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Effects of health decentralization, financing and governance in Mexico

Efeitos da descentralização, financiamento e governabilidade em saúde no México

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Keywords

Financing, health. Decentralization.
Social participation. Governance.

Abstract

Objective

To identify the effects of decentralization on health financing and governance policies in Mexico from the perspective of users and providers.

Methods

A cross-sectional study was carried out in four states that were selected according to geopolitical and administrative criteria. Four indicators were assessed: changes and effects on governance, financing sources and funds, the final destination of resources, and fund allocation mechanisms. Data collection was performed using in-depth interviews with health system key personnel and community leaders, consensus techniques and document analyses. The interviews were transcribed and analyzed by thematic segmentation.

Results

The results show different effectiveness levels for the four states regarding changes in financing policies and community participation. Effects on health financing after decentralization were identified in each state, including: greater participation of municipal and state governments in health expenditure, increased financial participation of households, greater community participation in low-income states, duality and confusion in the new mechanisms for coordination among the three government levels, absence of an accountability system, lack of human resources and technical skills to implement, monitor and evaluate changes in financing.

Conclusions

In general, positive and negative effects of decentralization on health financing and governance were identified. The effects mentioned by health service providers and users were related to a diversification of financing sources, a greater margin for decisions around the use and final destination of financial resources and normative development for the use of resources. At the community level, direct financial contributions were mentioned, as well as in-kind contributions, particularly in the form of community work.

Descritores

Financiamento da saúde.
Descentralização. Participação social.
Governabilidade.

Resumo

Objetivo

Identificar os efeitos da descentralização no financiamento e na governabilidade da saúde no México, a partir da perspectiva de fornecedores e usuários.

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Métodos

Estudo de desenho transversal realizado em quatro estados selecionados a partir de critérios geo-político-administrativos. Quatro indicadores foram analisados: fontes de financiamento, fundos de financiamento, destino final e mecanismos de distribuição dos recursos. As técnicas de levantamento de informação estiveram baseadas em entrevistas a profundidade com informantes-chave do sistema de saúde, líderes comunitários e de ONGs, técnicas de consenso e análise de documento. As entrevistas foram transcritas e analisadas por segmentação temática.

Resultados

Os níveis de efetividade e de participação dos usuários foram diferentes para os quatro estados. Os efeitos identificados foram: maior participação dos governos municipais e estatais no financiamento e na geração de serviços de saúde, aumento da participação das famílias no financiamento, maior participação comunitária nos estados mais pobres, conflitos de governabilidade gerados pela duplicação e confusão nos novos mecanismos de coordenação entre os três níveis de governo, ausência de sistema de prestação de contas, carência de recursos humanos e habilidades técnicas para programar, monitorar e avaliar mudanças no financiamento.

Conclusões

Identificou-se, em geral, efeitos positivos e negativos da descentralização do financiamento e governabilidade na saúde. Os efeitos mencionados pelos provedores e usuários foram relacionados à diversificação das fontes de recursos, maior margem para decisões acerca do uso e destino final dos recursos, bem como o desenvolvimento de normas de utilização. Ao nível comunitário, as contribuições financeiras diretas foram mencionadas, assim como as voluntárias, particularmente na forma de trabalho comunitário.

INTRODUCTION

The decentralization of health services in the Mexican public sector introduced significant changes in social, political and economic aspects, which in turn have had different effects on the financing and governance of the health system.

These recent changes, which come together with Mexico's new economic policy, have led to sectorial adjustments that are included in the Health Sector's Reform.^{2,*} This reform project, with the decentralization strategy, searches for healthcare alternatives adjusted to payment abilities and health needs for the whole population. There is a special interest in ensuring that those who require the service should not be marginalized from the system and should receive at least basic coverage for the promotion and conservation of health under the principles of financial protection, equitable access and good quality of care.^{**}

In this context, changes in financing policies for health services are one of the main elements in the Mexican decentralization strategy. During the first phase of this health system reform, in 1986, the Health Secretariat set forth the consolidation of a national

health system, where the decentralization strategy was implemented in 12 of the 31 Mexican states. The legal and normative decentralization framework included important guidelines for financing policies at the national, state and municipal levels. These guidelines referred more directly to changes in mechanisms for the allocation of financial resources and new financing alternatives for the production of services at a local level.^{***}

In 1994, with the approval of a new reform tool for the health sector, decentralization was once again used as a strategic line for the reform, proposing the consolidation of the process in states that were already decentralized, and extending it to non-decentralized states. In this second phase of the health system's restructuring process, new changes in financing policies were set forth, directed towards exploring financing mechanisms to generate new financing alternatives with local resources for the production of health services. In other words, the second phase of decentralization constituted one of the fundamental strategies of the 2001-2006 National Development Plan. So, as in most Latin American countries, a proposal was made to generate new social participation mechanisms, as well as political and financial management

*Secretaría de Salud, Subsecretaría de Prevención y Control de Enfermedades. Recursos para la salud en unidades de la Secretaría de Salud, 1999. *Salud Pública Méx* 2000;42(3):252-9.

**Secretaría de Salud. Programa Nacional de Salud 2001-2006. México, DF; 2001. p. 26-9.

***Secretaría de Salud. La descentralización de los servicios de salud: avances y retos: un análisis sobre la descentralización del sistema de salud mexicano para el período 1995-2000. México, DF: Consejo Nacional de Salud; 2002. p. 62-71.

strategies that would allow for a greater independence at state and municipal levels in the production as well as the financing of services.^{10,11}

In view of the importance of documenting the effects of these structural adjustments at local levels, it is sought here to establish that the states developed diverse strategies to finance their own health systems. Thus, challenges were documented at the operative level which could be faced by broadening the state and municipal financial participation and strengthening the management capacity of federal entities as a background for the two phases of the decentralization process.⁴

Since the introduction of decentralization has happened in times of economic crisis, its achievements have been heterogeneous and local experiences are not well documented. For this reason, local experiences were studied from the perspective of the social actors involved in the process. The applied framework allows to identifying lessons which could facilitate the diverse stages of the process, as well as challenges and barriers that should be considered in order to consolidate the policy's achievements.

The objective of this study was to show how the effects of the decentralization are perceived by the social actors involved in the processes and the effects of this decentralization process on Mexican states.

METHODS

A descriptive cross-sectional study was carried out in 2004. The universe of study included four Mexican states that were selected according to the following criteria: 1) different socioeconomic development, according to the Marginalization Index developed by the Population Board;⁸ 2) an implemented decentralization process, with changes in health service financing policies and in community participation; 3) the existence of a database with economic information; 4) technical capacity in health financing policies and decentralization, as well as in the management of some financing indicators to support data collection and collaborate with the research team in an interdisciplinary man-

ner, and 5) technical and political commitment to using the study's results.

Table 1 shows that three states had high marginalization indexes and one had a medium one, with great per capita income variation by state. The political parties identified at the local level were diverse, which points to greater political plurality. For the purpose of the study, the involvement of state teams was mostly high, though participation was limited by governmental and administrative changes. Selected states are located in the central and southern regions of Mexico and their names were omitted to preserve the anonymity of the sources.

Twenty in-depth interviews were applied in each one of the selected states, with the support of three researchers with experience in data collection: five decision makers, as well as medical and administrative personnel; five service providers at health centers; five representatives of civil organizations, as well as municipal representatives and, finally, five members of health committees and users of services at first level of care units.

The information was obtained through in-depth semi-structured interviews, using a thematic guide with questions and requesting authorization to carry out the interview and record it. Later on, the interviews were transcribed and analyzed by thematic segmentation, using the ATLAS.ti software. During this procedure, the information was analyzed using 12 thematic codes. Finally, to triangulate field data, consensus techniques were applied and workshops were held with selected key personnel in each state for the presentation of results and the revision of documents related to changes in financing policies and community participation after decentralization.

RESULTS

The information gathered in the studied decentralized states allowed to confirm that there has been a gradual reduction of the restrictions and locks of the previous centralized regime of the 1970's.

In general, positive and negative effects of decen-

Table 1 - Social and political characteristics of states studied. Mexico, 2004.

States	Per capita income	Marginalization Index	Political parties	Involvement in study	Decentralization
State A	Low	High	Center Right Left	High	1980's
State B	Medium-low	High	Center Right Left	High	1990's
State C	Medium-high	Medium	Center left	Very high	1980's
State D	Medium-high	High	Center right	Medium	1990's

tralization on health financing were identified. The effects mentioned by health service providers and users were related to a diversification of financing sources, a greater margin for decisions around the use and final destination of financial resources and normative development for the use of resources. At the community level, direct financial contributions were mentioned, as well as in-kind contributions, particularly in the form of community work.

Financing sources

This concept refers to the primary entities providing society with economic resources for different activities.¹ Of the documented positive effects, the most outstanding one refers to a diversification in these sources. In addition to resources provided by the federal level, the state contributions were a financing source that was broadly promoted by the federal policy. In this case, levels of contribution showed variations according to a set of economic and political variables and some outstanding cases were found.

Although achievements in the states were not reported homogeneously, informants highlighted the creation of organizations for assistance, such as the Public Welfare, the establishment of recovery quotas, the substitution of services and state and municipal contributions. Public Welfare was identified as a very important financing source for services and support for the poorest population. Since it provides assistance, this organization is able to combine its financing sources in order to achieve greater funding.

Besides referred contributions, another source of financial resources was identified, coming from municipal town halls. The identification of this resource allowed to determine that, since changes in the financing of health services began, there is possibility for greater participation of local financing sources, as well as a greater power for the allocation of available resources. This source of resources was identified at the local level. The direct contribution coming from users was also considered by providers as a source of financing in the states.

Allocation mechanisms

This information refers to criteria used in resource allocation and distribution. Annual adjustment mechanisms have been implemented for allocation, which allowed for prioritization of actions to be taken and for these to be channeled to the areas with greater health care needs. There has been less influence of the federation in the allocation of resources for municipalities and priority programs for the state. It is important to

observe that, at the operative level, flexibility in the system was reported. According to the interviewed informants, this flexibility facilitated the identification of new financing sources. As for financial allocation mechanisms, there was a greater political will and more financial support and evidence that, at the state level, the Secretary of Health promoted and guaranteed new financial resources according to local needs, in spite of budgetary restrictions.

One of the most positive effects in terms of the incorporation of new financing funds refers to the application of specific norms for the management of resources. This situation led to a greater acceptance of direct contributions in the community.

Governance

One of the most relevant findings of this study was that the negative effects of decentralization on the financing of health services were particularly found at the operative level, that is, where the services are provided. The service providers' perspective showed that personnel in charge of services lacked information and that there was also a set of political barriers. The users' perspective showed negative effects related to the financial burden involved in paying the recovery fees, as well as the lack of opportunities for participation in decision making to establish health care priorities of communities jointly with health services.

For health service providers, the reported negative effects included a lack of knowledge on general aspects of decentralization, as well as processes where there was low participation of healthcare providers at the operative level, a set of political barriers and a tendency towards centralization around the management of resources for programs operating at the federal level.

One of the negative effects derived from the lack of information on decentralization was that for the personnel, the initiative represented an increase in workload. In the case of State A, they reported that the new bureaucracy encouraged little participation of the main actors in the health system and of the community in the decision making process. There were adverse effects on some government health programs and difficulties in linking social participation to different health programs.

The case of State C showed how decentralization policies are largely unknown. In some jurisdictions, municipal authorities and operative personnel had difficulty in implementing the changes in financing policies. According to the interviewed person-

nel, most difficulties were generated by a lack of continuity in the new financing policies due to changes that exert pressure on the central levels of government.

Other negative effects reported by informants in charge of the operation of services are that decentralization was still not consolidated due to the regulating weight of the center (federal power). In this sense, decentralization kept pulling the best financial and human resources invested locally, towards the central level, and therefore generated confusion at the different government levels.

The perception that decentralization is still an unfinished process was reinforced by the presence of assistance programs defined by the federation and operated through the state health services. Since in these cases the federal level defined goals and priorities, operative personnel perceived that, in spite of decentralization, there is still dependence on the national central level, and there is confusion regarding the flow of authority and power in decision making.

There was also evidence suggesting some training in the management of financial resources after decentralization, as well as mobilization of new financial resources that were not being collected before decentralization. State C, with its 20 or so years of experience as a decentralized state, reported important benefits which have been identified by the service providers. There is evidence of a greater flow of resources with a more locally oriented management of decisions on resource allocation for local health programs. Also, a greater participation of users, suppliers, and municipal and state governments has been promoted to establish priority health needs.

The fact that two processes happened in parallel should be highlighted: the creation and incorporation of new financing resources and the development of frameworks and normative schemes whose function has been from the start to oversee, from the federal and state levels, the adequate use of financial resources. Flexibility was one of the attributes mostly highlighted by the interviewed informants.

Community financing and social participation

The role of health service users in the context of decentralization implies several levels of social participation in health. Users may participate through direct contributions to the financing funds by means of recovery fees, through in-kind participation for the generation of health infrastructure at the local level, or through a direct participation in health programs.^{3,9}

The most direct positive effect in terms of financing, reported by the interviewed users, referred to support for the operation of the health care unit, be it through fundraising and the awarding of economic resources to improve or expand the units, or through voluntary community work at the units. In this same sense, the increase of municipal contributions was also considered a relevant advantage.

Although community participation was already in place throughout the country before the end of the decentralization process, this policy helped define criteria which formalized channels through which community contributions were promoted. In this sense, ever since decentralization, there has been discussed a greater participation of the community in terms of financing, infrastructure and priority setting in health matters. Regarding financing, in State A, there is a significant contribution as in-kind financing to improve health infrastructure. The case of State A shows that manpower contributed by the inhabitants of several state municipalities has produced savings in running expenses and the channeling of these resources to health programs where service users themselves and community leaders have participated in establishing health priorities based on local needs.

Ever since decentralization and the changes in financing within the State Health System began, the population and its community leaders have taken on an active role in financial matters and in the production of services. The community has chosen representatives as members of the local health committees (integrated by suppliers and users), whose main task is designing and supervising health programs according to the main epidemiological problems at state and municipal levels.

From the user's perspective, the negative effects referred to a more limited access to programs in rural areas, to diverse forms of rejection of recovery fees and to the lack of clear criteria for community participation. As for financial sources, there was limited rural access to public welfare, and support was given only to the poorest urban zones, but very little went to rural areas. With decentralization, there have been discussed new and varied sources of financing; however, support for rural areas, in the form of donations and altruistic foundations, has been scarce.

Financial contributions were seen by users as a negative effect, above all in states like State C, where recovery fees were considered to be important. From their perspective, community participation has been limited to support in the form of manpower for the development of health programs through the role of

"health promoters". Community leaders and some users have participated in the monitoring of some health programs, but the community has been reluctant to make economic contributions directly towards health financing. In fact, through the interviews applied to several users, it became evident that there was a clear rejection of the recovery fee system that has been implemented as a result of the financing changes coming from decentralization.

In State D, recovery fees were described by users as a financial burden. In this context of community participation, as far as financing is concerned, under decentralization work was done to build awareness among the community regarding the importance of financial collaboration in health services, albeit with few results and a lot of resistance. In State A, there was a lack of clear criteria to stimulate user participation in health programs. A set of deficiencies in health services was described, which limits the identification of benefits and makes fees for services unattractive.

Some states reported on the role of political parties in the population's level of participation, stating that these political organizations manipulate the provision and financing of services. Also, references were made to the lack of spaces to motivate the operative personnel to participate. This situation, according to the interviewed personnel, generates inequity in the budget allocation carried out at the national level, whose mechanism is unknown by the state and municipal levels.

On the other hand, there is empirical evidence which allows to establishing favorable outcomes in the implementation of this policy in Mexico, as can be seen in Table 2.

This table shows that interviewed informants contributed to a broad variety of strengths in the states where one sees a great diversity of financing sources. There are also favorable effects of financing funds on infrastructure and the optimal use of financial resources. It is important to look at the references to a

Table 2 - Main strengths after decentralization on governance and health financing indicators. Mexico, 2004.

Governance-social participation: providers, users, community leaders	Financing sources	Financing funds	Allocation mechanisms	Final destination of resources
- Increased local participation in decision making	- Diversity of financial sources	- Greater autonomy for fund management	- Increase of allocation at the operative level	- Greater and better prioritization of needs
- Consolidation of the Health Committees	- Increase of recovery fees	- Increase of additional funds	- Strengthening of management	- Fulfillment of goals
- Reduced intervention of central political levels	- Greater municipal contribution	- Greater liberty to implement consolidated purchases for the jurisdictions	- Improvement of the payment system to service providers	- Timely solution of problems and/or greater solution capacity
- Strengthening of the role of community leaders in health matters	- Community contribution	- Autonomy for decision making	- Improvements in expenditure planning	- Optimization of investment expenditure
- Participation of social actors of the municipal level in the allocation of resources according to local needs	- Regulation of the destination of recovery fees	- Greater autonomy for resource management	- Allocation of resources to programs related to the State Development Plan	- Strengthening of the first level
- Changes in the municipality-state-federation relationship	- Creation of Public Welfare	- Possibility of financial transfers among chapters	- Greater local participation	- Strengthening of infrastructure
- Strengthening of the sanitary jurisdictions and of municipal health authorities	- Participation and contribution from the municipalities	- Regularization for the final destination of recovery fees	- Annual adjustments in the allocation	- Strengthening of operative work
- Better management of information	- Greater support from recovery fees	- Management of additional funds	- Less influence of the federation	- Optimization of operative expenditure
- Greater participation of NGO leaders	- Mixture of federal, state and municipal resources for health infrastructure	- Accountability of decentralized public organizations	- Simplification of workers' payment	- Greater prioritization of needs
- Improvement in decision making according to local problems.		- Training for fund management	- Greater political will regarding allocations	- Greater coverage
		- Increase of recovery fees	- Efficiency in expenditure programming	- Adaptation of the final use of resources to the needs of the local health system and to health conditions of the population
		- Fundraising for additional funds	- Improved contracts	

greater autonomy in the management of financial resources, as well as greater managerial development for a more efficient administration of resources.

The negative effects identified by providers at the operative level and by users, as can be seen in Table 3, suggesting important challenges in terms of the creation of spaces for social participation and mechanisms to reduce the financial burden of direct contributions by users. In response to this problem, the development and application of a regulatory framework for state and municipal contributions could help counteract the described negative effects.

Table 3 also shows effects related to the budgetary limitations with which state health systems operate. This also contrasts with the reference to the lack of knowledge on technical criteria and the lack of managerial abilities for resource administration. All these factors were related to the lack of local capacity for broadening the supply and production of health services.

DISCUSSION

The information presented in this study shows that in the decentralization-transfer process from the federal level to the states, adjustments were observed from which important lessons may be learned. The structural indicators and the establishment of local health priorities, confirms the strengthening of the local health system's capacity to assess the decentralization and decision-making processes, as has been mentioned in the literature.^{5,6}

With respect to the lessons learned for the transfer of functions from the federal level to the states, the compiled qualitative information suggests that there is a greater probability of increasing the alternatives of new financing sources in programs where users and providers are linked. That is, the level of social participation that is promoted and achieved in each state determines the financial diversity. The states where volunteer community leaders, NGO leaders, and users of health services themselves were involved

Table 3 - Main weaknesses after decentralization governance and health financing indicators. Mexico, 2004.

Governance-social Participation: providers, users, community leaders	Financing sources	Financing funds	Allocation mechanisms	Final destination of resources
<ul style="list-style-type: none"> - Lack of knowledge of the decentralization policies by municipal authorities and leaders, operative personnel and users - Excessive auditing that blocks a free social participation - State centralization of human and financial resources - Not depending directly on the federation or the state government (duality) - Demand of administrative personnel and lack of community support for the training of promoters - Blockage by some community leaders or NGOs in the system of recovery fees - Adverse effects of some programs directed from the central level, such as PROGRESA, PAC - Centralization of decisions by state-level leaders 	<ul style="list-style-type: none"> - Budget cuts - Centralization of NGO meetings and their beneficiaries - An adverse and turbulent socioeconomic and political environment - Budget limitations (allocation and cuts) - Limitation of financing sources - Poor municipal allocation (Area 33) for the support of health centers and/or hospitals - Rural access limited to Public Welfare - Scant support from donations and altruist acts - Lack of knowledge of the budget allocated by the State - Limited financial alternatives - Limited capacity for fundraising - Little financial participation of the states 	<ul style="list-style-type: none"> - Lack of a system of economic information and state accounting in health - Very limited access to financial information, especially to the origin of funds - Limited capacity for fund management - Budget increases diluted in chapter 1000 - Lack of knowledge of the amount of municipal allocations for health - Discontinuous community participation - Lack of flexibility in the use of funds - Dependence on external funds and programs - Lack of homogeneity in the recording of resource application 	<ul style="list-style-type: none"> - Allocation plan with little flexibility and without technical criteria - Inadequate delivery of resources - Management ability is determinant for allocation - Lack of knowledge by the state of the allocation mechanisms for the financial ceiling - Unfairness in allocations (federal) - Allocation plans are not very participative - Deficient expenditure planning - Limited influence in allocation decisions - Lack of knowledge of allocation criteria - Delay in some payments - Deficient allocation of expenditure - Lack of regulations for the adequate and timely channeling of municipal resources 	<ul style="list-style-type: none"> - Deficient provision - Limitation of operative expenditure - Little control in the final destination of extraordinary resources - Restrictions to re-allocate financing resources at local level - Lack of fairness in the final use of resources by different levels of care - Too many political commitments - Difficulties in planning - Absence of a monitoring system on budgeted vs. final destination of expenditure - Increased goals with insufficient personnel - Labor conflicts and pressures that directly affect the final use of human resources

were the states that showed greater financial contributions by NGO, contributions from donors, a greater increase in the economic contribution through recovery fees, a greater social participation in free manpower for the construction of health centers, and a greater impact and social commitment of health promoters. Thus, it can be noted that new financing alternatives can be developed at state and municipal levels, besides better financial allocation mechanisms in tune with local health priorities, both in terms of health systems and health needs of the population, when there is broad community participation.

The providers' discourse, which points to new financing mechanisms as a result of decentralization, establishes the importance of analyzing the local needs and allocating resources using technical criteria. This is important because in practice it has only been possible to implement some allocation mechanisms based on epidemiological criteria modalities, without being able to apply clinical and economic criteria.

As an effect of decentralization on new financing policies, another important finding was the contribution of community work to support the operation of health units. To this source were added state and municipal contributions, thus increasing the allocation of significant in-kind contributions.

On the other hand, for providers and users alike, a situation of organizational ambivalence has emerged among the three levels of government. In fact, sometimes, the level that makes the decision and takes on the financial responsibility for the allocation of resources for the different health programs is the national level. The financial decentralization policy aims to putting an end to the excessively centralist sense of government structures. However, the same findings herein presented, like the results from other studies in other developing countries,^{7,12} show that in terms of health service financing, state and municipal levels still depend to a great extent on the center, and only with a few exceptions, as in state D, has it been possible to develop important changes in financing matters.

As a conclusion, it should be highlighted the following three points:

- a) Regarding the effectiveness of the changes in financing policies as part of the state reform and particularly of the health sector reform, said changes result in a very relative effectiveness which varies from state to state. In fact, there are

states where increases in the financial sums are more important than in others, and this has no close relationship to the per capita expenditure in health or to the population's health needs. For instance, state B is one of the states with the highest marginalization index in the country; however, it is the state that receives fewer benefits from the increase in health expenditure. Thus, it is proposed making a more careful revision of the resource allocation formula that is being used and providing it with more flexibility, so that resource allocation done with fairness can be more effective. For example, the formula proposed by the legal framework for the allocation of municipal resources has to include more economic, clinical and epidemiological criteria, as well as new mechanisms to involve users in this process.

- b) In the four states studied, there is evidence of excessive control at the central level regarding the management of financial resources. In that regard, it is imperative to develop a mechanism where the local level can make a more adequate management of the financial resources assigned by the federal level, when dealing with health actions at the state level, or of state resources when dealing with health programs at the municipal level. In other words, as long as there is no trust, liberty and more responsibility in the process of allocation, reallocation and final use of resources, by type of health program at the local level, dependence and centralism in decision making will continue to thrive.
- c) As to lessons in community participation in health system financing, documented in the states studied, it can be highlighted (in some states more than in others) the following: direct economic contributions through the fee recovery system; contribution of free manpower for the construction of health centers; the direct economic contribution of some NGOs and well-to-do community leaders, and finally, the contribution from community leaders and users of health services for the establishment and surveillance of resource allocation and the operation of priority health programs according to local needs in both health and financing matters.

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REFERENCES

1. Abel-Smith B, Dua A. Community financing in developing countries: the potential for health sector. *Health Policy Plann* 1988;3:95-108.
2. Arredondo A. Financial indicators for health care decentralization in developing countries: a framework for analysis. *Health Syst Sci* 1998;1(3):345-64.
3. Arredondo A. Profils d'assignation de ressources à la santé en fonction d'indicateurs d'efficience et des coûts de production: une proposition pour les pays de l'Amérique Latine. *Rev Ruptures* 2000;6(3):41-50.
4. Arredondo A, Parada I. Financing indicators of health care decentralization in Latin American countries: information for health planning and financing. *Int J Health Plann Manage* 2001;16(3):259-76.
5. Bobadilla J, Frenk J, Freika T, Lozano R. The epidemiological transition and health priorities: health sector priorities review. Washington, DC: The World Bank; 1990. Future changes in demographic, epidemiologic and social factors; p. 14-6.
6. Bossert TJ, Larranaga O, Giedion U, Arbelaez JJ, Bowser DM. Decentralization and equity of resource allocation. evidence from Colombia and Chile. *Bull World Health Organ* 2003;81(2):95-100.
7. Collins C, Green A. Decentralization and primary health care: some negative implications in developing countries. *Int J Health Serv* 1994;24(3):459-75.
8. Consejo Nacional de Población. La marginación en los municipios de México, 1990-2000. México, DF: Secretaría de Gobernación; 2002. p. 35-63.
9. Dolowitz D, Marsh D. Who learns what from whom: a review of the policy transfer literature. *Polit Stud* 1996;44(2):343-57.
10. Gallardo H, Beeharry G. El desafío de la reforma en salud: foro de Europa y América sobre las reformas del sector salud. Washington, DC: Banco Mundial-IESE; 2002. Autonomía y competitividad de los hospitales públicos en el mercado de servicios de salud. p. 2-5.
11. Wodon QT, editor. Poverty and policy in Latin America and the Caribbean. Washington, DC: World Bank; 2000. p. 53-8. (World Bank Technical Paper, 467).
12. World Health Organization. World health report 2000: health systems: improving performance. Geneva; 2000. What resources are needed; p. 73-7.