Health Policy 120 (2016) 1183–1192

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Review

The impacts of decentralisation on health-related equity: A systematic review of the evidence

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ARTICLE INFO

Article history:
Received 25 April 2016
Received in revised form 3 August 2016
Accepted 5 September 2016

Keywords:
Decentralisation
Health system
Health care governance
Equity
Heath financing
Healthcare access
Health outcomes
Health-related equity

ABSTRACT

Background: Decentralised governance of health care has been widely adopted globally over the past three decades. But despite being implemented as a management strategy across many health systems, its impact on health equity is yet unclear.
Objective: To conduct a systematic literature review of the implications of decentralised governance of health care on equity in health, health care and health financing.
Methods: A systematic search of CINAHL, EconLit, Embase, MEDLINE, PsycINFO, PubMed, Scopus, and Cochrane database of systematic reviews was conducted. Articles that met the inclusion criteria examined entire health systems and the relationship between implementing decentralised governance and health-related equity. The quality of reporting of the included studies was assessed using a 10-point quality rating tool.
Results: Out of 808 articles identified, 9 met the inclusion criteria. The included studies were mostly explorative and used a range of quantitative techniques to analyse the relationship between variables of interest. The review found that depending on context, decentralisation could either lead to equity gains or exacerbate inequities. The impact of decentralisation on inequities in health and health care depends on pre-existing socio-economic disparities and financial barriers to access. While decentralisation can lead to inequities in health financing between sub-national jurisdictions, this is minimised with substantial central government transfers and cross subsidisation.
Conclusion: The implications of decentralised governance of health systems on health-related equity are varied and depend on pre-existing socio-economic and organisational context, the form of decentralisation implemented and the complementary mechanisms implemented alongside decentralisation.

1. Introduction

In the past three decades, health reform has become commonplace in most countries. As part of such reforms, decentralised governance of health systems has been adopted in some countries as a subset of broader health reforms or as a preferred management strategy [1,2]. The rationale for this policy choice varies across countries. A primary objective underpinning this choice is to improve overall health system performance [3]. The expectation is that decentralisation provides the opportunity for health systems to attain both technical and allocative efficiencies, empower local governments, increase accountability, and make gains in many areas including quality, cost and equity

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http://dx.doi.org/10.1016/j.healthpol.2016.09.003
0168-8510/

[4–6]. Furthermore, some of the compelling arguments for decentralised governance of health systems is the imperative to make health service responsive to local population needs and to improve access and quality of health care [6].

It is also argued on the other hand that decentralisation may result from a broader process of economic, political and technical reform [7], and could also be associated with neo-liberal reforms which were aimed at, among others, introducing austerity measures designed to minimise state expenditure, reduce the role of state in the provision of health care and to introduce competition and cost consciousness in the public sector [8,9]. Other researchers further posit that these reforms were in response to global pressure on governments by international agencies to rethink their role in service delivery and public management in the light of accumulating evidence of inefficiencies in existing health systems and their failure to deliver good quality health services and to make health care services accessible [10,19]. Due to the disparate objectives underpinning decentralisation reforms, it stands to reason that the impact of these reforms on health-related equity or their contribution to health-related equity may equally vary.

It is therefore unclear whether decentralisation leads to improvement in overall health system performance [11]; and the relationship between decentralisation and health system objectives such as equity, efficiency and cost effectiveness is unclear. Some studies indicate that the outcomes, benefits and challenges of decentralisation are mixed [8,12–14]. A universal objective of health systems should be to reduce inequality in health and promote equity [15], but the impact of decentralisation of health system governance on equity has been questioned [16].

A number of studies report negative or ambiguous effects of decentralisation on health care, citing inequity as a major concern [17–19]. Therefore, while decentralisation is generally expected to increase equity, there is little evidence to support this proposition [20]. Some researchers assert that decentralisation predisposes health systems to inequity because decentralised autonomy for decision making leads to disparities in approaches to health care between autonomous units [20,21]. This claim is however disputed by other studies, noting that decentralisation does not predispose health systems to inequity [6,22,23]. Yet some studies reveal that equity outcomes are further tied to the prevailing political setting and policy choice [20]. The prevailing polarised arguments in the literature demonstrate that there is inadequate empirical evidence to warrant definitive conclusions on the impact of decentralisation on health-related equity. In the view of Riutort and Cabarcas [24] there is an imperative for a systematic review of literature on this subject because current evidence is contradictory and ambiguous. This review is therefore situated in this context.

Two earlier attempts have been made to review the literature on this subject. The first study reviewed literature on the relationship between decentralisation and equity as part of a broader reform process in Latin America [24], while the second study examined the efficiency and equity consequences of decentralisation in health from an economic perspective [16]. This review is however important and differs from the earlier attempts in two ways: it provides the first systematic review of empirical evidence on the effect of decentralisation on health-related equity as a specific health system goal, and secondly it provides a global dimension to the implications of decentralisation on health-related equity. Specifically, it seeks to examine the empirical evidence on the implications of decentralised health system governance on health-related equity. To further provide a background to this review, the two concepts (decentralisation and equity) are examined in the ensuing sections.

1.1. Decentralisation

Decentralisation has been defined in several ways by several scholars [25–27]. Essentially, it is conceptualised as the transfer of authority and power in the public planning, management and decision making from national or higher level of government to sub-national or lower levels [28,29]. The transfer of power and authority may take several forms giving rise to some categoriastion of the concept. Although there is little consensus among scholars on the typology [4,30], a four-part typology of decentralisation namely devolution, delegation, de-concentration and privatisation is dominant in the literature [28]. The various forms or various approaches to decentralisation are however not necessarily found in their pure form in practice; but the distinctions reflect legal and institutional arrangements and different formal lines of authority but not necessarily the degree of local autonomy [29,31]. Bankauskite and Saltman [4] distinguish between them in the following; “Delegation transfers responsibility to a lower organisational level, deconcentration to a lower administrative level, devolution implies transferring authority to a lower political level and privatisation takes place when tasks are transferred from public into private ownership” (p. 10).

Deconcentration involves the transfer of administrative responsibilities to local offices of central government ministries [29,30]. The distinguishing feature in deconcentration is that the transfer of responsibility or authority is administrative rather than political and is often used as an opportunity to reorganise local services [29]. Although this is seen as the least form of decentralisation, it can provide a considerable level of discretion to local offices of the ministry to take decisions without constant recourse to the central ministry of health. On the other hand, devolution involves the creation or strengthening of sub-national levels of government such as local government units which are substantially independent of the national level with respect to a defined set of functions [29–31]. Devolution of health care responsibility or authority therefore occurs when the national level transfers responsibility for health care to such local authorities or local government units. Although these sub-national units may wield considerable level of autonomy due to their independence, they are rarely completely autonomous [29,31]. Also, while deconcentration results in the transfer of responsibility to subordinate administrative units of the same ministry of health, devolution leads to the transfer of responsibility to sub-national units which are considerably independent