

Health System Decentralisation in Venezuela during the 1990s

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ABSTRACT

This paper is a short view of the Decentralisation to the Regional Health Systems in Venezuela during the decade of the 1990s, and it is based on my doctoral dissertation. It begins with some theoretical and conceptual foundations used in the thesis. Second, the paper shows the analytical framework for the “policy trajectory” followed by the decentralisation process examined in the research. In a third section, some comments on the main findings with regard to the institutional outcomes are analysed, but details are not illustrated here. Section 4 is a review of the political and policy process factors conditioning the decentralisation process. Sections 5 and 6 analysed how the changes in the Venezuelan rules of the game impacted on decision rights and spaces in the Regional Health Systems. Finally, some concluding remarks are shown.

Introduction

Here the institutional challenges associated with the decentralisation within an inter-governmental relations system are examined, using a specific sector, health, and a particular country, Venezuela. To do so, we begin by analysing both the changes in the rules of the game of the inter-governmental relations system during the 1990s as a result of decentralisation and in the policy-arena constraints in the health sector in Venezuela. The idea is to identify how decentralisation of authority for the health sector has created new decision rights and spaces for Regional Governments to make reforms in terms of their strategic guidance, organisation, financing, and management of regional health services. From there, the paper examines the effects of these functional reforms on a set of institutional attributes such as autonomy, accountability, civil society participation and coordination.

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Given the exploratory nature of the research problem, qualitative methods and comparative analysis were used, as is usual in public policy and management analysis. The approach of “case studies research” served as the basis for the empirical findings, especially for the “sample” of Regional Governments examined. When relevant, in the the research some statistical tools were also used, to provide a quantitative support to the proposals.

In the paper the **Regional Health Systems** represent the main units of analysis, meaning that each Regional Health System can be seen as an organisation able to reform its functions of strategic guidance, financing and services delivery. But given the fact that the original research worked with a sample of five out of twenty-one Regional Governments, one has to be careful to refrain from making generalisations from this limited “sample”. The Venezuelan Intergovernmental Relations System and the health sector policy-arena constraints are identified as the context of the analysis.

From this derives the dimensions or variables examined, classified as follows:

- *Explanatory variables* represented by changes in the rules of the game due to decentralisation, as well as some health sector policy-arena constraints.
- *Intermediate (policy) variables* represented by the functional reforms in strategic guidance, financing and services delivery in the Regional Health Systems, using the new decision rights opened by the decentralised Intergovernmental Relations System;
- *Explained variables* represented by institutional attributes achieved by the Regional Governments (autonomy, accountability, civil society participation, and coordination). These attributes may be interpreted as institutional outputs generated by decentralisation and the consequent functional reforms in the Regional Health Systems, whenever the authorities use their decision rights and spaces to develop them.

The use of decision rights and spaces illustrates the extent to which a specific Regional Government exploits resources and incentives provided by the Regional Health Systems to

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exercise autonomy, open up to participation, and strengthen co-ordination and accountability.

1. Some theoretical foundations

Decentralisation is a concept with multiple meanings, but in order to discuss it from an intergovernmental perspective, the focus here is on the transfer of authority and functions from the Central Government to the Regional Governments, such that the latter can operate with a reasonable degree of *autonomy and accountability* in the performance of their responsibilities. But some conceptual precisions are necessary.

1.1 Theoretical framework

The decentralisation of authority and functions to Regional Governments has several dimensions: *political* (i.e. the open and transparent elections of Regional Governments authorities), *administrative* (i.e. the assignment of functional responsibilities to the Regional Governments), and *fiscal* (the assignment of sources of financing to the Regional Governments).

In order to get a better understanding of any decentralisation process it is useful to adopt a more comprehensive concept of intergovernmental relations. For instance, these relationships can be modelled as a “game” (Scharpf, 1997), where participants make use of different resources to influence outcomes, following their agendas, and subject to contextual and policy-arena constraints.

Behind this conception of intergovernmental relations, there is a policy process perspective where one finds: actors, interests, agendas and goals, resources, rules of the game, policy-arena constraints, strategies, implementation challenges, outputs and outcomes. These policy processes extended decision rights and residual rights, room for manoeuvre, and “policy spaces” for the actors involved. Thus, here we follows Grindle & Thomas (1991:8): “Within issues areas, a policy space consists of the range of options that could be

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introduced without major adverse consequences for policy makers, the regime or the reform itself.”

Given the fact that the focus was about a particular sector (health), the analysis required paying attention to sectoral policy-arena constraints conditioning to some extent the behaviour of actors involved in health policies, programmes and services. These constraints are understood here as historical circumstances, previous policy commitments, institutional capacities, authorities’ leadership, and the internal organisation, of a sector conditioning the policy space and content feasible for a reform process (Grindle & Thomas, 1991; Walt, 1998).

Following Prud’homme (1994), from a political perspective, decentralisation of an Intergovernmental Relations System is often defended under a set of promises or expectations, such as its higher *responsiveness and accountability* from the Regional Governments to the civil society; provision of public policy diversity (laboratories for democracy); acting as a countervailing power against Central Government monopolisation, and the opening of wider spaces for *civil society participation*. But decentralisation also implies some political risks such as parochialism, governance challenges due to the fragmentation in politico-electoral system and differences in political agendas, the need for political coalitions and parties discipline within Regional Governments.

Given these promises and dangers, we identified some political rules of the game and contextual conditions in the Intergovernmental Relations System that condition to some extent the behaviour of the actors and organisations involved. However, given the fact that some of them are not sufficiently explicit in the literature, here these rules have been derived from the following elements:

- i) **Electoral rules**, including open election of Regional Governments authorities, separation of these elections from the national ones, electoral system regime (proportional, first-past-the-post, mixed) and rules for representativeness of the legislature (especially with regard to territorial representation);

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- ii) **Limits on the terms of office for the Regional Governments**, affecting the temporal horizon of the political authorities;
- iii) **Rules on check and balances of different political instances** (executive, legislature and judiciary), including hierarchical political relationships and actors with veto power;
- iv) **Importance of civil society for Regional Governments legitimacy in the political and policy process**, including the issue of more territorial-driven agendas of local societies, bureaucracies and political actors;
- v) **Role of the political parties system**, including political discipline within the national parties with regard to subnational politicians.

From an economic and institutional perspective, defenders of decentralisation argue that it permits the matching of territorial provision to subnational preferences (*allocative efficiency and accountability*), facilitates mobilisation of additional resources through *public-private partnerships*, contributes to making services work fit better with communities' needs as a result of access to better information, and improves preferences aggregation because of *civil society participation*. However, decentralisation entails dangers such as inter-territorial disequilibria, fiscal indiscipline, lack of intergovernmental coordination, dispersed accountability, governance risks due to excessive participation, among others.

Given these promises and dangers, we identified some administrative rules of the game in the Intergovernmental Relations System that condition to some extent the behaviour of the actors and organisations. However, given the fact that some of them are not sufficiently explicit in the literature, here these rules have been derived from the following elements:

- i) **Legal and administrative authority for Regional Governments to assume a public function**, including the issue of concurrence or exclusiveness in the administrative authorities;
- ii) **Rules on separation of functions between levels of government** (strategic guidance, financing, services delivery, control and evaluations);

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- iii) **Institutional mechanisms for the implementation of the authority decentralisation**, including contractual risks arising from the arrangement for administrative decentralisation;
- iv) **New decision-rights and room for manoeuvre**, providing the Regional Governments with relative *autonomy* to organise public agencies territorially, appointing regional administrative authorities, and introduce new managerial strategies and practices;
- v) **National and territorial rules and practices with regard to civil service management** (hiring, remuneration, career development, etc.);
- vi) **Inter-sectoral and intra-sectoral coordination within regional jurisdictions**, as well as institutionalised mechanisms and practices for *intergovernmental coordination*;
- vii) **New accountability rules and practices** (regulations, controls, reports, communication with civil society, etc.).

Given those political and economic promises and dangers, we identified some fiscal rules of the game in the Intergovernmental Relations System that condition to some extent the behaviour of the actors and organisations involved. However, given the fact that some of them are not sufficiently explicit in the literature, here these rules have been derived from the following elements:

- i) **Regulations and practices with regard to intergovernmental transfers and own sources of revenues for financing** the autonomous and potentially *coordinated* Regional Governments performance;
- ii) **Rules on fiscal correspondence**, meaning synchronising the decentralisation of administrative responsibilities and sources of financing;
- iii) **New decision-rights and room for manoeuvre for Regional Governments**, fostering higher *autonomy* in the allocation of fiscal resources to sectors, programmes and line items, independently from those assigned by the Central Government;
- iv) **Rules and practices on mobilisation of extra resources** through *civil society participation and public-private partnerships*;

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- v) **Financial management rules and practices at all levels of government** (purchase strategies, budgeting, expenditure controls, fiscal flow mechanisms to improve promptness, etc.), providing more *accountability and transparency*.

1.2 Main concepts used

From the findings in the literature review, we made operationally the analytical framework for changes in a policy process as decentralisation, using the following concepts:

- **Rules of the game**, understood here as the set of formal and informal constraints a society establishes in order to regulate the actors' actions and interactions. Given our institutional setting in the Intergovernmental Relations System, these rules can be political, administrative and fiscal.

- **Actors**, defined here as the set of individuals, elites, groups and organisations, whose interests, policy-agendas and available *resources* make possible or not a policy process, as well as the speed and depth of its progress.

- **Contextual and sectoral policy-arena constraints**, understood here as the set of historical circumstances, sectoral regulations and practices, institutional capacities, and the internal organisation in a sector like health, which open or limit the strategic options actors can follow in the policy process of decentralisation.

- **Strategies** defined here as short and medium term actions, strategic alliances, and reactions to the actions of others, in order to achieve the actors' goals and visions, given some policy-arena constraints.

- **Institutional reforms (outputs)** in the Regional Health Systems. These reforms are defined in the same way as Grindle & Thomas (1991:4): "... deliberate efforts on the part of government to redress perceived errors in prior and existing policy and institutional

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arrangements.” A distinction is made between preliminary outputs achieved by the negotiation process of decentralisation (agreements, new rules and organisations, etc.) and institutional reforms in the strategic guidance, financing and services delivery functions of the Regional Health Systems, once the Decentralisation Agreements were signed.

- **Institutional attributes (outcomes)**, understood here as the set of effects on autonomy, accountability, civil society participation and institutional coordination generated by the above-mentioned institutional reforms. These attributes are defined as follows.

- **Autonomy:** Wider rooms for manoeuvre or residual rights for the Regional Health Systems to make the decisions about their different tasks. Autonomy can be expressed both at the *strategic and managerial level* (freedom to design policies and implement models of health care, organisation and management) and at the *fiscal level* (flexibility to move financial resources across programmes and services).
- **Accountability:** Efforts of the Regional Health Systems to inform other actors with regard to their performance. Accountability can be expressed at three levels: *procedural* (adherence to fiscal control and other public administration regulations), *to civil society* (communicating with other actors on their performance) and *in services delivery* (efforts to improve responsiveness in health management and interventions).
- **Participation:** Opening by the Regional Health Systems of spaces and mechanisms for civil society involvement in their activities. Participation can be expressed at three main stages: in *planning* (identification of health needs and priorities to intervene), in *services management* (contracting and monitoring resources for delivery), and in *social monitoring* (civil society involvement in surveillance activities).
- **Institutional coordination:** Systematic and regular actions developed by the Regional Health Systems to work together with other collective actors.

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Coordination can be expressed through health sub-systems interactions (*intra-sectoral*), sectoral relationships (*inter-sectoral*), and cooperation between levels of government (*intergovernmental*).

2. An analytical framework for the Policy Trajectory for Decentralisation

Although the regional experiences examined in the research showed the existence of some differences in the paths of health services decentralisation, it is feasible to identify a sort of “generic sequence” or **policy trajectory** in that process, which can be summarised in the following detailed stages. This is the analytical framework used here.

i. Beginning with the reform in 1990 of the rules of the game within the Intergovernmental Relations System, it was possible for the decentralisation process to be initiated in three dimensions: *political*: election of the regional political authorities through popular voting for three years terms, in electoral processes qualified as relatively transparent; *administrative*: the transfer of health authority and services to the Regional Governments; and *financial*: the relative strengthening of the financing function of the Regional Governments.

ii. Once elected in 1988, Governors in the Regional Governments examined in the research decided to give priority to the health sector. But they cannot avoid the historical development, institutional capacities and internal organisation of the health sector. These acts as sectoral policy-arena constraints. Thus, the Regional Governments faced a health system characterised by lack of strategic vision, fragmentation in the health care network, a lack of institutional coordination, hyper-centralisation, and especially a Ministry of Health with limited institutional capacity to exert its strategic guidance, financing and services delivery functions.

iii. Regional actors started by naming their own Regional Health Systems authorities and interacting with other national and regional groups since 1990. In order to begin their interventions in the health sector, they also made an assessment of services and

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programmes, and critical conditions they found regarding the initial resources available: deteriorated infrastructure, scarcity of health drugs and equipment, unmotivated health personnel, excess of administrative workers, limited financial resources, insecurity and corruption in the health facilities, lack of epidemiological and administrative records.

iv. The regional political and managerial authorities then decided to intervene in the health sector, but in developing strategies they found also institutional constraints such as:

- Restrictions imposed by the national administrative arrangements (Law of Decentralisation, Law of National System of Health);
- Lack of strategic guidance support from the Ministry of Health;
- Opposition from the national and the territorial authorities of the Ministry of Health;
- Unions and professional associations' resistance;
- Lack of support from the national political parties.

v. Recognising that these constraints would not change in the short-run, the Regional Governments developed the following preliminary strategic actions:

- Collective actions through the Territorial Council for Health;
- Individual regional interventions in health services (constrained by resources);
- Preparing the requirements for decentralisation (resources profiles, proposals);
- Political pressures by each Regional Government to achieve the decentralisation of health authority and finding new resources, especially seeking allies at the Central Government and the National Congress.

The following factors were analysed as an *explanatory variables* of the preliminary reforms developed by the Regional Governments in their Regional Health Systems. In examining that hypothesis, we attempted to generalise findings from the regional experiences examined in the research.

vi. In the policy process of health services devolution, the Regional Governments achieved preliminary institutional outputs (intergovernmental agreements, new rules, regional laws and organisations, resources gained, etc.), conditioned by the following general factors:

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- Political context (electoral periods, balance of powers between national and regional authorities, veto powers, coalitions);
- Economic context (economic growth, fiscal balance of the Central Government);
- Political and technical leadership of the regional and national actors;
- National priorities in the public policy agendas;
- Relative position and available resources of the different actors (Regional Governments authorities, regional allies and adversaries, national allies and adversaries).

vii. Once the Regional Governments had signed the Decentralisation Agreements for health authority devolution and started to receive the associated transfers from the Ministry of Health, one can say that administrative and fiscal decentralisation had begun. Then they developed functional reforms in strategic guidance, financing and services delivery at their Regional Health Systems (now with a larger scale than before).

viii. These functional reforms generated effects on institutional attributes, through a comparative analysis of Regional Health Systems functions in the five Regional Governments examined. This means establishing empirical relationships in which functional reforms in the Regional Health Systems generated gains or losses in terms of the effects on the institutional attributes.

A mention should be made regards to the relatively scarce academic production on the institutional reforms in the health sector decentralisation processes in Venezuela (Maingón, 1996; Fernández, 1998; González, 1999 and 2001; Zárraga, 2001; RESVEN Project, 2001 and 2004). The research attempted to contribute with both quantity and quality to the empirical literature on health sector decentralisation in Latin America, and especially Venezuela.

3. Main findings with regard to the institutional outcomes

Here, a synthesis of the theoretical and empirical implications of the research's findings is presented, concentrating attention on the relationship between decentralisation and the Profesor-Investigador en la Escuela de Empresa-Universidad Sergio Arboleda e Instituto de Estudios Superiores de Administración (IESA).

institutional attributes examined (Londoño & Frenk, 1997). Some issues for a future research agenda are also identified.

3.1 Decentralisation and autonomy

Decentralisation theory has indicated that efficiency and responsiveness improve when providers are closer to the people (Regional Governments, services providers) making decisions in a flexible and timely manner. Furthermore, it is expected that by having better access to the needs and preferences of territorial communities, regional actors are able to match decisions to civil society priorities.

In analysing the decentralisation of the health system, we stressed the evaluation of the autonomy conferred on different actors responsible for health services provision, especially examining the creation of new decision rights and spaces. But we showed that it is not enough for regional actors to have legal and administrative authority for decision-making (i.e., the autonomy conferred by law, so commonly used as the starting point for decentralisation). In reality, the literature reviewed and the empirical research concurred in indicating that regional actors also need political support and effective access to strategic resources (human, financial, material, information). Thus, reform efforts need to be directed towards these issues, particularly in a context of resources scarcity and low levels of health services. This is particularly relevant to understanding the logic of strengthening the strategic guidance function in a health system.

On the other hand, we showed that autonomy and strategic resources conferred on individual health organisations are also not enough, because the health system needs to perform inter-connectedly within an Intergovernmental Relations System. Recognising this network organizational approach, we considered it essential to evaluate whether the different autonomous components were aligned among the various health organisations. This implied observing how the management of the health system structured the allocation of decision rights and residual controls within the network for care provision. Therefore, the evaluation of strategic, financial and managerial autonomy called for empirical studies

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of the distribution of these elements not only among government tiers, but also within the different health care subsystems.

Hence, we showed that decentralisation can only fulfil its promises when each government tier and health subsystems has the strategic, financial and managerial autonomy to exercise the partial responsibilities that are assigned to them, within the overall health system network. This offers the right mix of autonomy and accountability.

Thus, in a future research agenda, one core challenge in evaluating the “optimal” design of health systems will be identifying those institutional arrangements in which decision rights and residual controls are distributed according to the comparative advantages of each government tier involved in service provision. It is according to these institutional capacities and advantages that autonomy can be delegated. As observed when examining the fundamental functions of a health system (strategic guidance, financing and service delivery), this is one of the core governance elements, which could be at stake under a decentralised Intergovernmental Relations System.

3.2 Decentralisation and accountability

In evaluating the performance of decentralised health systems, the accountability of the actors involved is a key issue. Decentralisation theory maintains that the closer the relationship between citizens and authorities, the stronger the incentives for the latter to be accountable. There is an underlying assumption that greater proximity enables citizens to access the relevant information to evaluate the performance of the Regional Governments or health service providers to whom authority has been delegated.

However, the research showed, directly or tangentially, that the institutional capacity of a decentralised health system to deliver a higher level of accountability entails highly demanding requirements such as:

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- i) Responsibilities explicitly delegated to Regional Governments or to health service providers (delegation of decision rights to entities in charge of policy and management functions).
- ii) Once these responsibilities have been delegated to Regional Governments, they must have autonomy and resources required to effectively manage these functions.
- iii) Capacity of citizens to process information and evaluate the performance of organisations in charge of health provision; this implies the existence of relevant information and tools (knowledge, techniques and equipment for information processing) for performance evaluation;
- iv) Mechanisms for citizens to demand that Regional Governments and/or services providers fulfil the responsibilities delegated to them, and for sanctions to be applied in the event of non-compliance. Likewise, it is pertinent that good performance be recognised;
- v) Mechanisms for actors to capitalise on social gains from good performance (votes, popular support, professional recognition, altruistic satisfaction).

These requirements to make a health system accountable are quite similar to the answers given by the economic theory of organisation. Following the “agency problems” perspective, it is possible to think in terms of a type of “contract” between agencies responsible for a health system functions and the citizens-beneficiaries of health care services. Here, the former act as agents of the latter in compliance with the tasks delegated to them. As a counterpart, the agents expect to receive political support and social recognition, among other social and individual dividends.

However, while it is true that citizens exercise the role of principal in that social relationship, in practice this refers more to their “constitutional” role than to their effective role. In reality, there is a large gap in the public sphere between being the principal and being able to exercise that function. Usually, citizens-users of services do not have sufficient resources to “force” agents (authorities, services providers, politicians) to comply with the responsibilities delegated to them.

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Moreover, citizens often do not have the information to evaluate the performance of their principals, either because it is not available, because its evaluation requires special training, or due to interpretation difficulties. This is particularly true in cases such as health services, where information asymmetries are structural. If, additionally, there are no mechanisms to make the agents fulfil their delegated tasks, the incentives for compliance and/or for the maximum effort by these actors may be considerably weakened and the probability of optimal performance in health care services provision reduced.

Under such circumstances, decentralisation cannot fully guarantee the accountability and willingness to respond of agents with delegated responsibilities in the health sector. This is more feasible when there is a set of institutional mechanisms available encouraging the agency-government to be more responsive to the demands of the civil society. Hence, the importance for a future research agenda examining institutional arrangements to be able to evaluate the performance of a decentralised health system.

3.3 Decentralisation and civil society participation

Decentralisation theory also promises greater participation for the civil society. It is expected that with more localised social issues upon which to decide, and observing a more direct relationship between tax contributions and public management in their jurisdictions, citizens will have more incentives to become involved in collective affairs.

For years, civil society participation was conceived almost with a short perspective, in which communities were simply receptors of information on public management. In recent decades, there has been an explosion of new participation modalities: ranging from greater significance in elections and citizen assemblies for the identification of collective needs and preferences, through the organisation of referenda, participatory budgets, sectoral consultation groups, to participation in public services boards, direct management of public programmes, social monitoring and surveillance groups, etc.

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The State-civil society relationship can involve contractual interactions in which non-governmental organisations and other manifestations of civil society are made directly responsible for health programmes and services that have traditionally been under the public sector. To my understanding, this not only extends the provision possibilities frontier of public and merit goods (improving efficiency in the delivery of health goods), but also intensifies civil society participation spaces in collective affairs, increasing democratic governance. A future research agenda should investigate whether greater civil society participation in more specific issues would enable a more fine-tuned aggregation of community preferences.

We pointed out also that the functional reforms developed by the Regional Health Systems opened up participation spaces enhancing more access to health care services. It is possible that this greater social capital development has increased pressures on the Regional Governments and health care providers to attend the needs of disadvantaged social groups, through grass-roots collective actions. This is so because the grouping of individuals with similar health care demands, as expected with decentralisation of health services, can exert influence over those who decide on health care delivery.

Likewise, we showed that civil society participation was also manifested in increased citizen responsibility with respect to public affairs, in what could be referred to *fiscal co-responsibility*. This is expressed not only in terms of participation in decision-making on health sector spending, services management and control, but also in somewhat greater citizen contribution to financing them. In theory, citizens would be more willing to contribute to public management when they perceive a greater link between payment and services received, either to expand public provision or contain it when it is seen as excessive.

We illustrated how decentralisation of the health system promoted some greater willingness of citizens to pay, especially when they perceived the connection with better health-care services. This is a form of shared responsibility in public management between the civil society and the State. However, following the health economics literature, it is necessary to

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avoid assuming that the only option available is out-of-pocket payment by charging health services users. In most cases, it is improbable that these contributions would finance costly health services and programmes. The empirical chapters in the research illustrated that communities can participate more at the sub-national level by making complementary contributions for specific activities to improve health conditions and their local services delivery facilities. Therefore, these “contributive participation” modalities must be conceived of as marginal contributions to health services management rather than as a regular basis for financing health care provision for communities.

We also showed some evidence that civil society participation entails risks like higher transaction costs for decision-making, especially when a greater number of actors and interests are involved. A future research agenda should study the probability of collective decisions being captured by elites and local groups, loss of control of the health system due to dispersion in decision-making, etc. There are also other factors unfavourable for the accountability of health care providers to be examined in the future, such as contracting imperfections; difficulties in monitoring and in enforcing sanctions on health services organisations; and the multiplicity of goals and principals in health care delivery. To some extent, we showed that agency problems could be magnified with a badly designed decentralisation process, thus affecting the responsiveness of the Regional Health Systems.

We showed that the lack of capacity of policy-makers to process information, and the interpretation problems arising from communication between citizens and public policy authorities, continues to be challenges to improving health systems through civil society participation. While it is true that some mechanisms have been developed to improve access and processing the “voice” of the people, in Venezuela there still seems to be a long way to go to ensuring credibility and enforceability of citizen voice.

Finally, in the absence of a reasonable degree of civic participation, accompanied by decision-making autonomy for the authorities receiving the demands from civil society, the lack of legitimacy in system-management decisions will probably be a source of health care

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delivery failures. Hence the importance for a future research agenda of examining the alignment of interests and agendas of the various actors.

In synthesis, we provided some evidence that governance of a health system can gain a great deal of legitimacy and allocative efficiency through civil society participation; yet, at the same time, this means that authorities must be ever-attentive to the greater challenges and higher costs entailed in involving new actors. The risk of not being able to satisfy the varied expectations is very high, and it places the very governance of the health system in jeopardy. The optimal strategy, if any, entails a delicate balance among voice, plurality and efficiency.

3.4 Decentralisation, coordination and health system integration

One of the greatest challenges facing decentralisation is for it not to become a centripetal force provoking disintegration of the health system: the so-called dangers of “coordination failures” in Intergovernmental Relations System. Given the need to operate within service networks, the institutional evaluation of health system decentralisation required analysing whether these risks exist, and how they affect the responsiveness of the Regional Health Systems, generating damage to the efficiency, equity and quality of health care.

In the research we showed that the decentralisation process increased the fragmentation in the Venezuelan National Health System. First, this was because of the incorporation of new regional delivery organisations operating in a segmented manner. Second, there was the lack of intergovernmental and regional intrasectoral coordination in spheres in which cooperative behaviour is needed to attend health problems.

This is a macro-organisational “perversity” that should be examined before deciding whether or not decentralisation has adverse effects on the proper institutional functioning of the health system. Therefore, it is enough to say here that a health system that aims at being efficient, equitable and effective requires a considerable degree of territorial coordination in terms of its strategic guidance, financing and services delivery functions. Given that

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decentralisation involves delegating some responsibilities and/or co-participation of Regional Governments in these activities, more research is needed to evaluate whether institutional performance requires a higher degree of formal cooperation among the actors in order to operate effectively.

Therefore, an institutional analysis of the effects of decentralisation on a health system requires the study of the coordination efforts within the Intergovernmental Relations System, analysing the incentives motivating actors to decide on whether or not to interact in a cooperative manner. In other words, in a future research agenda, it would be ideal to identify the main inter-organisational incentives motivating cooperative behaviour among the actors related to the health system. It would also be interesting to research the coordination efforts between the public and the private sectors in the Regional Health Systems.

In the research, brief references were made to these interactions, illustrating some low level of Regional Governments reforms extending the possibilities frontier for provision of health goods (e.g., the purchase of medical care services from private sector and/or from organised communities). It was presumed that these are virtuous practices in the institutional performance of a health system. We illustrates that decentralisation can foster these institutional arrangements, when sound decision rights and spaces are provided to regional actors. But again, this requires a virtuous mix of autonomy, accountability, civil society participation and institutional coordination.

4. Political and policy process factors conditioning the devolution process

The regional experiences in the research showed that the following political factors conditioned the initial process of health authority devolution in Venezuela, in addition to the policy-arena factors examined with regard to the Venezuelan National Health System.

4.1 National context under which devolution was negotiated

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Under different economic contexts faced by the regional negotiators (economic growth and fiscal surpluses for Aragua and Carabobo, economic stagnation and fiscal crisis for Miranda and Nueva Esparta, economic growth and fiscal deficit for Yaracuy), political conditions determined the speed and depth of the devolution bargaining's process by the Regional Governments. While Aragua and Carabobo (Miranda also in its first stage) found delays in their decentralisation process due to actors in Central Government using their veto power, Nueva Esparta, Yaracuy and Miranda (in its second stage) took advantage of the fragmentation in the political system to exert pressure on the Central Government.

4.2 Political and technical leadership of regional and national actors

We showed that the quality of the political and technical leadership is a determining factor of the results of the policy process. It is clear that Regional Governments like Aragua, Carabobo and Yaracuy had the privilege to be led by politicians and technicians with a strategic vision for their Regional Health Systems. Even Nueva Esparta showed how “impulsive leadership” was useful in improving the services delivery.

4.3 Political interactions between regional and national authorities

It is clear from the regional experiences examined in the research that the speed of decentralisation was conditioned by the actors' willingness to negotiate. It was during the transition government in 1993 that Aragua and Carabobo finally received a positive answer to their request for devolution. Even though these Regional Governments were pushing for many years, the cooperative conduct of Minister Pulido made possible the signing of the Decentralisation Agreements. On the other hand, in Miranda, Nueva Esparta and Yaracuy, coalitions were required within the fragmented political system to oblige the Central Government to sign the Decentralisation Agreements.

4.4 National priorities in the public policy agenda

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During the first stage of decentralisation requests, the Central Government had an interest in approving clear laws for its fiscal policies (Internal Revenues Reform, VAT, etc.) to satisfy the multilateral banks, and these would have been impossible without the support of the Congress members of the opposition parties and regional political actors. These political motivations seem to have partially compensated for the resistance of the Ministry of Health to devolution. With the advance of the decentralisation process, territorial actors increased the use of this sort of logrolling strategy, pressing for more fiscal resources such as those secured through FIDES (Intergovernmental Fund for Decentralisation), the Special Economic Assignment Law, etc. The Central Government, meanwhile, increasingly needed the political support of regional actors to get the approval of important legislation and public policies.

For a future research agenda, this brief discussion on the changes in the political system and the rules of the game raises questions such as: Could the autonomy achieved have “perverse” consequences due to the absence of Central Government controls and the lack of discipline in national political parties? Could one expect more accountability from the regional authorities, but at the cost of more parochialism in their public policy agendas? Has intergovernmental coordination been undermined because of the fragmentation of the political party system?

5. Effects of the changes of the rules of the game on the Intergovernmental Relations System

We showed that the changes in the rules of the game of the Venezuelan Intergovernmental Relations System generated new decision rights and spaces available for Regional Governments, fostering functional reforms in their Regional Health Systems. We identified the following set of decision rights and spaces in the political, administrative and fiscal dimensions.

5.1 Political decision rights and spaces

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Due to the open election of Governors since 1989, Regional Governments now had the political legitimacy to develop their own policies and management. But at the same time, this changed the accountability relationship of Regional Governments to their territorial constituencies. This explains, to some extent, the efforts by Regional Governments to incorporate civil society in different spheres of the policy processes of the Regional Health Systems. The re-election of Governors for one period motivated the need to show a more visible performance in the interests of regional constituencies. Regional Governments used their political legitimacy and some legal and fiscal resources to respond to these civil society demands.

The new electoral system of mixed type (proportional-open list) created political spaces for national and regional legislators to address a more territorial-driven agenda of public policy, and this led to greater willingness to approve regulations favourable to decentralisation. Meanwhile, the separation in time of regional and national elections increased the autonomy of the regional actors with regard to political parties and national authorities, fostering the development of their own policy agenda;

Due to the fragmentation in the political parties system, and the weakness of the Venezuelan Presidentialism, most administrative decisions relating to decentralisation required political coalitions and bargaining. Regional actors used their legitimacy to achieve the decentralisation of health services in exchange of political support, and to circumvent other actors with veto power in the devolution process.

5.2 Administrative decision rights and spaces

The Law of Decentralisation and its Regulations opened new decision rights and spaces for the Regional Governments to manage health services in their jurisdictions, under a regime of concurrent provision with the Ministry of Health. Once each Regional Governments decided to establish the Regional Health Systems, the disincentives and risks of the decentralisation arrangement seem to have been insufficient to inhibit the political and

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administrative decision of many Regional Governments, despite the lack of resources for decentralisation and the fact that the Decentralisation Agreement had not yet been signed.

Thus, the concurrent exercise of public authority in the health sector opened new decision rights for Regional Governments, resulting in functional reforms such as those examined in the research:

- Relative freedom to organise the Regional Health Systems territorially, choosing their health care models, and with autonomy to appoint regional health authorities;
- Freedom to introduce new planning and managerial practices, including some flexibility for personnel management;
- Scope for developing civil society participation mechanisms;
- Greater freedom for inter-sectoral coordination in their jurisdictions;
- Scope for incorporating new control and accountability rules.

With decentralisation, decision rights were opened to introduce variety into the implementation of national health policies, in addition to opening spaces in the design of regional policies, to the extent permitted by the national legislation, by other political actors and by available resources.

Nevertheless, due to the excessive concurrence in the health authority, there is an incomplete undertaking of public responsibility, generating inefficiency and a lack of accountability in both Regional Health Systems and the Venezuelan National Health System. Regional and national actors failed to see themselves as solely responsible for assuming the costs and benefits of their policy and management decisions. This is the result of the lack of clear definitions on the decision rights and residual controls over the decentralised public health system.

We also found limited decision rights created in relation to coordination and monitoring. In fact, the coexistence of decentralised and non-decentralised health services also created difficulties for inter-organisational coordination within the Ministry of Health, as well as problems of intra-sectoral coordination due to fragmentation in the whole Venezuelan

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National Health System. There also seem to be difficulties in the monitoring function, especially with regards to developing less formalistic performance evaluation.

5.3 Fiscal decision rights and spaces

The changes in the fiscal rules of the game provided the Regional Governments with higher degree of fiscal autonomy, since those inter-governmental transfers lacked significant conditionality in terms of the use of these resources. This is the case for the Situado Constitucional, and somewhat less for the Intergovernmental Fund for Decentralisation (FIDES) and Special Economic Assignment intergovernmental transfers. With these grants, the Regional Governments could now assign these resources to purposes considered to be of higher importance in their relationship with civil societies and for their strategic vision. There is considerable less autonomy with regard to the deployment of the categorical transfers for health associated with the Decentralisation Agreements.

Changes in the fiscal rules of the game at the Intergovernmental Regional System also enabled the Regional Governments to implement functional reforms such as:

- Allocation of fiscal resources to the health sector, independently from those assigned by the Central Governments;
- Greater possibilities for mobilising resources from other sectors;
- Relative freedom to assign budgetary resources according to programmatic, line item and sectoral priorities (in their own budget);
- Scope for financial management changes (promptness, transparency).

6. Effects of the changes in the sectoral policy-arena constraints on the Venezuelan National Health System

We showed two main features in the Venezuelan National Health System constraining the sectoral policy options available for decision-makers: the fragmentation of the Venezuelan National Health System and the weak institutional capacity of the Ministry of Health, especially with regard to its strategic guidance responsibilities. These structural features in

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the sectoral policy-arena led to a generalised lack of coordination, dispersed accountability, perverse autonomy due to fragmented initiatives by the different health sub-systems, and unequal coverage for populations served by these subsystems. This generated problems of governance in the health sector.

Similar conclusions are indicated by one specialist in the Venezuelan National Health System (Jaen, 2001:34-35): “Even though there are signs of certain advances, barriers associated with agency relationships at facilities continue to exist, especially due to the existence of divergent mandates, the absence of accountability systems, the presence of multiple principals, in addition to the limitations in modifying practices and control over resources.”

One challenge then is whether the decentralisation process opened risks of exacerbating these problems in the Venezuelan National Health System. This is the kind of worry generating the controversy between defenders of the Law of Decentralisation and the promoters of the Venezuelan National Health System Law; and this is also the reason why many national actors exerted pressure for stricter requirements for the Regional Governments in their decentralisation requests of health authority. These were efforts to introduce new policy-arena constraints in the health sector.

We looked at how the regional actors addressed all of these constraints, by collective and regional actions to advance their decentralisation process, as well as in reforming their Regional Health Systems. It is clear that the features described here for the Venezuelan National Health System generated severe sectoral policy-arena constraints for any decentralisation process of health authority. The research then showed how these institutional capacity constraints, especially in strategic guidance, imposed a sort of path dependence in the decentralisation process.

Concluding remarks

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The leadership of regional authorities, together with the political incentives, seem to have prevailed over the deficiencies of the decentralised Intergovernmental Relations System in developing the functional reforms in the Regional Health Systems. Political decentralisation appears to have provided a point of ignition and later of sustenance for these reforms, even where there is a lack of fiscal resources and where there are loopholes in the intergovernmental distribution of responsibilities in the health sector. At some point, most of these functional reforms got a life by their own, even without much attention from political actors.

On the other hand, the empirical research did not show evidence that neither the institutional attributes promised by decentralisation nor the coordination failures denounced by the critics were automatically generated through this reform strategy. On the contrary, the institutional outputs generated with decentralisation depended on a wide variety of political, administrative, fiscal, and even circumstantial factors, which in my view have not yet been studied enough in the literature.

In testing the relationship between an institutional framework (Intergovernmental Relations System rules of the game and policy-arena constraints) and the effects of functional reforms on the institutional attributes, one can say that, on balance, the decentralisation of health authority and services in Venezuela was mostly positive during the 1990s. However, as in any policy processes there remain are some issues for improving institutional design and implementation of the decentralisation process in the health service.

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