Healthcare Financing and Governance in Latin America

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Abstract

The main objective of this study was to identify trends and results associated with health financing and governance indicators in the context of health systems reform. Evaluative research integrating qualitative and quantitative analysis was performed. The three Latin American countries of Mexico, Nicaragua, and Peru were selected as the universe of study. The research methodology had two main phases. In the first phase, the study referred to secondary sources of data and documents to obtain information about the following variables: type of decentralization implemented, source of finance, funds of financing, providers, final use of resources and mechanisms for resource allocation. In the second phase, the study referred to primary data collected in a survey of key personnel from the health sectors of each country. Results showed that evidence reported in all five financing and governance indicators may identify the major weaknesses and strengths in health financing. In addition, there was a lack of human resources trained in health economics who can implement changes, a lack of financial resources independence between the local and central levels, negative behavior of the main macro-economic variables, and difficulty in developing new financing alternatives. However, other results showed that there was a sharing between the central and local government levels in the financing health services, the implementation of new organizational structures for the follow-up of financial changes at the local level, the development and implementation of new financial allocation mechanisms taking into account efficiency and equity principles, new technique of a per-capita adjustment factor corrected at the local health needs, and the increase of financing contributions from households and local levels of government.

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Introduction

New health financing policies and changes in health financing indicators after decentralization are the principal elements of health sector reform in a number of countries. It has increasingly been recognized, at both national and international levels, that management, financing, planning, and policy functions in the health sector may be carried out more efficiently and effectively if they are decentralized, transferring responsibility to a local level. However, there is growing concern that decentralization has failed to achieve the objectives for which it was introduced and can indeed have effects that limit health sector development (Hurley, 1995; Arredondo, 2000, 2005). The relationship between decentralization and financial changes in the process of health care reform in Latin American countries is complex. Analysis of recent attempts at decentralization and financial changes requires an understanding of the contradictory forces at work within the political systems, particularly, bureaucracies of Latin American countries (De Souza et al, 2002). In these countries strong centralizing tendencies coexist with particular forms of bureaucratic decentralization (Arredondo, 1997).

Centralizing tendencies remain predominant, with decentralizing forces both being caused by and serving to reinforce them. The type and degree of decentralization is strongly influenced by dynamic financial aspects, including sources of finance, agents, providers, final destination and mechanisms of financial allocation at the local, regional and national level. Local governments usually have authority to levy taxes. However, in developing countries, much of the national revenue comes from indirect taxes, especially customs and excise revenues, while buoyant local sources of revenue are hard to find (Collins, 1994; Abel-Smith, 1988). The local governments in these

countries are often by necessity heavily dependent on grants from the central government. In addition, governments often retain central control over finance in order to promote geographical equity. The sources for financing local government may therefore not differ significantly from those of local offices of central ministries, though the way the grant is made is likely to differ (Quentin, 2004).

In this context, many Latin American countries have tried to decentralize their health care systems. A number of different approaches have been taken, with varying results that reflect strengths and weaknesses for each country (Murray, 2000). The results are strongly related to changes made in the mechanisms for allocating financial resources, especially the new financing dynamics for health services in the context of health care reform (Bossert, 2000). This financing study of health care decentralization quantifies the resources involved and analyzes the dynamics of the sector, its opportunities and sufficiency. At the same time, the study suggests ways to mobilize and reassign resources within the system at a national and regional level (Aguinaga, 1997). The financial changes for decentralization have been made according to the current state of health financing. For Latin American countries, public treasury funds are the principal source of financing for central and local government health spending. In addition, compulsory contributions of employers and employees to social security systems or health and welfare funds are the major sources of financing for expenditure on social security health care programs (Cassels, 1995).

In Mexico, budgetary resources have been reallocated in several ways. Although total federal government expenditure on health has been reduced, the proportion assigned to the health sector has increased in

recent years (Alvarez, 1990). Analyzing the delegation of finances in the decentralization of health services in Mexico two constant factors emerge, setting a common pattern between decentralized and centralized health service organization (SSA, 2003). First, the continuation of separate federal and state sources of finance, without the state control of federal funds (SSA, 2004); and second, the maintenance of the federal labor relationship with all state health workers, right up to the director or minister of health. Thus, all decentralized state health services, whether called ministries, departments or institutes became, from the point of view of finance and control, de facto governmental organisms of both the state and the federal governments (González et al, 1992).

In Peru, through regional secretariats for health services and municipal clinics there is now considerably more local autonomy, and greater financial and administrative decentralization. Regional secretariats and municipal clinics have their own legal status, staff, and possess their premises and equipment. The directors of these units, who may or may not be health professionals, have been given greater authority to manage the health facilities, staff, equipment and budget. In addition, managerial support for municipal clinics and regional secretariats has been strengthened by new financial departments. However, the regional authorities did not press for financial devolution, as this would have implied greater responsibility than they could cope with. In spite of fiscal and administrative reforms made to strengthen regional governments' revenues, their share of federal fiscal appropriations is still meager and awkward in its application, and their tax bases are also weak (Prialé et al, 2002).

In Nicaragua, the constitution states very clearly

how the national health system should be organized. The structure designed for the health sector is completely coherent with the federal structure of the Nicaraguan state, with three autonomous spheres of power. A decentralized health system with only one authority in each sphere of power seems appropriate. Moreover, decentralization and community participation are explicitly mentioned as directives that the national health system must follow. The only political units in the country that provide health services to the population are at a county level, with some national units. The federal and state governments must provide the necessary financial resources and technical cooperation to ensure that their obligation to healthcare is executed. Since 1986, the implementation of health care decentralization in this country has been seriously obstructed by political changes in the federal government. Lack of federal/national policies to strengthen the ability of counties to execute their new functions remains a barrier to implementing decentralization. Also, the lack of a data base of the national health accounts, with which an analysis could be coordinated, has hampered decision making for health care financing in the context of decentralization (MINSA, 2003). In appendix A, we give more detailed information about the background and meaning of health care decentralization and financing changes in each country.

In summary, the tendencies both to centralized financial authority and decentralized administrative authority coexist in the health systems of Latin American countries. In a complicated and often seemingly confused manner these tendencies combine and conflict with one another, with the centralizing tendency remaining unquestionably dominant (Cercone, 2004). Moreover, this centralizing tendency results in the over-concentration of decision making at the top of the hierarchy and, in turn,

generates decentralizing efforts aimed at decongesting the overloaded levels of decision making within central ministries of health. In this environment, the possibilities for devolution of financial power from central bureaucratic agencies to local health units are not very favorable. In this sense, any financial issue for health care decentralization is related to the new local level financial authority and the control at a local level of the sources of finance, funds for financing, new mechanisms for resource allocation, and the final use of financial resources.

Conceptual considerations

An analysis of the financial aspects of health care decentralization requires the examination of several financial indicators to understand the changes in financing policies for health care reform (Hernández et al, 1995). The most commonly used conceptual framework for understanding the dynamic aspects of healthcare financing includes the definition of health expenditure as activities whose primary purpose is health improvement (WHO, 2000). This definition excludes large programs which impact on health, but whose primary goal is not health, for example general food subsidies, housing improvement and large urban water supply projects. However, this definition does leave room for significant differences in the manner in which countries account for health-related programs such as targeted nutritional services and water quality improvement (Ramesh et al, 1997; Gallardo, 2004).

Recently, a new and more appropriate method for analyzing the financial dynamics in health care was identified (Poulier, 2000). This method developed within countries, called National Health Accounts (NHA), has had recent application in developing countries. The NHA model incorporates different indicators of economic information

related to the production and financing of health systems. This model allows the creation of a register of financial information to be used for understanding the trends in the principal indicators for spending, facilitating the analysis of the availability of resources in the health system and the payment capacity of users, and therefore aiding financial planning for the sector. The objectives of the analysis of health spending promoted by NHAs are the following: a) to identify the protagonists and economic entities that participate in the financing of the sector; b) to identify the funds for the financing of the different social groups; c) to identify the allocation of resources according to the type of provider and the health program; and d) to identify trends and changes in different financing indicators (sources, funds, providers and allocation mechanisms), taking as a guide the reform strategies of the health sector, in this case the process of decentralization.

The NHA model is useful not only for knowing the spending levels associated with financing indicators, but also for identification of the qualitative and quantitative changes in these indicators, as well as knowing the expenditures made by households, health institutions and businesses. The core concept of National Health Accounts is the defining of the flow of funds. The approach used took into account the more limited data available to be in accord with the research questions. This required modifying definitions of both sources and uses of funds (Berman, 1996). Mexico and Colombia were to formulate the flow of funds in terms of three major levels: the original sources of financing, the financing funds, and the health care providers following an approach used in Egypt (Frenk, 1994, 1996; Arredondo 2005). In order to analyze the financial aspects for health care decentralization we added two more levels to this formulation: the final destination or financial resources utilization for different health programs,

and the mechanisms for financial resource allocation.

Independent of the patterns of decentralization, there are five indicators that permit the identification of the flows and dynamics of governance and financing for the three countries studied: the financing sources, the financing funds, the health service provider institutions, the final destination of resources, and the mechanisms for financing allocation**.** These indicators must be defined in order to analyze and understand the financial and governance aspects of health care decentralization. They are defined as follows:

-The sources of financing: The primary economic sources that provide the resources to the population for different activities. There are four sources of financing, classified according to the origin of the funds. These sources can be further classified either as internal or external. In the case of the health system, the internal sources are the government, industry and households. The external ones refer to the exchange that takes place within the health sector, through multilateral or bilateral agencies (Hsiao 1994, Arredondo 2005). Private sector (businesses) also is included since these entities finance the "buying" of healthcare services for employees.

-The financing funds: Reservoirs of economic resources, whose role is to administrate resources and buy medical services. These funds can be real or virtual, an important distinction since virtual funds can be used only in a limited way and they are in constant competition with the acquisition of other necessities (Abel-Smith, 1988). In addition, they depend on the preferences of individuals and can be drastically reduced by a period of lower income, an economic crisis or an adjustment in policy. Private sector, as a whole, is not a provider of healthcare services – it

buys/purchases healthcare services; or if a private hospital, profits from providing/selling healthcare services.

-The health service provider institutions: Government and non-government organizations providing health care services to the population. According to the sources of finance and consumers, there are three classifications of provider institutions: social security, public assistance and the private sector (Bossert, 1996).

-Mechanisms for financing resource allocation: The mechanisms for financial resource allocation for health expenditure include legal, political and technical principles. These mechanisms provide the means for financial resource allocation in the production of health care services, and the financing adjustments necessary for health care decentralization (Bobadilla, 1990, 1998).

-Final destination of resources: The classification of health expenditure by health service providers, according to its final destination and depending on the financing fund. The decentralization process requires health policy makers at a local level to make improvements on, and design new methods for, the management of the final use of resources. In doing so they must take into account local health priorities and act according to two major variables: system variables (supporting programs, current expense factors and investment, health services to be provided), and population variables (which include the type of services demanded at a local level: primary care, secondary care and third level care) (Musgrove, 1990; Collins, 1993; Gallardo, 2004).

A thorough analysis of the five financial indicators presented above allowed us to identify substantial changes that have taken place in the area of governance and financing policy in each country, and thereby assess the

feasibility of decentralization. The objective of this manuscript is to show the qualitative results regarding the strengths and weaknesses on governance and health financing indicators after decentralization in each country under study.

Methodology

This study used an evaluative longitudinal design in three Latin American countries. The countries were selected according to various criteria: -different economic development (per capita income); high-middle income, low-middle income, and low income; experience by a country of a significant period of financial adjustment for health care decentralization; policy makers must have been interested in, and receptive to, output from the study to ensure that the research results will be used; an existing database in the country to analyze the financial aspects of HCD; multi-disciplinary research capacity; relative political stability; reliability of the financial data on health.

The results of this stage gave the final selection of the three countries to be analyzed: Mexico, Nicaragua, and Peru. (See appendix A for more details). Through discussions with key personnel in each country, personnel were selected for interview and information sources identified. A field-work coordinator was chosen for each country and the field-work strategy was standardized, along with the instruments to be used. In the bibliographic search, 117 references from documents on healthcare reform/decentralization efforts published in three countries were identified. In addition, 26 unpublished documents were identified based on information given by key informants, providing an indication of the number of unpublished documents that exist. Key personnel were selected according to their level of participation in the

decision-making process in the development, implementation, evaluation, and/or monitoring of decentralization in each country included in the study. A total of 90 interviews were carried out in the three countries. The technique used for this stage of the study consisted of interviews with the key personnel and bibliographical revision. In order to make a qualitative analysis of the collected information, the interviews were compiled and analyzed into a database using the software ATLAS-TI.

To analyze the changes in financing indicators before and after decentralization, 1994 was chosen in our analysis to be the dividing line for decentralization. This decision was based on the following criteria held by all three countries: a) the decentralization process began for all three countries before 1994; b) because decentralization is an ongoing process, it may be considered an implementation strategy to be consolidated during the coming years; c) information sources on financing matters are not considered valid before 1990-1992, which was the base period for the implementation and validation of methods for the integration of national health account systems for the three countries in the study; and d) important changes took place in each country in 1994 that served to continue and emphasize the decentralization process. Based on these criteria, and on the availability, accessibility, validity, and reliability of the information on financing indicators, the period of analysis was defined as 1990-2000.

Results

Political aspects govern the implementation of decentralization in each country, aside from the technical-administrative criteria and the new organizational structures

that make the decentralization process feasible and concrete. In all three countries, the political framework for decentralization was formed by legislation and ministerial resolutions (policies) in health, which were approved by the appropriate legislative bodies. This framework, which originated in 1983, sets forth legal guidelines for a gradual implementation of health service decentralization in these countries. It takes into consideration both the production and financing of health services. It is noteworthy that in Peru new decentralization laws were still being proposed and approved in 1998 in order to reorganize the progress achieved and set forth new mechanisms of financial allocation.

In the three countries studied, new administrative organizations have been created in order to fulfill the decentralization process. These organizations have resulted from new plans for the organizational structure of health. In Mexico they are represented by the COPLADES (Comisión de Planeación Estatal de Salud) and SILOS (Sistemas Locales de Salud), in Nicaragua by the SILAIS (Sistemas Locales de Asistencia Integral en Salud) and the COLOS (Comisión Local de Salud), and in Peru by the ZONADIS (Zona Distrital de Salud), CLAS (Comités Locales de Administrción en Salud) and the CTAR (Comités Transitorios de Administración Regional). These organizations constitute elementary units in technical-administrative matters for the implementation, follow-up, monitoring and evaluation of decentralization.

Financing indicators and mechanisms for financial allocation for the period before decentralization were identified, in order to define a point in time from which the implementation of changes in financing policies began. There are similarities in the observations for the three countries studied. Decisions about the production of

services, as well as their financing, were completely being made at a central level, without leaving any margin for action at a local level. These decisions were made independent of the needs of each state, department, region, or county. Nevertheless, before the implementation of decentralization strategies, it is noteworthy that different financial resource allocation proposals were made to counteract the effects of centralized decisions. However, these proposals were taken into account only when decentralization became an explicit strategy aimed at achieving a greater equilibrium between the supply and demand for services.

There have been changes in financing indicators that were implemented or proposed in each country in order to make decentralization more feasible. In Mexico there was a stronger devolution of decision-making and the management of financing policies than in the other two countries. Although Nicaragua and Peru implemented budgetary decentralization, the responsibility for resources, funding, and financial flow remained at the central level. There are two financial strategies which stand out: the implementation of cost-recovery fee systems as new financing mechanisms, and the implementation of new methods for financial resource allocation at the departmental, state, and county levels.

We identified strengths and weaknesses in each country that had repercussions on the changes in financing policies after decentralization. In Mexico, the main strengths observed were the devolution of financing decisions and the sharing of responsibility for the generation of local financing sources between the state and municipal levels. The main weakness observed for Mexico was the absence of a culture of economic efficiency in the organizational dynamics of local health systems and in

human resources. In Nicaragua, the main advantages were new financial allocation mechanisms and budgetary decentralization.

The main disadvantage observed for the three countries studied was their great financial dependency on central level decisions. This was the primary disadvantage in Peru, where financial decentralization consisted in directly allocating financial resources to the regions from the Ministry of Finances, maintaining a system of decision-making at the central level. One of the main advantages in financing changes was the implementation of new mechanisms for financing and financial control, with the private sector's participation. Figure 1 presents a summary of changes in financing policies in the three countries. In this figure the strengths and weaknesses discovered in the analysis of financing indicators from the period after decentralization are given (sources, funds, providers, final destiny of resources). It is evident in Figure 1, that the strong points for each country were the changes in financing indicators. These changes range from the integration of economic information bases to the implementation of new financing mechanisms, along with the creation of new financing sources and new financial control mechanisms. The main weaknesses for each country, however, stem from a strong dependence on central level financing and, therefore, on the negative effect of macroeconomic variables on financing at state and municipal levels.

Conclusion

With respect to the financial decentralization pattern and its relation to financing changes, no pure decentralization pattern exists in any of the three countries studied. In each country one pattern dominates, but is

always mixed with different decentralization modes. For example, in Mexico the dominant pattern is that of delegation, mixed with decentralization and devolution variants. In Nicaragua and Peru, however, it was possible to identify a devolution pattern mixed mainly with decentralization oncentration and privatization variants. This was more so in the case of Peru, where the private sector played an important role in regulating the decentralization process.

In all three countries, once decentralization was implemented, an issue to be resolved was to end the historically legitimized financial and technical dependency of the local level on the central level. Another problem was the implementation of mechanisms for more efficient and equitable financial allocation. These two aspects have been the most difficult ones to achieve in the decentralization process, and have made necessary periodic adjustments to the decentralization proposal, both in its conceptual outlining and the methodological strategies for its political implementation.

The decentralization of budget decisions at state and local levels and the sharing of financial responsibility between different participants (providers and consumers), have made delegation feasible for decision-making on financing policies. This has led to an ever-increasing gap between existing resources and the needs of the population. This shared financial responsibility has also generated new conceptual and methodological frameworks for the evaluation and monitoring of health financing. In other words, the participation of new contributors for health financing requires new models of analysis to study and identify all financing indicators on health. A typical example is the application of an analytical model such as that proposed in this study.

The implementation of shared financial responsibility has also allowed progress to be made in the subject of separation of financing sources and funds. The power to separate financing sums according to their source (federal, state, and local levels of government, as well as consumers) becomes an important analytical tool in the planning, evaluation and monitoring of financing policies, particularly for the analysis of equity and the efficiency with which resources are finally allocated and used.

The new alternatives for financing sources in three countries include mechanisms for local fee recovery. In Nicaragua and Peru there exist only a small number of departments for which this financing source is being consolidated, and it is expected to be promoted and consolidated in the future. In Mexico, the fee recovery system is enforced in all the decentralized states (more than 50% of the states in the country). Furthermore, this financing mechanism is expected to be implemented with greater success in Mexico during phase II of decentralization.

The different components investigated in this study may be used to analyze the financial changes in the health sectors in Latin American countries at different stages of decentralization. Where decentralization has been in place for some time, modifications can be expected to the manner in which health financing changes are applied. For countries with mature decentralization, all five financial indicators of the framework can be used. For countries that have only just formulated their policies and the means for their implementation, or in which implementation has only recently begun, it is arguably not appropriate to look for change beyond organizational structures and processes. In these situations, the analysis should refer only to the way in which the components of the framework can contribute to

the design of instruments and methodology for assessment and analysis. In other words, all components may be used in a consideration of the financial variables to be monitored in an analysis of the effects of decentralization on financial aspects.

Little is known about how to demonstrate the effectiveness of institutional patterns and political and financial processes in the countries studied because indicators and technical criteria have been poorly developed in these fields. The analytical framework used was designed for rapid rather than exhaustive analysis and assessment; however, it helped to identify some effects of decentralization on health financing policies by using financial indicators. This tool has been used for retrospective analysis and must therefore rely on currently available information. The key components have been chosen with these criteria in mind. In this sense, the framework stressed changes in the five main financial indicators for the understanding of the macroeconomic dynamics of health systems in the context of decentralization: the source of finance and decentralization, funds of financing and decentralization, providers and decentralization, new mechanisms for resource allocation and decentralization, and final use of financial resources and decentralization.

Our findings highlight two primary problems that impede governance on decentralization in the three countries studied: Mexico, Nicaragua, and Peru. These weaknesses are a lack of human resources trained in health economics able to design and implement changes in financing policies, and a lack of financial resources independence between the local and central levels. These problems exist even in Mexico, where the local health system has considerable financial independence from the

central authorities. In addition, in the three countries studied we observed two events that had a negative effect on the financial changes proposed by the decentralization process. These events were the political situation that coincided with decentralization and the financial situation, according to the behavior of the main macro-economic variables. A further disadvantage, observed mostly in Peru and Mexico, was a slight drop in financing of the fund for public assistance and social security.

The main advantages to increase the governance on health policies were the following: the sharing between the central level and local levels of responsibility for financing and the production of services; the implementation of new organizational structures for the follow-up of financial changes at the local level and with participation of the public and private sectors in the planning, allocation, use and monitoring of resources; the development and implementation of new financial allocation mechanisms based on epidemiological, economic and organizational criteria, taking as a basis the efficiency principle; the development and implementation of new monitoring mechanisms in the allocation and final use of resources, taking as a basis the equity principle and using the technique of a per-capita adjustment factor corrected at the local, departmental or regional level; changes with positive trends in contributions from homes, despite economic crises existing in the three countries under study; and finally, the promotion and generation of a greater economic ambit with the introduction of new financing and health services economic evaluation schemes at all decision-making levels.

Weaknesses and strengths identified could be useful to establish the need of new financing mechanisms and participatory strategies for decision making in order to

create more governance and more governmental capacity to conduct health systems reforms in the studied countries. Analyzed trends and presented evidence suggest governance in health as the main social dimension to develop in order to democratize the health system as a whole. Considering this, there is a need to strengthen technical management and policy analysis, in order to consolidate decentralization efforts and create local capacity for conducting health system financing and reform strategies in countries under study.

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Appendix A. Selection of Countries

The information on various criteria was taken from different bibliographic sources and direct interviews by means of e-mail with officials in the selected countries. Information provided by the interviewees and data reviewed in the publications led to the selection of ten countries for analysis: Bolivia, Brazil, Mexico, Argentina, Chile, Peru, Nicaragua, Costa Rica, Panama, and Ecuador.

The identification of type of income was based on per-capita income indicators for the countries included in the World Development Report by the World Bank (1996). Four countries with a high-middle income (per capita income greater than US$3,000 (Mexico, Brazil, Argentina and Chile), three countries with a low-middle income (per capita income between US$1500 and $3000 (Peru, Panama, and Costa Rica); and three with a low income (per capita income under US$1500 (Nicaragua, Ecuador and Bolivia) were identified. Cultural similarity was assured by the fact that only Latin American countries were included in the study. In only five of these ten countries did the interviewed decision makers respond favorably with respect to their interest in the study and the possible utilization of the expected results. In only six of the ten countries (Mexico, Chile, Panama, Nicaragua, Ecuador, and Peru) had trustworthy and methodologically comparable databases on funds and financing flows in health. All ten countries had the capacity to form interdisciplinary teams.

To select the three countries ultimately studied, more detailed information on the decentralization and financing policies in each country was taken into account. This information was obtained from the aforementioned interviews and included the following variables:

background of health care decentralization; pattern of decentralization; financing policies; changes in the financing policies; background of national health accounts; reliability of databases; and political support from policy makers. For this stage in the selection process, only countries that had a background of studies and databases on funds and financing sources were included: Mexico, Chile, Panama, Nicaragua, Ecuador, and Peru. Of these six countries, three were selected (one with medium-high income, one with medium-low income, and one with low income) containing the following basic technical requirements: a background of decentralization; changes in financing policies; a system of national accounts in health; and reliable information.

Figure 1: Strengths and Weaknesses of Health Financing and Governance Indicators after Health Care Decentralization in Mexico, Nicaragua, and Peru

INDICATORS / COUNTRY	STRENGTHS	WEAKNESSES
MEXICO	-Identification of state/country government financial contributions. -High participation of homes in the expenditure. -Growing per-capita health expenditure trends, even with the economic devaluation crisis of 1994. -The health expenditure for public assistance institution in lower , compared to the social security institutions. -Growing trend in public expenditures (% GNP) -Positive trend of economic support for public assistance from the central government. -High percentage of capital-investment expenditure -Positive trends of local government contributions. to the financing of health programs. -Equilibrium between social security and uninsured.	-Health expenditure indicators by attention level follow a national trend and not a local trend. -There is no information system that can identify sources for state and county financing funds by type of institution. -It is not possible to analyze trends of final destination of financial resources; standardized information does not exist. -Contributions from households show a negative trend, which will affect the new financing alternatives. -Per-capita expenditures in health may present Decreases due to a devaluation. -There are no proposals for different changes in in financing policies in phase II-Decentralization. -Large fall in per-capita expenditures in 1994.
NICARAGUA	-Financial information systems organized by region, departments and counties. -Positive trend in the per-capita health expenditure -Growing trend in the contribution from homes to the total health expenditure. -Priority give to public assistance by government financial contributions. -Identification of financing indicators for health-related NGOs. -Positive trend in health expenditures as a proportion of the GNP. -Consolidation of financing for social security -Growing contribution from enterprises.	-Low participation of households. -Financing with high dependency on external cooperation, including NGO's. -Financing indicators have not been integrated into allocation mechanisms. -The expenditures by attention level and item do Not exist before decentralization. -It is not possible to develop indicators for financing contributions by the local level. -The per-capita expenditure is quite low with respect to other countries of the region, no with respect to the GNP. -There is no equilibrium between financing amounts of the different health funds.
PERU	-Financial information is concentrated at the Ministries/Departments of Finance. -Financing equilibrium among providers. -Low dependency on external financing. -High contribution from households to health expenditure. -Positive trend in per-capita health expenditure. -Equilibrium between running expenses and investment. -Growing trend in expenditures to public assistance with respect to social security and the private sector.	-Decrease in contributions from households since 1994. -Irregular trend in health financing from workers and enterprises. -Negative expenditure trends for social security and private sector after 1994. -There is no information to quantify financial contributions at the regional or local levels. -There is no equilibrium about the destination of expenditures for first, second, and third attention levels. -Mechanisms for allocation are not integrated into financing indicators.

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