to services is restricted by geographical, economic, social and cultural factors. It should include the usual demographic indicators -- age, sex and marital status as well as socio-economic indicators -- race, ethnic origin, occupation, residence, and other social variables. (Rosen, 1999).

Special studies aimed at probing aspects of the operation of the health services with particular reference to the issue of equity, can usefully supplement routine data. The studies should be designed not only to inform the debate on specific issues but also to provide clues about feasible solutions to the identified problems.

7. Monitoring and evaluation

The health system should include mechanisms for monitoring equity objectively. Interest in measuring equity has generated some useful tools and some valuable experience is

accumulating. In the first instance, monitoring equity is the responsibility of health authorities at each level of care. They must build into their service, sensitive indicators that would inform them of their performance with regard to equity and access to care.

In addition to such internal process it would be valuable to commission independent reviews of equity within the health system. Groups outside the health departments should carry out such reviews. Another option would be to assign responsibility for a national equity watch to a local non-governmental organisation.

With its strong commitment to this goal of equity and its accumulated knowledge and experience, WHO may provide useful guidance to the national programme. Because some of the issues involved are politically sensitive, many governments would not welcome the direct involvement of external agencies in the review process. The only exception would be the need to protect the rights of indigenous populations. United Nations agencies have developed programmes for monitoring the human rights of indigenous populations.

CONCLUSIONS

Decentralisation of health services can make useful contributions to efficiency, effectiveness and equity in health but the gains are not automatic. In order to promote equity, policy makers, planners and managers of decentralised health services need to pay attention to seven major issues: political commitment on the part of the governments, policy formulation aimed at promoting equity, equitable allocation of resources, the mobilisation of other sectors for inter-sectoral action, effective community involvement, information systems, and mechanisms for monitoring and evaluation.

FOOTNOTES

1. Growth monitoring, oral dehydration, breast feeding, immunisation, family planning, female education and supplementary feeding of pregnant women

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