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Methodological Guidelines for
Applied Research on
Decentralization of Health
Systems in Latin America

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ACRONYM LIST

Chile

FAPEM Facturación por Atenciones Prestadas en Establecimientos Municipales (FONASA Payment Mechanism to Municipalities)

FONASA National Health Fund

Colombia

ESE Empresas Sociales del Estado (Competitive semi-public insurance organization)

Bolivia

DILOS Local Health Directorates

OTBs Organizaciones Territoriales de Base (Territorial Base Organizations)

NGOs Non-Governmental Organizations

POAs Plan Anual Operativo Municipal (Annual Municipal Operative Plan)

CIAs

SNMN Maternal and Child National Insurance (Seguro Nacional de Maternidad y Niñez)

OBJECTIVE

This guide is to assist applied researchers design and implement research activities on decentralization of health systems in Latin America. It focuses on using national level data on decentralization and using field case studies at the local level. It is based on lessons learned from the experience of the Harvard School of Public Health in applied research in Chile, Bolivia, and Colombia.¹ This guide assumes that the researchers have some knowledge of economics, but is presented so that non-economists can understand the methodology. However, it will be necessary to have a skilled economist to carry out the national data analysis.

FRAMEWORK OF ANALYSIS

All research projects need to be based on theoretically-based frameworks of analysis.

One of the more common frameworks follows Rondinelli (1981), who identifies three principal categories of decentralization: deconcentration, delegation, and devolution. *Deconcentration* is generally the most common and limited form of decentralization, and involves the transfer of functions and/or resources to the regional or local field offices of the central government agency in question. Within a deconcentrated system, authority remains within the same institution (e.g. the Ministry of Health) but is “spread out” to the territorially decentralized instances of this institution. *Delegation* implies the transfer of authority, functions, and/or resources to an autonomous private, semi-public, or public institution. This institution assumes responsibility for a range of activities or programs defined by the central government, often through the mechanism of contracting. *Devolution* is the cession of sectoral functions and resources to autonomous local governments, which in some measure take responsibility for service delivery, administration, and finance.

In addition to the Rondinelli categories, the framework used in the Harvard studies is drawn from the principal-agent approach. In this perspective, the central government, generally in the figure of the Ministry of Health, is viewed as setting the goals and parameters for health policy and programs. Through the various modes of “decentralization” described above, the central government delegates authority and resources to local agents—municipal and regional governments, deconcentrated field offices, or autonomous institutions—for the implementation of its objectives.

This approach acknowledges that the central and local governments have at least partially differing objectives. Agents often have distinct preferences with respect to the mix of activities and expenditures to be undertaken, and respond to a differing set of stakeholders and constituents than national-level principals. Local institutions, therefore, may have incentives to evade the mandates established by the central government. Moreover, because agents have better information about their own activities than does the principal, they have some margin within which to “shirk” centrally defined responsibilities and pursue their own agendas. The cost to the principal of overcoming this information asymmetry is often prohibitively high.

¹ For results of this study see: Thomas J. Bossert (2000). “Decentralization of Health Systems in Latin America: A Comparative Analysis of Chile, Colombia, and Bolivia” Data for Decision Making Project and LAC Health Sector Reform Initiative. Boston: Harvard School of Public Health.

Within this context, the central government seeks to achieve its objectives through the establishment of incentives and sanctions that effectively guide agent behavior without imposing unacceptable losses in efficiency and innovation. Diverse mechanisms are employed to this end, including monitoring, reporting, inspections, performance reviews, contracts, grants, etc.

The process of decentralization may be seen as one of selectively broadening the “decision space” or range of choice of local agents, within the various spheres of policy, management, finance, and governance (Bossert 1998). The central principal voluntarily transfers formal authority to the agent in question in order to promote its health policy objectives. The degree and nature of this transfer differs by case, and shapes the function of the principal-agent relationship and the decentralized system as a whole. The case studies presented in this report do not seek to quantify formal decision space, but rather to offer a preliminary characterization of its range—narrow, moderate, broad—within an array of health system functions. The nature and extent of decision space is presented through “maps,” similar to Figure 1 presented below, which are complemented by an analysis of the history and context of decentralization reforms.

Figure 1. Standard Decision-Space Map

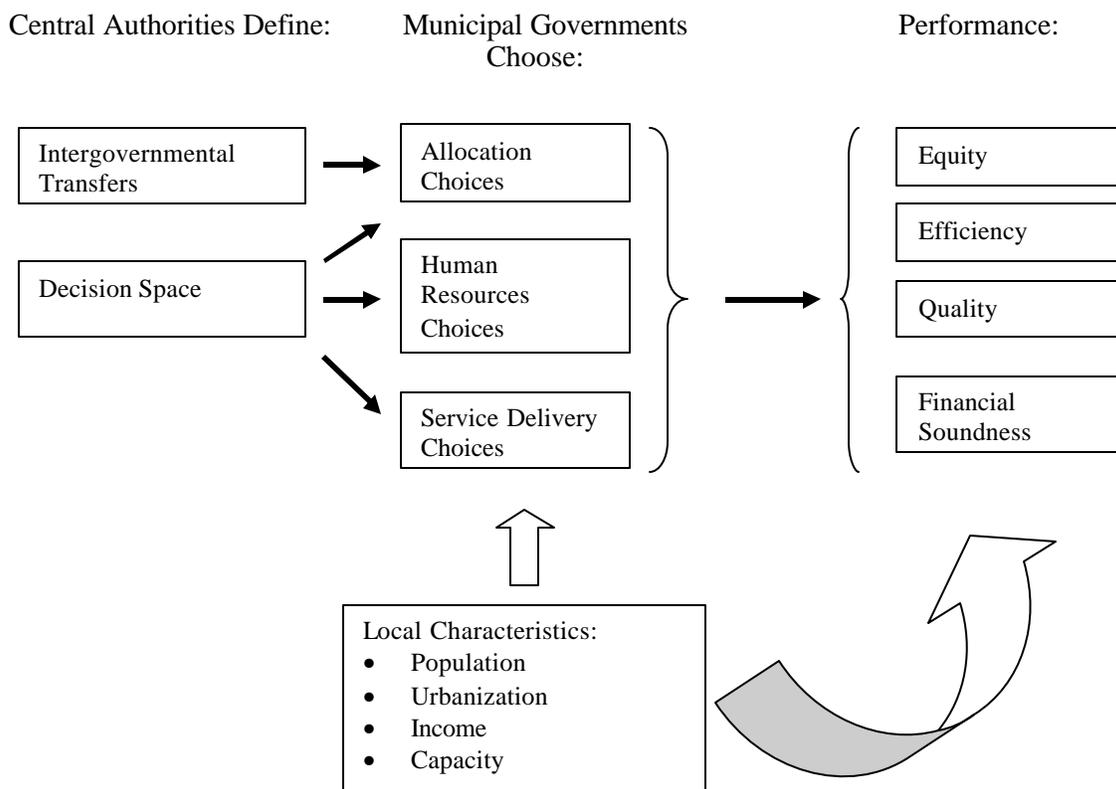
Function	Range of Choice		
	Narrow	Moderate	Wide
Finance			
Sources of revenue	⇒	⇒	⇒
Allocation of expenditures	⇒	⇒	⇒
Income from fees & contracts	⇒	⇒	⇒
Service Organization			
Hospital autonomy	⇒	⇒	⇒
Insurance plans	⇒	⇒	⇒
Payment mechanisms	⇒	⇒	⇒
Required programs/norms	⇒	⇒	⇒
Contracts with private providers	⇒	⇒	⇒
Human resources			
Salaries	⇒	⇒	⇒
Contracts	⇒	⇒	⇒
Civil service	⇒	⇒	⇒
Access rules			
Targeting	⇒	⇒	⇒
Governance rules			
Local government	⇒	⇒	⇒
Facility boards	⇒	⇒	⇒
Health offices	⇒	⇒	⇒
Community participation	⇒	⇒	⇒

There are other channels of control that the central government has to shape or override local decisions. The central government may offer incentives to local decision-makers to encourage them to make choices in favor of national priorities. These incentives can be in the form of matching grants in which the national government will provide funding for a priority activity if the local government will provide counterpart funding and implement the activity. Incentives can also come in the form of guidelines—for instance, model fee schedules—and other forms of technical assistance to upgrade local capacity and to influence local decisions. They may also come in the form of specific training and skill development in the areas that would strengthen central priorities. There may also be mechanisms for special recognition of achievements in priority areas, such as competitions for highest immunization rates among municipalities. Finally, the central government can simply provide services that are centrally directed, such as continuing to provide malaria control programs and vaccination campaigns run and funded by the central government.

Once we establish the range of choice allowed at the local level, the next question is: What choices do local governments make? For this analysis we examine the allocation choices that are made at the local level in response to choices allowed over central government transfers and with own source revenues. We investigate what choices are made about human resources at the local level. We also examine the choices made about service delivery and coordination among local governments.

Finally, we would expect different characteristics of the municipalities to influence the choices made and the performance of the health care system. For this analysis we examine how income of municipalities shapes allocation decisions, other choices and performance. In addition, population size, urbanization, relationships among major stakeholders, and institutional capacity might influence both choice and performance.

Figure 2. Research Model



A central question, however, is how do the different choices allowed at the peripheral level affect the performance of the system. We often expect health sector reforms to produce improvements in equity, efficiency, quality and financial soundness of the health system (Bossert, 1998).

SELECTION OF COUNTRIES

It is important to select countries that have had sufficient experience in the implementation of a significant degree of decentralization. It is not possible to evaluate the performance of the decentralization without data and adequate time to assess the changes in major variables. Countries studied should have clear evidence of increased "decision space" and sufficient time of implementation to assess trends.

If research is to be conducted over a 3-5 year period, or if the objective is to simply create a baseline and expect other research to be implemented later, it would be useful to start collecting data in systems that are about to or are just beginning to implement decentralization. The lack of sufficient baseline data for "before and after" studies has prevented clear analysis of the difference between centralized and decentralized systems.

SELECTION OF LOCAL RESEARCH TEAM

The local research team should be carefully selected to include health economists, social scientists, and skilled interviewers with experience in the health sector. If possible, it is preferable to develop local institutional capacity by selecting the team from a major research institution or from the Ministry of Health. However, selection should also account for limited time availability of experienced researchers and, in some situations, political considerations may have to affect selection in order to gain access for the field research and to have the results used by current authorities.

DEFINITION OF DECISION SPACE

The definition of the decision space should use models already established in the LAC country studies in order to develop a consistent comparative analysis. Annex I has a brief description of the decision spaces by function for Chile, Bolivia, and Colombia. Annex II is a blank decision-space map for copying to develop your own maps. The local team should review the major laws and regulations and develop formal maps for the decentralized unit(s) to be studied and, if major changes have been made over time, make a series of maps to display the changes.

NATIONAL LEVEL DATA COLLECTION

Data on some of the major variables to be studied are usually available in some form at the national level. These data need to be available for the unit of analysis of the decentralized unit—municipality, district, region, state, or province, depending on the country. This includes basic data on the unit, i.e. total population and/or percentage of the population in urban or rural areas, etc. Ministries of Health and of Finance usually have allocation data at least for

intergovernmental transfers from the central government to the local governments or from the Ministry to regions, districts, and facilities. Often they also have data on own-source revenue that the local governments collect in taxes and fees. This data may be only for revenues, but in many cases it also includes expenditure categories.

Ministries of Health also have data on utilization of facilities (consultations) and priority activities (immunizations, prenatal visits, nutrition, etc.). Mortality and disease prevalence data is also important, but often not available for the decentralized unit. Other data that are needed concern human resources—preferably by professional type and by payment mechanism (salary or contract) and the number and types of facilities at the decentralized level.

It is extremely important to have data on the population base of the decentralized units. Much of the analysis requires per capita calculations so the highest-quality data available on the catchment area of the decentralized unit are needed. In Chile, in addition to total population size of municipalities, we also had estimated beneficiaries of the municipal health services which, in cases where central Ministry hospitals also provided services, was less than the total population.

If possible it is also useful to seek data on elections at the decentralized unit level, the number of NGOs in the area, and other local conditions. This data should be available for as many years as possible, preferably beginning before the decentralization process occurs. However, it is seldom the case that national databases have breakdowns to the decentralized units before the actual decentralization is implemented.

Figure 3. Variables to Seek in National Data Bases for the Decentralized Unit Level

Expenditure Data
Total Health Expenditure
Total Health Expenditure Per Capita
Total Own-Source Revenue (for devolved systems)
Ratio of External to Own-Source Revenue (for devolved systems)
Expenditure on priority activities (eg. immunizations, prenatal visits)
Expenditures on types of facilities (PHC, Hospitals, Administrative Offices)
Utilization Data
Consultations per capita
Immunizations per capita (or per under fives)
Prenatal visits per capita (or per women in fertile age)
Epidemiological Data
Mortality rates
Prevalence of immunizable diseases
Human Resources
Number of doctors (by specialty), nurses, paraprofessionals, administrators, Maintenance and other staff
Number of civil service staff
Number of contract staff
(All the above data on a per capita basis)
Local Characteristics
Population Size
Urbanization rate
Socio-economic vulnerability index
Municipal capacity index
Number of NGOs per capita
Percent voting for party in power in central government

DATA ANALYSIS

Data analysis needs to focus on the questions being asked that can be answered by the data at hand. The central questions are whether decentralization has improved the performance of the health system or made it worse.

Therefore it is important to try to assess whether the decentralized system has resulted in changes in indicators of equity, efficiency, quality, and financial soundness of the system.

The first area to assess is the allocation decisions made at the local level. These decisions are "innovations" in our framework, but they also appear to have an impact on equity of access and other equity variables.

Allocation Decisions

Analysis of allocation should first identify the relationships between per capita health expenditures from local and central sources and population size, wealth of locality (e.g. total municipal income), and other local characteristics. This analysis should be done over the time period of available data. For devolved systems, the analysis of different sources of funding assists in examining the role of local choices that are relatively unrestricted (own-source revenues) and those which may be restricted by central government rules.

For example, in Chile, we analyzed the local and central government contributions by municipal income decile and demonstrated how they changed from 1991 to 1996. Tables 1 and 2 show this analysis.

Table 1. Chile: Expenditures on Primary Municipal Health Care per Beneficiary (1996)*

DECILES	TOTAL EXPENDITURE	CENTRAL GOVERNMENT CONTRIBUTION	LOCAL CONTRIBUTION
1 poorest	14479.5	10570.9	3681.6
2	12160.8	9219.7	2748.1
3	12205.0	8701.8	3543.9
4	12678.5	9241.7	3325.9
5	11608.2	8303.1	3221.5
6	12286.3	8178.3	3754.6
7	13826.3	9598.2	3889.8
8	11677.5	8367.7	3158.2
9	12231.0	8638.7	3121.4
10 richest	23496.0	9479.2	12808.8

Source: Prepared based on Subdere information

*Note: Averages by deciles of municipal income

Table 2. Chile: Expenditures in Municipal Primary Health Care per Capita (1991 and 1996)

DECILES	1991	1996	INDEX 91	INDEX 96
1 poorest	6380.93	14479.9	100.0	100.0
2	5975.59	12160.8	93.7	84.0
3	5720.30	12205.0	89.7	84.3
4	4787.16	12678.5	75.0	87.6
5	5413.89	11608.2	84.8	80.2
6	5408.82	12286.3	84.8	84.9
7	6819.40	13826.3	106.9	95.5
8	5653.75	11677.5	88.6	80.7
9	6817.58	12231.0	106.9	84.5
10 richest	13977.76	23496.0	219.1	162.8

Source: Prepared based on Subdere information

Note: Ordered by deciles of per capita income 1996

It is usually advisable to analyze each variable separately and then run a multiple regression analysis to determine which variables are more predictive or explanatory of the allocation decisions.

For instance, in Colombia (see Table 3) we attempted to explain total health expenditure using certification status (which brought wider decision space), revenue from central and own sources, and population size.

Table 3. Colombia: OLS Regressions for Total Health Expenditure per capita for 1994-1997

MODEL #1	1994 (N=1042)		1995 (N=1042)		1996 (N=1042)		1997 (N=1042)	
Independent Variables	Coef	Z	Coef	Z	Coef	z	Coef	z
Constant	6.5932*	9.53	9.1914*	6.90	15.6112*	7.70	-19.595	-1.07
Municipality Certification	-1.5835	-0.29	-2.68742	-0.34	-6.7553*	-3.19	-6.179*	-2.12
Department Certification	-4.133*	-3.77	46.4175	1.42	-8.1173*	-2.16	-15.23*	-3.66
Months Dept. certified	-.7905*	-5.06	-3.334**	-1.75	-.1638**	-1.52	.25066*	2.13
Months Mun. certified	-.17144	-0.31	-.036901	-0.08	.141438	0.73	.250132	1.19
External resources	.55744*	12.05	.862389*	8.95	1.59864*	12.81	4.7709*	3.29
Own resources	1.3859*	18.91	2.0423*	10.58	2.43916*	14.50	3.4655*	15.64
Population	----	----	----	----	----	----	----	----
% Urban	.98001	0.66	-2.0047	-0.74	-5.807**	-1.59	-18.34*	-3.75
R ²	0.4040	----	0.2794	----	0.3354	----	0.3732	----

* $|z| > 2.00$ ** $1.5 < |z| < 2.00$

Similar analysis should be done for the performance variables.

FIELD CASE STUDIES

Field case studies optimally should be designed after the results of the national level data analysis has given the researchers an idea of what would be the most important issues to evaluate at the local level. It is important to consider what the national data missed, such as quality issues that may not have national indicators, as well as interesting unexpected issues

that emerge from the national analysis, such as why rural areas appear to be more efficient than urban areas.

The number of cases may depend on available resources and difficulty of access, and the research should explicitly explain the criteria used to select the number and types of cases.

One possible set of criteria would be to choose municipalities with relatively similar characteristics on selected dimensions. In Bolivia we selected small and medium municipalities and excluded the large municipalities for which we felt there would be more unique variations.

If possible, municipalities with different degrees of decision space could be analyzed. In Chile, we compared centralized and decentralized municipalities with similar size and wealth.

It may also be important to select pairs of municipalities with similar types of services, such as those with only health posts, those with posts and centers, and those with hospitals.

Research teams should develop a Field Guide to help select who should be interviewed. It is important to get interviews from the local authorities responsible for organizing and administering the health system, the major health providers, and knowledgeable community representatives (from health committees or even local press). Several interviews should be held, usually over at least two days. Attempts to review and resolve conflicting information should be made. A detailed Interview Guide should be developed and tested to ensure that similar questions are being asked. Detailed and systematic reporting forms should also be developed so that the information can be easily compared and analyzed in the field and at the end of the fieldwork.

Depending on the skills of the interviewers and on the complexity of the questions, these guides may be more or less complex. An example from Bolivia is included in Annex III.

The field cases can be analyzed subjectively or there can be a systematic attempt to develop quantitative rankings of qualitative variables. An example of this latter method that was used in Bolivia is included in Annex IV.

ANNEX I. "DECISION-SPACE" CHOICES BY FUNCTION

Decision-space maps show some similarities and also significant differences among the three countries. First, there is in general only a moderate range of choice allowed to local municipalities. No municipalities had a full range of choice over key functions of finance and human resources. Significant restrictions remained in the control of the central government.

FINANCE FUNCTIONS

The finance functions are of particular importance in decentralization. The choice to control revenues allocated to the health sector, expenditures within the health sector and to set and retain fees are major instruments of local control. The choice to control revenues is a major means by which local governments can exercise their choice over whether health is a priority compared to other local activities like education, civic facilities, and roads. It is also a means by which wealthier communities can assign more resources than poorer communities, thus contributing to inequities in ways that centralized allocations may not. This choice was quite wide in Bolivia after the passage of the Popular Participation Law that allowed municipalities to assign a wide range (0-60%) of their intergovernmental transfers to health. This choice was later restricted by the Maternal and Child Health Insurance Law, which earmarked 3% of these funds specifically to supplies and equipment for the benefits package for mothers and children. In Chile, allocations to the health sector were formally made by a fee- for-service tariff set by the central authorities, but there was a ceiling to these fees—usually exceeded by utilization—and that ceiling was set by informal negotiations between municipalities and the Ministry of Health. This negotiation gave the local authorities some range of influence over this source of funding. In addition, local municipalities were allowed freely to assign their own-source revenues to health.² In Colombia, the municipalities received two sources of intergovernmental transfers, a municipal direct transfer and a transfer through the Departments (*Situado Fiscal*), both of which had percentage ranges that were earmarked to health. The municipalities had some choice within the percentage ranges and they could assign their own-source revenues to health.

Choices about expenditures of the health budget are also an important part of decentralization. Managing health expenditures can allow local managers to make choices that respond to local conditions and preferences, and may also allow for more technically efficient choices since local managers may know more about local staff, local input markets, and other factors. Chile initially granted local municipal authorities the widest choice on this function; however, this choice was restricted later by requiring expenditures to cover staff members that were protected by the new Human Resources Statute. Bolivia allowed municipalities to assign health resources within a wide percentage range, but later restricted this choice through the earmarked assignment of health funds to the maternal and child benefits package. In Colombia, certification granted municipalities control of expenditures, which was lacking in non-certified municipalities. Department authorities controlled most expenditures in uncertified

² In Chile, wealthier municipalities had to assign a significant portion of their revenues to a horizontal equalization fund (Municipal Common Fund) that reduced their choice over assignment of own-source revenues. This fund will be discussed in greater detail in later sections of this report.

municipalities. In all three countries, local own-source revenues assigned to health could be expended without central restrictions. Control over setting and retaining fees is also an important financing function. It is often argued that retention of fees at local levels increases the incentives for local managers to collect fees and to be more responsive to consumer demand. Control over setting fees also allows local managers to be more responsive to local market conditions. Bolivia and Colombia had a moderate range of choice over fees, either by an explicit range or by requirement that Ministry of Health approve local fee schedules. However, in Bolivia this changed when the Maternal and Child Insurance required that the basic package of services be provided free of charge. Chile required that all primary health care services be provided free of charge.

SERVICE ORGANIZATION FUNCTIONS

The ability of local governments to allow their facilities a significant degree of autonomy could be an important means for local governments to improve technical efficiency and quality through more flexible hospital management. In Chile and Colombia, this choice was not made at the local government level, but rather determined by national policy. In Chile, the hospitals were not devolved to municipal governments and therefore the municipalities had no choice over their organization. In Colombia, national policy required the creation of autonomous public entities (ESE) and offered municipalities little choice over this decision. In Bolivia, local hospitals were granted different degrees of autonomy by the local authorities, with little guidance from the national government.

In some countries outside the LAC Region, such as the Philippines, local governments are allowed to create or sponsor social insurance schemes. In none of the cases studied here was this authority allowed at the municipal level.

Another tool of local management for manipulating local incentives is the ability to determine the means of payment to local providers. In Chile, municipalities were first allowed to pay their staffs and contractors by any means allowed under the commercial code, until the Human Resources Statute restored the salary mechanism for primary care personnel. In Colombia, certified municipalities are allowed to pay salaries and bonuses, although this choice is restricted by union agreements at the national level. In Bolivia, the municipalities did not have jurisdiction over civil service salaries and were not expected to provide bonuses. They did have authority to pay contract workers under the municipal code.

A major tool used by the central authorities to control local choice is the ability of the Ministry of Health to define the norms and standards of service and of special programs. These norms can be quite general sets of priorities or they can specify assignment of personnel, infrastructure, equipment, and supplies to specific tasks and priorities. In Chile and Colombia, the Ministry exercised considerable control through well-defined and detailed norms and standards. In Bolivia, the Ministry's inability to disseminate and enforce norms and standards limited its control over local choice, initially allowing a greater range of choice in that country. However, with the implementation of the Maternal and Child Health Insurance, there was an effort to define and disseminate more standards in Bolivia, thereby restricting local choice.

HUMAN RESOURCE FUNCTIONS

Local control over human resources may be a major means of improving the technical efficiency and quality of service. If local managers have more control over their staff, including the ability to provide appropriate incentives, and hire and fire, then they may be able to improve services considerably. This capacity, however, may be limited by local pressures to provide patronage employment, rather than hire the most appropriate staff. Chile initially allowed the greatest range of municipal choice over determining salaries and removed the primary health care staff from national civil service protections. This choice was later severely restricted by the Human Resources Statute, which reestablished many of the civil service protections and restored a nationally defined salary range. In Bolivia and Colombia, local governments were given no control over local salaries or civil service staffing. Salaries, hiring, and firing were controlled by higher authorities. However, in all three countries, municipal governments could contract additional health staff, within some restrictions.

ACCESS RULES AND LOCAL GOVERNANCE FUNCTIONS

Access rules for targeting might affect how local authorities assign resources to the poor in their communities. If they are allowed significant choice on this, some communities might innovate and find new means of targeting the poor while others may make no effort to target their resources toward the poor and needy. While Bolivia granted moderate choice over local targeting before the Maternal and Child Health Insurance, this act specifically targeted local resources to mothers and children. In Chile and Colombia, national policies established access and targeting, and local governments had no choice.

Local governance is also a means of assessing the range of local influence on health systems. If local governments are elected there is a greater potential for local choices to be in concert with local popular preferences. In Chile the local mayors were initially appointed by the military government, however, after 1989, mayors were elected as they were throughout the study period in Colombia and Bolivia. Local authorities also had some choice in Chile over how to organize their local health administration and local facility boards, and there were three organizational options from which a municipality could choose. However, in Bolivia and Colombia, the organizational requirements for these governance instances were defined by national law.

Choice about community participation was left to the municipalities in Colombia and Chile. In Bolivia, the Law of Popular Participation defined an active role for the community organizations (OTBs and NGOs) without allowing municipal choice over the forms.

The following Decision-Space Maps shows how three Latin American countries have defined their decision spaces for the different functions.

Figure 4. Comparative Decision Space: Summary of Ranges of Choice

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
FINANCING			
Sources of Revenue		Colombia Chile Bolivia	
Expenditures		Colombia Chile Bolivia	
Income from Fees	Chile Bolivia	Colombia	
SERVICE ORGANIZATION			
Hospital Autonomy	Colombia Chile	Bolivia	
Insurance Plans	Colombia Chile Bolivia		
Payment Mechanisms		Colombia Chile Bolivia	
Required Programs & Norms	Colombia Chile Bolivia		
HUMAN RESOURCES			
Salaries	Colombia Chile Bolivia		
Contracts		Colombia Bolivia	Chile
Civil Service	Colombia Chile Bolivia		
Access Rules			
Targeting	Colombia Chile Bolivia		
GOVERNANCE			
Local Government			Colombia Chile Bolivia
Facility Boards	Colombia Bolivia	Chile	
Health Offices	Colombia Bolivia	Chile	
Community Participation	Bolivia		Colombia Chile
Total Decision Space:			
Colombia	8	5	2
Chile	7	5	3
Bolivia	9	5	1

DETAILED DECISION-SPACE MAPS

CHILE

Figure 5. Decision-Space Map of Primary Health Care in Chilean Municipalities in 1988

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of Revenue		Earmarked central transfer (FAPEM) negotiated with municipality Freedom to provide local financing constrained by scarcity of freely available municipal funds	
Expenditures			Allocation of expenditures according to local criteria (subject to technical provision norms)
Income from Fees	No Fees for municipal services		
Service Organization			
Hospital Autonomy	Not applicable		
Insurance Plans	No separate insurance		
Payment Mechanisms		Salary Bonuses Allowed	
Required Programs & Norms	Determined by SNSS		
Human Resources			
Salaries and Contracts			Broad freedom to set salaries and decide upon contracting according to local reality and resources
Civil Service			Municipal staff covered by private contracting law
Access Rules			
Targeting	Free access for public health system beneficiaries)		
Governance Rules			
Local Government	Mayors directly appointed by President		
Facility Boards		3 options for PHC facility governance and health offices	
Health Offices			
Community Participation			Community participation at discretion of municipality

Figure 6. Decision-Space Map of Primary Health Care in Chilean Municipalities (1996)

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of Revenue		Earmarked central transfer (FAPEM) negotiated with municipality	Freedom to provide local financing (constrained only by available municipal funds)
Expenditures		Allocations limited by salary and hiring constraints since salary expenditures are high proportion of PHC expenditures.	
Income from Fees	No Fees for municipal services		
Service Organization			
Hospital Autonomy	Not applicable		
Insurance Plans	No separate insurance		
Payment Mechanisms		Salary Bonuses Allowed	
Required Programs & Norms	Determined by SNSS		
Human Resources			
Salaries	New Statute established central norms for salaries		
Contracts		Contracts limited by Statute	
Civil Service	Statute establishes new civil service for municipal health workers		
Access Rules			
Targeting	Free access for public health system beneficiaries		
Governance Rules			
Local Government			Mayors elected
Facility Boards		3 options for PHC care facility governance and health offices	
Health Offices			
Community Participation			At discretion of municipality

BOLIVIA

Figure 7. Decision-Space Map of Municipal Government after Popular Participation Law in 1994

FUNCTION	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of revenue			Municipality can assign between 0-60% of co-participation resources to health. No restriction on assignment of local tax revenues to health.
Expenditure allocation		Non-salary expenditures relatively unrestricted, but no control over salary and cannot spend more than 15% of co-participation in contract salaries.	
Income from fees & contracts		Facilities can establish own fees within ranges approved by MOH	
Service Organization			
Hospital autonomy		Unclear rules over municipal hospital management structure allows some variation	
Insurance plans	No local insurance for public facilities		
Payment mechanisms		Salary paid by central government through regional offices. Payment to facilities for non-salary items has wide range.	
Contracts with private providers		Limited private contracts are allowed	
Required Programs and service norms		Service norms defined by MOH but allow moderate local choice within the norms	
Human Resources			
Salaries	Salary levels and payments determined by Regional Office of MOH, minor participation of local community in hiring and firing		
Contracts	Little or no contracting of non-permanent personnel; any contracting determined by Regional Offices of MOH		
Civil service	Centrally administered unified civil service		

Access rules			
Targeting			Only minor targeting by central authorities
Governance rules			
Local government			Democratically elected municipal governments
Facility boards	No facility boards		
Health offices	Popular Participation Law defines roles of municipal government, DILOS, and health facilities		
Community participation	Community participation in municipal government through OTBs and Vigilance Committees and in DILOS – determined by national level law		

Figure 8. Formal Decision-Space Map after Maternal and Child Health Insurance in 1996

FUNCTION	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of revenue		Municipalities are "forced" to assign 3.2% of their co-participation resources to a specific benefits package for health. No restriction on assignment of local tax revenues to health	
Expenditure allocation		Non-salary expenditures relatively unrestricted, but no control over salary and cannot spend more than 15% of co-participation in contract salaries.	
Income from fees & contracts	Facilities required to provide free basic package of benefits for mothers and children. For other services, facilities are allowed to establish fees within ranges approved by MOH		
Service Organization			
Hospital autonomy		Unclear rules over municipal hospital management structure allows some variation	
Insurance plans	No local insurance for public facilities		
Payment mechanisms		Salary paid by central government through regional offices. Payment to facilities for non-salary items has wide range.	
Contracts with private providers		Limited private contracts are allowed	
Required Programs and service norms	Service norms for basic package of maternal and child health more specifically defined by MOH.		
Human Resources			
Salaries	Salary levels and payments determined by Regional Office of MOH, minor participation of local community in hiring and firing		

Contracts	Little or no contracting of non-permanent personnel; any contracting determined by Regional Offices of MOH		
Civil service	Centrally administered unified civil service		
Access rules			
Targeting	Mothers and children targeted by MOH Seguro program.		
Governance Rules			
Local government			Democratically elected municipal governments
Facility boards	No facility boards		
Health offices	Popular Participation Law defines roles of municipal government, DILOS, and health facilities		
Community participation	Community participation in municipal government through OTBs and Vigilance Committees and in DILOS determined by national level law		

COLOMBIA

Figure 9. Decision-Space Map for Colombian Municipalities prior to Certification

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of Revenue	Earmarked Intergovernmental transfer: Percentage of "Municipal Participation" and other local taxes "forced" to be assigned to health.		
Expenditures	Departmental Control of <i>Situado Fiscal</i> Expenditures		
Income from Fees		Facilities determine and retain fees; municipal participants on boards influence decisions	
Service Organization			
Hospital Autonomy	Hospital autonomy defined by national law, no choice at municipal level		
Insurance Plans	Social insurance system defined by national law		
Payment Mechanisms	Most funding is direct budget payments to public providers		
Required Programs & Norms	Determined by Ministry of Health		
Human Resources			
Salaries	Salary scales determined by MOH in negotiation with unions		
Contracts		Use of contract employees allowed but in practice restricted	
Civil Service	New national civil service hiring and firing rules imposed with grandfathered protection for current employees		
Access Rules			
Targeting	SISBEN means test defined nationally and required to be implemented by municipalities		
Governance Rules			
Local Government			Mayors directly elected
Facility Boards	None		
Health Offices	Municipal Offices transferred from District offices of MOH		
Community Participation			At discretion of municipality

Figure 10. Decision-Space Map of Colombian Municipalities after Certification

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of Revenue		Situado Fiscal earmark allows range of choice of assignment to health and education.	
Expenditures		Assignment earmarks for "demand side subsidy" to insurers and set aside for PAB (promotion and prevention)	
Income from Fees		Facilities determine and retain fees -- municipal participants on boards influence decisions	
Service Organization			
Hospital Autonomy	Hospital autonomy defined by national law, no choice at municipal level		
Insurance Plans	Social insurance system defined by national law		
Payment Mechanisms		Some payment mechanisms negotiated between facility and insurers (municipal participates on facility board). Direct budget payments determined by municipal government	
Required Programs & Norms	Determined by Ministry of Health		
Human Resources			
Salaries	Salary scales determined by MOH in negotiation with unions		
Contracts		Expanded use of contract employees	
Civil Service	New national civil service hiring and firing rules imposed with grandfathered protection for current employees		
Access Rules			
Targeting	SISBEN means test defined nationally and required to be implemented by municipalities		
Governance Rules			
Local Government			Mayors directly elected
Facility Boards	None		
Health Offices	Municipal Offices transferred from District offices of MOH		
Community Participation			A discretion of municipality

ANNEX II. BLANK MAP OF DECISION SPACE

FUNCTIONS	RANGE OF CHOICE		
	NARROW	MODERATE	WIDE
Finance			
Sources of Revenue			
Expenditures			
Income from Fees			
Service Organization			
Hospital Autonomy			
Insurance Plans			
Payment Mechanisms			
Required Programs & Norms			
Human Resources			
Salaries			
Contracts			
Civil Service			
Access Rules			
Targeting			
Governance Rules			
Local Government			
Facility Boards			
Health Offices			
Community Participation			
Total Decision Space			

ANNEX III. BOLIVIA FIELD RESEARCH GUIDE

MUNICIPAL CHARACTERISTICS

This guide was used to obtain information on certain characteristics of the municipality that allowed us to explain observations in relation to changes in 1) performance, 2) the capacity for innovation in terms of providing services, 3) informal decision making structure, and 4) the decision-making process and the coordination mechanisms that have been adopted. The hypothesis is that the differences observed in these four areas should be related to the characteristics of the municipality. We looked for characteristics related to the community, the municipal government, and the representatives of health at the municipal level.

Community

- Does the community participate in defining spending priorities? Through what mechanism?
- Are there any leaders, especially those with certain specified skills?
- Are there NGOs operating in the health sector? In addition to providing services, do the NGOs promote larger allocations to health? How?
- Are there active OTBs? What is the relationship between the OTBs and the Vigilant Committees?
- What is the role of the OTBs and the Vigilant Committees in terms of planning health care spending? (Investigate the priorities that these institutions grant to the sector and if they effectively play a role in prioritization, control, fiscalization, etc.?)
- Are there Popular Committees for Health, Committees for Institutional Administration, or any other type of communal organization that promotes health? What role do they fulfill? Have they assumed tasks related to coordination and promotion not contemplated or assigned to other institutions?
- What is the attitude of the community in relation to health care services?

Municipal Government

- What type of experience does the mayor have? Is there support for the mayor? Is he popular? How many mayors have there been since the passing of the Popular Participation Law?
- What is the partisan composition of the municipal council? (Investigate any evidence for conflict).

- Does the Mayor have sufficient resources to contract skilled personnel? Is there anyone in charge of the health sector in the mayor's office? How much time do these functions consume? Does the mayor know/understand the functioning and the legal framework of the sector? Does he participate in the assigning of resources?
- How many times have they reprogrammed the POAs in the last few years? Are there significant gaps between what is programmed and what is executed?

Health Care Personnel

- What is the experience of those responsible for health care? Does this experience translate into a better management at the central level? Are there better quality services?
- What is the level of participation of those responsible for health in terms of municipal programming? What type of relationship exists between those responsible for health care and the municipal government?
- What special initiatives have been adopted by health care personnel? Do these initiatives substitute in any way for institutions or organizations that do not fulfill their duties?

INCENTIVES

Our goal is to identify programs, projects or the presence of institutions involved in health that, through their presence, induce some type of action on the part of the municipality in terms of spending or management in the sector. We try to identify the type of compromises that the Municipal Government makes that result in the presence of these institutions and establishes if, in terms of the existent resources, there is a substantial or any type of effect.

- Is there a national program like FIS, PROISS, or CCH present in the municipality that acts as a co-financier of health care investments? What is the impact of this organization in the community?
- Did the municipality receive any type of international or NGO collaboration specifically related to the health sector? What is the impact of this cooperation in terms of assigning sector resources?
- What impact have the current programs or institutions had in terms of resource allocation toward the health sector? Are they substitutes or complementary?
- Are there NGO conventions that compromise the municipality to assign a certain amount of resources to the sector? Or that they compromise on a certain type of management?

INFORMAL DECISION-MAKING STRUCTURE

At this point in the interview, we tried to establish how things really functioned within the municipality, especially in terms of decision space. We tried to establish who was a decision-maker and how decisions were really made including how reassigned responsibilities had been assumed. In order to do this we concentrated on certain aspects of the decision making

process such as how POAs were elaborated, how the budget was decided upon, and how institutions such as DILOS or health centers operated.

- Who are the principal participants (institutions, organizations, persons) in the decision making process in terms of health themes (resource allocation, priority definitions, etc)?
- In what areas does individual initiative (personal or institutional) act as an important motor in the sector?
- Who participates in defining the POA? Is it the health centers, health care personnel, the OTBs, and/or the DILOS?
- How are the health requirements defined for the POAs? Does the municipal government accept suggestions about what to include in the POAs in terms of health? Does the government take these suggestions into consideration?
- Has PACO been reprogrammed? How many times per year? Who knows about the reprogramming?
- How are the DILOS functioning? What have been the role and the activities of the DILOS most recently? What are the most important that the DILOS have carried out most recently? What are the most important decisions the DILOS have taken most recently? In what kind of environment do the DILOS have the most influence? How have the DILOS arrived at institutionalization?
- Who makes the human resource hiring decisions? Do the DILOS have any role in making these decisions? Does the mayor have any influence in these decisions? Does the director of the establishment have any influence in hiring and firing?
- In cases where the DILOS do not fulfill the functions assigned to them, is there another institution or person(s) that can assume this role? In what aspects?
- Are there any active Institutional Administration Committees? What role do they perform? Do they act as a substitute in any way for other institutions?
- How are allocations to health programmed? Who has the final decision in the allocation of resources to the sector? Do the Territorial Base Organizations have any influence? The Vigilance Committees? The health representatives (medical directors of the institutions)?
- Was there any reprogramming for the annual operating municipal budget this year? How were they reprogrammed?
- Once that PACO was approved how did they assign resources to the health sector? Who made the decisions on what and when to pay?
- Who pays the recurrent costs (electricity, water, administrative spending, etc.)?
- Are patients charged for any services? What types of services carry a charge? What are the fees? Who sets the fees and on what criteria are these fees based?
- Where does the income from these fees go? Who decides where this income goes?

INNOVATION

In terms of innovation, we were interested in the information related to the patterns of spending at the central level. We tried, as much as possible, to establish what factors explain the decisions related to spending and what is their significance in relation to health care provision. Additionally, we wanted to try and establish if there were any qualitative innovations that would have an impact on the operation and performance within the sector. The qualitative innovations can take various forms. We tried to be particularly attentive to cases with a significant amount of autonomy in terms of center management, generating resources, contracting personnel, subcontracting of services and the inter-municipal coordination of these services.

Management Autonomy

- Does the municipality decide how much to assign to the sector, without having to consult health care authorities? Is the funding granted through an account or in-kind? Is account reimbursement requested after the fact? If the municipality does not assign the funding or the account, are the funds made in a coordinated manner?
- What happens to the income from the health centers? Does the income go directly to the municipalities, so that the mayor or another person decides how to use the funds? Are the funds registered in the municipality and then later end up in the sector? Are they not registered with the municipality and the resources remain in the institution so that later it can be decided how to spend them?
- Who decides how the resources are spent in the institution? Are they used to cover the necessary expenses for the interventions in question? Are they put into a communal fund so that later they can be used for those things that seem necessary in the center?
- Is the refinancing of the National Insurance Plan for the Mother and Child sufficient to cover the prenatal services, births, services for infants, and children etc.? How are the deficits financed? Is the difference charged to the patient (that is, is the patient charged in order to receive adequate services?)

Resource Generation

- Apart from co-participation funds, what are the most important sources of internal funding for municipalities?
- Are there taxes or any other type of funds collected to be used to cover the fees in the health sector?
- Are patients charged for any services? What are the services that they are charged for? For example: accidents, appointments, etc.? What are the fees? Upon what criteria are these fees defined? Who makes these decisions?

Contracting Personnel

- Is there a margin of resources to be used in hiring health care personnel in the municipality (doctors, nurses, administrative personnel, cleaning personnel, cooks, ambulance drivers, etc.)?
- Who defines these contracts? How are they financed? Who makes the contract?

Subcontracting of Services

- Are there NGOs that offer services in the municipality? Who are they?
- Are there agreements among NGOs and the municipal government in terms of providing services?
- What are the general terms of these agreements? Is there any type of contract between the NGOs and the municipality in terms of providing services? Is there any reimbursement mechanism for the NGOs working within the agreement?
- If any type of reimbursement mechanism is in place, what is it based upon? Is it defined on the basis of numbers of services provided? Is it a fixed amount? Is it tied to the quality of services offered? Is it tied to the type of person attended to?
- Is the agreement in line with the Law of Popular Participation, Administrative Decentralization, the New Sanitation Model, and/or the Basic Maternal and Child Insurance Plan?
- If the answer to the above question was yes, do the NGOs respect this agreement?
- Is the presence of NGOs in the municipality positive or negative?
- Are there agreements with these institutions for providing services to the general, non-affiliated public? If yes, what is the impact of this agreement?

Inter-Municipal Coordination

- Are there people who are not residents of the municipality that solicit services in the municipality (institution)?
- Are there people in this municipality that are referred for health care services from another municipality? Are there patients in this municipality that go to other municipalities to receive health care?
- Why do you think that these patients prefer this health care facility? (Investigate about location, specialists available, better services, better quality, better infrastructure, etc.)
- Does the municipality have any control system to verify if services are provided only to inhabitants of this area?
- Are neighboring municipalities charged for attention given to their residents? Are there compensation mechanisms for services rendered between municipalities?

- Are there implicit or explicit agreements between this municipality and the neighboring or nearby municipalities in terms of providing health care services? Who is the person or institution that organizes such agreements?
- When health investment decisions are made, is the existence of institutions in neighboring municipalities taken into consideration?
- Is there a group that acts as coordinator between municipalities?

PERFORMANCE

In the visits and interviews we tried to establish the changes that we observed in relation to performance in terms of health care services. We gave special emphasis to aspects related to quality, utilization, equity, and efficiency. It is important to establish when the changes occurred and, if possible, the causes that contributed to the changes. Due to the lack of reliable interviews this part of the evaluation had an large subjective slant. Where possible we tried to incorporate the opinions of those interviewed with more concrete observations that may have been related (i.e. increase in utilization, provided more services).

Quality

- Has the municipality invested in the maintenance and improvement of the health care infrastructure? Has an improvement been noticed in terms of infrastructure and the endowment of equipment? Has the municipality been able to accumulate or gain access to funds for expenses in the health centers?
- Are the opinions of the health care centers taken into consideration in terms of which expenses are priorities? What expenses does the Municipality cover? Does the municipality have any form of measuring the quality of attention that is offered in the schools and health care centers?
- Is there any type of evidence that suggests that there has been a change (for better or worse) in the quality of health care services?

Equity

- What criteria have the municipality used to decide in what schools and health centers to invest in first?
- Is the infrastructure and equipment comparable between the different schools and health care centers of the municipality? Have there been efforts made to ensure that they are equal? Is there some minimum requirement for infrastructure and equipment in each health care center?
- Are there any efforts made to facilitate the access to the most needed services? Has any mechanism been installed in order to discriminate between the difference in the cost of providing health care services and the capacity to pay for these services?

- In those cases where there exists some type of scheme to incorporate equity measures in terms of providing services is the criteria explicit? Is it defined in an objective manner? Is it applied in an objective or subjective way? Are there forms on how it is applied?
- Is there evidence that, in the cases where it exists, the equity schemes function in the desired manner? Can you give us any concrete examples with objective data or with evidence from distinct sources?

Utilization

- Is there evidence of an increase in the number of persons attended to in terms of health care? Have they constructed a new infrastructure in order to attend to persons that before didn't have access to health care services?
- Has the range of services provided increased? What type of services? Is there objective evidence or patient registers that substantiate the changes? Has the infrastructure improved or the equipment increased so as to increase the number of services provided?
- Has the municipality invested in the construction of new health care infrastructure?
- Does the municipality have information that permits them to attend to a larger population (Schools/births?)
- Has the municipality increase the quantity of health care services that it can provide?

Efficiency

- Is there evidence that the municipality is making better use of their health care resources? Are there possibilities of deciding how to assign resources to those who provide the services? Is there more flexibility in the terms of the budget when it comes to schools and health care centers? Is there or are they developing the necessary institutional capacity? Are there coordination mechanisms between the different institution involved in the provision of health care services? Are there mechanisms so that the population can express their opinions in terms of the quality and cost of services provided?
- In which cases does the Municipality coordinate with the other government organizations in term of health care decisions (SNE/SNS/Prefectures/Programs/NGOs)?
- Are there clear coordinating mechanisms? Are there constituted and operating DILOS?
- How is the municipal investment coordinated in relation to the hiring of personnel?
- Does the municipality coordinate with neighboring municipalities in terms of their actions related to health care?
- In the case that there has been major investments in infrastructure or equipment:
 - Did the population have alternative or options before the investment was made? (i.e. did they provide the services in a municipality nearby for easy access?)

- How was the decision made? Who participated?
- Was there any incentive, like a leverage of resources, that may have influenced the decision?
- What has the result been? Is the infrastructure and equipment used? In what way? Is there sufficient demand to justify the investment? Are there enough human resources for the new infrastructure and equipment?

ANNEX IV. DESCRIPTION OF RANKING SYSTEM FOR SUBJECTIVE VARIABLES IN BOLIVIA CASE STUDIES

Due to the limitation on information and the scarce availability of qualitative data it was necessary to make the observations in terms of variables with a qualitative nature. With the purpose of establishing correlation's, and in the end to assure consistency in terms of each distinct case, we used a specific numeric system of variable classification. The classification of the independent or explanatory variables was based on a scale of 1-3. In general terms, 1 denoted an unfavorable or limited situation; 2, a neutral situation; and 3, a favorable situation. In the case of the variables related to change in the dependent variable or performance variables we used a scale of 1-4. One denoted a worsening in performance; 2, no change, and 3 and 4 denoted distinct grades of positive change. Below is a list of the variables, including the specific aspects of each variable that we considered in our analysis.

I. Change in Performance

1. Change in Quality (resolution capacity)
 - a) infrastructure (change in the availability and conditions of space , access to services)
 - b) equipment and instruments (change in the availability of medical equipment and instruments)
 - c) Expenditure (change in the diversity, availability and opportunity of medical expenditures)
 - d) Human Resources (change in the number and the qualification of health care personnel)
 2. Change in Utilization
 - a) Coverage (change in the number of persons that have access to the service)
 - b) Visits (change in the number of visits)
 - c) Services (change in the type of services offered)
 3. Change in Equity
 - a) Focusing of Service Provision (change in the definition of what services to provide)
 - b) Accessibility (change in the coverage of poor or vulnerable groups—costs, better services for less money, better resolute capacity)
 4. Change in Efficiency
Assigning of resources
 - a) priorities (change in the level in which the population's preferences are reflected—in terms of health)
 - b) investment (investment pertinence—justified investment in terms of the network)
 - c) Combination of expenditures (change in the relation between human resources, equipment or infrastructure—Better? Adequate?)
 - d) interjurisdictional compensations (have mechanisms been adopted and fulfilled)
- Service Provision
- a) doctor (change in the availability and reliability of services: water, electricity, communication)

- b) medical expenditure (change in the pertinence—adequate expenditures--, change in the availability—accessible when needed, quality-no past expenditures)
- c) basic services (change in the availability and reliability of the services: water, electricity, communication)

II. Profile of Key Informants

Mayor

1. Experience
 - a) Capacity (education level)
 - b) Experience as Advisor
 - c) Other experience in the mayor's office
 - d) Other experience in terms of management
2. Initiative
 - a) Negotiation Power (other system requests)
 - b) Capacity to propose solutions
 - c) Capacity to find support (population, cooperation, church)
3. Knowledge of the Rules
 - a) DILOS
 - b) Knowledge of their attributions
 - c) CAI's (Advisors of Information Analysis)
 - d) Participative Planning
 - e) SNMN
4. Respect for the Law
 - a) Agreement between programming and the execution of the POA's
 - b) Participative planning (participation in planning from health care personnel, OTBs and Vigilance Committees)
 - c) Fulfillment of what is stipulated under law (in terms of infrastructure and equipment maintenance and payment of operation expenses)
 - d) Participation from the DILOS according to the what is written in the law
 - e) Suspicion in terms of bad management (poor investment of funds)
 - f) Abuse of power (authoritarianism, particular use of public property)
 - g) "Prebendas" (family contracts, repartitioning of hits)

Doctor

1. Knowledge of the Law
 - a) DILOS
 - b) CAIs
 - c) SNMN
2. Experience
 - a) Specialization
 - b) Previous similar experience (years of service)
3. Initiative
 - a) Level of external support (technical cooperation, training, donations, programs, etc.)
 - b) Power of negotiation with local authorities
 - c) Proper initiative in the creation and the undertaking of IECC health care programs (Information, Education, Communication, and Counseling)

III. Relationships between Key Personnel

1. Mayor-Community
 - a) Support from the community vote
 - b) Incorporation of priorities in POAs
 - c) Level of corruption and poor management in the population
2. Mayor-Doctor
 - a) Fulfillment of insurance payments
 - b) Fulfillment of service payments (light, water, etc.)
 - c) Good communication (good dialogue between health care personnel and the mayor in terms of public health problems—receptiveness from the mayor)
3. Doctor-Community
 - a) Accessibility (native language, home visits, 24 hour attention)
 - b) Quality (respect for customs, good treatment, trust)
 - c) Socially sensible
4. Mayor-Municipal Council

IV. Initial Situation

1. Installed capacity before decentralization in terms of the population (infrastructure, equipment, ambulatory availability, human resources)
2. Availability of Other forms of health care (easy access in terms of distance, cost of going to other health centers in other municipalities, traditional medicine)
3. Health experience (functioning of health care facilities-good, bad, knowledge of the public medical service by the population, trust in the system, presence of health care centers with strong resolute capacity, number of doctors, adequate functioning in the service network)

V. External Factors

1. Incentives (Government policy, programs, funding, NGOs, International Cooperation)
2. Support (District, NGOs, International Cooperation)
3. Municipal Characteristics (noting those that stand out in each case)

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