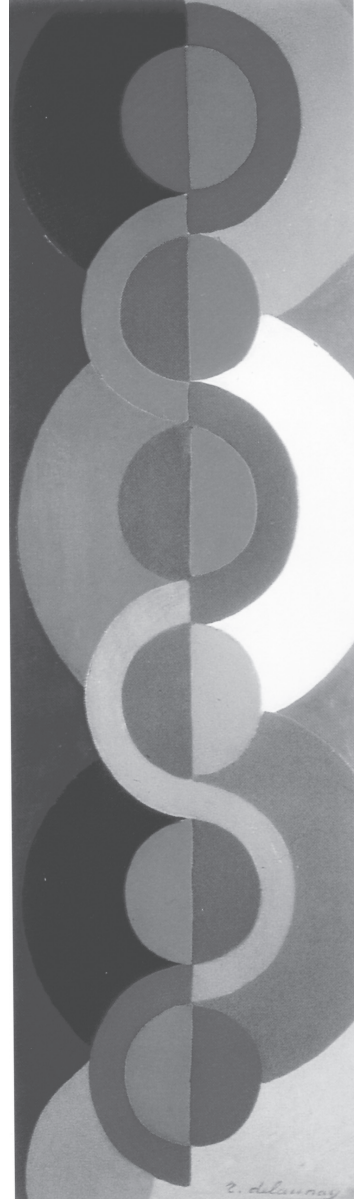

DOSSIER

**DECENTRALIZATION AND EQUITY:
A Review of the Latin America
Literature**

Monica Riutort
Fabio Cabarcas

**DESCENTRALIZACIÓN Y EQUIDAD:
Una revisión de la literatura
latinoamericana**

Monica Riutort
Fabio Cabarcas



Decentralization and Equity:

A REVIEW OF THE LATIN AMERICA LITERATURE

Monica Riutort • Fabio Cabarcas

Fecha de recepción: 10-06-06. Fecha de aceptación: 17-11-06

Abstract

A literature review of published articles were done to set a description of the historical background of health reforms in Latin America and to provide a brief description of the process of decentralization in countries such as Colombia, Brazil, Chile, Mexico and Costa Rica in order to illustrate different tendencies in the transformations of the health systems in the region.

This literature review demonstrated the increasing need of more systematic studies in this area. Although decentralization in theory may be a powerful mechanism to promote equity in health, it may be insufficient or prejudicial in the context of unclear policy intended to promote equity by the state. Moreover, the role of other concomitant phenomena like privatization and shortage of state funding of health must also be discussed. However, the evidence regarding the results of decentralization in LAC is still contradictory and ambiguous. It is not clear that its achievements could reach its intentions of improved equity in health in the region.

Key words: public health policy, health planning and administration, health inequities, equity in health, primary health care, decentralization.

Resumen

Se realizó una revisión de los artículos publicados, con el fin de presentar una descripción de los antecedentes históricos de las reformas en salud en América Latina y así establecer una breve presentación del proceso de descentralización en países como Colombia, Brasil, Chile, México y Costa Rica. De esta forma se ilustran las diferentes tendencias en las transformaciones de los sistemas de salud de la región.

Esta revisión de la literatura reveló la necesidad imperiosa de contar con más estudios sistemáticos en esta área. Aunque en teoría, la descentralización puede considerarse un mecanismo poderoso en la promoción de la equidad en la salud, puede resultar insuficiente o prejudicial en el contexto de políticas inciertas que promueven la equidad por parte del Estado. Igualmente, se debe discutir tanto el papel de otros fenómenos afines, por ejemplo la privatización, como la escasez de fondos estatales en salud. Sin embargo, la evidencia respecto de los resultados de la descentralización en América Latina y el Caribe es aún contradictoria y ambigua: no es claro que sus logros puedan alcanzar sus intenciones de mejoras en equidad en salud en la región.

Palabras clave: políticas de salud pública, planeación y administración en salud, inequidades en salud, equidad en salud, atención primaria en salud, descentralización.



Introduction

The document presented here is a part of a larger paper we are working on that examines equity and the reform of the health sector in Latin American and the Caribbean (LAC), focussing on the experiences gained, the lessons learned, and the strategic opportunities resulting from the reform of the health care sector.

This document is elaborated as a preliminary contribution to the discussion of the effects on equity as a result of the decentralization of the health system in LAC. Decentralization has been one of the key aspects of the health reform.

This document, which is a literature review of published articles, starts with a description of the historical background of health reforms in LAC. Secondly, it provides a brief description of the process of decentralization in countries such as Colombia, Brazil, Chile, Mexico and Costa Rica in order to illustrate different tendencies in the transformations of the health systems in the region. Then, it discusses the impact of decentralization on equity and finally it draws some preliminary conclusions based on the revision of the literature.

Methodology

A thematic review of academic literature on this topic was done. The objective is to prepare materials for encouraging a more sound academic discussion in the division's effort for educating health workers in several countries in Latin America. The selection of articles for this literature review aimed to include studies that evaluate specific results; changes in health equity, reduction or increase in inequities related to the policies of health reform; studies that evaluate policies

of the reform of the health system which have a direct or indirect impact on health equity; and some studies that reported pilot or demonstration projects. This thematic review is part of the ongoing academic activities of the International Programs Division of the Department of Family and Community Medicine at the University of Toronto in Canada.

The databases included PUBMED, Scielops and Journal Health Policy, including articles from 1995 to April of 2005. The keywords included were: Delivery of Health Care, Health Care Reform, Health Services Accessibility, Latin America, Caribbean Region, Health Care Sector and National Health Programs. Some other documents considered relevant to understand the background of the process of reforms are also referenced. Only the most relevant documents are referenced.

Background of the process of decentralization

Health Sector reform has been a, if not the key policy in Latin America and the Caribbean region (LAC) for the past two decades with a number of common ingredients (World Bank, 1993). These include increased limitations on the role of the public sector coupled with new incentives for the private sector and new forms of public-private relations, decentralization, integration of vertical programmes into mainstream delivery, hospital semi-autonomy, greater diversity in the financing of health care, new processes of priority setting and resources allocation, new incentives for health workers, and consumer orientation to service provision and community participation (Green and Collins, 2003). During the 1970's and 1980's, political leaders, users, providers, and researchers were all aware that the health care systems in Latin America had accumulated such a large

number of inefficiencies and inequities that something needed to be done to reverse and revert the increasing users' dissatisfaction, decreasing quality of care, and the need to improve equity and efficiency to the systems (Homedes and Ugalde, 2005).

The International Monetary Fund (IMF) and the World Bank took advantage of the crisis of the 1980's to press Latin American governments to introduce health reform as a condition for borrowing (CEPAL, 1994). This introduction could have responded more to ideological concerns and the interest on international granting agencies and did not include the epidemiological profile, the current health system or the resources and socio-political reality of the country. The World Bank Report of 1993, which was used by many countries as the main document for reform reflected an international ideological shift to neo-liberal or new right tendency. It is widely accepted that the reforms were rarely based on evidence, were top-down and were often externally imposed (Green and Collins, 2003).

Aiming to achieve equity in health through decentralization has been one of the main drivers of the health reform in Latin America. The reforms on the health care system in Latin America have promoted decentralization as a means of achieving multiple objectives, such as improved efficiency, better responsiveness of local conditions and local accountability to community priorities (Livak et al., 1998; Mills et al., 1990).

Often, however, even advocates of decentralization do not claim that these policies are likely to improve the equity of a health system. It is commonly argued that the decentralization of systems are more likely to redistribute resources in favour of the poorest areas and that local control and local financing will disadvantage poor communities

by allowing rich communities to fund more and better health care services.

Another objective of the reforms was to free central government funds to pay the huge public debts; shifting the financial burden of public services from the central government to provinces was an expedite way of accomplishing this. The policy of decentralization was introduced as a measure of democratization where the decision-making power would be shifted from an indifferent and incompetent central bureaucracy to the people, even in countries under dictatorial and authoritarian regimes.

The rationalization for decentralization of health services in Latin America can be summarized in the following points (Arredondo et al., 2004):

- a. Local decision-makers know and respond better to community needs, and avoid costly errors made by distant bureaucrats who tend to be ignorant of local health conditions.
- b. Community involvement in planning and supervision of local services increases participation and supervision of local communities, which in turn promotes democracy.
- c. Local controls and adjustment services closer to local needs contribute to a more efficient use of resources and produce greater user satisfaction.

Equity in health

The International Society for Equity in Health developed definitions of equity and inequity in health care which are now globally accepted:

Equity in Health has been defined as the absence of systematic and potentially remediable



differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically. On the other hand, inequity in health is defined as the systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.

Using the above definitions as a starting point, it is key to point out that inequalities are not always inequities. It has been suggested by Whitehead and others that the term inequity must be reserved for those differences that are unnecessary and avoidable, and also unjust (Whitehead, 1992). Whitehead prompts a number of questions regarding equity. For example, what are the differences that are unnecessary and avoidable? The studies done by Whitehead identify four categories in which the differences in health are unnecessary, avoidable and unjust:

- Differences due to life styles that harm the health of an individual or a social group, where the choices of the individual or the group are restricted.
- Exposure to work environments that are unhealthy and stressful.
- Inadequate access to services, which are essential to health, including other public services.
- The tendency that people who live in the poorest social strata suffer more illness.

There is also a difference that must be made between a population's equity to health and equity in the delivery of health services. The World Health Organization defines equity in health as the notion by which each individual and group must enjoy the highest level of physical, psychological and social well being

that is permitted by biological limitations. On the other hand, equity in the delivery of services means that resources and services of the health sector are distributed and provided according to the needs of the population, and the services are financed according to the capacity of the population to pay.

In a more operational manner, it can be said that when we talk about equity in relation to health status of a population we are talking about levels of mortality and morbidity experienced by the social groups of said population. Equity on health services delivery refers to levels of access, utilization and financing of health services that are experienced by the different social groups.

The differentiation of equity in health and equity of delivery of services is significant for the definition of health policies and programs that promote health. Due to analytical purposes, the results from the theoretical revision have been organized according to equity of resource allocation and equity of access to health services.

Process of decentralization and its impact on some of the countries in the region

Although decentralization can be defined as the transference of power and competences from the central government to peripheral levels of government, this means, changing the place where the decisions are taken and putting them under the control of the community (Guimarães, 2001); this implies a great variety of processes in the different countries of the region. First, different geographic levels can be involved. This includes not only provincial or municipal authorities, but also, on occasion, decentralized institutions or areas as well. In addition, the transfer can imply diverse functions that may include

autonomy of decisions and planning, autonomy of design or execution of resources or possibility of financial fundraising at the local level. Furthermore, the term decentralization can be used to describe autonomy provided to a

service provision unity (Homedes and Ugalde, 2002). Generally, the decentralization process can be characterized by grouping countries into several categories according to the grade of transference of power to the local level.

PROCESS OF DECENTRALIZATION

De-concentration Mexico, Costa Rica	Devolution Chile, Colombia	Autonomy of health care facilities Nicaragua, Peru
<ul style="list-style-type: none"> • Allocation of resources not based on needs. • Regional authorities continue applying allocation criteria based on historical budgets. <ul style="list-style-type: none"> • Public spending on health care has decreased because of structural adjustment programs. 	<ul style="list-style-type: none"> • It assumed region investing additional resources in health care services. • This can be positive if regions have resources but generally limited by region capacity to respond. • In devolution scenarios, inequalities are exacerbated. 	<ul style="list-style-type: none"> • User fees in hospital had different effects on utilization for the different socio-economic strata. • Higher income patient such more hospital (35% to 53% more); lower income used it less (25% to 20% less). • Fees are highly regressive and are known to exacerbate inequity in the use of services.
<ul style="list-style-type: none"> • Allocation of resources not based on needs. • Regional authorities continue applying allocation criteria based on historical budgets. <ul style="list-style-type: none"> • Public spending on health care has decreased because of structural adjustment programs. 	<ul style="list-style-type: none"> • It assumed region investing additional resources in health care services. • This can be positive if regions have resources but generally limited by region capacity to respond. • In devolution scenarios, inequalities are exacerbated. 	<ul style="list-style-type: none"> • User fees in hospital had different effects on utilization for the different socio-economic strata. • Higher income patient such more hospital (35% to 53% more); lower income used it less (25% to 20% less). • Fees are highly regressive and are known to exacerbate inequity in the use of services.

Source: author's design.

Initially, some countries completed a process of devolution, which can be defined as the complete transference of responsibilities to peripheral administrative units including transfer of financial resources (Kalk and Fleischer, 2004). For example, this has occurred in Chile and Colombia, which were the countries that followed more closely the guidelines provided by the World Bank and other international institutions. In both coun-

tries, decentralization has been accompanied by a great transformation of the health sector with increased participation of the private sector and a regulatory role by the state. The functions transferred to the municipal level, which have more decision-making autonomy and resource allocation, are primary health care services (Guimarães, 2001). Additionally, other specific functions were transferred. For instance, administration of



primary level hospital care was transferred to health areas that cover several municipalities in Chile. In Colombia, the administration of the subsidized sector was also transferred to the municipal level. These transferred functions can be contracted by the municipalities with other public or private entities within the country. Furthermore, the allocation of resources is decided by the central level in both countries although, in Colombia the municipalities have the possibility of raising financial resources from fees for services. In this latter country, when the municipalities can not provide, enough administrative capacity, the functions are assumed by the departmental level (Bossert et al., 2003).

In contrast to Colombia and Chile, other countries have achieved a process that can be more clearly defined as de-concentration, which is the transference of the execution of actions from one level of the government to another, without transference of autonomy of decisions. This category includes countries like Costa Rica, which made only few modifications to the previous system. Here, the main form of decentralization was the transference of functions to autonomous entities with decentralized levels. The reform put all provision of health care in the hands of the Costa Rican Social Security Fund (CCSS), leaving the Ministry of Health with supervising and stewardship functions. Health care provided by the CCSS is essentially free of charge for the great majority of the population (Rosero-Bixby, 2004b). The CCSS was put in charge of financing and providing services to the population (Bertodano Id, 2003). In this country, there has been transference of responsibilities in hospital care and primary health care from the Ministry of Health to the CCSS, but without autonomy of decisions (Guimarães, 2001). The privatization has a limited role although some changes in the essence of the reform have been proposed.

Decentralization in Mexico can also be described as de-concentration, but with a different system from that of Costa Rica. Mexico's system is composed of three principal subsystems: (1) a number of Bismarck-type social security institutes that provide health insurance for the formally employed and their families; (2) Ministry of Health's services and limited services from nongovernmental organizations for the uninsured population; and (3) a large private sector that is almost entirely financed out of pocket (Barraza-Llorens et al., 2002). In Mexico, the public sector and social security (including the military services) are responsible for more than 85% of the hospital beds. (Fleury, 2000). There is a mixed autonomy of resources in decentralized institutions with some central resources and some local ones (Arredondo and Parada, 2000). There, the dominant element of the reform was the creation of a single state system of health for the uninsured, which entailed transfer of responsibility for uninsured populations from the Mexican institute for social security (IMSS) and the State Coordinated Health Services of the Ministry to new entities under state authority. The case of Mexico has been qualified as an incomplete or non-existing decentralization in which the states did not gain a significant level of control over even a single aspect of the system, and most of the few new powers they gained have slowly been taken away from them (Gershberg and Jacobs, 1998). Privatization has also been limited. In 1996, Mexico implemented a package of reforms that encouraged decentralization, increasing competency of private institution to the IMSS by establishing a market-driven system for those who are covered by health insurance through mandatory social security or payment and a decentralized system of public minimum services for the poor (Laurell, 2001). These changes point are similar to the type of reform done by Chile and Colombia.

The differences between Mexico and Costa Rica reflect just part of the variety categorized as de-concentration, which adopts other forms in other countries. Brazil, for example, is a special case of the decentralization process in the region. There, the formulation of the reform process was tied to the democratic transition and is an attempt to consolidate a unique, public, universal and decentralized system of health, based on the idea of health as a citizen's right guaranteed by the state, apparently in an opposite route to world-wide dynamics (Almeida, 2002). The system is organized at the federal, state/provincial/regional, and municipal levels. The federal level is legally responsible for formulating and implementing national health policy. It is also in charge of system planning, assessment, and control, as well as resource allocation. Functions at the state level involve service coordination, distribution of financial resources, and decisions related to complex specialized technological interventions. The municipalities are responsible for handling the delivery of goods and services involved in health promotion, preventative care, health care, and rehabilitation. Funds are allocated to each state according to AIH (authorization for hospital admission) billing, always respecting the corresponding quantitative and financial ceilings. (Almeida et al., 2000). The system is composed of three main sub-sectors: 1. The public sector, which comprises publicly financed and provided health services, including services from the federal, state, and municipal levels and the armed forces, which have their own separate health care services. 2. The private sector (profit and non-profit) contracted by the public sector and paid through reimbursement systems, comprised of publicly financed and privately provided services. 3. The free-choice private sector, financed out-of-pocket or by corporate health insurance, comprised of privately financed and privately provided

services with different levels of insurance premiums and tax subsidies (Almeida et al., 2000).

To summarize, the decentralization processes in LAC during the last decades has been characterized by a great variety of reforms that imply transference of functions, resources or responsibilities from the central to the local level. There is a great diversity of characteristics along with simultaneity of other phenomena like privatization. However, there is also a pressing need to document these changes and measure the impact that they have had on the health sector due to the reform.

Effects of decentralization on equity in Health

Access to services

The available evidence in the revised articles suggests that health reforms have had mainly an adverse impact on the equity of access to health between different income groups. There is a gap in the services provided to poor inhabitants in comparison to the rich population, which is described in a great number of countries in the region. Studies on countries like Brazil, Mexico, Guatemala, Jamaica, and Peru coincide with the existence of inequalities in the services offered to rich and poor population (Almeida, 2002).

This tendency seems to have increased mainly in those countries that had a stronger privatization process such as Chile, where different packages of services are offered by private institutions in comparison to the public sector. This induces a segmentation observed in the market both between high- and low-risk individuals and those with higher and lower incomes. Those with relatively lower incomes



and relatively higher risk choose the public-sector insurance system, and thus opt for lower-quality care, because it is much more inexpensive. In fact, there are considerable disparities in the extent and quality of health coverage. In 2002, 3.2% of the patients covered by the private sector were 60 years of age or older, as compared with 12% of the patients seen at public facilities (Manuel, 2002). These differences seem to be more in terms of the quality than the access of services. Rich people are enrolled in private institutions and receive better health benefits. The poor can only afford the public sector with its lower benefits. Use of services (i.e., standardized unconditional expenditure) was very similar across income groups, differing significantly only for the wealthiest quintile (Sapelli, 2004). The government of Chile is in the process of reforming the health system again, giving priority to primary health care and providing an extended package of health services to the most vulnerable sectors of the population.

Health service in Colombia, with similar characteristics to the Chilean system, seems to have a better effect in the access to services of the population although the balance is not entirely satisfactory. Some authors have described a positive tendency that looks as if it were more related with an increment of the coverage of assurances than a real increment of the access to services. In a study held between 1993 and 1997, the coefficient of inequity (CI) for access to insurance decreased from 0.34 to 0.17; simultaneously, coverage increased from 23% to 57%, especially among the poorest segments of the population, where it increased from 3.7% to 43.7% as a result of subsidies provided by local governments. However, the CI for utilization of health care services did not vary significantly (Céspedes-Londoño et al., 2002). Increased disease prevalence and utilization of services among the insured,

due to biased selection of risks and moral hazards, were also documented.

Although these descriptions of some possible positive effects in equity of access between different income groups exist (Jaramillo, 2002), several barriers in access have also been described. In fact, a cross-sectional study of access to health services in Bogotá, where one fifth to fourth part of the population, identified four principal barriers to access: the lack of universal coverage, the existence of two regimes of affiliation, the limitations of the packages of health services and adopted mechanism of co-payments (Martínez et al., 2001). The coverage reached in Colombia is far from the expected according to the cost of the system. It has been reported that almost 40% of the population is in a situation of vulnerability (Hernández, 2002). Moreover, this lack of coverage entails serious equity problems. In 1999, 6 out of the 9 departments with less than 37.5% of dissatisfaction of basic needs had more coverage from subsidy than the national average, while 20 out of 24 departments with more than 37.5% of dissatisfaction had a lower average of coverage of subsidy than the national mean (Málaga et al., 2000). In addition, the existence of two regimens of affiliation serves to segment the access to health services as a result of criteria that do not depend on the population's needs but rather they are based on the income and labour status of people. Although in Colombia there is a universal basic package for those affiliated to the system, the offer of additional private packages implies a difference in the services. Even the basic package of services of the subsidised regimen includes fewer services than the package offered to those directly affiliated (Vargas et al., 2002). These differences may increase even more the inequity as they allow the acquisition of private additional packages by the rich population. Moreover, barriers of access to the poor population due to high co-

payments of those services included in their package have also been described (Homedes and Ugalde, 2005).

Moreover, Costa Rica, where the emphasis on privatization has been less, shows better tendencies in equity of access to services than Chile or Colombia (Guimarães, 2001). Its CCSS has the same package of services available to people with different capacity of payment (Vargas et al., 2002). There, practically the entire population has access to the health services of the CCSS. For example, 96% of all births in 1999 took place in CCSS hospitals (plus 2% in private clinics and 2% home deliveries) (Rosero-Bixby, 2004b). In addition, the data show substantial improvements in access (and equity) to outpatient care between 1994 and 2000, when the reforms were adopted. The share of the population whose access to outpatient health care was inequitable declined from 30% to 22% in pioneering areas where reform began in 1995-96. By contrast, in areas where reform had not occurred by 2001, the proportion underserved has slightly increased from 7% to 9%. Similar results come from a simpler index based on the distance to the nearest facility (Rosero-Bixby, 2004b). Furthermore, the percentage of people without equitable access to primary health services dropped by 15% between 1994 and 2000 in areas where health sector reform was implemented in 1995-1996, whereas areas that had not yet initiated health sector reform in 2000 experienced only a 3% reduction (Rosero-Bixby, 2004a). Thus, Equity in access to primary care has also improved considerably, perhaps because the first reforms were implemented in less developed areas of the country.

Contrary to Costa Rica, the health reform of 1996 in Mexico could imply the increment of a previous tendency of deterioration of equity in access to services. In fact, the creation of different service packages for the basic

mandatory health insurance, a variety of additional health plans with different premiums and co-payments, and direct fee for service will lead to a vast stratification in access and quality of services. There, the negative tendency in equity is a continuation of past practices. For instance, the richest 10 percent of households spent 8.5 times more than the poorest 10 percent in 1984, 16.4 times more in 1992, 18.3 times more in 1994, and 16.5 times more in 1996. Data also indicates that many low-income families cannot afford to pay for medical care: 46 percent of the poorest 10 percent of households were found to have medical care expenditures, in comparison with 76 percent of high-income families. There is also a difference in the kind of services purchased (Laurell, 2001). These tendencies even before the reform of 1996, can be explained by a reduction of the general budget of the IMSS and the failure of payments of funds for decentralized programs by the federal government.

Similar to Mexico, the experience of Brazil also shows that people in lower income groups experience more difficulties in getting access to health services. These differences are not only in the number of services but also in the types of services. Health care in Brazil still encompasses dual subsystems, which present distinct forms of institutionalization: the private service provides coverage to Brazilians who are younger, present lower risks, and who have higher purchasing power; the unified system of health provides direct services to those who have a lower or no purchasing power at all, and to those with a higher purchasing power but whose health care needs require a more complex mix of services (Elias and Cohn, 2003). In fact, the utilization rates by type of service varied, highlighting the large inequalities in quality of care delivered across income groups. The highest income group used about 500 percent more private services and about 100



percent more outpatient services than the lowest income group. On the other hand, people in the lowest income group used 67 percent more Health Center Services and 43 percent more emergency services than the highest income group. There were no social inequalities in the use of inpatient services (Almeida et al., 2000).

Studies that are referenced from other countries like Guatemala, Jamaica, and Peru coincide with the existence of inequalities in the services offered to rich and poor population (Almeida, 2002).

In addition to the inequality between different income groups, the decentralization process shows contradictory effects in the equity of utilization of services between geographical areas. Some countries seem to have a positive effect on equity. For example, in Colombia, a more equitable utilization of services between rural and urban areas and between municipalities with different income level is noted (Bossert et al., 2003), although there is a higher density of health resources in the biggest urban centres (Málaga et al., 2000). In addition, although geographical inequalities are described in Costa Rica, (Vargas et al., 2002), there is evidence suggesting a positive effect of the reform in reducing the gap between rich and poor regions (Rosero-Bixby, 2004b). Since the differences of the processes between these two countries are great, the reasons for these findings require further discussion. For instance, a more equitable distribution of allocation of resources between municipalities in Colombia as is showed below could play a role in these findings. In Costa Rica, the decentralization process focused initially in those areas with less access, which seemed to be an adequate policy due to the results in reducing geographical inequity.

A positive tendency can also be noted in Brazil, where the local government became

a stronger service provider and interregional differences in services supply diminished. The intensity of these changes, however, differed greatly from one region to another. Despite regulatory measures to increase efficiency and reduce inequalities within the health system, inpatient care delivery in 1996 remained highly unequal across the geographical regions, with inhabitants of the less developed areas less likely to have access to appropriate care. In addition, hinterland cities in the Southeast have a much better supply of physicians than do the less developed regions. This distribution of physicians, nurses and dentists results in a deficit in the poorer regions and cities and a surplus in the richer ones. (Almeida et al., 2000). Reform seems to improve geographic equity although there is still a big difference between regions. (Viana et al., 2002).

Unlike Colombia, Costa Rica and Brazil, the effects on geographical equity of access to services in other countries is less promissory. For example, in Chile, the results of the decentralization in terms of geographical equity are less clear. Although different policies to control the problem in equity exist, various studies show no changes or negative results from the reforms in relation to the previous tendencies in utilization of services between small and big municipalities and between rural and urban areas (Bossert et al., 2003; Homedes and Ugalde, 2005). Health insurance coverage displayed major geographic variations. Outpatient and in-patient medical care in the public sector showed substantial geographic variations. According to patient discharge records from national referral hospitals, only some 20% of total health care capability is used to treat 60% of the Chilean population living in regions outside the Greater Metropolitan area. In addition, the rural and poorest areas are covered preferably by the public sector, while the private is concentrated in the urban and wealthiest regions (Arteaga et al., 2002).

The evidence from Mexico suggests that there are more differences between geographical areas due to the reform. There, decentralization was originally initiated in 13 states in 1985 and was put on hold in 1987 owing to its negative effects on service delivery and acute conflicts between local health authorities and the population caused by the virtual closure of rural hospitals (Laurell, 2001).

Allocation of resources

The relation between decentralization and improvement of geographical equity in resources' allocation is inconsistent. For instance, it promoted a more equitable allocation of health resources among rich and poor municipalities of different incomes in Colombia (Bossert et al., 2003; Homedes and Ugalde, 2005) although a bigger capacity of negotiation of new resources in rich municipalities as well as in the private sector has been mentioned (Guimarães, 2001). In Costa Rica, where there is a centralized fund for resources' allocation, it has been reported that there is a better redistributive capacity (Guimarães, 2001).

A less clear relation has been shown in Chile and Brazil, where it seems to be a tendency to maintain inequities in allocation of resources. Although, a probable positive role of a fund for a more equitable reallocation of resources has been described in Chile, where, the tendency has been shown as steady (Bossert et al., 2003) or contrary (Guimarães, 2001; Homedes and Ugalde, 2005). There, analysis of primary care funding, however, suggests that municipalities allocating the highest per capita funds are not the ones with the greatest health care needs (Arteaga et al., 2002). In addition, in Brazil, a look at the estimated distribution of resources by region according to population demonstrates that the poorer areas have the biggest differential rates (Almeida et al., 2000).

In Mexico, a clearer negative trend in geographical equity of allocation of resources has been found (Ugalde and Homedes, 2002). There, the inequity between regions is also likely to increase despite the previous unfair geographic distribution of public resources—for both the social security system and the decentralized state systems. In addition, the reforms of 1996, due to the logic of competence, could affect poor areas and the more financial capacity of rich states will allow them to introduce more services. (Laurell, 2001).

In general, in only a minority of the countries in LAC where the reforms have been implemented, is there evidence of a decrease of inequities in resources allocation between geographical areas (Infante et al., 2000).

In addition to this inconsistency in geographical equity of allocation, equity of resource allocation between different levels of attention has been more consistently reported. In Colombia, for example, there was a redistribution of financial resources with an increased participation of first level services (Jaramillo, 2002). In Chile, the funding for primary attention is also guaranteed, even though other types of services have more inequity (Guimarães, 2001).

Discussion and conclusion

The decentralization defined as the transference of power and competences from the central government to peripheral levels of government has implied a great variety of processes in the different countries of the region. The process of decentralization in countries such as Colombia, Brazil, Chile, Mexico and Costa Rica illustrated different tendencies in the transformations of the health systems in the region. Although these tendencies are contradictory, this seems to indicate that decentralization is not the



magic solution to the problems in equity of health systems as is promoted by some international institutions.

In Colombia, there are some positive effects in equity that have been described, however, they are not clear and must be placed into perspective. Initially, although a positive effect is described by some authors in terms of equity of access between different income groups and geographical areas, others agree in the fact that several barriers are maintained and even created within the system. Some of the mentioned barriers are the lack of universal coverage, the existence of two regimes of affiliation, the limitations of the packages of health services and adopted mechanism as co-payments.

In addition, as the possible increment described is closely related with the increased coverage of affiliation and the creation of the subsidized sector there are some aspects that must be taken into consideration. Importantly, the old system differed in terms of the role of the insurance, as the most of the population did not need to be assured to have access to the services provided by the Ministry of Health. This means that real equity should be based on the comparison of access to services, which is not clear to have increased in Colombia.

The clearer effect in allocation of resources and geographical equity in Colombia has to be discussed by taking into account the costs of the services. Even though there has been an increment of 2 to 4 times the amount of financial resources of the system, the results are not proportional to these costs. The role of the intermediation of the private sector in Colombia has to be discussed in order to explain the inefficacy of the system.

The role of the partnership between decentralization and privatization should be

discussed in the case of Chile, where negative effects in equity of access and permanency of inequities of allocation of resources are found. Chile has a fragmentation of the population in terms of the public and private sectors of health that the process of decentralization has not been able to correct.

With a lower process of privatization, Costa Rica is the country that shows the clearest benefit effect of decentralization in terms of access to services and allocation of resources. However, the rationality of the intention of some stakeholders in that country to introduce changes toward the suggestions of the World Bank must be discussed.

Decentralization has also been accompanied by negative effects in Mexico, where an increment of inequity of access and allocation of resources has been described, and contradictory effects in Brazil, where although some advances have been made the inequities are still marked. Contrary to the Colombian case, in these countries, there has been a reduction of financial resources for health, which is specially described in the IMSS. This is accompanied with economical crisis in both countries with adjust measures under the guidelines of the neo-liberal ideology of the international organizations.

To summarize, although decentralization in theory may be a powerful mechanism to promote equity in health, it may be insufficient or prejudicial in the context of unclear policy intended to promote equity by the state. Moreover, the role of other concomitant phenomena like privatization and shortage of state funding of health must also be discussed. However, the evidence regarding the results of decentralization in LAC is still contradictory and ambiguous. It is not clear that its achievements could reach its intentions of improved equity in health in the region. This literature review

demonstrated the increasing need of more systematic studies in this area.

References

- Almeida, C., 2002. "Reforma de sistemas de servicios de salud y equidad en América Latina y el Caribe: algunas lecciones de los años 80 y 90". *Cad Saude Publica*. 18(4): 905-25.
- Almeida, C., Travassos, C., Porto, S. and Labra, M.E., 2000. "Health sector reform in Brazil: a case study of inequity". *Int J Health Serv*. 30(1): 129-62.
- Arredondo, A. and Parada, I., 2000. "Health financing changes in the context of health care decentralization: the case of three Latin American countries". *Rev Saude Publica*. 34(5): 449-60.
- Arredondo, A., Parada, I., Orozco, E. and García, E., 2004. "Impact of decentralization on health financing in Mexico". *Rev Saude Publica*. 38(1): 121-9.
- Arteaga, O., Astorga, I. and Pinto, A.M., 2002. "Inequalities in public health care provision in Chile". *Cad Saude Publica*. 18(4): 1053-66.
- Barraza-Llorens, M., Bertozzi, S., Gonzalez-Pier, E. and Gutierrez, J.P., 2002. "Addressing inequity in health and health care in Mexico". *Health Aff (Millwood)*. 21(3): 47-56.
- Bertodano Id, I., 2003. "The Costa Rican health system: low cost, high value". *Bull World Health Organ*. 81(8): 626-7.
- Bossert, T.J., Larranaga, O., Giedion, U., Arbeláez, J.J. and Bowser, D.M., 2003. "Decentralization and equity of resource allocation: evidence from Colombia and Chile". *Bull World Health Organ*. 81(2): 95-100.
- CEPAL, 1994. *Salud, equidad y transformación productiva en América Latina y el Caribe*. Serie Documentos Reproducidos, 41. Pan-American Health Organization, Washington, DC.
- Céspedes-Londoño, J., Jaramillo-Pérez, I. and Castaño-Yepes, R., 2002. "The impact of social security system reform on health services equity in Colombia". *Cad Saude Publica*. 18(4): 1003-24.
- Elias, P.E. and Cohn, A., 2003. "Health reform in Brazil: lessons to consider". *Am J Public Health*. 93(1): 44-8.
- Fleury, S., 2000. "Reshaping health care systems in Latin America: Toward fairness?" In: S. Fleury, S. Belmartino and E. Baris (eds), *Reshaping Health Care in Latin America. A Comparative Analysis of Health Care Reform in Argentina, Brazil and México*. International Development Research Centre, Ottawa.
- Gershberg, A.I. and Jacobs, M., 1998. Decentralization and Recentralization: Lessons from the Social Sectors in Mexico and Nicaragua. Working paper #379. Inter-American Development Bank, Washington, D.C. Retrieved Jun, 2005, from the World Wide Web: <http://www.iadb.org/res/publications/pubfiles/pubWP-379.pdf>
- Green, A. and Collins, C., 2003. "Health systems in developing countries: public sector managers and the management of contradictions and change". *Int J Health Plann Manage*. 18 Suppl 1: S67-78.
- Guimarães, L., 2001. "Modalidades de descentralización en el sector salud y sus contribuciones a la equidad: elementos fundamentales para la formulación de un marco normativo". Serie Informes Técnicos No. 76. Programa de Políticas Públicas y Salud. División de Salud y Desarrollo Humano. Organización Panamericana de la Salud., Washington, DC.
- Hernández, M., 2002. "Reforma sanitaria, equidad y derecho a la salud en Colombia". *Cad Saude Publica*. 18(4): 991-1001.
- Homedes, N. & Ugalde, A., 2002. "Privatización de los servicios de salud: las experiencias de Chile y Costa Rica". *Gac Sanit*. 16(1): 54-62.
- Homedes, N. & Ugalde, A., 2005. "Why neoliberal health reforms have failed in Latin America". *Health Policy*. 71(1): 83-96.
- Infante, A., de la Mata, I. and Lopez-Acuña, D., 2000. "Reforma de los sistemas de salud en América Latina y el Caribe: situación y tendencias". *Rev Panam Salud Publica*. 8(1-2): 13-20.
- Jaramillo, I., 2002. "Evaluación de la descentralización de la salud y la reforma de la Seguridad Social en Colombia". *Gac Sanit*. 16(1): 48-53.
- Kalk, A. and Fleischer, K., 2004. "The decentralization of the health system in Colombia and Brazil and its impact on leprosy control". *Lepr Rev*. 75(1): 67-78.
- Laurell, A.C., 2001. "Health reform in Mexico: the promotion of inequality". *Int J Health Serv*. 31(2): 291-321.
- Livak, J., Ahmad, J. and Bird, R., 1998. *Rethinking decentralization in developing countries*. World Bank Sector Studies. World Bank, Washington (DC).
- Málaga, H. et al., 2000. "Equidad y Reforma en Salud en Colombia". *Revista de Salud Pública*. 2(3).
- Manuel, A., 2002. "El sistema de salud chileno: 20 años de reformas". *Salud Pública Mex*. 44(1): 60-8.



- Martínez, P., Rodríguez, L. & Agudelo, C., 2001. "Equidad en la Política de Reforma del Sistema de Salud". *Revista de Salud Pública*, 3(1).
- Mills, A., Vaughan, J., Smith, D. & Tabibzadeh, I., 1990. *Health system decentralization: concepts, issues and country experience*. World Health Organization, Geneva.
- Rosero-Bixby, L., 2004a. "Evaluación del impacto de la reforma del sector de la salud en Costa Rica mediante un estudio cuasiexperimental". *Rev Panam Salud Pública*. 15(2): 94-103.
- Rosero-Bixby, L., 2004b. "Spatial access to health care in Costa Rica and its equity: a GIS-based study". *Soc Sci Med*. 58(7): 1271-84.
- Sapelli, C., 2004. "Risk segmentation and equity in the Chilean mandatory health insurance system". *Soc Sci Med*. 58(2): 259-65.
- Ugalde, A. & Homedes, N., 2002. "Descentralización del sector salud en América Latina". *Gac Sanit*. 16(1): 18-29.
- Vargas, I., Vazquez, M.L. and Jane, E., 2002. "Equidad y reformas de los sistemas de salud en Latinoamérica". *Cad Saude Publica*. 18(4): 927-37.
- Viana, A.L., Heimann, L.S., de Lima, L.D., de Oliveira, R.G. and Rodrigues Sda, H., 2002. "Significant changes in the health system decentralization process in Brazil". *Cad Saude Publica*, 18 Suppl: 139-51.
- Whitehead, M., 1992. "The concepts and principles of equity and health". *Int J Health Serv*. 22(3): 429-45.
- World Bank, 1993. *World Development Report; Investing in Health*. World Bank. Oxford University Press, Oxford.