



**A Resource
For Managing
Health Sector
Reform**

Issue Brief

Decentralization of Health Systems in Latin America

DDM Issue Briefs communicate important findings of our research on critical issues in health sector reform to key health policy makers, counterparts, and colleagues in the field.

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Decentralization has been welcomed by many as a means of improving the equity, efficiency, quality, and financial soundness of health systems. It has also been feared by many as an invitation to chaos, disruption of effective priority programs, local patronage, and waste. While decentralization is being implemented in a growing number of countries, there are few studies that show whether the advocates or the detractors are right.

The Data for Decision Making Project, with funding from the LAC Health Sector Reform Initiative of the LAC Bureau, has completed an applied research project on decentralization in three countries—Chile, Colombia, and Bolivia—that have recent experience implementing policies in this area. The results of this comparative research can provide useful guidance in evaluating the effectiveness of decentralization.

"Decision-Space" comparisons

The research was carried out with a "decision-space" methodology to determine the range of choice (from narrow to wide) that was allowed to local officials for different functions such as financing, service provision, human resources, and governance. We found that the "decision-space"

varied among countries as well as over time within countries. The tendency was for countries to give wider choice initially, but to reduce the decision space over time. In Chile, for example, municipalities were initially allowed to determine salaries and to hire and fire staff. Eventually, however, many of the national civil service protections were restored, thus reducing the choice allowed municipalities.

In general, greater choice was allowed over contracting of private services and governance decisions, while the decision space for financial allocations tended to be moderate. Human resources, service provision, and targeting of priority programs usually remained centralized. This tended to limit local control over those functions most likely to affect the efficiency of health services.

Performance

In each country we developed a national data base with a minimum of three years of data for municipalities in order to examine the impact of decentralization on equity, efficiency, quality, and financial soundness. The most important and reliable findings were related to changes in equity indicators at the municipal level.



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In all three countries, we found that per capita health spending was increasing during the period of decentralization. In Chile and Colombia, although wealthier municipalities were spending more per capita than poorer municipalities, the gap between them was narrowing over time, resulting in more equitable allocations. In addition, per capita utilization of health services was increasing and the gap between wealthier and poorer municipalities was also declining.

There are three important mechanisms that were likely responsible for greater equity of allocations. In Chile, there is a horizontal equity fund called the Municipal Common Fund, which reassigned up to 60% of the "own-source" revenues from the wealthier municipalities to the poorer municipalities using a formula based on population and municipal own-source income.

In Bolivia, the mechanism is the earmarking of central government transfers to municipalities, which requires that 3.2% of these transfers be assigned to fund a priority benefits package for mothers and children. And in Colombia, there is a mechanism requiring that a minimum percentage of central government transfers be assigned to health in general by municipalities.

Since the formulae in the three countries for intergovernmental transfers were largely based on population, these various mechanisms appear to have resulted in more equitable spending patterns. We also found some evidence that these mechanisms were protecting priority programs. In Chile, the municipalities were only responsible for primary health care, so spending increases did not go to hospital-based care. In Colombia, a proportion of one type of intergovernmental transfer was assigned to prevention and promotion, which resulted in a doubling of per capita expenditures on these programs and a narrowing of the gap between wealthy and poor municipalities.

Conclusion

These research findings suggest that neither the advocates nor the detractors of decentralization policies are 100% right. In most cases, decentralization is neither likely to lead to radical improvement in a health system, nor to produce a disaster. However, forms of decentralization that include mechanisms to improve equity, like the Municipal Common Fund in Chile and the earmarking of central funds in Bolivia and Colombia, can definitely improve resource allocations and utilization.

The range of choice allowed to municipalities is quite limited for certain functions that might be needed to improve performance—such as hiring and firing, payments to providers, and decisions about health service norms. It seems likely that experimenting with wider decision space, and appropriate incentives for guiding those choices might be worth evaluating for their impact on efficiency and quality.

Finally, it is clear that central authorities need more accurate information about what is happening at the municipal level. This will enable them to develop monitoring systems in order to adjust the decision space, incentives, and use of central funding to achieve national policy objectives in health.

For the synthesis study see Thomas J. Bossert (2000) *Decentralization of Health Systems in Latin America: A Comparative Study of Chile, Colombia, and Bolivia*. Boston: Harvard School of Public Health, Data for Decision Making Project/LAC Health Sector Reform Initiative.

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