Decentralization of Health Services in Latin American Countries: Issues and Some Lessons
# TABLE OF CONTENTS

DECENTRALIZATION OF HEALTH SERVICES IN LATIN AMERICAN COUNTRIES: ISSUES AND SOME LESSONS .............................................................................................................................................................................. 1

DECENTRALIZATION OF HEALTH SERVICES IN LATIN AMERICAN COUNTRIES: ISSUES AND SOME LESSONS ....................................................................................................................................... 1

## INTRODUCTION .............................................................................................................................................................................. 1

I. A CONCEPTUAL FRAMEWORK................................................................................................................................................................. 1

II. WHAT HAS BEEN DECENTRALIZED IN LATIN AMERICA? .............................................................................................................................. 1

   Responsibilities for Health Care Services ........................................................................................................................................ 8

   Financing Mechanisms and Basis for Transfers ................................................................................................................................. 9

   Labor Management .................................................................................................................................................................................. 12

   Powers to Set User Fees and Dispose of Proceeds ............................................................................................................................ 14

   Procurement of Non-Labor Non-Capital Inputs ................................................................................................................................. 14

   Investments in Physical Infrastructure and Equipment ..................................................................................................................... 15

   A Summary .................................................................................................................................................................................................. 16

III. IMPLEMENTATION AND RESULTS OF DECENTRALIZATION................................................................................................................ 17

   Obstacles to Decentralization ............................................................................................................................................................ 17

   The Consequences of Decentralization ............................................................................................................................................. 20

IV. CONCLUSIONS AND RECOMMENDATIONS .............................................................................................................................................. 21

   Conclusions .................................................................................................................................................................................................. 21

   Recommendations ................................................................................................................................................................................ 23

ANNEX A: A SYNOPTIC OF THE DECENTRALIZATION PROCESS IN SIX LATIN AMERICAN COUNTRIES.................................................................................................................... 25

   Argentina .................................................................................................................................................................................................. 25

   Bolivia .................................................................................................................................................................................................. 26

   Brazil .................................................................................................................................................................................................... 28

   Chile .................................................................................................................................................................................................. 29

   Colombia .................................................................................................................................................................................................. 30

   Mexico .................................................................................................................................................................................................. 31

REFERENCES.................................................................................................................................................................................................. 1
Decentralization of Health Services in Latin American Countries: Issues and Some Lessons

Introduction

Decentralization in the health sector has been continuously on the policy agenda of several Latin American countries for about two decades. Efforts to implement decentralization, on the other hand, have been at best patchy and halting, reflecting the contradictory expectations and interests that have driven the process. This paper argues that decentralization may make economic sense for only some types of health services (section I) and, consequently, that decentralization may simply not be the appropriate instrument to achieve some of the desired policy objectives in the health sector. Section II provides a comparison of the degree to which resources and responsibilities have been decentralized in six Latin American countries (Argentina, Bolivia, Brazil, Chile, Colombia and Mexico). Section III discusses the obstacles to the decentralization and some of the consequences of decentralization in these six countries. The paper concludes by revisiting the role of decentralization in the health sector policy toolkit and with a few basic recommendations. A synopsis of the decentralization experiences in each of the six countries reviewed is presented in Annex A.

I. A Conceptual Framework

In all of the countries being reviewed, decentralization in the health sector was initially prompted by political concerns. In Argentina and Brazil, decentralization accompanied the re-democratization process that followed a period of military dictatorship; and in Mexico, Bolivia and Colombia, decentralization permitted the inclusion of neglected actors into the political process (see ‘Decentralizing the State,’ Prologue). The common trait is that the decentralization process, that eventually found its way to the health sector, responded to national rather than sectoral objectives. The case Chile is different since the decentralization process was initiated by the military dictatorship in the early 1980s as an instrument to reduce the fiscal burden at central level. In Colombia, in addition to political concerns, the decentralization process was also a response to sectoral objectives (quality, efficiency). To the extent that decentralization was primarily motivated by reasons extraneous to the health sector, one would expect that any match between decentralization as a policy instrument with health sector objectives would be largely coincidental. In this section, “optimal” financing and delivery structures for different types of health services are
proposed, and the adequacy of decentralization as an instrument to achieve an efficient delivery of each category of services is discussed.

Health is somewhat different from the other sectors, such as education and roads, that were also decentralized in that some of the goods and services provided are almost pure public goods; i.e., they are both nonrival in consumption (they are not used up when a single individual uses them) and nonexclusive (the benefits cannot be owned by any single individual). Examples are provided in the first row of Table 1. These activities require Government financing if they are to have any chance of being provided in quantities that could meet the social demand for them. For such public goods, the decentralization of financing may be undesirable, but that of the decentralization of provision/management is a sensible issue which opens the discussion of pros and cons of decentralizing governmental decisions.

Some of these activities may be and are treated as local public goods, such as vector control, regulation or disease surveillance. However, because of the cross-jurisdiction externalities involved, the provision of these services need to meet minimum central standards so that quality of services and risks from disease do not vary widely across local governmental boundaries. For these public goods, one of the key questions for the public sector, whether central or local, is the adequacy of the services that it finances and the regulatory structure necessary to ensure that local government units or private firms comply with quality standards and recognize the externalities across subnational political borders in a consistent way.

From the consumer/citizen standpoint, individuals may benefit from the pure public health goods and services without even knowing that they exist (e.g. vector control), although they are generally well aware when the services are not adequately supplied. Management of the activity may not include interactions between suppliers and beneficiaries, so the direct client for services may be a Government functionary rather than the end user, creating principal-agent issues but also leaving open to cost and quality considerations whether the relevant governmental unit prefers to own-manage the activity or contract it out.
<table>
<thead>
<tr>
<th>Characteristics of Goods and Services</th>
<th>Examples</th>
<th>Financing (Private/Public) x (Local/National)</th>
<th>Provision (Private/Public) x (Local/National)</th>
</tr>
</thead>
</table>
| 1. Pure Public Goods in Health (Nonrival, Nonexclusive) | • Health Information  
• General Health Education  
• Disease Surveillance  
• Environmental Health  
• Vector Control  
• Regulation (market failures in information and insurance) | • Public: otherwise underfinanced  
• Decentralization sensible for local public goods, as long as national standards are maintained | • Public  
• Contract out (public bureaucracy is the client) |
| 2. Household Health Inputs with Strong Externalities (Rival, Nonexclusive) | • Immunizations  
• Sanitation  
• Safe Water  
• Prevention of Communicable Disease | • Public and some Private  
• Decentralization sensible for goods with strong local characteristics, as long as national standards are complied with | • Private preferred (reduces principal-agent problem of public provision) |
| 3. “Equity Goods” in Health (Rival, Exclusive) | • Acute Care | • Public and some private  
• Decentralization feasible if compliance with national standards | • Private |
| 4. Household Health Inputs that are Fundamentally Private Goods (Rival, Exclusive) | • Acute Care | • Private  
• Public management of insurance market failures  
• Public versus privately managed insurance  
• Single versus multiple payer | • Private |

A second set of services (row 2 in Table 1) in health are rival in consumption but nonexclusive in benefits, such as immunizations. Immunizations may provide “herd immunity,” for example, at a level of coverage substantially less than 100 percent. Thus they provide benefits to people who do not receive the service directly. There is a willingness to pay for the service but also an incentive to free ride; hence there is a strong rationale for at least partial government financing or compulsion to force private parties to purchase adequate quantities of the service. In practice, these services tend to receive heavy, if not exclusive, public financing, although some jurisdictions
do handle them primarily through regulations rather than through financing (e.g., requiring immunizations before children may enroll in school, requiring coverage in basic insurance benefit packages).

From the consumer’s standpoint, these services require direct interaction between medical personnel and patients (or, for water and sanitation, between the seller and the consumer). A large share of the population actually must consume them if they are to be effective as medical interventions for the population. It is important that the service function in a manner that pays attention to the client. Thus the management of the service at the point of delivery is important.

A third group (row 3) is that of private goods that involve some Government financing chiefly because of equity considerations, and as a substitute for insurance markets that fail to develop. Services in this third group are best privately provided. The final group of services (row 4) is that of essentially private goods that do not involve the Government either on the financing or on the provision side. The demarcation line between the third and the fourth group is not a conceptual one, but rather one that is obtained by subjecting prevailing solidarity objectives to the Government’s budget constraints.

For all of these categories of goods, any particular government may or may not choose to become involved in the delivery of the services. Even in the realm of public goods, it may choose to contract for such activities as disease surveillance, and its choice should be motivated by the relative quality and efficiency of contracting for the service or providing it directly. As we move from the top to the bottom of the table, though, and the personal consumption of the services becomes increasingly important and the case for government participation in the provision of services probably decreases. Since public provision of services may be a desirable option only for the first two categories of health goods, the issue of decentralization should therefore also primarily apply to these categories of services.

In the history of health care provision, this distinction between public and private goods, on the one hand, and impersonal versus personal services, on the other hand, has been muddled. As a result, governments and social security institutes have found themselves financing and delivering all kinds of services even though many could be delivered as well or better in a competitive market. Central Governments, having entered the business of medicine, then consider decentralization to be a matter of decentralizing or deconcentrating the management of facilities and personnel, when in fact lower levels of government may not have any advantage in skills, incentives, motives, or negotiating power to improve the management of such services. If a public hospital is
decentralized to a province, it may become no less of an employment agency than it was when managed by the central government.

Table 2 below shows the possibility set for financing and providing health care. The shaded area indicates the restricted possibility set (D, E, F) that many governments in Latin America have chosen for themselves. Within this set, the scope for choice is limited to the distribution of financing and provision across political entities, or political decentralization. That the possibility set should have been this one presumably derives from the fact that the sharing of political power was a goal in itself, as we argued earlier. The argument developed above is that A, B, and C – corresponding to public (national or local) or private financing with private provision - that had been obliterated from the possibility set, are often superior alternatives for improving the incentive structure for health service delivery to either D, E, or F. Within this expanded possibility set, decentralization is now one of two policy options, the other one being the separation of the financing of health services from the provision of these services. In practice, the purchaser-provider split is tantamount to granting management autonomy to the providers; various degrees of independence can be obtained through the autonomization, corporatization or privatization of providers. In the past 10-15 years, an emerging pattern has been for governments to understand better this distinction between decentralizing or deconcentrating political decision-making and financing in health on the one hand, and improving the incentive structure for delivery of health services on the other hand.

<table>
<thead>
<tr>
<th>Financing</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This framework is undoubtedly too simple to capture the true role of the public sector in health or to fully understand the decentralization efforts that have taken place in Latin America (see, for example, Preker 1999 and Musgrove 1999). However, it emphasizes two simple issues that should be addressed in decentralization policies in health. First, should responsibilities and financing of the high-externality functions in health be distributed across political entities, recognizing that many of these goods would benefit from local customization while also meeting minimum national standards for results (e.g., management of water-, air- and vector-borne diseases)? Second, how can services be improved in historically large, expensive and poorly functioning government-owned and operated delivery systems? While political decentralization may affect service delivery to some degree, this second issue is fundamentally an incentive problem that can be addressed through a variety of actions, such as splitting the financing function from provision, by creating autonomous units, by shifting budgeting from the input side to the output side, by encouraging competition by letting patients choose providers, and so on.

The next section synthesizes the decentralization experiences in six Latin American countries: Argentina, Bolivia, Brazil, Chile, Colombia, and Mexico. The section presents the common elements, organized around which levels of government are responsible for which activities, how funds are transferred from the center to state and local governments, and how responsibility for managing the various inputs (labor, capital, and procurement) has been affected. Although these countries have come up with different solutions along the spectrum of possibilities, with uneven results, their common story is one of partial political decentralization of service provision.
II. What has been Decentralized in Latin America?

Jurisdictionally, Latin American countries can be divided in two groups. The larger countries (Brazil, Mexico, Argentina, Colombia, among others) have a three-tier government system composed of the central government, states, departments or provinces, and municipalities. The smaller countries (Costa Rica and others in Central America, Chile, among others) have two-tier government systems composed of the central government and municipalities. In the smaller countries an intermediate administrative regional level seeks to coordinate municipal projects overlapping two or more jurisdictions. In Latin America, in federal and unitary governments alike, municipalities relate directly with the central government, rather than through their states. In most cases revenue flows directly from the central or federal level to municipalities. In addition, because of constitutional mandates or due to voluntary fiscal coordination laws (such as in Mexico), states and municipalities have very limited taxation powers (Castañeda, 1997a, Macias, 1999). As such, the issue of fiscal decentralization has not figured prominently on the policy agenda in the health sector.

Decentralization of health services in Latin American countries has characteristically proceeded through the devolution/delegation of subsets of key functions or responsibilities to different government levels rather than through decentralization of the whole set of functions to a subnational government or to a facility. This approach is symptomatic of the fact that the decentralization process was prompted by extra-sectoral considerations rather than because it was deemed an appropriate strategy to achieve efficiency in the health sector. In effect, the decentralization of subsets of inputs or functions coupled with a lack of clarity as to the structure of accountability is unlikely to have improved efficiency. In most cases, except Brazil, Argentina, and to some limited extent Colombia, personnel administration (salary scales, benefits, promotions, hire, fire, sanctions, etc.) remain at the central level, as a result of negotiations with workers’ unions. Limited personnel administrative matters (permits, promotions, etc.) have been delegated to states or municipalities.

In assessing the extent of decentralization and transfer of power and resources to subnational governments, particular attention is paid to the devolution of responsibility and authority over critical inputs such as labor, procurement (medicines and supplies) and investment in infrastructure and equipment.
**Responsibilities for Health Care Services**

While the central governments tend to retain responsibility for policy making, overall financing, and operation of highly specialized medical care centers (cancer, for instance), states or provinces (non-jurisdictional health regions in Chile) have often been given responsibility for provision of secondary and tertiary hospital care, and municipalities that for primary health care (Chile, Mexico and in most parts of Argentina). In big cities or metropolitan areas all levels of care can be provided by the same jurisdiction. The exception to this rule in the countries reviewed is Chile where a unit (the Health Region) is used for transferring responsibility for secondary and tertiary care. The selection of a jurisdictional unit, especially if elected by popular vote, is believed to have some merit in that political accountability can be pursued.

In practice, responsibilities among government levels have often been ill-defined or have changed repeatedly over a short period, hampering the consolidation of institutional and other arrangements at subnational levels. In Brazil before the new constitution of 1988, states were responsible for administering state health systems, while after 1988 the main responsibility for service provision and administration was given to municipalities. In Colombia, a 1990 health sector decentralization law was replaced by a more radical health sector reform law in 1993 when the decentralization law was just starting to be implemented. In Bolivia, all three levels of government and facilities directors have a stake in service provision and the ensuing accountability structure is unclear.

Table 3 below summarizes the sharing of responsibility among different levels of government in the six countries reviewed. The responsibility for the provision of primary health care (which includes a number of goods with strong externalities) is typically devolved to the municipal level. Responsibility for hospital care tends to remain centralized in Mexico and Bolivia. Colombia and, to a very limited extent, Argentina, have separated the financing from the provision of hospital care. Under Law 100 of 1993, Colombia granted public hospitals the status of “Social State Enterprises” defined as decentralized public entities with administrative autonomy, legal representation and ownership of assets. These hospitals are supposed to be weaned off supply subsidies and be able to operate from the sale of services to patients. In practice, no public hospital in Colombia lives solely off proceeds from the sale of services as of yet. Hospital autonomy is incipient in Argentina; one realm of recent progress is that some public hospitals have begun to bill insured patients. In Chile, the purchasing and provision functions are theoretically separated. In practice, however, public hospitals continue to be paid largely (80 percent) through historical budgets, the remainder 20 percent of hospital revenues is paid on a DRG basis. Brazil is
a special case in that the public sector entered into contractual agreements directly with private providers and public providers (a combination of cells B and E in table 2).

**Table 3: Service responsibilities at different levels of government**

<table>
<thead>
<tr>
<th>Government Level</th>
<th>Primary Health Care</th>
<th>Hospital Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/Federal</td>
<td>None</td>
<td>Specialty hospitals in most countries</td>
</tr>
<tr>
<td>State/Department/Province</td>
<td>Some role (supervision and monitoring) in most countries</td>
<td>Argentina, Mexico; Health Regions in Chile</td>
</tr>
<tr>
<td>Municipalities</td>
<td>All; Sanitary Jurisdictions in Mexico</td>
<td>Argentina, Bolivia</td>
</tr>
<tr>
<td>Facilities (where purchaser-provider split operated)</td>
<td></td>
<td>Brazil (mostly private provision); Colombia (in theory); incipient hospital autonomy in Argentina</td>
</tr>
</tbody>
</table>

**Financing Mechanisms and Basis for Transfers**

The current financing and transfer mechanisms attempt to reconcile three different and possibly irreconcilable objectives: reducing the fiscal burden at central level, sharing power and resources with local actors and, in some countries, increasing the efficiency and quality of service delivery. Sharing of roles and responsibilities with subnational governments may, as we argued before, not achieve anything by way of increasing the efficiency and quality of service provision, especially as long as the basis for financing is input rather than output-driven. It might actually take the public sector (be it at national or local level) to relinquish provision of services and focus on the financing side to achieve that objective.

**From one jurisdiction to another**

The main financial source remains the central or federal government, although states and municipalities also are pressed to contribute more of their own, generally limited, resources.-All in all, state and municipal contributions for health care (excluding transfers) are less than 20 percent of total health expenditures in most countries.

Transfer formulas to political sub-levels are generally complex and have a large population-based weighting. In Colombia, for instance, transfer formulas include, among other things, population
with unmet basic needs, and adjustments for local administrative and fiscal effort. Per-capita allocations are also being applied in Brazil for a basic level of municipal primary health care services and in Colombia for insurance for a basic health care package for the poor. These transfers then become the basis for local governments to finance services, which is typically done on an input-based, historical budgeting approach that ignores output and quality. In Chile, transfers to municipalities are based principally on per-capita allocations (70 percent), complemented with allocations for the provision of public goods.

Some countries use formula-based transfers to finance primary health care infrastructure and equipment by municipalities (Colombia, Bolivia, Mexico). In Brazil formula-based transfers also finance current expenditures and investments of municipalities under complete decentralization of service responsibility. Formula-based transfers have several advantages: (a) they are more certain as they are less dependent on political decisions; (b) they can be used as collateral for investments; (c) they add transparency to the system; (d) they can be used to rectify inequities in spending across subnational units; (e) they can provide incentives for localities to experiment with different forms of service delivery to economize on their budgets.

**From public purchasers to provider**

Most health care providers (hospitals and primary care networks) continue to be financed by direct historically-based budget allocations either through deconcentrated Ministry of Health Offices in states or through earmarked transfers to states and municipalities (Mexico, Bolivia). Current central government payments are rarely related to production or quality of the service provided. Some countries such as Chile have recently started, in a limited way, to introduce payments for Diagnostic Related Groups (DRGs). In Colombia, hospitals services are increasingly being financed – although it is not clear how fast - through reimbursements from insurance funds, there is a growing connection between delivering services and receiving payments. Argentina has had very limited success so far in its bid to transform public hospitals into autonomous entities that would receive payment for services produced (demand subsidies) rather than for inputs (supply subsidies). Transfers from provinces and municipalities to healthcare facilities therefore continue, for the most part, to be historically-based. Brazil is a special case in that there are relatively few public hospitals; a large share of hospital services are provided by private hospitals under federal fee-for-service and DRG reimbursement schedules (Castañeda, 1997c). Public providers are reimbursed according to the same fee schedules and mechanism as private providers. For ambulatory care reimbursement is made on an ex-post per capita basis. For primary health care the system is moving towards a capitated prospective payment (World
Bank, Report 18142). In recent years, there has been an explosive growth in the number of public hospitals (an increase of 61 percent over the period 1986-1996) that could reflect a growing disaffection of private providers with a payment system that is characterized by reimbursement rates that do not reflect average hospital costs.

There is little financial autonomy at facility level. Hospitals are paid the cost of personnel (usually a fixed staff and staff mix provided by law as in Chile, Mexico, Bolivia and Argentina), and costs of other inputs and services. Recently, there have been some efforts to finance hospitals and primary care providers on the basis of services provided (Colombia, Argentina) but these efforts have not been fully implemented. Moreover, hospital deficits and debts end up being paid by central or subnational governments (Brazil) or national health insurance funds (Chile).

The countries under review fall into two groups. The first group (Bolivia, Mexico) continues to operate essentially within a political decentralization framework; in these countries, payments and transfers are made to lower government levels on the basis of past budget history or according to some formula. The second group of countries recognizes the importance of separating financing from provision, but has difficulty in following through with its logical implication: granting public providers more management autonomy. The law instituting hospital autonomy in Argentina was passed in 1993; six years later not a single hospital has been granted full autonomy in the country.

In Chile, the ability of public hospitals to sell their services to insured patients is limited by law; as a result, public providers cater mostly to patients insured by the national health insurance fund. In two-thirds of the health districts, the mode of payment of these public hospitals is, for 80 percent, on a historical basis, and for 20 percent on a DRG basis. In the remaining health districts, public hospitals continue to be paid by supply subsidies. Colombia has gone farthest in recognizing the importance of separating financing from provision and of subsidizing patients rather than facilities. However, supply subsidization was never completely phased out so that hospitals have “benefited” from a duplication of budgets – which is the source of current financial difficulties in the health sector. In addition, there is increasing pressure from unions to revert to supply subsidies (Londoño). Because the purchaser in Brazil (Sistema Único da Saúde) is able to contract directly with private providers, the issue of provider-purchaser split is largely resolved in Brazil. However, there is a risk that Brazil might be reverting to a system where provision is mostly public; while the provider-purchaser split could theoretically be maintained when provision is mostly public, this reversion could reopen the door to the era of supply subsidization and soft budget constraints.

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1 This excludes the Hospital Pediatraco Garrahan, which was created as an autonomous hospital before the hospital autonomy law was passed.
Labor Management

Labor costs constitute a large portion of health care expenditures. In many countries, the wage bill represents over 60 percent of total costs at hospital level. At the primary level labor costs shares are even higher. While the ability to hire and fire has somewhat been decentralized, salary determinations tend to remain centralized, or decentralized at most to the State/Department/Province level. Table 4 below summarizes where the six countries are located in terms of personnel management.

Price

In many countries the price of labor or the conditions of employment are controlled not by subnational governments or administrators of health facilities but by the federal or central government, which enters into national negotiations with health sector unions every year. In Colombia, maximum salary levels for civil servants are set nationally every year. Local health authorities have the power to modify personnel remuneration schedules provided that they remain within their budget constraints and that they respect the centrally-determined salary caps. In addition, hospital directors can use part of an eventual budget surplus towards productivity bonuses. The actual occurrence of public hospitals running a budget surplus is rare, largely due to the fact that reimbursements from the public health insurance funds (EPS) have been slow to materialize. In Chile, the price of labor is centrally determined; however, a reform proposal is currently being discussed in the Senate to grant health regions the power to set salary levels for health professionals. Hospitals are theoretically able to use proceeds from the sale of services to insured patients towards productivity bonuses, but have been generally unwilling to do so.

Quantity

In most countries, subnational governments and health care facilities have only limited personnel management responsibilities and are constrained by strict national labor codes regarding health care workers. In some cases, State Health Secretaries have powers to hire, fire, and transfer hospital directors and staff (Argentina, Mexico, Bolivia). Chile is perhaps the sole case where primary health workers were effectively transferred to municipalities and lost their status as federal civil servants in the process.
Directors of government-owned health facilities generally have no power over their labor input in those countries that have so far focused on political decentralization (Bolivia, Mexico). Granting providers authority over labor is a component of hospital management autonomy, and it is therefore logical that it should be on the policy agenda in Argentina, Chile and Colombia. With the recent introduction of reforms giving more autonomy to hospital facilities, hospital managers are just beginning to receive more power over personnel in Argentina (Abrantes and Díaz Legaspe, 1999). In some of the provinces in Argentina that have empowered and equipped public hospitals to bill for services rendered to insured patients, there are explicit guidelines permitting the use of part of these proceeds towards productivity bonuses. In Colombia, public hospitals were transformed into ‘Social State Enterprises’ under law 100 of 1993. The status of hospital employees remained unchanged under the new regime: they stayed functionaries subject to general civil servants’ labor regulations. This has translated into a situation where subnational units are able to recruit but not to fire staff. An interesting experience took place in the Colombian province of Antioquia: the municipality agreed to pay for the severance package of all excess hospital personnel so as to give hospital directorates more labor management flexibility within the straight-jacket of public service regime. In Chile, health regions currently have limited authority to hire or fire hospital personnel; a reform proposal is being discussed to increase this power. Chilean municipalities have the authority to hire and fire primary health care professionals.

**Table 4: Authority to Manage Personnel by Different Levels of Government**

<table>
<thead>
<tr>
<th>Government Level</th>
<th>Salary Determinations (Price)</th>
<th>Hiring and Firing (Quantity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Bolivia, Colombia (defines salary caps),</td>
<td>Bolivia, Brazil (for federal health employees)</td>
</tr>
<tr>
<td></td>
<td>Mexico, Chile</td>
<td></td>
</tr>
<tr>
<td>State/Department/Province</td>
<td>Argentina, Brazil</td>
<td>Mexico, Argentina, Chile (Health Regions) for hospital staff, Brazil (for state health employees)</td>
</tr>
<tr>
<td>Municipal</td>
<td>Brazil (some municipalities can adjust salaries to ensure compatibility with federal and state workers)</td>
<td>Brazil (for municipal employees); Chile for PHC workers;</td>
</tr>
<tr>
<td>Facilities where purchaser-provider split operated</td>
<td>Colombia (adjustments based on budget availability at facility level); Argentina:(public autonomous hospitals can use proceeds from billing insured patients to increase staff remuneration); Chile (facilities can</td>
<td>Brazil for private hospitals, limited autonomy for public hospitals; Colombia (more power to hire than fire)</td>
</tr>
</tbody>
</table>
Powers to Set User Fees and Dispose of Proceeds

Most countries charge no or nominal fees for primary health care in central or decentralized facilities. In countries that operate within the framework of political decentralization, the norm is to have highly subsidized fees, if any, for inpatient or outpatient hospital services. Health care in those countries is subsidized through the facilities, i.e., from the supply side. The ability to set and retain fees is indicative of the fact that facilities have been granted management autonomy and that public subsidies have been shifted from the facility to the patient (demand subsidization). It should therefore come as no surprise that there should have been little or no progress in the ability of subnational authorities or facility managers to set or retain fees in those countries where decentralization has essentially been carried out along the political axis. In the case of Bolivia, decentralization to municipalities has paradoxically reduced the autonomy of health facilities to dispose of fees: the proceeds now have to be remitted to the municipal health authorities. In those countries, on the other hand, where a purchaser-provider split has begun to be implemented, facilities are at least partly able to retain and dispose of the proceeds from service provision. In Colombia, for example, proceeds from user fees can be used to procure inputs, medicines, to pay for public utilities and for budget deficits. A few provinces in Argentina have established guidelines for autonomous public hospitals for the use of proceeds from billing insured patients. In the province of Salta, for instance, public hospitals are allowed to use 50 percent of those proceeds towards productivity incentives for personnel, 30 percent for investments and operating and maintenance expenditures, and the remaining 20 percent has to transferred to a redistribution fund. In Chile, public hospitals can use the proceeds from the sale of services to insured patients for investments, maintenance, and for productivity bonuses. However, in a bid to switch to demand subsidization, budget allocations take into account the own-income generated in the previous fiscal year (hence tax the own-income by reducing the budget subsidy), so hospitals have often been reluctant to sell services.

Procurement of Non-Labor Non-Capital Inputs
The situation is again different in the two groups of countries we have identified. Bolivia continues to centralize much of the procurement of inputs and supplies. In countries that function within the political decentralization paradigm, the abandonment of central procurement is often prompted because of past experiences with corruption, poorly managed central warehouses and distribution systems, inability to respond to demand, and high loss rates. The decision to procure inputs centrally or locally in those countries where the purchaser-provider split has been operated follows a different rationale. Centralized procurement may continue to make sense for goods that necessitate national coordination (e.g., cold chain for vaccines), for goods that have a predictable demand (e.g., complementary nutrients programs), and for goods with strong externalities that do not require much local customization. Private goods (e.g., drugs) may best be procured at the facility level, although central mediation and group purchases may be helpful to increase the market power of individual providers. In Chile, the central procurement unit (Central Nacional de Abastecimiento) was converted into an intermediary procurement agency. The agency provides a price reference and hospitals have the option of procuring their supplies either through the agency or directly from suppliers if they can obtain better prices.

**Table 5: Authority to Buy Inputs (Medicines, Supplies)**

<table>
<thead>
<tr>
<th>Government Level</th>
<th>Norms and Procedures</th>
<th>Purchasing Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>All</td>
<td>Bolivia</td>
</tr>
<tr>
<td>State</td>
<td>All</td>
<td>All except Bolivia</td>
</tr>
<tr>
<td>Municipal</td>
<td>All</td>
<td>All except Bolivia and Mexico</td>
</tr>
<tr>
<td>Facility</td>
<td>None</td>
<td>Argentina (in autonomous hospitals), Brazil, Colombia, Chile</td>
</tr>
</tbody>
</table>

**Investments in Physical Infrastructure and Equipment**

Investment decisions have been one of the few activities that have been fully decentralized in many Latin American countries. While this has quickened responsiveness to local needs, it has also created problems in some countries (e.g., Brazil). First, since all three government levels are allowed to invest in infrastructure and have the money (often earmarked transfers) to do so, there is a tendency to over-invest in infrastructure and equipment. Typically, there is no explicit charge for rental of capital and equipment or for depreciation, so there is no countervailing incentive to use capital productively. Secondly, where states and municipalities have not also been responsible for financing personnel, they have tended to overlook the recurrent cost implications of their...
capital investments. In those countries it is thus common to find empty health care facilities because the central government has not filled the new staff slots and vacancies due to central budget constraints. The central government has even been reluctant to allow municipalities and/or community organizations to fill out those vacancies for fear that those new positions will eventually have to be absorbed in central government payrolls. Finally, limited managerial capacity has constrained the ability of municipalities to effectively maintain and expand infrastructure in countries such as Bolivia.

Table 6: Authority to Make Infrastructure Investments

<table>
<thead>
<tr>
<th>Government Level</th>
<th>Primary Health Care</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td></td>
<td>Chile (with input from Health Regions)</td>
</tr>
<tr>
<td>State</td>
<td>Mexico (sanitary jurisdictions)</td>
<td>Argentina, Mexico, Chile (for limited investments)</td>
</tr>
<tr>
<td>Municipal</td>
<td>All except Mexico</td>
<td>Bolivia, Brazil (with some State co-financing)</td>
</tr>
<tr>
<td>Purchaser-provider split operated</td>
<td></td>
<td>Colombia (with State &amp; Central co-financing)</td>
</tr>
</tbody>
</table>

A Summary

As judged by the generally low degree of autonomy and authority at the subnational and facility levels over critical inputs, the extent of decentralization in most Latin American countries has been limited. Subnational governments and facilities tend to have such a limited control over personnel that it may be impossible to effect substantial changes in quality or efficiency. They are limited in their ability to reduce (or increase staff), change staff mix or introduce reward systems to attain efficiency gains, change service composition or quality. Although states, municipalities and even facilities have considerably more liberty for investment decisions in infrastructure and equipment than they have for personnel, they are often constrained because there are no positions to operate new facilities, adding to unused infrastructure and waste. The situation is, however, not uniform; those countries that have granted public providers some measure of management autonomy have had some success handing over control over inputs (infrastructure, supplies, use of proceeds from sale of services) to providers, except, characteristically, the ability to hire and fire personnel. In Colombia, Argentina and Chile, providers are theoretically able to use part of the proceeds from
the sale of services to insured patients to give productivity bonuses to their staff. Providers and local jurisdictions in some countries have come up with creative solutions to circumvent the labor management rigidities they face; one such example is that of the municipality of Medellín which has helped hospitals to get rid of excess staff by offering them severance packages.

III. Implementation and Results of Decentralization

Obstacles to Decentralization

The implementation of decentralization has been a slow stop-and-go process. Some of the reasons have been political in that directly affected interest groups, such as health sector workers, have seen decentralization as a threat to their union power and as a way for the government to divide them. In most cases, health sector workers have agreed to decentralization / deconcentration only after receiving assurances (usually by law) that labor code regimes and associated benefits are maintained for themselves and often for new staff as well.

Other reasons have been economic. During the eighties, when many of these reforms started, there was an acute economic crisis in Latin America. Decentralization reforms cost additional money because, at least initially, there is some duplication of expenditure (central government employees are rarely transferred to other locations for example), there is a need to rehabilitate hospital and primary health care networks, and personnel must be trained. Decentralization and other reform efforts had to be halted due to the acute budget constraints that many countries faced. In Mexico, for instance, while the initial effort started in 1983 with 14 states, only in 1988 were the remaining 18 states decentralized.

Where more radical decentralization reforms have been planned (e.g. Colombia), the cost of accumulated pension benefits for health workers has been an important obstacle. Under planned reforms, states take charge of all personnel and payroll (under national civil service codes) and pension benefits. The central government promises to pay all accumulated pension benefits up to the moment of the transfer or when the decentralization law was enacted. Yet, very few countries have been able to make actuarial calculations of these benefits and to pay them as promised.

One other reason for delayed and incomplete implementation has been the reluctance of central planning bureaucracies to trust management at subnational levels. Because of the perception that
Subnational governments are incapable of receiving and providing health services, the national government imposes cumbersome and largely unnecessary certification requirements before a subnational government is devolved the responsibility for service provision. Furthermore, those certification requirements are never clearly specified with respect to content, dates and process, but are left to the interpretation of central government bureaucrats, leaving ample room for discretionary practices and negotiations, and for stopping the process with a change of Minister or other policies. In Brazil and Colombia, for instance, certification requirements include: a detailed yearly health operation and investment plan, the development of an information system, the incorporation of health personnel into state or municipal payrolls, and a working referral network.

To the perceived lack of capacity, one must add the issue of the real lack of capacity of subnational governments, especially municipalities, to carry out delegated responsibilities. In Bolivia, for instance, over half of the investment plans are not executed (Hartmann, 1999). The problem with capacity is that few if any health workers are transferred to subnational governments to help them meet their new responsibilities, and little is invested in training for those with new and unfamiliar managerial and technical responsibilities.

In some countries, there has been a lack of interest of subnational governments, with the exception of municipalities, to receive the new responsibilities. This lack of interest results, to a large extent, from the fear that the central government will not fulfill its financial obligations and fears of having to deal with powerful health sector unions. In Argentina, these fears currently also apply to hospitals that are in the process of obtaining autonomy from the provinces. Municipalities have been much more enthusiastic about receiving health care, especially responsibilities for investment, because they have received new transfers without the responsibility for actual service provision. With the exception of Chile and Brazil (for municipalities under complete decentralization) municipalities share the responsibility for primary health care service provision with the state and the central government, typically without the power to manage personnel, (Colombia, Mexico, Bolivia) so that the accountability structure for service provision is blurred. At each level of governance the other level can be blamed as a bottleneck preventing the system from functioning well.

To this list of reasons why decentralization has not progressed smoothly, it may be necessary to add that of an incomplete strategic framework with a mismatch of instruments to objectives, therefore requiring frequent halts and backtracking. After a few reform iterations, Colombia and Brazil seem to have settled for the following matching of objectives with instruments: achieving higher responsiveness and efficiency may necessitate the corporatization or privatization of the
provision of certain health services; equity objectives may best be achieved by directly subsidizing the poor; and cost-containment may require devising appropriate provider reimbursement mechanisms. Argentina, after more than a decade of political decentralization, is supporting the provinces to autonomize hospitals and shift subsidies to the demand side. Chile chose a similar path whereby the preferred strategy for effective delivery of private health goods for the middle and upper income groups was the creation of private insurance funds that contract for the most part with private providers. Provision of services for the poor, however, continues to be done in the public sector, and is financed for the most part on an input rather than an output basis. Chile has maintained a system that delivers public goods through decentralized public entities.

In Bolivia, Mexico and, to a large extent, Argentina, decentralization has been driven by extra-sectoral considerations (democratization, sharing of power with subnational levels, reduction of fiscal burden) rather than as an instrument to achieve specific objectives within the health sector. The decentralization efforts in the sector have consequently sometimes appeared misdirected. It is difficult to imagine that sharing responsibility for factors of production between levels of government, such as in Bolivia, is conducive to improving the delivery of health services. Decentralization in Mexico and Argentina, which has consisted in transferring resources and responsibilities down one level of government, is equally unlikely, on its own, to improve service delivery or contribute to contain costs. It is likely to worsen equity unless the federal level retains a role in equalizing resources (financial and human) across states. The recent attempts to create a purchaser-provider split in Argentina, in Colombia, and within Mexico’s social security system are perhaps indications that policymakers are coming to terms with the limitations of political decentralization for improving the delivery of services.

In a perverse way, the form of the initial decentralization can interfere with efforts to improve the service delivery dimension. Shifting hospital and other assets to the state and local levels, along with the investment budget, provides lower level politicians instruments that can be and are put to use for political purposes. Failing also to fully shift control of some inputs, management, and strategy decisions to the same level blurs accountability for results and further distorts political incentives because blame for failures can be shifted. In Colombia, for example, subnational politicians have successfully resisted or slowed elements of the national reform to improve accountability of services to clients (by splitting provision from financing) because of their desire to retain control over hospitals and budgets.
The Consequences of Decentralization

The impact of political decentralization on equity, efficiency, costs and quality of care has not been documented in a comprehensive or systematic way. Many countries report increases in coverage of services, especially of primary health care. It is not clear, however, whether this is the product of greater responsiveness to local needs caused by decentralization or simply because of increases in health expenditures that have occurred independently but concurrently with decentralization.

In a few cases political decentralization, especially to municipalities, has allowed increased community and NGO participation in service provision and establishment of collaboration arrangements between municipalities and those organizations. In Brazil, for instance, the Family Health Program (Programa de Saúde de Família) - which is based on interdisciplinary groups of a nurse, a physician, an auxiliary nurse and 4-5 community health leaders, providing primary health care services to groups of 800 to 1,000 families - operates quite successfully. In Mexico, over 22,000 health committees having been created by 1998 to oversee health provision and participate in health campaigns and training. In Bolivia, vigilance committees and grass-roots organizations supervise health provision and municipal expenditures at local level, although it remains to be seen if these committees are really effective.

Decentralization reforms seem to have resulted in a heavier fiscal burden. To a large extent this has resulted because formula-based transfers to municipalities, and, in some cases to states, have been made, in part for political reasons, with new monies rather than with reallocations from existing health expenditures. In Colombia, for instance, municipal transfers, a large part of which has to be spent on health investments, were created by constitutional mandate in 1991 as a fixed percentage of national revenues. In Bolivia, municipal transfers created by the Popular Participation Law are a fixed percentage of government revenues and represent additional resources for social services, including health. Another source of increased net expenditures on health are the budget allocations to pay subnational governments for increased salaries of health staff and accumulated pension and other benefits. Overall, increased expenditures in health have represented over 2% of GDP in some countries (Bolivia, Colombia), although not all the increase can be attributed to decentralization per se.

One practical problem that resulted from decentralization processes that divided responsibilities between government levels – with hospitals devolved to states and primary health centers to municipalities – is that it complicates the workings of the referral system, however well it might or might not have functioned previously. This occurs to a large extent because the financial transfers
for states and municipalities are usually disconnected, with both receiving direct transfers, often formula-based, from the central level to meet their specific service responsibilities.

The coordination-intensive decentralization process may be hampered by the absence of reliable information systems to monitor progress and/or signals of trouble in coverage, quality of service and efficiency. Quality and coverage indicators, when available, are indeed often unreliable. Reports of inefficiencies and misuse of funds come from the press rather than from reliable information systems. This situation is unsurprising insofar as a decentralized system may simply not produce much information because the information has little value where there are few transactions involving money, little competition, almost no incentive to regulate effectively, and decisions and resources are dictated from above. Decentralization or, for that matter any reform that multiplies the loci of decisions (autonomization, corporatization, privatization) increase the numbers of transactions, independent decision-makers, and alternatives to consider at each level. Providers who derive resources from the sale of services can no longer survive without precise and up-to-date information on their cost structure and revenue prospects, and because the public sector needs information to make sure that service and financial standards are being complied with. The amount of information generated is therefore endogenous to the system in place and the incentives it creates. It is therefore not surprising that the information systems that are in place in a centralized system fall far short of the information needs in a decentralized system. Complaints of inadequate information may therefore, paradoxically, be a sign of some success in decentralizing, which is not to reduce the urgency of solving the problem.

IV. Conclusions and Recommendations

Conclusions

- Decentralization in Latin America has often been promoted for a variety of political reasons (furthering a democratization process, reducing the pressure for power sharing from regions, or following constitutional mandates to increase transfers for subnational governments), and in the belief that decentralization would improve allocative efficiency, accountability, equity, quality, and contain costs. In other words, decentralization is viewed as if the only policy decisions were those of political and financial decentralization (from cell D to E and F in Table 2 above). This approach could apply fruitfully to public and quasi-public goods in health, but not necessarily to personal services that are directly managed by governments or social security institutes. Neglecting the critical issue of separation of financing from provision narrows the policy
toolkit to political and fiscal decentralization, neither of which may be a sufficient instrument to increase the efficiency of service delivery. In effect, political decentralization in most Latin American countries has left management practices and operation of hospitals and primary care networks largely untouched.

• Political decentralization has granted management autonomy to subnational levels only in partial ways. It has provided more liberty and flexibility to subnational governments in procurement and in investment decisions. While this flexibility has provided room for responding faster to health services needs and infrastructure, it has also contributed to duplication and waste as expenditure coordination among government levels has been difficult. New infrastructure and equipment provided by states and municipalities has often sat idle for lack of staff to operate it.

• The division of management responsibilities over inputs among different government levels that has come with political decentralization has had a negative effect on accountability. Responsibility has been devolved, some elements of management have been devolved, some financing has been devolved, but accountability has been dispersed in the process because these are partial devolutions. Nobody, except perhaps the national government (the provincial government in the case of Argentina), is fully accountable for service provision (amount, quality, opportunity).

• Financing mechanisms for hospitals and primary care networks have not changed with political decentralization. Most service centers continue to be funded based on historical line-item budget allocations with no relation to production or service quality. Only those countries that are attempting to operate a switch to demand financing have been experimenting with provider payment systems that link financing to production, such as fee-for-service or DRGs (Chile, Brazil, Colombia).

• There are signs that decentralization can bring important benefits at the primary health care level. Decentralization seems to have been accompanied by a net increase of resources available at primary level. More importantly, municipalities are able to customize public health programs (surveillance, immunization) to the needs of the community and better target services to the poor within their jurisdictions by involving communities and NGOs.

• A few countries are moving towards increased public hospital autonomy – Colombia in particular, and Argentina to a limited extent. In those countries, a link has begun to be made between financing and production, the structure of accountability is clear, and equity issues are
resolved by subsidizing needful patients and not facilities. An important and unresolved issue in those countries is whether hospital autonomization is sufficient to induce a change in behavior and increase efficiency. It is argued that deficits or debt incurred by autonomous hospitals end up being paid by central and or subnational governments. To the extent that autonomous hospitals do not face credible budget constraints, it is sometimes argued that corporatization or privatization might be preferable to improve the efficiency of service delivery. The experiences of Colombia and Argentina will need to be closely monitored to see whether hospital autonomy indeed improves efficiency.

**Recommendations**

Several basic recommendations are suggested by this range of experiences, however partial or narrow the decentralization has been.

- More direct attention should be paid to the question of how responsibilities and financing for health goods with high externalities should be distributed across political entities, recognizing both the benefits brought by local customization of public health programs to meet local demands and the need to meet minimum national standards. If such programs are decentralized, the benefits of equalization grants to raise service levels in poorer jurisdictions are compelling.

- The effect on accountability of differentially devolving responsibilities, financing, and control over inputs to sub-national levels needs to be corrected in countries that have already partially decentralized or deconcentrated, and the connection between new privileges, responsibilities, and accountability must be carefully designed into future decentralization plans.

- The role of the public sector in a decentralized system should be revisited critically. Careful attention needs to be paid to the three dimensions in Table 2 – financing, central versus local governance, and provision. Within this framework, it is probably preferable that the public sector create a hierarchy of interventions: adequate finance for public goods (probably at a much higher level than in most countries today); an intensive effort to provide information to governments, providers, and consumers; regulation as a substitute for financing and ownership; financing to correct inequities [preferably through subsidies that follow users and adequate financing in rural areas where health services cost about 20% more than in urban areas (World Bank, 1995b)]; and as a last resort, direct provision. In general, provision can probably be contracted out or privatized if this can be accomplished within an adequate regulatory framework, with reasonable transactions costs and considerable development of public information and accountability systems.
This is a very large if and requires sequencing and financing for the various processes involved. The benefits are probably considerable, the costs of acting are considerable, and the costs of doing nothing are probably considerable as well but difficult to observe.

- If the ultimate aim is autonomization/corporatization/privatization of public hospital services, political decentralization may not be a good transition because it may simply shift resistance to change to local interest groups.

- On the issue of labor relations, the solutions developed so far have not been effective. Difficult decisions need to be made up front in this area, and investment should be made now in attempting to discover options that have not been widely used that could increase the flexibility of localities in managing the cost of labor inputs.

- Establish clearly and unequivocally the cost of the services under the responsibility of states and municipalities and develop financing mechanisms to allow the states and municipalities to pay these costs, while creating incentives for them to reduce costs and improve services.

- Determine the financing mechanism by which resources will be transferred to states and municipalities to finance their responsibilities. Formulas are essential so that the transfer is done transparently and predictably. A large per-capita component in the formula (based on the cost of financing a minimal package of services per person) is a good option, but there must be allowances for correcting equity problems and providing adequately public health programs, which may vary across jurisdictions.
Annex A²: A Synopsis of the Decentralization Process
in Six Latin American Countries

Argentina

Decentralization of health services in Argentina both in the territorial/political sense and in the economic sense is quite advanced, judging by the proportion of the health budget that is executed at the subnational levels and by the decision powers that have been transferred to the provinces. Only about 14 percent of health spending in the public sector is done at the national level; 70 percent is done at provincial and another 16 percent at the municipal level. Less than one percent of inpatient facilities are administered by the national health authorities, some 70 percent are administered at the provincial level, and 20 percent at municipal level (Gonzalez-Prieto & Alvarez, 1999).

In addition, the public sector is not the most important financier or provider in the health sector. The public sector provides health coverage to about 46 percent of the population and accounts for about 23 percent of total health spending in the country. The social security system (based on the so-called “Obras Sociales”) provides coverage to 47 percent of the population and accounts for 35 percent of health spending. The private sector covers 7 percent of the population and accounts for 42 percent of health spending (insurance and out-of-pocket). The public sector owns about 37 percent of health facilities and 54 percent of hospital beds, while the private sector owns 61 percent of health facilities and 43 percent of hospital beds (Gonzalez-Prieto & Alvarez, 1999).

The first wave of political decentralization in Argentina (1978) was understood as decentralization to the provincial, rather than the municipal level. The drive for decentralization was to alleviate the fiscal burden at the central level, rather than a quest for efficiency or equity. Responsibility for running health facilities and budget were transferred to the provinces. The resources transferred from the federal to the provincial level were not earmarked for the health sector; provinces could therefore choose how much they want to allocate to the health sector from their own budget and from the federal transfers.

The early 1990s brought a second wave of decentralization with the transfer of the last federal hospitals to the Municipality of Buenos Aires, and the transfer of some provincial health responsibilities (especially primary health care) to the municipalities and, importantly, the emergence of the concept of the autonomous public hospital (HPA). The scope of autonomy of these hospitals includes their ability to bill Obras Sociales and private health insurers for services provided to their beneficiaries and to retain a part of their earnings. This ability has been the drive for the different provincial decentralization laws or decrees. In other aspects, the provinces have

² The countries case-studies in this annex borrow loosely from the CEPAL report.
adopted different models and paths so that the degree and form of decentralization differs widely from one province to the other.

In general the decentralization resembles more deconcentration because it does not include the transfer of human resources or a legal framework for autonomy. Only the province of Salta envisages a transfer of assets and personnel to the hospitals. Salta had even envisaged that the hospitals would be privatized, but eventually decided to maintain their hospitals under public law. Two provinces, on the other hand, (Córdoba and Neuquén) have chosen not to go down the path of hospital autonomy, invoking the fear that decentralization would (a) lead to coordination failures and inefficiency (duplication of facilities and equipment); and (b) to discrimination against the uninsured population (which do not provide income) and in favor of the insured one as hospitals become more dependent upon reimbursements from insurers. The low level of autonomy effectively achieved in those provinces that have joined the hospital autonomy program is attributable to similar fears and to worries that decentralization would increase the public deficit (the province being the residual claimant), would provoke strong opposition from labor unions, and would reduce the political power of the province. In a few cases, provinces have tolerated the adoption by some hospitals of some degree of autonomy, in the absence of the legal framework allowing it (e.g., Perico hospital in Jujuy). (Gonzalez-Prieto & Alvarez, 1999). Annex B summarizes a study that was carried out by Prieto et al. in 1999: they looked at the extent of decentralization in 19 public hospitals against 9 criteria. They conclude that only one hospital (that was created as an autonomous entity) is close to being a totally decentralized unit.

Innovations such as public health insurance for financing health services to the poor and management contracts between the province and its hospitals are currently being implemented, and will help achieve the separation of financing from provision. The success of this system hinges upon health providers behaving in a more business-like fashion. Hospital autonomy seems to be as far as most provinces currently and hesitantly willing to go to obtain such behavior.

**Bolivia**

The public sector provides coverage directly to about 30 percent of Bolivians, and through the social security system to another 14 percent. The private sector provides coverage to some 30 percent of the population. The remaining 26 percent either have no access to services or use traditional medicine (Ruiz Mier & Guissani, 1997).

Decentralization in Bolivia has been used as an instrument of democratization. After a number of failed efforts in the 1980s, the process was precipitated by the so-called ‘popular participation law’ of 1994 that provided for the recognition of 311 municipalities. This law also transferred property rights of health centers, medium and high-complexity hospitals, including national reference hospitals, to the municipalities. The transfer of responsibilities included those of infrastructure maintenance, equipment, and the supply of inputs. The process was furthered with the administrative decentralization law of 1996 that transferred some personnel administration
responsibility to the departmental level. The central ministry, however, continued to be responsible for personnel recruitment and firing, and for negotiating salary levels every year with health sector unions. Decision on the number of staff, both administrative and medical, allocated for public health centers is determined centrally and municipal governments do not participate in the decision-making process. A new public health model was implemented in 1996 with a view to update the public health system to the new legal framework, actors and to the current public investment strategies.

One of the particularities of the Bolivian experience of decentralization has been the sharing of roles and responsibilities between the municipal and the departmental levels. While many countries have delegated primary health care to municipalities, higher-complexity health care to departments, the demarcation line in Bolivia has been along the control of particular types of inputs. The municipalities are thus responsible for the maintenance and equipment of the health infrastructure, while the departments are responsible for personnel administration. In this model, municipalities and departments therefore each have control on some of the factors of production and close vertical coordination is needed to ensure effective service provision. Municipalities and departments additionally have to coordinate up with the national ministry of health, which plays a regulatory role and is responsible for the administration of essential drugs, and down with the local communities to ensure local concerns are factored in (CEPAL, 1998). Local health directorates have been created in an attempt to effectively achieve coordination between all the players in the health sector; these are formed by representatives of the municipal government, of the departmental health directorate, and of the local community. The mandate of these directorates includes preparing and proposing annual operational budgets and investment plans for the health sector to the municipal government, negotiating health personnel, and proposing and negotiating health service provision agreements with different actors. To date, these directorates have fallen short of this goal and the coordination failure prevails; all three levels of government have a stake in service provision so that accountability for quality and coverage is diluted.

The decentralization efforts have increased spending at local levels and allowed municipalities to invest more in the maintenance and operation of the health facilities. Only about 12 percent of health spending is done at national level; some 62 percent are done at the departmental level, and the remaining 26 percent at the municipal level. The major source of fund for the health sector remains transfers from the central level. This transfer-based financing system limits the actual degree of autonomy and control over inputs at subnational levels. The new model has also actually diminished financial autonomy at facility-level: facilities have lost their autonomy to municipalities that now manage the user-fees collected by the facilities. Financial autonomy at facility level has also been reduced with the implementation of the Maternal and Child Insurance (1998). Public health providers, which are required to provide free care to pregnant mothers and children under five years of age for diarrhea and respiratory diseases, are typically inadequately compensated for these services by the municipalities.

While there has been a definite transfer of responsibilities to the lower administrative levels in the health sector, there has been little progress made to separate the financing from the purchasing
functions. Apart from the Maternal and Child Health Insurance and the Old Age Medical Insurance, health purchasers are not clearly identified. The type and scope of services to be provided are not clearly determined leading to a disconnect between demand and provision. Health providers, for their part, are not given the instruments to behave in a more businesslike fashion: indeed, the last few years have seen a reduction in the degree of autonomy of the health facilities to retain payments for services provided, and to decide upon resource allocation and medical inputs.

**Brazil**

The decentralization process in the health sector was initiated in the late 1970s. The initial efforts were aimed at optimizing the use of resources in the health sector, integrating the public sector, reducing power at central level, and strengthening subnational levels. Parallel to the decentralization process, efforts were made to integrate the social security institute that provided health care to urban formal sector employees and their dependents with the ministry of health that provided health care to rural uninsured workers and indigents. The integration was achieved in 1988 with the establishment of the single health system (SUS).

Unlike Argentina and Mexico, decentralization in Brazil is primarily a municipal affair. The process of enabling municipalities to manage their own health system has been very gradual and has involved a formal qualification process. By December 1996, 137 municipalities, accounting for 16 percent of the Brazilian population, administered their own health system. These, mostly urban, municipalities administered some 20 percent of hospital expenditures of the SUS. Another 2,300 or so (or 42 percent of the total) municipalities had gained ‘incipient’ autonomy which allowed them to participate in planning activities and licensing private providers in their territories; their ambulatory and hospital care budgets were, however, still prepared and approved by the federal government. For their part, states are responsible for reviewing policy implementation, for monitoring and evaluation systems and for providing technical and financial assistance to municipalities in their jurisdictions.

In practice, the decentralization process has suffered from a number of shortcomings. The reimbursements to public and private providers have been substantially lower than the costs of services (especially for preventive care). Private participation in the SUS is decreasing as a result of the discrepancy between costs and reimbursements. The expansion of private health plans is also contributing to divert private providers away from the SUS. Municipalities, for their part, receive insufficient transfers (US$12 per year per capita) to provide the package of primary health care services, surveillance and control of communicable diseases, and sanitation. Decentralization has not altered the fact that most of the funding for the health sector is still from the federal level in spite of the fact that states and municipalities have increased tax revenues considerably following the 1988 Constitution. The decentralization process has also been hampered by the fact that the design is complex, especially regarding the pre-requisites and certification requirements before autonomy is granted to municipalities.
Notwithstanding the numerous shortcomings of the system, the health system in Brazil has definite virtues. The purchasing side is integrated (reducing the scope for cream-skimming); the purchasing and provision functions are separated; the provision of private health goods is largely done by the private sector (private providers account for over 70 percent of publicly-funded hospital admissions); and the financing of public goods, goods with externalities and "equity goods" (basic health measures, nutrition, epidemiological and sanitary surveillance, etc) is central, although their delivery tends to be through federal agencies rather than municipalities. Another interesting characteristic of the Brazilian system is the fact that hiring of personnel is done at state and municipal rather than federal level.

**Chile**

The decentralization process in Chile that was initiated in the early 1980s was part of a wider reform process that aimed at introducing market mechanisms in the health sector, at redefining the role of the State, and at decentralizing primary health care to the municipal level (Chile is organized as a unitary system with two government levels: the central government and municipalities). To that effect, primary health care facilities and personnel were transferred to the municipalities while public hospitals were transferred to the twenty-six quasi-autonomous health service units. One of the significant aspects of the reform has been the change in the mechanism for financing public health providers from historically-based budget allocations to financing according to the quantity and quality of services provided. The financing system for municipal health services was changed from a fee-for-service to a capitation system in 1994. Simultaneously the development of private health insurance was encouraged: private health funds were allowed to operate and collect compulsory payroll contributions to provide private health care.

The issue of the payment of hospital personnel has somewhat hampered the efficient implementation of these mechanisms. Personnel are paid according to fixed payrolls, following pay scales and personnel administration rules that are established by the ministry of health. With the introduction of new payment systems (payments by DRG and prospective payments), it was expected that personnel services could be included in the fee schedules. This has, however, been difficult to be implemented. Currently hospitals continue being paid by a combination of supply and demand financing. The issue of primary health care personnel was solved differently. Their transfer to the municipalities led to their losing their civil servant’s status. Henceforward, primary health care workers would negotiate their work conditions directly with the municipalities. In the recent years, however, there has been some pressure from the labor unions to re-centralize the personnel hiring and management functions (CEPAL, 1998).

While municipalities have relatively more control over inputs than in other Latin American countries, their autonomy is constrained by the fact that the ministry of health determines to a large extent their primary health care spending. The municipalization of primary health care delivery in
Chile has nonetheless been considered a success that owes much to the continued commitment of the ministry of health to primary health care, the clear definition of responsibilities for municipalities, the simplicity of the outputs to be delivered, the clarity and simplicity of payment mechanisms, and the improvements in municipal administrative capacity.

As a result of these reforms the health system in Chile was transformed in several important ways: the share of people covered by private insurance plans had increased substantially (to about 27 percent of the population in 1997); the proportion of hospital beds in the public sector had decreased from 90 to 75 percent; and there had been a significant expansion of rural health post infrastructure and equipment. Although measures of efficiency are not readily available, there are clear indications that public hospitals are performing better (average hospital stay down, occupancy rates above 75 percent, etc.).

The health sector reform in Chile indicates a judicious use of decentralization. Decentralization is not seen as the principal instrument to increase efficiency in the delivery and financing of secondary and tertiary care. For that purpose, a partial purchaser-provider split is sought instead. Decentralization of inputs and responsibilities to lower levels of government is, on the other hand, seen as an apt instrument to increase the efficiency of provision of public goods, goods with externalities and of equity goods.

Colombia

Over the last 30 years, health sector reforms in Colombia evolved from a focus on deconcentration (1960s) to the decentralization/devolution and privatization (1990s) of service provision. Since none of these reforms was ever fully implemented, the current situation inherits a little from each of the earlier phases. Devolution started in 1990 when the ministry of health mandated the transfer, over a five-year period, of primary health care facilities, personnel and budgets to municipalities and of secondary and tertiary hospital care to departments. The transfer ran into implementation difficulties (burdensome certification requirements, insufficient resources to pay for the cost of decentralization) and only a handful of municipalities took over their responsibilities.

The decentralization process was furthered with the law 60 of 1993 (Ley 60). Transfers to departments for health and education subsequently increased in a significant manner (from 15 percent of government revenues in 1993 to 24.5 percent from 1996 onwards). These transfers are administered autonomously in those departments that have been certified. Transfers to municipalities for health, education and other infrastructure expenditures increased from 15 percent of the central government’s current revenues in 1994 to 17 percent in 1997 and is expected to increase to 22 percent by year 2001. The main problem that has been identified with these transfers is that they bear little relation to local health needs or to the costs of services.
In the midst of implementation of the decentralization reform, a more radical reform was enacted at the end of 1993 (Ley 100). The reforms adopted a strategy of separating financing from the provision of services; promoting competition among insurance suppliers and among service providers; providing direct targeted subsidies for the poor; and aiming at providing health services to the population irrespective of ability to pay. Two insurance regimes were created to implement the solidarity principle: a contributory regime designed to cover salaried and independent workers and a subsidized regime for the poor (a direct subsidy to pay for a basic package of health care services).

The decentralized character of the new system is situated in the fact that the subsidized regime is administered and financed through municipalities (CEPAL, 1998). The latter are responsible for the identification of poor beneficiaries, for affiliating the beneficiaries with a private or public health insurance company (ARS, Administradora del Regimen Subsidiado); and for authorizing the payment of the corresponding premium to the ARS. Other decentralized features of the system include the devolution to departments and municipalities of a number of financial, organizational and personnel responsibilities, with departments having achieved a greater degree of autonomy than municipalities. The area of slowest progress has been vis-à-vis personnel management: the margin of maneuver for renegotiating salary levels and employment conditions has been almost nil. Hospitals were converted into ‘Autonomous Social Enterprises’ and hospital financing is shifting from the supply to the demand side - but progress has been slow. The process of hospital autonomization has been hampered by lack of clarity as to: who will pay the pension debts and within what time-frame; and the conditions, including the state of the infrastructure, under which hospitals will be transferred.

The decentralization efforts in Colombia have been far-reaching and have brought about radical changes in the incentive structure. Among the pending issues are the fact that financing is done through transfers to states and municipalities, and is somewhat unrelated to specific health needs and costs, and the fact that because of political pressures from health workers, public hospitals have had difficulty implementing the switch to demand financing.

**Mexico**

The public health sector in Mexico consists of several entities. The Ministry of Health (SSA) is responsible for the definition of health sector policies and the regulation, supervision and strategic planning for the health system, and for the provision of health care for the uninsured population (currently about 42 million people) through its own extensive network of health facilities. Alongside the ministry is the Social Security Institute (IMSS), which provides comprehensive health insurance to some 41.5 million people through its own provider network; 67 percent of IMSS health insurance revenues come from payroll taxes and 33 percent from general taxation.

Another insurance scheme, jointly funded by the SSA and IMSS, brings coverage to an additional 11 million people, mostly in rural and indigenous communities. Parallel social security schemes
exist, such as those for the public employees (ISSSTE), and for the national Oil Company (PEMEX). The private sector, both on the provision and financing side, is small but growing. Currently some 2 million Mexicans have private health coverage.

The decentralization efforts, initiated in 1983, constituted an effort to share political power with the state governments, to reduce the fiscal burden at central level, to rationalize the supply structure and to improve management. The process was a gradual one, involved only 14 of the 32 states, and was limited in its scope. The process did not involve either health jurisdictions or health facilities. Resource allocation autonomy at state level was limited to revenues obtained locally. Budget execution remained highly centralized: the share of their budget that was executed at state level, was sensibly the same for decentralized states (24 percent in 1995) and for those states that had not been involved in the process (21 percent in 1995) (CEPAL, 1998). The period was characterized by rival efforts by IMSS to deconcentrate (more with an eye to self-preservation than to promote devolution).

With the advent of the Zedillo administration in 1994, decentralization was back on the agenda. The sectoral motivations were to increase coverage and improve the quality of care for the uninsured population, and the wider political motivations were to increase the efficiency of public administration. The second phase of decentralization was initiated in 1996; it differed from the first one in that it involved all of the states, and made the sharing of roles and responsibilities between levels more explicit, but resembled it in that decentralization did not reach the level of health jurisdictions or facilities.

The second phase of decentralization brought about the creation of ‘decentralized public organisms’ (OPDs), which are semi-autonomous state agencies whose governing board includes the state governor, a representative of the federal ministry of health, a trade union representative and the state health minister. Clarity has been achieved in a number of areas: resources from the federal level to the states are allocated according to well-established criteria; the transfer of human resources from the federal level to the states has been negotiated with the national union; infrastructure, goods, and equipment have been transferred to the states; and municipalities have been given limited responsibilities in the areas of planning and infrastructure. Monitoring and conflict resolution are done by the National Health Council.

With the reform, the states became accountable for all health care services for the uninsured population, and obtained control over the execution of its health budget. The decentralized budget increased from 4.8 million pesos in 1995 to 16.4 million in 1999. The functions of the federal ministry of health were concomitantly redesigned and its normative and planning role strengthened. Spending at the federal ministry level decreased from 12.2 million pesos in 1995 to 9.5 million in 1999.

IMSS has been involved in parallel deconcentration efforts, with the creation of 7 regional directorates in 1995, and 139 medical zones in 1997 (each providing health care to a population between 100 and 200 thousand people). These medical zones are expected to evolve into
budget-holding ‘medical areas of autonomous management.’ So far deconcentration has fallen short of the planned full management autonomy in such areas as personnel, procurement, equipment, infrastructure and maintenance. Plans for the current and the next few years however hold promises of a purchaser-provider split, involving the development of the purchasing function within IMSS, and the introduction of reimbursement to providers through risk-adjusted capitation and DRG systems.

The political decentralization process within the SSA began in the early 1980s and accelerated in the 1990s; full decentralization at the state level was recently concluded (last State decentralized in early 1999). There seems to be little or no progress, on the other hand, separating financing the purchasing from the provision function. The decentralization process in IMSS has been equally slow but there are more explicit plans to operate a purchaser-provider split. Recent agreements signed with the Ministry of Finance and the Ministry of Auditing and Administrative Development aiming at financial autonomy and commitments by IMSS delegations to sign agreements with specialty hospitals and medical zones represent the initial steps towards this split.

### Organization of health services, 1998

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<th>Characteristics</th>
<th>SSA</th>
<th>IMSS</th>
<th>IMSS - Solidarity</th>
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<td>Tripartite: government, business, and workers</td>
<td>Program within the regulatory structure of the IMSS</td>
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<td>Partial</td>
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<td>Tripartite: federal, workers, and employers</td>
<td>Federal and supported by the IMSS administration</td>
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### Annex B: Hospital Autonomy in a Sample of 19 Public Hospitals in Argentina

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<th>Juridical Autonomy</th>
<th>Hospital Management</th>
<th>Strategic Planning</th>
<th>Administ.²</th>
<th>Procuremt. Inputs</th>
<th>Investmt.¹</th>
<th>Financial¹⁰</th>
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Source: Prieto, 1999

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³ Autonomy if has legal standing as a public enterprise.
⁴ Decentralized if hospital board elected by community and hospital director nominated by board.
⁵ Decentralized if planning carried out by hospital staff and does not require approval by central level.
⁶ Decentralized if administrative guidelines developed by hospital and do not require approval by central level.
⁷ Decentralized if under the authority of hospital board.
⁸ Decentralized if under the authority of hospital board.
⁹ Autonomous when hospital budget comes from sale of services to private and public insurance funds.
¹⁰ Autonomous when hospital board manages staff (price and quantity) according to private law.
¹¹ Autonomous when hospital free to contract with private and public insurance carriers and other health care providers.
References


