

# Decentralisation in South Africa: Options for District Health Authorities in South Africa

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**T**he transfer of authority and responsibility for some public functions from one level of government, especially national government, to a second sphere (provincial) or a third sphere (local governments) has been adopted by many countries with the understanding that such health system decentralisation can help to address political, managerial and operational issues in terms of systemic efficiency and cost-effectiveness.

While South Africa's health system is already structured with a certain degree of decentralisation, the implementation of National Health Insurance (National Health Insurance) and the proposed creation of District Health Authorities as outlined in the Green Paper on NHI, implies that the country will now have to undertake several further steps in decentralising its health system. If poorly designed or ineffectively implemented, decentralisation can exacerbate existing inequalities and inefficiencies and create new challenges and problems.

This chapter explores several possibilities for the implementation of a coherent decentralisation system which addresses the health needs of the population. The authors also provide an extensive overview of the various forms of decentralisation and then offer some lessons, caveats and important issues that must be taken into account in the country's journey to further decentralisation. The potential role of the National Department of Health in a new decentralised system is considered, and several criteria to guide and stagger the decentralisation process are offered.

The authors conclude that while decentralisation is not without its disadvantages, decentralisation of health care services in South Africa can make a phenomenal impact on the quality and access to much-needed health services for the most vulnerable populations, particularly women and children and further note that ongoing monitoring and evaluation against set targets will be needed in order to achieve successful implementation of the envisaged NHI-funded health system.

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## Introduction

Most of the world's larger countries are decentralised to some extent (e.g. Canada, Australia, the United States of America, India, Indonesia, Brazil), as indeed is South Africa with its strong provincial government structure.<sup>1,2</sup> However, a number of health systems (including those of Indonesia and Rwanda) have devolved even further by transferring various functions from provincial level down to local level, this being one option of the model that South Africa is now pursuing.

South Africa's health system is already structured with a certain degree of decentralisation, and the advent of NHI facilitates significant flexibility in this regard. Many countries have adopted health system decentralisation to address political, managerial and operational issues in terms of systemic efficiency and cost-effectiveness.

Political aspects include responsiveness, based on the premise that smaller units would be more willing and able to reflect local concerns.

Managerial challenges arise when, for example, all decisions flowing to the centre overburden the executives, resulting in slow and bureaucratic decision-making. Those at the central office will not be aware of local circumstances and will lack information about local conditions. If much routine decision making is decentralised, managers may have more time for broad strategic thinking and planning and will not be overwhelmed by operational detail.

Operationally, because decentralised decision-making would be more rapid and would occur closer to the actual workplace, the quality of managerial leadership and employee morale could improve. As a result, employees would feel more responsible for the consequences of their actions and be more careful and enthusiastic in their work, thus increasing both efficiency and quality.

### Pros and cons of decentralisation

Decentralisation is not without its disadvantages, which can become much more significant if the decentralisation plan is poorly designed or ineffectively implemented. Decentralisation can increase costs if individual units are too small, causing duplication of functions and equipment that are consequently not fully utilised. Similarly, appropriate levels of specialisation can suffer if workloads or operational scale are too small. Duplication, under-utilisation and increased costs would result from specialists being nonetheless employed in such units.

Other problems arise from standardisation versus local variation. Allowing for too much local choice can undermine uniformity and comparability of data systems, standards and practices. This can lead to reduced quality of care, or can produce situations in which important national priorities do not receive sufficient attention in particular local areas, especially if the overall goal is to establish a unitary health system. On the other hand, too much restriction of local initiative would undermine much of the core purpose of decentralisation.<sup>3</sup>

### Types of decentralisation

Decentralisation can take many forms that have different characteristics, policy implications and conditions for success. Bossert argues that the degree of choice that local officials have over

different health system functions – which is known as the 'decision space' – is a critical characteristic of any decentralisation plan.<sup>4</sup> This approach identifies a range of choices over the key functions in a health system that officials at different levels of government are afforded, and suggests that decentralisation does not transfer all choices to other levels but rather allows narrow, moderate or wide choice over the functions of financing, service delivery, human resources and governance.

There are various forms of decentralisation.<sup>5</sup>

Deconcentration shifts responsibility from national government units to officials within the same agency who are responsible for defined geographic areas of the country. In South Africa, the Departments of Correctional Services, Home Affairs and the South African Police Services are examples of a deconcentrated government service. Such deconcentration efforts are primarily aimed at achieving the managerial and operational advantages previously noted.

Devolution involves the transfer of functions to lower-level, politically accountable entities and is one aspect of South Africa's proposed model, whereby the DHA would be accountable to local elected officials, and those officials in turn would be democratically accountable to their constituents for the quality of service. Devolution could also mean transferring responsibilities for health services to municipal governments.

Delegation involves the transfer of responsibility for decision-making and administration to semi-autonomous organisations at the provincial or district level, not wholly controlled by national government but ultimately accountable to it and/or to local governments. The thinking behind delegation is that the new structures would have increased discretionary power that is not available to regular government agencies, such as exemption from the constraints of the regular national civil service, or an ability to charge user fees.

Each of these options, and variations thereof, would suit different interventions in the formulation of NHI in South Africa, for example: contracting directly with service providers could be routed to a hospital management team, a health centre manager, or the private health sector.

### Political challenges of decentralisation

Of the three types of decentralisation, devolution requires political decentralisation. The purpose of shifting decision-making to lower levels is to give citizens and their local representatives more power in public decision-making, based on the theory that such participation is more effective in smaller geographic areas where mutual knowledge is greater, distances are shorter and scales are smaller. This could generate more citizen influence in the formulation and implementation of health policies, and decisions would be better informed and more relevant to diverse social interests within the context of national policy and healthcare framework, and the health system.

In South Africa, such levels of citizen participation are legally encouraged, but are not necessarily active. For such political decentralisation to succeed in the South African health system, much preparatory work would have to be conducted. Statutory

and possibly even constitutional amendments would be required, including those needed to create health political units at the decentralised level. In addition to formal legal changes, effective health agency in this new context would have to be encouraged and developed.

### Fiscal challenges of decentralisation

To carry out their functions, the DHAs would need adequate revenues. Such fiscal decentralisation can take many forms, only some of which are applicable to South Africa. The most obvious option would involve direct intergovernmental transfers (like the current conditional grants). These could be allocated to the new entities on a risk-adjusted population basis from either national or provincial governments. Another alternative involves asking local governments – at least in part – to support the decentralised entities from local tax revenues (as is the case in Chile). In addition, the DHAs could raise funds from various donors (be these international or local sources, the private or non-government sector).

Apart from taxes and donations, another broad financing option is revenue received through patient care. The optimal route would involve DHAs collecting revenues from the new National Health Insurance Fund or being funded on a capitation basis to deliver a set package of care. Around the world, some decentralised entities collect user fees from patients, but this is not likely to be politically acceptable in the South African context, except perhaps for certain specialised services. In some countries, public entities have engaged in co-financing or co-production with private providers who contribute money, infrastructure or personnel to the care process. However, this requires a flow of revenue (from out-of-pocket payments by patients or from medical insurance) to create private profit opportunities. A new development to monitor in this regard is the recent exploration by the Gauteng Health Authorities of having public patients attended to in private hospitals, given the non-availability of beds in the public service (while the private sector's bed vacancy rates can reach 46%).

Bossert and Larranaga.<sup>6</sup> note that if the financing burden is fully shifted to local governments, regions with higher incomes and a higher tax base will be able to finance better services. The same is likely to be true for options that depend on patient care revenues other than those from a national health insurance fund. On the other hand, if a system of need-based transfers from national government is followed, decentralisation can contribute to, or at least maintain, an equitable allocation of health resources to areas of different incomes, which is a key requirement for universal access. This is highly relevant for South Africa in terms of setting up DHA financing structures.

In creating any allocation formula for intergovernmental transfers, certain features of the South African situation would need to be addressed. In particular, the distribution of hospitals is such that there has been, and will continue to be, substantial inter-district and inter-provincial flows of patients from hospitals in poor regions to areas where the nation's major referral centres are concentrated. This would need attention in the construction of any new distribution formula, including the option of funding primary and secondary care separately from tertiary care.

### The role of the centre in a decentralised system

Even if national and provincial health departments were to decentralise many functions to DHAs, they would need to retain important policy and supervisory roles. The National Department of Health would have a critical role in promoting and sustaining decentralisation by developing appropriate and effective national policies and regulations and by strengthening DHA capacity to assume responsibility for their new functions. One of the Department's major roles would be to create or maintain enabling conditions to allow the 52 DHAs to take on more responsibilities, notably delivering on NHI contracts.

In the transition period, such skills and competencies will vary from DHA to DHA across the country, so that the process of transferring responsibilities would have to be steered in a flexible manner. In addition to training, the central ministry has to be in a position to offer technical assistance to DHA officials, private sector providers and local health non-governmental organisations (NGOs) with regard to the planning, financing and management of decentralised functions.<sup>7,8</sup> Moreover, given the inter-district variation in terms of needs and capacities, the success of decentralisation will depend heavily on capacity-building and training of national, provincial and DHA officials, programmes for which should be tested and refined in the NHI pilot districts.

However there are, a set of functions that the Department of Health should not decentralise, as they are essential for the effective execution of its core responsibilities. These include planning, managing, budgeting, holding DHAs accountable for their performance, and ensuring a health system that is coherent and affords universal access to quality health care for all.

### Beginning the process of decentralisation to the districts in South Africa's health system

The following general guidance on the functional areas in which the DHA would have a greater role is offered in the NHI Green Paper.<sup>9</sup>

- Once established, the DHA will be given the responsibility of contracting with the National Health Insurance in the purchasing decisions for health services and as a contracting agent will be supported by the NHI Fund sub-national offices to manage contracts with accredited providers.
- Ensure that services that are planned for are adequate for the population that is located within a defined health district.
- Monitoring of the performance of contracted providers and linking performance to a reimbursement mechanism that is aimed at improving health outcomes.
- Adherence to the envisaged separation of the functions of purchasing and provision of services within the National Health Insurance.

Decentralisation in South Africa should be seen as an iterative process. The scale of change that would be required between the current status of the health system and the vision thereof under a fully implemented National Health Insurance plan is immense, and would have to be undertaken as a series of reforms. Seen thus as a 'decentralisation journey', each step should successively

strengthen the capacity of district institutions, provide experience with the advantages and disadvantages of various alternatives, and prepare all role-players and stakeholders for further movement in the direction of the ultimate plan. Moreover, the NHI Green Paper clearly contemplates that not all districts would move at the same rate – given variations in sophistication, capacity and circumstances.

Whilst there is no single ‘right way’ to effect decentralisation, and despite the international evidence for how decentralisation can improve health system performance being fairly slim, the following propositions are based on the experiences of decentralisation in a number of different countries.<sup>13</sup>

Decentralisation involves a combination of decisions: how much choice local officials are to have (decision space) over separate functions of the health system; what capacities and competencies are needed at the various local levels; and how local health officials are held accountable to both local elected officials and higher administrative authorities.

To proceed in an appropriately phased manner, those responsible for the decentralisation process should assess the existing strengths and weaknesses of the various public and private structures that carry out health systems activities at various levels. Given issues of scale and accountability, they should carefully consider which functions are best carried out at specific levels of government.<sup>10</sup>

For functions that should be provided by the DHAs but for which there is no current capacity, appropriate steps for training, technical assistance and capacity development would need to be put in place. Similarly, existing management control and information systems should be audited and plans put in place to adapt those already established or create those that would be needed, thus allowing decentralisation to function effectively. The service journey along this route has begun with the development and implementation of the Ideal Clinic Realisation initiative and Primary Health Care (PHC) Re-engineering, but much work towards governance and leadership decentralisation remains to be done.

## Criteria for deciding how to begin the decentralisation journey

In this section we review various criteria for guiding the decentralisation journey.

### General considerations

Decentralisation is both a technical and a political process, and trying to do too much too fast risks failure, discrediting the entire enterprise and overwhelming the system. It is therefore important not to overtax the capacity of the system and to proceed with caution and at a steady, deliberate pace.

To develop added capacities, however, existing institutions must be challenged. An institutional system which is never taxed, pushed and stretched may never have the incentive or the opportunity to develop further capacities to grow and progress. Thus the phasing of the process requires an honest understanding of the actual situation in the field and careful judgement to balance divergent considerations.

Training should be phased and designed to complement the transfer of responsibilities. It is tempting to believe that a ‘rational’ training scheme would require all technical training to occur before transfers of responsibility. In fact, international experience highlights the

advantages of a parallel rather than a sequential approach. The pressure of added responsibilities can be an effective motivator in having staff work hard on mastering new skills, assuming that appropriate performance-based accountability structures are in place, which may not always be the case. In other circumstances, there may be a need for retraining given the mindsets that prevail.

Improving local technical capacity is easier than developing local political capacity. In places where the decentralisation of functions to local governments has been most successful (e.g. Chile, and Kerala in India),<sup>15</sup> those local governments had established roots of accountability to local populations, some managerial competence and reasonable levels of local participation before health functions were added to their responsibilities. In other cases (e.g. Yemen) decentralisation to the provincial level merely multiplied the opportunities for corruption. In Yemen, the issue was not technical competence but a lack of effective democratic accountability. In South Africa, there are pockets of excellence in the management of health services at local level, but these would have to be multiplied quickly if the programme were to become national in scope. The key would be to determine the nature of the DHA and whether the role of local government is to be the DHA itself or to have membership of the DHA.

The national government would have a continued and important role to play in setting priorities and maintaining accountability. For decentralisation to lead to better performance, certain standards and norms should be established at a national level, and key systems (information, monitoring, accounting, procurement and contracting, human resource management and logistics) would need to be strengthened. The key to effective decentralisation is both a shift in authority to the periphery and an increase in the extent to which those now responsible could be held accountable for their actions – a process which requires comparable data from across the system. Recent developments in data improvement, e.g. in the establishment of the Permanent Perfect Team for Ideal Clinic Realisation and Maintenance (PPTICRM) are a step towards this ideal, but depending on the payment models to be designed for PHC and hospitals, more would be needed.

DHAs should have the authority they need to respond to variations in local conditions and experiment with innovative approaches to carrying out their tasks: As with the necessity for judicious pacing, the extent of decentralisation is subject to conflicting considerations. On the one hand, the government is likely to want to retain the capacity to see that certain central priorities are pursued (e.g. HIV prevention, improvement in infant and maternal mortality). Yet the main rationale for decentralisation is to allow local processes to have an impact on service delivery choices and innovations. Similarly, with districts varying in capacity and creativity, an effective system would allow for experimentation at the district level to facilitate the development of emerging good practice and to encourage inter-district learning and competition.

### Reasons for caution in decentralising activities

Activities should not be decentralised if they require lower level units to develop technical capacities that are difficult to acquire and for functions that do not have to be undertaken at a decentralised level: This point requires a careful review of the available human resources and training capacity, and the difficulty of the training required. For

example, basic supervisory skills, or the fundamentals of clinical process improvement, can be taught effectively in relatively short periods of time if supplemented by hands-on practical project work done by trainees. Expertise in the design of electronic medical records or sophisticated knowledge about which international manufacturers of generic medicines have reliable quality, require a more specialised technical background. On the other hand, population size, urbanisation, sophistication and resources will vary across the 52 districts, such that some may well have higher capacity or more specialised skills than others and this should be factored into the decentralisation process.

Functions should not be decentralised if they are characterised by large economies of scale – that is, unit costs are significantly lower at high volume. Economies of scale arise when the costs of added units of output are low compared to average costs. Average costs decline significantly as volume increases. In health care, there are two main instances of this.

First, if an activity requires extensive capital investment, the production capacity of that unit should be fully utilised to minimise average costs. Thus, decentralised units should not be allowed to make commitments to investment projects that will result in excess capacity, low utilisation and higher unit costs. This has happened in many countries (e.g. in Saudi Arabia) where decentralised units found themselves responding to local political pressures for increasing local hospital capacity. In the South African context, this may require some centralised investment planning, managed financing as well as effective monitoring and evaluation systems.

A second source of economies of scale functions is in the area of intellectual property. Once an idea or analysis has been done, or a new product or practice developed, that practice can be used in other locations at low or almost no cost, without re-doing the development work. As a result, some countries have centralised key analytical tasks. For example, the development of clinical guidelines and decisions on billable services is done by the National Institute for Health Care Excellence (NICE) in the UK and by the Institute for Quality and Efficiency in Health Care (IQWiG) in Germany. These are centralised national bodies whose decisions apply system-wide. The German example is especially relevant to South Africa because that system combines centralisation of this function with decentralisation to the sub-national (state) level for many key activities, such as payment negotiations and insurance operations.

Functions such as information systems, quality monitoring systems and basic planning objectives, should not be decentralised if doing so undermines the capacity of higher levels of government to plan and manage the system as a whole. This is central to the ability of local units – such as District Health Councils – to hold their own managers accountable by being able to reliably compare their performance with what is happening in other districts. Similarly, higher levels of government need reliable and comparable information from across districts and provinces to undertake their supervisory and planning functions. Developments in the District Health Information System (DHIS) are advancing this proposition. The critical issue here is how various data elements are defined. Thus cost accounting systems need to be standardised, as do diagnostic categories and the way in which units of output are counted.

It is also essential that all electronic data systems have their information encoded in a common format so that it can be easily

combined and analysed. There are various ways to accomplish this. In Germany, electronic records are provided to physicians by private vendors, but all must meet common data definition and coding requirements so that their content can be submitted to, and processed by, regional data collection centres. Taiwan uses a universal ‘smart card’ information system to collect all clinical and billing information, even though significant payment decision-making resides at provincial level. In Egypt, a previous government instituted a centralised system of hospital quality auditing, even though the use of that information for management purposes was decentralised to the provincial level (called ‘governorates’). Nonetheless, DHAs should be free to establish their own supplementary output and quality monitoring systems, or to experiment with innovative ways to collect data – as long as this can be done in ways that are consistent with national specifications and data definitions.

Functions should not be so decentralised that doing so undermines the capacity of the national government to effectively pursue national priorities: It is not unusual for local political leaders and authorities to have priorities that are not consistent with those of the national government. For example in Ghana in the 1980s, decentralisation of some budgetary decisions led to a de-emphasis on prevention and public health versus curative services, which was a step away from central priorities. Similarly, in various countries there has been local opposition to reproductive health services, smallpox and polio immunisation and HIV screening. Again, given varying circumstances district by district, there should be some flexibility at the local level striking a balance with national concerns. Government therefore needs to find a way to hold lower levels accountable for meeting output or outcome priorities – even while allowing them sufficient room to respond to local needs, circumstances and preferences.

### Reasons for being more aggressive about decentralising activities

Functions should be decentralised if detailed information about the consequences and opportunities of alternative implementation choices are most readily available at the local level: One of the advantages of a decentralised system is that some decisions are best based on detailed knowledge of local conditions that is most effectively available at the local level. For example, facility managers often have the best information about employee performance that is relevant to hiring, termination, bonuses and promotion. Similarly, they may be the most knowledgeable about the attitudes and competence of potential private sector general practitioner contractors, the advantages and disadvantages of various service locations, or about local employment patterns that could be used to devise optimal hours of operation for various services. However, there should be clearly defined processes through which the local authorities must make their choices so as to avoid corruption, patronage and poor technical choices.

Functions should be decentralised if local circumstances vary significantly in ways that appropriately influence policies and priorities: While some priorities may be appropriately set nationally, the ways in which those priorities are best pursued may well vary according to local conditions. Optimal service design may be different in urban and rural locations, for different settlement patterns, or for groups with different social customs or religious beliefs. Allowing managers the discretion, for example over resource allocation and staffing patterns within an accepted framework of authority, can

be appropriate – again provided that some process, output and outcome-based systems of accountability at National Department of Health (NDoH) level are in place.

Functions should be decentralised if doing so shortens decision-making cycles and responsiveness to local concerns: One argument for decentralisation is that it can improve the rapidity and responsiveness of decision-making. For example, districts should be empowered to both track customer satisfaction and to respond with process improvement efforts to address such concerns. There should be no need to secure approval from higher levels of authority to make modest expenditures for these purposes (e.g. to repair windows, paint walls or purchase basic equipment) on the basis that there is an in-built quality of performance factor, below which such functions can be taken back by national or provincial departments of health. The utmost care must be exercised under such conditions to obviate the effects of poor management or leadership, or both.

Functions should be decentralised if doing so is part of a plan to attract and retain effective management at local levels: If District Management teams are to be effective, they should be staffed by managers who take professional pride in their work and derive satisfaction from it. Insofar as most or all important decisions are made at other levels, such jobs would not be attractive to the kinds of individuals whom the Department of Health would prefer to recruit for such positions. It would be critical to put forward non-financial incentives for managers, not only as a recruitment strategy but also to facilitate retention of such scarce capability. However, cognisance should be taken of why the previously introduced financial incentives, e.g. Rural Allowances, Scare Skills Allowances, and the Occupation-specific Dispensation have not achieved this aim.

### What and what not to decentralise

International experience and the foregoing conceptual analysis lead one to identify functions that should probably not be decentralised, as well as those that should be decentralised early and later in the decentralisation journey.

#### Functions that should probably not be decentralised

The design of core data definitions such as those for cost accounting, quality control, clinical activity and medical records should be done nationally. There are significant economies of scale in this enterprise and these require scarce technical skills. The exact methods for collecting these data could be somewhat flexible, although there are also reasons to believe that asking each district to fully design its own collection system is not optimal – and the centre should play at least a technical assistance role in this regard. Local managers should be free to produce added studies or collect additional information, but only nationally uniform reporting definitions would allow for supervision and planning with a consistent database.

The NDoH should lead the development of evidence-based guidelines, clinical pathways, benefit packages and essential medicines lists. Again, economies of scale, the need for specialised expertise and insuring fairness across provinces and districts necessitates this decision. There is ample international evidence (e.g. from Chile and Turkey) that nationally set clinical guidelines can lead to improvements in both the process and outcomes of care.

The selection of service and broad budget priorities, basic institutional and service design approaches, efforts to increase human resources, decisions and negotiations about medicines purchases – all of these also are probably appropriate national responsibilities. However, some allowance for DHAs to reprioritise budgets – within certain limits – in view of local needs (which may be very variable) should also be part of the system.

Basic systems to insure and regulate accountability and transparency at the district level including contracting processes, purchasing regulations, terms of employment for staff and basic decisions about governance structures, are essential to ensuring that districts function as intended, while at DHA level there should be effective monitoring systems that provide accountability to the NDoH.

Supervisory responsibility over key regional or national level hospitals should be of a higher and strategic level, while the operational supervision can be executed by the DHAs.

#### Functions to consider for decentralisation as part of the first steps on the decentralisation journey

- Responsibility for and authority over improvement of clinical and service quality within the general guidelines and norms and standards established at the national level – including locations and hours of operation, the design of clinical and administrative processes, consultation with local communities to identify priorities and re-deployment of staff
- Responsibility for implementing the new Municipal Ward-based Outreach Team model of community health workers and Ward-level primary health care, and tracking its implementation
- Increased ability to shift resources across budgetary lines to implement improvement efforts with commensurate accountability
- Increased authority over human resource decisions, which includes the authority to 'hire and fire' – recognising that many aspects of wages, hours and other terms and conditions of employment are set by union-management negotiation at the national level
- Some initial ability to contract with private, subject to compliance with national norms, processes and rates
- Responsibilities for the development of community outreach activities – including periodic performance reporting to the community – to begin to develop accountability at the district level.

#### Functions to consider for decentralisation as one proceeds along the decentralisation journey

- Broad authority to reallocate budget resources in order to meet set DHA population health targets
- Increased flexibility in developing payment and contracting arrangements with specific providers based on a DHA framework linked to national policy, assuming that the DHA will contract with the NHI and then sub-contract locally
- Increased flexibility in developing and testing new delivery

arrangements, with commensurate capacity-building programmes through which DHA and DMTs have been trained

- Responsibility for developing and implementing new primary prevention strategies tailored to local circumstances
- Responsibility for regulating clinical quality of services provided by private sector providers, against specified national standards.

## The structure of the DHA and its accountability to local authorities

### Basic choices

There are several key choices to be made in deciding on the governance structure of the DHA. The NHI Green Paper suggests that the DHA will be the intermediary between the NHI funding agency and the providers. In this role, it should also function as a supervisor and planner – in essence, as a manager of the managers of those doing service delivery.

A central decision will hinge on how this new organisation will relate to local, provincial and national government. In a classic devolution approach, the DHA would be attached to the local government, as is the case in many countries. It could be a semi-autonomous agency (or corporation) at 'arms-length' from the municipal government, or a department within the municipal government. As part of a municipal department, local health officials would be strongly accountable to the local municipal government and its leaders, who have to make decisions about many sectors, not merely health. A semi-autonomous DHA, with a board selected in part by the local authorities, would have more independence from the municipal political processes.

A complexity here would arise should any of the 52 districts not 'match' existing local government boundaries, although there are very few if any such cases currently, since the boundaries of the two structures are coterminous. Thus devolution would involve the need to create an independent supervisory structure (e.g. the District Health Councils) that would be less likely to attract sufficient political attention and energy to ensure effective accountability. In those districts where the DHCs have been non-functional, at least initially (and during a transition period) the DHA could be a part of the provincial government.

Such a devolved model contrasts with the way entities like the DHA function in 'deconcentrated' systems, such as in the UK. Under that model, district officials would be appointed by the Department of Health or the provincial authorities and would not be notably accountable to local officials. Thus the relatively centralised character of the system would remain, as it has in the UK. Mixed models are also possible, with district managers appointed by the national or provincial government but also accountable in various ways to local representative groups.

### Managerial requirements inside the DHA structure

Were the new system to be fully developed, the District Manager within the DHA would in effect be the Authority's Head of Department or Chief Executive Officer, who would be able to 'hire and fire' and would be accountable to the DHA Board, the District Health Council

and to higher authorities at the provincial and national level – with the exact arrangements evolving along the decentralisation journey. Responsibility for signing the performance agreement with the NHI and accountability for it is a key question.

One option would be to institute a 'manager of managers' at the provincial level (e.g. a Deputy Director-General of NHI) who would meet regularly with each district manager, review how they are doing, provide support and assistance, and ask probing questions. Exactly how the district managers would relate to such an individual, and to representatives of the local population, is one of the design challenges facing the DHA. (If this option were to be chosen, separate and specialised training for the individuals assuming these 'manager of managers' roles would be needed.)

Not only do relationships of the District Manager (DM) upward have to be clarified, the same must be done for their relationships downward. The ability of the DMs to deliver services will be dependent on what happens at the facility level. Thus there will need to be clear guidelines on the oversight role of the DM in relation to the chief executive officer (CEO) of a primary health care facility or of a district hospital. Such guidelines will need to clarify what can be delegated to the institutional managers, as well as the discretion the districts will have to experiment with various arrangements in this regard. This situation becomes more complicated if each CEO is directly contracted by the NHI.

The process through which district managers (and others) are selected would have a great impact on the performance of the DHAs. This is especially true in terms of their attitudes, values and leadership skills. Thought should be given to how to improve recruitment and training.

One possibility is a version of the selection process for Officers Candidate School used by both the US and the British Army, whereby candidates are asked to participate in week-long encampments at remote locations during which they are placed in leadership situations while instructors and observers examine how they respond. Another option, with a longer lead-time, is for all public officials to attend a general or health-specific Government School of Training for professional development. Such an arrangement has parallels in many countries – from the grandes écoles in France, to military academies like Sandhurst in the UK, to schools of public administration in the US. Such a system would require the envisaged training for DHAs to be aligned with this broader government training initiative.

### Local accountability

The DHA should be accountable to both the higher administrative authorities at the provincial and national level and to the local population that it serves. Local accountability could play a role in reducing corruption and in assuring that national norms and programmes are well implemented. It is also an important mechanism for informing local health officials of the specific priorities favoured by the local population.

Certain aspects of ensuring accountability to the local population would require investigation by the Department of Health, The respective roles of the District Health Councils and the District Health Authority and whether both would be active would need clarification. Would the DHA have its own board, and if so, how would it be selected? Would the DHA hire the district health manager or would that responsibility be assigned, at least initially, in whole or in part to

provincial or national levels? For example, one level might compile a list of eligible candidates and the other level might make selections from that list.

If district managers are to be accountable to a local agency, there are various options for the construction of such a body, including local elected officials from within the district, selected members of other health councils or committees, or representatives of various stakeholder groups such as patients. The board members could be chosen through specific local elections, or by either higher authorities or local elected officials from lists presented by representatives of different interest groups.

Regardless of the method chosen, the degree to which the DHA is accountable to the local population would depend in part on who chooses the DHA board and/or the members of the District Health Council. To the extent that they are selected by the provincial or national level, the body in question is likely to be more accountable to national priorities and less responsive to local issues and perceived needs.

Several methods could enhance accountability to local populations.

- Specific functions could be assigned to require approval by the local representative body; for instance, in some countries, payment of local salaries is authorised only if the local body certifies the attendance of the providers.<sup>21</sup>
- The local body could be responsible for mobilising additional funds for health activities and the health offices could be held responsible for using these funds for achieving local objectives.
- Local bodies could be made responsible for reporting or certifying performance indicators (for instance, in Performance Score Cards) to higher authorities, thus providing a form of citizen audit on the achievement of provincial or national objectives.

### Implications for training

In a decentralised environment, the evolving role of the district manager would be more demanding in terms of the quality of services expected by local populations and arising from more effective monitoring and evaluation. Managers would have more authority than they have now but also more accountability, and they would have to cope with an expanded scope of activities and new ways of operating. As the system decentralises, a new type of leadership at the district level would be required. Choices about how much decision space to allot to District Management Teams would have to focus on the capacities of local managers for effective decision-making. Training should be aligned with these new responsibilities.

In practice, the process described in Table 1 (see end of chapter) could be applied to refine proposed job descriptions and their associated competencies. The new management competencies and skills required would be:

- Communication skills: technical writing, presentation skills.
- The ability to analyse local conditions including mastery of essential epidemiology and demography and an ability to apply these to the specific contexts of each catchment population.

- A substantive understanding of the effectiveness of various prevention and service delivery alternatives, especially with regard to health conditions that are a national priority. For example, the DMTs should understand the options available to them in reducing HIV transmission or maternal, child and infant mortality.
- Mastery of planning and budgeting tools and techniques: managers should be familiar with accounting concepts including income statements and cost and variance analysis, and of reimbursement methodology, so as to be able to plan, manage and track revenue and expenses.
- The ability to plan and manage human resources, including providing supervision, analysing workloads, designing job descriptions and accessing required training in order to ensure that staff composition and performance are commensurate with district needs. This requires a focus not only on clinical providers but also on motivating the support and administrative staff that are critical to successful operations.
- Procurement management (which been identified as a serious shortcoming in the current system): this requires a thorough understanding of the goals, vulnerabilities, rules and processes of procurement. DMTs should be able to devise alternative strategies to counter procurement shortcomings.
- Contract management, particularly as it relates to the public-private interface: a general understanding of the contracting process, its rationale, alternative ways of proceeding and the appropriateness of different approaches in various circumstances. Knowledge of the existing legal and regulatory framework in South Africa is essential to ensure the integrity and effectiveness of the process.
- The capacity to monitor and improve clinical and service quality: this includes responsibility for the operation of primary health care facilities, oversight of district hospitals and management of referral.
- The ability to design and implement mechanisms to improve accountability and transparency and to reduce corruption and patronage. Examples include appropriate purchasing and hiring processes, auditing requirements and public reporting systems.
- Understanding the need and methods for engaging in monitoring and evaluation: this would involve developing an appreciation of their role in advancing public health, understanding of the operations of South Africa's health system in South Africa, as well as willingness and ability to co-operate with external evaluators, including regarding service innovations.
- Understanding of the district manager's role in relating to the newly appointed Deputy Directors-General for NHI who would be placed at provincial levels and for now, through whose offices primary health care funding would flow to the District Health Authorities.

## Managerial decision space within the DHA

The following section reviews in more detail some of the key issues to be considered in allocating decision space to the DHAs in a variety of specific functional areas.

### Planning and budgeting space

Many health systems decentralise some degree of decision space for planning and budgeting to local agencies. Usually, national authorities specify broad health objectives and strategies, within which local authorities can choose their own priorities.

To ensure coherence and accountability, it makes sense for the national government to develop and disseminate standardised frameworks and formats for districts to use in their own planning process, and to provide the training that district officials will need in their use. Such tools help to guarantee a minimum level of quality in district planning efforts and to ensure that planning documents can be reviewed and compared efficiently. Such planning tools in turn guide district officials in the use of the information in their local information systems.

In such systems, it is also usual for standardised budgeting processes to be developed nationally, along with ceilings and guidelines for different budgetary categories so that local planning is done within realistic budgets, potentially tied to NHI funding. As the DHAs develop capacities and improve their performance, the planning and budgetary space may be expanded to facilitate a wider terrain of choice, as long as key performance objectives are achieved.

The DHA should work within national frameworks and objectives, using planning and budgeting tools to develop their own plans based on local information and knowledge of the local conditions and needs.

The DHA plans and budgets should also be a vehicle for accountability, both to higher administrative levels (province and national), and to local representatives such as the District Health Councils and elected officials in local government. Auditing of expenditures against the planned budget and other mechanisms of accountability should be established at the outset of the process of decentralisation to the DHA.

### Financial management space

Until the NHI is established, it is likely that the DHA will continue to receive the bulk of their funding from the provinces. However, in anticipation of NHI, the DHAs need to develop capacities to manage a funding flow drawn in part from volume-based patient service revenue, such as per capita payments for patients registered at primary care facilities, diagnosis-related groups (DRGs) for district hospitals, or service payments for other activities.

To do this, DHAs will need cash-flow management systems and skills. They will need to develop the capacity to forecast revenue, manage expenditures over time, record and respond to variations in cash flow and establish reserve funds. It is likely that such systems will need to be established and staff trained in their use for some months before the transfer to NHI payment. This will allow for a period of 'shadowing' the operation of the new system before the new payment methodology takes effect, thus obviating the risk of revenue and expenditure mis-matches.

In addition, the DHA should be able to mobilise additional funding either from local governments, donors or from sales of services to the private sector. In Chile, for instance, local government provides up to one third of the costs of local primary care budgets from their own revenue sources and untied transfers.<sup>22</sup>

### Human resources development and management space

Expanding the role of the DHA in hiring, firing, promoting and contracting staff is often regarded as a major advantage of decentralisation. Greater control of human resources management is a key instrument for local managers to motivate and improve the performance of their staff. However, without sufficient safeguards, and standards and transparency in the processes of human resource management, local choice can become a means of selecting and rewarding or punishing staff for reasons other than improved performance, such as nepotism, patronage and other forms of corruption. Therefore, it would be important for the DHA to have greater authority over human resource management, but the NDoH and/or provincial departments would have to develop transparent merit-based systems of hiring, firing, promotion, contracting and transfers within which the DHA would have to function.

In some countries, the local authorities are allowed to make human resources decisions only for non-professionals, reserving the management of physicians and nurses for higher authorities. Rarely, however, does centralised control over staffing assignments result in improved distribution without changes in incentives (both financial and non-financial) for work in underserved areas.<sup>23</sup>

A key human resources management issue is negotiating with provider unions. In many countries, it is the national level that negotiates with the national or confederations of unions, and local authorities have a minor if any role in determining salary levels, working conditions and other key human resources conditions.<sup>23</sup> The issues to be handled by the DHAs in negotiating with local unions should be determined. In many countries, local public service commissions play a key role in human resources management.<sup>23</sup> This may entail a supervisory role to assure that the national civil service norms are respected by the local administrative agencies of government, or the agency might undertake appointments and dismissals. It is likely that in South Africa, the DHAs would be responsible for, and have the competencies to execute, the human resources management processes, and that the public service commission would supervise these and assure that the required standards are adhered to.

In the initial stages, the DHA might be allowed to offer bonuses for improved performance of staff and develop its own incentive schemes, but within the 'budget envelope', this function could be transferred to managers of the facilities.

Given variations in service needs, the DHA should have some role in planning for the type and recipients of training to align capacity-building with observed needs. There are, however, good reasons for setting national minimum levels of training that are generic across all districts. The extent to which districts should have their own training capacity should be further explored. Some basic training functions might well be part of district responsibilities, while other, higher-level training is likely to be best done more centrally, in light of economies of scale and the need for specialised expertise.

## Space for contracting with private sector providers

It is likely that initially at least, the National Department of Health will establish standardised contracts for DHAs to use in contracting with private providers. However, as contracting capacities develop within and between the DHAs, more flexible contract negotiation, taking into account local conditions, can become appropriate – provided that these also occur within transparent and nationally standardised processes. In some countries, contracting with the private sector is encouraged only when public providers are insufficient to cover the demand (as in the Chilean case).<sup>9</sup>

The extent of private contracting is likely to vary over time and from place to place. Initially there are likely to be ‘contracting in’ arrangements with private physicians to provide services in public facilities. Over time, such providers may be contracted to accept publicly insured patients in their practices and private hospitals may also be contracted for this purpose. This process is used in Colombia and other countries where funding follows the patient.<sup>9</sup> Currently the health authorities in Gauteng Province have indicated that they are embarking on such a venture to secure private hospital beds for public sector patients. International experience shows that arrangements like these work best when there are multiple private sellers seeking such contracts, which leads to competitive price discipline.

If DHAs have too much responsibility – before their contracting skills are developed – they risk being out-negotiated by private sector actors and/or making flawed decisions. Hence the scale of local contracting should be implemented in tandem with appropriate skills development.

Appropriate systems for monitoring the performance of contracts constitute a critical component of all effective contracting. At the very least, many districts are likely to need technical assistance in the establishment of such systems.

The DHA should also be given responsibility for training in contracting skills.

## Space for payments to public facilities

A capitated payment system is envisaged for primary care while allowing patients to register in a variety of specific facilities, public or private, with hospitals ultimately being registered on a DRG system. How public providers will be paid for other services (e.g. public health prevention efforts) remains to be determined.

The question of how the DHA relates to public providers also needs further development to define the extent to which the health centres or the hospitals would become quasi-autonomous entities with independent financial management. In the short run, DHAs should develop mechanisms for allocating their budgets to providers in their districts and it is likely that, at least initially, this will and should be done within limits and according to guidelines developed at the national level.

If providers do develop the appropriate legal and management structure, over time the NHI agency may pay some or all public facilities directly, or it may contract with the DHA which will act as a ‘wholesaler’ for those facilities.

If DHAs receive risk-adjusted per capita budgets, it is likely to be appropriate for one DHA to purchase services from another, in cases

where required health services are not available in the purchasing district. Such an arrangement would involve transfer of funds between DHAs. Whether the rates involved would be negotiated between the DHAs, or set at the provincial or national level, remains to be determined.

## Quality management

The new Office of Health Standards Compliance will have responsibility for establishing and enforcing quality standards for various classes of facilities. The Office will operate with considerable independence as an external monitoring agency.

While some clinical pathways and process norms are likely to be set on a national level, districts will have shared responsibility for setting norms in areas not under national guidelines, including detailed operational goals for local levels of service quality.

The DHAs will be responsible for maintaining quality in all facilities in the district in keeping with both national and local norms. This will require that they collect and report quality information in line with national data frameworks, identify quality failings and initiate quality improvement efforts.

## Disease surveillance

There are good reasons for the National Department of Health to define the standards and process of disease surveillance to assure accurate, consistent and comparable record-keeping and reporting. However, if sufficient capacity in epidemiology and disease risk assessment is developed for DHAs, there may be room for local priority-setting in disease surveillance – provided that national reporting obligations are met. For example, district authorities in some rural areas may focus on surveillance of a locally endemic tropical disease – an effort that would not be a priority in a large urban area.

Linked to epidemiology is the monitoring of demography, that is, internal migration of the population between provinces and between districts, especially those among the most marginalised who need specialised services.

The responsibility for aggregating these data should reside at the national level. This effort is well advanced in South Africa, given that the NDoH has set up a global positioning system (GPS) tracking and tracing system for each of the provinces, by which all the population, health, demography and epidemiology data have been captured to the nearest square kilometer. By utilising this system, each DHA would be able to monitor their district’s health indicators.

## Service delivery

The DHA would have responsibility for implementing the new model of Municipal Ward-based Outreach Teams of community health workers and ward-level primary health care, and for tracking related implementation.

Responsibility for ensuring the quality and efficiency of services at hospital facilities should be supervised by the DHA.

Responsibilities for the development of community outreach activities, including periodic performance reporting to the community, should be allocated to the DHA in order to develop accountability at the district level.

### Other functional areas

There are a variety of other functional areas in which the DHAs might play a role, such as medicines supply, equipment procurement (including information systems), equipment maintenance, building construction or leasing, and property acquisition. Many detailed decisions are required to be made in each of these areas.

The issues to be explored in this regard include:

- > What role should the DHAs play in supply chain operations?
- > Should they be responsible for maintaining stock records and actively ordering from central stores?
- > How well is the current central stores system working across the country?
- > If DHAs are to assume this role, should the systems be designed on a district, provincial or national level?
- > Should the DHAs be responsible for procuring supplemental supplies in instances where stock-outs occur, and if so, how should this role be organised?
- > To what extent should their decisions be constrained by national policy on essential medicines, procurement arrangements, policies on generic fulfillment and so forth?

In each of these areas, a detailed assessment of the strengths and weakness of current practice and the development of new policies and systems where appropriate are required.

### Auditing and transparency

If the DHAs are to be held accountable – especially with regard to financial controls (including purchasing and hiring) – the health system will require effective auditing as well as mechanisms to use audit results to promote transparency and accountability. Recent difficulties experienced by the NDoH in this area suggest this is of major importance.

The recent Auditor-General's Report<sup>12</sup> noted that there are very strong national standards for auditing, but problems occur in implementation, as demonstrated in those provinces where budgets have been overspent.

This need will have to be addressed within the new decentralised system through five distinct but inter-related initiatives.

Firstly, the administrative structure and reporting responsibilities for the audit function at national, provincial and district levels will have to be determined.

Secondly, clear rules and procedures for transparency in planning, budgeting, procurement and human resource management should be developed.

A third step would be the development of appropriate training activities to ensure that staff are aware of and competent in the use of these systems.

A fourth measure would relate to ensuring transparency in how DHAs carry out these functions, including, for example, the possible use of web-based systems for procurement and for competitive recruitment for key staff – as has been done in Chile.<sup>12</sup>

The fifth and perhaps most important step would be the recruitment of managers committed to honesty and efficiency in DHA operations. This would entail finding and training managers with skills to supervise and motivate staff. Moreover, managers need themselves to be managed in ways that support and encourage them to fight corruption and patronage in district operations.

### Conclusion

The decentralisation of health care services in South Africa can make a phenomenal impact on the quality and access to much-needed health services for the most vulnerable populations, particularly women and children. This chapter has explored several possibilities for implementation of a coherent decentralisation system which addresses the health needs of the population, noting that ongoing monitoring and evaluation against set targets will be needed to achieve successful implementation of the envisaged NHI-funded health system.

Table 1: Developing a prototype management plan for a District Health Authority

<p>A prototype plan for District Management teams is needed as a foundation for training team members in the new National Health Insurance structure. The district team will be embedded in a complex vertical structure, the shape and scope of which will depend on its functions and responsibilities in reporting to the provincial and national levels, and in turn, supervising various provider entities including community health centres and hospitals.</p> <p>The first step in developing this prototype plan is to clarify these relationships. This will involve a great number of design parameters, some of which are unpacked below:</p> <ul style="list-style-type: none"> <li>❖ How will the budgets for the districts be set?</li> <li>❖ What will these budgets cover?</li> <li>❖ Will they be developed using a population-based formula or will the districts have to prepare annual budget proposals?</li> <li>❖ Will capital and operating expenses be treated separately or together?</li> <li>❖ Will they be subject to the same or different processes?</li> <li>❖ How will funds be allocated to providers? This involves two basic decisions: the basis or unit of payment, and the rate.</li> <li>❖ Will the basis or method of payment be specified on a provincial or national level (e.g. capitation for primary care doctors and DRG per-admission payment for hospitals)?</li> <li>❖ Alternatively, will districts have some flexibility in this regard?</li> <li>❖ Will the rate or price be set provincially or nationally, or by negotiation between providers and the district?</li> <li>❖ If there are to be either reimbursement or contract negotiations, will these occur case by case or only occur between the district and its providers under a unified agreement?</li> <li>❖ Will financial control and expenditure audit also be a district responsibility?</li> </ul>
<p>Complementing any payment and budget system will be the skills – and hence the training needs – generated by the system of cost accounting and financial management, which has been a persistent problem at the institutional and district level in South Africa. Whether or not all providers will be required to follow standardised accounting conventions and allocation rules will have a major impact on supervisory responsibilities and concomitantly, on capacity-building and training requirements at district level.</p> <p>A similar set of questions arises in other major related functional areas – especially human resources, purchasing and supply chain management:</p> <ul style="list-style-type: none"> <li>❖ To what extent will providers be bound by provincial or national process rules?</li> <li>❖ What flexibility will districts have to alter or modify those rules?</li> <li>❖ To what extent will districts have compliance audit functions?</li> <li>❖ Will districts themselves have responsibility for hiring and firing and/or for purchasing?</li> <li>❖ Will districts be responsible for managing district stores and for supply chain functions to clinical care sites?</li> <li>❖ Will these systems of re-ordering and supply be specified provincially or nationally, or will districts have some design responsibility as well as any implementation responsibility?</li> <li>❖ Will the information systems related to all these functions be essentially specified for the districts to implement?</li> </ul>
<p>Beyond these operational functions, the role of districts in supervising clinical quality must be clarified.</p> <ul style="list-style-type: none"> <li>❖ Is it anticipated that clinical pathways and guidelines for treating various diseases will be set at higher levels or will the districts be responsible for any of these?</li> <li>❖ Will they be expected to participate in guideline development if this is done at a higher level?</li> <li>❖ Will the districts be responsible for monitoring quality of care among providers? This could involve both monitoring the appropriateness of care and some system for reporting and investigating patterns of avoidable errors.</li> </ul>
<p>Again, these functions are interdependent with the relevant information systems.</p> <ul style="list-style-type: none"> <li>❖ Will there be central decisions on the forms of patient records to be kept or will districts have some initiative in this regard?</li> <li>❖ Will they have any responsibility for clinical audit and/or for quality inspection of facilities?</li> <li>❖ In terms of guideline compliance, will districts have any responsibility for enforcement and/or education (e.g. in the area of continuing professional education) to facilitate such improvements?</li> </ul>
<p>The same set of questions arises with respect to service quality.</p> <ul style="list-style-type: none"> <li>❖ Is it expected that districts will have a supportive, a regulatory or an incentive-based role vis-a-vis service quality among various sites of care?</li> <li>❖ Will they be responsible for creating standardised systems to monitor process criteria such as waiting times?</li> <li>❖ Will they have a similar role with regard to patient satisfaction surveys?</li> <li>❖ Will they need to have consulting expertise on process improvement to support such activities at the facility level?</li> </ul>

<p>Once this set of questions informing the design of the District Management team has been finalised, developing the prototype plan requires answering them. To achieve this, we propose the following seven-step process:</p>
<p>Step 1: Develop an inclusive list of possible functions that might be assigned to the districts, by (a) consulting various past documents, proposals and presentations that discuss ideas for district structure; (b) reviewing the literature about world-wide experience to distill the functions assigned to comparable entities in different national systems; and (c) conducting a set of interviews with Department of Health leadership and knowledgeable experts in South Africa to elicit their visions for the district structure.</p>
<p>Step 2: Develop a set of normative criteria for determining which activities should be assigned to various levels of government. Possible examples include exhausting economies of scale, constructing information systems that allow for inter-district comparisons, and responding to desires for local control.</p>
<p>Step 3: Prepare a report outlining a proposed set of responsibilities for the District Management team. This will be based on applying the criteria developed in Step 2 to the inclusive list developed in Step 1. The report would review the rationale for the proposed list of functional responsibilities, and outline the critical 'close calls' and strategic design decision that remain to be fully resolved.</p>
<p>Step 4: Undertake a consultative process with Department of Health leadership to develop an 'interim functional design.' This could be achieved through a series of interviews, a half-day or day-long workshop, or a combination of the two. If the combination approach is chosen, it is recommended that key informant interviews be held first, closely followed by a more inclusive stakeholder workshop.</p>
<p>Once the functional responsibilities have been clarified, three additional tasks (Steps 5, 6 and 7) will need to be completed.</p>
<p>Step 5: Construct a proposed organisational structure for a district office to conduct these tasks. Continued consultation with the Department of Health would be required for this construction, specifically on the operating budget envisaged for the district. Given the intensely complex matrix of delivery systems that would be supervised by different districts, it might be concluded that two (or even three) prototypical structures would have to be developed.</p>
<p>Step 6: Develop proposed job descriptions for each of the critical leadership positions in the prototypical district structures. This can be executed at various levels of detail.</p>
<p>Step 7: Describe the competencies required for each job description. Comparing this 'ideal' with the 'actual' levels revealed in the survey lays the foundation for developing an instructional plan.</p>

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