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DECENTRALISATION OF DISTRICT HEALTH SERVICES IN THE FREE STATE PROVINCE

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DECENTRALISATION OF DISTRICT HEALTH SERVICES IN THE FREE STATE PROVINCE

by

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DECLARATION

I declare that the thesis titled **"Decentralisation of District Health Services in the Free State Province"** is my own work and that all sources used were acknowledged by complete reference.

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Oliver!
Oh Captain! My captain!
Our fearful trip is done,
The ship has weathered every track,
The prize we sought is won...
The port is near....
Well – is the prize won? The best memory for Oliver Tambo is making hope a reality for South Africa to remain a truly democratic, non-racial, non-sexist and united, currently and in the years to come.

The light shines in the darkness, and the darkness has not overcome it!

ABSTRACT

Experiments with decentralisation began in the late 1970s and continued throughout the 1980s. Decentralisation is regarded as a key element of the primary health care approach. It is initially seen as having important political value that can be used as a means to enhance health service policy. However, in many instances, western donors who believe that because one form of decentralisation works in developed countries, it will also work in the developing world often pursue decentralisation.

The challenge facing the South African National Health System and the Free State Health System in particular, is to design a comprehensive programme to redress social and economic injustices brought about by apartheid to the majority of the population to ensure that emphasis is placed on health and not just medical care so that issues relating to socio-economic conditions such as poverty, water and sanitation, and proper housing should be addressed adequately. At present, implementation of the District Health System (DHS) based on primary health care (PHC) approach is provided by the Free State Department of Health (FSDOH) and by local municipalities on an agency basis. The above approach is concerned with keeping people healthy, as it is with caring for them when they become unwell.

In an endeavour to address aforementioned challenges, the South African Government of National Unity (GNU) has adopted decentralisation as a model for both governance and management. Decentralised governance is embodied in the Constitution of the Republic of South Africa, 1996, in the form of powers and functions for the three spheres of government. The powers and functions of the local sphere of government bear testimony to the importance of this sphere in particular. The GNU, through its adoption of the Reconstruction and

Development Programme (RDP) in 1994, committed itself to the development of a DHS based on PHC approach as enunciated at the Alma Ata conference in 1978.

The hypothesis for this study indicated that decentralisation of DHS in the Free State Province will enhance efficiency and equity and thus make local public representatives accountable for services rendered. The hypothesis and research objectives for the study were validated by means of literature review and empirical survey.

The thesis outlines the conceptualisation and forms of decentralisation and also draws lessons from the experiences of various countries including Canada, Zambia, Indonesia, and Brazil and highlights the need to approach the formulation and implementation strategies for health sector reforms systematically, rather than importing, uncritically, structural models developed abroad. Political considerations are inherent in any decision made and a political environment limits the extent of decentralisation. Without doubt, the most serious mistake any reformer can make is to assume decentralisation to be a managerial exercise devoid of political cause and consequences.

The thesis concludes by presenting analysis and interpretation of research findings while also outlining key recommendations that might be of assistance for identifying an appropriate form for decentralisation of health services.

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CHAPTER 1

OVERVIEW ON IMPLEMENTATION OF DISTRICT HEALTH SYSTEM AND DECENTRALISATION FOR ENHANCEMENT OF DISTRICT HEALTH SERVICE RENDERING.

1.1 Introduction

Eighteen years of democracy has brought major changes to the health sector reform in South Africa and the Free State Province in particular. Major constitutional and legislative reforms have seen the South African state undergo massive transformation leading to the adoption of the implementation of the District Health System (DHS) policy based on the Primary Health Care (PHC) rendering. Although the DHS has been implemented for more than eighteen years in the Free State, the transformation of the fragmented and inefficient apartheid health system into a coherent and unified National Health System (NHS) capable of addressing the health needs of the population, especially those living in poverty, was and still remain a massive challenge.

Before 1994 the South African state, through its apartheid policies, was driven by a rule-based administrative culture that took little cognisance of the needs of the majority of South Africans. Also of importance was the fact that the rendering of health services was more curative-focused (hospi-centric) and even inaccessible and unaffordable to the majority of the population in South Africa. The South African democratic state is committed to fostering development by way of a service-oriented culture that places people's needs at the forefront of state endeavours.

In an attempt to address the aforementioned challenges, the South African Government of National Unity (GNU) adopted decentralisation as a model for both governance and management. Decentralised governance is embodied in the Constitution of the Republic of South Africa, 1996 in the form of powers and functions of the three spheres of government. The powers and functions of the local sphere of government bear testimony to the importance of this sphere in particular. The GNU, by its adoption of the Reconstruction and Development Programme (RDP) in 1994, committed itself to the development of a DHS based on a PHC approach as enunciated at the Alma Ata conference in 1978. This approach is the philosophy behind which many health systems around the world have been reformed, and out of which has developed the concept of DHS. In the health sector, decentralisation, involving a variety of mechanisms to transfer fiscal, administrative, managerial and/or political authority for health service rendering from the provincial health authority to an alternative local sphere of government has been promoted as a key mechanism of improving health sector performance.

The research attempts to conceptualise the DHS in terms of what it is in relation to the transformation of health services in South Africa and Free State in particular. An endeavour to explain the relevance and adoption of DHS is outlined. The research attempts to highlight the relationship between the DHS and local government, with particular reference to the Integrated Development Planning and functional integration.

An attempt is made to define decentralisation, elaborate on the rationale of moving from centralisation to decentralisation of health services. Various forms of decentralisation, the relationship between decentralisation and

democracy as well as to effective governance at local government level are explained in depth in the chapters that follow.

Key lessons are drawn from international experiences, especially focusing on both the developed and developing countries, to compare how decentralisation of health services was undertaken. Particular reference is outlined on how decentralisation of health services was undertaken in Canada, Indonesia, Zambia and Brazil and critical factors that need to be taken into consideration during the decentralisation process. The South African health sector will be able to utilise mechanisms which contributed to the success of decentralisation in the aforementioned countries.

In conclusion, a summary of all important aspects that form the mainstay of the research as well as of important recommendations for future reference is outlined and thus help in the formulation of proper policies for decentralisation of health services.

1.2 Background and reason for study

The challenge facing the Free State Health System is to design a comprehensive programme to redress social and economic injustices brought about by apartheid to the majority of the population to ensure that emphasis is placed on health and not just medical care so that issues relating to socio-economic conditions such as poverty, water and sanitation, and proper housing should be addressed adequately. Currently, the implementation of district health system (DHS) based on the PHC approach is provided by the Free State Department of Health (FSDOH) and by local municipalities on an agency basis. The above approach is concerned with keeping people healthy, as it is with caring for them when they become

unwell. These concepts of 'caring' and 'wellness' are promoted effectively and efficiently by creating small management units of the health system, adapted to cater for local needs as required by the Integrated Development Plans (IDPs) of municipalities. It is against this background that the decentralised district health services to district municipalities in the Free State will enable the district health authorities to take responsibility for the health of the population within their geographic areas.

The topic justifies research because district municipalities had never provided any health services in the past and thus even their capacity to render new services (health services) in an effective and efficient manner will be put to the test. It is for this reason that an appropriate form of decentralisation such as delegation will be proposed as a model to enable the Free State Department of Health to account on how district health services are being rendered to the general populace.

1.3 Problem statement

Following on the reasons advanced to justify why the research needs to be undertaken, the problem is worth researching due to the following:

- The implementation of the District Health System remains a challenge in the Free State Province due to the fact that district health services are rendered by two distinct authorities (province and local government).
- The capacity and readiness of district municipalities to render primary health care services also remains a challenge.

Although the aforementioned elements are covered in the research, the researcher focuses more on the latter element, which outlines various forms

of decentralisation, their relations to DHS and ultimately to local government for efficiency, effectiveness and accountability.

1.4 Hypothesis

The research is guided by the following primary hypothesis:

- Decentralisation of district health services in the Free State Province will enhance efficiency and equity thus making local public representatives to be accountable for services rendered.

Derived from the aforementioned hypothesis, eight secondary hypotheses are postulated as follows:

- Decentralisation of district health services will enable community members to participate actively in activities relating to health and thus ensure that their health needs are met.

- Decentralisation of district health services will ensure that both politicians and officials serving various municipalities will be accountable to the communities in terms of health services rendering.

- Decentralisation of district health services will ensure that capacity is created so that those who are charged with the responsibility of rendering primary health care are able to do it in an effective and efficient manner.

- While decentralisation of district health services will both increase accountability, efficiency and effectiveness, it will also serve as a means

of boosting staff morale and encourage local initiatives and flexibility in the light of local and changing circumstances.

- Decentralisation of district health services will ensure that decision-making concerning health matters takes place closer to the communities as they will highlight their needs.

- Decentralisation will enhance multi-sectoral and multi-agency collaboration at the lower service provision levels thus rendering services in an integrated manner.

- Decentralisation will contribute to improved allocative efficiency by allowing the mix of services and expenditure to be shaped by local needs, epidemiology and provider skills and performance.

- Decentralisation will enhance greater equity by the distribution of resources among traditionally marginalised regions and groups.

1.5 Aims and objectives for study

The Free State Department of Health (FSDOH), like other health departments in the Republic of South Africa (RSA), is grappling with the consolidation of the gains achieved during the past 18 years of health sector reform, with particular reference to the implementation of an integrated district health system. Thus, it is essential for Primary Health Care (PHC) services to be consolidated in the province to address issues relating to equity and functional integration before decentralising those (PHC services) to district municipalities.

The main aim of the research is to conduct an in-depth investigation of forms of decentralisation such as delegation, devolution, de-concentration and privatisation, to enhance the well-being of the people by empowering local voters to change the kind, quantities and qualities of the public services they receive from their local authorities. The primary purpose of the research is, therefore, to investigate:

- How district health services will be decentralised in accordance to the provisions of the appropriate legislative framework.
- How local residents will hold locally elected public representatives accountable for their actions.
- How to make the environment conducive for local participation in collective decision-making and thus assisting in reducing political alienation among residents and policy-makers.
- How to build capacity of governance structures (District Health Councils) for efficiency, quality, equity and accountability.
- How to provide adequate support to district municipalities in terms of resource allocation, to render the PHC services.
- How to uphold the principles of cooperative government for efficiency, effectiveness, equity and quality.

The intent of the research is to contribute towards understanding the decentralisation of district health system in the Free State Province and the Republic of South Africa in general. This will enhance local accountability in terms of how health services rendering will take place at the district municipality level.

1.6 Research methodology and nature of data to be collected

The researcher will use various methods in conducting the research. Both qualitative and quantitative methods will be used. The use of these two methods is solely based on the fact that the researcher seeks to operationalise certain given concepts in order to measure them.

1.6.1 Research design

In light of the aims and objectives highlighted above, the research is qualitative in nature. Unlike quantitative research which is more precise, qualitative researchers are more concerned with building theory from the foundation, based on the experiences drawn from other countries internationally that had already undertaken the process of a decentralised district health system. An empirical survey is undertaken to test the validity of the hypotheses postulated above. The empirical study is in the form of an analysis of data collected by means of questionnaires.

1.6.2 Collection of data method(s)

Data are collected by means of the following methods:
Literature study comprising relevant books, published articles, journals, relevant unpublished Master's or PhD theses, published papers, including conference papers. Provincial and national reports, and health reviews.

- Legislative framework – Acts, White Papers and policy documents.
- Questionnaires.
- Structured interviews – the researcher will use qualitative interviews to provide in-depth analysis of the research problem given.

- Internet for comparative analysis and drawing experiences from other countries in Africa and other parts of the world.

1.6.3 Data analysis

The data obtained from questionnaires and interviews are analysed to check the validity against the hypotheses as postulated above. The goal of data analysis is to integrate the themes and concepts into theory that offers an accurate, detailed, yet subtle interpretation of the research arena. Once the analysis is complete, the interpretation thereof is essential for policy-making, for theory and for understanding the social and political world relating to the decentralised DHS in the Free State. It should be noted that a thorough empirical analysis and findings is outlined in Chapter 9.

1.7 Key words and concepts

The research is characterised by the following key concepts:
District health system; primary health care; centralisation; decentralisation; efficiency; effectiveness; equity; accountability; functional integration; transformation; reform; integrated development planning; community participation; municipal health services.

1.8 Explanation of concepts

It is of paramount importance to elaborate upon some of the concepts used in the research so that a clear and confirmed understanding of the intended meaning of concepts used is captured. A brief exposition of clarification of concepts is given in the paragraphs that follow.

1.8.1 District Health System and Primary Health Care

District Health System (DHS) based on Primary Health Care (PHC) is more or less a self-contained segment of the national health system (NHS). It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, private, or traditional. A DHS therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, and communities. It includes self-care and all health workers and facilities up to and including the hospital at first referral level and an appropriate laboratory, other diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities (Tarimo 1991:4).

Pillay *et al.* (1998:5) states that the key elements of the above description are:

- The DHS is part of the National Health System.
- The health district is a well-defined population in a clearly demarcated geographical area.
- It includes all health services and resources whether public or private.
- All services including community hospital services are part of the system.

The DHS is a decentralised health care delivery system, which seeks to provide a comprehensive package of primary health care services to all persons within a defined geographic area (Toomey 2000:9).

From the foregoing it can be inferred that within each health district there should ideally be a single employer of all public sector personnel and single governance and management structure. This is intended to eliminate current fragmentation and duplication that exists within the health system in South Africa, including the Free State Province. A brief description of primary health care will be given in the paragraphs that follow.

According to Görgen *et al.* (2004:29), PHC means community involvement and the use of local human and physical resources to provide a range of preventive and curative services and health promotion measures that are both accessible and affordable for the local population. The term "primary health care" was clarified at the Alma Ata Conference of the World Health Organisation (WHO) in 1978 as referring to essential health care which comprises eight elements, namely, health education, food supply, drinking water supply and sanitation, maternal and child care, including family planning, vaccinations, endemic diseases, miscellaneous diseases and injuries and essential drugs.

The PHC approach calls for a major change in attitude both towards the concept of health and in the understanding of appropriate actions to improve the unacceptably of the low health status of many groups in society. It also recognises the need for a new relationship between health-service professionals and members of the community. PHC is essential for care universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. It forms an integral part both of the health systems in the country of which it forms the nucleus and overall social and economic development of the country (Abel-Smith 1994:106).

From the aforementioned, it can be concluded that, from a South African perspective, the policy framework of DHS was adopted in 1994 by the Government of National Unity to address fragmentation and inequitable health service rendering by using PHC as a vehicle.

1.8.2 Centralisation and decentralisation

The words centralisation and decentralisation have for decades formed part of the terminology of the organisation science. However, the two terms have been used in so many different ways that they probably have limited useful meaning. Centralisation is the tightest means of coordinating decision-making in the organisation. Decentralisation of decision-making will empower those at a lower level of the public institution to emerge with creative solutions to challenges they face. The power dispersed down the chain of line authority is called decentralisation (Fox *et al.*1991:85).

It can be argued that in a centralised public institution only a manager in the higher hierarchy has the experience and the knowledge to make decisions and the managers in the lower level may not have the training and thus will remain disempowered if he or she had to decide on policy issues. It may be difficult if they are promoted as they have depended on their seniors for total guidance. Not being burdened with tasks that subordinates could have performed satisfactorily, managers can concentrate on the work that is appropriate to their level in the organisation (Schwartz 1980:294).

A decentralised public institution is one in which important management functions are cascaded down towards the operating levels of the institution. Management functions are decentralised by delegation from higher to lower levels of the hierarchy. Decentralisation is a fundamental aspect of delegation, to the extent that authority is not delegated it is centralised

(Koontz & O'Donnell 1974:96). The Free State Department of Health was engaged in the process of consolidation of primary health care services from local municipalities to the province with the aim of decentralising them to the district municipalities for effective and efficient health care provision.

From the aforementioned, it can be deducted that decentralisation of the management functions and authority contribute to proper decision-making and to make those rendering health services to account to the communities they serve. The research attempts to elaborate on the nature and extent of decentralisation, with particular reference to district health services, in the chapters that follow.

1.8.3 Efficiency, effectiveness, equity and accountability

- Efficiency: According to Liebenberg (1989:27), efficiency refers to the relationship between public resource consumed and goods and services produced. Efficiency, therefore, implies that resources are not wasted on one service or client to the detriment of another. The most attractive option for dealing with potential over-expenditure is an increase in efficiency, allowing the same level of service activity to be provided, at the same quality, for fewer resources (Green 1995:262).

- Effectiveness: Liebenberg (1989: 41) defines effectiveness as indicating the extent to which public programmes achieve their objectives, goals or other intended effects. A programme and its activities are selected and planned with care so that they can produce the desired goods and services that will meet the objectives of the programmes. Effectiveness, in this regard, relates to results. In contrast, efficiency relates to process

and costs. Where an industry is of primary and strategic importance for the efficient and effective operation of the economy, and where competition threatens the continued existence of such a vital industry through the irrational and unnecessary proliferation into a great number of small enterprises, it can be argued that such an industry should be nationalised and consolidated into one large enterprise (Gildenhuys 1993:39).

- Equity: Green (1995:55) asserts that equity is a term frequently used, though usually loosely. It is often confused with equality. Equity, though related to equality, is different, in particular through its incorporation of the idea of social justice. A variety of possible definitions of equity exist, including the following as stated by (Green 1995:55):
  - equal health;
  - equal access to health care;
  - equal utilisation of health care;
  - equal access to health care according to need; and
  - equal utilisation of health care according to need.

Equity, therefore, is a model of motivation that explains how people strive for fairness and justice in social exchanges or in a give-and-take relationship (Kreitner & Kinicki 1995:171).

- Accountability: Spiro (1969:14-20) explains that a person is responsible to his or her principal for the efficient and effective execution of his or her assignment, to the extent that he or she is, or the purpose of the assignment, under the control and command of another person or institution. In light of the above it can, therefore, be concluded that those public institutions and persons responsible for the management

and administration of public funds are accountable to the taxpayers for the efficient and effective execution of their tasks.

Accountability can be explained in terms of obligation. If the accounting officer of a department is to be held responsible for the efficient and effective management of the finances of his department, it means that he is under a personal obligation to ensure that the financial management of his department is effective and efficient. Such an officer is personally obliged to give account to the higher authorities, and cannot therefore be excused for any financial malpractices nor can he put the blame on anyone else (Gildenhuys 1993:57). One of the traditional cornerstones of democracy is the fact that each political representative, as well as each public official, is subject to accountability. It implies that both political office-bearer and official should account to the public for all their activities geared towards enhancement of the quality of life of the citizens. It is generally accepted that they should display a sense of responsibility when performing their official duties: in other words their conduct should be above reproach so that they will be able to account for their acts in public (Cloete 1986:17).

1.8.4 Functional integration

Toomey (2000:6) argues that functional integration is, at its core, all about bringing together of different functions and activities within and between organisations to address common problems, and to meet shared objectives. It requires a management system that can coordinate a number of activities and participants to achieve a common goal.

According to Pillay *et al.* (1998:26), an underlying aim of the DHS is to promote primary health care services which are fully integrated within the management of a district health team, in order to make the most efficient use of scarce resources. Integration seeks to find the best strategy for mobilising resources, and using specialised disciplines, programmes and personnel within a district. Functional integration is not about doing away with specialists or removing all vertical structures in the management of health services, but is about making them work in harmony (Pillay *et al.* 1998:26).

1.8.5 Transformation and reform

According to Watson (1993:1128), transformation denotes to change completely in form, appearance or nature. It implies, in the case of the South African Health Sector, to change health structures and institutions completely. The South African Government regards transformation as a dynamic, focused and relatively short-term process, designed fundamentally to reshape the public service for its appointed role in the new dispensation. Transformation can be distinguished from a broader, long-term and on-going process of administrative reform that is required to ensure that the South African Public Service keeps in step with the changing needs and requirement of the domestic and international environments (White Paper on Transformation of the Public Service 1995:2).

From the foregoing it can be concluded that the change processes need not, and should not, be based on an over-simplified dichotomy between radical once-off transformation on the one hand and incremental reform on the other. In fact, a need exists to combine transformation in some areas with gradual piece-meal reform in others. What is really needed is a strategic

approach, yet pragmatic and feasible. A brief exposition of reform is outlined hereunder.

According to Watson (1993:872), reform means change made to a system or organisation that is intended to improve it and remove unfairness. Administrative reform seems inextricably linked to the rationalisation process. The reform process has especially been spurred on by the 1993 constitutional provisions and been driven by the dire need to adapt to a changing public service ethos such as accessibility, openness and transparency, customer-focus and value for money and to a fluid socio-political environment (Van der Walt & Helmbold 1995:114). Cheung (1996:453) states that the health sector reform can be seen to be an interactive process involving various institutional (and bureaucratic) actors each of whom is active, inventive, assertive and goal seeking, trying to find an appropriate strategy to enhance its self-interest in the mist of ambiguities and contingencies within choice-laden contexts.

1.8.6 Integrated Development Planning

Integrated Development Planning (IDP) is a process through which municipalities prepare a strategic development plan, for a period of five years. The IDP is a product of the integrated development planning process. The IDP is a principal strategic planning instrument that guides and informs all planning, budgeting, management and decision-making in a municipality. According to the Municipal Systems Act, 2000, all municipalities (i.e. Metro Municipalities, District Municipalities and Local Municipalities) have to undertake an integrated development planning process to produce integrated development plans. As the IDP is a

legislative requirement it has legal status and it supersedes all other plans that guide development at local government level.

In a nutshell, the IDP is about the municipality identifying its priority problems that determine its vision, objectives and strategies followed by identification of projects to address the issues. A very critical phase of the IDP is to link planning to the municipal budget (that is, allocation of internal or external funding to the identified projects) because it will ensure that implementation of projects and hence development is directed by the IDP (Coetzee *et al.* 2000:6).

1.8.7 Community participation

Community participation in government affairs has become one of the vital tenets of democracy in South Africa as enshrined in the Constitution of the Republic of South Africa, 1996. Hence, Burkley (1993:59) states that participation involves organised efforts to increase control over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control. African, Asian or Coloured communities in South Africa were disadvantaged in many ways due to exclusion.

According to Fox and Meyer (1995:20), community participation is stated as "... the involvement of communities in a wide range of administrative policy-making activities, including the determination of levels of service, budget priorities, and the acceptability of physical construction projects in order to orient government programmes toward community needs, build public support, and encourage a sense of cohesiveness within society."

Participation educates the public about their civic duties and promotes responsibility (Thornhill 1983:237).

Bekker (1997:35) purports that the reality in South Africa is that local communities are not constructively involved in day-to-day local government affairs. For the above reason, local councillors and officials have to depend heavily on their instincts in making policies that can be reconciled with the conceptions and desires of the inhabitants of towns and cities.

From the aforementioned, it is clear that community participation is vital in ensuring that citizens take part in activities of the government and also by being involved in policy decisions.

Municipal Health Services

Schedule 5, Part B, of the Constitution of the Republic of South Africa, 1996 stipulates that Municipal Health Services (MHS) are an exclusively local government function. The National Health Act, 2003 (Act 61 of 2003), defines MHS as a list of environmental health services, excluding port health, malaria control and control of hazardous substances. The MHS are to be rendered by metro municipalities (Category A) and district municipalities (Category C). Both national and provincial departments of health play a monitoring and evaluation role.

1.9 Contents of the research

The research consists of ten chapters and each chapter commences with an introduction, the context and the conclusion. A brief exposition of each chapter is given in the following paragraphs.

- **Chapter 1** deals with the introduction of the study. The reader is given a glimpse of health sector transformation, with particular reference to the implementation of DHS. The importance of the study, its objectives, formulation of hypotheses, the methodology and data collection and analysis attempts to give impetus to the topic being researched. Key concepts that form the mainstay of the research are elaborated upon in order to share the light and bring understanding.

- **Chapter 2** deals with the meaning of transformation in the health sector. It also deals with policy and legislation for DHS in South Africa, the conceptualisation of DHS, its relevance, its relation to local government, with particular reference to the Integrated Development Planning and functional integration.

- **Chapter 3** attempts to give a clear distinction between centralisation and decentralisation in the public sector. It also outlines how service rendering can be enhanced through decentralisation and centralisation. The pros and cons of both centralisation and decentralisation are explained in terms of advantages and disadvantages. Factors determining the degree of decentralisation management and the balance between decentralisation and centralisation are clearly elaborated.

- **Chapter 4** deals with the nature and extent of decentralisation of health services and in the public sector. The rationale of moving from centralisation to decentralisation of health services will also receive attention. The various forms of decentralisation such as de-concentration, devolution, delegation and privatisation will also be covered in detail. Lastly, an endeavour to explain the relationship between decentralisation of health services and democracy, as well as the effective governance at the local sphere of government will be given.

- **Chapter 5** puts more focus on functional integration of health services. It commences with explaining the meaning of functional integration. It further attempts to relate functional integration to both health and local government sectors.

- **Chapter 6** attempts to give the meaning of delegation. It also strives to outline the importance of delegation of health services to district municipalities in the Free State.

- **Chapter 7** deals with community participation in health services rendering. It also highlights the importance of governance structures relating to health and their effect on rendering health services.

- **Chapter 8** deals with the experiences that South Africa can draw on and learn regarding how decentralisation of health services was implemented successfully in both the developed and developing countries such as Canada, Indonesia, Zambia and Brazil.

- **Chapter 9** outlines the analysis and findings of the research.

- **Chapter 10** entails the summary of all chapters into a conclusion. It also outlines recommendations that may be used for future reference in the quest to enhance effective, efficient and accountable local government.

- **Bibliography** outlines all references that assisted in compilation of the research.

CHAPTER 2

TRANSFORMATION OF HEALTH SERVICES IN SOUTH AFRICA

2.1 Introduction

Since 1994, the South African government is engaged in a series of transformation processes that are geared towards redressing the imbalances of the past caused by apartheid. The health sector, like any other sector, introduced policies and legislation that have been aimed at addressing fragmentation, duplication and inequality. In order to address the above challenges, the South African government adopted a policy on District Health Systems (DHS), used as a mechanism by means of which primary health care is rendered. This chapter commences with a discussion on the legacies of the past and thus provides a brief exposition of the meaning of transformation in the health sector.

The conceptualisation of a district health system is dissected and more emphasis is on advancing reasons why the DHS is relevant and its relation with local government, the integrated development plan and functional integration. An attempt to summarise all issues outlined in the text is done at the end of the chapter.

2.2 Legacies of the past

Before 1994 the South African government, through its apartheid policies, developed a health care system that was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions

and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care (ANC 1994:1). The net result has been a system that was highly fragmented, biased towards curative care and the private health sector, inefficient and inequitable. Teamwork was not emphasised, and the doctor played a dominant role within the health hierarchy. There had been little or no emphasis on health (defined as not merely the absence of disease but also taking into consideration the socio-economic status of the client) and its achievement and maintenance, but there has been great emphasis on medical care (ANC 1994:1).

Furthermore, Benatar (1997:891) indicates that in the 1930s it was recognised that health care could not be provided for the growing and diverse South African population by allowing entrepreneurial medical services to develop haphazardly. The plea for a national health service by the president of the Medical Association of South Africa in 1931 was echoed by the government-appointed National Health Services Commission in 1944. The rejection of that proposal, the subsequent election of a Nationalist government in 1948, and the institution of apartheid were associated with the development of a health service characterised by racial discrimination, fragmentation, poor coordination, duplication of services, and a predominant focus on hospital-based care rather than primary care.

Chikane and Netshitenzhe (2003:7) argue that some of the details of the apartheid policy, which sought the exclusion of the majority from full participation in all aspects of the South African society, including health care, had begun to crumble by the late 1980s. However, by 1994, the essence of apartheid remained, with Africans denied the franchise, a society divided along racial lines and the social exclusion and neglect of the

majority on a matter of State policy, including the rendering of health services. Government health programmes perpetuated a strict racial hierarchy with the greatest allocation going to Whites, and Africans receiving the least. Socially, the late 1980s was characterised by a major phase of urban migration as influx control collapsed due to political pressure applied through defiance campaigns, for example, occupation of any available land by civic organisations and the United Democratic Front (UDF). The aforementioned state of affairs gave rise to large-scale informal settlements (any piece of available land was occupied without due regard for human settlement policy of the government) without basic services such as clean water and sanitation and that negatively affected health care (Chikane & Netshitenzhe 2003:8).

From the aforementioned, it can be concluded that the Government of National Unity formed in 1994 inherited a highly fragmented and bureaucratic system (a system governed by a plethora of rules and regulations) that was tailor-made to provide health services in a discriminatory manner. Services for Whites were better than those for Blacks (Africans, Coloureds and Indians), those in rural areas were significantly worse off in terms of access to health services as compared to their urban counterparts. Expenditure on tertiary services was 70% whilst primary health care (PHC) services was 30% (Health Systems Trust 1999:67), though this problem has been addressed to a lesser extent by the South African government during the last eighteen years. It is imperative therefore that the policy objectives should be centred on the reconstruction and development of the health sector in a manner that the entire health care provision system is transformed.

2.3 Meaning of transformation in the South African health sector

The transformation of health service provision in South Africa, and the Free State Province in particular, should be seen and understood as the constituent component of the transformation of the state and the public sector as a whole. The improvement of health conditions of the citizens of South Africa will depend on a complete overhaul of social delivery (mechanisms that are aimed at addressing poverty, unemployment and human settlement) within the context of social transformation. The existence of high levels of poverty and malnutrition, inadequate infrastructure and poor living conditions of the majority of the population will continue to exert pressure on the health service provision system (Benatar 1999:6).

The political paradigm shift that occurred on 27 April 1994 requires the South African health sector to undergo fundamental changes. The apartheid ideology had designed a service that would ensure the entrenchment of racial separation and White domination. Despite the constitutional changes, as enshrined in the Bill of Rights of the Constitution of the Republic of South Africa, 1996, that have taken place, South Africa is still characterised by serious social, racial, gender and political divisions, though the latter has been addressed at a very slow pace. The programmes such as affirmative action and equity that are aimed at redressing the imbalances of the past have been put in place in 1995 to rectify the inequitable services in the public health sector and the public service in general (White Paper on RDP 1995:4). It is for this reason that the total transformation of the public service, and health sector in particular, plays a pivotal role in the eradication of the apartheid past by ensuring reconciliation, reconstruction, development and nation-building (Burger *et al.* 1996:41).

Guided by the principle of national reconciliation, the South African government adopted the Reconstruction and Development Programme (RDP) and the Constitution, 1996, to orient and re-unite society towards a common purpose; that of a socially coherent and economically equitable society. In progressing with the process of reconciliation, reconstruction and development, the South African Public Service established public institutions that are accessible and responsive to community needs. However, this process has not been completed, in ensuring that the health sector is democratised and the transformation process entrenched (White Paper on Transformation of Public Service 1995:11).

The social transition that must follow the political transition in South Africa will pose major challenges for many decades. The need to reduce fragmentation of health services and inequities is undisputed given the limited resources that the South African government has at its disposal to address the needs of the general populace (White Paper on Transformation of Public Service 1995:11). However, the means to reduce the two major challenges (fragmentation and inequality) are less clear, especially in the face of rapid population growth and minimal additional resources in an economy that is growing less rapidly than hoped for by the South African government. Benatar (1997:891) asserts that health care reform exemplifies the many challenges facing South Africans. Profound shifts in thinking about the social forces influencing health and disease underlie the shift from a conventional bio-medical model of health care (that emphasises drugs and expensive high-tech machines) to the primary health care approach within a fixed or even diminishing public budget. The move towards a primary health care approach in South Africa is not the same as a shift in emphasis toward a primary care in highly industrialised nations such as Canada and

Japan. The difference is that the primary health care approach in South Africa is nurse-driven and community-oriented while Canada and Japan still place the doctor as the champion of primary care.

In recurring argument, Van Rensburg (1999:1) states that the South African health care system, along with the society in general, is undergoing profound transformation which in many respects resembles a full-scale social revolution. The thrust, direction and significant markers of this reform (as intended for the health sector) were spelt out in broad terms in the Reconstruction and Development Programme (1994 Policy Framework of the African National Congress), which subsequently became the South African government's framework for reform, the essence of which has later been formally captured in the Constitution, 1996. After almost eighteen years of rule by a democratically elected government, questions may well be posed about the progress of transformation in the health sphere. In an endeavour to give an account of the reform process, its direction, depth and pace, as well as of its effects on health and health care, the following questions are relevant: What is the essence and direction of the transition, and how fundamental has it been? What are the main achievements and gains of the health reform affecting its outcomes? What has been the effect of reform on the health and well-being of the population (Van Rensburg 1999:2)?

From the foregoing, it is asserted that progress has been achieved in respect of making health care accessible by means of clinics that are operating for 24 hours where both promotive and preventative measures are employed before chronic medical conditions can ensue. The primary health care is provided for free at the clinics. Fundamental reforms in the South African health sector are discussed in the following paragraphs.

2.3.1 Fundamental transformation in the South African health sector

It should be recognised that the current health reforms are not entirely the initiative of the current government. The previous government had already introduced several reform measures, although most of these were largely nullified by the constricting influence of the unchanging socio-political order, which had little room for the fundamental reform of the health system (Van Rensburg *et al.* 1992:31). The current government changed the political landscape, which did not embrace contributions from all sections of the population to that which is inclusive and democratic. The African National Congress (ANC) led government introduced fundamental reform, with the Reconstruction and Development Programme (RDP) (ANC 1994a) and the National Health Plan (ANC 1994b) serving as frameworks for conceptualising and directing the reform process, both at the broader societal level and in the health sector. During the past eighteen years these frameworks have been detailed and mandated by a series of official policy papers and legislation at national and provincial spheres such as the Free State Health Act, 1996, White Paper for the Transformation of the Health System in South Africa, 1997 and the National Health Act, 2003.

Since the new dispensation in 1994 two main policy strategies steer the health reform in South Africa: first, a pronounced shift towards primary health care (PHC) and, second, the introduction of a district health system (DHS). The two strategies set out definite plans for the redress of structural deficiencies and distortions created by previous dispensations. From the policy reforms, numerous changes in the structure and contents of the health system and in health care have resulted. Among these, the following may be seen as the most important:

- **Primary health care: shifting the emphasis and echeloning (giving high priority) care**

Universal access to comprehensive PHC constitutes the crux of the government's health plan and enjoys the highest priority in the current health policy. The aim is to change the focus of health care from health professionals at secondary and tertiary levels to community, patients and primary care (Abbot 1997:30). This has been partially achieved through out-reach programmes where health specialists visit the clinics and give expert advice to community service doctors.

Van den Heever and Brijlal (1997:80) declare that along with the shift to PHC, there is an inevitable change in the relative importance of the levels of care as the client goes through the continuum of care, that is starting at the clinic which provides the primary health care, the regional hospital which provides the secondary level of care and tertiary hospital which provides specialised care. In the public sector, increasing emphasis is being placed on first line care and facilities (clinics and community health utilisation rates that indicate an increase in access. In tandem w or district and regional hospitals to support the PHC referral network. To curb the once strong emphasis on hospital, curative and specialised care and to allow for development of PHC, 30% of the health budget is being systematically diverted away from tertiary, academic and specialised hospitals while significantly increased funding is allocated to PHC.

- **District health system: decentralising and regionalising health care**

The adoption of the DHS as a model for the South African health system represents another fundamental reform. A significant departure from the past is the decision to create a unified, but decentralised national health

system based on the DHS model. One of the main reasons for this is the belief that the DHS model is deemed to be the most appropriate mechanism for the provision of PHC. In addition the decision to decentralise the delivery of health care is consistent with the overall policy to decentralise government (Pillay *et al.* 2001:4).

In light of the above, Sharp *et al.* (1998:57) states that authority and decision-making are increasingly devolving on regional and the emerging district offices, while management autonomy at the level of the facility is being maximised. District health councils are to have greater responsibility for both the determination of priorities and the allocation of funds in their areas of jurisdiction.

Although district health development is used frequently as the slogan, the greater part of the concept is still to be transposed into practice, which leaves the aim of the foremost current reform far from accomplished. Obstacles hindering the development of DHS have only recently begun to surface, namely, the preparedness of the centre to devolve authority and the ability of the periphery to assume responsibility effectively (Van Rensburg 1999:6). The enactment of the National Health Act, 2003 has facilitated the decentralisation of authority to local sphere of government through intergovernmental relations structures such as District Health Councils.

- **Dismantling fragmentation: unifying segregated and divided structures**

In the previous dispensation, as alluded to in the preceding sections, health care was highly fragmented: geographically, structurally, racially, and in terms of authority with 14 health authority structures – one national,

homelands and TBVC states, and three 'own affairs' ministries. This formerly fragmented health structure has been consolidated under a single national ministry of health, which is responsible for overseeing, supporting and coordinating the entire health system of the country. The health authorities of the nine provincial governments (Provincial Health Councils) embody a decentralised, 'federal' style system, with more power entrusted to the provinces than before as each province is in a position to promulgate its legislation which regulates how health services are rendered. In turn, the provincial health councils are now developing, coordinating and supporting the emerging district health councils (DHCs) that in coming years are to assume ever-greater responsibility for the health of local communities. This process is far from complete. In fact, the publication of the White Paper on Local Government, 1997 has introduced an entirely new phase in the restructuring of health, shifting the responsibility for PHC increasingly to local authorities and communities. In turn, this implies that the currently still fragmented provincial and municipal authorities and service structures are to be integrated into consolidated district structures supported by cooperative government structures (Van Rensburg 1999:7).

- **Dismantling apartheid: Africanising and feminising the system**

It stands to the credit of the South African government that it has, in a relatively short time, decisively succeeded in dismantling apartheid structures, laws and measures relating to the public health sector, including those which had resulted from the homelands and TBVC states, separate amenities, group areas and tri-cameral policies. As part of this de-racialisation of the public health sector, the reform process has introduced forceful affirmative action, designed to Africanise the public health system, with due sensitivity to gender (Van Rensburg 1999:7).

Direko (1999:4) echoes the above sentiments by stating that the Constitution of South Africa, 1996, guarantees equality. The provincial administrations, including the Free State Provincial Administration, have a duty to ensure that it does not violate the right to equality. To meet this requirement, the Constitution, 1996, permits adequate measures and programmes being put in place to redress the imbalances of the past, for example, publication of the White Paper on Affirmative Action in the Public Service, 1997, the Employment Equity Act, 1998 (Act 55 of 1998), as well as the Gender Commission, to ameliorate the present persistent and systematic injustices such as historically gender-biased occupations like engineering and high management echelon that certain groups and individuals in South African society continue to suffer. The programmes such as skills development should, therefore, be consistent with, and integral to the legal guarantees of equality, as enshrined in the Constitution, 1996, for historically disadvantaged groups and persons in various communities. The targeted groups are Blacks, women and people with disabilities.

The Constitution, 1996, stipulates the desired character and composition of the South African public service must be representative of all its citizens. Hence, section 195(1) of the Constitution, 1996, stipulates that: "Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness and the need to redress the imbalances of the past to achieve broad representation."

Van Rensburg (1999:7) states that prior to 1994, Whites accounted for 90, 2% of management staff, while 87% of all managers were male in the

public sector. These once almost 'all white' and 'all male' top management structures have been systematically revised, starting with the top echelons of political and management bodies at the national and provincial spheres, moving steadily downwards in the personnel structure, and producing a thoroughly reconstituted staff corps more accurately reflecting the demographics of the country (Mametja & Reid 1996:98). Hence 80% Blacks (Africans, Indians and Coloureds) and women figure prominently in the national Portfolio Committee for Health and in provincial Standing Committees on Health. Most of the executive committees for health in the provinces are headed by Africans and women, while Africans and women also feature prominently as provincial heads of health, as executive managers, as general managers, senior managers in various directorates of health at both national and provincial spheres. For example, in the Free State Department of Health out of 4 General Managers positions 2 are occupied by women. It should be noted that although women featured in similar structures highlighted above before 1994, it was on a limited scale as compared to the present dispensation.

According to section c1.1 (iii) of the Free State Government Official Policy on Affirmative Action (1998:4), "representivity is a substantive process. The notion of equating quotas and representivity shall therefore be rejected as a standpoint of the Free State Provincial Government. Quotas alone will not contribute towards achieving the transformation goals of the administration, but they have to ensure that they add value to efficiency, productivity, and service rendering. They have to ensure that no appointment or promotion of Black (African, Coloured, and Indian), female, or person with disability leads to tokenism or window-dressing. Detailed support and affirmative programmes such as the employment opportunities must be submitted to the Special Programmes Sub-directorate.

The Free State public service must ultimately reflect the demographic population of the province." To monitor progress, the Special Programmes Sub-directorate is afforded an opportunity to address the executive management and the Member of the Executive Council (MEC) for Health on a monthly and quarterly basis on the effect of the Affirmative Action Policy.

Jeffery (1998:140) asserts that numerical goals and time-tables must be used in countering any under-representation of the designated groups and preferential treatment in appointments and promotions must be given to suitably qualified people from these groups, in order to ensure equitable representation at all levels. Equitable representation is to be ascertained by reference, among others, to the composition of the economically active population, both nationally and provincially, as well as to the pool of suitably qualified Blacks, females and persons with disability.

The number of individuals who are suitably qualified cannot be confined to those with formal qualifications or relevant experience. Recognition of prior learning and individual competencies are also essential. Employees, trade unions and labour department officials are entitled to monitor the employees' progress and take further steps if this is not considered reasonable (Jeffery 1998:140).

According to Botha (1999:31), top management must commit itself to an equitable system of employment and employment equity should form part of the strategic management plan in an organisation. As part of their performance contracts, senior managers incorporate employment equity as a key performance indicator and thus able to report on progress made.

Employment equity, at best, is not an easy process as the provisions of Employment Equity Act, 1998 (Act 55 of 1998) are not always in line with the needs of the institution. For instance, in an endeavour to address representivity within a particular speciality such as financial management, a public institution has to ensure that quality, skills and the love of work are not compromised to prevent qualified audit statements from the Auditor General. However, if a commitment and principle of employment equity is backed up by a sound plan which has the support of all, for example, trade unions and employees in general; a reasonable chance of success can be expected (Botha 1999:31).

The legacy of apartheid has left South Africa with gross inequalities. This phenomenon manifested itself, among others, in human resource policies and practices, as well as in social practices that promoted a White-male dominated workforce and discrimination against Blacks, women and people with disabilities. This discrimination was institutionalised in the apartheid regime. The systemic educational discrimination against Blacks, job reservation practices that discriminated against Blacks, as well as systemic blocking of opportunities for economic advancement for Blacks were the major obstacles in the achievement of a representative workforce in South Africa (Mboweni 1998:5).

Mboweni (1998:5) states further that the socialisation process in patriarchal society and gender stereotyping have resulted in discriminatory employment practices that exclude women from occupying managerial positions. This state of affairs is further compounded by a lack of an environment supportive to a working woman with domestic responsibilities. Hence, Shilowa (1995:7) sees affirmative action as being used not only to

end racial and gender discrimination, but also to end disparity of power between workers and management and between urban and rural areas.

Affirmative action is a proactive development process that aims to assist with the creation of, *inter alia*, greater employment equity. It is a process that should be integrated holistically to involve the entire organisation and all its participants. In many organisations, however, affirmative action has been a process whereby Blacks have been trained and developed by a series of ad-hoc training programmes while organisational culture, policy, and procedures have been left largely untouched (Human 1995:27).

In echoing what has been highlighted above, Human (1995:27) indicates that it is often argued that affirmative action could widen rather than narrow the 'equity gap' and may lead to tokenism and to lowering of standards. This argument is frequently posed as a justification for retaining current entrance criteria to jobs and for the organisations without the 'requisite' entry criteria or persons specifications. A lowering or changing of the entrance criteria (such as the years of experience and educational qualifications) in respect of a particular position in order to allow Blacks and women to compete, will only lead to tokenism if it can be proved that the level of entry qualification has predictive validity in respect of performance on the job. In other words, that in order to do the job to the required standard the job incumbent must have a certain educational qualification and/or number of years of experience. These personnel reforms have, as stated above, involved a concerted effort in terms of human resource development, although they drew criticism from certain quarters for being implemented in an uncoordinated way (Van Niekerk & Sanders 1997:14).

In response to the above, it can be submitted that the target regarding progress on race and gender might have increased at the beginning of the new millennium and as such for the South African health sector to be effective and efficient it needs to strive towards achieving representivity by promoting Blacks, women and people with disabilities.

- **Rectifying discrepancies and distortions: redistributing personnel and redirecting patients**

The rectification of prevailing discrepancies and inequities in health care is a two-pronged process. First, it implies equalisation in terms of the geographical, racial and socio-economic distribution of personnel and facilities – thus, large-scale reallocation of resources. Second, it involves the more even and appropriate referral and flow of patients to the various providers and facilities. With reference to the elimination of discrepancies in the distribution of health facilities and providers, as well as in the quality and accessibility of care, explicit provincial reallocation of resources commenced in 1995/96. It aimed to accomplish greater inter-provincial equity, that is, per capita equity in provincial health allocations by national government (Van Rensburg 1999:8).

Various measures and mechanisms intended to achieve such equity being implemented in the South African Government Health Department, and the combination of the PHC approach and the DHS, once fully functional, could eventually pay significant dividends in this regard. The array of options under consideration by the National Department of Health includes redistributing personnel after training to under-resourced areas by means of retraining; providing incentives to encourage medical workers to work in rural areas; limiting opportunities for private practice in over-serviced

areas; introducing contractual obligations for those receiving subsidised training; requiring newly qualified medical and other health professionals to a certain period working in the public sector prior to entering private practice; introducing compulsory community service (or further in service training) for all professionals, including doctors, pharmacists, nurses, rehabilitation officials and health therapists, dentists and environmental health practitioners (Department of Health 1996b). Importing Cuban doctors to serve communities in under-served areas and strengthening the public sector in order to attract staff from the private sector and will also alleviate the needs for trained people (Van Rensburg 1999:8).

In light of the above, Baez (2004:14) states that the Gauteng Department of Health has avoided regarding Cubans doctors simply as people to fill posts and has attempted to use them strategically in the development of comprehensive PHC for the province in areas of great deprivation. The doctors have made a significant contribution to the provision of PHC services in transforming health services over the past years. The Cuban doctors' dedication and professionalism serve as a model in PHC in the department's efforts in restructuring the health services in the Gauteng Province (Gauteng Department of Health Annual Report 2003:32).

With regard to the flow of patients to providers and facilities, various guidelines and measures are being devised to effect a more appropriate and cost effective referral flow. Both the PHC and the DHS approaches dictate that patients using the public sector should enter the health care system at the lowest level of care (PHC clinics) and, if required, systematically move upwards into the higher echelons of care. To restrict the bypassing of PHC facilities, will stop the unjustified use of public hospital facilities, and financial barriers in the system. Furthermore, the whole intention of the

DHS is to regionalise health care, which implies that facilities and health workers be deployed in such a manner and in such numbers as to ensure that patients are able to receive the appropriate health services in their own regions and districts, with the sole exception of services of a tertiary nature (Van Rensburg 1999:9).

- **Free health care: rendering services more accessible and affordable**

Historically, the African National Congress (ANC) has always been an ardent agitator against private-for-profit health care in South Africa, envisaging the eventual phasing-out of private care. Originally stated in the Freedom Charter (1955), this commitment has been more recently reiterated in both the Reconstruction and Development Programme (RDP) (ANC 1994a) and the National Health Plan (ANC 1994b). In line with the above approach, and with the principles of equity and accessibility, and particularly in order to remove financial barriers for vulnerable groups, the government has thus far systematically phased in and expanded free health services. Such socialisation of health care stands in sharp contrast to policy under the previous government where the deliberate strengthening and expansion of the private sector in health care was one of the mainstays of health policy, *inter alia*, to alleviate the burden on the state by curbing expenditure and scaling down the public sector. This resulted in a strong, competitive and lucrative free market in the health sector, encouraging high-tech medicine and pharmaceutical development, but eventually also inflating costs (Department of Health 1996b).

Since mid-1994, significant progress has been made towards free health services, first introduced at all state health care facilities for children under the age of six years and for pregnant women. Subsequently free PHC

services were expanded to include all public health centres and clinics; still later, free services were introduced for children up to twelve years of age at all public clinics (Van Rensburg 1999:10).

In light of matters raised above, Chikane and Netshitenzhe (2003:21) state that implementation of the free healthcare programme has resulted in increased utilisation rates that indicate an increase in access. In tandem with these measures, and in particular to limit the expansion of the private health sector, a number of regulatory measures have been proposed which are aimed at reforming the private health sector.

The reform of a fundamental nature has indeed taken place, generally in the direction intended by the South African government and at a remarkable pace. This applies particularly to health policy, but also to the structure and content of the health care system. However, certain crucial aspects of the health system such as addressing equity and a shift from hospi-centric (curative) type of care to primary health care remained unchanged, have been only superficially altered, or are even drifting in the same problematic direction that so strikingly characterised the previous dispensation. In respect of the effect of the reform measures on health and the well-being of the population, it is perhaps too early to infer real gains, although, theoretically at least, positive outcomes for health and well-being seem logical (Van Rensburg 1999:2). In echoing what has been raised in the foregoing, it is clear that the democratic South African government introduced a policy shift from fragmented, rule-bound and hospi-centric health care provision system to a district health system that uses primary health care as a mechanism to render health services. The policy and legislative framework for a district health system in South Africa is discussed in the following paragraphs.

2.4 Policy and legislative framework for DHS in South Africa

The policy on the district health system (DHS) has developed steadily since 1994. However, it is still very much in line with the 1994 National Health Plan for South Africa, published by the African National Congress (ANC) and the Department of Health's 1995 District Health System policy document and White Paper for the Transformation of the Health Sector, 1997. The policy has now been encapsulated in legislation in Chapter 5 of the National Health Act, 2003 (Act 61 of 2003) (Wilson 2005:1).

As stated in the beginning of Chapter 2, the rationale for adopting the DHS was included in the African National Congress National Health Plan for South Africa (1994) and the Reconstruction and Development Programme (RDP). What was also needed, however, was a more fully development policy and implementation strategy. This was drafted by a team of officials from the nine newly established provinces under the leadership of the National Department of Health. The policy document entitled 'A policy for the development of the district health system for South Africa' was released for public comment at the end of 1995 (Pillay *et al.* 2001:13).

Pillay *et al.* (2001: 14) point out that while the document was positively received by most who reviewed it, there were a few criticisms of the process and aspects of the content. Local government health officials were critical that they were not formally represented on the team that developed the document arguing that those that were responsible for the document did not understand local government and how it operates. A second criticism, again largely from local government health officials was against one of the three governance options listed in the draft policy document. Provision was made for one of the three governance options, *viz.*, the provincial option,

the local government option and the statutory District Health Council (DHC). Local government officials charged that the document provides for a structure outside of the local government area of jurisdiction and will therefore not be accountable to it. Some local government officials were also critical of the proposal of creating health regions whose role would be to assist in the creation of the health districts. Notwithstanding the above criticisms the National Department of Health adopted the document and included aspects of it into the White Paper on the Transformation of the Health System that was formally endorsed by the South African Parliament in 1997 after a series of hearings on the document (Pillay *et al.* 2001:14).

The White Paper on the Transformation of the Health Services in South Africa, 1997, captures the vision for health care as outlined in the National Health Plan for South Africa and as stated above: "Changes dictated by the Constitution, 1996 include the devolution of certain responsibilities for health services to the provincial and local spheres. To give effect to this mandate, it is essential that, *inter alia*, a district health system (DHS), in which responsibility for service delivery is entrusted to the district level, be established as soon as possible." The goal outlined in the Reconstruction and Development Programme (RDP) is to have a single National Health System (NHS), based on a district health system. The country will be divided into geographically coherent, functional health districts. In each health district, a team will be responsible for the planning and management of all local health services for a defined population. The team will arrange for the provision of a comprehensive package of PHC and district hospital services within national and provincial policies and guidelines.

Against the above background, Haynes and Hall (2002:85) maintain that a National Health Policy for a DHS was first set in the early 1990s by the

African National Congress (ANC) Health Plan. Subsequently, it has been expressed in a number of other documents such as the Reconstruction and Development Programme and the White Paper for the Transformation of the Health System, 1997. The National Health Plan for South Africa adopts the PHC approach and brings services into line with international thinking and practice. Crucial to this is the strengthening of community level services and development of the DHS. The plan shows the main focus of health care to be at interface between the community and the health system, with the district health services in support. This may be seen as idealistic, but it does emphasise the vision of health care (PHC and hospital) to be close to the people, at district and community level, with an emphasis on development, community participation and the community taking an active role in development of plans as determined by their own needs. The community is also seen to be part of the evaluation system (Hall 2003:3).

The White Paper on the Transformation of the Health Services, 1997 (WPTHS 1997:6) further outlines some implementation strategies, to be in collaboration with and negotiated between local and provincial government, because of the constitutional requirement for local government to be responsible for "municipal health services". It emphasises that the district should:

- Be responsible for its budget and for planning its services.
- Develop effective referral systems with neighbouring districts.
- Providing the full-basket of PHC services.
- Ensuring provision of all support services – finance, human resources, transport, laboratory, drugs and other supplies and maintenance services (WPTHS 1997:6).

Hall (2003:4) asserts that Health MinMEC (Forum for Minister of Health and MECs of nine provinces) restated their commitment that primary health care provided by a municipal based district health system, should also include twelve principles listed in the White Paper on the Transformation of the Health Services, 1997. MinMEC further committed themselves to a DHS that includes:

- A comprehensive district health services (PHC package and district hospital services).
- A district health plan that is part of the district Integrated Development Plan (IDP).
- A structure and processes to ensure cooperative governance, joint planning and seamless service provision.
- Joint funding from municipalities and province.
- A single health budget with clear components and budget lines.
- A single management structure.
- All staff being part of single public service.
- All staff being ultimately employed by the district (or metro) municipality.

The National Health Act, 2003 (Act 61 of 2003), also outlines in Chapter 5 how district health systems should be established. The principles highlighted above are also included. The conceptualisation of a district health system is outlined in the sections that follow.

2.5 The conceptualisation of the district health system

District health systems, comprising primary health care and first referral hospitals, are key to the provision of basic health services in developing

countries, including South Africa. They should be prioritised in resource allocation and in the building of management and service capacity (Segall 2003:5).

In an attempt to define DHS in 1986, the World Health Organisation's Global Programme Committee stated that a district health system based on primary health care is more or less a self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, private, or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health workers and facilities up to, and including, the hospital at first referral level, appropriate laboratory and other diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities (Hall 2003:2).

In the South African context a well-functioning health district is that it contributes to sustained health status improvements by the provision of equitable, efficient, technically good quality, acceptable, appropriate and affordable health care (Gilson et al. 1997:5). Fundamental to the restructuring of the South African health services is the concept of a district-based health system. This is acknowledged in both the RDP Base Document and the ANC's National Health Plan. So much emphasis is placed on the district because it is at precisely this point that top-down planning meets bottom-up reality: it is within the health district that services

are - or should be – closest to the people and that the people can become part of the services. A district health system is thus the means for providing quality primary health care to everyone in a defined geographical area. It is a system of health care in which individuals, communities and all the health care providers of the area participate together in improving their own health (Harrison 1997:3).

Having provided a contribution regarding the conceptualisation of district health system, it is important to explain its relevance towards rendering of health services and its relation to local government and the integrated development planning (IDP).

2.5.1 Relevance of the district health system in health service rendering

More than 34 years after the 1978 Alma Ata International Conference on Primary Health Care, PHC remains central to the health policy of most African countries, including South Africa. This is true even though the World Health Organisation's ambitious goal of 'Health for all by 2000', which was to be achieved with the help of PHC, has long since been shelved. Despite the difficulties of translating the PHC strategy into practice, the fact remains that in the current socio-economic circumstances there is simply no realistic alternative if the whole population is to be provided with basic health care, especially in rural areas. As a matter of public interest, governments remain in charge of organising an affordable health system, which offers a wide range of services of an acceptable quality (rather than merely vertical special-focus programmes). This health care system needs to be accessible to the entire population, including the destitute, for whom special rules should apply (Görgen *et al.* 2004:28).

Görgen *et al.* (2004:28) note further that major efforts have been undertaken by the international community to implement the PHC strategy, with numerous projects and vertical programmes. Yet, within a few years, most of these proved to be inefficient, non-sustainable, and in some cases even counter-productive to the efficiency of the local horizontal health services. Finally, it became clear that selective vertical approaches (i.e. focusing on one specific disease or on family planning) resulted in short-term successes only. The above programmes were unable to ensure the sustainable implementation of the PHC strategy. The concept of primary health care calls for services to cover the entire spectrum of preventative and curative medicine. This can only be provided within the framework of an integrated health care system, an objective that cannot be achieved overnight, but offers far more sustainability than any fast-track programme.

The weakest level in most health systems is probably that of the district, and the failings of district services have been cited in attempts to discredit the whole notion of primary health care. A district health system cannot function properly in isolation: in particular it should have firm links with its provincial authorities, and should benefit from the comprehensive involvement of the community it serves (Newell 1989:81).

To illustrate the above point, Segall (2003:21) confirms that the relegation in the World Health Report 2000 of primary health care to a 'second generation' reform – to be superseded by third generation reforms with a market orientation – flows from an analysis that is historically flawed and ideologically biased. Primary health care has struggled against economic crisis and adjustment and neo-liberal ideology often averse to its principles. To ascribe failures of primary health care to a weakness in policy design, when the political economy has starved it of resources, is to blame the

victim. Improvement in the working and living conditions of health workers is a precondition for the effective provision of public health services.

Görgen *et al.* (2004:31) argue that critics of the district approach point, not without justification, to the persistently poor quality of many health services, especially state services, in most countries of sub-Saharan Africa. However, the reasons for this tend not to be supported by substantial evidence. The shortcomings of the systems are rather a reflection of the challenges faced by the society in which they operate: socio-economic crises, political mismanagement and corruption at every level of society. In public services in particular, and the health service is no exception, these factors have led to appalling mismanagement and lack of commitment resulting in a drastic drop in the quality of services provided. There is no realistic way of replacing the comprehensive, integrated district health system (DHS). What is needed to ensure the desperately needed qualitative improvements to the DHS is an integrative, inter-sectoral reform policy for the system as a whole.

Newell (1989:83) emphasised the relevance of DHS by stating that district health services are looked upon as the backbone to primary health services, yet they are the weakest segment of most health systems. From the community point of view, advantages of a district health service include 1) low cost services, 2) use of local residents as health workers, 3) an opportunity for the community to influence the form in which medicine is provided and 4) a more receptive community to health related information. But for a successful health programme, the peripheral village based centre needs to be an integral part of the community as well as being intimately linked with the next level of health services, take care of a majority of the

existing health problems in the community and have an effective referral system.

The district health system is being introduced in South Africa, including the Free State, for a number of important reasons as stated by Harrison (1997:4):

- **Try to meet the health care needs of every citizen**

There is a need to plan and implement health services that address the needs of all the people in every part of South Africa. In the past, health care was provided to people who came to the clinic or out-patient department without knowing whether services reached every citizen in need.

- **Provide a simple, logical service**

Primary health care has been provided by a number of different health departments, for example, in many areas, local authorities and the provincial health department have provided different bits and pieces of health care. A child brought along to the clinic because she was sick often had to go to another clinic on another day to get immunisations. This led to big inefficiencies in service rendering, and a health service that treated problems, rather than people! There is therefore a great need to integrate the services.

- **Let local decisions be made locally**

Managers at national or provincial level made big decisions about health care in most of the areas. These higher-level managers appointed and dismissed local staff, decided how money for health services was to be

spent and planned new services. There is a need to create a system in which local people – who know local needs best – have control over their budget and make important decisions.

- **Involve people in designing the services they use**

People who received health care often had little say about the services provided to them. They had no real way of expressing their dissatisfaction, or of helping to plan and implement better services, therefore, a need exists to involve people in improving the services they use.

- **Focus on improving health**

Like many parts of the civil service, large, complex bureaucracies have developed in health service management and administration. A lot of paper is generated; many meetings held, but how much of this actually changes people's health? How much actually improves services? District health care is meant to shift the focus from administering health services to really improving the quality of care.

After giving a brief exposition of the relevance of DHS in the aforementioned paragraphs, an attempt is undertaken to explain how local government relates to DHS.

2.5.2 Relation of district health system to local government

For several years the term health district and health sub-district have been used on World Health Organisation definitions. However, the demarcation process and final restructuring of local government in December 2000 has

meant that boundaries and terminology have had to be adjusted. To ensure consistency and prevent confusion, the term district should be used consistently by all three spheres of government, namely, national, provincial and local. Since the term 'District Municipality' is a legal one contained in the Municipal Structures Act, 1998 (Act 117 of 1998), and Municipal Systems Act, 2000 (Act 31 of 2000), the term 'district' must refer to the 47 district municipalities. With the inclusion of the 6 Metropolitan Municipalities, South Africa has 53 'health districts' which cover its full surface area (Baron & Asia 2001:21).

In analysing further, Baron and Asia (2001:21) maintain that although the health sector would have preferred to have a 'health district' based on a much smaller geographical unit, all policy documents since 1994 have urged the need for 'health districts' to be consistent with political and administrative boundaries. Thus the Health MinMEC meeting held on 13 February 2001 decided that the term 'health district' will refer to a District or Metropolitan Municipality and the DHS is now based on the borders of these 53 municipalities. All the public sector PHC services within a health district, including health care rendered by local government, should fall under the management of a single structure in a district health system (Pillay *et al.* 1998:39).

Given the differences in current health services rendering capacity of municipalities it is possible that a one size fits all strategy may not be feasible or desirable. It may be better to build on the current capacity of municipalities even if in the short term some health districts may have more than one health rendering authority. However, this should only be entertained if, via negotiations and joint planning, services are perceived to

be seamless to the users and that there is an absence of duplication of services (Pillay *et al.* 2001:21).

From the foregoing, it can be explained further that district health services are concurrent functions of both the provincial and national Department of Health in terms of the provisions of the Constitution, 1996, and as such can be assigned or delegated to district municipalities based on established capacity to render such services. One of the strategic documents of the municipalities, which form the mainstay of service provision, is the integrated development plan (IDP). The IDP and DHS will be discussed thoroughly in the following paragraphs.

2.5.3 Integrated Development Plan and the district health system

In South Africa, the reorganisation of municipalities across the country is seen as critical in the post-apartheid era. Whereas during the previous dispensation local authorities had a limited role to play in development and governance, the new dispensation emphasises strong local governance with a developmental agenda (Silwana & Maine 2004:91).

Silwana and Maine (2004:92) postulate further that the establishment of the new system of local government has far reaching implications. The significance of the new system as well as the magnitude of the transformation that it seeks to accomplish is yet to be appreciated by most South Africans. The implementation of the practices outlined in the legislation has the potential of yielding extremely capable and effective local governance machinery.

Integrated development planning (IDP), as a tool for community-based planning and service rendering, lies at the centre of the new system of developmental local government and represents the driving force for making municipalities in South Africa more strategic, inclusive, responsive, and performance driven in character. However, the reality is that the legacy of separatist thinking in planning, management and governance is deeply embedded and will take a combination of policy ingenuity, political will, administrative determination and focused civil society participation to make the new paradigm for democratic local governance a reality (Silwana & Maine 2004:92).

The National Health Act, 2003 (Act 61 of 2003), provides for the development of a District Health Plan that has to be aligned with the integrated development plans of municipalities in a given district. The restructuring of the health system for the provision of equitable health care to all citizens continues to be at the centre of Free State Department of Health and National Department of Health agenda. Despite major challenges and constraints, including an exodus of health workers from the public sector, 'transformation fatigue', dwindling public sector funding, lack of adequate support systems and resources, progress has been made in terms of implementation of district health system (Harrison 1997:25).

It is against the aforesaid background that Harrison (1997:25) maintains that development of integrated district health plans which incorporates all activities geared towards attainment of predetermined goals and objectives of the Department was realised by a concerted effort by parties from both province and local government. The integrated district health plan is then aligned to the integrated development plans of municipalities to avoid duplication and fragmentation.

Having given a brief exposition of how integrated development plans relate to the district health system, the importance of functional integration is outlined in the paragraphs that follow.

2.5.4 Functional integration and DHS

Due to the national political legacy of apartheid and multiple health authorities and capacity deficits that it created, South African health services have been characterised by massive fragmentation between curative and preventative services, between the races and between multiple vertical services. The result has been health services that are grossly varied in quality and often also inaccessible. The National Department of Health has endorsed at all levels, the provision of comprehensive primary health care (PHC) services for all, provided within the structures of a district health system. Despite what has been highlighted above, the integration of health services 'on the ground' has remained elusive as multiple health authorities continue to function in isolation. For the community member, it means that different parts of the PHC 'package' are sought at different sites. It is a costly, inefficient and clinically compromised system requiring change (Toomey 2000:9).

Toomey (2000:9) argues further that the district health system is in itself new to South Africa and is being developed at the same time that primary health care services are being promoted. The district health system is a decentralised health care provision system that seeks to provide a comprehensive package of primary health care services to all persons within a defined geographic area, referred to as a district. It is helpful to note that national processes must address some of the challenges faced by the district. Such recognition helps to focus energy on where a positive

influence is made towards developing district health services. A focus on service provision is needed to ensure that primary health care services are accessible to the community. Functional integration is a strategy to assist in improving service rendering within the districts.

Without a strategic approach, it is likely that the current fragmentation and duplication of PHC will continue for several years. Functional integration provides a process to improve quality of care by greater integration of the health system. It has been tried over the past few years and there are both successes and failures, and challenges to implementation. Crucial to the success of functional integration are a number of key requirements. Functional integration often starts as a process of informal cooperation and then progresses through verbal agreements and common practice before being captured in a formal, signed service level agreement. The better the quality of the preceding informal cooperation and common practice, the more likely it is that the formal agreement will truly reflect the best interests of staff and community. However, formal agreements can also be improved over time and functional integration can also start with an initial service level agreement (Department of Health 2003:2).

From the aforementioned it can be deduced that functional integration is not an end in itself but part of a process in the development of a district health system.

2.6 Conclusion

This chapter has tried to capture some of the key issues relating to the transformation of South African health sector, given the legacies of the past, the health sector has done quite well in terms of giving meaning to the

transformation of health services. This has been evidenced by formulation of various policies that culminated in the promulgation of the National Health Act, 2003 (Act 61 of 2003).

A significant departure from the past is the decision to create a unified, but decentralised national health system based on the district health system (DHS) model. One of the main reasons for this is the belief that the DHS model is deemed to be the most appropriate mechanism for the provision of PHC. DHS is relevant because it is a means by which the health care needs of every citizen are met. Health districts should be consistent with the political and administrative boundaries of district municipalities so that both the politicians and healthcare officials become accountable to the community they serve.

In order to realise what had been stated above, the National Health Act, 2003 (Act 61 of 2003), provides that the district health plans must be aligned to the integrated development plans of the district municipalities. The integration of health services has remained elusive as multiple health authorities continue to function in isolation. Functional integration provides a process to improve quality of care by the greater integration of the health system. The district health system, therefore, is a decentralised health care provision system, that seeks to provide a comprehensive package of primary health care services to all persons within a defined geographic area. An in-depth analysis regarding centralisation and decentralisation of health services will be dealt with in the next chapter.

CHAPTER 3

CENTRALISATION VERSUS DECENTRALISATION OF HEALTH SERVICES

3.1 Introduction

Emerging from the Primary Health Care (PHC) Conference held at Alma Ata in 1978 the health care provision system has undergone significant changes. Underpinning the principles of PHC is community participation, inter-sectoral collaboration, integrated health services, health promotion and making health care accessible to the communities served. The 1990s was the period in which most developing countries, including South Africa, adopted a decentralised health system with the notion of decentralising more authority to the local sphere of government as well as health districts.

Centralisation is viewed as a response to the need for national unity, whereas decentralisation is in response to the demands for diversity. Decentralisation, therefore, is viewed as the transfer of part of the powers of central government to provincial government or local government. The principal objective of applying either one of the two (centralisation or decentralisation), is to optimise efficiency and effectiveness of health services provision.

Conceptualisation of centralisation and decentralisation will be outlined in depth in the text. More focus will be on mechanisms employed to enhance health service rendering by centralisation and decentralisation. The pros and cons of both centralisation and decentralisation will be discussed, as well as factors influencing the degree of centralisation and decentralisation

of authority. All aspects mentioned above will be discussed in the following paragraphs.

3.2 Conceptualisation of centralisation and decentralisation

The major difference between centralised and decentralised authority is in who makes the important decisions in a public institution. In centralised authority, top managers make important decisions. In decentralised authority, middle and lower managers also make important decisions (Smit & Cronje 2004:199).

Many health-structures, particularly in some developing countries, are of a highly centralised nature (often as a result of the structures set up by former colonial powers) with decisions, both those of a broad policy nature and more detailed operational decisions relating to service provision, being made nationally. Hence Dejon (1978:101) notes that a centralised public health institution is one in which most of the major planning and policy decisions are made at the uppermost levels of the organisation.

Centralisation occurs when little authority is delegated to lower management levels, resulting in few decisions being made at these lower levels. This implies that all major decisions, including the allocation of budget and supply chain management, are done centrally at the Head Office of the organisation (Rue & Byers 1989:255; Koontz & Weihrich 1988:219-220).

Centralisation, therefore, can be explained in terms of the hierarchical level at which decisions within a public institution are made as indicated by Daft (1997:324) that centralisation is the concentration of decision-making

authority near the top of public institution. Geographic centralisation, also known as institutional centralisation, is the concentration of government institutions at the central sphere of government. The concentration results from a move in power from the periphery to the centre. Within a single institution in or central office of a particular area are activities of a certain nature (Dimock & Dimock 1983:213).

Functional centralisation is the integration of administrative functions and their concentration at the centre. This implies that the overall authority pertaining to a particular government function is concentrated in a single department (Roux *et al.* 1997:102). A brief exposition on decentralisation is elaborated hereunder.

According to Bonnal (2005:1), decentralisation has, not only been an administrative value, but also a civic dimension, since it increases the opportunities for citizens to take interest in public affairs; it makes them get accustomed to using freedom. As an example, a political decision was taken on moving certain towns falling under the jurisdiction of previously cross border municipalities to municipalities in other provinces without consultation with the local community, has resulted in legal battle between the affected communities and the current government. In recurring argument, Bonnal (2005:1) claims that the community defied the order to be moved from Gauteng Province to North West Province by resorting to unrests that led to the demolition of houses of councillors and state property in Khutsong Township. Decentralisation policies are part of vigorous initiatives to support rural development, for example, in South Africa, the government has declared impoverished municipalities as Presidential nodes in which efforts that are geared towards addressing developmental issues such as addressing poverty and unemployment enterprise development

while enhancing economic growth of the rural municipalities receive attention from appropriate participants by through implementing infrastructural projects. In its most basic definition, decentralisation is the transfer of part of the powers of the national government to provincial government or local government (Bonnal 2005:2).

Mutahaba (1989:69) states that decentralisation is the transfer of legal, administrative and political authority to make decisions and manage public functions from the central government to field organisation of those agencies, subordinate units of government and semi-autonomous public corporations. This implies that decentralisation increases the authority of the subordinate, by the superior, to make decisions at a specific level in a public institution.

Donnelly *et al.* (1992:801) aptly describe decentralisation as the pushing downward of the appropriate amount of decision-making authority. Decentralisation is a philosophy that entails dispersion of considerable authority and responsibility by managers to their subordinates by delegation. The amount of authority and responsibility dispersed enable managers to participate in decision-making processes of a public institution (Boone & Kurtz 1992:250).

Litvack (2005:1) identifies the following factors that have potential for improved service quality by the decentralisation of health care provision: one, exactly how these benefits can be realised, and two, the specific effect of different health systems reforms are not well understood as the principal lesson obtained from the experiences of various countries is the need to approach formulation and implementation strategies for systematic health sector reforms, rather than importing, uncritically, structural models

developed abroad. A systematic approach to policy formulation must begin by clarifying the problems the health sector reforms are intended to address. Several features of health care (for example, the controversial nature of some services such as family planning, the importance of formal training for personnel, and the integrated nature of services) make decentralisation in the health sector more complex and potentially more difficult than in other sectors such as education where the service is rendered by one authority. Since decentralisation in the health sector is often politically driven (local authorities will not always accept capacity challenges as hindrance to optimal service delivery especially when capacity has been put as a precondition for decentralisation), and the theoretical benefits tend to get more attention than the more concrete facts of actual experiences from other countries.

Without proper planning and acknowledgement of the lessons learned by other countries, decentralisation of health care can be disappointing at best and detrimental at worst since the stated objectives of decentralisation are to bring about fundamental changes in the health system that will help meet national health objectives while making the system functionally, organisationally, and politically sustainable. As the specific national objectives vary from country to country, so will the decentralisation strategies adopted. This note raises issues to consider, such as the political and administrative commitment from all spheres of government, if decentralisation is to bring about beneficial results (Litvack 2005:1).

Litvack (2005:1) states further that the term 'decentralisation' is used to describe a wide variety of power transfer arrangements and accountability systems. Policies range from the transfer of limited powers to lower management levels within current health management structures and

financing mechanisms to extensive sectoral reform efforts which reconfigure the provision of even the most basic services. The parameters for decentralisation such as the speed, the pressures, and the scope of issues to consider vary considerably.

Burns (2003:167) contends that in the case of decentralisation, certain powers and functions are delegated to an independent body, which exercises these powers autonomously. A good example of decentralisation is found in the relationship between central government and the provincial governments, as well as the relationship between provincial governments and local governments.

Decentralisation has become very popular in South African public institutions as a method of empowering employees. By decentralising power and authority, a more democratic public institution is created where managers at lower levels can decide on issues such as allocation of resources in their departments, differentiated salaries for employees, and flexible working hours (Smit & Cronjè 2004:199).

From the preceding sections, it can be noted that the principles of applying an appropriate form of decentralisation are relative to what should be decentralised in relation to meeting the national health policy objectives. Enhanced health service delivery through centralisation and decentralisation is discussed in the following paragraphs.

3.3 Enhanced health services provision by means of centralisation and decentralisation

The White Paper on Transformation of the Public Service (RSA 1995:23) provides that many countries in recent years focused on a thorough re-evaluation of the role of the State and in the public service in their societies. In the process, there has been a move away from centralised and corporate planning approaches towards more pragmatic approaches based upon the principles of sound management.

The public service, including the health sector, has been criticised in the White Paper on Human Resource Management in the Public Service (1997:25) as emphasising regulation and adherence to centrally-determined processes and that it has a rigid classification of tasks and lack of workforce mobility. In order to shift from administering personnel to managing people, human resources shall be managed by those closest to the point of health care provision. Where appropriate, functions would be devolved from the centre and become wholly the responsibility of departments. The White Paper on Human Resources Management, 1997 provides further that human resources management would be managed in a decentralised manner.

Bonnal (2005:1) is of the opinion that both forms of administration co-exist in different political systems. There seems to be consensus since the 1980s that too much centralisation or absolute local autonomy are both harmful and that it is necessary to put in place a better system of collaboration between the national, provincial and local centres of decision-making.

Planning, as an activity, needs to be closely tied in with the general decision-making process of the South African ministry of health. Furthermore, it has been discovered through experiences from other countries such as Zambia and Ghana that decentralisation of certain parts of the decision-making process is a necessary, though not a sufficient, condition for primary health care. In some countries decentralisation occurs more generally within the overall government system. Given the resultant trend towards decentralisation of the managerial process, it is important that certain planning decisions are similarly decentralised.

Furthermore, it has been argued earlier that there are good reasons for some elements of the planning assessment to reflect the differences in both epidemiological and demographic patterns between areas and for the responses to the needs so that they become consistent with differences in patterns and modes of rendering service. It also allows for differences in community views to be incorporated. Decentralisation may also be a more appropriate means of fostering multi-sectoral solutions to health problems. Since this may be so, where resources permit, the development of locally-based plans would appear to be entirely consistent with the tenets and objectives of promoting primary health care (Green 1995:319).

Green (1995:320) states further that the speed at which, in practice, decentralisation is possible, however, will depend largely on the availability of sufficient personnel with the requisite skills. During the transitional stage, it is likely that central support will need to be provided for the peripheral planning personnel. Indeed, it is likely that certain specialised skills will always be in such short supply that they remain at the centre, providing expert advice to the peripheral units. These may include, for example, planning skills in the area of human resources. Genuine

decentralisation would suggest that peripherally based planners are seen as accountable to the broader peripheral decision-making process rather than to the centre. There may, however, be a temptation to view planners as outposts of the centre, with prime responsibility to the central planning function. If this temptation is not resisted, then there is a danger that local managers and communities will not identify with the planning process, and will see it as an imposed central process.

Green (1995:320) asserts further that even where resources do allow full decentralisation, some planning functions such as ensuring that national development guidelines are understood and followed by local plans; ensuring that national policy guidelines in technical areas are set and incorporated into local plans; maximising resources available to the health sector, in part by undertaking a representative role in relation to central government and to donor agencies; ensuring consistency between local plans; planning shared or national services (such as training or specialised facilities) where these are appropriate; providing support for national legislative changes where necessary; overall national human resource planning; and allocating centrally provided resources to local levels, some planning functions will need to remain at the centre.

Richardson and Baldwin (1976:86 -91) explain that centralising public health sector activities enables government to formulate national policies in such a manner that the activities are standardised when executed. Such uniform policies facilitate the evaluation of the execution of activities on the basis of the determined policies. By centralising activities, the South African health sector will not be equipped to make decisions pertaining to public demands and thus unable to direct and monitor its response, through the activities, to the demands.

It is submitted that due to the size of the public service, it would have been impossible to function if there was no delegation and if all the decision-making was centralised. Most of the functions in the public service are decentralised. There are regional offices of most of the national departments that can take the decisions at the periphery. Different regional offices of the Department of Labour are able to accept and process applications in terms of the Unemployment Insurance Fund Act, 1966 (Act 30 of 1966). These offices have inspectors who investigate complaints against employers who have allegedly transgressed the Basic Condition of Employment Act, 1997 (Act 47 of 1997). Due to the decentralisation of these functions, the people have easy access to the public service and service delivery is enhanced.

As explained earlier in the text, health care service provision will only be enhanced when a balance is struck between decentralisation and centralisation. Advantages and disadvantages of both centralisation and decentralisation of health services will be discussed in depth in the paragraphs that follow.

3.4 Advantages and disadvantages of both centralisation and decentralisation of health services

It is hardly surprising that, given a strategy of employing meagre resources to achieve what ought to be complex social ends, centralisation should be increasing within the National Health Service (NHS). Nor is it surprising that such centralisation should be accompanied by rhetoric pointing the other way, to 'decentralisation'. Control of resources and regulation of rationing approaches in particular (or rather, procedures for denial of certain types of care) have to be a responsibility of 'the centre' if the centre's

objectives are to be met and political accountability for the health service rendering is to remain. Increased operational decentralisation is therefore accompanied by increased strategic centralism. This may not be a bad thing, of course an operational decentralisation may increase efficiency, while strategic centralism may ensure that national priorities are met, or at least sought – and indeed in the most cost-effective way (Paton 1996:270).

The centralisation or decentralisation of activities by public health sector organisations result in the organisations gaining many benefits, depending on the extent to which centralisation is implemented. Roux *et al.* (1997: 104) consider the following as **benefits of centralisation**:

- **Exercise of maximum control**

Exercising maximum control as a result of all activities being executed under the constant supervision of the senior officials is possible. Such maximum control over centralised activities enhances the senior officials' accountability and responsibility over the execution of the activities.

- **Standardisation of work procedures**

Achievement of a great degree of standardisation by the use of particular work procedures, processes and labour savings devices by all units of an institution results from centralisation. The evaluation of activities executed using such standard work procedures become possible.

- **Equity assurance**

Assurance of equity in the treatment of all health care consumers affected by the activities of the centralised public organisation, such as employees and customers. Equal treatment of all workers and customers ensures fairness in their handling by senior management of the organisation.

- **High level of specialisation**

Derivation of benefits due to specialisation resulting from a great division of labour, related to the great amount of activities performed within a

centralised organisation. The high level of specialisation within such an organisation is advantageous in that workers gain detailed knowledge about their sphere of work, thus become specialists and not generalists.

- **Minimised uncertainty**

Uncertainty and sudden changes are minimised because of strict adherence to organisational procedures. Uncertainty within a centralised organisation is reduced as a result of all operations of the organisation being carried out according to laid down procedures. The occurrence of sudden changes is also minimal due to the fact that the centralised organisation operates in a relatively stable environment.

Additionally, Mills *et al.* (1990:15) explain that some degree of centralisation is sometimes required and desirable, particularly for certain functions, such as national policy formulation and coordination of activities at lower levels, for example, central ministries have a crucial role in sustaining decentralisation by creating many of the enabling conditions for decentralisation. A strong central government is needed to ensure equitable redistribution of financial, human and other resources across different regions of the country. More important, there are many examples of countries such as the Philippines, Zambia and Indonesia, which indicate that policy commitment at the central level is vital for the implementation of many sexual reproductive health programmes such as family planning, adolescent sexual and reproductive health, abortion and HIV/AIDS.

Although the principle of centralisation is beneficial to public health sector activities, different **setbacks for centralisation** are identified as Hilliard and Wissink (1996:82) explains hereunder:

- **Diminished participatory democracy**

Centralisation diminishes participatory democracy as it encourages authoritative management styles. In centralised organisations, senior management, without the contribution of other personnel, makes decisions pertaining to these organisations without using mechanisms such as consultation, thus rendering participative management non-existent.

- **Remoteness between organisation and customers**

A lack of close interaction exist between a centralised organisation and the community it serves, because the central office of the organisation makes decisions that affect its customers without the contribution of the customers as a result of the remoteness between the organisation and its customers.

- **Lack of decision-making authority**

The units of the centralised organisation have little or no authority in decision-making over their activities as all their activities are regulated by rules and procedures formulated by central office. Such rules and procedures limit the responsiveness of the units to local needs of their customers, together with the adaptability of these units to changing local conditions.

In view of the aforementioned, Stoop and Grabe (1993:25-28) outline **obstacles of centralisation** as follows:

- **Strict adherence to prescribed duties**

Uniformity, which dictates that similar post descriptions have exactly the same duties, irrespective of the location in which the posts are used, limits organisation flexibility due to strict adherence to prescribed duties. Such adherence results in slow response by, and sometimes unresponsiveness of, an organisation to varying needs of its customers.

- **Restricted worker capabilities**

Capabilities of workers, in relation to decision-making, are restricted as decisions are guided by regulations. Such decisions tend to be predictable

and are aimed at providing accountability. Innovation of workers is thus curbed and dynamic administration discouraged.

- **Overemphasised resource utilisation**

Overemphasis is placed on resources and their utilisation due to the great importance attached to financial control by unit managers. Such concentration on resources creates a shift in organisation goals from those related to providing high quality service at the lowest possible cost to those concerned with administering within specified codes and directives. The all-consuming objective of low administrative cost in the execution of activities, linked to the codes and directives, cause inefficiency that is blamed on the organisation system and not on organisation personnel as the personnel lack the decision-making authority

In addition to obstacles for centralisation, Albers (1974:75) also asserts that management hierarchy, viewed as a structure of the communication centre via which information relevant to organisational decisions flows and control is exercised over organisational units, is greatly affected by the implementation of centralisation in an organisation. This is the case because the amount of information channelled to the communication system is closely related to the extent to which decision-making is centralised.

Ikiara (2001:1) argues that in the post-independence period, centralised political and economic system has been generally preferred largely because it was regarded as the most effective way of forging national unity. There is a need, however, to review this assumption. There are a number of weaknesses that are associated with a centralised system. Firstly, one of these is the power that is given to the central authorities in the management of national resources. Such powers tend to cause tension and intensify struggle to acquire such powers. Secondly, centralisation tends to promote

inequity in resource distribution and could stifle socio-economic development in some of the areas, especially those, which are politically marginalised such as health care. Thirdly, the centre tends to monopolise policy formulation and implementation, giving the districts limited chance to increase their capacity to manage their affairs.

It is clear from the above that the disadvantage of centralisation is that decisions made at the apex of the hierarchy involve more communication centres. Centralisation, therefore, can easily overload the system and create bottlenecks in the flow of information. This in turn reduces the speed of decision-making. Employees who are charged with health service rendering therefore cannot act promptly in a centralised organisation and thus services to the community are adversely affected.

Decentralisation of the health sector is concerned with changing the manner in which health systems are organised. Conceptually, it is a change in power relations between the central government level and other participants in the health system, including statutory local government entities, lower levels of government administration, private enterprises, and state-owned enterprises and non-governmental organisations (Maceira 2005:1). Decentralisation will also afford opportunities for promoting healthcare service provision in other settings. Though limited, experiences suggest that, given sufficient decision space and assuming local levels identify sexual and reproductive health as a priority, there is potential for local decision-making to further sexual and reproductive goals. As an example, Chongo and Milimo (1995:39) purports that the increased decision space allowed by decentralisation in Zambia enabled the creation of an innovative partnership between a District Health Management Team and a large referral hospital to improve the availability and quality of maternal services

in the district and to improve efficiency by reducing the number of normal child births at the referral hospital. Following the devolution of primary health care to municipalities, the maternal health programmes in Chile received an infusion of resources, resulting in expanded coverage (Chongo & Milimo 1995:39).

According to the World Health Organisation (WHO) (2010:84) there are a multitude of **potential benefits of decentralization** of health care in the literature. Some of the most cited are:

- A more rational and unified health service that caters to local needs.
- Decrease in duplication of services as the target populations are more specifically defined.
- Increased innovation of service provision by experimentation and adaptation to local condition.
- Increased accountability, transparency and quality of health services through user oversight and participative decision making.
- Reduction of inequality between rural and urban areas.
- Greater integration of activities of different public and private agencies.
- Improved inter-sectoral coordination.

As explained earlier in the text, decentralisation is an important tool to improve the functioning of governance. It is a dynamic political process, a learning process, a mix with centralisation. Decentralisation should not go in isolation as a separate entity. It is an integral part of the governance system.

Roux *et al.* (1997:105) also add the benefits of decentralisation in the following paragraphs:

- **Rapid completion of activities**

Rapid completion of activities due to organisational functions being closer to the customer and also resulting from the avoidance of unnecessary delays in the performance of activities. It is quicker to execute functions that are customer-oriented when functions are brought close to the customer.

- **Enhanced adaptability and flexibility**

Enhanced adaptability and flexibility of activities are brought about by the informed status of unit workers about conditions in which the activities are performed. This information on local conditions enables units to adapt their activities to suit the specific conditions. Increased organisation flexibility and quicker decision-making, resulting in a speedy response to customer needs and environmental changes, are made possible (Rue & Byars 1989:255). Koontz and Weihrich (1988:236) argue that decentralisation, either functional or geographical, assists an organisation to adapt to a quickly changing environment because, via its units, an organisation is able to perceive changes and introduce appropriate adaptation mechanisms.

- **Reduced burden on senior management**

Headquarters personnel are relieved of decision-making on routine activities as such activities are delegated to units and branches of the organisation. Personnel of central office, therefore, are provided with the opportunity to concentrate their energies on long-term planning and overall policy formulation crucial for the effective and efficient functioning of the organisation. Relieving senior management from time consuming and mundane activities (Rue & Byars 1989:255).

Decentralisation greatly reduces the burden on senior management of an organisation in that they do not necessarily have to supervise each unit of

the organisation. As a result of the freedom from supervision of units enjoyed by senior management, they are able to focus their attention on the general objectives and long range planning of the organisation (Scanlan & Keys 1979:189).

- **Improved accommodation of customer needs**

The increased ability of a decentralised organisation to accommodate meaningful customer needs, providing realistic service catering to the needs of the customers peculiar to each unit is important. Operations of an organisation are brought closer to the customers, thus providing an opportunity for adaptation and adjustment of activities by an organisation, where and if necessary. The close proximity of an organisation to its customers and local conditions makes modification of the organisation services necessary to suit the customers in the prevailing conditions (Charlesworth 1951:203).

According to Maceira (2005:2), decentralisation and the primary health care (PHC) approach became closely associated after the Alma-Ata Conference in 1978. Since then, PHC has been understood as mechanism for achieving better health, underpinned by principles such as equity, community participation and inter-sectoral collaboration. The push for decentralisation has rarely been based on evidence of its benefits, but rather on its potential to improve the quality and efficiency of government health services. However, decentralisation should not be an end in itself; rather it should be the means to accomplish the broader goals of equity, efficiency, quality and access to health care. Chapter 9 of the thesis deals with empirical analysis and findings of the survey undertaken at randomly selected health facilities in five districts within the Free State Province on decentralisation of district health services, Table 9.4 deals with the explanation provided by the respondents to the question on the consequences of decentralisation.

Slightly less than half of the sample stated that decentralisation will lead to improved health care service provision/home-based care, with less chance to lose patients in the system (48.4%), followed by less than a fifth who indicated that it will reduce bureaucratic red-tape and enhance communication and teamwork (18.8%). Similarly, the majority of the respondents believed that conditions for service provision will be better after the decentralisation process compared to the period before (See Figure 9.7 in Chapter 9).

Maceira (2005:2) outlines **the advantages of decentralisation** as follows:

- Capacity to improve efficiency and quality of care.
- Under certain conditions, decentralisation can obtain greater equity.
- Increase responsiveness of the health system to local needs.
- Develop service delivery innovation and local adaptation of service.
- Improve inter-sectoral coordination.
- Matching health services closely to local needs and preferences would increase allocative efficiency and improve quality of services from the user's perspective.
- Fewer levels of bureaucracy, greater knowledge of local needs and greater accountability may increase technical efficiency.

Smit and Cronjè (2004: 201) argue that decentralisation has the following advantages:

- By decentralising, the workload of top management is reduced, enabling them to devote more attention to strategies.
- Decision-making improves because decisions are closer to the core of action and time is not wasted by first referring the matter to a higher authority. In respect of the main aspect that needed to be decentralised, Table 9.6 in Chapter 9, respondents highlighted authority/decision-

making/recruitment and employment of health care workers (60.6%) as paramount. The other main aspect to be decentralised, as indicated by respondents, includes the recruitment aimed at decreasing staff shortages (60%).

- There should be improved morale and initiative at the lower levels of management. These managers feel that they participate in managing the organisation and are prepared for greater responsibilities. They should experience a great deal of job satisfaction.
- Decentralisation of decision-making renders it faster and more flexible. This is necessary in a rapidly changing environment.
- Decentralised authority also fosters competition because performance is constantly compared among colleagues.

After giving a brief exposition of the benefits of decentralisation in the foregoing, focus is given on the **disadvantages of decentralisation** in the paragraphs that follow.

- **Intensive and expensive training**

Donnely *et al.* (1992: 206) argue that decentralisation of authority usually requires more intensive and expensive management training. The initial cost of training is high because managers must often be retrained to make decisions once made at higher levels.

In the Free State Provincial Government, the human resource management function was decentralised from the central human resource management to the different provincial departments. From personal experience, the author is aware that there are problems with the handling of pensions as in the different departments there are no skilled people to process pension applications and there are unnecessary delays. It can be concluded that for decentralisation to succeed the personnel must be trained.

- **Sophisticated planning and reporting methods**

In terms of the Public Service Act, 1994 (Act 103 of 1994), the head of the department has the authority to discipline an officer for misconduct. In the Free State Provincial Government this authority was delegated to the different heads of provincial departments. The Director General is still responsible and the provincial departments have to report regularly to him on what is happening.

- **Loss of control**

Control at the top in a decentralised organisation may be more difficult. The further decisions are removed from the highest level, the more difficult it is to pinpoint problem areas and take corrective action. The top manager may lose touch with what is really happening in the organisation (Schwartz 1980:295).

When authority is delegated to another, methods of control should be laid down to ensure that the authority would not be misused in any way. The top manager must still have control about what is happening (Cloete 1994:123).

Although decentralisation can be beneficial to organisations, some constraints are experienced as a result of this practice as argued in the under-mentioned paragraphs by Scanlan and Keys (1979:185).

- **Too much independence**

The independence enjoyed by the organisation units may be detrimental to the welfare of the organisation in instances where the units tend to be more conscious of their own aims than those of the organisation. This great independence problem can be avoided or controlled by organisations ensuring that their units strongly identify with them and their overall objectives.

- **Economic considerations**

The extra costs incurred through decentralisation resulting from the necessity to employ a large and competent staff component of specialists to work in various organisation branches have to be weighted against the benefits derived from decentralisation. High costs are also incurred as a result of duplication of activities of central office at branch level.

Albers (1969:194) identifies the setback of decentralising organisations as follows:

- **Coordination and control problems**

Since decentralisation involves a certain amount of planning and control, every management level below that of the chief executive of an organisation is subject to decisions made by senior management, necessitated by the need to coordinate organisational activities and achieve unity of purpose in an organisation. Such coordination and control would be difficult if units were delegated and the authority to make crucial decisions that affects the achievement of organisation objectives.

Donnely *et al.* (1992: 206) add the following constraints of decentralisation:

- **Necessity for sophisticated methods**

A requirement for more sophisticated planning and reporting methods, in the case of both functional and geographical decentralisation, as methods of measuring overall accountability for the assignment of delegated authority have to be established. Such methods are required because, although senior management delegates this authority, it retains accountability for the achievement of the organisation mission. It relies on the delegated authority and its use in the performance of activities to achieve this mission.

Berkely (1988:47) mentions the following as constraints of decentralisation:

- **Curbed specialisation**

Decentralisation curbs specialisation due to the inability of decentralised organisations to develop and retain as much variety and depth of expertise at branch level as at central office level.

- **Increased operational costs**

Expensive duplication of services, in the sense that the same services offered at central office are also offered by its branches, result in a decentralised organisation increasing its costs incurred for the provision of the same services.

According to Maceira (2005:3), it is a reality that each potential benefit of decentralisation has a potentially corresponding disadvantage. For example, decentralisation can create opportunities for communities to participate in local level planning, decision-making and monitoring of sexual reproductive health services through involvement in community-level management teams. However, inadequate flow of information between local government and civil society, and the lack of training and guidelines regarding the role of these community-level management structures, may undermine their effectiveness.

Maceira (2005:3) summarises the following as problems to decentralisation:

- Local levels of government may not necessarily support national priorities, making the implementation of national policies and provision of public goods difficult.
- Existing shortages of skilled staff may be exacerbated following decentralisation because the same pool of skills has to be spread thinly across decentralised units.

- Human resources are generally scarce in developing countries and this fact reduces the effectiveness of the reform process.
- Lack of a global strategy and poor coordination at local level may negatively affect resource gaps between jurisdictions.

The above assertion about advantages and disadvantages of decentralisation, confirms that fundamentally, decentralisation reform changes the manner in which the public institution runs its business or health services are rendered, including sexual and reproductive health care. The critical challenge in a decentralised health system lies in achieving a careful balance of power between central and local levels in decision-making, priority setting and resource allocation, to ensure that decisions favour, or at the very least do not negatively impact on, availability and equitable access to health services. Factors determining the degree of centralisation and decentralisation will be discussed hereunder.

3.5 Factors determining the degree of centralisation and decentralisation of health services

Various factors can influence the centralisation and decentralisation of health service or functions. Such factors will be outlined in the following paragraphs though the author will commence with those affecting centralisation and those that influence decentralisation will be deliberated at a later stage in the thesis.

3.5.1 Factors influencing centralisation

Before public sector organisations decide to engage in the practise of centralisation, certain factors have to be considered as argued by Scanlam and Keys (1979: 183).

- **Geographic dispersion**

The growth rate of an organisation affects the degree to which that organisation is centralised. An organisation that does not have a growing customer base spread throughout a region or district tends to remain centralised as no need exists to expand its facilities that satisfactorily serve its customers. In order to be able to cope with immediate situations, local units of an organisation have to consult the central authority to execute certain activities.

- **Organisation size**

A decision to centralise activities by public sector organisation, is influenced by the size of each organisation. An organisation that is small may undertake diverse activities, which may necessitate the granting of autonomy to its units engaged in their undertaking. Such granting of autonomy, involving delegation of authority, is not practised as management believes that, due to the small size of the organisation, delegation of authority can be done without (Stoner 1978:284).

According to Koontz and Weihrich (1988:225) the degree to which an organisation is centralised in terms of its activities is affected by the following factors:

- **Desire for uniformity of policy**

Organisations that value consistency favour centralisation of their activities as centralisation is the easiest way of attaining and maintaining consistency. Consistency attained by uniformity of policy leads to an organisation that enjoys certain internal advantages such as standardised organisation systems, for instance accounting and financial records. The standard

systems in turn make comparison of relative efficiency of departments and maintenance of low costs easier than in a decentralised organisation.

Organisations that encourage uniformity in all areas except in major issues tend to favour decentralisation due to the belief that such conformity may result in standard employee treatment, progressive execution of functions, and elimination of competition among organisation units, efficiency and development of effective managers.

- **History and culture of an organisation**

The historical background and culture of an organisation greatly influence its decision to centralise its activities, especially organisations with a background of internal expansion. They also tend to maintain centralised authority as the control of activities in such organisations can be done more effectively by centralisation. Although some organisations that are a result of mergers and consolidations are generally decentralised due to the maintenance of independence of units in the organisations, these organisations still remain mainly centralised.

- **Management philosophy**

The philosophy and character of senior management determine the extent to which the centralisation of activities takes place in an organisation. Senior managers who are despotic and cannot delegate authority for the execution of activities that they enjoyed performing before becoming top level managers are hesitant to decentralise. Such managers fail to perceive decentralisation as a way of promoting economic efficiency; employee initiative and participation in the decision-making of an organisation hence they do not advocate and/or make use of decentralisation in their organisations.

- **Availability of managers**

Public organisations with a shortage of managers are limited to the pattern of centralisation of activities because delegation of activities by decentralisation requires the existence of qualified and experienced managers to whom authority can be delegated in an organisation. As a result of the shortage of qualified and experienced managers, organisations tend to be centralised.

In some instances, senior managers of centralised organisations use the shortage of qualified managers as an excuse for maintaining the centralisation of activities, while the main reason for not decentralising is the need by the managers to magnify their importance in an organisation. Failure by the managers to develop managers from their subordinates is also another reason for maintaining centralisation. The management of some organisations discourage decentralisation because of their belief that organisations should be centralised in order for them to require only few good managers. Organisations managed by such managers may experience difficulty in training subordinates with potential to take over from such managers and have to rely on external sources of recruitment to replace or fill management posts.

- **Abilities of lower level managers**

The abilities of lower level managers of an organisation affect the level to which that organisation centralises its activities. This is the case in that organisations with senior managers who doubt the abilities of junior managers are inclined to centralise their activities as senior managers do not delegate authority to their subordinate managers. This lack of delegation by senior managers reduces opportunities for junior managers to develop their

decision-making and management skills, making decentralisation difficult (Stoner 1978:285).

Experience has shown that certain central-level functions should not be decentralised, if, for example, according to Kolehmainen-Aitken and Newbrander (1997:68):

- a function is critical to attaining national health goals and its sustainability at the local level cannot be guaranteed, i.e. registration of pharmaceuticals to ensure the quality and appropriateness of pharmaceutical supply;
- the local level lacks the capacity to perform the function, such as the registration of health professionals which requires legal expertise and professional ability to assess their qualification and competence; and
- undertaking the function at peripheral level is not cost effective, such as bulk purchase of pharmaceutical products and the maintenance of biomedical equipment.

3.5.2 Factors influencing decentralisation

- **Personality of the manager**

The management style and philosophy of the manager will determine the degree of decentralisation. Managers differ greatly in their willingness to let go and permit lower echelon personnel to make decisions (Schwartz 1980:299). The top management may be reluctant to delegate further as there are managers who equate authority with power and therefore view decentralisation as undermining their power and influence in the organisation (Donnelley *et al.* 1992:207).

Koontz and O'Donnell (1974:208) maintain that the character of top executives and their philosophy have an important influence on the extent to which authority is decentralised. The authors argue further that sometimes the top manager is despotic, brooking no interference with the authority and information he jealously hoards.

The extent to which a policy of decentralisation can be carried out may be limited by the personality of the manager. The psychological make-up of some managers inhibits their willingness to delegate decision-making. The manager who effectively delegates authority must be willing to release the right to make decisions to his subordinate (Albers 1974:189; Koontz & O'Donnell 1974:203).

- **The degree of the risk involved**

The reluctance to decentralise may be influenced by the degree of the risk involved. The overriding factor determining the extent of decentralisation is the criterion of costliness. The more costly the action to be decided upon, the more probable that the decision will be made at the upper level of management (Koontz & O'Donnell 1974:204).

- **Lack of competent people**

In order to avoid expensive mistakes it is better to delegate only when there are competent people to perform the functions. A real shortage of managerial skills limits the extent of decentralisation of authority since the delegation of decision-making assumes that trained managers are available (Koontz & O'Donnell 1974:209).

Decentralisation is therefore only possible if persons are available who are sufficiently trained and experienced to accept and implement authority.

The lack of competent persons explains a reluctance to decentralise authority (Schwartz 1980:299; Albers 1974:189)

- **Ability to report to one central agency**

The ability of employees at unit level of a public institution to report to only one senior official is considered in the determination of decentralisation. Public health institutions considering decentralisation should have mechanisms that enable workers to provide feedback on their activities to one senior official. In the specific organisation, workers should report only to one specified senior official and not be expected to report to every senior official. Public institutions with mechanisms that enable employees at unit level to report to one senior official are more likely to be decentralised than those public institutions lacking such mechanisms (Charlesworth 1959:258).

- **Complexity of environment**

Decentralisation is used by public organisations (for example, Health Department) that operate in complex environments in an attempt to increase their effectiveness and their adaptability. In a hostile and difficult environment, public organisations tend to have centralised tendencies such as top-down decision-making, in order to protect themselves from the prevailing environment. Unlike these centralised public organisations, decentralised public organisations tend to operate in environments that require delegation of authority due to the units of the organisations operating in varying environments at the same time (Flynn 1993:169).

While each country is unique in the details of the response its specific situation requires, some basic factors that promote successful transfer of

power remain constant as asserted by Kolehmainen-Aitken and Newbrander (1997:69). These include:

- Identification of the motivating factors for decentralisation.
- Establishment of realistic goals, objectives and expected results.
- Definition of decentralisation for each context.
- Adjustment of the legal and regulatory framework.
- Development of new management systems and processes.
- Estimation of required resources, both human and financial.
- Training of management staff at all levels.
- Monitoring, evaluating and refining the decentralised system.

As alluded to above, it can be stated that indeed centralisation and decentralisation of a service or function cannot happen out of the blue, but there are specific factors that need to be taken into consideration before such action can be taken as highlighted above.

3.6 Conclusion

Centralisation and decentralisation contribute to effective and efficient health services rendering. The critical challenge in a decentralised health system lies in achieving a careful balance of power between central and local levels in decision-making, priority-setting and resource allocation, to ensure that decisions favour, or at the very least do not negatively affect the availability and equitable access to health services.

Certain factors, such as the desire for uniformity of policy and the lack of competent people, influence the degree to which centralisation and decentralisation of authority should take place. It is thus essential to note

that for health services to be rendered in an efficient and effective manner, such aforementioned factors, and many others, should be considered when centralising or decentralising authority to lower levels of government. The nature and extent of decentralisation of health services in the Free State is discussed in depth in the chapter that follows.

CHAPTER 4

NATURE AND EXTENT OF DECENTRALISATION OF HEALTH SERVICES IN THE FREE STATE

4.1 Introduction

Decentralisation has long been advocated as a desirable process for improving health systems. Decentralisation is not only an administrative value, but also a civic dimension, since it increases the opportunities for citizens to take interest in public affairs; it makes them accustomed to using freedom. The accumulation of these local, active, pernickety freedoms, is born the most efficient counterweight against the claims of central government, even if it were supported by an impersonal, collective will.

With decentralisation, local decision-makers gain new responsibilities for planning and resource allocation, and therefore require additional skills. Yet there is ample evidence to suggest that capacity for managing at local level has proven problematic without the added burden of decentralisation.

Decentralisation is regarded as a key element of the primary health care (PHC) approach. Before one country follows the form of decentralisation of another country, it is important for the country interested in adopting another approach to be clear about its reasons for wanting to decentralise. It is against the aforementioned background that the chapter attempts to outline reasons for decentralisation, different forms of decentralisation, as well as of the relationship between decentralisation of health services, democracy and effective governance at the local government sphere.

All the aforementioned aspects are discussed fully in the sections that follow.

4.2 The rationale for decentralisation of health services

While policies and programme direction often originate at the national level, health services are provided, though not necessarily administered, at the local level. In a move to bring administration and direction of health care services closer to communities many countries have used a variety of mechanisms to decentralise health care services. The expressed goals of decentralisation are to meet local needs, improve the efficiency and quality of services, and ensure equity in health care (Jimenez & Smith 2005:10).

Jimenez and Smith (2005:10) argue that there are many complex reasons why governments in various countries, including South Africa, have commenced or are beginning to start decentralising their services. Looking at the historical perspective and analysing the reasons for the decentralisation of policies and their evolution, it is evident that different local factors have played a major role in different countries, for example, political ideology, demand for more regional autonomy and the need to rationalise overburdened and outmoded administrations. The main argument for decentralising decision-making in health is that local decision makers have greater knowledge of the health needs of their populations and of local conditions that affect the production of health care than provincial and national policy makers (Jimenez & Smith 2005:10).

Much of the decentralisation which has taken place in the past decade has been motivated by political concerns, for example, in Latin America, decentralisation has been an essential part of the democratisation process as

discredited autocratic central regimes are replaced by elected governments operating under new constitutions. In Africa, and South Africa in particular, the spread of multi-party political systems is creating the demand for a more local voice in decision-making (The World Bank 2001:3).

The World Bank (2001: 3) states that although politics is the driving force behind decentralisation in most countries, fortunately, decentralisation may be one of those instances where good participation and good economics may serve the same end. The political objectives to increase political responsiveness and participation at the local level can coincide with economic objectives of better decisions about the use of public resources for increased willingness to pay for local services. At least five conditions are outlined for successful decentralisation (Bonnal 2005: 2):

- ✓ The decentralisation framework must link, at a point, local financing and the authority to the service provision responsibilities and functions of the local government – so that local politicians can bear the costs of their decisions to deliver on their promises.

- ✓ The local community must be informed about the costs of services and service provision options in order to make meaningful decisions. Participatory budgeting, such as in Peru, Alegre, Brazil, is one way to create this condition.

- ✓ There must be a mechanism by which the community can express its preference in a way that is binding on the politicians – so that there are credible incentives for people to participate.

- ✓ There must be a system of accountability that relies on public and transparent information that enables the community to monitor the performance of the local government effectively and react appropriately to that performance – so that the politicians and local officials have an incentive to be responsive.

- ✓ The instruments of decentralisation – the legal and institutional framework, the structure of service provision responsibilities and the intergovernmental fiscal system – are designed to support the political objectives.

Standing (2002:20) asserts that a good starting point for understanding decentralisation processes in a given setting is to examine the objectives for the decentralisation, the context in which it occurs, who are the participants, and their different agenda. This section attempts to describe the motivations and the rationale for decentralisation, the role of context and actors in shaping differences in forms and scope of decentralisation in different settings.

4.2.1 Motivations for decentralisation

Decisions to decentralise health systems have not always been well considered and intentional. In many settings, the reform has been initiated on the basis of its theoretical benefits rather than concrete evidence of its beneficial influence on health system performance (Kawonga 2003:179).

Kawonga (2003:179) argues that two main forces appear to have motivated much of the decentralisation in practice: technical (or management) motives, aimed at enhancing efficiency and management; and political

motives aimed at democratisation of the state and ensuring greater accountability to communities. In practice, either one of these factors takes prominence. Technical and political motives interact to provide impetus for the reform.

Generally, decisions to decentralise power within the health sector have been motivated by technical reasons such as the need to address deficiencies in the health system, including poor quality services, and inefficient management and provision of health services. Donor, bi-lateral and multi-lateral organisations have often been influential in such decisions, frequently defining the terms of decentralisation policies in countries, and sometimes using loans or grants as leverage (World Bank 2001:55).

Decentralisation reforms initiated during the late 1980s and 1990s, especially in Africa, but also in other regions, were largely motivated by technical objectives and have been donor-driven. For example, the World Bank provided loans to Ghana. These loans were on condition that the government implemented decentralisation of the health system, while Indonesia received a substantial World Bank loan to ensure the implementation of World Bank-driven decentralisation of the health sector (Gyapong *et al.* 1995:110); (Nunn 2003:67).

Aitken (1999:86) states that decentralisation motivated by political concerns has usually been undertaken as part of political transformation in a bid to expand democracy. Decentralisation by means of devolution was commonly implemented in such instances, characterised by the transfer of power to local government to enable greater community representation through elected leaders, and greater accountability of officials to the electorate. Thus, a politically motivated decentralisation of the whole

public sector was often as part of a national development strategy that extended beyond the health sector. In this regard, the health sector may not have been a prominent actor in the decision-making and planning for decentralisation because political decisions to decentralise were at times made outside the realm of the health sector, requiring unwilling compliance of management of the health sector. In South Africa, the Free State Province in particular, the development of DHS was seen as a way of rectifying a fragmented and inequitable health system inherited from the apartheid era.

4.2.2 Context and processes

Context plays a key role in shaping decentralisation experiences and determining how successfully decentralisation implementation will be in achieving their political or management objectives. Commonly documented contextual factors that enhance the effective implementation of decentralisation include (Brijlal *et al.* 1998:19):

- ✓ Political and bureaucratic commitment to the reform, in the absence of which success is unlikely.
- ✓ Some basic initial capacity to initiate planning and implementation.
- ✓ Existence of effective channels of community participation and accountability.
- ✓ Local control over resources to facilitate appropriate use of resources matched to local needs.

Gilson and Travis (1997:24) identified a number of process elements and mechanisms that need to be in place in order to facilitate successful decentralisation. These factors are elaborated upon in the following paragraphs.

- ✓ Consensus building: highlights the importance of surveying the terrain and identifying participants in respect of the opponents and proponents of the reform.
- ✓ Regulatory framework and administration guidelines: enabling legislation is necessary, but not sufficient for implementation of decentralisation. Clear administrative guidelines defining roles and responsibilities are useful.
- ✓ Phasing and piloting: a gradual and deliberately well-planned approach, with incremental scaling-up as capacity develops.
- ✓ Policy champions: establishing the implementation units to drive the health sector reform process enables focus and dedicated attention to implementation.
- ✓ Restructuring: this is often an overlooked process, but it is important to restructure and re-define roles for the levels to avoid confusion about their respective new roles.
- ✓ Capacity building: must be appropriate to context and equip officials at all levels with wide-ranging skills for their new roles. Lack of management capacity undermines implementation.

Generally, successful implementation is not necessarily dependent on the form of decentralisation adopted, but rather on a complex mix of contextual, organisational and institutional factors (Mills *et al.* 1990: 37). The general argument for decentralising health care in the Free State is the potential for improved service quality and coverage; for instance, Table 9.7 in Chapter 9 reflects that foremost among the most important aspects respondents were satisfied with the prospect of better health care provision to communities (57.4%). Yet the issues of, exactly how benefits can be realised, and the specific effect of different health system reforms are not well understood. Several features of health care (for example, the

controversial nature of some services such as family planning, the importance of formal training for personnel, and the integrated nature of services) make decentralisation in this area more complex and potentially more difficult than in other sectors (Litvack 2005:23).

Litvack (2005:24) adds that since decentralisation in the health sector is often politically driven, the theoretical benefits tend to get more attention than the more concrete facts of actual experiences in other countries, which is mixed. Without proper planning and acknowledgement of the lessons learned by other countries, decentralisation of health care can be disappointing at best and detrimental at worst. This note raises the issues to consider if decentralisation is to bring about beneficial results.

Görgen *et al.* (2004:41) state that for several years now it has been the declared reform policy of low-income countries to decentralise the administration in most sectors. This political turnaround away from a more centralised system is in part a response to the past failures of centralised government decision-making, which has all too often gone hand in hand with corruption. It is hoped that further-reaching decentralisation of decision-making authority in the health sector, as in other areas, will increase citizen involvement resulting in greater social justice and more effective health care systems. Quite apart from the aspect of democratisation, it is assumed that the breakdown of the health sector into operational sub-units (health districts) will boost quality and bring efficiency gains.

The rationale for decentralisation is the ability to provide equitable, efficient and good quality health service provision. The forms of decentralisation are discussed thoroughly in the paragraphs that follow.

4.3 Forms of decentralisation

Gilson and Travis (1997:27) believe that there is no ideal form of decentralisation, and the selected option must be appropriate to country context. Regardless of the form of decentralisation adopted and implemented, the degree of success varies, often depending on how well the local context was considered prior to implementation, and the strategies used during the implementation process. To understand the critical function of local decision-making the following question is asked: "who gets power (what level of the health system)?

Görgen *et al.* (2004:42) state that decentralisation is the transfer of central government powers, that is, decision-making authority in fields of planning and management, to a lower level. Four distinct forms can be identified:

- ✓ De-concentration
- ✓ Delegation
- ✓ Devolution
- ✓ Privatisation

It is important to note, however, that the aforementioned forms of decentralisation are never clear cut, but are a kind of shorthand for various forms of structural arrangements to distribute power. The forms of decentralisation are discussed thoroughly in the following paragraphs.

4.3.1 De-concentration

De-concentration involves shifting of the workload or expertise without decentralising the decision-making power from the centre to the regional or district offices within the structure of the ministry of health. It is the

shifting of powers from the centre to peripheral units (Baer 2005:2). Since de-concentration involves the transfer of administrative rather than decision-making power, it is seen as the least extensive form of decentralisation. Nevertheless, de-concentration has been the form of decentralisation most frequently used in the developing countries since the early 1970s. As for the ministry of health, it implies imbuing local (for example, district) management with clearly-defined administrative duties and a degree of discretion that would enable the local officials to manage without constant reference to ministry headquarters. De-concentration may be accompanied by the amalgamation of both central and local government health services within the local organisation, in order to facilitate the planning and management of health services on an integrated basis (Baer 2005:2).

Bonnal (2005:2) indicates that the first major trend in decentralisation of health services was administrative de-concentration. In the context of de-concentration processes, different ministries transfer their functions and authority to provincial and/or local out-posts. This limited form of decentralisation only concerns relations between the central sphere of government and their lower spheres. De-concentration means that decision-making remains at the centre, the other spheres of government being limited to transmitting orders and implementing decisions. Though decisions regarding crucial issues are made at the centre, the spheres with de-concentrated authority can, by delegation, make decisions concerning less important issues.

When initiating a de-concentration process, governments seek mostly to bring their personnel to a particular location, or by assigning some responsibilities to provincial or local authorities, while retaining

administrative control over decisions taken locally. De-concentration was seen at first as a more efficient way of organising the work of public administrations, which would make it possible to appreciate the usefulness of each category of citizens. It was thus considered a condition for the efficient functioning of the state, but it was also admitted that the necessity for coordination and that of having the general interest prevail in government action, meant that the state could not cede all its powers to local jurisdictions. Other considerations associated with democratisation came to reinforce the trend toward de-concentration, which appeared to be a means of reducing the dissatisfaction of citizens toward local jurisdictions (De Beer & Swanepoel 2004:9).

Burns (2003:166) points out that the de-concentration of power usually takes place within a specific administrative hierarchy such as a state department. The transfer of discretionary power is more readily accepted in the relationship of de-concentration. The purpose of this form of decentralisation is to ensure the quick and efficient execution of duties and a division of labour. The ministerial head of a department is simply not able to perform all the functions of his department, and may delegate many of these powers to the director-general, who in turn may delegate them to heads of departments and other administrators for effective functioning of the department.

Pillay (2004:1) defines de-concentration as a process in which functions are transferred from higher to lower locally-based spheres within administrative system. In the South African context, de-concentration translates into the 'provincial option' whereby provincial Departments of Health retain responsibility for health service provision, a responsibility discharged by District Management Teams (DMTs).

4.3.2 Devolution

Devolution in the stricter sense is closest to the complete form of decentralisation in which the lower spheres, in respect of resource control, policy formulation, implementation, monitoring and evaluation, achieve autonomy. In fact, devolution is the creation or strengthening of sub-national levels of government (often provincial government or local government) that are substantially independent of the national sphere in respect to a defined set of functions. They normally have a clear legal status, recognised geographical boundaries, and a number of functions to perform, and a statutory authority to raise revenue and control expenditure. They are rarely completely autonomous, but are bodies largely independent of the national government in their areas of responsibility rather than subordinate units as in the case of de-concentration. In the health sector, devolution implies much more radical restructuring of health service organisation than de-concentration. Devolution implies involving the creation or strengthening of lower spheres of government which are substantially independent of the national sphere (Pillay 2003:1).

Bonnal (2005:5) stresses that decentralisation by devolution makes it possible for inhabitants of a town, a department, or region to settle their administrative affairs by means of their elected representatives. All the same, during the first wave of this form of decentralisation, local jurisdictions were placed under the supervision of a representative of the national government, with the task of making a posterior check on the legality of their decisions. New waves of decentralisation gradually improved the representation of citizens in the process of decision-making. Representative democracy was limited, nevertheless, especially with local elite assuming the decentralised functions. This situation made it necessary

to strengthen the process with participatory democracy, based on civil society organisations.

According to Baer (2005:1), devolution is the transfer of powers from central to local government. Devolution means the handing down of power from higher to a lower sphere within a system. It is the handing down from either central or provincial government or the Department of Health of responsibility for determining local health objectives or for defining key aspects for business. No government responsibility for a publicly funded health service would relinquish all responsibility for setting objectives (Paton 1996: 4).

The last factor in decentralisation by devolution is the desire to respond to regional aspirations, which reflected the awareness of a community of interests at this sphere, and the desire of citizens to participate in the management of their affairs. Hence the region appeared in the debates on decentralisation as the most appropriate sphere where reinforcement of institutions, and the coordination and coherence of actions could be ensured. Regions are the sub-national jurisdictions, which in recent years, have become the principal focus of economic development, and the most fitting administrators of public equipment (Bonnal 2005:5).

Heywood (1996:131) states that devolution is the transfer of power from central government to subordinate regional institutions (to 'devolve' means to pass powers or duties down from a higher authority to a lower one). Devolved bodies thus constitute an immediate sphere of government between central and local governments. However, devolution differs from federalism in that, although their territorial jurisdiction may be similar, devolved bodies have no share in sovereignty; their responsibilities and

powers are derived from, and are conferred by, the centre. In its weakest form, that of administrative devolution, it implies only that regional institutions implement policies decided at central institutions. In the form of legislative devolution (sometimes called 'home rule'), devolution involves the establishment of elected regional assemblies invested with policy-making responsibilities and a measure of fiscal independence.

Devolution, like de-concentration, is one form of geographic decentralisation, but unlike de-concentration, involves the legal transference of authority by a central institution to sub-units of the institution to execute specified activities. It is the transfer of important decision-making sovereignty to lower spheres of government (Görgen *et al.* 2004:42). Entailed in devolution is the inter-organisational transfer of authority to geographic units of local government outside the command of central or provincial government. Devolution is characterised, among others, by units having clear and legally recognised geographical boundaries over which to exercise authority and within which to perform public activities. A serious intention, by the centre, of granting authority and independence to the unit should exist, together with not having the unit under direct central control (Mutahaba 1989:72).

Khosa (1999:18) claims that in line with the South African Government's decentralisation policies, and the provisions of the Constitution of the Republic of South Africa, 1996, in respect of the devolution of responsibilities to the provincial government and to local government, the Department of Health has adopted the District Health System (DHS) as a means for the provision of primary health care services in the country.

Collins (1989:168) argues that decentralisation in itself does not guarantee that service rendering will be more responsive to local health needs; elite groups are just as likely to pursue their own interests as central sphere officials and politicians. Moreover, decentralisation can be used by governments to strengthen social and political hierarchies of power within their countries. Devolution often includes a degree of dependence on locally-generated revenue. As some areas are wealthier than others, benefits from improved health care by decentralisation will to some extent depend on where people live.

The legal transfer of power to locally elected political bodies (local government) that are substantially independent of the national sphere in respect of a defined set of functions (Mills *et al.* 1990:160; Conyers 1981:109) are rarely 'completely autonomous' but are bodies largely independent of the national government in their areas of responsibility, for example, raising revenue and staff appointments. The policy function is usually the only function retained centrally.

4.3.3 Delegation

Delegation involves the transfer of managerial responsibility for defined functions to the organisations that are outside the central government structure and only indirectly controlled by the Ministry of Health (MOH). Ultimate responsibility remains with the MOH, but its agent has broad discretion to carry out its specified functions and duties (Mills *et al.* 1990:173). The exact managerial and funding relationships vary, but all day-to-day executive decisions are given to the institutions.

Robins (1976:229) argues that delegation is the means for granting authority downward to subordinate administrators, thereby giving them both certain rights and providing certain prescribed limits for them within which to operate. Included in delegation are assigning duties to subordinates, transferring commensurate authority that enables the subordinates to execute the duties and acceptance of accountability for the performance of these functions by subordinates. The responsibility for the delegated activities remains with the superior delegating the authority. Among the requirements for successful delegation is the superior's confidence in the subordinates' abilities and conscientiousness in the execution of activities.

According to Thornhill (1985:61) delegation, in relation to geographical decentralisation, is a process by which units of an organisation are allocated activities that contribute to the realisation of objectives of an organisation. Such units are vested with appropriate authority to act and decide about the activities they perform. Units conferred with this authority should be staffed with competent workers, in terms of experience and qualification, to perform the allocated activities. Adequate discretion and independence of action to employ own methods in the performance of the activities, subject to formal procedures of the organisation, should be given to the units.

The inability to delegate effectively is not necessarily an issue of a project manager's confidence in his or her employees; rather, it points to a difficulty in the project manager's ability to let go of old tasks in which he or she had been successful in the past. Managing an entire project creates a gulf between the manager and the ability to see a direct result of his or her work, for this reason some are tempted to get back into the old, hands-on activities that were so fulfilling. Delegation does in some ways remove the

project manager from directly observable results. It throws him or her into a sort of "no-man's-land" where everything is in limbo until a milestone is reached or the project is completed – sometimes two months later, sometimes two years later. Effective delegation does not mean that everything should be handed to everyone who happens to be willing (Ghattas & McKee 2001:59).

Van der Waldt and du Toit (2003:191) assert that delegation in the public sector can be described as the yielding of authority by a person in authority to a subordinate so that the latter can act independently, within limits. Provincial governments can therefore devolve their authority to local governments to perform certain functions on behalf of the provincial legislature. This means that responsibility can be delegated, but not liability. There should be fixed procedures for performing functions and clear, formal instructions for delegation so that every institution knows the associated powers and duties.

Delegation refers to transfer of functions and responsibility to the local sphere to achieve greater efficiency by increasing cost control, flexibility and responsiveness. The ultimate responsibility remains with the central government, but its agents have broad discretion to execute its specific functions and duties. In the health field, delegation has, for example been used to manage teaching at hospitals. Delegation has also been used to organise the provision of medical care financed by social insurance. Delegation is not compatible with de-concentration. If the management of entire national health services is delegated to a separate organisation, the role of the ministry of health would be confined to strategic and policy issues (Cloete & Wissink 2005:167).

Kelly (1980:56) describes delegation as the assignment of authority by a manager to subordinates, while the manager retains responsibility. A subordinate is allocated sufficient autonomy to plan and direct the activities of his or her unit through delegation. Delegation is undertaken in instances when a superior has more work to do than can personally be performed. The delegated authority should clearly be defined to avoid any misunderstanding between the superior and subordinate as to the degree of authority delegated by one to the other. Hence, Görgen *et al.* (2004:42) argue that delegation is the transfer of managerial responsibilities of government to an independent controlling body, such as a non-governmental organisation (NGO). The purpose for the delegation of administrative power is to facilitate the division of labour, since very often administrators and administrative bodies simply cannot cope with the practical execution of all their administrative functions. It is, however, a primary rule of administrative law that a discretionary power may not be delegated to another body or person in the absence of express or implied statutory authority (Burns 2003:164).

4.3.4 Privatisation

According to Baer (2005:1), privatisation denotes the transfer of government functions to NGOs or the private sector. It involves the transfer of government functions to voluntary organisations or to private profit-making or non-profit making organisations, with a variable degree of government regulations. Since many governments cannot afford any major expansion of health services or even maintain existing services, they need to seek alternative sources of financing and service provision. Financing mechanisms may include free service provision by non-governmental organisations, indirect or third party payment in the form of various

insurance schemes, or increased direct consumer payment or 'cost-recovery' (though with substantial public funding), while the options for service provision may involve non-governmental and voluntary organisations providing services or greater reliance in the private sector (Baer 2005:2).

Van der Waldt *et al.* (2002:8) affirm that an important objective of government is to expand the general economic welfare. In South Africa, a major debate took place on how government could best achieve this goal. When the current government of South Africa came into power in 1994 there was a strong indication and much speculation that it would nationalise all or most public enterprises. This would have meant that most public enterprises would have been state owned and monopolistic in nature. However, the government adopted a strategy of privatisation to enhance economic development and encourage investment in the country. Although government is not advocating complete privatisation (selling) of state assets, it has made provision for alternative forms of service rendering to ensure that excess government spending is reduced whilst at the same time promoting the effective and efficient utilisation of existing financial resources.

Gilson and Mills (1995:184) argue that privatisation implies that mainly voluntary organisations, not for profit private organisations and missions providing services on behalf of government.

The aforementioned forms of decentralisation are useful for identifying the institutional location of the newly-transferred powers; however, it tells little about the crucial aspect of decentralisation; namely, the range of choice that is granted to the decision-makers at the decentralised spheres.

Decentralisation is often considered a once-off event to transfer power at one time and in one quantity to the new institution allocations. That may not be true in most settings because variations and changes do occur over time in the process of decentralisation. In fact, decentralisation is a dynamic relationship of changing powers between the centre and the periphery. In practice, these different forms of decentralisation are used at the same time for different functions and may not necessarily be found in their pure form.

4.4 Relationship between decentralisation of health services, democracy and effective governance at the local sphere of government

Bonnal (2005:1) states that decentralisation has kept its promise so far as the strengthening of democracy at the national level is concerned, as well as at the central government's commitment in favour of rural development. It has thus contributed toward moving away from the bias toward urban areas in matters of development; to improve the management of the coordination of integrated rural development projects, and ensuring their sustainability. Decentralisation has also reduced poverty which results from regional disparities, by paying more attention to the attendant socio-economic factors, in facilitating the gradual increase in development efforts, and the promotion of cooperation between the government and NGOs, while increasing transparency, accountability, and the response capacity of institutions.

The will of the relevant political participants at the national sphere and at the provincial and local spheres to go ahead with decentralisation and taking actions for appropriate policy and legislative changes for orderly

transfer of power is the key prerequisite to decentralisation. A constitutional and/or legislative framework is needed to reinforce the legitimacy of the political decision and commitment for reform and to provide coherence, direction and purpose to the whole exercise. It underscores the primary responsibility of the executive branch of government to take the initiative and the importance of providing a locus of initiative for the reform at an early stage (Gilson & Mills 1995:184).

Local government control offers the advantage of making health services more accountable to the public. Many countries have created full-fledged government systems at the local sphere that have powers and resources to render services. The decentralisation of authority for health system functions and decision-making to local governments is as a result of political, economic and health policy trends. The local government, within the health sector, may have the responsibility for the provision of basic health care and preventive and public health programmes in addition to healthy living: basic education, water and sanitation, environment, social care and housing. This gives the health sector managers an opportunity, as a member of the local government management team, to interact with other development partners and incorporate health into all development projects and programmes. The local government also takes more responsibility for indirect health-related functions such as citizens' rights and obligations, enforcing and maintaining standards (Pillay 2004:5).

Pillay (2004:13) adds further that provincial health departments have a critical influence in the future path of decentralisation. They must re-assess how to work with local government and also with their own facility networks. Acting responsibly towards lower spheres begins from the understanding that all spheres have different functions and must work

together to support service provision. Protecting the quality of service provision requires a careful combination of central guidelines and space for local sphere innovation. Managers at lower levels must receive support that enables them to become problem-solvers.

In its democratic political aspect, decentralisation as currently conceived and increasingly practiced in the international development community has two principal components: participation and accountability. Accountability, as one of the tenets of democracy, is the degree to which local governments have to explain or justify what they have done or failed to do. Improved information about local needs and preferences is one of the theoretical advantages of decentralisation, but there is no guarantee that leaders will actually act on these preferences unless they feel some sort of accountability to citizens (Litvack 2005:1).

As alluded to earlier in the text, decentralisation and democracy enables government to come closer to the people it serves; it create a platform for participation, thus enhancing accountability and transparency. Governments compete for citizen support, and become more responsive to the needs of the people. Local government is a mechanism via which all democratic endeavours are realised.

4.5 Conclusion

Decentralisation of the health sector is concerned with changing the way health systems are organised. Conceptually, it is a change in power relations between central government level and other participants in the health system, including statutory local government entities, lower levels of

government administration, private enterprises, state-owned enterprises and non-governmental organisations.

Decentralisation should not be an end in itself. Rather it should be the means to accomplish the broader goals of equity, efficiency, quality and access to health care. Generally, two main forces have motivated decentralisation in practice: pressures from within the health sector (technical concerns) and pressures from outside the health sector (political concerns. Decentralisation can take several forms, namely, de-concentration, delegation, devolution and privatisation. It is argued that copying forms of decentralisation between countries, particularly by developing from developed countries, carries high risks of inappropriate transfer. This is not to say that decentralisation policies should not be followed, since they may be important for health systems development and possibly needed to promote democracy in the developing world.

By decentralisation accountability as one of the democratic tenets, can be engendered by local government in response to the community needs and aspirations. Functional integration as the key strategy for full implementation of district health system is deliberated thoroughly in the next chapter.

CHAPTER 5

FUNCTIONAL INTEGRATION: A KEY STRATEGY TOWARDS FULL IMPLEMENTATION OF DISTRICT HEALTH SYSTEM IN THE FREE STATE

5.1 Introduction

A simple departure from the past is the decision of the South African Government to create a unified, but decentralised national health system based on the District Health System (DHS) model. One of the main reasons for this is the belief that the DHS model is deemed to be the most appropriate mechanism for the provision of primary health care. DHS is relevant because it is by means of it that health care needs of every citizen are met. Health districts are supposed to be consistent with the political and administrative boundaries of district municipality so that both health care providers and politicians become accountable to the community they serve.

The National Health Act, 2003 (Act 61 of 2003), provides that the district health plans should be aligned to the integrated development plans (IDPs) of the district municipalities. In South Africa, including the Free State Province, the integration of health services has remained elusive as multiple health authorities continue to function in isolation. Functional integration, therefore, provides a process to improve quality of care as a result of greater integration of the health system. The district health system is a decentralised health care provision system that seeks to provide a comprehensive package of primary health care services to all persons within a defined geographic area.

Having introduced the policy imperatives around functional integration, the researcher will seek to clarify functional integration as a concept so that discussions in the text are viewed in context and understood throughout the study. Key requirements for effective functional integration such as the political and top management vision and leadership, planning and implementation issues are discussed in depth in the following paragraphs.

5.2 Conceptualisation of functional integration

The concept of integration has been the subject of differing interpretations. It can be understood in the sense of the integration of services (functional) in the execution of a programme, in the sense of greater collaboration or indeed a fusion between two programmes (for example, a programme for the control of sexually transmitted diseases and family planning programme), or in the sense of a programme in the package of activities provided by a polyvalent (multi-function) service (Criel *et al.* 1997:3).

In addition, Criel *et al.* (1997:3) argue that health and family planning services are integrated in many different ways, for instance for a director of a private family planning organisation, functional integration might mean adding pre- and post natal and obstetric services to the programme. The Director General of a Department of Health may view functional integration as adding family planning services to the existing programme of health services. A health centre manager in a district clinic may perceive functional integration as holding maternal and child health (MCH) and family planning sessions concurrently, rather than having separate clinics on different days. These are all examples of integrated health services, the common denominator being that two or more types of services previously

provided separately are offered as a single, coordinated, and combined service.

Pinho *et al.* (2000:215) assert that the 1993 World Development Report (WDR) Investing in Health defined a set of health sector reforms (HSR) which were shaped by neo-liberal macro-economic policies; these were introduced into developing countries by the Bretton Woods Institutions since the early 1990s. Implicit within these reforms, was functional integration of primary health care (PHC) services predominantly driven by efficiency.

The move towards functional integration of a primary health care provision system was not unique to the WDR-defined health sector reform. The 1994 International Conference on Population and Development (ICPD) saw 179 countries commit to ensuring sexual and reproductive health among their populations. This commitment was motivated by the conceptualisation of sexual and reproductive health, as elements of primary health care, within a human rights framework, and as forming a fundamental cornerstone of transformative development critical to the eradication of poverty and the realisation of sustainable economic growth (UN Report 1994:4). One of the areas given considerable attention within ICPD Programme of Action (POA) was recognition of the central role of a strong, integrated health system that would sustain sexual and reproductive health care provision, be responsive to local needs, and ensure equity and quality of care.

As outlined earlier in the thesis, the World Health Organisation (WHO) (1996:5-7) states that there is a need to strengthen understanding among advocates and decision-makers of the role of integration, as one of the mechanisms associated with a primary health care programme, in

facilitating or determining district health care provision system. The World Health Organization (WHO) defines integration of health as the process of bringing together common functions within and between organisations to solve common technologies, and resources to achieve these goals. The definition is firmly linked to the development of district health services, implying multi-purpose clinics and staff; integrated programme planning with many objectives; and the inclusion of different levels of health services and other sectors (WHO 1996:5-7). Similarly, Briggs *et al.* (2001:38) define integration as a variety of managerial or operational changes to health services to bring together contributions, organisation, management and provision of particular service functions. Integration aims to improve the service efficiency and quality.

Segall (2003:26) confirms that integrated comprehensive primary health care approach takes on a broader systems approach. Its starting point is a concern for meeting overall health and health-related socio-economic needs. Such an approach is informed by social science, or social epidemiology. As such, it promotes reforms that address not only health inequities, but broader socio-economic issues too, and results in horizontal structures, especially for the district health system. It recognises that health systems should be understood as core social institutions indispensable for reducing poverty and for advancing democratic development and human rights (Unger *et al.* 2003:38).

Freedman *et al.* (2005:20) state that governments should aim for a comprehensive and integrated health system that has adequate capacity to respond efficiently to the needs of the population. The inclusion of vertical programmes within this system, as alluded to above, will depend upon the extent to which such programmes are able to enhance primary health care

without weakening the existing health infrastructure. On the other hand, ensuring comprehensive, integrated health services may require compromises in programme efficiency and cost effectiveness so that the integrity of the social and equity goals is maintained.

There is a need to have a clear understanding of the agenda underpinning actual integration policies. Hence the WHO (1996:15) states that it is possible to identify different forms of integration that have emerged as a response to a number of configurations of both external contextual socio-economic and political factors, as well as of reform processes within the health system. These can broadly be divided into the following three categories:

- Integration of service tasks within a given setting, where the service provided is coherent from the user's perspective (focusing predominantly on integration at point of service).
- Integration at the level of planning, management and support functions.
- Integration of different institutional and organisational components and across sectors as part of a comprehensive health system based on the primary health care approach.

It can thus be submitted that the forms of integration serve as the basis for functional integration. Hence Pillay *et al.* (2003:3) point out that functional integration means structured cooperation and collaboration between provincial and local government health rendering authorities for the purpose of decreasing fragmentation and duplication, enhancing integrated service provision, and increasing efficiency and quality of primary health care. This takes place in the absence of legal, financial and administratively integrated governance and management structures.

Fleury (2005:1) purports that in highly developed countries, in order to enhance the efficiency of health care systems, the search for better practices and new organisational models is an issue. As a result of economic pressures and a succession of failed attempts to enhance services coordination, the concept of integrated service networks has recently emerged as a way of structuring health care, particularly for chronic and complex problems. Coordination and continuity of services is an old preoccupation, but what emerged in the 1990s was the idea of creating a network of services linking autonomous health care and social service providers in a given district to treat specific health problems or clienteles such as serious mental health disorders or the frail elderly. Functional integration, therefore, deals with systems of governance, management, information, resources allocation and evaluation.

In addition, Fleury (2005:2) explains that integration affects all components of a system. It involves restructuring clinical practices for the clientele and the relationships between health professionals, service lines and organisations at different levels of governance: strategic (upper management), tactical (middle management), and operational (staff). The concept of network brings a territorial dimension to the idea of integration, and pertains to the organisation of services for a specific health sector. All organisations involved in a given area and with a targeted clientele will thus be mobilised to coordinate their action. Depending on client and resources volume, networks may serve one or more local districts. Integrated service networks are based on an acknowledgement of considerable inter-dependence among the participants and organisations in a given district and sector of intervention.

Functional integration focuses on how the health provision system functions and thus seeks ways to integrate the services as opposed to integrating the authorities. In this way it is a timely strategy, relevant to the challenges the South African health care system currently faces. In short, it provides integrated primary health care services to the client in the midst of multiple health authority structures (Toomey 2000:13).

As indicated earlier, it is clear that functional integration is able to bring together different functions and activities within and between organisations to address common problems, and meeting shared objectives. It requires a management system that coordinates a number of activities and participants to achieve a common goal; against this background key requirements for effective functional integration are discussed in the paragraphs that follow.

5.3 Key requirements for effective functional integration

Utilising functional integration, the organisations look for ways to enhance how they function, the ways they provide the integrated health care services at one service point and thus making them more accessible to the general populace within a given district. Hence Pillay *et al.* (2003:6) state that there are four key requirements to implement functional integration. The requirements follow the planning cycle, which include the preparation (vision and leadership), planning, implementation and evaluation. These requirements are discussed below.

5.3.1 Political and top management vision and leadership

The Constitution of the Republic of South Africa, 1996, designates the terrain in which the public health service executes its tasks. A reflection on

the macro-organisation of the state must therefore, also seek to understand the role and place of public servants relative to the challenges facing functional integration of primary health care services and the institutional framework in which it has to operate in order to make it possible for health services to be rendered in a seamless manner to the consumers of goods and services (Mufamadi 2005:4).

Mufamadi (2005:4) states further that while each one of the three spheres of government has its own mandate and scope of operation, they have the joint responsibility for provision of health services; all three spheres of government serve in unison only one citizen. In other words, the distinctive functions of each sphere must fuse with the functions of the other two spheres in order to provide integrated and coherent government for the country as a whole. Inadequate inter-sphere coordination and integration have tended to enfeeble growth and development, including health care provision.

In the light of the above, there is a need for strong commitment from both the political and administrative leadership to support provincial and local government in an endeavour to give practical effect to those functional integration policies; provinces and municipalities are the spheres that actually render primary health care services to the people. As it were, the spheres carry the main weight of expenditure budgets that are spent on providing education, social grants, public health services, transport infrastructure, access to basic levels of water, sanitation and electricity.

Furthermore, Al-khuzayem *et al.* (1997:229) argue that in Asir, Saudi Arabia, a restructuring of the health care system in the early 1991 was the basis of integration. The authority of the peripheral health areas, their

responsibilities and their relationship with the regional health administration at Asir General Directorate of Health Affairs were defined. Asir was divided into 14 integrated health areas. The division was based on demographic, social, economic and geographic criteria and also regarding the ease of communication and transport. The director of the district hospital is also the director of the primary health care centres which refer to the district hospital.

Conferences, meetings and seminars were held on the concept of functional integration of health services in Asir for all health workers in the integrated health areas to explain the new approach. A problem that arose early was the opposition by some senior staff members to delegating their authority to staff in the peripheries. Initially staff at the integrated health areas was not clear about their responsibilities and relations within the system. Therefore, the technical department in Asir General Directorate of Health Affairs launched in-service training to help overcome some of these inadequacies (Al-khuzayem *et al.* 1997: 30).

Toomey (2000:23) notes that in the current environment of transition in South Africa, change processes must be pursued concurrently from 'top down' and from 'bottom up'. Employees (for example PHC nurses) need both professional security of knowing that management has authorised the change process, and the social and political security of knowing that the participants have all been consulted and are supportive of the change process. Until employees are assured that both consultations and authorisations have occurred, they will regard the change process as too 'risky' to engage in and will exhibit avoidance behaviour towards the change process itself.

Pillay *et al.* (2003:6) state that senior politicians in the provinces and municipalities must instruct their managers to proceed with functional integration, and the senior managers must have a clear vision of what they want to achieve and how they intend achieving it. At the political level, functional integration needs to be debated and a way forward agreed to at the Provincial Health Authority as stipulated by the National Health Act, 2003 (Act 61 of 2003). In each province this body should provide the vision and leadership and monitor progress made in the implementation of functional integration.

Once agreement has been reached at the Provincial Health Authority, the Member of the Executive Council (MEC) for Health and the municipal councils via the mayors must instruct their managers to implement whatever decision has been reached. This is best done by each district, the District Health Council as provided for in Act 61 of 2003, is designed as a structure to facilitate a cooperative role in facilitating functional integration. It can also get insights into the health needs of communities from clinic committees, other community representatives and non-governmental organisations (Pillay *et al.* 2003:6).

From the aforementioned, it can be inferred that functional integration plans should be a combination of a top down and bottom up approach in that there should be leadership and commitment from the top as well as buy-in to the concept of functional integration by all management and staff. In particular, the frontline staff expected to implement functional integration should be consulted about plans and motivated and supported in their efforts. It is for this reason that planning is vital for the implementation of functional integration.

5.3.2 Planning functional integration

The integration of various policy and programme components may occur in varying degrees at the national, provincial, district, local and other administrative levels. The administrative and functional integration are not mutually exclusive; attempts to integrate services without an effective administrative structure (integrated or not integrated at the various levels) may be counter-productive (Pratt *et al.* 1989:23; Simmons *et al.* 1990:187-188; Michell *et al.* 1994:10). The relationship between administrative and functional integration is complex, and undertaking primary health care provision requires an improved understanding of the conceptual and practical linkages between administration in relation to planning and service rendering to use a limited pool of resources.

Bruce (1994:152) suggests that in planning functional integration, service integration might involve the linkage of several provider functions at the service provision point and would require modification of worker roles, allocation of time and referral requirements. Programme planners must therefore consider the extent to which administrative integration will occur at the provincial, district and local spheres. Potential issues include staff inter-action or consolidation, streamlining of records systems, and salary adjustment.

At the centre of functional integration planning is the acknowledgement to address issues of equity and improving quality of care, a systems approach is required, recognising that many health problems cannot be addressed by means of health 'interventions' alone. Within a health context the concept of 'intervention' often gives the impression of reality that can be isolated and 'intervened in', favouring individual interventions and measured by

specific health outcomes. This leaves aside the complex dynamics at a community level that can only be understood and addressed by the development of a common understanding of the problem across sectors, and of coordinated responses to the problems identified (Weller *et al.* 2003:67)

Al-khawashky (2000:750) asserts that integration of health resources, whether technical or financial, depends to a large extent on the adoption of a strict national policy and mechanism that involves and coordinates nationally generated and internationally donated resources for health and other health-related sectors. Such integration should start at the national planning phase through a multi-sector health related structure, and be directed to achieve the set targets of the national health plan in a complementary fashion. The technical or financial role of all national partners concerned should be defined, taking into consideration the envisaged or committed resources of the UN as well as bi-lateral, international or multi-lateral agencies and non-governmental organisations.

People need to understand the larger context within which a change process operates. A lesson demonstrated during the planning phase is that people need to know that the project is in essence in the implementation of the functional integration as provided for by the National Health Act, 2003 (Act 61 of 2003) and primary health care approach, as well as by the political will that these policies represent, is necessary for effective change. Accordingly, it is a significant support to the change process of functional integration when national and provincial policies can be presented by health authorities (Toomey 2000:24).

Based on the above discussion, Tambouris and Spanos (2004:281) believe that integration of health services has many dimensions and different

aspects including organisational, technical, societal and legal factors that must be considered whenever related changes are to be effected. Integrated health services are not just a theoretical concept, but they respond to a very real public concern – they wish to see joint health services that allow the people to receive a seamless service rather than being shunted from 'pillar to post'.

In South Africa, the transformation and restructuring of the public service is still a major challenge facing the country. First, it is the public service, especially in a developmental state, whose features are very similar to those of contemporary South Africa, which has to spearhead development and help the country to advance towards the next successful decade of democracy. However, for such a public service to provide uninterrupted health services to the citizens, it has to systematically be integrated to ensure synergy and proper coordination of government affairs and provision of public health goods and services (Maphunye, 2005).

Pillay *et al.* (2003:7) claim that planning should be done to ensure that operational plans for functional integration are developed and implemented appropriately. Joint planning should involve a rapid appraisal of areas of strengths and weaknesses (areas of possible collaboration, cooperation, integration of services), identification of duplication and overlaps and gaps. A service provision plan using the primary health care (PHC) package as the basis should be developed and gaps and overlaps identified. The aim should be to provide the full PHC package as listed in the PHC Norms and Standards Publication produced by National Department of Health.

The most significant accomplishments of the planning phase are the identification of and consensus regarding project initiatives and the initial

strategic plans for these initiatives. The initial strategic plans, in turn, guided the implementation process in the second phase of the project (Toomey 2000:25). Once appraisal is done of provincial and local government services, this information can be used to draw up a joint district health plan for service provision (this plan should also inform the development of the integrate development plans (IDPs) of municipalities). This plan will then guide the activities of the joint management teams and set the indicators that will be measured (Pillay *et al.* 2003:7).

Having identified functional integration initiatives in the planning phase, actions are highlighted during the implementation phase as described in the following paragraphs.

5.3.3 Implementation issues

Uppermost on the agenda of the South African Government for the on-going social and economic upliftment and transformation of society is improvement in the provision of integrated health services in a given district to the people of South Africa. Currently provision is hampered by weaknesses in numerous areas, including, among others, national frameworks and policies that do not extend to local government in the areas of service rendering and public health administration and management and marked differences in remuneration and conditions of service in the public health service and local government which make mobility and transfer of functions difficult. It is against this background that the government of the day has introduced a Single Public Service as a measure that seeks to ensure greater alignment across the three spheres of government in the areas of human resource management and development, and service rendering (Fraser-Moleketi, 2008:6).

Furthermore, Fraser-Moleketi (2008:6) purports that the Single Public Service is an initiative to harmonise the conditions of services across government, so that the government is able to work better in the pursuit of integrated health care provision. Health workers and health managers within a given district must all know who is responsible for doing what.

Pillay *et al.* (2003:7) and Toomey (2000:29) emphasise that key in the implementation phase of functional integration is the formation of joint management structures, from both the provincial and local government, to facilitate operational planning and the implementation of functional integration. These teams should have clear terms of reference which gives guidance as to processes and procedures to be followed to make local agreements. The process should be led by managers who are skilled leaders, who can negotiate complex changes and who can be pro-active with problem solving, these managers will need support and guidance from senior provincial and local government managers in a variety of ways, including leading by example, which means there should be good cooperation between provincial and local government at senior management level.

In making functional integration realisable, the facilitator assists the strategic teams to translate the planning efforts of the planning phase into tangible, achievable action steps that could then be undertaken in the implementation phase. As in the planning phase, the significant activities of the implementation phase are monthly meetings of each strategic team focusing solely on their particular functional integration effort as well as on joint meetings of all strategic teams to report back and 'cross pollinate' ideas and requires intensive communication in the form of project updates at regular district meetings (Toomey 2000:30).

Funding the district health services will come from both provincial and local government. At present, these two sources have different financial years. What is important is that joint planning is linked to budgeting that can support the plans and interventions. This will require joint consultation on budget and joint management (Pillay *et al.* 2003:8).

Based on the above analysis, it can be asserted that functional integration is not an end in itself, but a process in the development of a district health system. Experience has shown that unless key requirements are in place, problems that arise can be tackled in a systematic manner.

5.4 Conclusion

Functional integration is a change management strategy that is tailored to the current South African health environment. Nurses on the ground effect significant changes in the rendering of primary health care if encouraged to do so and provided with a structured 'safe' process.

The district model for functional integration of primary health care services demonstrates the necessity to build relationships, communicate, consult and negotiate before productive planning can really begin. It is evident that senior management support from all health authorities involved is essential for successful functional integration.

Functional integration is ultimately about relationship building between the various health authorities which in turn leads to open dialogue, problem identification and cross-authority negotiations around changes required for improved provision of primary health care services. It is a key strategy for the achievement of decentralisation necessary for district development.

Functional integration focuses on how the health provision system functions and thus seeks ways to integrate the services as opposed to integrating the authorities. Key requirements such as proper planning, implementation and evaluation are central to the effective functional integration. Once the nature and extent of functional integration have been realised, it would then become relevant that mechanisms for delegation of primary health care services to local government for efficiency, effectiveness and accountability are being investigated in the chapter that follows.

CHAPTER 6

DELEGATION: A TOOL FOR EFFICIENCY, EFFECTIVENESS AND ACCOUNTABILITY

6.1 Introduction

Delegation is a more extensive form of decentralization. By delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous public institutions not wholly controlled by the central government, although ultimately accountable to it. Governments delegate responsibilities when they create public enterprises or corporations, health authorities, housing authorities, transportation authorities, special service districts, semi-autonomous school districts, regional development corporations, or special project implementation units. Usually these public institutions have a great deal of discretion in decision-making. They may be exempted from constraints on regular civil service personnel and may be able to charge users directly for services.

This chapter commences with a synopsis of conceptualising delegation in respect of health services. The chapter goes on to outline the rationale of delegating health services to local government and also deliberating on the advantages and disadvantages of delegating health services to local government. Finally the chapter concludes with a summary of elements inherent in delegating health services to local government. These aspects are discussed in the paragraphs that follow.

6.2 Conceptualisation of delegation

As one form of decentralisation, delegation of health services is a pervasive global trend that seeks to enhance client responsiveness, administrative efficiency and improved service access, especially at the local sphere of government. Within the context of decentralisation, delegation can be defined as changing relations within and between a variety of organisational structures or bodies, resulting in the transfer of authority to plan, make decisions or manage public functions from the national level to any organisation or agency at the sub-national level. Other frequently cited forms of decentralisation such as de-concentration, devolution and privatisation were discussed fully in the preceding chapters (Collins 1989:168-171).

Usually decentralisation is seen as a process in which the authority, resources, and functions are transferred from central government agencies to other institutions at the periphery of the national system with decision-making largely vested with the people. Hence, the World Health Organisation, (WHO) (1996:7) confirms that delegation refers to the transfer of functions and responsibility to the local level to achieve greater efficiency by increasing cost control, flexibility and responsiveness. The ultimate responsibility remains with the central government, but its agents have broad discretion to execute its specific functions and duties. In the health field, delegation has been used, for example, to manage teaching hospitals, for example. Delegation has also been used to organise the provision of medical care financed by social insurance. Delegation is not compatible with de-concentration. If the management of entire national health services is delegated to a separate organisation, the role of the

ministry of health would be confirmed to strategic and policy issues (WHO 1996:7).

To emphasise what has been cited above, Rakich *et al.* (1992:214) claim that another important contemporary development in the concept of authority and responsibility pertains to delegation. Almost without exception classicists (for example, Frederick Taylor, Henri Fayol and Max Weber) thought decisions should be made at the lowest possible sphere in government and that this was compatible with good decisions. This means top management should not make decisions on routine matters that could be handled at a lower sphere. The theory of delegation was first expounded by classicists. It is now considered an integral part of the question of how centralised or decentralised decision-making in government and in public organisations should take place. Decentralisation is closely related to delegation, but it is more; it is also a philosophy of organisation and management.

According to Pimstone (1998:7), given its constitutional responsibilities relative to those of a lower sphere of government, the central government is still constitutionally and legally strong. It is within the internal operations of the cooperative governance model, where the central government dominates, determining policy, finance and administration of the health system. However, because of the complex public health policy role of the central government, it does not mean that an analysis of delegated cooperative governance of the public health system is entirely dependent on the political and governance system; it also hinges on the patterns of the delegation and organisation of a health system.

The South African decentralised public health and finance systems also reflect extensive a-symmetry between responsibilities and expenditure assignment on the one side, and own revenue on the other. This has resulted in a severe fiscal gap for the provincial governments, which are the main deliverers of public services, such as public health. The researcher is of the view that the a-symmetrical arrangements in the public finance system within South Africa, and the Free State in particular, are primarily determined by political and macro-economic policy considerations. The contention is, therefore, that the provincial government's key concern will be its ability to: maintain and macro-manage public health policy implementation through norms and standards; manage the macro-economic and fiscal policy processes and their implementation; and ensure uniform levels of decentralised public health administration. An a-symmetric approach would, therefore, allow the central government either to delegate (accountability still rests with central government) or devolve (provinces become responsible and accountable) certain competencies to certain provinces that have the capacities to provide a full range or some parts of public health services such as primary health care (PHC) services. In the same breath the provincial department of health can thus also be in the position either to delegate or devolve health services to the local sphere of government (guided by the level of capacity to provide either a full range or parts of public health services). Clearly, such a practice allows both central and provincial government to distinguish between strong and weaker municipalities and assess which functions ought to be delegated or devolved to municipalities (Dillinger & Fay 1999:26).

The delegation of public health policy and implementation is further complicated by a set of principal-agent relationships between the provincial and local governments. According to Burki *et al.* (1999:22), it is within this

set of relationships that municipalities act both as agents of higher spheres of government and principals (or more precisely as agents of their own constituents) in the provision of local services. In this relationship central and provincial government has acted as the principal of policies, but also determining the norms and standards against which provision and efficiency are measured, including resource allocations (Plaatjies 2008:62-63).

Based on the above analysis, Barte and Uys (2002:141) argue that delegation, as one form of decentralisation, is the cornerstone of a health reform initiative, particularly in a multi-party democratic state such as the Republic of South Africa. Any changes or reforms (political ideology) brought about to the system of government in a country invariably have an effect on the political system, structure, functions and finance of the various levels of government. The said criteria are thus interrelated. Delegation of health services has been a major theme of governance in recent decades.

Decentralisation, in the form of delegation, by placing government closer to the people, fosters greater responsiveness from policy-makers to the will of the citizenry which results in a closer congruence between public preferences and public policy. This is not only because decision-makers in decentralised health units are likely to be more knowledgeable about and attuned to the needs of their areas than are centralised national government decision-makers, but also because delegation permits these decision-makers to be held directly accountable to the local citizens by means of local elections (Wolman 1990:32).

Wolman (1990:34) and Smith (1985:5) add that delegation is desirable because by delegating health services to the local sphere of government will elicit interest from the local community to participate in all decisions that

affect how health services are rendered. By participating in decisions that are geared towards healthcare provision, anchor citizens to the political system and thus enhancing democratic values. Delegation of health services to the local sphere of government also engenders political education and debate: a prerequisite for the opportunity for citizens at the local level to define, discuss and decide upon the health problems facing their area.

Furthermore, Gildenhuys (2004:7) notes that the Public Finance Management Act, 1999, provides that no government institution, minister, public administrator, or any other civil servant may do anything without being authorised to do so. In a liberal democracy the primary authority is vested in the registered voters. Where the rule of law prevails, the Constitution of the Republic of South Africa, 1996, theoretically approved by the voters, constitutes the highest authority. It has already been explained that the mandate or command is the simplest form of delegation. In such cases the legislature decides and commands a government department to be established for executing the policies contained in the relevant law (Gidenhuys 2004:9).

White (1959: 23) states that it is generally accepted that it is impossible to standardise the word delegation, however, as another form of decentralisation, the word has a certain connotation, namely the presence of a function at the centre that may be dispersed, that is 'away from the centre'. While decentralisation denotes 'transference of authority, legislative, judicial or administrative, from the higher sphere of government to a lower sphere', delegation denotes transferring responsibility for specifically defined functions (e.g. health services) to organisations that are outside the regular bureaucratic structure (e.g. district municipality) and are

only indirectly controlled by the central government or provincial government (Meenakshisundaram 1994:11).

From the foregoing, Mayhood (1993:1) submits that most individuals and governments favour the concept of delegation because it implies the unblocking of an inert central bureaucracy, addressing managerial inefficiency, giving more direct access to the people, and thus stimulating the whole nation to participate in national and provincial development plans. In summary, the Constitution of Republic of South Africa, 1996, provides for an extremely decentralised political system. Strong powers are entrenched at the provincial and local spheres, indicating a potentially effective implementation system if the institutional capacity of lower spheres can be strengthened (Cloete 1999:324).

Rondinelli (1983:188) adds that delegation is about the transfer of authority and responsibility to semi-autonomous agencies not directly under the control of central government. Delegation is about the transfer of functions to regions or functional development authorities, state-owned enterprises, or special project implementation units that often operate free of central government regulations (concerning personnel, recruitment, and procurement) and that act as an agent for the state in performing prescribed functions with the ultimate responsibility for them remaining with the central or provincial government.

The transfer of functions to different entities, which act as agents, explicitly sets the functional and structural context of the principal- agent relationship. The agent according to Rondinelli (1983:190) acts on prescribed delegated functions with overall control over the function still that of central government. This form of decentralisation (delegation) requires a vertical

dissection at the central level itself and the formation of separate and possibly parallel hierarchies within the public health sector (Collins 1994:79). Collins (1994:79) also refers to this type of decentralisation (delegation) as a system of indirect administration as there is no direct supervision of the agency.

From the aforementioned, Paton (1996:32) argues that delegation involves the transfer of managerial responsibility for defined functions to organisations (often termed state-owned enterprises) that are outside the central government structure and only indirectly controlled by central government management, of increasing cost control, and of setting up an organisation that is responsive and flexible. The ultimate responsibility remains with the central government or provincial government in the case of Free State Province, but its agent (district municipalities) has broad discretion to execute its specified functions and duties. Delegation has been used, for example, in large scale agriculture activities (e.g. infrastructure projects and hydro-electric schemes). In the field of health, delegation has been used to manage teaching hospitals, for instance, in both the Republic of Tanzania and Zambia, the teaching hospital is organised as a state-owned enterprise institution with its own board of management, and loosely responsible to the Ministry of Health (Galbraith 1992:88).

Various factors play a role in determining allocation of services to be rendered to the community. Some services must be provided as close to the community as is possible while others do not necessarily have to be close. According to Thornhill and Hanekom (1995:169) the provision of public health services implies authoritative decision-making on what services are to be rendered on which geographical area, what particular services ought to be rendered at which sphere of government and, what public institution is

responsible for rendering what particular service. It is against this background that a synopsis of a rationale of delegating health services to district municipalities is discussed in the paragraphs that follow.

6.3 Rationale for delegating health services to local government

Primary health care (PHC) was internationally accepted in 1978 as the preferred system for health care. It is defined in the Declaration of Alma Ata and includes essential care, which is appropriate, available and affordable to the community and the country. It is health care provided as close to the community as possible with full participation by the community. It forms part of the national health system. In 1986 the World Health Organisation declared that the most appropriate means for the provision of PHC is the district health system (DHS). The DHS is based on a defined geographical area with a defined population and includes all health care services within that area (Versteeg *et al.* 2009:6)

Versteeg *et al.* (2009:6) state that the PHC approach for health care was re-affirmed in 2008, the 30th anniversary of the signing of the Declaration of Alma Ata. The World Health Assembly in May 2009 endorsed this by stating, *"...[we] strongly reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multi-sectoral action, decentralisation and community participation as the basis for strengthening health systems"*. Following the democratic elections of 1994, South Africa adopted primary health care (PHC) via the district health system (DHS) as the basis for the national health system. All health policies and legislation since then have affirmed this approach. A decentralised approach is favoured and ultimately for the services to be rendered by a municipal based DHS, under one management

authority. To attain this has been a difficult and long road as fragmentation of the services had to be overcome before the new system could be established.

The Constitution of the Republic of South Africa, 1996 designates national and provincial government as responsible for health care and local government as responsible for municipal health services (MHS), but does not define these two competencies. The Constitution requires, in terms of Section 156(4), provinces to assign to local government any competence where there is capacity and willingness to render the service, this includes health service.

There have been long delays in finalising health legislation to support the policy direction of PHC and the DHS. The concurrent development of local government legislation influenced decisions made in health policy implementation. The White Paper for the Transformation of Health Services, 1997 guided the National Health Minister and Members of Executive Council (MinMEC) and in 2002 the MinMEC decided that the district and metropolitan municipalities would be the level at which the DHS would be developed. Uncertainty around the definition of MHS continued until the National Health Act, 2003 (Act 61 of 2003) confirmed a minimalistic definition of some elements of environment health. This meant that the balance of PHC services remained the responsibility of the provincial government.

At the time there was a move towards decentralising PHC to metropolitan and some district municipalities who were already rendering the services. However, fragmentation of the services remained. In 2005 the National Health Council (NHC), which had been set up in terms of the provisions of

the Act 61 of 2003 took the decision to take all PHC services to the provincial sphere. This decision was taken in the interest of bringing the services under one authority, the province, and consolidating the services until 2015 when the decision would be reviewed. The plan for 2015 is to delegate or assign PHC functions to municipalities which have the capacity and willingness to provide the services. This delegation or assignment is to be in terms of signed Service Level Agreements between the province and the municipality concerned. The decision was accepted and endorsed by Provincial Health Councils and other relevant bodies.

6.3.1 Legal Implications

It should be noted that delegation of health services from a higher sphere of government to a lower sphere of government is to be guided by the provisions of various legislation relevant to health service rendering. These legislative frameworks are discussed in the paragraphs that follow.

6.3.1.1Functions and Powers

Municipal health services, in keeping with the developmental mandate of local government, are listed as a Schedule 4B function in the Constitution of the Republic of South Africa, 1996. It therefore follows that local government has full executive and legislative authority over this function (section 156(1) and (2)) of the Constitution, 1996. The manner in which functions are currently listed in the Schedules to the Constitution, however, sheds very little light on what these functions practically entail. Overlapping powers and functions have in the past led to duplication, inefficiencies and in certain instances, turf battles between provincial departments and municipalities (Steytler & Fessha 2007:320–338)

Furthermore, Steytler and Fessha (2007:338) add that given the importance of health care as an essential service and constitutionally entrenched right, confusion and unclear mandates in respect of the rendering of this function can be ill-afforded. The negative effect of uncertainty in respect of which sphere of government is responsible for providing personal primary health care threatens to undo some of the gains achieved in the health sector in post-apartheid South Africa.

The National Health Act, 2003 (Act 61 of 2003) defines municipal health services as all aspects of environment health such as water quality monitoring, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases (excluding immunisations), vector control, environmental pollution control, disposable of the dead and chemical safety. It appears that the above definition excludes the personal health aspects of primary health care (PHC). This interpretation is in keeping with the executive policy decisions and frameworks that preceded the promulgation of Act 61 of 2003.

6.3.2 Judicial interpretation

In the case of *Independent Municipal and Allied Workers Union and Others versus President of the RSA and Others* 3298/2006 it was argued that the definition of municipal health care in section 1 of National Health Act, 2003 (Act 61 of 2003) is unconstitutional because it does not include "primary health care services" which were an integral component of municipal health care prior to the enactment of Act 61 of 2003.

The Court examined the current definition to determine whether it has the effect of limiting municipal health services to what the applicants

considered to be the "narrow" function of environmental health services. In examining this definition, the Court placed particular emphasis on the expansive use of the word "includes". The Court therefore found that the list of functions in the definition in National Health Act, 2003 (Act 61 of 2003) is by no means a closed list, but is rather inclusive of primary health care services.

It is important to note that the Act 61 of 2003 does not create watersheds between primary health care and municipal health care. While it defines municipal health care it does not explicitly define primary health services as being a Schedule 4A function. This left the door open for the Court to conclude that primary health care may in fact form part of municipal health care. If the Act 61of 2003 had specifically defined primary health care as part of the Schedule 4A competence, the Court would not have been able to reach this conclusion.

The Court furthermore looked at the transitional arrangements that were contemplated by the National Health Act, 2003 (Act 61 of 2003). Section 34 of the Act 61 of 2003 provides that:

- Until a service agreement contemplated in section 32 (3) is concluded, municipalities must continue to provide, within the resources available to them, the health services that they were providing in the year before National Health Act 61 of 2003 took effect.

On the basis of section 34 and the definition in the Act for municipal health services the Court made a declaratory order to the effect that:

- Municipal health services within the meaning of section 1 of the Act 61 of 2003 includes health services ordinarily provided by municipalities at the time the Act came into operation.

While this judgment confirms that the definition of municipal health services in Act 61 of 2003 includes "primary health care" it appears to give and take with the same hand. Despite the fact that the content of "municipal health services" is now certain, strangely, the Court continues to approve the removal of authority and resources related to primary health care from municipalities to provinces. The position of the Court is thus that:

- Municipalities have the authority over primary health care and;
- National and provincial health governments have the power to remove that authority from municipalities.

The judgment therefore provides very little certainty in respect to how municipalities should approach this function. This judicial interpretation of the function however, remains unchallenged. Practically, it means that those municipalities, who are in favour of retaining personal primary health care, have an opportunity to challenge an attempt by provincial government to take the function away.

6.3.3 Assignment of primary health care

If the interpretation of the court is accepted that municipalities are entitled to provision PHC as part of their original function and power as listed in Schedule 4B, it creates a legal misnomer to engage in discussions around the assignment of the function. It is unnecessary for an original power to be assigned to municipalities by way of service level agreements or memorandums of understanding. Municipalities should have executive and legislative authority in respect of this function and should be able to fund the function by means of own revenue and its portion of the equitable share. Alternately, if it is argued that PHC is not an original function of

municipalities, and is in fact a provincial competence, then there are strong arguments in favour of assigning the function to municipalities.

6.3.4 Rationale for delegating health services

While policies and programme direction often originate at the national sphere, health services are provided, though not necessarily administered, at the local sphere. In a move to bring administration and direction of health care services closer to communities, many countries, including South Africa, have used a variety of mechanisms to decentralise health care services, especially using delegation as an evolving mechanism to ultimate devolution of health services to local government. The expressed goals of delegation are to better meet local needs, improve the efficiency and quality of services, and ensure equity in health care (WHO 2000:13).

There are many complex reasons why governments in various countries have started or are beginning to start decentralising their services. Looking at the historical perspective and analysing the reasons for the decentralisation of policies and their evolution, it is evident that different local factors have played a major role in different countries, e.g. political ideology, demand for more regional autonomy and the need to rationalise overburdened and outmoded administrations (WHO 2000:14).

Many countries have realised the need to strengthen peripheral and local authorities and have adopted decentralisation as one of the major means of implementing reforms for better efficiency, quality and equity. The objectives of decentralisation have been diverse. On a philosophical and

ideological level, decentralisation, in the form of delegation, has been seen as an important political ideal, providing the means for community participation and local self-reliance, and ensuring the accountability of government officials to the population. On the pragmatic level, decentralisation, in the form of delegation, has been seen as a way of overcoming institutional, physical and administrative constraints on development. It has also been seen as a manner of transferring some responsibilities for development from the centre to the periphery.

The 1990s witnessed globalisation occupying centre stage at both international and national policy debates along with the issue of delegation. Within the health sector, delegation of finances, through untied/un-earmarked grants and responsibilities, emerged as an important topic in the agenda of national governments, international organisations and development agencies. The increasing trend towards privatisation of health services and the expansion of the private sector as a motor of economic growth has fostered closer partnerships in health. Globalisation has also influenced the community structure, family values, life styles and the disease pattern. A decentralised health system, in the form of delegation, is considered to be more able to address these changing situations by acting promptly and appropriately according to the local environment (The Lancet 1998:1777).

The Lancet (1998:1778) states that in addition, globalisation has enhanced the spread of market-oriented reforms in health. The economic decline in developing countries has eroded public health resources resulting in widespread degradation of health infrastructure and decline in the health status. The poorest section of the population is affected the most from the increasing inequity in health. Decentralised self-governing local

institutions are seen as a means for identifying and reaching the poor more effectively and for mobilising additional resources for public health.

6.3.5 Critical issues for decentralisation of health care

Policy-makers and other leaders often underestimate the complexity of designing and implementing fundamental changes in management systems that decentralisation, in the form of delegation, requires if health care provision is to improve significantly. Therefore, the following issues need to be addressed in the delegation of health care, according to Cassels (1997:2) and Tarimo (2000:4):

Improving equity: In order to improve equity in health care, the decentralised system, in the form of delegation, needs to ensure that resources are allocated according to need; that quality health care services are available and accessible according to need, regardless of the prevailing social attributes; and that payment for health services is made according to the ability to pay.

Improving efficiency: Improvement of overall efficiency of health care services will depend on allocative and technical efficiency. Allocative efficiency will occur by allocating resources to cost-effective and appropriate level of care, and according to the local needs. Technical efficiency, on the other hand, will occur when the right mix of resources (human, money, material and method) is used.

Improving quality: The process of decentralisation, in the form of delegation, needs to ensure that the quality in health care is not compromised. Appropriate mechanisms need to be established for quality assessment and continuous quality improvement at all levels and sectors of health care services – public, private, voluntary or non-profit organizations.

Level of decentralization: Almost all countries of the Region have undertaken decentralisation of health care, in the form of delegation, as part of overall political and civil service reforms in general and health sector reform in particular. Depending upon the socio-economic and political realities, each country has to consider or identify an appropriate mix and level of centralised and decentralised functions, responsibility or authority to best meet its policy objectives.

Voluntary agencies and the private sector may be able to tap resources and provide more efficient services, particularly curative services which the government cannot provide. They may also work in areas that the government avoids because they are controversial or are too expensive or suited to voluntary provision. It involves complex considerations of the ability of the consumers to pay, the motivation of the providers, and patterns of government regulation, and requires detailed examination of the extent to which privatisation may contradict government objectives such as equity of access to health care. It is important, therefore, that privatisation does not remove from the government all burdens of health management. A strong regulatory authority is required to monitor the supply and quality of both health services and supply industries and to ensure the coordination of services on a geographical basis.

Stewardship: Stewardship becomes more important in decentralisation. The government should take responsibility for the welfare of the population and be concerned about the trust and legitimacy of the services provided. It will require vision, intelligence and influence, primarily by the ministry of health which must adapt itself as a learning organisation limited to management of change. As capabilities of the lower sphere to implement tasks that have been handed over improve, the central sphere should focus more on this stewardship.

6.3.6 Local governments and health system provision

Janovsky (2000:12) argues that local government control offers the advantage of making health services more accountable to the public. Many countries, including South Africa, have created fully-fledged government systems at the local level that have powers and resources to provide services. The decentralisation of authority for health system functions and decision-making to local governments is an outcome of political, economic and health policy trends. The local government, within the health sector, may have the responsibility for the provision of basic health care and preventive and public health programmes in addition to healthy living: basic education, water and sanitation, environment, social care and housing, etc. This gives the health sector managers an opportunity, as a member of the local government management team, to interact with other development partners and incorporate health into all development projects and programmes. The local government also takes more responsibility for indirect health-related functions such as citizens' rights and obligations, enforcing and maintaining standards (Janovsky 2000:12)

Two major issues are likely to arise when any country considers including health functions under the local government. First, health makes heavy demands on recurrent expenditure. Yet, local governments often have a very limited tax base and may rely on revenue sources such as land or property taxes whose yield cannot easily be increased. In developed countries, therefore, the trend has been to shift health services ownership and/or financing out of local government hands, as health services have become too expensive for the local authorities to maintain. If the cost is covered by the central government by grants to local governments, then this implies heavy dependence of the local government on the central

government and a likely reduction in local autonomy. At best, it can be seen as a reasonable response to the question of how to turn over the responsibility for complex development activities to poverty-stricken and under-staffed local authorities (Tarimo 2000:12).

Tarimo (2000:12) argues that second, decentralisation, in the form of delegation, may complicate efforts to construct a logical hierarchy of health services and to set up a regional structure. This is not an insoluble problem. In many countries, primary health care services are the responsibility of the local government and the provincial or central governments remain responsible for secondary and specialist services. Although local governments raise their own revenue, central government grants are an important source of revenue. The allocation of strategic resources (personnel and capital investment) and setting national priorities are strictly under the control of the central government based on planning and financial subsidies. The experience so far from developing and developed countries indicate that it is feasible to decentralise health services, in the form of delegation, to local government structures, but this requires heavy state involvement in financing and considerable cooperation among the local authorities to provide the more specialised services as well as maintaining equitable and quality services throughout the country.

A synopsis of advantages and disadvantages of delegation of health services is outlined in the paragraphs that follow.

6.4 Advantages and disadvantages of delegation of health services

Saltman *et al.* (2007:70) assert that context and historical situation matter both for the argumentation as well as for the functioning of decentralisation,

especially in respect of delegation. Different situations call for different structural responses and specific historical, social and cultural trajectory is a factor in building arguments and driving the process. The merits of specific arguments have to be weighed against concrete cases. The national context and history, the bureaucratic and civil society infrastructure and capacity, the political institutions and broader value base in society will influence the appropriateness of various structural choices in particular circumstances. Translated into health services, this could indicate that the optimal level of delegation is likely to vary across different sub-functions.

6.4.1 Advantages of delegation of health services

- ✓ Saltman *et al.* (2007:71) states that proximity between decision-makers and population provides better match between service/payment levels and needs/preferences. This means better utilisation of resources and more satisfied users. Delegation of health services, therefore, creates differentiation and thus possibilities for exiting to units with preferred service level and payment combinations. Recruitment of human resource contribution becomes more efficient as delegated health-care authority can be used to hire the right persons. Staff may be more motivated in smaller units where they feel that they can have a real influence.

- ✓ Furthermore Vrangbaek (2007:63) in Salman *et al.* (2007:72) submitted that delegation improves control and accountability, staff motivation, coordination across units, patient flow and resource utilisation. Delegation creates opportunities for local adjustment and experimentation with organisational solutions that may spread to other units through a systematised learning process.

- ✓ Delegation of health services creates a countervailing power to poor decision-making at the central level. Delegation of health services improves input and throughput performance and thus creates better conditions for meeting the objectives of productivity, efficiency and effectiveness, quality, service and expenditure control (Saltman *et al.* 2007:71).

- ✓ It is often argued that decentralised structures provide improved possibilities for transparent and acceptable linkages between preferences and financial burdens. Hence Baldersheim and Rose (2000:120) state that the political/administrative argument that decision-makers, in respect of delegation of health services, are closer to, and in more frequent contact with, the population in decentralised units and thus have a better chance of becoming aware of population needs and preferences. The possibilities for participation and voicing opinions will provide opportunities for citizens to give contributions to political decision processes in health care, and will thus generate a better match of preferences and service/taxation levels and other benefits such as greater awareness of cost and benefits (Peters & Wright 1998:99).

- ✓ Jacobsen and Thorsvik (2002:139-140) emphasise that delegated decision-making may facilitate the use of knowledge and experience accumulated by local staff as well as by improving flexibility and adaptability in the organisation and thus motivating employees and stimulating entrepreneurship.
- ✓ Extending the arguments as highlighted above, to delegated public health organisation, it can be submitted that internal coordination is easier in decentralised units where administrative hierarchies are less elaborate and several functional areas may be located within the same

structure. Locating different services within decentralised structures may lead to improved communication; an example would be joint administration of primary care, rehabilitation and social services. This may lead to better coordination of patient flows and more timely and flexible utilisation of services where local knowledge and experiences are used (Pollitt 2005:99-101).

6.4.2 Disadvantages of delegation of health services

- Delegation may lead to inequality in financing of health systems. Risk of political capture by strong industry or interest groups is greater in decentralised units. It is harder for minority groups to gain formal representation in local democracies. Exit is not a real option as employment and accommodation options are limited. It may be difficult to attract qualified personnel to remote areas. Centralised planning creates more uniform standards (Politt 2005:48).

- Politt (2005:48) argues further that delegation reduces equity and fairness as service and quality will differ across delegated units depending on local capacity and choices. Coordination and optimal patient flow across units require a strong hand from central level. Learning across units will not take place without centralised collection of information and control of performance.

- The central level must retain power to force delegated units to adopt best solutions and implement centrally divided plans. Delegation weakens coordination and creates situation of duplication of services. Drawbacks of small-scale production will reduce efficiency and quality in some cases. Externalities from the decision of one unit may negatively affect

the performance of other units, for example, competing for contributing factors such as personnel and patients (Saltman *et al.* 2007:73).

- In addition to earlier discussions, Baxter (1984:432) explains that when powers are assigned, the authority and duty to exercise them, and the responsibility for their exercise, is transferred in full. A less complete transfer of powers is delegation, in terms of which one public authority authorises another to act in its stead. Although the practical necessity of delegation has always been recognised, the power to delegate does not automatically exist: it must be provided for, either expressly or implicitly.

6.5 Conclusion

Delegation is a more extensive form of decentralisation. By delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it.

It is clear that effective form of decentralisation such as delegation cannot rest simply on the transfer of authority, functions and resources from the national to the local authorities, but that it must be accompanied by a range of measures, including adequate training designed to support the newly-empowered local authorities and creating a conducive environment. Depending on the policy conditions, decentralisation can give rise to equity or inequity.

In order to give rise to equity, the programmes of delegation have to be linked to policies, for example, on national health planning, resource allocations and community participation. Relatively stronger groups may have louder voices, thus reducing the likelihood that the needs of the poor will be heard unless specific measures are taken to assure that relatively disadvantaged and/or marginalised groups' perspectives are taken into consideration. With increasing enthusiasm for delegation as a strategy of promoting efficiency and public accountability, it is important not to overlook the role of the centre, particularly in relation to equity issues. In a delegated system, the centre needs to establish equitable means for allocating resources between districts and to ensure the existence of effective mechanisms for managing the health labour market.

The most appropriate form of decentralization such as delegation depends on the country situation. Decentralisation of health services, in the form of delegation, will also deepen local democracy and stimulating community participation. This aspect is expounded thoroughly in the following chapter.

CHAPTER 7

COMMUNITY PARTICIPATION FOR EFFECTIVE HEALTH SERVICES RENDERING

7.1 Introduction

Community participation and decentralization have a symbiotic relationship. The proximity of sub-national governments to their constituents will only enable them to respond better to local needs and efficiently match public spending to private needs if some sort of information flow between citizens and the local governments exist. On the other hand, the process of decentralisation can itself enhance the opportunities for participation by placing more power and resources at a closer, more familiar, more easily influenced sphere of government. In environments with poor traditions of citizen participation, decentralisation can be an important first step in citizen-state interaction. To sustain this interaction empowerment of the community/civil society is mandatory.

It is in light of the above that the chapter focuses on discussing the conceptualisation of community participation in the context of decentralisation of health services. Strengthening people-centred governance by popular participation as one of the basic tenets of entrenching democracy is also discussed at length in this Chapter. The role of governance structures as organs of people's power and their influence on decentralisation of health services is outlined in the Chapter. Lastly, the chapter concludes by giving a brief and concise summation of all elements which highlight the role of community participation in decentralisation of health services.

7.2 Conceptualisation of community participation

The concept of community participation has a long history in development discourse, emerging from the critique of top-down state-led development strategies. In the sphere of health, the Alma Ata declaration in 1978 heralded international recognition of the model of primary health care (PHC) implemented by the participation of the community. In 1994 the Programme of Action of the International Conference on Population and Development (ICPD) described women's participation in reproductive health service management and provision as central to ensuring quality of care and promoting human rights (United Nation 1994:8), a position shared by women's rights and health movements in Asia. There are also contemporary social movements in diverse sectors promoting participation as a perquisite for claiming socio-cultural, economic and civil and political rights (Gaventa *et al.* 2002:40).

Magnussen *et al.* (2004:168) contend that the Alma Ata declaration requires that interventions come from the needs of the community, expressed and subsequently led by community members. Global health problems cannot be resolved by distant policy-makers and planners. Involvement of individuals and communities mobilises local resources to deal with health problems. Implied in the concept of participation is decentralised physical location. Programmes need to be founded and researched in the locality in which they will be applied. The Alma Ata declaration also recognises that the issue of accessibility to health services and resources has historically been a barrier to effective care and that placing emphasis on curative, tertiary care hospitals in urban centres often precludes access for a mostly rural population (Askew 1991:57).

Countries also need to strengthen their PHC care by the development of inter-sectoral forums at every level. Human health should be a cross-cutting issue throughout the decision-making process in different sectors and at different levels. Health policy development should involve those sectors, agencies, and social groups that are critical to achieving better health. This can be achieved by the advocacy for health objectives as integral to socio-economic development and through engagement of different sectoral partners and community structures in the consensual process (McIntyre & Gilson 2000:238).

David et al. (1998:4) argued that community participation in health is a complex entity that has been examined extensively in the literature and continues to be of great interest among community health workers. The genesis of the idea and its conceptual development are primarily attributed to large multi-national health institutions, particularly the World Health Organisation (WHO). However, the implementation of community participation is the ultimate responsibility of local health programme initiators. It is at the local level where day to day realities of incorporating community participation into health service provision are confronted.

Community or public participation in health, sometimes called citizen or consumer involvement, may be defined as the process by which members of the community, either individually or collectively and with varying levels of commitment: (a) develop the capability to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and maintain organisations in support of those efforts; and (d) evaluate the effects and bring about necessary adjustment in goals and programmes on an on-going basis (Vuori 1986:5; WHO 1991:39). Community participation is therefore a strategy

that provides people with the sense that they can solve their problems by careful reflection and collective effort action.

From the aforementioned, it can be submitted that while many individual factors contribute to the achievement of greater community participation in health such as (1) recognition of the right and duty of people to participate in public and community affairs, including personal health; (2) institutionalised health system inability to provide for all health related needs; (3) recognition that planned social changes in health can only be achieved by focusing on community as the major locus (focus) of attention. Collective wisdom holds that the core value of community participation is that it provides a mechanism for people to participate in activities that have the potential to influence positively upon their health (Annett & Nickson 1991:3).

Dujardin (1994:1263) and Oakley (1992:132) contend that one of the most attractive aspects of community participation is its widely reputed health and social benefits. While the health literature is seriously lacking in empirical studies that specifically demonstrate these benefits, it is widely accepted, based on, theoretical grounds and personal experience, that it facilitates many positive outcomes.

Perhaps the most important benefit cited is the heightened sense of responsibility and conscientiousness regarding health and the concomitant gain in power achieved by the acquisition of new skills and control over resources. Participants have the opportunity to educate themselves to the possibilities of controlling their own destiny, often resulting in a more equitable relationship between the so-called clients or recipients of health services and the providers (Nichter 1984:239-240). A related benefit is the

potential for greater diffusion of health knowledge in the community and greater use of indigenous expertise (White 1982:77).

Kahssay and Oakley (1999:10) argued that community participation in health is a process. It is a process of initiation and sustaining dialogue with various members of a particular community in a structured manner with the view to consulting them as equals in a programme of activities that aim at building a team between programme managers and community members. It is also important to understand health problems in the community, to find common solutions to such problems and to act together to solve these problems using as much human and material resources as possible from the community. Community involvement in health development, therefore, is a process by which partnership is established between the government and local government and local communities in the planning, implementation and utilisation of health activities in order to benefit from increased local self-reliance and social control over infrastructure and technology of primary health care (Rifkin 1986:15).

According to the White Paper for the Transformation of Health Systems in South Africa, 1997, it is essential to obtain the active participation and involvement of all sectors of the South African society in health and health-related activities. All sections of the community, all members of households and families and all individuals should actively be involved, in order to achieve the health consciousness and commitment necessary for the attainment of goals set at the various levels. The people of South Africa have to realise that, without their active participation and involvement, little progress can be made in improving their health status.

WHO (2002:3) states that, during the Fifty-Fifth Session of the Regional Committee for South-East Asia in Jakarta, Indonesia, community participation is crucial for promoting successful decentralisation. Whether decentralised management of healthcare will be more responsive to local needs depends on decentralisation being accompanied by increased involvement of the community in some way in order to define those needs. Access to information on the health system performance is critical for the promotion of accountability. Unless the community knows what goods and services are provided, how well they are provided, who the beneficiaries are, and how much they cost, the community cannot demand effective governance and service provision. The decentralisation process itself may be inadequate to promote community participation. Additional mechanisms are, therefore, required within the local institutions if communities are to have an effect on health services provision.

Reid (2000:2) maintains that in respect of healthcare delivery active community participation is key to building an empowered community. Not only is participation a requirement for primary health care (PHC) empowerment programmes, but it is also critical to community success. Participation, therefore, is the heart that pumps the community's life blood, its citizens, into the community's business.

7.3 Strengthening people-centred governance by means of popular participation

Popular sovereignty and decision-making by the people, is not an idealistic fantasy which democratic system can manage without – it is the very essence of democracy. Nor does the fuller exercise of democracy impede government which serves the people. On the contrary, only more

accountable and responsive government can ensure this: a prospect for more capable and effective government depend on whether there is more democratic government (Friedman (2011) in Plaatjies 2011:58).

The central role of citizens in effective democratic government is summed up by a South African government policy document – 'Batho Pele' or 'People First'. While it is often honoured largely in the breach (that is, the policy is more advocated than being practised), it does pinpoint the priority that should lie at the heart of democratic government. Democracy differs from other systems of government in one crucial way – it is meant to ensure popular sovereignty or rule by the people (Dahl 2006: 48; Friedman 2008: 15). This assumes that every adult member of a political community (a state or province or city, for example) is entitled in principle to an equal say in the decisions that govern it. In principle, the level of education or knowledge of technical issues does not give any member of the political community greater rights to a say than another – still less do race, gender, creed, wealth or political connection entitle anyone to more of a say than others. This is justified on the ground that there is no objective or generally agreed criterion for determining that one person's opinion is more valid or of more value than another's.

Omarjee (2009:4) argued that no society has ever achieved a state in which everyone participates equally in all decisions on which they have a view and none ever will. However, progress towards this goal is the standard by which the progress of democracies is measured – including of course democracy in South Africa. This has important implications for governing. It means that the opinions of citizens matter more than those of experts and so the democratic content of a government must be measured by the extent to which it responds to citizens, not by its technical expertise. In principle,

any decision should be judged on whether it is supported by most citizens, not on whether it reflects the current expert consensus (on those rare occasions on which there is one!). It also means that, in principle government is always the servant, the citizenry always the master. The role of government in a democracy can never be 'service provision' because this implies that it is the role of government to impose on a passive citizenry a range of goods and services. It is, rather, public service, which implies that the government's task is to respond to the needs of citizens. This means citizens ought to decide what government does and government ought to respond. When officials decide that urban planning requires that people's homes be demolished, they are engaged in 'service rendering' – they are using the latest technical data to give people what they are assumed to need. When people demonstrate against this, they are saying that they do not wish to be 'delivered to' but that they want to be listened to; they demand democratic government rather than rule by technicians (Omarjee 2009:4).

Davids *et al.* (2009:218) assert that popular participation is, in essence, the empowerment of the people to effectively involve themselves in creating the structures and in designing policies and programmes that serve the interests of all and to contribute to the development process and share equitably in its benefits. Therefore, there must be an opening up of the political process to accommodate freedom of opinions, tolerate differences, accept consensus on issues as well as ensuring the effective participation of the people and their organisations and associations. This requires action on the part of all, first and foremost of the people themselves. But equally important are the actions of the State and the international community, to create the necessary conditions for such an empowerment and facilitate effective popular participation in societal and economic life. This requires

that the political system evolves to allow for democracy and full participation by all sections of society.

It is essential to emphasise that the role of the people and their popular organisations is central to the realisation of popular participation. People have to be involved, committed and indeed, seize the initiative. In this regard, it is crucial that they establish independent people's organisations at various levels that are genuinely grassroots, voluntary, democratically administered and self-reliant and that are rooted in the tradition and culture of the society in order to ensure community empowerment in self-development (Davids *et al.* 2009:218).

It is an easily verified truism that the Constitution of the Republic of South Africa, 1996, is internationally appreciated as laying the foundation for grass-roots democratisation and good governance, based on a developmental orientation as embodied in the ideas of developmental local government and the integrated development plan (IDP) (White Paper on Local Government Transformation 1998; Mhone & Edigheji 2003:1-7; Chipkin 2002:57-78). The White Paper on Local Government Transformation, 1998, suggests that municipalities should develop mechanisms to ensure citizen participation in policy initiation and formulation and the monitoring and evaluation of decision-making and implementation.

The success of a developmental state depends on the involvement of social partners. The approach to governance in South Africa places strong emphasis on building a broad front for development that involves a strong relationship between government, labour, business and other organisations that are formed by different groups of citizens (civil society). Government,

therefore, will work with all sectors in society to build a better life for all. When launching the slogan "Moral regeneration campaign" government tried to involve faith-based and educational organisations in a partnership since they are much better placed than government to reach their members and address moral issues that will help re-build the society (Chipkin 2002:57-78).

Rahman (1993:150) contends that what gives real meaning to popular participation is the collective effort by the people concerned in an organised framework to pool their efforts and whatever other resources they decide to pool together, to attain objectives they set for themselves. In this regard participation is viewed as an active process in which the participants take initiatives and take action that is stimulated by their own thinking and deliberation and over which they exert effective control.

Based on the above analysis, it can, therefore, be argued that participatory governance is central to the success of any democracy. Lack of public participation, especially at the sphere of local government, means that citizens do not have the platform to engage elected representatives about policy, service provision and decision-making which affects them. Informed citizens are generally active citizens, who are able to play a central role in shaping their communities and lives. It is against the foregoing that the role of government structures and their influence on health services rendering is discussed below.

7.4 Role of governance structures and their influence thereof on health services rendering

Community participation in health takes many forms and can be manifested at an individual or collective level; it can be formal or informal and occur on an ad-hoc or more structured basis. At an individual level, forms of community participation include the use of community health workers, home-based carers and lay counsellors to augment the services provided by the formal health services. Participation can also take the form of involving communities in conducting needs assessments and joint planning of health services, and assisting in the provision and monitoring and evaluation of these services (Bennet *et al.* undated; Baez and Barron 2002:39; Gryboski *et al.* 2006:88).

Bennet *et al.* (undated) suggest that there are essentially two main modalities through which communities can influence their health care. The first is by participation in health activities within the community; for example, community based healthcare, and the second is by representation on structures which deal with the management of health issues. These structures include a community health committee or clinic committee that are accountable to the community and which is part of the governance of the clinic.

Ramiro *et al.* (2001:68) contend that the process of decentralisation of health services is long and complex, especially in countries with fragile democracies like the Philippines. The objective of decentralisation cannot be achieved by simply changing the system of governance. A more thoughtful groundwork for decentralisation is necessary before broadened participation and empowerment of the community can be attained. Thus, a

number of policy changes are recommended to strengthen the Local Health Board (LHB) as a mechanism to broaden community participation. First, the importance of the LHB as a means for community participation should be vigorously advocated to a municipality or local government unit (LGU) leaders, health workers and other participants by the combined efforts of the Department of Health and the Department of Local Government. Part of the advocacy should be approached by the discussion of the roles, responsibilities, expectations, accountability and benefits that could be derived from being an active LHB member. Second, local activities to raise the consciousness of the community should be conducted by the LHB and non-governmental organisations (NGOs) to strengthen the appreciation of a holistic and democratic system of governance. Third, there should be more community representatives on the LHB, selected by consensus by the community during village assemblies to balance the influence of the local government officials. These community representatives could come from NGOs engaged in activities other than health (e.g. environment, social services, and agriculture), people's organisations and unorganised community members (Ramiro *et al.* 2001:68).

Bennet *et al.* (2001:20) argue that governance refers to the way in which control is exercised over hospitals and other health services, and the powers vested in the governing body, in this case the health authorities, at district, provincial and national level to exercise such control. In general, health governance structures are the actions and means taken by society to organise itself in the promotion and protection of the health of its population, a governance structure can be an existing board, committee, council or commission that has been authorised to fulfil governance duties and responsibilities (Dodgson *et al.* 2002:36). In South Africa, health governance structures refer to clinic committees, community health forums,

hospital boards and district health councils. These structures are created to provide an avenue for communities to give feedback into the planning, provision and organisation of health services and to play an oversight role in the development and implementation of health policies and provision of equitable health services in accordance to the provisions of the National Health Act, 2003. The aforementioned health governance structures are intended to give expression to the principle of community participation at both local and district level.

One of the potentially most enduring problems facing governance is uncertainty about roles and responsibilities. Where these are unclear and have not been clearly articulated, progress and achievements of governance structures have been slow (Loewenson 2000:44; Boule 2007:54; HST 2007:36). Conversely, in instances where there has been clarity on the expected roles of governance structures as in the case of the health centre committees (HCCs) in Zambia, these structures have flourished (Ngulube *et al.* 2004:64).

7.5 Conclusion

Community participation is a principle that is accepted by all spheres of government in South Africa and other countries world-wide. Participation is one of the cornerstones of democracy and has equal benefits for politicians, public servants and civil society. Community participation in health care takes many forms and can be manifested at an individual or collective level; it can be formal or informal and occur on an ad-hoc or more structured basis.

Participation in the management of district health facilities by means of community management committees has been found to improve performance by strengthening the accountability of providers to clients. The involvement of diverse groups based on kinship, ethnicity or culture facilitates the expression of grievances and collaboration in problem solving. Participation encourages a sense of ownership of, and support for, ways of solving local health care problems. Empathy and trust between health care providers and their clients are encouraged.

In general, health governance structures are the actions and means taken by society to organise itself in the promotion and protection of the health of its population, a governance structure can be an existing board, committee, council or commission that has been authorised to fulfil governance duties and responsibilities. Health governance structures are intended to give expression to the principle of community participation at both local and district level.

In summary, to be both effective and long lasting, community participation must become a successful and integral part of the entire community's common experience and not remain as a structure imposed from outside. It must be rooted in the expectations of the community, supported by on-going access to required and usable information and to significant commitment of organisational staff and material resources, and be given genuine support by health professionals and managers, and by the political/administrative system. Perhaps more important, though, is gaining the understanding of the nature of human social interaction and community participation.

It is imperative for South Africa and the Free State Province in particular, to draw lessons from international experiences in respect of the success of forms of decentralisation of health services in both the developed and the developing countries.

CHAPTER 8

KEY LESSONS LEARNT FROM INTERNATIONAL EXPERIENCES ON DECENTRALISATION OF HEALTH SERVICES

8.1 Introduction

Decentralisation is context-specific, related to political, geographical, social and economic conditions. Therefore, although countries can learn from each other's experiences of decentralisation, comparing decentralisation outcomes between countries is not easy. In addition, when assessing decentralisation within a country the complex mix of internal influences resulting in its formal planning, implementation and outcome should be borne in mind. These include the size of the country, the choice of the level of decentralisation, the composition of local health authorities, the extent of community participation, the sources of finance, the control and supervisory practices, the planning responsibilities, the civil service attitudes and the level of inter-agency collaboration. All these variables affect the decentralisation policy outcome and as such will impinge upon the appropriateness of any applicable learning experiences.

Health problems are not the same across societies and cultures; health and social services are organised differently; the democratic process and socio-economic conditions are different; public versus private providers, including NGOs, play different roles; and countries or even different states within a large country are at different stages of development. Thus, different forms of decentralisation, from de-concentration to privatisation, may be appropriate. It is clear that there is no unique formula, nor any

simple technical fix for meeting the health-care needs in an effective and efficient manner maintaining quality and equity. What is needed is a right mix of approaches.

In light of the above, the focus of this Chapter is on literature review that helps in drawing lessons from other countries internationally such as Canada, Zambia, Indonesia and Brazil in respect of how decentralisation of health services were implemented. The aspects of health services decentralisation followed in these respective countries are discussed in the paragraphs that follow.

8.2 Canada

Armstrong and Armstrong (1999: 1201) assert that an indicator of the size of Canada is that St John's, Newfoundland, is equidistant from Moscow and Dawson City, Yukon. Yet Canada has a population of just over 30 million. Its 10 provinces vary in population from tiny Prince Edward Island with lower than 140 000 inhabitants to Ontario with well over 11 million. Its three territories together have barely 100 000 residents spread over 3.9 million square kilometres of land. It is no surprise, then, that since its inception the Canadian public health-care system has been decentralised. Since Canada became a nation in 1867, health-care has been primarily a responsibility of the provinces. They have strongly defended their rights, and have often been supported by private insurers and providers in their resistance to a national health system.

Yet the 1937 Royal Commission on Dominion-Provincial Relations emphasised the chaotic financial results on business if some provinces, acting independently on health insurance, levied taxes on employers that

placed them in a less competitive position in respect of business in provinces that did not. Thus, Taylor (1978:7) argued that when a public health-care system became a top priority after the second world war, planners sought to balance local control with the need for some degree of uniformity throughout Canada, and therefore in the collection of tax contributions by the federal government.

Taylor (1978:7) asserts the federal government, unable to achieve federal-provincial consensus, used its spending power to bring provinces into a national plan. The strategy was simple. Making an offer no province could resist, the federal government promised to pay half the costs of hospitals and, later, of doctors' services, as long so the provinces conformed to some basic principles. These two initiatives were later brought together, and the principles made more explicit, in the 1984 Canada Health Act. According to the 1984 Canada Health Act the five principles are mutually reinforcing, in ways that are designed to ensure reasonable equity, access and conditions.

The five principles of the Canada Health Act

- **Portability**: Citizens are eligible for coverage in all provinces. This means that employees can follow job opportunities both within and between provinces, without losing their coverage and without restricting flexibility of the labour force. When residents are signed up to a provincial plan, they can access care anywhere in the province. The portability requirement also means that provinces without the resources to provide many specialised treatment can purchase them in other parts of the country, ensuring coverage for their citizens while efficiently using resources.

- **Public administration** enables governments to distribute services more effectively and efficiently, and with more stability. It allows for public debate and planning; integration and continuity are also more readily achieved with public administration. Private insurance is implicitly or explicitly forbidden, and there is no opting out of paying taxes for the public system. Ottawa: Minister of Public Works and Government Services (1979) believes that the combination of stable financing and prohibition of for-profit coverage for medically necessary services significantly reduces the need for bureaucratic controls, excessive record keeping, and the regular re-negotiation and constant surveillance of contracts, and it permits the development of systematic coverage in equitable ways.
- **Universality**: Everyone is covered, which is not only more democratic, but also cheaper and more efficient. The 1964 Hall Royal Commission that led to the creation of medicare rejected a two tier system with means testing for eligibility on the grounds that up to three quarters of the population would be eligible for subsidy, depending on the income cut-off thresholds, and the administrative costs of a programme would outweigh the benefits (Taylor 1978:7).
- **Accessibility**: Health services must be provided under uniform terms and conditions; this explicitly forbids a two tiered system, user fees, or other means of providing differential or preferred access or different facilities linked to different payment needs. Taylor (1978:7) argued that The Hall Royal Commission rejected differential treatment primarily on the "pragmatic tests of administrative and financial feasibility," but Canadians have also come to value this principle because it is more equitable and more effective to base access on need rather than on ability to pay. The 1984 Canada Health Act also includes "reasonable compensation for all ensured services". It recognises that decent pay is

essential for those providing services in order to ensure not only quality and stability but also fairness. Only doctors and dentists are mentioned specifically in the list of individual providers, but the act refers to reasonable compensation for hospitals and those hospital services include the services of all who work in it.

- **Comprehensiveness**: Although the 1984 Canada Health Act does not extend much beyond medically necessary services provided by doctors and hospitals, it does include all services required within these confines. The rationale is simple: to do otherwise would limit access, increase administrative costs, and define care too narrowly in light of what is known about the determinants of health.

Strengths of the system

Adherence to the principles has helped ensure both choice and equitable treatment for patients, providers, and employers. Supplemented by federal equalisation payments to the poorer provinces, it has also promoted equity among provinces that vary enormously in population and wealth, while providing them with enough flexibility to develop their own ways of providing care. Basically, the Canadian medicare system provides public payment for private practice and private provision (Evans 1993:37).

The federal and provincial governments pay, but much of the provision is left to those who delivered care before the public system was introduced. The main difference is that, under the public system, almost all the hospital and doctors' bills go to the provinces. With its contribution to health care clearly defined, the federal government could and did withhold money from any province contravening the principles of the Canada Health Act. Similarly, provinces controlled hospitals through negotiated budget

allocations while setting standards for care. Hospitals were run mainly by locally appointed boards, and doctors were the main gatekeepers to the system, with the doctors guaranteed payment under a negotiated fee for service system. This left doctors, patients, and hospitals with a wide range of choices, especially in urban settings (Armstrong & Armstrong 1999:1202).

Tensions and weaknesses

Payment schemes

The payment schemes that contributed to provincial, hospital, and doctor control also made it difficult to estimate or limit expenditures. Evans (1993:37) argued that although the period of the most rapid escalation ended with the establishment of universal coverage in 1971, the federal government soon became concerned about writing blank cheques to the provinces. By 1977, it had unilaterally started to cap its transfer payments to provinces and to shift the form of its support from cash to the creation of tax space for provinces. In 1995, it eliminated the specific health transfer altogether, collapsing federal funding for health, post-secondary education, and social assistance into the new Canada Health and Social Transfer and dramatically reducing its cash transfers. As a result, it is no longer possible to determine the exact federal contribution to health-care funding.

According to Armstrong and Armstrong (1999:1202) in addition to the pressure that reduced federal funding places on individuals and on provinces, the new funding method has two important consequences for democracy. Firstly, by concealing the size of its cash transfers for health care, the federal government makes it more difficult for the electorate to hold it to account. Secondly, by reducing its transfers, the federal government reduces its capacity to enforce the popular five principles. For

their part, cash strapped provincial governments resist being told how to spend their money by a federal government that is no longer making a clear, large contribution to health care.

The provinces have responded to the federal cutbacks by reducing hospital budgets significantly. This was initially done by reductions to global budgets, leaving hospitals with considerable control. More recent cuts, and a new emphasis on managerial directives based on formulas for costs and care, have altered this balance of power. Provinces have started to close hospitals, and to place them under the control of newly established regional boards. The specific nature and form of this devolution varies from province to province, but all regional boards have budgets determined by the province; at least some of their members are provincially appointed; and hospitals are often severely restricted by provincial directives. These changes have been largely informed by management theory taken from the for-profit sector, without evidence of its applicability to a public health system (Evans 1993:38).

Similarly, Armstrong and Armstrong (1999:1202) state that devolution to regional boards has proceeded with little assessment of its consequences for either democracy or access. Provinces have also responded to federal reductions by removing public funding from some services, by failing to cover new treatments and services, and by offloading responsibility for some services to municipalities and to private providers. What provinces have not done is seriously challenge the fee for service payment scheme that covers most doctors. Their associations negotiate fee schedules with provincial governments, and doctors then simply send in their bills. Strategies to bring doctors' billing under control have had limited impact.

When fees are frozen, doctors bill for more, and for more expensive, services.

Lomas *et al.* (1997:371) purports that discussion about devolving powers to the regional level, and about this being a good thing for Canadian health care, is not new. However, at least two things were new in the 1990s. First, devolution was no longer merely being discussed; it was being implemented in every province except Ontario. Second, there is, paradoxically, less agreement than before on whether devolution is a good thing for Canadian health care. Indeed, there is a great deal of scepticism about it. Recent reviews by the CMA and the Ontario Premier's Council on Health, Well-being and Social Justice concluded that there has been little evaluation of devolved authority for health care.

Despite this scepticism, most provinces are using devolution as the latest panacea for the woes of their health care systems. During the late 1980s and early 1990s nearly every province produced a "blueprint for change" for its health care system through a Royal Commission. Both the woes and proposed solutions documented during these exercises were remarkably consistent. The solutions all involved devolving at least some authority to local levels in order to contain costs, improve health outcomes, increase the flexibility and responsiveness of care provision and better integrate and coordinate services. In other words, devolution was largely seen as an instrumental means to achieve other ends, not as an end in itself (Lomas *et al.* 1997:371).

These changes, highlighted above, arguably constituted the most radical restructuring of medicare since its inception, with far reaching implications for governments, citizens, physicians, hospitals and other interest groups.

Little, however, has been written in the popular press or in academic journals about this "leap in the dark." Given the concerns about the efficacy of this approach to health policy, it is important to document, monitor and evaluate progress as these devolved authorities become the governance mechanism for health care in 9 of the 10 provinces (Lomas *et al.*1997: 372).

Devolved authorities and their provincial governments

The devolved authorities are acutely aware that the provincial governments that created them also control their budgets and the rules under which they operate. To this extent, the devolved boards could be the locally based enforcers of the provincial government's expectations; that is, they could be de-concentrated arms of their parent body. However, in some provinces, such as Saskatchewan, there is a move to determine needs-based funding formulas objectively. This trend may afford the devolved authorities some protection from arbitrary fiscal punishment if they deviate from the provincial government's expectations (Mhatre & Deber 1992:645).

Furthermore, Mhatre and Deber (1992:646) assert that there is still, however, a "rulebook," which often expresses the requirements for delivery of core services. Such documents have been completed or are being developed in Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland. Most core-service documents are introduced with general wording, in order to allow the devolved authorities significant discretion. To date, however, few devolved authorities have ventured far from traditional allocations of funds. Only time will tell whether the authorities will make radical departures from accepted patterns of local resource allocation and whether, in response, provincial governments will

feel compelled to tighten the wording of core-service documents and reduce the authorities' discretion.

Devolved authorities and their citizenry

Devolved authorities' best protection from becoming enforcers on behalf of provincial governments or being held captive by provider interests may be their credibility as effective local representatives of their citizens' needs and preferences. The difficulty is differentiating local needs, expressed by well-informed citizens seeking the public interest, from local wants, expressed by narrowly informed citizens seeking satisfaction of self-interest.

One of the devolved authorities' biggest challenges will be to gain credibility by distinguishing between these two forms of community expression and placing different values on them, while maintaining cordial relations with the entire community. Good information will be a necessary, although likely not a sufficient, element in achieving this goal (Hurley *et al.* 1995:34)

Hurley *et al.* (1995:35) state that the role of the local citizenry in devolved authorities remains unclear, partly because of the failure to distinguish between citizen contribution and governance. Citizen contribution into decisions made at the local level on local matters—local planning and allocation— is one option. This, however, is not the same as community governance, which involves elected local citizenry making the decisions for their locality. Citizen contribution implies only community participation through advice and influence to experts. Citizen governance implies a pre-eminent role for elected local citizens, regardless of their level of knowledge, and a lesser role for experts. These approaches appear to have

become inextricably intertwined in Canada's current debates over the governance of devolved authorities. The confusion has arisen despite evidence that most citizens wish only to be consulted and that they expect and prefer that "the experts" take responsibility for actually making the decisions.

Lomas and Veenstra (1995:37) argued that in their attempts to negotiate compromise, devolved authorities must decide how to weigh the sometimes competing views of the provincial government, providers and citizens. In dealing with the provincial government, their legitimacy and formally devolved power are at stake. In dealing with the providers, their ability to manage reform without making workers disgruntled is at stake; while dealing with the local citizenry, their credibility is at stake.

Saltman *et al.* (2007:290) assert that although the Canadian Constitution vests jurisdiction over most health care activities at the sub-national (provincial) level, the Canadian Federal Government nonetheless exercises some broad direction over health insurance programmes by attaching conditions to its intergovernmental transfers. In addition to its regulatory responsibilities in respect of drug patents and drug and food safety the Federal Government is also responsible for providing health care and benefits to designated groups, although it increasingly purchases such services rather than providing them directly. It also funds most health research and may choose to take on a coordinating role for health related functions such as health protection, disease prevention and health promotion. The Canadian Institute of Health Information (CIHI) gathers Canadian health information which can be used to stimulate health policy, management of health care system and public awareness of health affecting factors.

During the 1990s, nine of the ten provinces and one of the three territories restructured health-care provision by setting Regional Health Authorities (RHAS). The RHAs were envisioned as intermediate bodies between the provincial government, on one hand, and individual health institutions and providers, on the other. The health mandate of the RHAs varies in scope among the provinces and territories, as does the autonomy given to their managers. Provinces varied in the extent to which other sub-sectors such as public health, home care, addiction services or mental health are assigned to RHAs, retained as provincial programmes, or left to private providers. RHA funding comes entirely from the provincial budget. While the creation of RHAs is sometimes portrayed as decentralisation, governance and decision-making were taken out of the hands of individual hospitals, nursing homes and similar institutions, thus also representing a centralising element (Saltman *et al.* 2007:292).

Having discussed how Canada implements decentralisation of health services in various provinces and territories, it will be interesting to expound how the decentralisation of health services has been approached in Zambia.

8.3 Zambia

Zambia is a landlocked country in southern Africa. It is three times larger than Uganda, covering 752 600 square kilometres. Its population of 8.09 million people (1990 census) is about half that of Uganda, which was about 16 million in 1990. Zambia is administratively divided into 9 provinces and 72 districts. There are no political councils at the provincial level. A Deputy Minister and a Permanent Secretary manage each province. The role of the provincial administration is the management of central government

departments (Jeppsson & Okuonzi 2000:274). Districts constitute local authorities in Zambia; each local authority council consists of elected district councillors, members of parliament and two representatives of each chief. In the 72 districts, 4 are city councils, 14 municipal councils are found while the rest are ordinary district councils. Each district's delimitation proceeds from constituency wards, before it reaches the lower levels of section and finally village. The political, administrative and financial power held by each of these levels is, however, strictly limited.

Health sector reform, particularly in the low-middle income countries, has in the last two decades focused on decentralisation of health systems as a strategic and effective option for the reform of health systems. Reform by decentralising health systems has also been implemented as part of a broader form of political and administrative reform. Following the World Bank's 1993 *'Investing in Health'* Report, a movement for the decentralisation of health systems emerged. Among some of the countries that implemented strategic health reform has been Zambia (Chitah & Bossert 2001:11)

Zambia has attracted considerable attention in recent years for its ambitious programme of health sector "decentralisation." While the national government initiated and then restricted a process of political decentralisation to the municipalities, the health sector decentralisation followed its own separate process. The roots of the current reform programne date back to the Medical Services Act, 1985, which provided for the creation of semi-autonomous hospital management boards for all major hospitals (more than 200 beds). The hospital boards were appointed by the Minister of Health (MoH) in 1992 and have authority to set fees and manage staff (Mpuku & Zyuulu 1997:96). In 1992, further legislation was

passed requiring the districts to establish district health boards to oversee the districts.

In 1993, district health management teams (DHMTs) were established as the technical managers of the district health offices in each of the country's 58 (now 72) districts. This same year saw the establishment of the Health Reform Implementation Team (HRIT) at the national level to act as a coordinating body to promote the full implementation of the legislated reforms. This body was established outside the Ministry of Health and had a close association with foreign technical assistance, giving it greater flexibility and autonomy in exercising its mandate. In 1994, the DHMTs were followed by the creation of the district health boards, which were to act as the supervisors, and ultimately, employers of the DHMTs. The DHBs were set up side-by-side with the pre-existing hospital boards, but the relationship between the two remains somewhat unclear (Comprehensive Review 1997:5).

In 1995, the National Health Service Act was passed, calling for significant changes in the role and structure of the Ministry of Health and for the establishment of an essentially autonomous health service rendering system. The MoH Directorate of Medical Services was replaced by the semiautonomous CBoH, which has the functions of having to "monitor, integrate, and coordinate the programme of the Health Management Boards" (Mpuku & Zyuulu 1997:116). The transition to CBoH has entailed a reduction in management personnel at the central level. The MoH headquarters staff has been cut from 400 to 67, and the new CBoH headquarters will have a staff of 118 when fully implemented (Fielden & Nielsen 1998:77).

The "new" MoH was primarily a policy-making and regulatory institution and its directorates have been reduced to three: human resources and administration, planning, and development. The MoH was to have no direct health service provision responsibilities, and would instead contract these services to the CBoH. The CBoH, for its part, was to have responsibility for executive functions related to health service provision, including: commissioning health services; regulating health services; directly administering failing district or hospital management boards; quality assurance; human resource policy; planning and management; budgetary administration and management (Foltz 1997:65).

According to Mpuku and Zyuulu (1997:97), the organisation of the health service rendering system is based on four distinct levels:

- The ***Central Board of Health***, operating as the national coordinator of health service rendering.
- The **District Health Management Team (DHMT)** and first level hospital and secondary and tertiary level major hospitals governed by the District Health Boards and Hospital Management Boards, respectively. Under the coordination of the CBoH, the district and hospital boards act as supervisors of DHMT and hospital management units. The boards are expected to be the employers of both management teams under the planned "de-linkage" of personnel from MOH to districts; however, this process has been only partially implemented. The DHMT is to be responsible for policy implementation and service provision via a network of health facilities.
- **Health centres** provide services under the supervision of DHMTs and district health boards. There are plans to convert smaller health centres into health posts, each with a single professional staff member. Health Centres have Facility Committees and Neighbourhood Committees to

encourage community participation. The reform programme also provides for the creation of a number of structures for popular participation, including area health boards, health centre advisory committees (HCACs), and neighbourhood health committees (NHCs).

The new organization of the MOH/CBoH forms the basis for a significant decentralisation of health expenditures. Under the new system, the DHMTs prepare costed, district annual work plans on the basis of contributions from constituent health facilities from the Neighbourhood and Facility Committees and approved by the District Board of Health. District budgets and work plans must be approved by the CBoH, and budget transfers are made directly to the district level on a monthly basis, contingent upon satisfactory quarterly performance audits by the provincial offices and a review by the district basket steering committee (Fielden & Nielsen 1998:77).

Chitah and Bossert (2001:15) claim that in complement to fiscal decentralisation, user fees have been re-introduced as one of the cornerstones of the health care financing and health reforms. Districts and hospitals are permitted to set their own fee levels. National exemption guidelines are set for certain diseases, age groups, and services while districts have control over the implementation of the exemptions for the poor. Current user fee policy requires health centre revenues to be submitted to the district-level offices for accounting. A large portion of the fees is then to be redistributed to the facilities, but the accounting procedures and current practices for allocations are not transparent. While the management of cost-sharing revenues differs significantly from district to district, there does not seem to be any correlation between the level of fees generated by a facility and those redistributed to it by the district.

- **De-concentration, Devolution and Decision Space at the Local sphere**

Applying the public administration framework to the decentralisation process in Zambia is complicated by the multi-layer institutional framework, facilitating a purchaser – provider split. It is clear that the creation of the Central Board of Health and the transfer of major responsibilities for day to day operations to that body is a case of *delegation* of authority to a semi-autonomous agency. The transfer of responsibilities to the District Health Management Teams which are still under the administrative purview of the central authorities can be seen as a process of *de-concentration* (Chitah & Bossert 2001:14).

However, the granting of some authority to the local representatives on district health boards and local community committees can be seen as an attempt to provide local accountability similar to processes of *devolution*. In a strict sense, since the transfer of authority is not to a local government body such as the municipal councils, it is not devolution; however, the introduction of this measure of local accountability is more than is usually implied in other national processes of de-concentration. It is this kind of ambiguity that makes the public administration framework somewhat weak as a framework of analysis. Nevertheless, for the purposes of argument the Zambian case as primarily one of de-concentration and delegation will be considered (Chitah & Bossert 2001:14).

Having analysed how decentralisation of health services was approached in Zambia, it will equally be essential also to focus on how decentralisation of health services was undertaken in Indonesia.

8.4 Indonesia

- **Development of the Indonesian National Health System**

Simatupang (2009:83) asserts that previously one of the most centralised countries in the world, Indonesia has moved to be one of the most decentralised in a relatively short period since the beginning of decentralisation known as the "Big Bang" in 2001. With decentralisation in place, provinces and municipalities demanded more autonomy which resulted in the creation of new jurisdictions. From 26 provinces and 313 municipalities in 1999, the number of jurisdictions grew to 33 provinces with 440 municipalities in 2004.

There exists a substantial amount of literature on Indonesia, which mainly focuses on the fiscal design of decentralisation such as expenditure and revenue assignments and also the design of the intergovernmental transfer system. However, after almost a decade since the reform, there is only limited empirical evidence on the relationship between decentralisation and outcomes of development sectors (Simatupang 2009:83).

The WHO (2010:60) states that at Independence, the Government of Indonesia inherited a weak and unevenly distributed health system to which most of the population has only limited access. In the early 1950s a new health system, in which curative and preventive medicine were integrated, was piloted in Bandung. This system - subsequently known as the Bandung Plan - became the blueprint for the new national health system: a network of public health facilities throughout the country with a health centre at the sub district level and a hospital at the district level.

By the mid-1990s, there were more than 7 000 health centres based on ensuring distribution of public facilities, staffed by obligatory government service for all new graduates in medicine, nursing and mid-wifery. The doctors, most nurses and midwives staffing these facilities were also allowed private practice after hours. A village mid-wife programme was in the mid-1980s and staffing and funding was implemented through central control.

The whole public system, including staffing and funding, was managed in a top-down, hierarchical manner consistent with the 'Health for All' paradigm. Almost all resources were transferred to district governments through centrally specified earmarked grants. The provincial level had an important role for supervising programmes and providing technical assistance (WHO 2010:70).

Heywood and Choi (2010:60) argued that alongside these public facilities there was also a range of private ones which included a limited number of private hospitals and clinics and a large number of private facilities established by private providers to staff public institutions. These private practices become an important source of ambulatory health care, but they are not routinely included in the health information system. The source of health care from nurses' private practice is seldom acknowledged; in fact, government regulations forbid them to provide private practice.

By the late 1990s, the Indonesian health system was basically a private health system, with two thirds of the financing and more than half of the services being private. The health facility distribution allows consumers to choose a facility and/or provider. This was the result of a transition that commenced with the original staffing strategy. There was low government

spending on health, with out-of-pocket spending approximately 70% and two-thirds of all ambulatory care from private providers. The private sector was an important source of care for the poor. Half of all hospital beds were in private hospitals, with low levels of utilisation by the poor. The government ignored the transition to a predominantly private system, and the health strategy statements still read as if the public sector were the main provider (Heywood & Choi 2010:64).

Hill and Eang (2007:632) assert that decentralisation process commenced in 2001, with the responsibility for the provision of services assigned to districts within a year. Experienced observers at the World Bank declare that "Central regional transfers remain the dominant means of financing but the earmarking is gone"; and "since decentralisation districts decide how to spend their own resources". These moves all seemed consistent with the idea that decentralisation expands choice at the local level and leads to an increased "decision space".

Expectations from decentralisation in the health sector were high. However, decentralisation in Indonesia was not a planned event, but rather a political event implemented following the 1997 financial crisis. Improvement of health services was at best a secondary objective. The central health ministry was not prepared to assume a new role as system manager, nor were the districts, which lacked many of the skills needed to plan and manage the health sector. The provincial level of government was assigned a minor role, and the central government now had the task of dealing directly with more than 400 districts, something it had not done before and was not equipped to do now (Hill & Eang 2007:633).

The challenges of implementing this new decentralised system were compounded by the absence of regulations needed to clarify the roles and

tasks of the central, provincial and district spheres. As the district is the crucial level in decentralisation of the health sector in Indonesia, we have been looking more closely at how the system is functioning there with emphasis on health facilities, human resources, public funding and system performance (Hill & Eang 2007:635).

Based on the above discussions, it can be argued that there are lessons that can be learnt from Indonesia in respect of the repercussions of rapid decentralisation. Indonesia completed a health personnel and health facilities transfer in 2001, less than two years after enacting Laws 22 and 25. This rapid decentralisation process did not provide enough detail on functional and operational responsibilities, resulting in confusion and divergence between provinces and districts, some indicators worsened as immunisation rates fell. The last focus is on drawing lessons from Brazil in respect of decentralisation of health services.

8.5 Brazil

Decentralisation is a ubiquitous feature of the health sector reform throughout the world. Its virtues are extolled by those that adhere to the Primary Health Care movement as expressed in the Alma Ata Declaration of 1978 and in the more market driven approaches that have informed health sector reform in many countries, particularly in the early 1990s. Despite its many advantages, there is a growing concern that decentralisation, particularly when inappropriately formulated and implemented, can have negative effects on health and health care development (Bossert 1996:148; Collins 1996:163; Collins & Green 1994:60).

Collins *et al.* (2000:114) argued that decentralisation has been linked with increased bureaucratic costs, inefficiency and political manipulation. It has also been associated with increasing organisational fragmentation and constraints on the development of national health policy objectives and strategic planning. The paradox of health sector decentralisation is that, while it is justified in the name of equity, it can quite easily lead to inequity, particularly in devolved forms of decentralisation.

There is a clear need to develop understanding of the policy processes leading to decentralisation, the appropriateness of decentralisation policies themselves, the conditions leading to effective decentralisation, and to assess the influence of decentralisation on health and health sector development. One way in which this can be done is by developing understanding of concrete processes of health sector decentralisation. There is a need for a realistic process of international learning in the area of health sector decentralisation, and recent work has sought to develop this (Collins *et al.* 2000:114).

It can therefore be submitted that analysis of decentralisation as an aspect of health sector reform, will be outlined in the paragraphs that follow.

The Unified Health System (UHS) and decentralisation

Between 1964 and 1985 Brazil was ruled by military governments known for their political repression, rigid centralisation and strong emphasis on economic growth as opposed to social development. The military had inherited a fragmented health care system based on the public financing of Ministry of Health provision in addition to a number of compulsory health

insurance schemes for employees from the formal sectors of the economy (Horn 1985:47).

Horn (1985:47) adds that the system continued as fragmented operating within government policies that focused on economic development as opposed to social welfare. Those working in the informal sector and the rural areas were largely excluded from these social security arrangements. As a result, public sector health care tended to be concentrated in the more developed south and south east of the country and exclude the urban and rural poor. A development during the years of the military governments was the growth of the private sector, including private (particularly for profit organisations) provision of publicly financed care through social security arrangements. In addition, government subsidies were given to support private hospital construction.

An important feature of health sector reform in the 1980s was its explicit political character and its relation to the fight against the military regime. Health sector reform became a fundamental feature of the fight to re-democratise the society and the political regime. Of relevance here was the Public Health Reform Movement—a wide ranging and loosely organised coalition of social and political groups emerging from the mid 1970s and dedicated to a democratic reform of the health sector. It included progressive members of health professional and occupational groups along with intellectuals, trade unionists, and social popular movements promoting the need for improved health and municipal reformers and held broad links with opposition political parties (Horn 1985:47).

Souza (1996:18) points out that the movement's progress saw it widen its appeal to social movements, women's groups and neighbourhood

associations, although Viana *et al.* (1997:332) draw attention to the important role played by a professional elite in the reform process. Cohn (1992:768) has signalled out a dual political strategy adopted by the movement: '...active participation in struggles to re-democratise the nation, specifically focusing on health issues, and the elaboration and implementation of proposals for the institutional re-organisation of health care, primarily through the strategy of occupying spaces within the State apparatus.' This infiltration of the government machinery was accompanied by a whole series of symposia, meetings and conferences supporting the cause of reform. The Movement was able to exert an important influence over the post dictatorial reforms. The health sector in Brazil has undergone important changes, particularly with the development of the Unified Health System (UHS). Decentralisation is an important principle of UHS and advances have been made in transferring responsibilities and resources to the local government units, known as municipios.

8.6 Conclusion

The lesson to be drawn from the review of decentralisation in developing countries, and the pros and cons of the delegation of powers to the lower level is that decentralisation is an extremely complex topic and that it is very dangerous to make generalisations about why particular policies have been adopted and how they have evolved. It is probably even more difficult to draw conclusions about how decentralisation should be undertaken. Each country has had its own experiences and their relevance to other countries is probably fairly limited. However, many countries have, at different times, felt the need to institute large-scale health sector reforms that favour a greater degree of decentralisation.

The principal lesson obtained from the experiences of various countries is the need to approach formulation and implementation strategies for health sector reforms systematically, rather than importing, uncritically, structural models developed abroad. A systematic approach to policy formulation must begin by clarifying the problems the health sector reforms are intended to address. There is nothing to be gained from implementing change for the sake of change.

It should be acknowledged that each country is unique, with its own history, internal priorities, resource availability and political ideology. What is an effective decentralisation strategy in one country may not be relevant or feasible in another. In certain situations, decentralisation may not necessarily be appropriate at all.

The stated objectives of decentralisation are to bring about fundamental changes in the health system that will help meet national health objectives while making the system functionally, organisationally, and politically sustainable. As the specific national objectives vary from country to country, so will the decentralisation strategies adopted.

In the last decade in particular, in countries where the majority of revenue for health services has come from international donor agencies, the driving force for decentralisation policies has been the process of state limitation (restrictions on the role of the public sector) as part of structural adjustment policies. These expectations in their breadth and diversity help illustrate one of the fundamental problems of transferring decentralisation models between countries. Of critical importance when assessing the validity of experience exchange is that decentralisation as a concept is not a stand-alone neutral issue. It remains deeply embedded within the political, social

and economic roots of a country. Decentralisation can therefore be viewed as a means to a number of ends but not as an end in itself. However, there is often a difference between the clearly stated objectives of decentralisation and the implicit and unstated reasons why governments should actually promote it.

The 'top down' implementation of a policy, even by a strong government, without due regard for a process of consultation and adaptation is very likely to fail. Decentralisation will only be accepted and made to work through a process of consultation that allows genuine 'top down' and 'bottom up' interaction. This necessitates prior consultation with all the policy actors and taking account of the context. The first task for any government is to decide which form of decentralisation should be selected. The process of policy development, however, must reflect what is politically feasible as well as being economically and managerially possible, and points to the importance of an incremental process of decision-making.

It is argued that copying forms of decentralisation between countries, particularly by developing from developed countries, carries high risks of inappropriate transfer. This is not to say that decentralisation policies should not be followed, since they may be important for health systems development and possibly needed to promote democracy in the developing world. Rather, there is a need for thorough policy analysis by a country seeking to attain possible benefits from decentralisation. It is recommended that this include piloting and experimentation of aspects and forms of decentralisation most appropriate to the characteristics of the country concerned to ensure a suitable fit.

CHAPTER 9

RESEARCH FINDINGS AND INTERPRETATION

"Individuals who enjoy good health rightly think of themselves as fortunate. But luck has little to do with the broad patterns of disease and mortality that prevail in each society. The striking variations in health conditions among countries and cultural groups reflect differences in social and physical environments. And increasingly, the forces that shape health patterns are set in motion by human activities and decisions" (Eckholm, 1977:18-19).

9.1 Introduction

Chapters 2 to 8 reviewed the relevant literature on the decentralisation of district health services. This chapter reports on the empirical findings of the investigation. The survey is based on a simple random sampling of 84 health-care professional nurses operating in health facilities within four district and one metropolitan municipalities and collection of quantitative data by means of questionnaires distributed randomly at health facilities targeting health professionals. Qualitative data was received through facilitation of focus group discussions among health managers from the provincial government, metropolitan municipality as well as four district municipalities. It should be noted that the researcher engaged the Head of Department (HOD) of Health in the Free State in respect of seeking permission to conduct an empirical study within health facilities. The researcher explained the purpose of the study and the target population within sampled health facilities across four districts and one metropolitan municipality. The HOD: Free State Health granted oral permission for

carrying out the study and thus referred the researcher to Acting General Manager: District Health System to take the matter further. The purpose of the study was further elaborated to the Acting General Manager: District Health System. A meeting was then convened by Acting GM: DHS with all five district managers where the purpose of the study was further elaborated; oral consent was further obtained from them for distribution of questionnaires (Appendices 2, 3 and 4) and letters (Appendix 1), detailing the purpose of the study as well as acknowledging their participation in the study, to primary health care (PHC) managers, healthcare professionals, and stakeholder forums of sampled health facilities. The aforementioned questionnaires and letters were distributed by hand to the respondents through the help of district managers of health.

The research instruments in the form of questionnaires and focus group discussion guide (Appendices 2, 3, 4 and 5) were developed. Questionnaires (Appendices 2, 3, and 4) consisted of closed ended questions and semi-structured questions and were used to survey PHC managers, healthcare professionals as well as health forum stakeholders' biographical data. The focus group discussion guide (Appendix 5) consisted of both open-ended and semi-structured questions. The semi-structures questions were designed to guide the participants to respond to key aspects of the research questions. The open-ended questions accorded opportunity for the respondents to express their perspective on the issues relating the problem statement and the primary hypothesis.

The next section focuses on the biographic characteristics of the sample, followed by their knowledge about the decentralisation process.

9.2 Biographic information

This study was conducted among 84 health-care professionals from the five districts of the Free State Province using simple random sampling method. Figures 9.1 and 9.2 present the gender and municipal districts where the respondents are working. The vast majority of the health-care workers who participated in the study are female (83.3%). In respect of the district representation, the study reveals that most of the respondents were from Xhariep (32.1%), followed by Fezile Dabi (21.4%) and Motheo (19%).

Figure 9.1: Gender

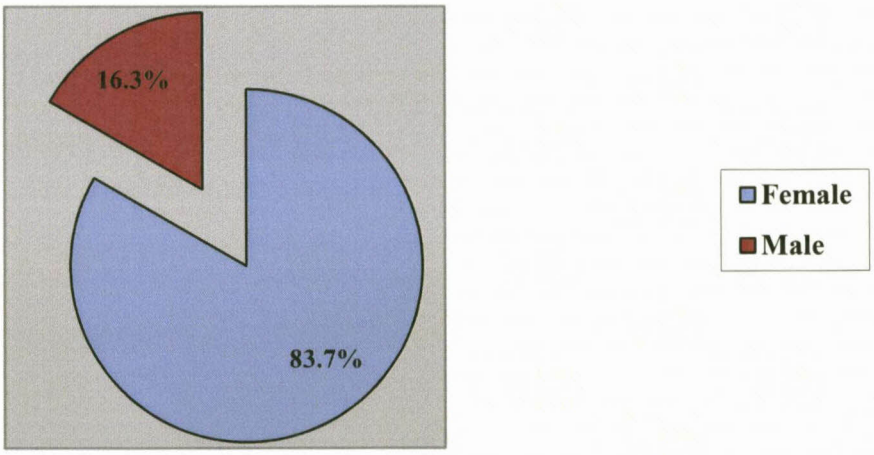
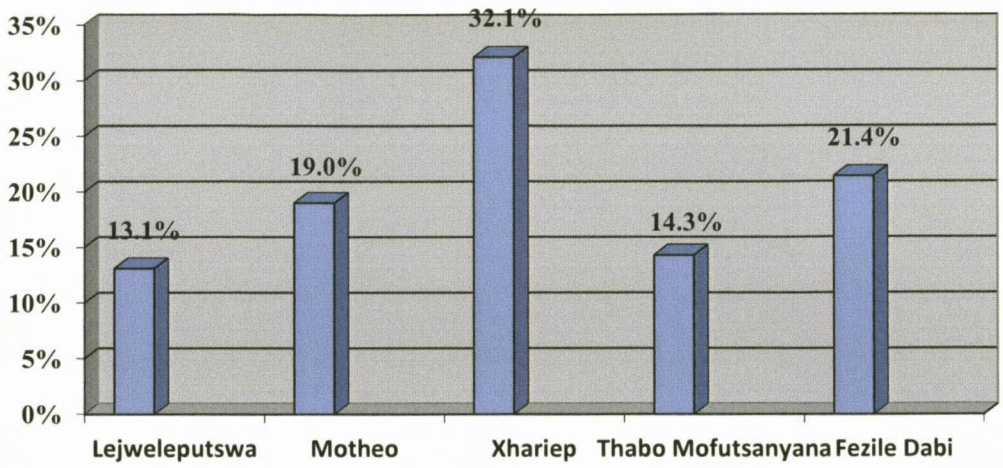


Figure 9.2: District



9.2.1 Employment

From Table 9.1 it is evident that more than half (55.6%) of the respondents who answered the question about their occupation were Professional Nurses, followed by Nursing or Operational Managers (19.4%).

Table 9.1: Occupation

Occupation	**No.**	**%**
Professional Nurse	20	55.6
Nursing/Operational Manager	7	19.4
Dietician	3	8.3
General Assistant/Admin Clerk	3	8.3
Environmental Health Practitioner	1	2.8
Clinical Psychologist	1	2.8
Pharmacist	1	2.8
Total	*36*	*100*

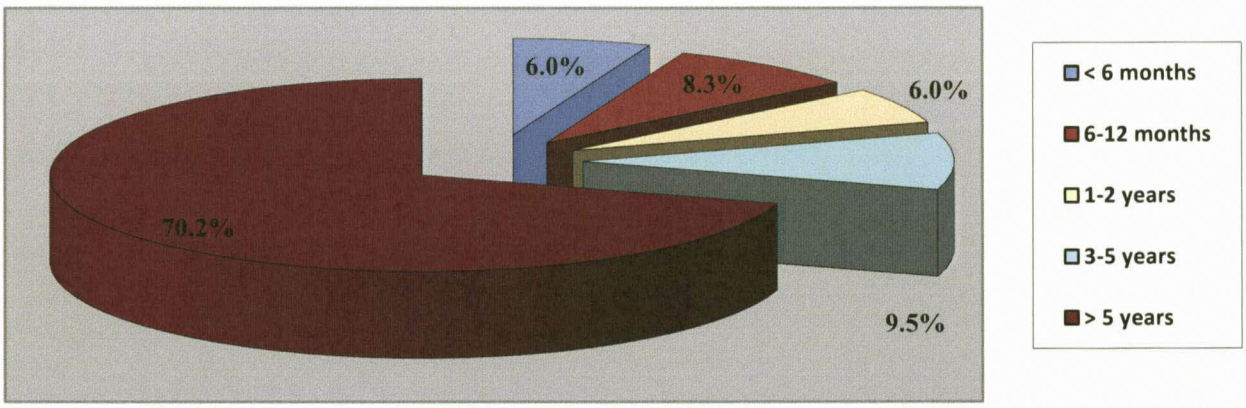
The vast majority (79.8%) of the respondents were working at a public clinic (Table 9.2).

Table 9.2: Workplace

	No.	%
Public clinic	67	79.8
District Office	10	11.9
Mobile Clinic	6	7.2
Public hospital	1	1.2
Total	*84*	*100*

As can be seen in Figure 9.3, more than two-thirds (70.2%) of the health-care workers have worked for more than 5 years and 9.5% between three to five years at their current workplace.

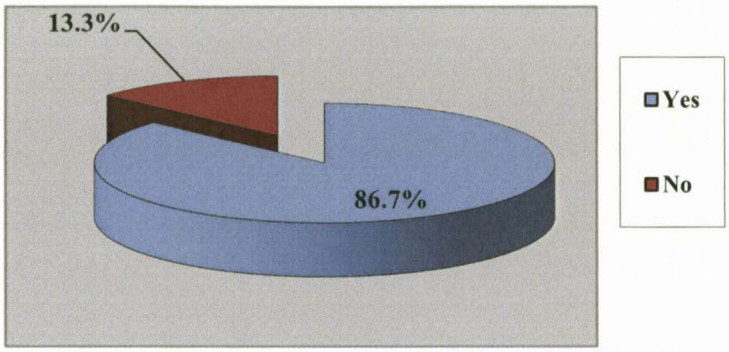
Figure 9.3: Duration of employment



9.3 Knowledge about the decentralisation process

When asked whether they know about the decentralisation of PHC services, the vast majority (86.7%) of the respondents indicated that they do know about the process (Figure 9.4).

Figure 9.4: Knowledge about the decentralisation of PHC services?



Subsequently those who indicated that they know about the decentralisation process were asked to explain how they learned about the process. According to Table 9.3, 72% of the respondents learned from their supervisors about the decentralisation process and 13.3% from colleagues.

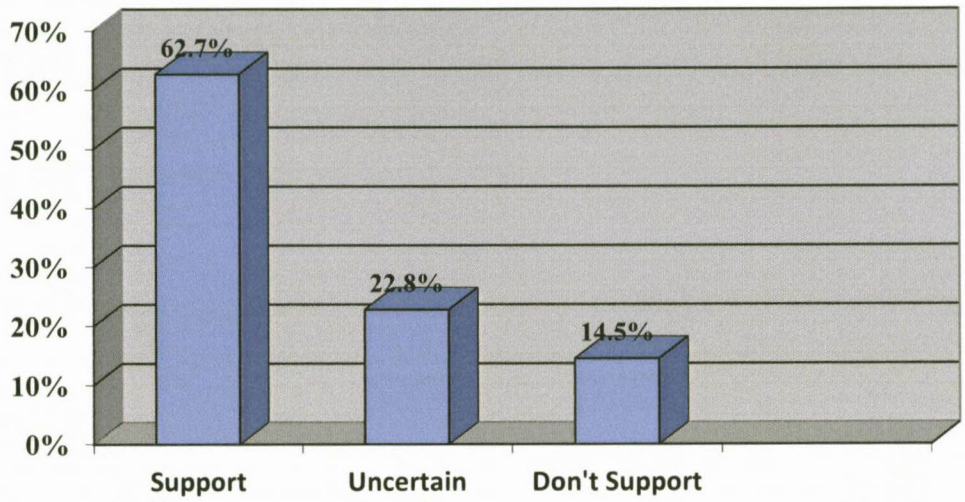
Table 9.3: Source of information about decentralisation

Source of information	**No.**	**%**
Informed by supervisor	54	72.0
Informed by colleagues	10	13.3
Learned from the media	4	5.3
Provincial officials	3	4.0
Researcher	2	2.7
From tertiary studies	1	1.3
Government Policy	1	1.3
Total	*84*	*100*

9.4 Perceptions about the decentralisation process

In this section the general perceptions of the respondents are broadly measured in respect of their support or non-support for the decentralisation process and the potential consequences of the process. In terms of support (see Figure 9.5), 62.7% of the respondents revealed that they support the proposed decentralisation process.

Figure 9.5: Supporter of decentralisation?



When asked what the consequences of decentralisation would be for their work, more than two thirds (69.5%) of the respondents indicated it will have positive consequences compared to 13.4% who stated that it will have negative consequences (Figure 9.6).

Figure 9.6: Consequences of decentralisation for work

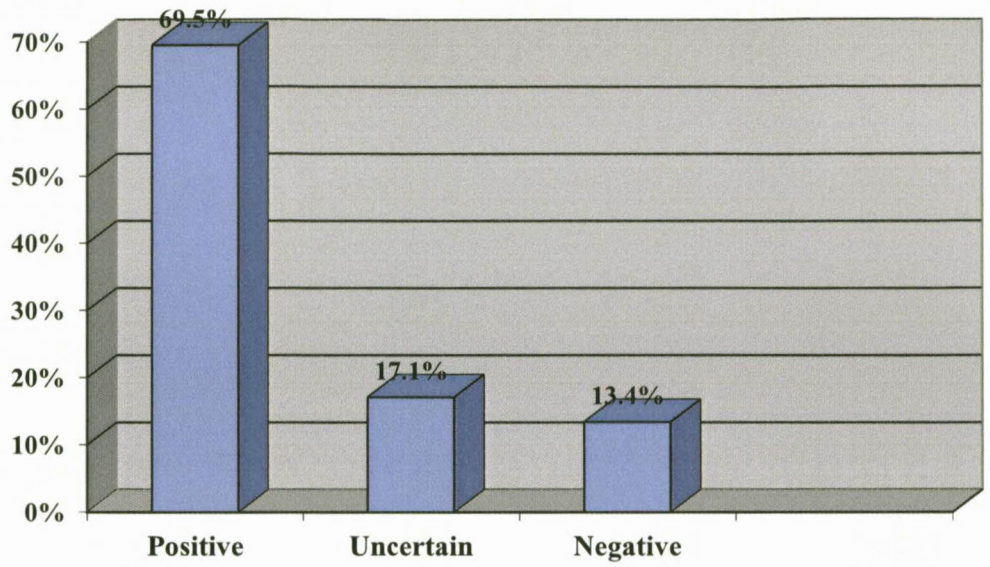
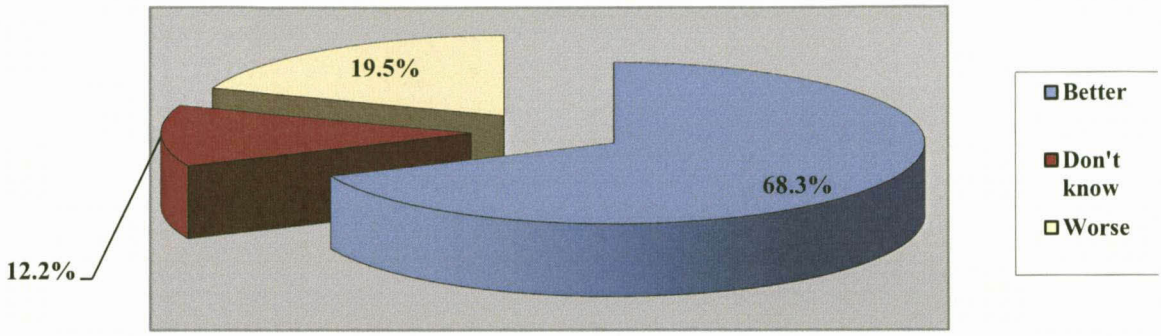


Table 9.4 deals with the explanation provided by the respondents to the question on the consequences of decentralisation. Slightly less than half of the sample stated that decentralisation will lead to improved health care service provision/home-based care, with less chance to lose patients in the system (48.4%), followed by less than a fifth who indicated that it will reduce bureaucratic red-tape and enhance communication and teamwork (18.8%) and 17.2% who did not know their fate because they have never been consulted. Similarly, the majority of the respondents believed that conditions for service provision will be better after the decentralisation process compared to the period before (Figure 9.7).

Table 9.4: Reason why decentralisation will have positive/negative consequences

Reason	No.	%
I don't know my fate. I was never consulted. There is no communication about the decentralisation process	11	17.2
Will lead to improved health care service provision/home-based care, with less chance to lose patients in the system	31	48.4
Lead to job loses	2	3.1
Practitioners are going to leave the Public Service due to burnout and unfavourable working conditions	5	7.8
Will reduce bureaucratic red-tape and enhance communication and teamwork	12	18.8
Municipalities already have enough troubles in respect of service delivery. This will only contribute additional burden on municipalities	1	1.6
Not in favour of decentralisation	2	3.1
Total	*64*	*100*

Figure 9.7: Will decentralisation lead to better or worse conditions for service provision?



9.5 Impact of decentralisation on work

Item 12 of the questionnaire asked the respondents to indicate to what extent they agree or disagree with the statements relating to the proposed decentralisation of district healthcare services captured in Table 9.5. The majority of the respondents believed that the quality of care provided at the workplace will improve (63.8%) but that they will experience serious staff shortages (60.2%).

Table 9.5: Extent of agreement or disagreement with the following statements

Statement	%		
	Disagree	Uncertain	Agree
1. The quality of care provided at my workplace will improve	13.8	22.5	63.8
2. Management of public health care facilities will improve	15.7	27.7	56.6
3. Lack of material resources will be a serious problem at public health care facilities	22.9	19.3	57.8

4. We will experience serious staff shortages	15.7	24.1	60.2
5. Management will be much more supportive	22.9	34.9	42.2

9.6 Main preferred aspects that should be decentralised

In response to the question: what are the three main areas of responsibilities that they would like to see being decentralised the pattern that emerges (see Table 9.6) from the two aspects selected according to the highest percentage is quite interesting. In respect of the first main aspect that should be decentralised according to the respondents, the management of programmes/referrals (38.4%) and financial management: budgeting, purchasing of material (28.3%), features highly. In respect of the second main aspect, authority/decision-making/recruitment and employment of healthcare workers (60.6%) and the procurement of promotional material for programmes, including resource management (21.1%) were the leading aspects that should be decentralised. The two leading aspects chosen as the third main aspect that needs to be decentralised were the recruitment aimed at decreasing staff shortages (60%) and the auctioning of redundant material (20%).

Table 9.6: Main aspects preferred to be decentralised

First main aspect	**%**
Financial management: budgeting, purchasing of material	28.3
Management of programmes/referrals	38.4
Appointment of staff/human resources	1.7
Choice on Termination of Pregnancy (CTOP)	3.3
Training	3.3
Defaulter tracing/client consultations to include family	5.0
Policy formulation	11.0
Second main aspect	

Procurement of promotional material for programmes/ resource management	21.1
Authority/decision-making/ Delegation/Recruitment and employment of health-care workers (nurses and doctors)	60.6%
Training	5.2
Emergency Medical Services/Education, Information and Communication	13.1
Third main aspect	
Auctioning of redundant material	20.0
Recruitment aimed at decreasing staff shortages	60.0
Emergency Medical services	12.0
Referrals	8.0

9.7 Important aspects satisfied with, or dissatisfied, with about the proposed decentralisation of district health-care services

In this section of the report, the focus is on the single most important aspect that respondents were satisfied with and another that they were dissatisfied with the proposed decentralised district health-care system.

Table 9.7: Single most important aspect satisfied with about decentralisation process

Aspect	No.	%
Independence and authority/stop red-tape/unity	6	9.8
Prospect of better health care provision to communities	35	57.4
Improved preventive role of the Department of Health/Fact that families, instead of an individual, will be monitored	7	11.4
Improved HAART services	3	4.9
Less workload and better salaries (benefits)	7	11.4
Not in favour of decentralisation	1	1.6
Municipalities are sometimes bankrupt – not pay salaries	2	3.3

Total	*61*	*100*

According to Table 9.7, foremost among the single most important aspect with which respondents were satisfied with was the prospect of better health-care provision to communities (57.4%). The leading single most important aspect that respondents were dissatisfied with was the lack of communication/consultation/knowledge about the process (27.8%) and increased workload and home visits (25.9%). Other leading aspects included failure to manage infrastructure and support staff (16.7%) and that patient management will be problematic (high defaulter rates; free movement of patients between facilities) (see Table 9.8).

Table 9.8: Single most important aspect dissatisfied about the decentralisation process

Aspect	**No.**	**%**
Increase workload/home visits	14	25.9
Lack of communication/consultation/knowledge about the process	15	27.8
Failure to manage infrastructure and support staff	9	16.7
Treatment bias - some health-care providers may provide preferential treatment to patients they know.	2	3.7
Health care provision will suffer: shortages of resources, both material and human resources	3	5.6
Patient management will be problematic (high defaulter rates; free movement of patients between facilities)	7	13.1
Competition for resources between districts	4	7.5
Total	54	100

9.8 Suggested measures that can be taken to strengthen the decentralisation of district health-care services

Finally, the respondents were asked how the decentralisation of district healthcare services could be strengthened. The following responses were provided:

- Do not know/no idea 6 (13.3%)
- Supervision should be provided at all levels 5 (11.1%)
- Services provision should be accompanied by with proper referral system 13 (28.9%)
- Do not compromise quality health-care provision. Qualified personnel should be employed to better manage resources 19 (42.3%)
- Health care provision should remain a provincial function 1 (2.2%)
- Involve everybody in the process 1 (2.2%)

9.9 Qualitative findings

One focus group session was conducted in December 2011 with senior health managers from the Free State Provincial Government (Health Programmes); Mangaung Metro Municipality; Xhariep-, Motheo- and Thabo Mofutsanyana Health Districts.

9.9.1 Background on the decentralisation process

Considering the profound influence that decentralisation has on employees, a feature that became evident in this study is the divergent views of the health managers on the effect of the process. In order to obtain an understanding on the rationale behind the decentralisation of district health-care services, participants mentioned the following factors:

- Primarily District Health Council initiative to move towards single public services.
- Budgetary constraints due to parallel structures between the provincial government and municipalities.
- Norms of health not adhered to by some sectors.
- Salary disparities.
- Less bargaining power of health-care workers.

The following statements capture the responses of the participants:

It was a National Health Council decision that all health-care services should be consolidated by 2014. This is a move towards single public services, because there were huge disparities in the salary of nurses at municipal clinics and those managed by the province **[Provincial Official].**

Since 30 June 2007, clinics that were managed by local government were transferred to the province, with the exception of Environmental Health Services. By the 1st July 2007, the then Mangaung Local Municipality was the last municipality to still manage its own clinics **[Motheo District].**

Budgets were different although medication was never a problem at local government level. The current government inherited the previous healthcare system which was based on the National Party's policy of

segregation, hence the different norms applied between different clinics **[Mangaung Metro Municipality]**.

Again, according to the legislation, primary health care is the competency of the provincial government. What happened is that the province was transferring money to municipalities to operate clinics on its behalf **[Thabo Mofutsanyana]**.

... there were even different open hours between the different clinics... **[Provincial Official].**

Another problem was there used to be three clinics in one small town. One for Africans, one for Coloureds and one for Whites... Local municipalities will budget for clinics, but that was not enough. The norms and standards of the National Department of Health were also not adhered to... **[Xhariep]**.

9.9.2 Advantages of the decentralisation process

The following advantages of decentralising health-care services were identified by the participants: improved service provision; better salaries, and uniformity:

It has to do with the rendering of services to the people. A major advantage is that several government documents support the decentralisation of services, for example, the White Paper on Local Government Transformation and ASGISA **[Mangaung Metro Municipality]**.

If you look at the issue of salaries, municipalities were graded and, therefore, nurses were paid according to the level of grading of a municipality. Municipalities such as Mangaung paid well because of its grading. Nurses were reluctant to work at rural municipal clinics because of the low grading of such municipalities. Some municipalities even failed to pay nurses at times due to lack of available funds. Consolidation of services will solve this disparity in salaries. **[Provincial Official].**

One major advantage is the issue of uniformity. Unlike in the past where provincial clinics and municipal clinics will have different standards, when the national government came up with certain resolutions and provinces adopts them, municipalities could decide whether they adopt them or not. It is no longer the case as everybody is bound by the same resolutions... [**Thabo Mofutsanyana**].

In the past, nurses did not fall within the same bargaining council. As a result, some had more bargaining power than the others. Municipalities were using SALGA and the provincial clinics provincial bargaining structures..

9.9.3 Challenges experienced in the past attempts to decentralise

The participants also mentioned that during the last attempt to decentralise services, the major challenge emphasised was the payment of provident funds and other financial implications.

The centralisation of services had a huge effect on employees. One problem was that the Provident Fund of employees could not be transferred from one fund to another. Again, I strongly believe that employees we are not

properly informed about the process. To date, we still have many employees who are about to retire, but because they abused their money, they will be left with less pension money. The whole process created poverty among many....[**Lejweleputswa Municipality**].

No legislation was in place which could facilitate the movement of provident funds between municipalities and the province. It could only occur between national and the provinces. As a result of this, a service consultant was appointed to engage individual employees on their personal situations. Employees were advised to invest their money in preservation funds as it was difficult to transfer the money to the government pension fund. One major unintended consequence of this process was that people took their money and spent it on luxuries... [**Thabo Mofutsanyana**].

... but what discouraged employees to invest their money was that a certain portion had to be taken by the consultants. People felt that they had worked hard for many years for others just to come and share their windfall. The thinking at that time was "I'd rather take my money, instead of sharing it with strangers'... [**Mangaung**].

It also appears that health-care workers experienced other financial challenges which included the payment of Unemployment Insurance Fund (UIF) and the Occupational Specific Dispensation (OSD):

We also had a situation where the municipalities in Bloemfontein and Bethlehem contributed more to the provident funds than the province. Most of the others contributed less than the province. A decision was taken to mitigate the situation. An audit was done in 2001/02 and everyone was treated equally irrespective of whether they were from the province or

municipalities. White people got a danger allowance when they worked in Black townships in the past. Generally, however, people were not willing to lose the money that has accrued [**Motheo**].

Municipal employees also lost their UIF money when they were transferred to the province. In order to mitigate the situation, a short-term solution promised at the time was the payment of OSD of R1 200 for 3 months. This was never implemented and it became a highly contested issue at the High Court after IMATU and SAMWU filed an application. Their main argument was that Section 197[1] *of the Labour Relations should not be compromised* ... [**Mangaung**].

9.9.4 What is needed to ensure the success of the decentralisation of health-care services?

The following suggestion was made in respect of what could ensure the success of the process:

- **Political interference.** *This whole decentralisation and centralisation processes is often dictated by politicians. These processes could only succeed when the genuine interest of community members are taken into consideration* [**Thabo Mofutsanyana**].

[1] The takeover of an entity or part thereof by a new owner or a new management often causes loss of jobs and employees are often desperate to stay on with the new enterprise. On the other hand, the new owner/management very often already has its own staff and wants to avoid the expense of taking on additional employees. The law relating to takeovers of going concerns has been expanded and is no longer confined to situations where one business buys another or where two entities merge. The Labour Relations Act (LRA) was amended in 2002 to include a "service" in the definition of an entity that may be taken over as a going concern for purposes of section 197 of the LRA (Israeltham, 2010).

- **Capacity.** *We need to be honest with ourselves. Once the decision is taken to decentralise services, we should assess whether we have enough capacity to carry out such a mandate...* **[Motheo].**

- **Financial influence study.** *We should audit all services and determine what it will cost to provide them. In the past, the municipality was left with a deficit of R20 million as a result of managing health-care services. The Treasury gave us far less than what was budgeted. It is municipalities that will bear the brunt of such improper planning* [**Mangaung**].

- **Involve districts.** *When services are consolidated or decentralised, we* [district services] *are always the last to hear about it. We play a significant role in rendering health-care services in the provinces and we need to be consulted...* [**Xhariep**].

Other suggestions included:

- Proper communication channels.
- Support from senior managers
- Continuous monitoring and evaluation

9.10 Interpretation of research findings

Based on the analysis of data highlighted earlier in the text, the following interpretation in relation to whether the study favoured the decentralisation of district health services is outlined below:

- Supporting legislative frameworks

According to qualitative findings most essential legislative frameworks governing the country dictate that South Africa must implement a decentralised governance in order to establish and address the health-care needs of the people. These legislative frameworks include the Constitution of the Republic of South Africa, 1996, National Health Act, 2003 (Act 61 of 2003), the White Paper on Local Government Transformation, 1998 and the White Paper for the Transformation of the Health System in South Africa, 1997, and they provide for the decentralisation of health care and municipal health services to the local sphere of government.

- Knowledge among health-care professionals regarding the decentralisation of health services

From the findings of the study it became clear that a significant number of health-care professionals and managers have adequate knowledge about decentralisation of health services. This is supported by the fact that the majority of health care professionals were present when primary health care services were provincialised from 2003 until 2005 in order to address uniformity of conditions of service affecting healthcare workers and ensuring that the consumers of health-care services receive services from one authority. It is against this background that was provided by means of questionnaires and focus group discussions that will make decentralisation to be embraced and be facilitated with ease. For instance, the vast majority (86.7%) of the respondents indicated that they do know about the process (Figure 9.4).

- Capacity audit at the level of municipalities

The notion to assess and audit the capacity of municipalities will help determine the level of healthcare services to be decentralised as well as the form of decentralisation that needs to be undertaken. This statement is supported by qualitative findings derived from focus group discussions comprising senior managers who indicated that before health services can be decentralised, district municipalities should first be assessed in respect of both human and financial capital in order to determine the state of readiness.

- Decentralisation of health services will engender community participation and enhance service provision

Most of the respondents asserted that decentralisation will facilitate direct interface between the state and communities at the local sphere of government and will encourage local citizens to influence decisions that are aimed at addressing health problems prevalent within their geographic area. According to Table 9.7, foremost among the single most important aspect respondents were satisfied with the prospect of better health care provision to communities (57.4%) as opposed to 5.6% of those who believed that health care provision will suffer.

- Support for the decentralisation of district health services

In terms of support (see Figure 9.5), 62.7% of the respondents revealed that they supported the proposed decentralisation process. More than two thirds (69.5%) of the respondents indicated that decentralisation will yield positive consequences for their work (see Figure 9.6). In terms of preferred

aspects that should be decentralised 60.6% of respondents indicated authority/decision-making/recruitment and employment of health-care workers as preferred aspects that should be decentralised (see Table 9.6). It can be noted that there is great support of decentralisation of district health services as indicated by the findings of the study.

From the above interpretation it is apparent that the study helped in addressing the research problem and will also help to outline specific recommendations for the type of decentralisation that the Free State Health Department will have to follow.

Based on aforesaid analysis of research findings, it can be asserted that the primary hypothesis, namely, "Decentralisation of district health services in the Free State Province will enhance efficiency and equity thus making local public representatives to be accountable for services rendered," should be retained. This matter is supported by 86.7% of respondents who indicated that they possess sufficient knowledge about decentralisation, as well as 57.4% of respondents who pointed that decentralisation will bring prospects of better health provision to the community. Furthermore, more than two thirds (69.5%) of the respondents indicated that decentralisation will yield positive consequences for their work (see Figure 9.6).

Derived from the aforementioned hypothesis, eight secondary hypotheses as postulated below are also retained based on the research findings and analysis derived from both quantitative and qualitative data highlighted in the preceding paragraphs:

- Decentralisation of district health services will enable community members to participate actively in activities relating to health and thus ensure that their health needs are met.

- Decentralisation of district health services will ensure that both politicians and officials serving various municipalities will be accountable to the communities in terms of health services rendering.

- Decentralisation of district health services will ensure that capacity is created so that those who are charged with the responsibility of rendering primary health care are able to do it in an effective and efficient manner.

- While decentralisation of district health services will both increase accountability, efficiency and effectiveness, it will also serve as a means of boosting staff morale and encourage local initiatives and flexibility in the light of local and changing circumstances.

- Decentralisation of district health services will ensure that decision-making concerning health matters takes place closer to the communities as they will highlight their needs.

- Decentralisation will enhance multi-sectoral and multi-agency collaboration at the lower service provision levels thus rendering services in an integrated manner.

- Decentralisation will contribute to improved allocative efficiency by allowing the mix of services and expenditure to be shaped by local needs, epidemiology and provider skills and performance.

- Decentralisation will enhance greater equity by the distribution of resources among traditionally marginalised regions and groups.

9.11 Conclusion

It should be noted that decentralisation of district health services in the Free State Province should be seen as an endeavour by the current government to expedite the health reform agenda that is aimed at affording local citizens an opportunity to participate in decisions that affect their own health. In order for this to happen, factors such as determining capacity audit of municipalities as well as demonstrating political will, need to be attended to in order to determine the form of decentralisation to be undertaken. The research findings and interpretation of findings will assist in this regard.

CHAPTER 10

CONCLUSION AND RECOMMENDATIONS

10.1 Conclusion and recommendations

Decentralisation of health-care services has the potential to improve the efficiency of health services and equity of outcomes as highlighted by the research findings and interpretation in Chapter 9. Decentralisation of management functions and authority contribute to proper decision-making and to make those rendering health services accountable to the communities they serve. Decentralisation of the health sector is concerned with changing the manner in which health systems are organised. Conceptually, it is a change in power relations between the central government sphere and other participants in the health system, including statutory local government entities, lower spheres of government administration, private enterprises, state-owned enterprises and non-governmental organisations.

The South African health sector reform and transformations, with particular reference to Free State Province, has done quite well in terms of giving meaning to transformation of health services. This has been evidenced by formulation of various policies that culminated in the promulgation of the National Health Act, 2003 (Act 61 of 2003).

Decentralisation contributes to effective and efficient rendering of health services. The critical challenge in a decentralised health system lies in achieving a careful balance of power between central and local spheres in decision-making, priority-setting and resource allocation, to ensure that

decisions favour, or at the very least do not negatively affect availability and equitable access to health services.

In elaborating on the nature and extent of decentralisation, it should be noted that decentralisation is regarded as a key element of the primary health care (PHC) approach. Decentralisation has, not only an administrative value, but also a civic dimension, since it increases the opportunities for citizens to take interest in public affairs; it makes them accustomed to using freedom. Decentralisation should not be an end in itself; rather it should be the means to accomplish the broader goals of equity, efficiency, quality and access to health care. Decentralisation can take several forms, namely, de-concentration, delegation, devolution and privatisation. It is argued that copying forms of decentralisation between countries, particularly by developing from developed countries, carries high risks of inappropriate transfer.

Functional integration is ultimately about relationship building between the various health authorities which in turn leads to open dialogue, problem identification and cross-authority negotiations around changes required for improved provision of primary health care services. It is a key strategy for the achievement of decentralisation necessary for a simple departure from the past is the South African Government's decision to create a unified but decentralised national health system based on the District Health System (DHS) model. One of the main reasons for this is the belief that the DHS model is deemed to be the most appropriate mechanism for the rendering of primary health care. DHS is relevant because it is through it that health care needs of every citizen are met. The district model for functional integration of primary health care services demonstrates the necessity to build relationships, communicate, consult and negotiate before productive

planning can really begin. Functional integration focuses on how the health provision system functions and thus seeks ways to integrate the services as opposed to integrating the authorities.

Delegation is a more extensive form of decentralisation. Through delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it. As one form of decentralisation, delegation of health services is a pervasive global trend that seeks to enhance client responsiveness, administrative efficiency, and improved service access, especially at the local sphere of government. In order to give rise to equity, the programmes of delegation have to be linked to policies, for example, on national health planning, resource allocations and community participation. The expressed rationale for delegation is to meet local needs, improve the efficiency and quality of services, and ensure equity in health care.

Community participation is a process of initiation and sustaining dialogue with various members of a particular community in a structured manner with the view to consulting them as equals in a programme of activities that aim at building a team between programme managers and community members, to understand health problems in the community, to find common solutions to such problems and to act together to solve these problems using as much human and material resources as possible from the community. In the sphere of health, the Alma Ata declaration in 1978 heralded international recognition of the model of primary health care (PHC) implemented through the participation of the community.

Health governance structures have been created to provide an avenue for communities to contribute and give feedback into the planning, provision and organisation of health services and to play an overseeing role in the development and implementation of health policies and provision of equitable health services in accordance to the provisions of National Health Act, 2003 (Act 61 of 2003). The aforementioned health governance structures are intended to give expression to the principle of community participation at both local and district level.

The lessons learnt from other countries internationally such as Canada, Zambia, Indonesia and Brazil in respect of how decentralisation of health services was implemented, revealed that decentralisation is context-specific, related to political, geographical, social and economic conditions. The overwhelming lesson to be drawn from the review of decentralisation in developed and developing countries, and the pros and cons of the delegation of powers to the lower sphere, is that decentralisation is an extremely complex topic and that it is very dangerous to make generalisations about why particular policies have been adopted and how they have evolved.

Therefore, although countries can learn from each other's experiences of decentralisation, comparing decentralisation outcomes between countries is not easy. It should also be noted that in line with the MinMec resolutions of 2000, the Free State Department of Health had completed the provincialisation of primary health care services from local municipalities. The purpose was to address salary parity of all PHC personnel; implementation of primary healthcare package; and decentralising primary health care services to all district municipalities for effective and efficient health care delivery.

Based on the analysis and interpretation of empirical findings as well as lessons drawn from international countries through conducting literature study, it can be noted that both the primary hypothesis as well as supporting eight secondary hypotheses should be retained for the same reasons highlighted in Chapter 9.

The following recommendations are set out in light of nine chapters above, namely:

- Identify the main planning, financing, human resource, service rendering, operational, and/or information functions that some degree of decentralisation would improve, as well as of objectives for each function.
- Consider carefully which decisions would be made most effectively at the central sphere and which at the local spheres, by local health or local government authorities. Do this in light of the objectives and the capacities of the metropolitan and district municipalities.

- Map out the current administrative and financing structure and identify potential sources of tension, conflicts, capacity problems, and political issues at the level or sphere to which health services are decentralised. Consider building in phased implementation, capacity building, feedback mechanisms, and monitoring and evaluation (M&E) plans.
  Maintain a monitoring system for key policy processes and interim results related to the objectives of the decentralisation. Establish and enforce a feedback and decision process for using monitoring information to keep decentralisation reforms on track and/or make midcourse corrections.

- Identify major interested and affected parties, clarifying potential winners and losers, as well as developing plans for negotiation, compromise, advocacy, and problem solving to overcome participant issues.

- Where possible and relevant, consider pilot testing decentralisation components that are likely to be most problematic and for which particular consensus may need to be reached.

- Using the objectives of the decentralisation, establish an M&E plan that uses routine monitoring information in combination with periodic field reviews in order to determine the success of the form of decentralisation followed. To avoid unintended consequences, consider developing a longer-term evaluation design that measures the influence of the decentralisation on the major objectives of the programme, as well as on the bigger picture health sector objectives in the country.

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Appendices

APPENDIX 1

Letter to respondents

KNOWLEDGE, ATTITUDE AND PERCEPTIONS TOWARDS THE DECENTRALISATION OF PRIMARY HEALTH CARE SERVICES

Dear Respondent

You have been selected to participate in a survey designed to collect information on aspects relating to the decentralisation of Primary Health Care Services (PHC) in the Free State. This study is conducted under the auspices of the University of the Free State.

The information that will be collected will be useful for planners and policy makers in revising strategies in the decentralisation of PHC services in the Free State. In particular, it is hoped to gain a better understanding of your experiences, frustrations and needs. Participating in the survey will give you an opportunity to share your experiences and views on a variety of issues related to the decentralisation of PHC services. Thus, the success of this survey entirely depends on your kind co-operation. The information collected will be handled with the greatest confidentiality and your anonymity will be guaranteed. Thus, your name will not be connected to your views and there will be no way in which you will be identified. We are simply interested in your personal, honest opinion. Put your completed questionnaire in the envelope and hand it back to the Official.

We thank you for your valuable contribution and time.

Should you have any queries concerning any aspect of the survey, you are welcome to contact the researcher at the following contact number: 082 772 8126

Thank you.

_____

MOTSOARI M.C

APPENDIX 2

Questionnaire for Primary Health Care Managers

QUESTIONNAIRE FOR MANAGERS

Please mark the appropriate code with a cross.

1. **Gender**

Female	1
Male	2

2. **Occupation**

_____

3. **How long have you been working in this position?**

Less than 6 months	1
6 months – 1 year	2
1-2 years	3
3-5 years	4
More than 5 years	5

4. **Please indicate to what extent you agree or disagree with the following statements relating to the decentralised health care system:**

Statement	Strongly Disagree	Somewhat Disagree	Uncertain	Somewhat Agree	Strongly Agree
4.1 The quality of care provided at clinics improved	1	2	3	4	5
4.2 Management of PHC facilities improved	1	2	3	4	5
4.3 Communication between health care authorities and myself is adequate	1	2	3	4	5
4.4 Lack of material resources is a serious problem in the district					
4.5 The district experiences serious staff shortages					

5. **How are important messages communicated in the district?**

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6. **Briefly explain how health care facilities are monitored:**

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7. **Briefly explain how the district is accountable to communities:**

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8. **On a scale of 1 to 5 where 1 represents 'very satisfied' and 5 represent 'very dissatisfied,' how you would rate your level of satisfaction?**

Aspect	Degree of satisfaction				
8.1 Enjoy coming to work	1	2	3	4	5
8.2 Discipline amongst nursing staff	1	2	3	4	5
8.3 Commitment amongst staff members	1	2	3	4	5
8.4 Staff development	1	2	3	4	5
8.5 Promotional opportunities	1	2	3	4	5

9. **Decentralisation and transformation may have brought about changes that affect your job. Please indicate how these changes affect your daily functioning in terms of the following:**

Statement	Not at all	Sometimes	Most of the time	Always	Uncertain
10.1 Policies	1	2	3	4	5

10.2 Technology	1	2	3	4	5
10.3 Involvement of other participant	1	2	3	4	5
10.4 Training and development	1	2	3	4	5

10. What is the <u>single most important</u> aspect that <u>satisfies</u> you about the decentralised health care system?

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11. What is the <u>single most important</u> aspect that <u>dissatisfies</u> you about the decentralised health care system?

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12. What are the TWO most important aspects that you would you like to see addressed that will help to make your work more pleasant?

12.1.....

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12.2.....

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Thank you for your time and cooperation.
Please DO NOT FORGET to put your completed questionnaire in the envelope provided!

APPENDIX 3

Questionnaire to Healthcare Professionals

QUESTIONNAIRE FOR HEALTHCARE PROFESSIONALS

Please mark the appropriate code with a cross.

1. **Gender**

Female	1
Male	2

2. **Occupation**

_____

3. **Where do you work?**

Public hospital	1
Public clinic	2
Other (*please specify*)	
Other (*please specify*)	

4. **How long have you been working at this place?**

Less than 6 months	1
6 months – 1 year	2
1-2 years	3
3-5 years	4
More than 5 years	5

5. **Do you know about the decentralisation of PHC services?**

Yes	1	
No	2	→ Go to **Q7**

6. **How did you learn about the decentralisation of PHC services?**

Informed by supervisor	1
Informed by colleagues	2
Learned from the media	3
Other: (Please specify)	

7. **Are you a supporter of decentralisation certain powers to district and metropolitan health authorities?**

Yes	1
No	2
I do not know	3

8. **What would you consider the consequences of decentralisation for your work?**

Strongly Positive	Positive	Negative	Strongly Negative	I do not know
1	2	3	4	5

9. **Please explain your above answer:**

_____

_____

_____

_____

10. **How successful do you think the decentralisation of district health services to district and metropolitan municipalities will be?**

Very Successful	Successful	Don't Know/ No opinion	Unsuccessful	Very Unsuccessful
1	2	3	4	5

11. **In your opinion, do you think that the decentralisation of district health services will produce results that better serve the people of the Free State than would have been likely or possible under the pre-decentralisation arrangements?**

Yes – much better	Yes – a bit better	Neither better nor worse	No – a bit worse	No - a lot worse	Don't know/ No opinion

1	2	3	4	5	6

12. **Please indicate to what extent you agree or disagree with the following statements relating to the proposed decentralisation of district health services.**

Statement	Strongly Disagree	Somewhat Disagree	Uncertain	Somewhat Agree	Strongly Agree
12.1 The quality of care provided at my workplace will improve	1	2	3	4	5
12.2 Management of public health care facilities will improve	1	2	3	4	5
12.3 Lack of material resources will be a serious problem at public health care facilities	1	2	3	4	5
12.4 We will experience serious staff shortages	1	2	3	4	5
12.5 Management will be much more supportive	1	2	3	4	5

13. **The proposed decentralisation of district health services may lead to changes that may impact on your job. Please indicate to what extent the following WILL affect your daily work routine:**

Statement	**Not at all**	**Sometimes**	**Most of the time**	**Always**
13.1 Policies	1	2	3	4
13.2 Technology	1	2	3	4
13.3 Involvement of other participants	1	2	3	4
13.4 Training and development	1	2	3	4

14. **What are the THREE areas of responsibilities that you would like to see being decentralised??**

14.1 _____

14.2 _____

14.3 _____

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15. **What is the single most important aspect that you are satisfied with about the proposed decentralised health care system?**

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16. **What is the single most important aspect that you are dissatisfied with about the proposed decentralised health care system?**

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17. **Do you have any further comments to make about how the decentralisation of health care services can be strengthened?**

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Thank you for your time and cooperation.
Please DO NOT FORGET to put your completed questionnaire in the envelope provided!

APPENDIX 4

Questionnaire for Health Forum Stakeholders

QUESTIONNAIRE FOR COMMUNITY- DISTRICT – PROVINCIAL HEALTH FORUM STAKEHOLDERS' REPRESENTATIVE SURVEY

Please mark the appropriate code with a cross.

1. **Gender**

Female	1
Male	2

2. **In which health care forum/board are you serving?**

_____

3. **How long have you been serving in this forum/board** (*in years*)**?**

_____years

4. **Please indicate to what extent you agree or disagree with the following statements relating to the decentralised health care system. With the decentralisation of powers...:**

Statement	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Don't Know
4.1 My Forum/Board will remain an effective means of providing input into the Local/District/Provincial Health Care Services.	1	2	3	4	5	6
4.2 The method of appointing individuals to my Forum/Board will be less effective	1	2	3	4	5	6
4.3 I will not be able to see the influence of my Forum/Board's recommendations in my region	1	2	3	4	5	6

4.4 Community Participation in my Forum/Board decisions will be effective	1	2	3	4	5	6
4.5 My Forum/Board will not be sufficiently informed about Local/District/ Provincial Health Care issues	1	2	3	4	5	6
4.6 My Forum/Board will result in improved health care in my region	1	2	3	4	5	6
4.7 I may become an effective member of my Forum/Board.	1	2	3	4	5	6
4.8 My Forum/Board ability to provide a free expression of ideas may be hampered.	1	2	3	4	5	6

5. **How successful do you think the decentralisation of health care services to district and local municipalities will be?**

Very Successful	Successful	Don't Know/ No opinion	Unsuccessful	Very Unsuccessful
1	2	3	4	5

6. **In your opinion, do you think that the decentralisation of healthcare services will produce results that better serve the people of the Free State than would have been likely or possible under the pre-decentralisation arrangements?**

Yes – much better	Yes – a bit better	Neither better nor worse	No – a bit worse	No - a lot worse	Don't know/ No opinion
1	2	3	4	5	6

7. **What THREE areas responsibilities that you would like to see being decentralised?**

7.1 _____

7.2 _____

7.3 _____

8. **What is the <u>single most important</u> aspect that <u>satisfies</u> you about the proposed decentralised health care system?**

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9. **What is the <u>single most important</u> aspect that <u>dissatisfies</u> you about the proposed decentralised health care system?**

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10. **What are the TWO most important aspects that you would you like to see addressed that will help to make your work more pleasant?**

10.1.....

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10.2.....

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11. **Do you have any further comments to make about how the decentralisation of health care services can be strengthened?**

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Thank you for your time and cooperation.
Please DO NOT FORGET to put your completed questionnaire in the envelope provided!

APPENDIX 5

Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE

1. Please provide a general background on the decentralisation process in the Free State Province.

2. What was the rationale behind the decentralisation of district health services?

3. What are the advantages of the decentralisation process?

   3.1 For employees

   3.2 For the community (patients)

4. What are the challenges experienced during the past attempts to decentralise health care services in the Province?

5. Please mention the challenges experienced by the Department of Health/Municipality.

6. Please mention the challenges experienced by the employees.

7. What is needed to ensure the success of the decentralisation of healthcare services?