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Decentralization and Health System Governance

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Introduction

The contribution of health policy research to both the theory and the practice of decentralization has been voluminous but often disappointing. This chapter argues that the challenge for health systems analysts is to adopt and use categories from other social sciences, especially economics, political science, and comparative social policy, in a thoughtful way. Their concepts and analyses engage with fundamental issues of institutional design that explain the causes and consequences of decentralization in meaningful ways.

These categories and concepts will allow analysis of health systems and policies to engage with debates about absolutely crucial questions: how do policies get made? What determines the patterns of equality and inequality in society? What kinds of structures promote quality, access, and cost containment? How do we promote citizen and patient engagement in health policy? How do we prepare systems to face new challenges as diverse as technological change, the demographic transition, and global warming?

What is decentralization?

Decentralization is one of the most popular and controversial components of health sector reform, a core issue for health system governance. Unsurprisingly, it is hard to define (Peckham et al., 2007). Various definitions have been widely accepted and diffused by researchers and international agencies, such as the World Bank and World Health Organization (WHO), as a guide to member countries, as a reason for decentralize and as solutions for state building. Policy recommendations are vital but are, of course, only one side of the problem. Implementing the allocation of resources, legal power to act, and responsibility for provision to lower levels of government has proved to be a highly contested effort. Furthermore, the terminology of federalism and decentralization might

have different understandings within countries or even within government departments. As a result, application of any given definition depends on real empirical backing, since legal arrangements can be misleading; for instance, in Italy, there was a gap of decades between the constitutional provision creating regions and the actual creation of regions as functional governments (Fargion, 2005).

One approach is to focus on legal terminology, notably in the discussion of whether a given country is 'federal'. This approach is unproductive for scholars of health policy; not only is federalism open to definitional dispute, but there are formally non-federal countries with extensive autonomy for component units and there are federal countries in which the federal government dominates policy (Rodden, 2004).

One of most popular approaches, which very much avoids the trap of legalism, is to sidestep debates about federalism and simply define decentralization as the transfer of authority for planning, management, and decision-making from central to lower levels of government. A typology developed by Rondinelli, a World Bank economist, a classic in the field, states that delegation is the transfer of responsibility to a lower level of government or organization, devolution is the transfer of authority to the lowest political level, de-concentration involves the allocation of responsibilities to a lower administrative level (local branches of the same organization), and privatization means the transfer of functions from public to private sector (Rondinelli, 1983). Rondinelli's definition has had surprisingly broad impact on the literature given its serious flaws. Informed by the early 1980s commitment of the World Bank to shrinking states and expanding markets, it combines almost every policy initiative that shrinks the central state into an overly broad analytical category.

The drawbacks of Rondinelli's approach include one that is common to many technocratic analyses of health policy: a lack of attention to the kind of units that are to have more powers under decentralization. Privatization and moving bureaucrats' offices around are obviously not the same phenomena as assigning powers and responsibilities to different units within government. But even when we focus on decentralization properly understood, as internal to the state, there is a key distinction that many analyses downplay (Saltman et al., 2007). That is the distinction between elected and unelected units of government – between political and administrative decentralization.

The basic difference is that elected governments have politicians who are substantially accountable to their voters for their actions. Elected and unelected units are very different creatures, and an analysis that muddies the difference is likely to produce weak analysis and weaker policy advice. There are two basic reasons. First, elected governments are locally accountable and therefore might not want to do what the central government asks. Second, politicians seeking electoral office are a very different kind of actor from bureaucrats appointed to a

given position, and have incentives to seek credit, avoid blame, promote their party, and defend their autonomy. As a result, decentralization within a central state, as in the French Regional Health Authorities (Jones, 2013) or Health Boards in Scotland (Bevan et al., 2014), can be seen as a kind of administrative reform and judged accordingly, while decentralization to elected governments needs to be seen as constitutional politics, with accordingly higher stakes and unpredictability. They should neither be conceptualized, nor recommended, nor evaluated in the same way.

Progressing past this distinction, a useful approach, developed in health services research, has been the analysis of 'decision spaces' (Bossert, 1998). Bossert's approach focuses on identifying the scope and terrain in which a given government can make and implement its decisions. A government tightly bound by law and limited resources has a limited decision space, while one with extensive legal autonomy and revenues has a large decision space. The virtue of this approach is that it allows researchers and policy-makers to focus on what a given government can do and what constraints it faces. It thereby allows them to tailor recommendations to their addresses' actual capacities, and contribute to broader political discussions about what kind of decentralization is advisable. Its limitation is that the comparative analysis of decision spaces rapidly points to a few recurrent patterns known to students of comparative politics. Working out what constitutes decision space depends on comparative politics insight.

For comparative research, the most developed framework is that of the Regional Authority Index, which divides decentralization into 'self-rule' or a single government's ability to make policies on its own, and 'shared rule' or the extent to which a government (Elazar 1987) can influence another level of government. These two do not automatically correlate: in German health policy there is a very high level of shared rule and limited regional self-rule, while in Canada provincial self-rule is very impressive and shared rule very limited. The Regional Authority Index has been very open about its coding and data, though it does not have very specific health sector data (Hooghe et al., 2010).

The Organisation for Economic Co-operation and Development (OECD), meanwhile, has been expanding its research programmes on decentralization, with increasing amounts of work from both its health division (Paris et al., 2010) and its Fiscal Network, which considers broader expenditure issues including health expenditure. The next section discusses some of the research agendas that have worked with this data.

Effects of decentralization

The literature on decentralization is large and diffuse, and often highly normative. There are three broad approaches with different focuses whose findings

collectively fit together, but present a long string of specific questions. They come from, respectively, the economics discipline, political science, and comparative social policy scholars. All three focus on the design, responsibilities, actions, and interactions of elected governments; de-concentration or administrative reshuffles within health ministries are best regarded from the perspective of public administration and management.

Economic models

The welfare economics literature has long argued that the provision of public services, such as healthcare, should be located at the lowest feasible jurisdictional level. Smaller governments would be more responsive to the preferences of their constituencies, therefore providing better services (Oates, 1999). For this reason, in a policy recommendation paper, the World Bank argues that decentralization 'can help to improve the performance of the public sector, assist in combating corruption and help countries in their efforts to reduce poverty' (Wetzel, 2001). The rationale is that because local governments are closer to citizens, they would be better informed on the needs and demands of the population and therefore could provide services more efficiently than the central government. This is the basic concept of 'subsidiarity', whose meaning in economics and liberal political thought is that affairs should be left up to individuals and the lowest possible level of government; this is distinct from a more Catholic concept of subsidiarity, which puts the focus on families and institutions such as the Church.

A second economic argument focuses on competitive intergovernmental relations, drawing from the Tiebout (1956) model, for local expenditure on public goods. In this model, local governments compete among themselves and firms to provide public services at a reasonable price. Citizens would 'vote with their feet' and settle in communities that offer a mix of services that suit their preferences. The larger the number of jurisdictions and variations among them, the better are the chances consumer-voters have to satisfy their preferences. Similarly, jurisdictions might offer services to attract certain types of consumer-voters and firms.

Competitive intergovernmental relations could also lead to a race to the bottom; for instance rivalry between jurisdictions and firms could be so intense that local governments would have incentive to lower taxes, public spending, and regulatory standards. In healthcare, this would mean a restricted package of care, such as a low priority for chronically sick or elderly people or policies that restrict access. As with most economic models, there is a germ of truth in the Tiebout approach, but its restrictive assumptions automatically mean that it is a thought experiment rather than a description of reality. Notably, empirical literature on races to the bottom does not find them universal or reliably consequential (Hansen, 2006).

Combining these two concepts – subsidiarity and competition – we arrive at the basic dictum of fiscal federalism, which is that policies should be carried out at the most localized level that can internalize its externalities. It suggests that health systems should be financed with the largest possible risk pool and greatest diversities of taxes, while delivery that demands local administration and accountability is a good candidate for decentralization, and economic development issues (such as elaborate hospital facilities or subsidies to pharmaceutical firms) might be decentralized so that competition can discipline excess (Peterson, 1995).

Testing this logic in the case of health systems of Europe, Adolph and collaborators (2012) found broad compatibility with this dictum. Countries broadly followed the predictions of fiscal federalism, with the national level being responsible for framing laws, financing, and running pharmaceutical policy, provision at the regional level, and implementation, and public health responsibility spread across levels of government. However, this study found substantial variation in keeping with political realities such as the presence of stateless nations and the recency of decentralization – the focus of political approaches.

Political approaches

In contrast to the above, the politics literature questions the understanding of health system as a rational economic decision. According to 'second generation of fiscal federalism' as defined by its apparent leader, Barry Weingast (2009), efficient decentralization depends on the political context and institutions capable of constraining self-interested politicians. Therefore, political context may reflect several threats to federations such as large regional debts if regions are not bound to national borrowing rules (Rodden, 2005) or excess provision of services (Berry, 2009); the results could be needlessly distortive, inefficient, costly, or inequitable and even undermine the stability of the federal state (Bednar, 2009).

The question is then which political institutions matter for decentralization. Comparative studies of the effects of decentralization on welfare states point to a combination of institutional mechanisms. The first is the structure of veto players (actors capable of blocking legislation), such as the presence of a second house (bicameralism) that can have a different composition and create opportunities to block legislation (Tsebelis, 2002). A second is the extent of autonomy of sub-national governments and the mechanisms of coordination by the central government. They might or might not care to collaborate and make policy successful, as the development of the Affordable Care Act in the United States has shown us (Jones and Greer, 2013).

The third important variable to consider is then the ability of jurisdictions to raise and allocate funds. Even elected jurisdictions might not have

full autonomy to legislate or decide over public policies attributed to them. Financial limitation and conditions attached to earmarked funding imposed by the centre affect which policies will be provided and to whom.

The politics literature also engages with the proposition that decentralization produces increased efficiency or quality through democratization. The literature on this topic is essentially ambiguous: decentralization changes governance and its effects, but does not have systematic predictable effects in theory (Treisman, 2007) or in overall practice (Gerring and Thacker, 2008) or in health (Costa i Font and Greer, 2013; Greer, 2006).

Finally, there is a group of scholars that is concerned with bureaucracy and coordination problems effects of decentralization. This assorted literature relies on geography reasoning and the problems of territorial control – what we might call 'feasible federalism' (Adolph et al., 2012: 1597). It has to be considered that larger states may have diversity and geographical problems that suggest the need for strong regional governments, while small states face fewer problems of allocating authority to specific levels of government. For health governance, this means that states with larger populations generally have powerful regional governments than smaller states.

However, more governments mean more need for intergovernmental coordination. It is hard to coordinate among different units of a single organization, but harder still if it involves coordination between different elected politicians with their own local, electoral, partisan, and policy objectives. The result is that while on one hand most big states are decentralized, on the other hand most decentralized states have extensive literatures about the problems of intergovernmental coordination (Trench, 2007).

One of the biggest weaknesses of this approach is its institutionalist focus. With a few notable exceptions (e.g. Béland and Lecours, 2008; Erk and Koning, 2009), the political science approach focuses on institutions as both cause and consequence and prefers to seek causes within institutional design. While there is a logic to this approach, especially if it is contributing to debates about institutional design, it has limitations: few of the authors in this tradition deal with the interaction between institutions and contextual factors such as inequality, economic change, and evolving political preferences. Institutions reflect the preferences of the people who set them up, but after that they shape preferences in most of these models – which is at odds with the many ways in which decentralized states and health systems are being changed right now by forces such as Europeanization, financialization, demographic transition, new social risks, and the rise of the carceral state with its dramatic health consequences.

Comparative health and social policy

This literature, which straddles sociology, political science, and social policy, has been focused on the search for a simple answer to one key question: what

is the relationship between decentralization and the generosity of the welfare state? There have been two main approaches (Greer, 2009). On one side, there is a macro-comparative literature which finds a relationship between political decentralization and less generous welfare states (Castles, 1999; Huber and Stephens, 2001). The posited mechanism is generally 'fragmentation', which impedes decisive legislation (Huber et al., 1993). The category is a rather vague one, incorporating federalism, bicameralism, and referenda – an effective variable for explaining politics in Switzerland and the United States, less so in Belgium or Spain. It is also compatible with economic arguments that intergovernmental competition reduces the size of the government overall by disciplining expenditure by sub-national governments.

The problem with the finding is that it is in a sense fictitious: 'fragmentation' is a combination of very different aspects of shared and self-rule, and the generosity of the overall welfare state is an average that obscures territorial policy variation; in this literature, data either are often confined to pensions or are very aggregated OECD data.

On the other side, there is a literature composed of case studies and qualitative research on the social policies of sub-national governments. This literature frequently finds that they are leaders in the generosity and effectiveness of policy development (e.g. McEwen and Moreno, 2005). The problem with such studies is often weak external validity and case biases, especially towards the study of Catalonia, Quebec, and Scotland.

When it is hard to reconcile case studies in comparative politics with quantitative analyses, the problem is likely to be in the quantitative variables; with aggregate (or pensions-only) data for a dependent variable, and fragmentation for an independent variable, it is easy to see the reductivism of such analyses. As with the economic and political science approaches, the result is to direct our attention to key variables below the level of 'decentralization'.

Key variables of decentralization

What, then, are the issues that have been identified and which contribute to the effect of decentralization on health systems (Greer, 2009)? The first is the allocation of resources. What can regional or local governments do? The source of local and regional government revenues matters in a number of ways. Insofar as local and regional governments depend on their own tax bases, the result is inter-territorial inequality; richer regions will generally have lower tax rates and better services than poorer ones. Insofar as they are beneficiaries of inter-territorial redistribution, the scope for equalization is increased but their lines of accountability become more confusing. A regional government that relies on the central state for much of its revenue can be torn between accountability to the central government and accountability to its own voters. Accountability

to the central state can involve, for example, conditional grants in which the central state finances regional activities that conform to its requirements. The basic question for policy analysts to ask is how much interregional equalization takes place between governments, and what conditions come with it.

The second, also crucial, is the allocation of responsibility. What can governments do, what must they do, and what tools are available to them to do it? Decentralized countries generally have constitutional and ordinary laws that explain the allocation of powers, sometimes in great detail, as in Spain or Italy, and sometimes in the form of short constitutional documents that enumerate the powers of the federal government, as in the United States or Canada. In practice, constitutions are not a very good guide to actual activity and must be complemented by policy analysis: which governments actually are legally bound to do what? For example, in Germany, the core social insurance system is federal, but hospital planning is under the authority of the *Länder*, which are regional governments.

Finance and responsibility, put together, constitute self-rule in the terms of the Regional Authority Index: the extent to which a given regional or local government can make its own decisions independent of constraint from another government. The next question is shared rule: the extent to which governments can influence each other. In Germany, for example, *Länder* responsibility for hospitals means that regional governments are involved in many health policy decisions at the federal level. By contrast, Canada's centralized provincial and federal governments deal with each other in a diplomatic style reminiscent of international politics, and US states are often little more than lobbies in Washington.

Behind this institutional structure lie a wide range of contextual factors, starting with inter-territorial and interpersonal inequality – the distribution of wealth across territory, the distribution of wealth across the population, and the distribution of rich and poor within each territory. These shape the effects of central and regional programmes (decentralizing programmes can exacerbate both kinds of inequalities) as well as the politics determining financial formulas and regional responsibilities.

The biggest contextual factor is the one that explains decentralization in many states: diversity. While there are some homogeneous decentralized states, such as Austria, Brazil, and the United States, there are also states that are decentralized in order to hold together (Stepan, 1999) in the face of pressures for greater autonomy by their component stateless nations. Decentralization in Belgium, Canada, Spain, the United Kingdom, and arguably Italy and Switzerland is explained by the difficulties of democratic coexistence for multiple nations within a single state. This kind of decentralization puts the spotlight on a fact that can be obscured in other cases: federalism and decentralization are frequently conditions of the existence of the state. It is not

just an entrenched fact in Canada or Belgium – and it is hard to imagine those countries re-centralizing, no matter what good it might do for their health systems. It is also entrenched for good political reasons. The result is that analyses from small, homogeneous countries that centralize or decentralize on the margins of local government or within the state apparatus have almost no applicability to the problems of multinational states with powerful decentralized governments.

Finally, some variables seem impervious to any broad-brush decentralizing approach. Corruption, for example, seems to have no consistent relationship with decentralization. For every case of local transparency and accountability-improving governance, there is a case of local trouble, with decentralized governments forming the backwaters of corruption, and there are many cases of ambiguous outcomes (Grindle, 2009). Reformers pin hopes on decentralization in corrupt centralized systems, and pin hopes on centralization in decentralized corrupt systems.

Likewise, it is essentially impossible to come up with generalizations about the relationship between decentralization and health policy's trinity of cost containment, quality, and access. While there are cases of decentralization contributing to the expansion of healthcare access by causing governments to compete on generosity, there are also stories of decentralization producing fiscal strains that diminished quality and access; in Spain, the former was the case in the 1980s (Costa-Font and Rico, 2006) and the latter the case after 2010 (Greer, 2010).

In some countries, there has been evidence that decentralization caused governments to compete to do better (Wallner, 2012), as for example happened with waiting times among the different UK health systems, but that depends on a certain amount of luck as well as political agendas and is by no means certain. A positive relationship between decentralization and quality, cost containment, or access would be assisted by improved, comparable, regional data on inputs, outputs, and outcomes. Such data are surprisingly sparse in many countries (Bevan et al., 2014).

Case studies

These two illustrative cases present some of the healthcare decentralization dimensions but do not mean to provide a comprehensive analysis. The first case is Brazil, a homogeneous, middle-income, long-standing federal state, which turns out to be more centralized than the label federal would suggest, and whose centralization has contributed to dramatic health policy and health advances in recent years.

The second case is the United Kingdom, long regarded as centralized, but which is actually a multinational state whose ethnic conflict management has

created centrifugal politics with four very different health policies emerging amidst debates about whether the state should remain intact at all. They show different advantages to centralization, which overcame problematic local and state policies in Brazil, and to decentralization, which permitted experimentation and allowed parts of the United Kingdom to escape English reforms. They also show that decentralization is no simple concept.

Brazil: 'Centralized decentralization'

Brazil has one of the most decentralized health systems among developing countries, with more than 5,000 municipalities and 27 states being responsible for healthcare provision. A reform conducted in 1988 determined a free and universal, tax-based system that is different from the previous model of private healthcare, targeted to formal workers and centrally managed. The municipalities became responsible for planning and organizing local initiatives in collaboration with states, while the Ministry of Health (MoH) is responsible for coordination and financing the system (for an overview, see Chapter 13 by Giovanella and Faria).

Decentralization of the health sector in Brazil is paradoxical. Although the reform increased the autonomy of local governments in the provision of healthcare, the union still has the authority to legislate on where and how much resources will be used. For example, local governments are bound by the constitution to spend at least 15 per cent of their revenues on healthcare, and recently approved federal legislation set the items of spending that can be understood as health expenditures. Had the states wielded veto power over the central government, it would be unlikely that these changes would have occurred (Arretche, 2009). Therefore, local policy choices in healthcare cannot be understood if we do not take federal norms into account.

During the 1990s, several ministerial directives (*normas operacionais básicas*, NOBs) were issued to regulate the transfer of federal resources, planning, and social control to sub-national governments (Levcovitz et al., 2001). Because the municipalities have constitutional autonomy to decide over healthcare, the first NOB on health in 1991 received little support from local governments (22 per cent) as there was no stable source of funds to commit to the MoH demands. After a period of intergovernmental negotiation, a new resolution was issued in 1993, increasing the flexibility of local governments to decide, based on their administrative capacity, which services they would be able to provide – ranging from primary to secondary and tertiary healthcare. Because the MoH was still facing a shortage of resources, only 63 per cent of the municipalities committed to some level of healthcare provision and only 114 municipalities took full responsibility, including tertiary care.

The 1996 NOB established that federal healthcare transfers would be made directly to a specific account of states and municipalities for healthcare funding.

Resources coming from banking transactions and from legislation binding the three levels of government to commit resources for healthcare increased the ability of the MoH to finance the system, and virtually all sub-national governments adhered to the national policy orientations. A failure to comply with the agreements would disqualify the municipality from receiving resources in the following year.

In 2006, a new ministerial directive was issued to reorganize the federal transfers to sub-national governments. Since 1996, resources had been earmarked to 130 specific health programmes, such as HIV/AIDS and dental assistance, conditioned to the rules of the MoH for each programme. The 2006 resolution merged the programmes into blocks of funding such as for health surveillance or pharmaceutical assistance. The federal government's objective was to reduce fragmentation and increase the decision space of local governments on where to allocate these funds. Nevertheless, the creation of the block funding was not able to break the fragmentation in healthcare funding, as earmarked transfers are still in operation within each block.

If sub-national governments had opted not to adhere to the MoH resolutions, it would have increased their self-rule – their capacity to formulate their own health policies – but it would have cost them the federal transfers. Because in 2010 half of the municipalities received only 5 per cent of their total budget from their own revenues, federal transfers are crucial for healthcare implementation for most local governments in Brazil (Arretche and Fonseca, 2014). As sub-national governments began to adapt to the MoH guidelines throughout the 1990s, the cost to reverse the commitments made so far increased as several initiatives were already in operation.

In summary, the starting premise that Brazil is a highly decentralized nation whose federalism constrains its welfare state and democracy is only partly right. Once we examine the legal and financial power that the federal government has developed, we see a much higher degree of centralization in its health system.

The United Kingdom: 'The fragile divergence machine'

Brazil has been federal for a very long time, and its borders and basic national homogeneity have been established for an equally long time. The United Kingdom presents a very different picture. By long-time caricature a unitary state synonymous with 'England', it is actually a recently decentralized state with the basic politics and institutions underlying its allocation of health policy powers and responsibilities shaped by multinational population (Greer, 2004; Trench, 2007).

The United Kingdom of Great Britain and Northern Ireland, to use its full name, is presently formed out of four different jurisdictions with different political histories. England is the largest, with about 85 per cent of the population and annual gross domestic product (GDP) of the United Kingdom, but Northern

Ireland, Scotland, and Wales are separate jurisdictions with, since 1998, their own 'devolved' autonomous governments that are responsible for operation of social services. England has no government of its own; it is governed directly by the UK government.

Devolved administrations are funded by unconditional block grants whose allocation, through the Barnett formula, builds in a very gentle decrease in funding disparities and gives the devolved administrations higher per capita public expenditure than the equivalent English services. Since the inherited allocation of funds has no relationship to any definition of need, it is possible to critique the formula from many perspectives. The solution has been to increase the Scottish government's percentage of resources that it makes up from Scottish taxes. The theory is that this will increase the accountability of the Scottish government to its voters, increase its autonomy, and defuse the argument that Scotland should have more autonomy.

This system was not developed as a health policy but as a response to the problems of managing a multinational state. The United Kingdom had long had a system of administrative decentralization, with separate territorial administrations for Northern Ireland, Scotland, and Wales to reflect their very different and complex histories. But these administratively decentralized units rarely diverged in policy; any divergence was in implementation and in the actors involved in policy. Contentious policies of the Conservative governments of Margaret Thatcher and John Major meant that the Labour party, when it came to office, was converted to devolution and easily able to win referendums creating the decentralized Scottish and Welsh governments. Decentralization in Northern Ireland, also a Labour action, was a part of its long-standing and complex sectarian politics.

While dissatisfaction of regional elites in Scotland, including those who worked in healthcare, certainly contributed to the formation of a decentralizing consensus, and health services were part of a generally social-democratic tone to Scottish nationalism, it would be strange to regard Scottish or Welsh devolution as a policy decision to be evaluated for its health policy impact. Rather, any negative consequences are part of a complex multinational politics to be managed, and the interaction of nationalism and health policy is woefully understudied (for an exception, see Béland and Lecours, 2008). Scotland's failed 2014 referendum on secession has given impetus to plans for further devolution of taxing and spending responsibilities.

The combination of broad responsibilities for welfare state services and very limited financial autonomy means that the devolved and UK governments have considerable autonomy to pursue different models of health service organization, but limited ability to seriously change service provision. The asymmetry of the United Kingdom, in both the power of the UK government and the sheer size of England, also means that the UK government's policies constrain

devolved policies. Human resources for health, for example, is an area that is heavily influenced by the size of the English educational system, training system, and labour market (Greer and Trench, 2010).

Since 1998, there has been a double movement in UK health policies (Greer, 2013). On one hand, each of the four governments has tightened the central grip on health services at the expense of local units and professionals, albeit in very different ways such as mergers in Wales and very powerful regulators in England. On the other hand, politicians have found very limited incentive to pay attention to health services in each other's systems, and so there is little effort to coordinate even what should, legally, be coordinated (Greer and Trench, 2010).

If Brazil's lesson is that superficially decentralized systems can have a high level of centralization, sufficient to create Brazil-wide health policies, the lesson of the United Kingdom is that the politics of multinational states can create impressive levels of divergence. The lesson of both countries is that the word 'decentralization' or 'federalism' means little; what matters is how laws, money, and policies actually work.

Conclusion

Decentralization is often presented as if it were a simple, technocratic, good thing for health policy. Less frequently, it is presented as if it were a simple, misguided, bad thing for health policy. But the word 'decentralization' contains many things. The effects of a given decentralizing policy depend on the details of the politics, the policy, and the context. It is no panacea. Neither policy research nor policy advice benefits from treating centralization or decentralization as a simple concept.

Rather, the answer to the question of what decentralization does to health is simple: it depends. And as always when 'it depends' is the answer, the solution is to move to a more theoretically informed, but precise level of analysis. Health policy scholars would be advised to draw on the valuable concepts and debates from the rest of the social sciences, which show us the way – and also make it clear just how much the rich empirical evidence from healthcare research has to offer. In the meantime, a degree of caution in policy advice and analysis about the costs and benefits of rearranging territorial institutions for healthcare would be advisable.

Summary

- Decentralization of different services, to different kinds of elected and unelected governments, under different circumstances, has substantially different effects. Political decentralization is radically different from

administrative decentralization, and analysis or policy advice that confuses them will be unhelpful.
- There is no consistent effect of decentralization; costs and benefits in terms of efficiency, responsiveness, innovation, competition, and democracy all depend on complex institutional, historical, and service delivery issues.
- The specific design of decentralized governance can have substantial consequences for the incentives and constraints facing policy-makers.
- Decentralization, and the specific way it is organized, can have important effects on the equality and equity of health services, though there are serious data problems in gauging its effects.

Key reading

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