Centralized health care more cost-effective, offers better access to preventive services

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Families from rural Mexico who receive health care from centralized clinics run by the federal government pay up to 30 percent less in out-of-pocket expenses and utilize preventive services more often than those families who access decentralized clinics run by states, according to a study by researchers at the UCLA School of Public Health.

The findings are published in the September issue of the Journal of Social Science and Medicine and are currently available online.

The data were drawn from a comprehensive survey of 8,889 rural families from seven states in Mexico conducted in 2003 by Oportunidades, Mexico's principal anti-poverty program. The findings contradict the widely perceived notion that decentralized systems — in which local knowledge and resources can be more effectively used to address local needs — are superior to centralized organizations.

The study measured the effectiveness of centralized and decentralized providers using two measures: overall health expenditures by users (both centralized and decentralized providers offer free health care and drugs at rural clinics) and the utilization of preventive services (higher use reduces the cost of treating preventable conditions in the future).

Since centralized and decentralized organizations rarely operate within the same country during the same time period or cater to comparable populations, Mexico's health care-delivery system provides a unique opportunity to compare the two approaches side by side.

Starting the mid-1940s, the public safety net for Mexicans not covered by the Mexican Social Security Institute or other federal social security institutes was administered by the federal government. The government provided a limited bundle of cost-effective services, including primary and preventive care and basic hospitalization to the poorest rural areas of the country.

During the 1980s, the government undertook an ambitious decentralization plan that gave half the Mexican states oversight over these health services. A new administration interrupted the process, but it was restarted in the 1990s. Since then, both centralized and decentralized health care services have co-existed in 17 Mexican states without competing with one another.

The study revealed that households serviced by decentralized providers reported higher out-of-pocket health expenditures and lower utilization of preventive services, spending almost 40 percent more out-of-pocket and utilizing preventive care 7 percent less than households serviced by centralized providers. The households studied showed no differences in terms of age, years of schooling, family size, insurance status, employment, need and most community infrastructure measures.

Providers that were devolved to state governments during the first round of decentralization in the early '80s performed slightly better than providers decentralized in the '90s. This suggests that over time the performance of decentralized providers may improve.

"We find that the Mexican experience can be useful to other developing countries in Latin America (e.g. Chile or Brazil) and other areas of the developing world (e.g. China, Iran, Turkey) where relatively professional centralized governments have considered decentralization as a policy mechanism to reform their national health systems," said Arturo Vargas Bustamante, the study's lead investigator and an assistant professor of

health services at the UCLA School of Public Health.

Vargas Bustamante suggests that the centralized providers have four attributes that may give them an advantage:

- Type of service: Because the types of services provided to rural populations do not require a high degree of specialization and are relatively homogenous and less sensitive to local taste and variation, centralized providers may be able offer these services more efficiently.

- Quality of care: Centralized providers have more public resources to provide better services and employ more incentives and monitoring to improve the quality of care. For example, centralized providers can offer more generous pensions and benefits to their employees, compared with the average decentralized provider.

- Experience: In the three decades since decentralization began, centralized providers may have resolved functional issues that decentralized providers may still be tackling.

- Local capacity: Even if local authorities are closer to their communities and are more familiar with their characteristics and limitations, they still need managerial skills to provide health services that require some level of expertise. If these skills are less developed among decentralized providers, they will not be able to perform better than centralized providers.

The study suggests that decentralization may be less effective because state governments do not always match the public resources that are taken away by the federal government.

The researchers note that the single advantage enjoyed by those served by decentralized clinics is access to health campaigns. These are useful in providing basic interventions such as vaccinations, screenings and health education. The study suggests that decentralized providers could reduce users' out-of-pocket costs by offering more mobile health services and strengthening the network of clinics where follow-up treatments would be available to people reached by health campaigns.

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