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Federalism and Decentralization in the Health Care Sector

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Federalism and Decentralization in the Health Care Sector

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Introduction

Health care is one of the most financially onerous and contested social policy responsibilities of governments in the early 21st century. In the summer of 2011, we were asked by the Forum of Federations to conduct a multi-country study on federalism and decentralization in the governance, financing, administration or delivery of health care. Our contributors examined Switzerland, Canada, Germany, Pakistan, South Africa, Brazil, Mexico and Nigeria. This particular selection offered a good range of different approaches to federalism and health system decentralization upon which to draw policy lessons and for those latter understudied countries, a base line for future scholarly investigation.

We developed a detailed, common template based on a comparative policy methodology developed by Rose (2005) and the use of decision space analysis as originally proposed by Bossert (1998) and as subsequently developed in the health systems literature (Roman et al. 2017). While most conceptual frameworks on decentralization tend to privilege structure, we used a decision space analysis that allowed us to evaluate the implementation and ongoing management – the practices on the ground – of any health system.

In each federation, authors identified and described five structural features comparable across jurisdictions: 1) the assignment of constitutional responsibility for health and healthcare; 2) the existence (or not) of a national law on healthcare establishing rights and responsibilities; 3) the sources of revenue directed to public sector health care and the public and private sources and proportion of financing; 4) the funding and budgeting process of the central government's health ministry relative to that of the subnational governments; and 5) the organization and governance of the publicly financed or subsidized part of the health system.

Using the decision space analysis approach, we also sought to address the following issues related to health system decentralization:

- The range of decision space choices (narrow, moderate, wide) in terms of governance rules, access rules, health human resources, health organization and financing
- The capacities of subnational governments and delegated health authorities
- The relative reliance of subnational governments on external (central government revenues) as opposed to internal revenues for health expenditures
- The extent of conditionality attached to central government health transfers to subnational governments
- The nature of the interactions between central and subnational governments in terms of health policy and planning including the intergovernmental mechanisms
- The trends in the last 5-10 years in terms of health system decentralization or centralization

All eight case studies are recognized as constitutional federations (Griffiths 2002), however, they differ in terms of the age and historical evolution, economic and social circumstances, and stability and degree of political, fiscal and constitutional decentralization. Based on the World Bank rankings, the countries can be classified into three groups: high-income (Canada, Germany, and Switzerland), high middle-income (Brazil, Mexico, and South Africa) and low middle-income (Nigeria and Pakistan). While some have experienced long periods of peace and great political stability, others have suffered through protracted periods of war and dictatorship. Indeed, some countries face ongoing threats of secession from some of their constituent units and the possibility of civil war, factors that can have a pronounced impact on the structure and management of these federations (Marchildon 2009).

A constitution is not amendable except through a procedure that generally requires the consent of a significant proportion of the constituent units. These constituent units at the regional level – known as states, provinces, cantons, or Länder depending on the country – are orders of government, with a parallel authority to that of the central government, with the ability to act directly for their respective residents. In all cases, constitutions assign powers to the central government and the constituent units. In some countries, powers are constitutionally divided between two levels of government, and in others, among three – central, regional, and local. The starting point for understanding how a particular health system is configured in constitutional federations begins with an examination of the country's constitution.

Constitutions in some countries assign powers in health and health care to respective orders of government in watertight compartments. In contrast, other countries have constitutions which ignore health care as a category, and responsibility and authority must be inferred from more general language. In a few cases, constitutions assign the responsibility for health care to two or more levels of government in "concurrent" lists of functions that are either shared or managed in a parallel fashion. It is essential to examine the actual practices of the governments that constitute a federation to determine the degree of health system centralization or decentralization.

In some cases, the fiscal capacity of the constituent unit is sufficient to carry out its health system responsibilities but in other cases it is almost entirely reliant on fiscal transfers from the central government and thus subject to considerable political pressure and influence in the exercise of its authority. In some cases, the central government establishes a right of access to health care that may create an obligation that the constituent units only have limited capacity to deliver – what some might call an unfunded or underfunded mandate.

Health system centralization or decentralization in federal countries must be put into the context of the overall decentralization of these particular federations. Two methods have been devised to measure the degree of decentralization. The first is to determine the fiscal capacity of the central government relative to its constituent units. This analysis was

completed by federalism scholar Ron Watts for each of our case studies with the exception of Pakistan (Watts 2008).

Table 1.1: Fiscal Capacity of Central Governments Relative to Constituent Units, 2000-2004

Federal country case studies	Central government revenues (before transfers) as a % of total government revenues	Central governments transfers as a % of constituent unit revenues	Central government expenditures (after transfers) as a % of total government expenditures
Switzerland	40.0	24.8	32.0
Canada	47.2	12.9	37.0
Germany	65.0	43.8	37.0
Brazil	69.2	30.0	59.5
South Africa	82.0	96.1	50.0
Mexico	91.3	87.9	58.7
Nigeria	98.0	89.0	59.7
Source: Derived from Watts (2008), Table 9 (p. 102), Table 10 (p. 103), and Table 11 (p. 105).			

Table 1.1 presents the countries ranked in ascending order of the central governments' revenues (before transfers) as a percentage of total government revenues. This first column illustrates the federal government's fiscal capacity, including its potential to use transfers to subnational governments to exercise its policy influence – generally referred to as the spending power in federal systems (Watts 2009). The higher the average per capita income in a country, the greater the degree of decentralization, whereas lower per capita incomes are associated with more centralized federations. The second column provides an overall picture of the degree to which constituent units are reliant on central government revenues. Health care can be one of the most extensive areas of responsibility assumed by constituent units and the revenues needed to deliver these services requires some combination of own-source revenues and transfers from the central government. The third column presents the expenditures of central governments as a percentage of all government (federal, regional, local) spending once all transfers have been made.

We also compared federations based on their respective degree of both de facto decentralization and constitutional decentralization using Ferran Requejo's results. The former is calculated on a host of political and fiscal factors and outcomes while the latter is based on the constitutional division of powers and formal governmental structures. Each of these forms of decentralization is enumerated on Requejo's 20-point scale (20 being the most decentralized) based on a range of indicators including, for example: the constitutional guarantee of subnational self-government; an upper chamber with representatives appointed by subnational institutions; the allocation of unallocated powers to subnational governments; and the regulated right of secession of at least some subnational units (Requejo 2010). Table 1.2 summarizes Requejo's results for six of our country case studies since Pakistan and Nigeria were not assessed in his study.

Table 1.2: Degree of Actual and Constitutional Decentralization Based on 20-point Scale

Federal country case studies	**Degree of de facto federalism**	**Degree of structural decentralization**
Canada	16.5	13.0
Switzerland	14.0	15.0
Germany	12.0	14.0
Brazil	11.0	13.5
South Africa	7.0	9.0
Mexico	5.0	11.0
Source: Derived from Requejo (2010), Table 13.2, p. 287.		

The results are mainly consistent with Table 1.1 with two important differences. First, Canada is more decentralized than its constitutional form would imply, a result that is consistent with the high degree of fiscal autonomy exercised by its provincial governments. Second, South Africa is less decentralized than its formal governmental structure would indicate, a fact that is also consistent with the fiscal power of the central government and the correspondingly limited fiscal capacity of provincial governments in that country.

Health System Decentralization in Practice and the Decision Space Framework

To provide a comparative framework for this study, we examined health system decentralization in terms of the "decision space" that constituent units exercise in practice. This allowed us to consider the other laws and intergovernmental practices that determine the actual autonomy of constituent units. This analysis was first developed, applied and extended by one of the editors in his earlier work (Bossert 1998; Mitchell and Bossert 2010; Bossert 2015). Decision space is categorized according to the degree of decision-making choice in terms of key functions, shown below in Table 1.3, and sub-functions under each function. For each function, subnational units are determined to have either *narrow*, *moderate*, or *wide* decision space in administering their responsibilities.

Table 1.3: Health Care Decision Space for Subnational States within Federations

Functions	Range of Choice		
	Narrow	Moderate	Wide
Financing (revenue and expenditures)			
Service organization and delivery (required programs, payment mechanisms, autonomy of hospitals, and local insurance plans)			
Human resources (salaries, contracting, civil service rules)			
Access rules (targeting, benefits)			
Governance rules			
Source: Derived from Bossert (1998) and Mitchell and Bossert (2010)			

The *financing* functions focused on how much choice the subnational units had for raising revenue and allocating expenditures. *Service organization* includes autonomous hospitals, local insurance plans, payment mechanisms and norms and standards, including required programs. In many countries national control over norms, standards and required programs is a significant means by which central authorities restrict local choice. *Human resources*, including choices over salary levels, making contracts with individual providers, and civil service rules is a major decision-making area and is often defined by national rules. *Access rules* define the populations that are targeted for specific attention, especially for subsidies, free access to public facilities or social insurance. *Governance rules* involve choices of the composition of facility boards, district offices and types of community participation.

We then asked the authors to focus on three areas associated with health system decentralization. First, to identify the fiscal capacity of constituent units to generate own-source revenues and the administrative (i.e. human) capacity to regulate, implement and manage subnational health systems. Second, to examine central government fiscal transfers to constituent units by describing the proportion and extent to which health transfers are conditional or unconditional and, if possible, the extent to which the transferring government achieves its policy purpose, and the extent of policy autonomy of receiving governments. Third, to describe the intergovernmental processes and agencies as well as the coordinating mechanisms with some assessment of the federalism culture as they pertain to health care policies and programs.

The authors needed considerable latitude in selecting the key functions and sub-functions relevant to their respective case studies. Moreover, they had to exercise their own judgment (with some assistance from the editors to maintain consistent interpretations among authors) in deciding the degree of functional decision-making exercised by subnational states. Finally, the authors were asked to describe what they perceived to be the recent trends in centralization or decentralizations for the health system as a whole. While somewhat speculative, it is grounded in a careful study of the existing constitutional distribution of powers as well as the actual decision space choices exercised by subnational states within each country.

Federalism and Constitutional Assignment of Roles and Responsibilities

Federalism is a constitutionally determined administrative and political structure (Marchildon 2009). Constitutions in some countries (South Africa, Brazil, Mexico,) define specific roles for each level, and in others (Pakistan, Nigeria, Germany, Switzerland, South Africa,) grant authority and responsibility to several levels in "concurrent lists" of functions that are either shared or parallel in implementation. In some cases (Switzerland, Germany, South Africa, Nigeria), significant background about the general federal structure is required before discussing the specific application to health; while others (Pakistan) have constitutional items or amendments focused directly on health sector issues.

The bulk of the constitutional decentralization in some countries (Canada, Mexico, Switzerland) assigns responsibilities to the state, province or canton levels; however, in others specific responsibilities are also assigned to the next levels down, usually municipalities, districts or counties (Switzerland, Brazil, South Africa, Nigeria). In these cases, there is a competitive tension among the sub-federal levels with some countries (such as South Africa, Mexico) with strong provincial or state authorities which limit the lower levels to very narrow decision space. Brazil is an exception which by constitution assigns the major responsibility for health to the municipalities and sees the state and federal levels in a supporting role. However, in practice Brazil's Unified System restricts the decision-making power of the municipalities. In Pakistan, the constitutional amendment granting significant devolution to the provinces, has resulted in a recentralizing of authority from the districts to the provinces.

The "right to health" in both Mexican and Brazilian constitutions acts as a vehicle for federal involvement – some would say interference – in subnational states and municipalities. Similarly, the federal spending power and standards of coverage for medically necessary services in the Canada Health Act function as a constitutional means of limiting provincial decision space. Although in Switzerland the constitution explicitly makes health an individual responsibility, since it contains a constitutional commitment to equity and it requires both central and cantonal governments to assure that individuals have economic protection against illness and old age, it offers some ground for central responsibility. In Germany, the constitutional commitment to "uniform living conditions" may function in a similar way by establishing uniform rights across the different states. In South Africa, the constitution allows the federal level to intervene in provincial and municipal health governance if the provinces are not achieving national policy norms, if another province is endangered, or for national security issues.

There do not seem to be clear differences in the way decentralization in health is structured based on whether a country's governments are organized in a presidential system (Brazil, Mexico, Nigeria), a parliamentary system (Germany, Canada, Pakistan), or a mix of these two main systems (Switzerland, South Africa).

What does seem common in federal systems is the importance of coordinating mechanisms among non-federal governmental health ministers. These mechanisms include the Mexican Board of Health, the Brazilian Tripart Intergovernental Commission (CIT), the Swiss Conference of the Cantonal Ministers of Public Health (CCMPH), the Nigerian National Council on Health and the Federal/Provincial/Territorial Council of Ministers of Health in Canada. These are usually advisory bodies that provide a forum for interaction and sharing of information. In most cases, these are not bodies that can make binding decisions; however, the Swiss CCMPH is able to sign binding "treaties" with the Confederation.

There is an unusual situation in Germany where some functions are held at the national legislative level but the state governments, collectively, have a veto over changes in legislation in one house of the legislature – the *Bundesrat*. Depending on the political party that dominates the Bundesrat, this can prevent the federal executive from achieving its health policy reforms.

It is also important to consider the historical evolution of federalism – as an extreme case in Germany the states were independent before the federal government was created and indeed, the creation of the

welfare state and social insurance was part of a long historical process of strengthening the central government. Other nations were formed as federal states at the end of colonial periods that established the nation-state (Mexico, India, Pakistan, Nigeria) or in a more gradual evolution to self-government (Canada). Switzerland and South Africa may be something in between, with fierce cantonal and linguistic identities in Switzerland, and the apartheid fragmentation of townships in South Africa. Nigeria's federalism is also based on the recognition of the geographic domination of distinct ethnic groups.

Political Economy and Capacities

The cases reviewed here span a wide range of different political economy characteristics, from low-middle-income Nigeria and Pakistan to high-middle-income Brazil, Mexico and South Africa, to high-income Canada, Germany and Switzerland. The role of market economy versus more state intervention may also influence the character of decentralization. Political economy approaches also include varieties of political systems even within countries over time, including authoritarian military regimes in Nigeria and Pakistan, relatively authoritarian democratic systems such as Mexico under the PRI, and varieties of parliamentarian systems in Canada, Germany, India and Pakistan and presidential regimes in South Africa, Switzerland and Nigeria (Immergut, 1990). Recent literature on the role of corporatism as a governance structure may also influence federalist and decentralized systems (Acemoglu and Robinson 2012).

Despite the small number of cases and variety of political economy characteristics, we did identify what we call "capacities" that are at least potentially influenced by having differing levels of economic resources, different roles of the private sector and different governing structures. The capacities required by subnational governments to carry out their responsibilities seem to depend on the level of income in the country and on differences between regional and local governments. In particular, the capacity to take on greater decision space at state or provincial

levels is not an issue in high-income countries such as Canada, Germany and Switzerland. However, lack of capacity appears to be a major issue in lower-income nations, and lower administrative levels (municipal, or district) seem to have more concerns about their respective capacities to assume more "decision space." In South Africa, for example, the provinces clearly have greater capacities than do the districts; however, there is also a significant variation across the provinces in terms of both administrative capacities and the relative level of corruption.

In some middle- and low-income countries, the capacities of the national ministries of health and other health agencies such as the social insurance agencies are also limited. In South Africa and Nigeria the technical and managerial capacities at the national level are insufficient for managing a decentralized system. Fragmentation of health funding and provision, as illustrated by Mexico, can act as a further constraint in terms of subnational capacities.

In several countries (Mexico and Brazil) non-federal governments had to demonstrate capacities in order to gain additional decision space. In the first process of decentralization under the de la Madrid government in Mexico, only twelve states qualified in terms of technical staff and administrative capacity.

Corporatism in Mexico and in Germany, and to a lesser extent in Switzerland, is also an additional structure that may play an important role in decentralization. In Germany the "meso" level semi-autonomous corporatist "peak" organizations, made up of the sickness funds and the providers, are delegated the responsibility to reach agreements on payments and coverage issues, in some ways replacing the role of the governmental line organizations at the state and local levels. In Mexico the corporatist structures of the dominant political party (PRI) for decades structured the centralized health system. As democratization processes eroded the support for the PRI, openings for a more decentralized federation have encouraged greater decision space at the state level.

The fragmented financing institutions in some countries seem to have the effect of reducing some aspects of decentralization. For instance, in Mexico the large social insurance parallel system of IMSS (Mexican Social Security Institute) is a major funder and provider of

health services and is highly centralized. Another set of parallel structures in Mexico are the OPD (Decentralized Public Organizations) which manage federal block grants to the states, bypassing their state treasuries. Similarly, the alternative funding sources for social health insurance schemes in Germany and Switzerland also fragment the control that is assigned to subnational governments. So while these subnational units have increasing formal control over the public tax financed system some of that control is eroded by these parallel structures.

It has long been recognized that the degree of local control follows a sequence of ebb and flow between the center and the subnational units (Nathan 1993). Mexico, for example, decentralized to some states in the 1980s, recentralized in late 1980-90s, and decentralized again in recent years. Following another process of decentralization is the use of decentralization by democratic governments that follow centralizing military dictatorships. In Nigeria and Pakistan the drive for increased decentralization was seen as an antidote to the military government and a part of the democratization process.

States can also create greater decentralization by replacing government programs and regulation with market-based mechanisms and private sector actors. Indeed, governments have used privatization as a conscious strategy to achieve a greater level of health system decentralization (Atun 2007). However, in our case studies, it was more common for governments to introduce reforms that mimic market effects rather than engage in outright privatization.

The introduction of financing reforms in which money follows the patient rather than providing historically based budgets to facilities has had an important effect of reducing control of both federal and non-federal levels. Especially in systems where the patient can choose the location of services (as in Switzerland) or private as well as public services (as in Brazil) may lead to shifts from control by local governments to facility-level choices. South Africa, for example, is considering the creation of an insurance agency which will purchase services from both public and private facilities directly (without provincial or district involvement) and may pay according to the choice of patients.

One of the most important institutional differences among countries is whether the state funds and provides health services directly or whether the state acts principally as a regulator of health insurance. The choice of these two policy instruments is determined by the political and social history of the country as illustrated by the evolution of social health insurance (SHI) from its Bismarckian origins in the late nineteenth century (Saltman and Dubois 2004).

While often not a constitutionally assigned role (except in Switzerland), the role of SHI institutions plays another complicating factor in assessing the decision space of both the federal and non-federal governments. Although tax revenue either from the federal treasury as in Germany, or the enforced cantonal subsidy in Switzerland, is part of the SHI funding, the major source of funding comes from non-governmental SHI funds, which in general reduces central government control. Other countries, like Mexico, have a combination of funding sources including earmarked major tax transfers and a separate autonomous social insurance agency.

This issue is likely to become more important as SHI countries attempt to implement a policy of universal insurance coverage as promoted by the World Health Organization. For instance, South Africa and Mexico are discussing the introduction of National Health Insurance (NHI) in a way that introduces a major split between those holding the funds as a separate payer and the decentralized governments as organizers of providers. In addition, Nigeria has just started a social insurance program mainly for public sector employees which may be expanded to a larger portion of the population.

Decentralization: Decision Space Framework

The original contribution of this comparative study is to widen the description and possible results of federalism with a finer-grained analytical framework for defining the characteristics of decentralization, called the “decision space approach.” We examine the concept of decentralization as a way of fleshing out the concept of federalism with specific attention to the “decision space” that is allowed at the different subnational levels. In addition to the constitutional assignment of roles and

responsibilities for specific health functions, laws and practice also determine the amount of decision space that each level is able to exercise.

Each case study includes a "decision space map" which allows us to discuss the general comparative degree of decentralization for health sector decisions for the first subnational level and to assess the differences in the decision space for specific functions. The decision space for sub-federal levels for most functions is either restricted by constitutional or federal laws to narrow or moderate levels. Few functions at the subnational level have a wide range of choice. The exceptions are Pakistan and Canada, and to a lesser extent, Brazil.

The cases display a wide variation both in the types of functions that are constitutionally or legally granted to the subnational governments and their degree of choice over those functions. At one extreme is Pakistan, where wide choice has been granted to the provinces for most of the possible functions and where the ministry of health was disbanded for over a year and responsibilities for national-level health sector functions were distributed among other ministries. At the other extreme is Germany where the central government has significant control over many of the functions of the social health insurance schemes and through them the provision of services.

In general, we might array the countries from the most decentralized to the most centralized: Pakistan, Canada, Switzerland, South Africa, Brazil, Mexico, Nigeria, Germany. As this order suggests, there is no clear argument for decision space to be associated with political (authoritarian or types of democracies) or economic (high, middle or low income) factors. There are some functions that generally have been reserved to the national level, even in the extremely decentralized case of Pakistan. These include: drug quality issues, national immunization campaigns, control of epidemics, negotiation with international donors, and quality control and accreditation.

While financing decision space varied considerably, in Switzerland and Canada the non-federal levels have significant ability to mobilize their own source revenues through taxation powers. By contrast, in Germany the health insurance funds are largely dependent on national authority over income and risk definitions as well as 10% of their funding.

In the other countries (Brazil, Pakistan, Mexico, Nigeria, South Africa) the non-federal levels rely on the taxation power of the federation and are highly reliant on intergovernmental transfers from the federal government. In these countries the formality of the assignment formula and the conditionality of the grants have important implications for the decision space of the non-federal levels. Some grants are unconditional and allow states, provinces or municipalities to make decisions about how much will be allocated to health.

It is also interesting to note that the declining portion of funding from federal sources in Canada (now less than 20%) and Switzerland (only 6%) has led to greater autonomy of the provinces and cantons. In Brazil, despite the decline in central government funding from 75% to 44%, the federal funding remains substantial and supports the dominance of the Unified System. In South Africa, the formula assignment of block grants to the provinces with no conditionality has been relatively low compared to the need and left many provincial health systems with insufficient levels of health funding. In Nigeria, the block grants are unconditional but have resulted in significant differences in health allocations from state to state. State governments and hospital boards in Nigeria can raise fees without federal approval giving them moderate control over income and expenditures. In South Africa no fees are allowed for primary care but hospital fees are negotiated between provincial and federal authorities.

Service delivery decision space, including payment mechanisms for facilities, also varies considerably. Germany, Brazil, Mexico and Nigeria are relatively centralized on the choices of standards and requirements for specific health programs and rules on payments to hospitals. Canada allows some provincial choice based on medically necessary services. By contrast, Switzerland allows wide choice to the cantons. Pakistan allows considerable provincial choice limited mainly by international agreements. Choices over hospital autonomy also varied with Canada, Switzerland and Germany allowing wide choice, Mexico allowing state choice but few states using this authority. Brazil, Nigeria and Pakistan allow a moderate range of choice.

Human resources tend to be one of the most overlooked function-

al areas yet it is critical to the ability of subnational governments to administer and regulate health systems. Here, decision space for most sub-functions ranged from wide choice in the Canadian provinces and Swiss cantons to moderate for Mexican, Nigerian, and Brazilian states and German Länder. Interestingly, most human resources choices on salaries and civil service rules are still centralized in Pakistan despite the radical devolution of the 18th Amendment. They are also narrow for provinces in South Africa. Nigeria has federal salary rules but states tend to set their own salaries resulting in some labor conflicts. Civil service rules are also federally defined in Nigeria. In Germany federal guidelines on payments allow some variation in the Länder. Contracting staff is a cantonal responsibility in Switzerland and a provincial responsibility in Canada and Pakistan. In Mexico labor agreements limit the provincial authority over contracting staff. Contracting is a federal responsibility in Brazil and South Africa.

Access decisions have two fundamental dimensions. The first addresses citizens' access to insurance coverage or services. The second addresses the size of the basket of covered services. Both of these decisions tended to be defined by constitution or national level laws, even in the more decentralized countries of Switzerland and Canada. However, failure to enforce federal rules in Nigeria tends to allow states a moderate range of choice and even with federal universal access in South Africa, provinces have some choice over priorities. The link to targeting in social welfare programs allows some provincial and cantonal moderate choice in Canada and Switzerland.

Governance rules also varied considerably with South Africa and Canada having centralized definitions of facility board composition but provincial definition of district offices, while Swiss cantons have moderate choice on boards but wide choice on community participation. Although Mexico allows state decisions about state administrative structure most follow national models and no facilities have boards. In Brazil the states have authority over boards and district offices. South African provinces had moderate choice over community participation with federal expectation that provinces would encourage community participation. Although there are national guidelines in Nigeria, the lack of enforcement leads to significant variation among local governments.

In Germany the federal government has oversight over national social insurance plans but the states have oversight over state insurers.

Policy Implications

From this review we see that federalism and decentralization have significant variations among countries and that they are complex phenomena which evolve along different country-specific paths. It is extremely challenging to provide policy recommendations based on lessons from a small group of countries and apply them unmodified to others. There are no empirical studies that show the impact of different types of decentralization on health sector outcomes so we cannot conclude that one type of decentralization produces better performance than another. Nonetheless, we make a few observations that could be useful to policy makers dealing with health system decentralization within federal countries.

First, constitutions seem to play a significant role in defining the range of decision space at all levels. Without clearly specified roles for states, provinces, cantons, and local governments, the range of choice allowed at these subnational levels tends to be assumed by the national level. Therefore, policy advocates for more decentralization might try to introduce clearer subnational responsibilities in either new constitutions or amendments to existing constitutions. In the case of quasi-federations without constitutions that apportion powers and responsibilities between the central state and subnational states, decentralization advocates might consider new laws or amendments to existing laws.

Second, in more decentralized systems, policies to establish intergovernmental institutions and processes are one way to encourage cooperation and greater policy and program symmetry among the subnational units without absorbing functions into the national level.

Third, policy makers should consider the political economy of their country and governmental capacities, recognizing that greater decision space at subnational levels is likely to be more effective in higher-income democratic countries with more local democratic and administrative capacity than in low-income and less democratic contexts.

Fourth, while it is not clear that use of the market produces better

outcomes, it is likely that policy makers who are considering policies of decentralization ought to consider the potential effects of policies that introduce more market and private sector choice. More use of the market tends to give beneficiaries a greater role in determining the utilization patterns for public services and the capacities for addressing these new patters need to be developed at whatever level has more decision space.

Fifth, the current wave of interest in social health insurance makes it also important for policy makers considering decentralization policies to consider the design and implementation of this new funding mechanism. If a SHI agency is to provide funding directly to health providers, the role of direct public funding through subnational governments will be reduced since they will no longer have the "purse strings," however, they may still have influence through coordinating mechanisms and regulations.

Sixth, choices about decision space functions to be assigned to subnational units should consider that in general some functions may be best retained at the federal level: drug quality, immunization campaigns, control of epidemics, negotiation with international donors (in the case of lower-income countries), and quality control and accreditation. Financing choices that encourage greater decision space at local levels are likely to require greater local capacities both to administer those funds and to mobilize additional resources from local taxes and other revenues. Unconditional grants from the federal government are also likely to require strong local capacity to be effective. Due to the heterogeneity of the findings, our study does not provide clear policy guidance on decision space for functions of service delivery, human resources, access rules and governance.

Conclusion

This comparative overview has suggested that the concepts of federalism and decentralization cover a wide variety of actual experience. We have identified some relationships between political economy characteristics and elements of federalism and decentralization especially in

terms of capacities of health systems, specifically at lower administrative levels. We have also found some interesting policy processes that may be important for future studies: the role of corporatism and the fragmentation of the health financing systems. For our focus on decision space we find that some functions seem to be retained at the central level even in the most decentralized health systems. Who controls funding also is important in defining the range of choice allowed at lower levels, with greater dependence on central transfers reducing decision space at lower levels. We find however for most other functions, variety of decision space does not lead to clear prescriptive patterns.

While we make some policy recommendations, these are given with caution and recognized limitations. We unfortunately do not have sufficiently scientific studies to demonstrate which of these varieties has led to improved health system outcomes. The agenda for research now should focus on developing more sophisticated studies of the impact of these different characteristics on the ultimate outcomes we would like to encourage health systems to achieve: especially improved and more equitable health status, reduction of financial risk of illnesses, and general public satisfaction with their systems (Roberts et al. 2004). A significant investment in this kind of research could deliver more confident recommendations for policies.

We contend that it is important to assess federalism and decentralization in a more fine-grained analysis than the usual more simplistic forms. It is useful to describe both the functions and the range of choice that the constitutions, laws and regulations as well as actual practices in evidence at the subnational levels to understand the complex relationships embodied in each country's administrative structure. There are quite a variety of forms of decentralization in this optic of "decision space." We hope that this approach can be used in more cases to generate a more sophisticated understanding of the widely debated issues of federalism and decentralization.

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