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# LATIN AMERICA AND CARIBBEAN HEALTH AND NUTRITION SUSTAINABILITY:

Technical Support for Policy,  
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**POLICY REPORT No. 1**

**LESSONS FROM THE CHILEAN MODEL OF  
DECENTRALIZATION:  
DEVOLUTION OF PRIMARY CARE TO  
MUNICIPAL AUTHORITIES**

Draft for comments only

**Thomas Bossert, Ph.D.**

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LESSONS FROM THE CHILEAN MODEL OF DECENTRALIZATION:

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Project Director

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LAC Health and Nutrition Sustainability

## EXECUTIVE SUMMARY

Chile's innovative municipalization of primary care system represents a form of decentralization called "devolution". It is an interesting alternative to the more common form of decentralization, "deconcentration", which transfers authority from central units to peripheral units within a single organization, the Ministry of Health. By contrast the Chilean model transfers operational authority for specific services (in this case primary care facilities) from the Ministry of Health to other institutions, the 325 municipalities.

This Policy Report reviews the implementation of this unusual form of decentralization in order to assess its potential as a viable policy for other Latin American countries, especially Child Survival Emphasis countries.

The municipalization of primary care services was a reform initiated in the 1980's by the military government of Augusto Pinochet (1973-1989). It is currently being revised by the democratic government of Patricio Aylwin (1990-present). The program transferred responsibility for operation of all primary health care facilities (posts and centers) from the direct control of the Ministry of Health to the local municipal authorities. The physical facilities and health care staff were transferred to the municipalities, which signed contracts with the MOH to provide a minimal level of primary health care service to their populations and to follow Ministry of Health policies and norms. Along with the primary health facilities, approximately half of the total public health staff was transferred from the Ministry of Health to the municipalities.

Funding for the primary health care system remained largely in the central government's control through a central fund, the Fondo Nacional de Salud (FONASA), which implemented a reimbursement mechanism, *Fracturación por Atención Prestada en Establecimientos Municipalizados* (FAPEM), to reimburse municipalities for the services provided. Municipalities could also provide their own resources to supplement these funds, either using their own local tax revenues or funds from a redistributive Municipal Common Fund. There is no cost recovery in Chilean primary care facilities.

### Achievements

The decentralization process has been quite successful. It has effectively shifted responsibility for local decision-making from the Ministry of Health to the municipalities, although within fairly strict norms set by the Ministry. Local authorities make budgetary and personnel decisions and some service decisions. In general, there appears to have been an increase in the number of services provided after the municipalization occurred.

### Problems

The initial implementation of municipalization found that the municipalities were poorly prepared to administer the services. Most lacked sufficient skills and training in administration of health services. In addition, until recently the municipal authorities were appointees of the military regime - undermining the potential for local participation and responsiveness to local concerns.

Perhaps most important, the complex reimbursement mechanism was poorly designed. It first paid for specific services, giving incentives to provide higher cost services. Then it was adjusted to place an historically based ceiling similar to the previous budgeting procedure. This system, however, encouraged continuing inequalities of service by retaining the historical bias against the higher cost rural services and poorer communities. As a result the municipalities with the highest per capita reimbursements received 2.5 times more per capita than did the poorest municipalities. The wealthier communities furthermore could provide additional funding from their own sources, further exaggerating the inequalities of the system. While rural communities depended on the central fund for 85% of their primary care revenue, urban communities only received 65% from the central fund, and supplemented these funds with their own revenues.

At the same time, the military government also reduced its direct contribution to the national health budget. The result of this reduction was an almost 30% decline in transfers from FONASA to the municipalities between 1980 and 1989. This situation, combined with the inequalities of the system, left particularly the poorer municipalities with significant reduction in funds and probably a decline in service availability and quality.

The system was also plagued with problems of inadequate referrals between the municipal system and the Ministry-run secondary facilities in the Health Service Areas; in some cases patients were inappropriately referred to avoid costs for the municipalities. Supervision to assure adherence to Ministry norms was also weakened by the devolution. Preventive programs, never strongly supported in the previous system, appear to have also suffered in the transfer of responsibility.

Finally, personnel problems emerged with the transfer of half the staff out of civil service career paths and into a less clearly defined and less secure municipal system of employment.

### New Solutions

The new democratic government, with assistance from donors, has implemented and proposed significant changes to reduce some of the problems outlined above. They are providing administrative training for municipal authorities, municipal officials are now elected, national funding for primary health care has been increased significantly (but is still below historic levels), and personnel career paths and standard employment conditions are being implemented for primary care personnel. The government is also considering several options for improved funding mechanisms -- including a capitation system and an adjusted "fee-for-service" system weighted for cost variations in poorer communities. Finally, municipalities are being encouraged to promote prevention through a variety of specific nationally-sponsored programs.

### Application in Other Latin American Countries

Decentralization is being attempted in a variety of Latin American countries, however, only Colombia appears to be applying a model similar to the municipalization model of Chile. Most

other systems are experimenting with different forms of deconcentration within the Ministry of Health.

The applicability of a devolution model will be limited by the administrative strength of the local authorities. In countries with strong municipal or district governments, like Colombia, devolution would be a viable option. However, few of the Child Survival Emphasis countries have this local capacity. In these countries a form of deconcentration would be more advisable, and indeed many have already initiated processes of deconcentration.

Nevertheless, the Chilean experience has lessons that are useful for deconcentration processes. Many of the problems with the initial reforms emerge also in processes of decentralization within Ministries of Health. The revisions that the current democratic government is making provide important elements that can be applied in either form of decentralization. These include:

- Providing programs to enhance administrative capabilities at lower institutional levels

- Designing budgetary and reimbursement schemes which provide the proper incentives for cost containment while at the same time accounting for higher costs of services in the poorer and more needy areas

- Assuring that career paths allow staff to advance in a predictable and merit-oriented ladder

- Strengthen the systems of supervision and referral at the same time as decentralizing decision-making authority

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## ACRONYMS

- DAP -** Direccion de Atencion Primaria (Directorate of Primary Health Care at Health Service Area)
- FAPEM -** Facturacion por Atencion Prestada en Establecimientos Municipalizados (Reinbursement Fund for Municipalities)
- FONASA -** Fondo Nacional de Salud (National Health Fund)
- HSA -** Health Service Area (??spanish??)
- ISAPRE -** Instituciones de Salud Previsional (Managed Care Organizations)
- NHS -** National Health System (Sistema Nacional de Servicios de Salud)
- SERMENA -** Servicio Medico Nacional (National Medical Service for Employees)
- SNSS -** Sistema Nacional de Servicios de Salud (National Health System -- current public hospital system)

## **I. INTRODUCTION**

Chile has implemented a major decentralization program that has gained wide interest in Latin America. The program transferred authority and responsibility for the operation of primary care facilities to the municipal government. The central government continues to provide most of the funding for these activities and the Ministry of Health establishes policies and program norms which the municipal governments are responsible for implementing. This form of decentralization in which responsibility is transferred from one institution to another is defined as "devolution" in contrast to "deconcentration", in which a single institution transfers authority for specific decisions from the center to peripheral units.

This Policy Report presents the lessons Chile's decentralization model have for A.I.D.'s program activities in the LAC region -- in particular the applicability of this innovation in Child Survival countries. It is designed for use by USIAD Missions and the LAC Bureau in policy dialogue and project design. The report is organized into three sections:

- 1) Background: a brief overview of the Chilean health system and a description of the processes of reform initiated by the military government and continued by the current democratic government.
- 2) Chile's Decentralization Model: a specific review of the military government's decentralization initiatives, the problems that emerged during implementation and the reforms that the democratic government has initiated.
- 3) Applicability: a review of possible applications of this model of decentralization for other countries in Latin America and for A.I.D. policy.

A companion report, Policy Report No. 2, "Lessons from Chile's Health Financing Innovations", presents a review of the privatization options for increasing the use of private providers and for creating a private insurance industry.

## **II. OVERVIEW<sup>1</sup>**

Over the last twenty years, the Chilean health system has evolved from a state dominated National Health System toward a more mixed public/private system. This transition was initiated in the 1980's by the military government of General Augusto Pinochet (1973-1990) with free market-oriented reforms which opened the system to private initiatives and decentralized primary care facilities, turning over their operation to municipal governments. These changes brought many advantages as will be noted below. However, problems emerged as the public

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<sup>1</sup>The Overview section for both Policy Report Number 1 and 2 are only slightly different. If you have read the other report you may skip this section and begin with Section III.

systems suffered declining funding, inequalities of resources and access emerged, and inappropriate incentives distorted service delivery. The new democratic government (Patricio Alwyn, 1990-present) has retained many of the reforms but has reasserted the regulatory role of the state in order to overcome some of the inequalities and inefficiencies that emerged during the initial reform period.

#### A. State Dominated Health System (1952-1981)

The Chilean National Health System, initiated in the 1950's represented a model of a state dominated health system that many Latin American countries have emulated. In particular, Costa Rica, Nicaragua and Jamaica, have developed similar universal systems. In addition, several aspects of the Chilean system have been replicated in social security systems in countries now among A.I.D.'s priority Child Survival Emphasis countries.

The hallmarks of the Chilean system were its principles of high levels of coverage by public services, free service funded from general government revenues and a special earmarked payroll deduction, and public employment for most health providers.

The Chilean National Health Service (NHS) and National Medical Service for Employees (SERMENA) were two centralized programs that accounted for most of the health services of Chile. The NHS covered approximately 60% of the population: blue collar workers and indigents. In 1968, SERMENA was reformed to provide specific services to white collar workers through a "preferred provider system" that allowed approximately 25% of the population access to health providers in both the public and private sectors through a voucher system that also included a co-payment scheme.

Largely funded through the national budget, NHS also received funds from the mandatory payroll deduction (in the 1980's it rose from 4% to its current 7%) from blue collar workers. SERMENA was funded by a similar deduction from white collar workers.

The NHS was responsible for more than 90% of the hospital infrastructure of the country, as well as a large network of primary health care facilities: rural and urban health posts, rural medical stations, health clinics and health centers. This system was not unlike that of most Ministries of Health in Latin America.

SERMENA was primarily a funding mechanism, allowing a privileged class of workers access to private physicians mainly for outpatient care, without denying them access to the major public hospital system. Both systems were subject to detailed norms and were strictly supervised by the Ministry of Health.

Although the public health system provided both preventive and curative services, the overwhelming majority of services were curative, even in the primary health care facilities.

## B. Free-Market Reforms

In the 1980's, the military government implemented a variety of organizational and financing changes oriented toward encouraging decentralization, cost recovery and privatization of services. These reforms were based on an ideology that defined a more limited public role -- reserving for public responsibility only those services that are public goods (i.e. that have public benefits that individuals are not likely to pay for, such as preventive programs for mothers and children) -- and providing a targeted safety-net for the poor. Many of these types of innovations have become A.I.D.'s recommended policies for health financing policy changes, especially in Child Survival countries. In addition, other donors, especially the World Bank, promoted similar innovations. Chile, once again, became a model that other countries are attempting to emulate.

## C. Enhancing the Regulatory Role of the State in a Decentralized and Privatized System

When the new democratic government took power, a debate emerged between those who sought to restore the prior primacy of the state sector and those who sought reforms that would strengthen the regulatory power of the state, without changing the structure of the decentralization and of the private sector. The state-oriented proposals sought to significantly increase the general government support for the state sector, and some expressed interest in restoring the unity of the system, replacing the municipalization with the notion of deconcentration of a single state system.<sup>2</sup>

The government, however, chose to support reforms that would establish a regulatory role for the central national government, both with the municipalities and the private sector, without restoring the unitary health system and without undermining the private sectors advances. International agencies, including AID, the World Bank and IDB have been instrumental in the development of this approach.

This orientation sought to resolve specific problems that had emerged during the decade of implementation under the military reforms. These problems included: 1) a major decline in public subsidy to primary care which increased inequalities between those wealthier communities which could mobilize their own resources to compensate for the loss of subsidies and poorer communities which could not; 2) inequalities and distortions created by the new private health insurance schemes (the ISAPREs); 3) personnel problems created by the devolution of primary care system to the municipalities; 4) inadequate cost-recovery mechanisms for the publicly managed health insurance system; 5) lack of incentives for preventive programs. It involved a series of actions including increases in the general government expenditures for health care, a

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<sup>2</sup>Deconcentration means that some powers and authority for specific activities would be assigned to lower administrative levels, without a rupture of the central authorities control of planning and budgeting.

variety of initiatives designed to improve emergency service, rural health care, and preventive programs, and new legislation for the municipal primary care program and the ISAPREs.

The sequential context of the reforms is important to recognize in considering the application of some of the Chilean reforms to other countries. The reform processes grew out of a unique progression of changing political objectives and orientations. Many of the regimes that are currently supported by A.I.D., have not experienced the period of radical reorientation toward free market approaches, and perhaps can initiate more moderate reforms oriented toward shifting the role of the central government from provider of services directly to one with a more regulatory function.

A general lesson to be derived from the Chilean experience would be to encourage policy reforms that incorporate the current Chilean government's proposed program of establishing a regulatory role for the central Ministry and at the same time providing means to decentralize state services and expand the private sector.

### **III. CHILE'S DECENTRALIZATION/MUNICIPALIZATION MODEL**

The NHS, which was highly centralized up to the mid-1970s, had undertaken several deconcentration initiatives before the 1980's reforms. It operated within the general governmental administrative structure which in the 1970's was regionalized to 13 regions under the administrative control of a centrally appointed Intendente and his regional staff of representatives from each Ministry. Regional levels gained significant control of personnel and internal budget transfers, however, the central Ministry retained responsibility for both general policy and specific norms and standard-setting, which it imposed with considerable detail. Control over norms and standards allowed the Ministry to maintain significant uniformity in the system, limiting the range of decisions which regional authorities could exercise.

The core of the 1980's decentralization reforms was to transfer operational authority for primary health care facilities to the 325 municipalities. This transfer, a companion to the transfer of responsibility for educational facilities, was initiated in 1981 but accomplished mainly in the period 1987-88. The municipalities were given ownership of the existing primary health care facilities and personnel were transferred from the National Health Service to the municipal government, or in some large cities, a semi-autonomous corporation. Approximately half the public health staff were transferred to municipal programs. (Casteñeda, 1990, p.140)

Funding for this service remained largely in the hands of a centrally managed fund -- that receives public funds and a portion of the payroll deduction assigned for health services (see companion Policy Report on Chile's Health Financing Innovations). The municipalities entered into a contract which required them to provide a minimum level of primary health care service to their populations, according to the Ministry of Health norms.

Operational responsibility for hospitals was also decentralized, but not to the municipal level. Under a new National System of Health Services (Sistema Nacional de Servicios de Salud -- SNSS), 27 newly created Health Service Areas (HSAs) administered the hospital system in their geographic localities. These administrative units are based on health catchment area criteria and do not conform to other governmental divisions; nevertheless, the Director of the HSA coordinates with the regional office of the Intendente. The Director, through the Director of Primary Health Care (DAP) also retains oversight of municipal primary care system in his area.

The SNSS also retains central control over the public supply system -- Central de Abastecimientos -- which procures and distributes a large portion of the medicines, equipment and supplies (including milk for the major public nutrition program) that are used by all public facilities, including the municipal primary health care facilities. However, many municipalities and hospitals also may under certain conditions purchase medicines from local pharmacies. (Casteñeda, 1990, p.141)

One key element in this decentralization process is the funding mechanism for reimbursing municipalities for their services. In 1979, the National Health Fund (FONASA) was established (replacing NHS and SERMENA) as a separate institution responsible for funding both primary and hospital services. This fund is financed from mandatory pay-roll deductions (now 7% of salary), general government revenues, and other sources of revenue such as co-payments for vouchers for preferred providers and fees for services contracted in public facilities. Just over 40% of the fund comes from general government revenues. (Oyarzo, 1991, p.61) FONASA provides most of the funding for municipal services through a reimbursement mechanism (FAPEM), which specifies reimbursement for different types of specific services for which municipalities submit monthly invoices. Each facility, however, has a monthly ceiling, established on the basis of historical spending levels. This ceiling does not take into account cost differentials for rural and other disadvantaged municipalities. For a variety of reasons the ceiling declined in real terms since it was instituted, resulting in lower than historic spending levels in the primary health care system. Between 1982 and 1985, FAPEM funding declined 25.2%. (Jimenez and Gili, 1991, p.165)

Municipalities are also allowed to contribute their own resources -- which come from a variety of local taxes and a central government redistributive Municipal Common Fund. This fund receives a proportion of the municipal revenues from license plates, business taxes, and other sources and reassigns these funds to municipalities according to a formula based on the number of tax exempt properties in the municipality, population size and proportion of local revenues in total municipal budget. (Casteñeda, 1990, p. 295)

The municipalization process also involved a major personnel system reform. Half of the total Ministry of Health workforce prior to the reform period were employed in the primary health care facilities which were transferred to the municipalities. This staff was reassigned from civil service employment -- with its fairly rigid salary scales and high level of job security -- to one of two mechanisms at the municipal level. Most employees were shifted to a similarly regulated municipal government service, which retained national public sector norms for salaries, but does

not have as great a level of job security as in the national civil service. Municipalities retained the right to hire and fire. A second mechanism is the semi-autonomous public development corporation, which was formed mainly in large municipalities, and which includes neither job security or rigid pay scales.

The shift in employment status has introduced the possibility that employment will depend on performance, rather than be guaranteed. If utilized in a merit system, this discipline may increase performance and improve service. It may also allow a more efficient use of personnel - since staff needs can be defined by efficiency criteria in delivering services, rather than by available staff, or static norms.

The central objectives of decentralization are usually to obtain greater efficiency and responsiveness in the use of health service resources to different needs of localities. Decentralization is assumed to promote flexible management at levels close to the beneficiaries. Collateral effects are to raise management skills at lower administrative levels; to promote greater community participation; and to encourage the allocation of additional local resources to the health care system.

The decentralization process has in part achieved some of these objectives. Municipalities and HSA's have gained some control over decisions related to financing and staffing of the health system. Presumably those involved in these decisions are gaining experience and skill in managing financing and human resources. Some municipalities are also providing additional resources to the health systems. Many municipalities are deviating from norms and standards that have been established by central authority, partly in response to local differences and special needs.

These changes have also been associated with improved services. An improvement in health facilities and an increase in services delivered occurred after the transfer to municipalities, however, some primary care programs for mothers and children (home visits and vaccinations in rural areas) suffered declines. (Jimenez and Gili, 1991, p.161)

## PROBLEMS OF THE REFORMS

### Administrative Weakness

Many municipalities lacked administrative capacity to manage the local primary health care system. (Raczynski and Serrano, 1987) Weak administration and lack of municipal experience in health care led to considerable confusion and arbitrary decisions by the mayors, contributing to conflicts with health facility and, in some municipalities, rapid turnover of staff. With low municipal salaries, it has been difficult to attract and retain officials with sufficient management skills.

## Undemocratic Municipalities

Further undermining the role of municipal decision-making, the local municipal government was not popularly elected until recently. The mayors were appointed by the military regime. Most of the decentralization therefore, only involved the participation of appointed officials and was not particularly responsive to, nor conducive to, genuine local community participation.

## Poor Reimbursement Mechanism and Inequitable Local Funding Sources

Although total government spending in health increased over the period 1980-89, most of this increase was due to the increase in the mandatory pay-roll deductions from 4% to 7%. Support for the sector from government revenues (aporte fiscal) declined by over 30% during the period. (Oyarzo, 1991, p.62)

For the primary care system, in the period 1982-85 public transfers from FONASA to the municipalities fell 31.6%. (Jimenez and Gili, 1991, p.163) Since then, there has been some recuperation of these losses. A study comparing FONASA funding for municipal primary care facilities for 1988-91 found that real expenditures increased 6.1% in 1989 and declined 4.7% in 1990. (MINSAL, Evolucion, 1991)

More important, however, has been the tendency for the declines in public subsidies from FONASA to increase disparities among rich and poor municipalities. Based on rough per capita estimates and national estimates of costs for specific interventions, the FAPEM mechanism first gave incentives for increased production of specific services which led to an explosion in expenditures. In response, the government applied a historically based ceiling, which in effect restored the previous process of historical program budgeting. However, this system was biased against poorer, and especially rural, municipalities since the standard reimbursement scheme did not cover their higher unit costs for services, transport, and drugs. One of the results of this mechanism was that the municipality with the highest reimbursement per capita received 2.5 times more per capita than did the municipality with the lowest reimbursement.

Municipalities were encouraged to provide their own budgetary resources to cover the "gap" between the FAPEM contribution and the actual costs of services. While rich communities could assign significant resources, the poor were often unable to cover the gap. In 1985, rural communities depended on FAPEM for 85% of their revenue while urban communities were able to reduce this dependence to 65% by mobilizing additional resources of their own. (Jimenez and Gili, 1991, p. 167)

## Distortions Toward Curative Care

The decentralization process did not enhance the preventive character of the services. Indeed, the pressures on the system at the local level probably reinforce the bias toward curative care, because the competition for good physicians has bid up their salaries, with the resulting depletion of funding for preventive services and paraprofessional personnel.

In addition, the initial FAPEM system, since it reimbursed specific services rather than per-capita allotments, encouraged the use of curative interventions -- which received higher reimbursements -- rather than preventive approaches.

## Referral and Supervision Problems

As in most systems which place operational responsibility for primary care in the hands of an institution separate from the hospital care facilities, the Chilean decentralization process also created significant referral problems between the municipal-based primary health care system and the HSA administered hospital system. The appropriate mechanisms for improving referral systems between the institutions were not developed, despite the oversight responsibility of the HSA Director for municipal programs. In some cases, the incentive for primary care facilities was to over-refer patients, since shifting them from municipal responsibility to the SNSS reduces the municipal level expenses.

The organizational disjunction between the SNSS and the municipalities also affected the role of supervision of primary health facilities. While the HSA has theoretical responsibility to supervise and to assure that the municipal services are functioning according to Ministry of Health norms, it has been harder in practice to implement this supervision. Many municipalities are not applying national norms and supervisory visits by HSA officials appear to be increasingly rare.

## Personnel Problems

The shift of primary care providers from civil service to municipal employment has brought a breakup of the professional service, insecurity, lack of career path and motivating factors, incentives to increase salaries of physicians and a decline in salaries for auxiliaries and competition among municipalities in which poor rural communities are at a disadvantage.

The loss of civil service status has resulted in a significant morale problem among primary health care staff, who view the shift from civil service as a loss of job security. The divorce from civil service also means that careers for health providers in the primary health care system may preclude future employment in secondary and tertiary care facilities, now under a different employment system.

In addition, there has been an increase in costs for some areas with some municipalities paying higher salaries especially for physicians. Overall salaries are higher than they were prior to the devolution (in part to compensate for loss of "employment benefits" associated with civil service) and during the transitional period the total salary portion of the health budget was higher in facilities which were transferred to the municipalities than in those facilities remaining under central government control.

It is likely that the system reinforces greater inequalities for disadvantaged municipalities, unless new initiatives allow for increased salary and other incentives for staff in poor and rural communities.

## **NEW SOLUTIONS OF THE DEMOCRATIC GOVERNMENT**

When the new democratic government assumed power in 1990 it began a series of initiatives to address each of the problems identified above.

### **Elections**

Under the new municipal electoral law elections were held in December 1992 for mayors and Consejos Municipales. Municipalities are now likely to become more democratic and responsive to community participation.

### **Administrative Training and Management Information Systems**

To address the ~~problem~~ of lack of administrative and management experience at the municipal level, each of the major donors, A.I.D., the World Bank and the IDB are supporting significant programs to strengthen the management information and costing analyses at the municipal and consultorio level, and to provide general management training for health and municipal officials.

### **Increased National Funding Levels**

In 1990, a special additional fund from tax revenues was added to support primary health care initiatives in the most critical areas. The planned national budget for 1991 allocated an additional 11.7% to the municipal primary health care facilities. (MIDEPLAN, Informe Social, 1991, p. 75)

New funding mechanisms supported by donors are emphasizing local initiative through competitive proposals rather than top down programs -- these programs are gaining increasing national budget support that is likely to assure sustainability of donor programs. These programs include the Rural Health Program, the program to assist non-governmental organizations in health, and the Quality Assurance Program).

## **New Reimbursement Mechanisms**

The new government is considering a proposed new mechanism to replace FAPEM. This mechanism would be based on a per-capita allotment, with additional adjustments for a variety of socio-economic and geographic conditions -- coordinated with Diagnostic Related Groups (DRGs) at secondary and tertiary level and with some barriers to referrals from primary to higher levels.

The A.I.D. Non Project Assistance, is supporting consideration of a dual system: 1) a capitation system which assigns resources based on a per capita basis weighted for health status and proportion of population in extreme poverty; and 2) an adjusted "fee-for-service" system weighted by variations in service delivery costs. This adjustment was estimated to increase the average funding per capita by 45%.

The World Bank project is reviewing mechanisms for the hospital sector which would promote the use of DRGs for allocation purposes.

## **Personnel Career Path**

Significant efforts are being initiated to develop a functional career path at the municipal level in order to provide more employment stability, establish minimum base salaries, allow options for transfer (both permanent and temporary) between the municipal and national systems, and provide salary incentives for continuing in primary health care. (MINSAL, Proyecto de Ley sobre Estatuo de la Atencion Primaria de Salud Municipal, 1992)

AID's Non Project Assistance is supporting efforts to develop a career civil service for the municipal system which is designed to promote a clear career path and reduce competition among municipalities for health professionals.

## **Preventive Programs**

Under a program supported by A.I.D., the government has initiated improvements in physical and human resources in selected primary care facilities, improved emergency room service and pharmacies in some facilities, extended shifts for some personnel, and a variety of small scale projects to improve quality of care and upgrade health promotion efforts. (MINSAL, Programa de Mejoramiento, 1991 and Sitrick, 1992) In large measure, these programs have been oriented toward improving the preventative aspect of the primary care system and toward improving equity in the system. A.I.D. also supports preventive programs of non-governmental organizations.

## **III. APPLICABILITY OF MUNICIPALIZATION MODEL FOR OTHER COUNTRIES**

Many countries are now considering decentralization (devolution and deconcentration) processes -- including municipalization. The Chilean model is one which emphasizes devolution of operational authority to the preestablished local municipality. It implies a more radical break with the central authority than other decentralization schemes which retain the single Ministry central authority but assign increasing levels of authority and responsibility to local Ministry officials. The Chilean model suggests that devolution to a separate local administrative unit is a viable option and should be considered for possible implementation.

However, while the Chilean model has resulted in effective decentralization, with local authorities actually able to make decisions on budgetary, personnel and some service issues, it has significant limitations which for many countries may make it a less viable alternative to deconcentration within the Ministry of Health.

The central limitation is the administrative capability of the local authorities in most Latin American countries. Chilean municipalities are more robust administrative units than counterparts in many other countries, especially the Child Survival Emphasis countries. Even with greater administrative capabilities, they have had difficulties managing the primary health care system. Some countries, like Colombia and the Southern Cone countries, have stronger municipal authorities; however, most Child Survival Emphasis countries have very weak local municipalities. Unless they are in a process of strengthening the municipalities through other government programs, it would be unlikely that they would have sufficient administrative skills to manage the budgetary, personnel and service decisions for health facilities. In these countries, the deconcentration model, in which authority is transferred to local units within the Ministry of Health has more applicability. In this option, the Ministry would be able to train a cadre of local health officials, already familiar with many of the administrative, budgetary, personnel and service issues. Indeed, in most of the Child Survival Emphasis countries some form of deconcentration is in process. For instance, Honduras and Peru are strengthening the regional levels of their ministries, and Guatemala and Nicaragua are reinforcing the district level.

Even if the municipalization process is not adopted, however, the Chilean experience has some lessons for any form of decentralization. The revisions that the current democratic government has made in the municipalization process provide guidelines that would be useful to apply in a process of deconcentration within a ministry of health. The following list should be considered in policy dialogue and program activity designed to promote decentralization.

1. **Funding Mechanisms that assure Equity and Adequate Funding Levels**

The central and local funding mechanisms should be clearly established to maintain support and to provide a mechanism for guaranteeing at least a minimum acceptable level of funding (if not per-capita equity) among the local units. If local sources of funding are to supplement the centrally supplied funds, some redistributive mechanisms should be developed (either through the central funding mechanism or through a municipal fund

similar perhaps to the Municipal Common Fund) that would allow poorer municipalities or districts to provide sufficient funds to maintain access and quality of services.

If central budgets are the only source of funding, allocation norms should be established to assure that sufficient funding is distributed to the poorer and more needy communities.

The initial Chilean experience with a reimbursement scheme oriented toward payment for services, which led to an explosion in high cost services, suggests that such a scheme needs to be avoided. Some combination of per capita and service provision needs to be established to assure adequate funding without providing perverse incentives.

## **2. Management Training**

Management training for local administrators (including elected officials if appropriate) level should also be initiated in order to strengthen these capabilities at the local levels. This training should precede, or be simultaneous with, the actual devolution of authority. Training should involve the central or regional authorities who will maintain norm setting and supervisory roles. This staff will need to develop diplomatic skills to encourage compliance.

## **3. Strengthen Referral Systems from Primary to Secondary Systems**

The problems of referral and counter referral emerge even within a single centrally administered ministry of health, when the authority and responsibility for the primary care system is devolved to a separate administrative structure this break requires the development of a more cooperative and communicative system between the two health systems. In both systems of decentralization, attention must be paid to strengthening supervision and referral at the same time that authority is transferred to local levels.

## **4. Establish Clear Career Path**

If the devolution implies a new personnel status for the primary care workers at the municipal level then some regulation should allow a nationally regulated, merit-based career path for health personnel in both the national and municipal or district systems.

In systems that remain unified, the career path for personnel at the local levels should also be defined in order to provide incentives for those with strong management skills to remain at this level.

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