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H N P D I S C U S S I O N P A P E R

# Decentralized Systems of Health Care Delivery and the Role of Large Cities

## A Comparative Analysis

Emanuela di Gropello

July 2002





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**Emanuela di Gropello**

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## Health, Nutrition and Population (HNP) Discussion Paper

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## Health, Nutrition and Population (HNP) Discussion Paper

# DECENTRALIZED SYSTEMS OF HEALTH CARE DELIVERY AND THE ROLE OF LARGE CITIES: A COMPARATIVE ANALYSIS

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Paper is part of a special Technical Assistance Program to the city of Johannesburg in South Africa  
The World Bank, Washington DC, June 2000

**Abstract:** South Africa is going through an important political and administrative reorganization and a series of structural reforms. The responsibility for primary health care, which was mostly provincial, is about to be decentralized to the Local Government level. The main purpose of this paper is to analyze the on-going decentralization process in the Gauteng province and determine the role that Great Johannesburg can play within this new decentralized framework. To extract lessons and recommendations for Gauteng and Johannesburg, the paper takes a close look at the case of three middle-income Latin American countries, Chile, Colombia and Brazil, which offer valuable experience in the design and implementation of decentralized systems of health care delivery at the country and city level. It also looks at other international experiences. At the city level, the paper concludes that the case of Bogota in Colombia seems to be particularly relevant to the selection of a decentralized health care model for Johannesburg. It also shows that, in the longer run, the experiences provided by the current reforms in the UK and New Zealand would be worth looking at. Finally, a more general conclusion of the report is the finding that there is a wide range of possible roles for large cities in primary health care delivery and that the extent of this role will very much depend on the decentralization strategy adopted at the national level and on a number of key characteristics at the city level, among which the political and administrative structure, the fiscal and institutional capacity and the demographic structure could be identified.

**Keywords:** decentralization; social service decentralization; decentralized systems of health care delivery; health care reform; health care delivery; social service delivery in large cities; decentralized systems of health care delivery in large cities.

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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## FOREWORD

Experiments with decentralization in the health sector began in the 1970s in Western Europe and have since spread to many developing countries. This discussion paper looks at some of the dimensions of decentralization in the central province of Gauteng and the city of Johannesburg, South Africa, where on-going political and service delivery decentralization reforms are particularly noteworthy for their magnitude and expected impact.

The historical origins of decentralization go back a long way. Decentralization fundamentally changes property rights by shifting power from one level of government to another. A unique feature of ancient Greek civilization was the absence of a central ruler—no king, no emperor. Instead, hundreds of fully independent poleis, city-states, flourished in Greece and in its colonies around the Mediterranean and the Black Sea between 800 B.C. and 300 B.C. Each city-state became a testing ground for small innovations in laws, economic policies, and political organization. A central tenet of Plato's Republic related to diluting the excessive power gained by the emerging aristocracy through a form of decentralization of the city-state.

The 1950s to 1970s witnessed significant centralization in the way medicine and health care was organized in Western Europe. This shift of power toward centralized responsibility for the health sector had some noteworthy advantages. It led to a greater engagement of the State in the financing of health care. And it allowed closer coordination of strategic public health activities where private markets had failed.

But centralized structures are “bureaucratic” in nature and often unresponsive to the population or patients that they are supposed to serve. Decentralization — keeping ownership public but passing control over decision rights, responsibility, and accountability to lower levels of government — was seen as a possible middle road between heavy-handed centralized control and a return to the laissez-faire approach of the “invisible hand” that had dominated health care for centuries.

In the early 1980s, many developing countries began to follow a similar path. Decentralization in the health sector was part of a broad agenda for reforming the State. Used by many stakeholders, each with its own special vested interest, decentralization was a powerful political tool.

Decentralization may be both spacial (geographical) and functional. It often takes three different forms:

- Deconcentration – transfer of decision rights, power, responsibility and accountability from central to peripheral agencies that remain under central control (e.g. to regional, provincial, state or dependent local authorities)
- Delegation - transfer of power, decision rights, responsibility and accountability from central to peripheral agencies that are not under direct control (e.g. semi-autonomous agencies, NGOs and autonomous local governments)
- Devolution - transfer of power, decision rights, responsibility and accountability from central to peripheral agencies that to lower levels that have formal powers and functions assigned through statutory or constitutional provisions.

In the real world there is often a mix of these forms of decentralization. Furthermore, administrative systems and management practices often combine centralized and decentralized features. The scope of transfer may include the transfer of decision rights, power, responsibility and accountability for one or more function – political oversight, planning, governance arrangements, financing, service delivery systems, human resources, consumer choice, fiscal

control, management, administrative systems, etc. Some analysts even consider privatization as the extreme endpoint in the continuum of decentralization.

During decentralization, problems may arise due to:

- Tensions between central and peripheral levels of decision making
- A desire to delegate and but limited capacity to assume new responsibility at the decentralized level
- A need for continued vertical and horizontal functional integration, referral systems and continuity of care in the face of an increasingly fragmented system
- Political objectives that may not be consistent with the optimal configuration of health financing and service delivery in the health sector

Assessing the results of decentralization is often difficult for a variety of reasons. The objectives of decentralization are often not clearly specified. There is not universally agreed framework or terminology for decentralization making it difficult to compare reforms from one setting to another. Intent is often not fully translated into action and when it is, that action may be different from the original design. Political processes may have as big or bigger impact on outcomes than the technical contents of the reform. Finally, such reforms take time. Assessment are often made long before the complex reforms have been fully implemented.

Many of these feature are seen in this Discussion Paper on decentralization in South Africa, with lessons from three Latin American countries (Chile, Colombia and Brazil) and elsewhere (New Zealand and the UK). The political and fiscal reforms under implementation in Gauteng, and the on-going health care reform and institutional transformation of Johannesburg are all expected to lead to a substantial change in the role and responsibility of Johannesburg in the provision of primary health care delivery. Policy makers are asking: “What institutional set up would better enable Johannesburg to take up its new responsibilities? Which accompanying fiscal/financing arrangements should be put in place?”

The author of the Discussion paper provides insights into the current health care decentralization reform that is under way in Gauteng and Johannesburg. The report: (a) reviews the main issues at stake in this decentralization process; (b) discusses at length the role of Johannesburg in the new decentralized framework; and (c) undertakes an extensive analysis of some international experiences in health care decentralization which leads to practical lessons and recommendations for the city of Johannesburg and, more generally, to a number of insights on possible roles for large cities in health care delivery.

It is hoped that this Discussion Paper will contribute to the on-going discussion on the decentralization of health care delivery in South Africa and Johannesburg and to the current debate on the implementation of decentralization policies in the social sectors in the Bank.

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Editor of HNP Publication Series

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## EXECUTIVE SUMMARY

South Africa is going through an important political and administrative reorganization and a series of structural reforms, which involve as well the health sector. The responsibility for primary health care, which was mainly provincial, is about to be decentralized to the Local Government level. The main purpose of this paper is to analyze the on-going decentralization process in the Gauteng province and determine the role that Great Johannesburg can play within this new decentralized framework. To provide some useful comparative benchmark and extract lessons and recommendations for Gauteng and Johannesburg, the paper takes a close look at the case of three middle-income Latin American countries, Chile, Colombia and Brazil, which share some similarities with South Africa and have undertaken quite extensive reforms in their health sectors, among which a decentralization of primary health care to some extent similar to the one planned in Gauteng. Ultimately, the paper aims at detecting a set of possible roles of large cities in health care delivery, drawing on these and other experiences.

### **PART I: A Typology of Models of Health Care Delivery and its Link with the Role of Large Cities**

The vast literature on health care delivery models and the multiple experiences of health care reform around the world make it possible to detect a typology of models according to a number of key dimensions:

- the level of integration of the four main institutional functions that characterize health care delivery (regulation, financing, articulation<sup>1</sup> and production)
- the level of integration of populations (horizontal integration or segregation)
- the level of territorial decentralization of the main functions
- the level of institutional decentralization of the main functions

The combination of all these dimensions gives rise to a more complex typology of models, each of them with specific characteristics which will have a different impact on the efficiency, quality and equity of health care delivery. The range of options of health care delivery models at the country level will have, in turn, consequences on the role of large cities in health care. The role of large cities is likely to reflect, partly, the model implemented at the country level, which will reflect characteristics of the country (political, institutional, fiscal, demographic, etc) and the nature and complexity of the health care services, and partly the characteristics of the cities themselves.

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<sup>1</sup> This function refers to the organization and management of care consumption (OMCC) and involves key activities that allow financial resources to flow to the production and consumption of health care, like determining service specifications, carrying out population/epidemiological needs assessment of the population served, enrolling populations into health plans, determining a strategy to assure quality health care, selecting providers that are qualified to provide services, selecting the payment mechanisms of the providers, contracting for services.

## **PART II: Decentralized Systems of Primary Health Care Delivery and Role of Large Cities**

### **2.1 Decentralization in the articulation and production of health care**

#### **2.1.1 The experience of the Gauteng province and Johannesburg**

**Gauteng: before the reform.** Gauteng, with a population of approximately 7 million habitants, is one of the nine provinces constituting the Republic of South Africa. It is, as all the other provinces, a deconcentrated unit of government as it is managed by appointed and not elected provincial authorities. It is formally divided into 5 administrative regions and 25 elected Local Governments. Up to now, the provision of primary health care was the main responsibility of the province, through the provincial department of health, which financed (through own revenues and federal transfers), planned and produced Primary Health Care (PHC) services through a comprehensive network of PHC clinics and some hospitals offering PHC services. Local Governments (LGs) also financed (largely through own revenues), planned (following provincial instructions) and produced some PHC services through their smaller network of municipal clinics, focusing, but not restricted to, on public health and preventive services. Thus, PHC services were being provided by institutions managed and financed by different sub-national levels and subject to different employment rules in the same geographic area, creating a partial horizontal segmentation.

**Gauteng: after the reform.** The Constitution of South Africa (1996), together with the White Paper on Local Governments (1998) and the National policy on Health (1996), created the basis for organizing primary health care delivery into District Health Systems, which is currently already being done, and, in the near future, attributing the primary responsibility for their management to the Local Governments. The health care reform is proceeding in parallel with a major political reform occurring in the whole country. The political map of South Africa is about to change completely with the general elections of November 2000, which will create a complete new set of Local Governments. The health care decentralization process involves the Gauteng province, where it was decided that the Local Governments would assume the main responsibility for the delivery of PHC. Following the election, the existing 25 Local Governments will be partly merged into 3 unities (Johannesburg, Pretoria and East Rand) and partly grouped into 3 District Councils.

#### **Main issues raised by the transfer of responsibilities in PHC:**

- Little information exists on the type of institutional arrangements that will be adopted to manage the services and the capacity requirements for managing the services are not specified neither.
- The upgrading process of municipal clinics and the subsequent transfer of responsibility are made rather problematic by the fact that the minimum PHC package that the municipalities (or LGs) will have to provide (or will be formally held accountable for) has still not been adequately defined and costed.
- Should only the provincial clinics and policlinics be transferred to the new LGs or should the transfer also include district hospitals ?
- To be capable of assuming their new responsibilities the future LGs will need to have the adequate fiscal and financial set-up. Several options are possible and should be discussed,

raising issues like the optimal proportion between different sources of funds and the design and allocation of fiscal transfers.

**Johannesburg.** Greater Johannesburg<sup>2</sup> will have a specific role in this decentralized system of PHC delivery.

### **The political, administrative and fiscal reform**

IGoli 2002 and the Municipal Structures Act lead to the proposal of transforming Johannesburg into a unicity, with only one elected council, the Metropolitan Council, and one revenue basis, abolishing the four existing Municipal Councils. The metropolitan administration will then be divided into a central administration and eleven administrative regions

### **The health care reform**

The political and fiscal reforms to be implemented in South Africa and Gauteng in combination with the ongoing health care reform and the iGoli 2002 Johannesburg plan will lead to a change in the responsibility for the delivery of PHC in JB. The main responsibility for PHC delivery will be attributed to the newly elected Metropolitan Council. The PHC staff and facilities will be managed by the city's central administration and the eleven administrative regions through their central and regional health units. More precisely, it is planned that the central health unit located in the central administration will determine the overall primary health care strategy and allocate a budget to each of the eleven regional offices, which, through their regional health units, will operate the services.

Several aspects of the institutional set up are still under discussion, among which the fiscal set-up that will be chosen (under which specific form the funds will be transferred and how they will be distributed across the regions), the relative role of the regional health units and district health authorities and the extent of responsibilities attributed to the regional units (will the regional health units only strictly operate the PHC facilities, or will they also have a role in the articulation of health care, determining which services should be provided beyond the essential package and other aspects of service organization ?).

## **2.1.2 The experiences of Chile, Colombia and Brazil**

**The process in the three countries.** Below, we discuss the main characteristics of the decentralized model of primary health care delivery applied in Chile, Colombia and Brazil: three Latin American countries that decided to decentralize the responsibility for primary health care to the sub-national level and which, as mentioned in the introduction, share some common characteristics with South Africa.

### **Sub-national level involved**

In the LAC case, the favorite option has been to transfer the responsibility for PHC delivery to existing elected Municipal Governments, making Local Health Districts (when in place) coincide with the geographic area covered by the Local Government

### **Institutional arrangements**

In Brazil and Colombia municipalities do not really have the choice on how to manage PHC: they are supposed to operate PHC facilities directly, through the constitution of Local Health Departments or Secretaries run by Health Managers appointed by the Mayor. In Chile, municipalities had two possible options at the moment of the decentralization reform: they could either operate PHC services directly through the constitution of

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<sup>2</sup> Which, from now onwards, we will simply indicate as Johannesburg or JB.

Municipal Local Health Departments, or do it through the constitution of non-profit maximizing Private Health Corporations

### **Capacity requirements**

In Brazil and Colombia, the actual transfer of the full range of PHC services to the municipalities was, firstly, preceded by a deepening of the political and fiscal decentralization process, secondly, and additionally, by a specific “certification” process which ensures that a set of stringent institutional and capacity requirements are met by the municipalities. In contrast, in Chile, the transfer was carried out without previous fiscal and political reforms and institutional and capacity requirements were not as explicitly stated as in the other two cases

### **Staff management**

In Chile and in Brazil, medical and non-medical staff is managed with great autonomy at the municipal level (the staff is in fact defined as “municipal” staff), while in Colombia, this autonomy is limited by the application of central employment rules, which restricts local flexibility in dismissing medical staff and fixing salaries

### **Type of PHC institutions transferred to the local level**

In both Brazil and Colombia, a comprehensive definition of PHC districts was adopted and Local Governments were formally given responsibility for the administration of both PHC health centres (clinics and policlinics) and district hospitals (which mostly provide PHC outpatient and inpatient services). Only PHC services provided in some higher level hospitals are excluded. In contrast, in Chile, only PHC centres were decentralized, all hospitals of whatever level remaining the sole responsibility of the regional sections of the Ministry of Health

### **Determination of the PHC package**

In the Latin American case, this issue was not always tackled with the greatest clarity or logic. In Chile, the PHC package was adequately identified and specified but little freedom was left to the municipalities to complement it. In Brazil, the PHC package has not been adequately defined, leaving more freedom to the sub-national level, but also leading to more coverage disparities among areas. Only in Colombia, the package seems to have been adequately defined and the municipalities be also given the necessary freedom to complement it. The type of services generally included in the package varies across countries

### **Budget allocation across PHC institutions**

In Brazil, municipalities are free to choose how to allocate their budget across the different institutions. Most of them introduced competition in their payment system, purchasing services from both the public and private sector. In Colombia, the range of options is more reduced. Finally, in Chile, the payment mechanisms are completely centrally determined

### **Financing and fiscal arrangements**

In the three countries, own revenues represent a relatively small proportion of the total financing of PHC, reflecting a Latin American trend. In Chile and Colombia, there is a lack of autonomy in determining most tax bases and rates. In all three countries, transfers come mostly from the Central Government and an attempt was made to incorporate equity and efficiency indicators in their allocation formulae. In both Colombia and Brazil, however, the lack of reliable information systems together with the insufficient supervision and monitoring have had negative consequences on the effective application of these allocation formulae



## **Main lessons for Gauteng :**

- The basic PHC strategy adopted in the three Latin American countries is similar to the one that will be applied in Gauteng: in all cases, the responsibility for PHC is given or will be given to the constituted Local Governments, with no distinction of size.
- In all countries, with the exception of Chile, Local Governments have a very heterogeneous size. The adopted PHC strategy implies that, as long as they have elected metropolitan Local Governments, small, medium and large cities are transferred the responsibility for articulating and producing PHC services. The lack of differentiation per size might create problems for the very small municipalities and for large and medium cities, suggesting that the strategy might need to be adjusted. The Colombian and Brazilian cases suggest a possible option through the “certification” process.
- The three Latin American models did generally leave little choice to the Local Governments on how best to carry out their new responsibilities, with the consequence of leaving generally little choice to large cities. The Chilean option of running the services through Private Health Corporations, as well as the increasing autonomy given to the Local Health Districts in the context of a Local Government system in Colombia could, however, be relevant to the case of Gauteng and Johannesburg.
- The problems that the lack of staff management flexibility created in Colombia suggest that Local Governments and, as a consequence, large cities, should be free to manage the PHC staff with a minimum of central intrusions.
- As in Chile, in Gauteng as well it is planned to decentralize only the PHC centres to the municipal level. The main issue here is that the municipalization of PHC centres, excluding the district hospital, will lead to an artificial divide between level one hospital services and primary level care, producing a division between two symbiotic components of a single system and creating a referral problem. The experience of Latin America seems to suggest that, at least in the long run, a comprehensive Local Health District is more performing than a less comprehensive one, even if more resources and skills are necessary to manage it.
- On the basis of the Latin American experience, and taking account of the important spatial socio-economic inequities that characterize all the countries under analysis, it seems adequate to fix a minimum PHC package (giving, however, flexibility in adjusting this package to local characteristics) and hold the Local Governments accountable for it to both the central level and the local population.
- The Latin American experience might also be helpful to Gauteng for determining the minimum PHC package. There seems to be a case for a comprehensive interpretation of the PHC package because of the referral problem. A possible option would be to adopt a comprehensive version of the PHC package and transfer the whole responsibility for it to the Local Governments after a certification process similar to the one adopted in Colombia and Brazil.
- If approximately 30% of the PHC expenditures keeps on being financed by municipal revenues in Gauteng, that will locate it around the Latin American average. This is not a high proportion and will create a dependency from other levels of governments similar to the Latin American case, with the related financial uncertainty and loss of local accountability. The first issue can be tackled promoting a formal legislation of the transfers (as in Colombia and Brazil). The second issue requires an increase in the proportion of own funds, which, ideally should come

from a few revenue sources, like property taxes and user charges, and high levels of autonomy in determining bases and rates (reflecting more the Brazilian experience).

- No standard receipt seems to exist on the issue of transfers, equity and efficiency. The main clear difference between Gauteng and the three Latin American countries examined is that it is envisaged that in Gauteng PHC will be financed by a combination between own funds and provincial transfers, making the Local Governments agents of the province, while in the Latin American countries practically all transfers come directly from the central level, building a direct principal-agent relationship with the centre. The two models have different advantages/disadvantages. On the specific characteristics of the transfers, the Latin American option of specific or general conditional transfers allocated according to specific formulae taking into account both equity and efficiency indicators is a correct one if the main objective is to get a minimum and efficiently produced PHC package across municipalities. In that respect, Gauteng seems to be moving in the right direction. The Latin American case offers no experience on the allocation of fixed budgets (except for hospitals), but provides some on the application of the capitation option (Chile) and of fiscal/financial effort indicators (Colombia and Brazil). However, the main issue might be the one of implementation of the formulae. This requires an amount of information and supervision proportional to the complexity of the formula suggesting (a) to keep the formula simple and (b) to build a clear inter-governmental cooperative structure where, for instance, deconcentrated structures of government assist the Central Government in implementing the formula. In Gauteng, this role could be fulfilled by the existing administrative Health Regions.

**Role of large cities in PHC: the cases of Belo Horizonte, Bogota and Santiago.** What about the role of large cities in PHC in the three analyzed countries? Below, we provide a detailed characterization of the role of three selected large cities: Belo Horizonte (Brazil), Bogota (Colombia) and Santiago (Chile).

### **1. Belo Horizonte: A Case of a Centralized Metropolitan Government**

Belo Horizonte is a city of approximately 2 million habitants, with its own elected Municipal Government and its own fiscal basis complemented by transfers received by both the State and the Federal Government. Through its appointed Municipal Health Secretary, it runs, with great autonomy, the Local Health District System, composed of 142 health centres, 4 mixed units and 1 general hospital. This centralized model of PHC delivery has the advantage of providing a centralized planning, financial and technical management which takes advantage of economies of scale and of the institutional and fiscal capacity present at the central metropolitan level. Its main and strong disadvantage, however, is that it does not take into account preference diversity and does not promote local accountability

### **2. Bogota: A Case of a Deconcentrated Metropolitan Government**

Bogota is a city of approximately 7 million habitants, with its own elected Metropolitan Government and its own budget which includes own fiscal and non-fiscal revenues and revenues transferred by the national Government. It is in turn divided into 19 Sub-Municipal Governments of approximately 360,000 habitants on average, which are headed by 19 appointed Mayors. Through its newly created District Health Secretary, the city runs, with great autonomy, a network composed of 130 health centres and 8 PHC hospitals. Since 1992/93, two main processes are under way: the transfer of more administrative autonomy directly to the Local Health District Authorities and a gradual deconcentration of the responsibility for PHC to the 19 sub-municipalities. The deconcentrated model of PHC delivery is more socially efficient than the centralized one because it is better suited to take account of the different needs and preferences of

the population. However, it might be little conducive to local accountability compared to a two-tier metropolitan model where the primary responsibility for PHC delivery lies with elected Sub-Municipal Governments with individual fiscal bases

### **3. Santiago: A Case of Jurisdictional Fragmentation**

Santiago is a city of approximately 6 million habitants divided into 51 municipalities of approximately 200,000 habitants, each with its own elected Local Government (since 1992) and its own, even if small, fiscal basis. The city does not have any central Metropolitan Government or revenue basis. In this jurisdictional fragmented structure, the responsibility for the delivery of PHC has been transferred to the 51 municipalities which run, on average, 4 health centres. The main advantage of this fragmented model of PHC is that it is quite sensitive to citizens' preferences and emphasizes local accountability. Its main disadvantage is the lack of a central structure capable of providing centralized coordination and planning, as well as equity corrections, when necessary

#### **Lessons for Johannesburg:**

From the experience of these three large cities, we can extract some general and more specific lessons relevant to Johannesburg.

- The three cases confirm that the role of large cities tends to be the result of the combination between the decentralization model applied at the country level and the political/administrative/demographic characteristics of the city.
- Three different models of health care delivery with the advantages and disadvantages explained above have been reviewed. The first two models are still applicable to the Johannesburg case, since the exact political/administrative structure of the city has still not been defined, as well as some of the characteristics of the decentralized health care delivery model implemented in Gauteng. The Santiago model is not applicable anymore in its general characteristics but might produce some recommendations on more specific aspects.

#### **Which model for Johannesburg ?**

**Option 1: centralized PHC delivery model.** It is unlikely that the management of PHC will remain centralized at the city level since this would make it impossible to satisfy consumers' needs in an adequate way, considering the large size of the city. The difficulties faced by Belo Horizonte, smaller than Johannesburg, in promoting popular involvement and resource mobilization are another indication that, in spite of some advantages, a centralized model of PHC delivery is not adequate to large cities.

**Option 2: deconcentrated PHC delivery model.** The more likely option up to now for JB is the creation of a deconcentrated metropolitan structure which will be in charge of the operation of PHC services. That would imply that the city would be divided into local health districts of approximately 350,000 habitants, exactly as it is the case in Bogota, managed by 11 deconcentrated regional offices, which would correspond to the 19 sub-municipalities of Bogota. A closer look at the experience of Bogota would then be highly advisable. In the light of the Bogota experience, it is recommended to confer a high level of autonomy in the production and articulation of PHC to the regional units of JB (higher than the autonomy conferred to the sub-municipalities of Bogota): this would produce a higher level of decentralization and local involvement than in the case of Bogota and, as long as the functions of the different levels are very precisely identified, have a positive impact on local accountability.

**Option 2-bis: deconcentrated and functionally decentralized PHC delivery model.** Another option of PHC delivery structure, which would be feasible within the deconcentrated administrative structure, might be the one, also applied in Bogota, of a transfer of high levels of autonomy in the provision of PHC services to autonomous Local Health District Authorities (denominated above “functional” decentralization). That could have definite advantages on the social efficiency and, even, local accountability side as long as the District Authorities are representative of the district population. This option is not necessarily alternative to the PHC deconcentration one. However, the relative functions of the regional units and of the District Health Authorities should be very carefully defined.

**Option 3: fragmented or two-tier PHC delivery model.** The Santiago model is the only one which it will not be possible to adopt any more since the Municipal Structures Act, which promoted the unicity structure in the whole South Africa, has to be compulsorily applied. The assessment of the Santiago model has been generally positive highlighting, in particular, its positive impact on social efficiency, local accountability and resource mobilization. These considerations might suggest that keeping the current political/administrative structure of JB, with more numerous and institutionally and financially strengthened local councils, might not have been a bad option on the health care delivery side. An innovative feature of the Santiago model that could still be applied to Johannesburg is the administration of the primary health care services by private non-profit corporations. In the JB case, that might be applied giving the option to the regional offices of either directly manage the services or contract them out to private corporations.

- In conclusion, the current transformation towards a more centralized health care delivery model in JB has to be very carefully assessed in the light of all the possible advantages but also disadvantages of the model, and options of institutional arrangements for making service management more socially efficient have to be detected and carefully designed. A simple deconcentration of PHC articulation and production functions might not be enough requiring a truly “functional” decentralization of these two functions. Otherwise, it is important that the regional units be as autonomous as possible in the execution of their responsibilities and the central unit be able to concentrate on a supervision, coordination, technical assistance and redistributive role. It is essential that the current political and fiscal transformation, started for reasons exogenous to the health sector, combined with the on-going health care reform, be able to promote a more efficient use of resources without losing on social efficiency and quality grounds.

## **2.2 Decentralization in the articulation of health care and role of large cities**

Another type of decentralization, less frequent, involves the transfer of responsibilities to sub-national units in the mere area of articulation of health care services (in general, both primary and higher levels of care). The sub-national units would then typically act as intermediaries, organizing the consumption of care with no direct responsibility in the production of the services. The Latin American experience does not provide any explicit case of such a model. Such a model is, however, provided by the UK and New Zealand cases, where this type of responsibilities have been attributed to autonomous health authorities (called District Health Authorities in England and Regional Health Authorities in New Zealand).

**Could large cities undertake this role?** The “intermediary” role is very different from the one of service delivery and, typically, will presume that the sub-national units become skilled at writing, negotiating and monitoring the implementation of contracts. Additionally, there must be

more than one provider, so that a purchaser can demand price concessions and back that up with the credible threat to go elsewhere if the provider does not offer lower prices. Thus, at first sight, this role is likely to be more attractive to large cities with substantial technical capacity and whose health care systems are extensive enough to offer a number of alternative providers for the city to choose among. However, at second sight, a large city might represent too many individuals to be capable of effectively fulfilling individual preferences, suggesting that it might be better to divide it into a few purchasing authorities with potential access to all the providers of the city.

### **Lessons for Johannesburg:**

The application of such a model to the JB case might require to transfer the articulation responsibility to a set of sub-units covering each a fraction of the city's population. This role could be attributed to the eleven planned to established. This would require the central administration of the city to allocate a budget across the regions which would then be responsible for the health status of their respective populations and contract with competing autonomous providers to deliver the required services. This model has several advantages, however it requires a number of stringent conditions to be met, conditions that do not seem to be currently met in JB suggesting that, at this stage at least, a decentralization model like the one applied in the analyzed LAC countries seems more suitable.

### **2.3 Institutional decentralization and role of large cities**

Finally, another type of decentralization, often called "autonomization", refers to the transfer of responsibilities in the provision of the services directly to the health institutions (primary and higher levels of care institutions). This type of decentralization is being more and more applied based on the conviction that giving more autonomy to the health institutions is a necessary condition for producing efficiency and quality gains in health care delivery.

**Consequences for the role of large cities:** Whatever the previous role of the city in health care delivery, its main role will become one of a regulator since a system which becomes more open and diverse through institutional decentralization (and competition) will need a strengthened regulatory function which will need to be shared by the centre and the sub-national levels. The responsibilities of the city in financing, articulation and/or production will diminish following the transfer of responsibilities operated by the institutional decentralization, while its regulatory functions will increase. Within the context of an institutional decentralization, regulation should be interpreted in a broad sense and involve setting, implementing and monitoring the rules of the game for the health system, as well as providing it with strategic direction. Among its regulatory functions, the city might be well placed in helping with the implementation and monitoring of centrally fixed criteria and standards for the assessment of performance of the articulating organizations and institutional providers of services acting on its territory.

It might also help in the implementation of the formulae for resource allocation among non-governmental articulating organizations and/or institutional providers and introduce and manage compensatory and targeting mechanisms to correct any undesired equity consequence of the institutional decentralization. Finally, it might collect and offer public information about the performance of providers and insurers (if the articulation is undertaken by non-governmental organizations) to protect the consumers.

## **Lessons for Johannesburg:**

JB's central and regional administrations would become less involved in the direct provision of services and more in the regulation of such provision requiring other types of skills. A complex and effective regulatory framework would need to be constructed involving the different available levels to ensure that the institutional decentralization is in line with the consumers' interest and capacity to pay.

## **SOME CONCLUDING REMARKS**

The Latin American cases analyzed offer some practical experience on the design and implementation of systems of decentralized health care delivery at both the country and city level which provides some useful point of reference for Gauteng and Johannesburg. In particular, at the city level, the analysis has shown that the case of Bogota in Colombia seems to be a particularly useful case to look at given the reforms currently planned in JB. In the longer run, the experience provided by the current reforms in the UK and New Zealand, in particular the ones on the separation between articulation and production, would also be worth looking at.

In more general terms, we have seen that there is a wide range of roles for large cities in primary health care delivery, going from cases of high involvement of the central metropolitan level (and its deconcentrated levels) in all the functions of the delivery, including the direct production of the services, to cases of little or, even, no involvement. For large cities, it will be preferable to move from high levels of involvement in all the main functions of PHC delivery to lower involvement levels largely focused on regulatory functions (technical assistance, supervision, redistribution) and, to a lesser extent, financing and articulatory ones. The main reason for this is that lower levels of government, the local health districts and the PHC institutions themselves will be usually in a better position to respond to the specific needs of the population and do it in a more accountable way. The functional and institutional decentralization cases as well as the Santiago and London cases exemplify this type of decentralized PHC delivery models in urban environments. However, as shown throughout the paper, which role will be eventually adopted by the city will depend on the decentralization strategy adopted at the national level and on some main characteristics of the city itself. Among the city's characteristics relevant to the selection of a PHC delivery model, the following could be identified:

-**the political and administrative structure** of the city: centralized, deconcentrated, two-tier or jurisdictionally fragmented metropolitan structure. The more decentralized the metropolitan structure, the more likely it is that the main responsibility for PHC delivery will be attributed to lower independent levels, leaving little role to the central or centrally controlled metropolitan government.

-**the fiscal capacity** of the city, measured by the existence and size of the local revenue basis, and the distribution of this fiscal capacity among the existing levels of the metropolitan structure. The higher the local revenue basis and the more centralized is its administration, the higher will be the role played by the central metropolitan level in the financing of PHC delivery.

-**the institutional capacity** of the city and of the existing levels of the metropolitan structure to undertake the different functions constituting health care delivery. The stronger and centralized this capacity, the higher will tend to be the role of the central metropolitan level in health care delivery.

-**the demographic structure** of the city, in particular the size of the population and its distribution within the city according to socio-economic status. The larger the city, the smallest

will generally tend to be the role of the central metropolitan structure, favoring decentralized models of PHC delivery. However, the higher the level of socio-economic segmentation within the city, the more extensive will generally need to be the role of the central level (either through a more centralized model of delivery or an active redistribution policy).





## INTRODUCTION

South Africa is going through an important political and administrative reorganization and a series of structural reforms, which involve as well the health sector. In particular, the responsibility for primary health care, which was mainly provincial, is about to be decentralized to the Local Government level. The main purpose of this paper is to analyze the on-going decentralization process in the Gauteng province and determine the role that Great Johannesburg can play within this new decentralized framework. To help us in this task, we take a close look at the case of three middle-income Latin American countries, Chile, Colombia and Brazil, which share some similarities with South Africa in terms of level of development, social disparities and relative weight of the public and private sector in the health sector. These three countries have undertaken quite extensive reforms in their health sectors, among which a decentralization of primary health care to some extent similar to the one planned in Gauteng. We hope that the analysis of their experiences, including the role that they have reserved to large cities in the process, will make it possible to extract some useful lessons for Gauteng and Johannesburg. We also hope to be able to detect a set of possible roles of large cities in health care delivery, on the basis of these and other experiences.

The paper is divided into two main parts and an annex. Part I provides an analysis of a typology of health care delivery models with the main objective of detecting a set of key characteristics and models which will be related to the role played by large cities in health care delivery. In Part II, we concentrate on the decentralized systems of primary health care delivery and develop the Gauteng and Johannesburg experiences, as well as the Latin American one, with the objective of providing a concrete analysis of primary health care decentralization reforms and the possible role of large cities. The part also includes a brief analysis of other experiences. Finally, for completeness, the annex provides a comparative analysis of the decentralized systems of higher levels of care.

### **PART I: A TYPOLOGY OF MODELS OF HEALTH CARE DELIVERY AND ITS LINK WITH THE ROLE OF LARGE CITIES**

Health service systems have certain features which distinguish them from normal markets. Among the most important ones, we can mention:

1. universal access: in most communities it is considered essential to support the sick and to provide everyone with access to medical and care services. As education, health is a good with an high impact on equity.
2. externalities: the social benefits of health will tend to be larger than the private benefits of it leading to an under-production of health services.
3. complexity and uncertainty: uncertainty permeates health care. Individuals' future health status is unknown and subject to random fluctuations. The capacity to benefit from health care is to some extent unknown by either the individuals or the professionals that offer treatment.
4. information difficulties: there are substantial asymmetries of information at all levels of a health system. Individuals lack information about the range and efficacy of treatments and that determines an asymmetry of information between patients and doctors or health care providers. Another asymmetry of information occurs between funding agencies (public or private) and

health care providers, the latter having more information than the former on their services and treatments.

As a consequence of points 2, 3 and 4, traditional market mechanisms fail to operate efficiently and alternative socially and technically efficient ways of providing health care have to be found, taking account of the distributional concern, as well.

## A typology of models

The vast literature on health care delivery models and the multiple experiences of health care reform around the world make it possible to detect a typology of models according to a number of key variables. In Table 1 below, we attempt to represent this typology focusing on four main dimensions:

- the level of integration of the institutional functions (regulation, financing, articulation and production)
- the level of integration of populations (horizontal integration or segregation)
- the level of territorial decentralization of the main functions
- the level of institutional decentralization of the main functions

### a) According to the integration of functions and populations

The two first sets of dimensions are due to Frenk (1997), which introduces them to characterize the typology of health system models existing in Latin America.

**Level of integration of the main functions.** The first dimension refers to the level of vertical integration or separation of the main functions constituting health care delivery. The current trend in health care delivery reforms is to promote a separation of these different functions, contrary to traditional models of health care delivery where all or most of these functions were integrated.

*Separation financing/production.* In particular, there is a tendency towards a separation of the financing function, which, typically, refers to the mobilization of money from different sources<sup>3</sup> and its accumulation in real or virtual funds<sup>4</sup>, and the production function, which refers to the combination of inputs into a production process that takes place in a particular organizational structure and leads to a set of outputs. This separation involves the end of budgets assigned in advance to public providers and the introduction of negotiated competitive contracts which force health institutions to compete and, hopefully, to increase the quality and efficiency of health care delivery. In fact, this form of managed competition, which can involve only public organizations or public as well as private ones, mimics business-like practices in the private sector largely through tendering for contracts. Competition is driven by the fact that provider organizations no longer receive budgets but are contracted for care.

*Separation financing/articulation.* Another separation which is now commonly suggested in the latest types of reforms even if still not very often applied is the one between the financing function and the “articulation” one. This function refers to the organization and management of

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<sup>3</sup> Households, firms, government at all levels.

<sup>4</sup> Social insurance funds, public budgets for health care, etc.

care consumption (OMCC)<sup>5</sup> and involves key activities that allow financial resources to flow to the production and consumption of health care, like determining service specifications (type of service, price, volume, quality), carrying out population/epidemiological needs assessment of the population served, enrolling populations into health plans, determining a strategy to assure quality health care, selecting providers that are qualified to provide services, selecting the payment mechanisms of the providers, contracting for services. To make this function explicit and to assign it to a distinct entity (public or private) allows for a transparent connection among the various components of the financing-production process. In other words, it has the advantage of facilitating the articulation between populations and providers, on the one hand, and, financing agencies and providers, on the other hand, to increase responsiveness to consumers and provide a more cost-effective use of resources.

**Level of integration of populations.** This second dimension refers to the extent to which different groups are allowed access to every institution in the health system. At the end of the dichotomy is segregation, whereby different segments of the population are segregated into different health care institutions, and at the other end is “horizontal integration” where all groups in the population have potential access to all institutions.

**Models of health care delivery.** On the basis of the level of integration of the different functions and populations, it is possible to distinguish five broad models of health care delivery, indicated in the first row of Table 1.

As far as the level of integration or separation of the different institutional functions is concerned, the most vertically integrated are the unified public model and the segmented model. In the unified one, all functions are carried out by the State through a vertically integrated system which does not create any incentive for improved efficiency and quality of the services. In the segmented one, each institutional segment- the Ministry of Health, the social security institutes and the private sector- performs all the functions. In an intermediate position, we can locate the so-called public contract model (also called managed competition and the contract state) and the atomized model. Both models operate a clear distinction between the financing/purchase of the services (which is either public or private) and their production along the lines explained in the previous paragraphs. Finally, the less integrated model is the structured pluralist one which provides an explicit and specialized assignment of functions. In particular, the regulation and articulation functions are made explicit and greatly strengthened. This model, as the public contract one, also promotes an horizontal integration of populations relying on an extended social security system to achieve universal coverage under principles of public finance.

## **b) According to the level of decentralization**

We have complemented the two highlighted dimensions by two other dimensions that capture in an explicit way the degree of territorial and institutional decentralization of the different functions constituting the health care systems within the public sector.

**Territorial decentralization.** By territorial decentralization, we mean the transfer of responsibility for one or several functions (and to different extents) of health care delivery to sub-national territorial units. Decentralization can take the form of a “devolution” if it involves the transfer of responsibilities to autonomous sub-national governments or health authorities (elected regional, provincial, local governments, elected regional health authorities, etc), of a “deconcentration” if it involves the transfer of responsibilities to semi-autonomous

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<sup>5</sup> The term “articulation” is meant to convey the notion that this function pulls together and gives coherence to various components of health care.

deconcentrated structures of the Central Government or the Ministry of Health (appointed provincial and regional authorities, appointed regional health authorities, etc) or of a “delegation” if it involves the transfer of some specific function to semi-autonomous agencies, usually with boards of directors representing separate corporate interests<sup>6</sup>. In most cases, the new institutional arrangements can be seen as principal-agent relationships, where the Central Government (or Ministry of Health) acts as the principal with objectives of equity, efficiency and quality and the sub-national units act as agents that are given resources to achieve these objectives. By attributing to the agents a role in service delivery it is hoped to increase the social efficiency of delivery, through the better fit between supply and demand produced by the better access to information on local needs and preferences of the agents, as well as its quality and technical efficiency through increased accountability, technical choices more appropriate to local conditions and local resource mobilization. The intensity of the principal-agent relation will vary with the extent of responsibilities being transferred, which, in some cases of devolution, can be so wide to lead to very weak or purely formal principal-agent relations, but, in most cases, is limited by the fact that significant authority and responsibility remains at the centre.

**Institutional decentralization.** By institutional decentralization (or “autonomization”), we mean the transfer of responsibility for one or several functions directly to the provider institutions (public hospitals or public health centres), which, as a consequence, gain autonomy within the public sector. Autonomy can increase even more and eventually become complete if institutional decentralization leads to “corporatization” or, even, privatization. This type of decentralization is supposed to enhance the quality and efficiency of service delivery through a better responsiveness to consumers and increased accountability, with the advantage of distancing the providers from government’s entities preventing politicization of decision-making and ensuring a more flexible organization. Among its disadvantages, it is very demanding of effective regulation and can have undesired consequences on equity.

**Models of health care delivery.** In Table 1, we have indicated the most common types of decentralization.

*Decentralization of provision at the sub-national level.* The first one involves the transfer of the provision of health care services, including articulation and production, to sub-national territorial units. The services are now provided by the sub-national units and are, typically, financed by a mix of local funds and inter-governmental transfers, or just by transfers (involving or not a decentralization of the financing function as well). This particular model conceals still many possible differences, as, beyond the different local funds/transferred funds mix, the type of sub-national unit involved varies, as well as the effective level of autonomy in the articulation and production functions of the units with respect to the central level and the institutional arrangements<sup>7</sup> adopted to carry out the new functions. To identify a decentralized model of health care delivery it is at least necessary to identify the type of sub-national units involved, the intensity in the transfer of responsibilities and the financing and institutional arrangements of the new delivery system.

*Decentralization of articulation at the sub-national level.* A second type of decentralization, less frequent, involves the transfer of responsibilities to sub-national units in the mere area of articulation of health care services. This type of decentralization requires the articulation function to be explicit. In this type of framework, the sub-national units would in fact act as intermediaries, accepting to organize the consumption of care in a certain area, with no direct

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<sup>6</sup> In some cases, “privatization” is also considered a form of devolution. We will not interpret decentralization this way here.

<sup>7</sup> Which, similarly, can be more or less freely determined by the sub-national units.

responsibility in the production itself of the services. The implementation of this model would typically bring the sub-national units to accept contracts by the central authority in return for buying services for all its citizens. The units would then contract with various independent providers (including public and private providers) for all of the care for those people in their area. This “wholesaler” role would greatly facilitate the articulation between populations and providers and between financing agencies and providers.

*Institutional decentralization.* A third type of decentralization involves the transfer of responsibilities in the provision of the services directly to the providers, ie to hospitals and health centres. It is therefore the institutional decentralization or autonomization introduced previously. It mainly consists of transferring autonomy to the providers in fields like investment decisions, personnel management and budgeting. In most cases, some financing will be decentralized as well.

*“Full” decentralization.* Finally, both types of decentralization can be applied: at the sub-national and institutional level. This decentralization model can have several advantages (in terms of resource mobilization, satisfaction of consumers’ needs, etc), but can also produce tension between sub-national units and health institutions if the respective roles of these different agents are not carefully defined. This is why an alternative option consists in decentralizing at the sub-national level articulation (and regulation) functions, decentralizing the production directly at the health institution level. The main advantages of this option is that it gives the main responsibility of provision to the units which are closer to the consumers and better know how to manage the health services, within the broader framework of the sub-national levels which, in turn, can articulate health services at the territorial level to ensure that a sufficient amount and variety of health services are provided to the population (solving the externality problem typical of health markets), protect the consumers from providers’ abuses (due to the asymmetric information between providers and consumers) and operate pro-equity interventions.

### **c) According to the level of integration and decentralization**

Now, the combination of all these dimensions gives rise to a more complex typology of models indicated in Table 1. We will not discuss each one of these models, which are simply produced by the combination of the different dimensions explained above, but report in Table 1 a brief characterization of each of them, illustrated with country cases <sup>8</sup>.

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<sup>8</sup> Some countries are repeated several times as they can be classified under several models.

Table 1: Typology of health care models

	Vertical functional integration/ Horizontal population integration: Unified Public Model	Vertical functional integration/ Population segregation: Segmented Model	Vertical separation of functions/ Population segregation: Atomized Model	Vertical separation of functions/Horizontal population integration: Public Contract Model                      Structured Pluralist Model	
Centralized	Centralized unified public model	Centralized segmented model	Centralized atomized model	Centralized public contract model	Centralized structured pluralist model
Sub-national decentralization of provision	Decentralized Unified Public Model  Canada (*)	Decentralized Segmented Model (Ministry of Health and/or Social Security System decentralized)  Chile (*)  South Africa (*)	Decentralized Atomized Model (MOH or SS)  USA	Decentralized Public Contract Model (application of competitive contracting to sub-nationally run (and private) hospitals or health centres)  Brazil, Sweden (Stockholm model), Colombia	Decentralized Structured Pluralist Model (articulation is explicit and carried out by distinct institutions: private, other decentralized levels of government, etc)  Colombia (articulation explicit through the EPS (**), the newly created private insurance companies)
Sub-national decentralization of articulation (no production)					“Non-traditional” Decentralized Structured Pluralist Model (articulation explicit and carried out by the sub-national units)  UK, New Zealand
Institutional decentralization of provision	Institutionally Decentralized Unified Public Model  Canada (*)	Institutionally Decentralized Segmented Model  South Africa (*) (starting in tertiary health care hospitals)	Institutionally Decentralized Atomized Model  USA	Institutionally Decentralized Public Contract Model (application of competitive contracting to public hospitals or health centres which are given some autonomy in provision)  Colombia, UK (hospitals), New Zealand (hospitals)	Institutionally Decentralized Structured Pluralist Model (articulation is explicit and carried out by non-governmental public or private entities)  UK (primary health care: GPs fundholders)  Colombia
Sub-national + institutional decentralization of provision	Fully decentralized unified public model  Canada (*)	Fully decentralized segmented model  South Africa (*) (just starting)	Fully decentralized atomized model  USA	Fully decentralized public contract model (application of competitive contracting to sub-nationally run health institutions which are given some autonomy in provision)  Colombia	Fully decentralized structured pluralist model (articulation is explicit and carried out by private, public non-governmental entities or other levels of government)  Colombia
Sub-national decentralization of articulation (and regulation) + institutional decentralization of provision					“Non-traditional” Fully Decentralized structured pluralist model (articulation and regulation explicit and carried out by the sub-national units)  UK, New Zealand

(\*) Even if performance enhancing incentives have been introduced in both secondary and primary health care making the vertical integration less obvious than before. No explicit contracting mechanisms still.

(\*\*) EPS = “Empresas Promotoras de Salud” (Health Promoting Firms)

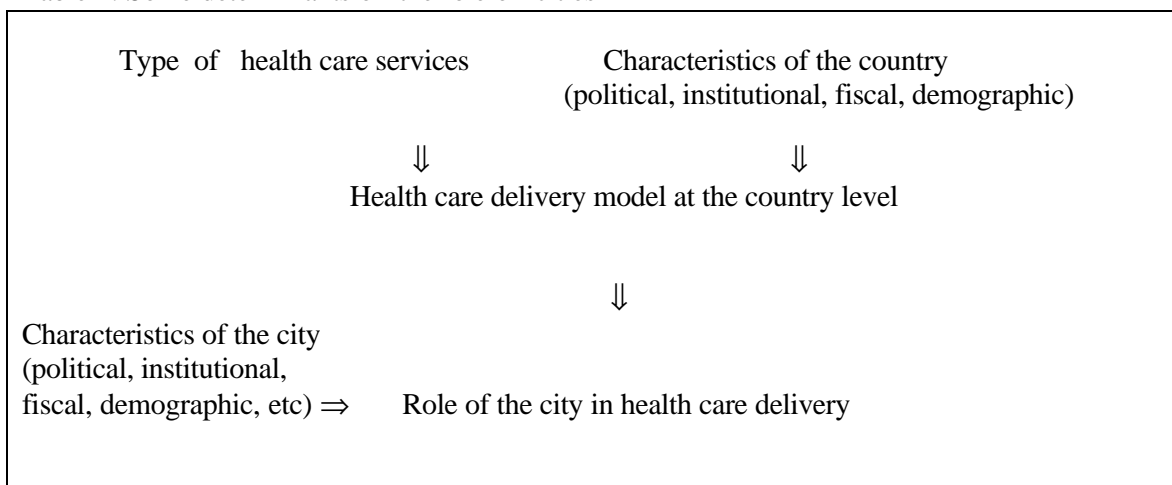
## Link with the role of large cities

Each one of these models has specific characteristics which will produce different impacts on the efficiency, quality and equity of health care delivery. Without entering into this discussion, what is important to highlight here is that the range of options of health care delivery models at the country level will have consequences on the role of large cities in health care. In fact, each of these models, with its specific characteristics, combined with characteristics of the cities themselves, is likely to imply a different role for large cities. For instance, a decentralized public contract model will imply the transfer of responsibilities in health care provision to large cities if they coincide with the sub-national units involved in the decentralization process and will attribute them a role which is likely to depend on the specific characteristics of the decentralized model<sup>9</sup>, on the application of the contracting approach and of the universal social security coverage strategy, and on characteristics of the cities (political, institutional, fiscal, etc).

It would be an endless exercise to attempt a categorization of roles in health care of large cities according to the characteristics of the models above mentioned.

What is clear is that the role of large cities is likely to reflect, partly, the model implemented at the country level<sup>10</sup>, which in turn will reflect characteristics of the country (political, institutional, fiscal, demographic, etc) and the nature and complexity of the health care services<sup>11</sup>, and partly the characteristics of the cities themselves (see Table 2).

Table 2: Some determinants of the role of cities



Among the cities' aspects which might be important to look at to determine the possible role of the city in health care delivery are the following:

- political and administrative aspects (type of political and administrative structure of the city)
- fiscal aspects (existence of a local revenue basis, composition of the local revenue basis, access to national transfers, access to credit, etc)

<sup>9</sup> Capacity requirements, intensity of the transfer of responsibilities, financing and institutional arrangements, including the level of autonomy on these, etc.

<sup>10</sup> Or of a sub-national level in cases of federal countries with no uniform policy.

<sup>11</sup> Personal services or non-personal (public good) services, primary health care services or higher levels of care services.



-institutional aspects (measures of institutional capacity)

-demographic aspects (population size and density, socio-economic distribution of the population within the city, etc)

Thus, determining the possible role of a large city in health care delivery will in fact require to understand the health care delivery model being implemented at the national level in relation to the specific city's characteristics. The role of the city will have to be compatible with both its characteristics and the on-going health care reform, with a range of options all the broader the more aspects are left undetermined by the national model<sup>12</sup>.

### **Focus of the paper**

Now, the paper will look in greater detail at one of the three main dimensions that constitute the models: the decentralized structure of delivery, relating it to the role that has been suggested for or is currently adopted by large cities. The two other dimensions, the integration of functions and the integration of populations, should have been analyzed separately as well, since they are also likely to have an impact on the role of large cities. However, that would have produced a too long treatment of the topic. Within the decentralized structure of health care delivery, a separate analysis will be conducted of the three main models: the decentralization of production and articulation, the decentralization of articulation and the institutional decentralization, assessing their different impact on the role of cities. The emphasis will be put on the first model for being the most frequently adopted in primary health care which, as mentioned above is the main focus of our analysis, and the more general one<sup>13</sup>. The analysis will be undertaken for primary health care. A treatment of secondary and tertiary health care is, however, provided in the Annex. The paper starts with an analysis of the South African case and then moves on to the Latin American and other cases.

## **PART II: Decentralized systems of primary health care delivery and role of large cities**

### **2.1 Decentralization in the articulation and production of health care and role of large cities**

#### **A) The experience of the Gauteng province and Johannesburg**

##### **Gauteng.**

Gauteng, with a population of approximately 7 million habitants, is one of the nine provinces constituting the Republic of South Africa. It is, as all the other provinces, a deconcentrated unit of government as it is managed by appointed and not elected provincial authorities. It is formally divided into 5 administrative regions (Pretoria, West Rand, Central Wits, East Rand and Vaal) and 25 elected Local Governments.

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<sup>12</sup> Institutional arrangements, management of the competition among providers, etc.

<sup>13</sup> As it could also lead to the other two models if flexibly applied.



## **The situation before the reform:**

### **Sub-national level(s) involved**

Up to now, the provision of primary health care was the main responsibility of the province, through the provincial department of health, which financed, planned and produced PHC services through a comprehensive network of PHC clinics and some hospitals offering PHC services (district hospitals and some SHC hospitals). Local Governments also financed, planned and produced some PHC services through their smaller network of clinics, focusing, but not restricted to, on public health and preventive services. Thus, PHC services were being provided by institutions managed and financed by different sub-national levels and subject to different employment rules in the same geographic area, creating a partial horizontal segmentation.

The 5 administrative regions were considered health regions and, as such, had some responsibility in PHC delivery as well, but their role was mainly restricted to the promotion of health service coordination, of effective referral systems, of some public health measures and equity in health service provision between health districts, the provision of support services at the health district level and the coordination of the allocation of provincial resources for health service provision to the health districts.

### **Extent of responsibilities and fiscal/financing arrangements**

The province has very little own fiscal capacity. Its own revenues represent approximately 7% of the total unconditional funds of the province (see below). The provincial budget is mainly composed of two main types of transfers from the Federal Government:

- general transfers divided into 4 main components (education, health, social welfare and a basic component) with weights based on the percentage of overall provincial spending on these services, called unconditional<sup>14</sup> equitable share grants.
- specific transfers with pre-assigned allocation to specific uses (called conditional grants) (within the health sector, typically used for hospital rehabilitation, new academic hospital construction, health professionals' training, primary school nutrition, etc).

The health budget is then allocated across the provincial hospitals and clinics. Additionally, the province also finances a part of the PHC services provided in the municipal clinics through a specific transfer (often referred to as agency payment).

As far as the articulation and production functions of the province are concerned, it can plan the type of services to be provided and manage freely both staff and facilities subject, however, to national rules on the employment policy and basic services to be provided. In general, the services provided in the provincial clinics consist mainly of curative personal PHC services.

Local Governments are elected bodies with their own revenue basis, mainly composed of user charges and the proceeds of the property tax. They also receive an equitable share of the national revenues and some conditional grants with pre-assigned uses from the federal

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<sup>14</sup> The grants are considered unconditional because they can be spent freely within each of the sectors and they do not require the recipients to fulfill any particular condition for receiving them. However, the weights attached to the different sectors introduce some form of conditionality, according to standard terminology.

government. However, these last two sources of revenues are very minor. As mentioned above, they receive provincial funds under the form of a specific transfer to the municipal clinics.

A characterization of the main financing sources of PHC in Gauteng is given in Table 3.

Table 3: A characterization of the main health care financing sources in Gauteng

Proportion of PHC financed by municipal revenues	Type of municipal revenues	Characteristics of the transfers	Conditions attached to the transfers	Allocation criteria
28%	Property tax, user charges, turnover tax	<p>-General transfers from the national government to the province (so-called equitable share grants)</p> <p>-Specific transfers from the national government to the province (so-called conditional grants) in the health sector</p> <p>-Specific transfer from the province to the municipalities to run municipal clinics</p>	<p>-the transfers have a basic component and 3 other main components directed to education, health and welfare, according to proportions decided nationally on the basis of the relative sizes of these sectors in the provincial budgets (18% of the grant was directed to health in 1999)- There are no conditions on their specific use</p> <p>-are allocated for specific uses within the health sector (little for PHC, generally for hospitals)</p> <p>-No conditions on its use, apart having to finance municipal clinics' services</p>	<p>-basic component: allocated according to the size of each province's population</p> <p>-health grant: allocated across provinces according to provincial need for public health care which is determined according to the proportions of people that benefit from private medical aid/insurance and those that do not, giving to people without medical aid four times the weight of those with</p> <p>?</p> <p>Allocated according to municipal population and fiscal capacity</p>

Local Governments are free to operate their PHC clinics, applying, in particular, their own employment policy, but the package of the basic PHC services to be provided by municipal clinics has been defined at the provincial level. In Gauteng, this compulsory package consists of four main sectors:

- environment
- preventive
- rehabilitating
- promotive

In fact, most municipal clinics provide more than these basic services. Additionally, we should add that, in view of the reform to come (see next section), the traditional separation between municipal and provincial PHC services is tending to fade as both types of clinics are being little by little upgraded to include all types of PHC services. The idea is that, once upgraded and

providing the same services, all the clinics are then formally transferred to the Local Governments. Currently, LG and provincial health services work together, on the basis of cooperation rather than on any form of structured district management team (there are however some exceptions), to synchronize the activities of provincial and municipal clinics and manage the recently constituted Local Health Districts (which coincide generally with the geographical area of the municipalities and are composed by the municipal clinics as well as the provincial clinics and district hospitals).

## **The reform:**

### **Some background information**

The Constitution of South Africa (1996) established that the Local Governments had the same legitimacy than the other levels of Government (Province and National) and attributed them a specific role in social and economic development issues. These are the main functions of the LGs according to the Constitution:

- to provide a democratic and accountable government for local communities
- to ensure the provision of services to communities in a sustainable manner
- to promote social and economic development
- to encourage the involvement of communities and community organizations in the matters of local government

This created the basis, together with the White Paper on Local Government (1998) and the National policy on Health (1996) for organizing primary health care delivery into District Health Systems (or Local Health Districts or Systems), which is currently already being done, and, in the near future, attributing the primary responsibility for their management to the Local Governments<sup>15</sup>.

### **A characterization of the on-going reform and the main issues at stake**

This process was extended to the Gauteng province, where it was decided that the Local Governments would assume the main responsibility for the delivery of PHC.

In Table 4, we summarize information on the political, fiscal and health care ongoing reforms in Gauteng with the objective of illustrating the complex set of reforms which are being undertaken at the same time. We show some of the characteristics of the decentralized model of primary health care delivery that will be applied, highlighting the sub-national level involved, the institutional arrangements and capacity requirements, the extent of responsibilities transferred in the articulation and production of the services (including staff policy issues) and the financing and fiscal arrangements. Since many of these characteristics are currently object of debate, we also indicate where the main issues are and some suggested options. In fact, we discuss below some of the main issues raised by the on-going decentralization process. This is just a preliminary discussion aimed at illustrating the state of the debate. A more comprehensive discussion will be developed in the next section.

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<sup>15</sup> However, two other options for managing the DHS are: attributing this responsibility to Statutory Health District Authorities or to the Provincial Health Departments (this latter case, usually as an interim arrangement). In general, the Local Government option was selected. This is certainly the case of Gauteng.

Table 4: A characterization of the decentralized system of primary health care delivery in Gauteng

	Some characteristics on the political, administrative and fiscal structure of the province	Sub-national level selected – Coordination with Local Health Districts – Definition of PHC package	Main institutional arrangements and capacity requirements for the transfer of PHC
<p>South Africa (Gauteng province)</p>	<p>The province (of approximately 7,000,000 habitants) is divided into 5 Administrative Regions and 25 Elected Local Governments. From November 2000 the political structure of the province will change. Apart from the 5 regions, there will be 3 Metro cities (Johannesburg, Pretoria and East-Rand) and 3 District Councils (grouping 10 Local Municipalities of an average size of approx. 140,000 habitants). The Metros will all have elected metropolitan governments, while the 3 DC will be composed of several municipalities with elected Local Governments.</p> <p>The 3 Metros and the smaller Local Governments which will constitute the District Councils will all have their own local revenues, composed mainly of user fees, property tax and turnover levies. As far as the Metros are concerned, the previously separate local fiscal bases (owned by the current Local Governments which constitute the Metros) will be aggregated into one unique fiscal basis.</p> <p>All Local Governments also receive an equitable share of the national revenues. However, the amount is very small as it represented only 2% of the equitable share directed to the provinces in 1999. Additionally, Local Governments receive some specific conditional grants with pre-assigned uses from the national government. These grants are managed by the province which has to transfer them to the Local Governments. However, these grants are above all directed to the provinces which have their main source of revenues in the equitable share grants.</p> <p>What will happen in the future ?</p>	<p>PHC will be devolved from the Province to the newly elected Municipal Governments, including the 3 Metros, so that LGs will become the sole responsible for the delivery of PHC (except PHC hospitals and PHC services provided in SHC hospitals). The LGs will formally head the Local Health Districts (composed of the current municipal and provincial clinics and polyclinics) which will be redesigned to fit with the new borders. However, in some cases, municipalities will be too big to act as health districts. In the metropolitan municipalities, it is planned that the health districts will correspond to metropolitan sub-structures.</p> <p>The precise package that the new LGs will be enforced to provide, as well as the costing and monitoring of that package, is still an issue.</p> <p>In the Gauteng province, municipal PHC services have been formally defined as being constituted only of 4 sectors:</p> <ul style="list-style-type: none"> <li>-environment</li> <li>-preventive</li> <li>-rehabilitating</li> <li>-promotive</li> </ul> <p>However, a suggested minimum PHC package should include:</p> <ul style="list-style-type: none"> <li>-diagnosis and management of acute minor ailments</li> <li>-maintenance and initiation of therapy for chronic diseases</li> <li>-maternal and child health</li> <li>-reproductive health</li> <li>-basic mental care</li> <li>-tuberculosis treatment</li> <li>-preventive services: antenatal care, immunization, cervical screening, growth monitoring and promotion</li> <li>-promotive services</li> </ul>	<p>Main institutional requirements:</p> <p>Not fully specified. Health authorities will need to be appointed by the Local Governments and fulfill certain minimum requirements.</p> <p>It is envisaged that if the smaller municipalities do not have the necessary capacity to take over the new PHC functions they can either form associations or even rely on the District Council they are part of to provide the services.</p>

Table 4-continue

Financing and fiscal arrangements for PHC	Staff policy for PHC
<p>PHC is likely to be financed through a combination of provincial grants (coming from the provincial budget, constituted entirely from the Equitable Share Grant and the Conditional Specific Grants) and local revenues. What will be the exact proportion between these sources of funds still has to be defined.</p> <p>Currently, some estimates suggest that an average of 28% of PHC is financed by LGs' own revenues in the province (which, probably, does not include PHC services provided by the hospitals), with a variation going from 10 to 50% according to the income level of the municipality. This proportion should anyway not be reduced (be considered as a minimum).</p> <p>Horizontal equity: Allocation rules of the provincial funds across LGs might take into account population and fiscal capacity (as the distribution of the provincial subsidy to municipal clinics does now) to introduce elements of redistribution. However, fiscal effort might be jeopardized hampering efficiency. Other issue: the allocation of the budget should take into account the distribution of the provincial hospitals, as PHC services are provided there too.</p> <p>Fiscal gaps: will be tackled through the determination of the relative and total amount of provincial funds to be transferred to the LGs and through the determination of the local revenue basis. As a pre-condition, the PHC package needs to be exactly determined and costed.</p> <p>Efficiency and cost-containment: a fixed budget per LG should be negotiated, related to the provision of a pre-determined number of services.</p> <p>% of PHC over total exp in health: difficult to say. 20% of all provincial funds are directed to district-based services (but that does not include PHC services financed by the LGs and PHC provided in hospitals)</p> <p>Number of PHC centres: 465 in 1995 (192 provincial (including joint provincial/municipal facilities), 273 municipal)</p> <p>Habitants per PHC centre: approx. 15,000 habitants per health centre</p>	<p>Staff will be managed autonomously by the LGs. Provincial staff will become municipal staff and be subject to municipal and not central rules. Main issue: initial staff transfer from the provinces to the LGs: who is going to assume this cost ?</p>

**Parallelism between the political and health care reforms.** The on-going health care reform is proceeding in parallel with a major political reform occurring in the whole country. The political map of South Africa is about to change completely with the general elections of November 2000, which will create a complete new set of Local Governments.

As indicated in Table 4, in the Gauteng province, the existing 25 Local Governments will be partly merged into 3 unicitys (Johannesburg, Pretoria and East Rand) and partly grouped into 3 District Councils.

The three cities will all have an elected unique metropolitan government and unique fiscal basis to end up with the inequity created by different local fiscal bases. The 3 District Councils will be composed of several elected Local Governments, each with its own fiscal basis.

As mentioned above, after the election, the primary responsibility for PHC delivery will be transferred to the newly elected Local Governments.

**Main issues raised by the transfer of responsibilities in PHC.** Some important issues are raised by the transfer. We will review the main ones below, centering the analysis on the intensity of the responsibilities being transferred, the financing and fiscal arrangements for service delivery and the management of the transition phase. We will provide a more comprehensive coverage of the issues involved in the implementation of a decentralized system of health care with the analysis of the Latin American experiences. We will examine how these issues have been tackled by the Latin American countries analyzed, hoping to draw some lessons for the South African case.

*Sub-national level involved, institutional arrangements, capacity requirements.*

Apart from the determination of the sub-national level which will be responsible for the provision of the services (the newly elected Local Governments), little information exists on the type of institutional arrangements that will be adopted to manage the services and which, at least in theory, the Local Governments should be free to determine. Several options are possible and will be briefly discussed in the next section. Capacity requirements for managing the services are not specified neither. It is just mentioned that, in case of a lack of capacity, the smaller Local Governments of Gauteng will have the possibility either of forming associations or of involving the District Councils in the provision. How capacity should however be measured ?

*Intensity of the transfer of responsibilities (in production and articulation)*

**Upgrading process and PHC package.** The upgrading process and the subsequent transfer of responsibility are made rather problematic by the fact that the minimum PHC package that the municipalities will have to provide (or will be formally held accountable for) has still not been adequately defined. It is clear that the minimum package will be more comprehensive than the one that it is currently compulsory to provide in the municipal clinics of Gauteng (see above), as most PHC services provided in the provincial clinics will have to be maintained, the municipal clinics are already providing more than the compulsory municipal package and, in fact, the upgrading process seems to be based on a rather comprehensive definition of the services. However, it is necessary to determine and agree on the minimum package to go on in the upgrading and transfer process, avoiding the risk of misunderstandings with the new Local Governments. An example of suggested minimum PHC package is provided in the Table. It might make sense to have the precise package defined and negotiated by the national Ministry of Health, the provincial health department and the future Local Governments. Once the package has been defined, another issue is its costing, as only then it will be possible to determine how to finance it. Several techniques exist for that: an estimation might be done of the average cost per PHC consultation and multiply this estimate by the potential number of visits per capita and the total users of the public sector facilities (this excludes non-personal care) or the existing budget might simply be used as a basis. In any case, this needs to be carefully done as well.

**Type of PHC institutions to be transferred to the new LGs.** In theory, a local health district should include a network of PHC institutions, including clinics, polyclinics and PHC hospitals (the so-called first-referral hospital). In Gauteng, this structure does not really exist as most local health districts have in fact just a network of provincial and municipal clinics and, possibly, provincial polyclinics. There are

only 8 district hospitals in the province. Given this structure and to avoid any complication, it was decided that, at least for the time being, only the provincial clinics together with the few polyclinics (even if the transfer of polyclinics is also subject to some discussion) would be transferred to the responsibility of the new Local Governments. Is this approach the correct one ?

Finally, other issues, not currently at the centre of the debate, will need to be tackled: the effective level of autonomy that the Local Governments will have in determining the types of PHC services once the minimum package is being provided, their autonomy in determining the payment mechanisms of the PHC providers and their autonomy in managing medical and technical staff. As far as this last point is concerned, it is likely that the municipalities will be able to manage their staff with satisfactory levels of autonomy since they all staff should become municipal staff. Some national (provincial) rules, however, might still be partly applicable.

### *Fiscal and financing arrangements*

An important issue refers to the fiscal and financing arrangements that will have to accompany the transfer of responsibilities. As seen above, Local Governments have their own revenue basis and receive a very few general and specific transfers from the centre. They also receive a provincial transfer which represents around 23% of the total municipal clinics' expenditures. To be capable of assuming their new responsibilities the future Local Governments will need to have the adequate fiscal and financial set-up. Several options are possible.

The main option consists of financing these new responsibilities with a combination of provincial and local revenues. The main issues at stake here concern the proportion between these different sources of funds and the design of the provincial transfers, including the rules that will be applied to allocate the provincial funds across the municipalities. These are two important issues as different proportions of own/transferred funds will have an impact on local accountability, while the allocation of transfers will have an impact on the equity and efficiency of delivery. A discussion of these issues is provided in the next section where the Latin American example is presented.

**Proportion own funds/transferred funds.** As far as the average proportion own funds/transferred funds is concerned, it makes sense to assume that the Local Governments' contribution should not be lower than it is now (it represents currently around 30% of the total PHC clinics' expenditures). However, that needs to be negotiated with the province and will also depend on the definition of the package and its costing. This proportion might in fact be even higher if the municipalization leads to an increased resource mobilization through a higher level of local involvement and the health care reform is accompanied by a fiscal reform that increases the local revenue bases (apart from unifying them). In any case, the actual little capacity of most LGs to recollect their own tax and service revenues suggests that this aspect as well will need to be tackled to make an increase in own revenues possible.

**Design of provincial transfers.** The main challenge here is how best to allocate these funds across municipalities to preserve equity fostering at the same time efficient behaviours. Many alternative ways of designing the transfers exist and we refer to the next section for a discussion of this topic. The main issues in the Gauteng context are: under which specific form should the provincial funds be transferred to the Local Governments? Should they be conditional on the financing of a particular set of services of the PHC package or left unconditional? How should they be allocated across the Local Governments? The equity issue seems to a particularly important one as shown by the fact that real per capita regional health expenditure (considering only district level health expenditures) was approximately 40% higher than the provincial average in the Central Wits region in 1999 and lower than the average elsewhere<sup>16</sup>.

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<sup>16</sup> See South African health care review (1999, chapter 3).

Allocation of transfers between LGs. A current opinion is that all provincial funds might be allocated across municipalities according to a formula taking into account population and fiscal capacity to introduce elements of redistribution. This is how the provincial payment to municipal clinics is being currently allocated. However, this allocation rule might lead the Local Governments to reduce their fiscal effort.

An attractive and suggested option might be to allocate a fixed provincial budget per Local Government, covering an established proportion of the production cost of the minimum PHC package and adjusting the budget by socio-economic variables (poverty, income per-capita, degree of ruralness, health care needs, etc). This option would promote cost-containment and fiscal efficiency while preserving equity. However, this approach requires the minimum PHC package to have been established and costed. Another issue is that to be applicable, such a methodology might require a change in the formula adopted for the determination of the health care share of the equitable share grant and its allocation across provinces, as the two formulas might not be compatible<sup>17</sup>. Finally, such an option might be very difficult to apply now without a transition stage and it might be more realistic to keep on allocating the provincial budget across municipalities according to historical costs and then switch to other allocation criteria: utilization patterns, capitation, fixed budgets, etc. These different allocation criteria are already being tested in theory.

Other financing options might in fact exist like increasing the equitable share grants directed to the municipalities, which would make the Local Governments more dependent on national revenues and less on provincial ones. PHC services' user fees might be introduced to complement the existing local income sources. Finally, an increased access to credit of municipalities might help to cover the new financial burden.

### *Management of the transition phase*

Another important currently debated issue refers to the transition phase itself and in particular to the costs that will be incurred during this phase. The two big issues here concern the transfer of the provincial facilities and staff to the municipalities. As far as the physical facilities are concerned, the financial problem might be quite easily solved making the province giving them in comodato for a certain renewable period of time to the municipalities. The real issue is the extra-cost produced by the staff transfer due to the current disparity between the municipal and provincial wages and labour conditions. If we apply the principle that equal work should lead to equal pay, it is clear that the somewhat 4,000 provincial staff that are about to be transferred to the local level will have to be paid as much as the current municipal staff and have the same employment conditions. Who will pay this extra-cost is a current matter of debate. These financial costs will be accompanied by political costs related to the loss of power that will be incurred by the province after the transfer. This loss might make the necessary provincial financial transfers particularly difficult to negotiate and raises the issue of the specific role that provinces should maintain after the transfer.

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<sup>17</sup> To be more precise, it has been determined that the current health grant is smaller with the current formula than what would result from applying a "costed norms" approach based on the estimation of the cost of provision of a PHC package and that, additionally, the allocation of the health grant across provinces is quite unequal and unrelated to the cost of care (according to recent estimations (see South African health care review, 1999, chapter 3), it appears that the total real per capita provincial health expenditure is 60/80% higher than the national average in the Gauteng and Western Cape provinces, while it is lower than the national average in the other provinces). Within such a framework, it might be difficult to allocate the provincial funds across municipalities according to the cost of the PHC package. The adoption of a costed norm approach in the allocation of national revenues across provinces (and Local Governments) has in fact been advocated by the Financial and Fiscal Commission (2000) of the Gauteng province.



## Johannesburg.

Let's turn now to the role of large cities, and specifically Greater Johannesburg<sup>18</sup>, in this decentralized system of PHC delivery. In Table 5, we show some political and fiscal characteristics of the city as well as a description of the on-going health care decentralization process.

Table 5: A characterization of the role of Johannesburg in the decentralized system of primary health care delivery in Gauteng

	Role of large cities in PHC and main requirements	Case Study: Some political, administrative and fiscal characteristics of Johannesburg	Case study: the role of the city in PHC
South Africa (Gauteng province)	The 3 Metros will have an extensive role in PHC delivery. Their 3 elected Local Governments will receive the primary responsibility for PHC. No particular requirement seems to exist to assume this role.	<p>Greater JB has approximately 3,800,000 habitants (even if the exact number is somewhat unclear) and will be managed by an elected Metropolitan Council headed by an Executive Mayor or Committee. The city's administration will be divided into a central administration, headed by an appointed Chief Executive Officer, and 11 administrative regions (of approx. 350,000 habitants), headed by appointed Regional Executive Officers, responsible for operations and direct services to communities. The services operated at regional level will be:</p> <ul style="list-style-type: none"> <li>-health</li> <li>-arts and culture</li> <li>-libraries</li> <li>-social services</li> <li>-sport and recreation</li> </ul> <p>At the central metropolitan level, and part of the Office of the Chief Executive Officer, there will be a Finance Central Administration in charge of all matters relating to the single city budget.</p> <p>The budget will be composed of the city's own revenues (property taxes, user charges, turnover tax) complemented by national (ESG and CG) transfers and provincial transfers for specific sectors.</p>	<p>As LG, JB will have the primary responsibility for the delivery of PHC services. Its role, through the Central Health Unit located in the Central Community Services Office, will possibly involve the following functions:</p> <ul style="list-style-type: none"> <li>-supervision-monitoring-overall strategy</li> <li>-planning (minimum PHC package), allocation of the budget across the 11 regions and purchasing functions (of PHC services from the 11 regions)</li> <li>-financing of PHC</li> <li>-production of PHC (staff and facilities are devolved to JB)</li> </ul> <p>The role of the 11 regions, through their Regional Health Managers, will possibly include the following functions:</p> <ul style="list-style-type: none"> <li>-articulation functions (relative priorities, budget allocation among ultimate providers, etc)</li> <li>-production functions (autonomy in hiring and dismissing, responsibility for maintenance, etc)</li> </ul> <p>Financing sources of PHC in JB:</p> <ul style="list-style-type: none"> <li>-local revenues: right now representing 27% of the total funds</li> <li>-provincial funds: 73% of total funds</li> </ul> <p>PHC p/c in JB: An estimation was made in 1999 that 225 Rands p/c might be necessary. Data of 1999 indicate a PHC expenditure p/c of 217 Rands.</p> <p>% of PHC exp over tot exp in health (1999): 28% (but that includes also private expenditure)</p> <p>Habitants per PHC: approx. 26,000.</p>

<sup>18</sup> Which, from now onwards, we will simply indicate as Johannesburg or JB.

## The Political, Administrative and Fiscal Reform

**iGoli 2002 and the Municipal Structures Act lead to the proposal of transforming Johannesburg into a unicity, with only one elected council, the metropolitan one, and one revenue basis, abolishing the four existing Municipal Councils. The metropolitan administration will then be divided into a central administration and eleven administrative regions**

Johannesburg (intended as Greater Johannesburg and corresponding to the Central Wits region) is a city of almost 4 million habitants. Currently, the city is managed by a Metropolitan Council, which constitute a first tier of government, and is divided into 4 elected Municipal Councils (the Eastern, Western, Northern and Southern), which constitute a second tier of government, and, on average, have around 950,000 habitants<sup>19</sup>. It has thus a two-tier metropolitan structure. Each tier has exclusive jurisdiction over certain services (Great JB Metropolitan council, for instance, has exclusive jurisdiction on electricity, transport and public safety, among others), and share jurisdiction with the other tier for other services (Great JBMC shares for instance jurisdiction with the four municipal councils for services such as water and sanitation, community services (including health), planning, finance, corporate services and human resources). Each tier has its own revenue basis, with the 4 Municipal Councils managing property taxes and user charges, and the metropolitan authority, user charges (mainly charges in the electricity and water sectors (43% of total revenues) + sewerage (10%)), property taxes and the turnover tax. The Metro Council has an important redistributive role as it has imposed a uniform property tax rate across the Local Councils and shifts any resulting fiscal surplus from one council to another.

However, due to the financial and institutional problems faced by the councils, it was agreed that a unified, metropolitan-wide initiative was necessary to focus on the critical problems and this whole effort, which brought to the appointment of a City Manager and a Transformation Manager, resulted in the development of a broad strategy for the restructuring of the city with the name of “iGoli 2002”. This strategy, together with the Municipal Structures Act which passed in January 2000 and defined a new system of metropolitan government for South Africa, led to the proposal of transforming Johannesburg in a unicity, with only one elected council, the Metropolitan one, and one revenue basis, abolishing the 4 existing Municipal Councils. It also led to the proposal for a complete reorganization of service delivery at the city level, which included several initiatives. Among the main ones: the creation of utilities for water and sanitation, electricity and waste management; the creation of agencies for roads, parks and cemeteries; the privatisation of Metro Gas, land, housing, the city market and the airport; and the corporatisation of other services, among which the city theatre and urban and economic research. According to this plan, only a core of selected services would still be kept at the core administration level, including, among others, community services, planning and development, corporate services and finance, infrastructure and contract management. Eventually, it is planned that the central administration will perform the functions of a “purchaser” regulating, formulating policies and managing contractual arrangements with the utilities, agencies, corporatised units or the regional administration. This last structure will be the component responsible for those functions which need to be implemented at the local level. It is in fact planned to divide JB into 11 administrative units (called regions) headed by 11 appointed regional directors and to make each of these regional structures responsible for the delivery of specific services.

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<sup>19</sup> These Municipal Councils are constituted by the municipalities existing under the apartheid regime which have been “twinned” to eliminate the biggest disparities.

## The Health Care Reform

**The political and fiscal reforms to be implemented in South Africa and Gauteng in combination with the ongoing health care reform and the iGoli 2002 Johannesburg plan will lead to a change in the responsibility for the delivery of PHC in JB. The main responsibility for PHC delivery will be attributed to the newly elected Metropolitan Council. The PHC staff and facilities will be managed by the city's central administration and eleven administrative regions through their central and regional health units. Several aspects of the institutional set up are still under discussion**

Currently, as in the whole Gauteng province, PHC is being delivered in both municipal and provincial clinics. Provincial clinics are larger and more comprehensive than the municipal ones. In fact, most provincial PHC centres are referred to as Comprehensive Primary Health Care Centres and include a whole range of PHC services, including curative care for all ages, chronic care, ante-natal and post-natal care, treatment of sexually transmitted diseases and, in some cases, preventive care, while municipal PHC centres mainly provide child health, immunization, reproductive health, treatment of STD and TB and geriatric preventive and chronic care. In all, 129 provincial and municipal PHC centres (including health posts) existed in GJ in 1999 (28 provincial and 101 municipal). There are also a few PHC centres which are jointly managed by the province and the municipalities<sup>20</sup>, bringing the total of PHC centres to 145 (see Table 6). PHC delivery, as in the rest of Gauteng, has been recently organized into Local Health Districts. These districts coincide formally with the 4 Municipal Councils (which run the municipal clinics) but are managed either through formal District Management Teams, constituted of both provincial and municipal managers, or simply by an informal cooperation between the province and the municipality. As in the rest of Gauteng, PHC services are financed by a combination of municipal and provincial revenues: 73% of PHC was financed by the province in 1999 vs 27% by the municipalities. The role of the central Metropolitan Council in health care delivery is above all one of technical and managerial support and supervision.

The transformation of the city into a unicity, abolishing the 4 Municipal Councils, together with the dominant role given to Local Governments in the administration of PHC in Gauteng will lead to attribute the main responsibility for PHC to the newly elected Metropolitan Council, transferring all provincial PHC staff and facilities (with the exception of the district hospitals) to the city. There will be however a discrepancy relative to the suggested model of PHC delivery insofar as if, as recommended, the District Health System is redesigned to fit with the new borders of the Local Government, it will end up covering a geographical area and a population far too large for allowing an efficient PHC provision. In this specific case, thus, and taking advantage of the deconcentrated regional structure promoted by iGoli 2002, the Local Health Districts will be redesigned to fit with the geographical areas of the 11 administrative regions (and thus will cover a population of approximately 350,000 habitants).

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<sup>20</sup> Which, in most cases, means that there are 1 provincial facility and 1 municipal facility either on one site or under one roof but separate.

Table 6 : Distribution of the PHC centres across the 4 districts in Johannesburg

	Habitants (based on 1996 census) <sup>21</sup>	PHC centres	Habitants per PHC centre a/
<u>The eastern district</u>	632,713	- 20 municipal clinics, 2 provincial clinics <sup>22</sup> , 1 NGO clinic <sup>23</sup> and 2 jointly managed municipal/provincial clinics	26,363
<u>The southern district</u>	1,465,229	- 52 municipal clinics, 20 provincial clinics and 4 joint municipal/provincial clinics.	19,279
<u>The western district</u>	566,111	- 14 municipal clinics, 4 provincial clinics and 2 joint municipal/provincial clinics.	28,305
<u>The northern district</u>	666,014	- 15 municipal clinics, 2 provincial clinics and 7 joint municipal/provincial clinics.	35,053
Tot (average):	3,330,067	145	22,965 or, more exactly 26,206 with the current population data

Notes: a/ Slightly underestimated since compares 1996 population figures with 1999 facilities figures.

**Main unresolved issues.** Given this, there are still many uncertainties regarding the implementation of the reform in Johannesburg. The uncertainties concerning the intensity of the transfer of responsibilities in production and articulation from the province to the Metropolitan Council, the general fiscal and financing arrangements accompanying this transfer and the management of the transition phase are similar to the ones facing the other LGs in Gauteng and will not be repeated here. Some financing issues, however, will be more specific to Johannesburg. One specific issue, for instance, concerns the possible consequence that a decrease in the allocation of provincial funds to the Central Wits region, induced by a correction of the existing unequal distribution (see section on Gauteng), might have on the availability of funds for PHC. If this happens, it will be all the more necessary for the Metropolitan Council to increase its own revenues to be able to finance a larger share of service delivery. What will be the effective margins for increasing the revenue basis? It is hoped that the reorganization promoted by iGoli 2002 will lead to a better administration of many economic services leading, in turn, to a more efficient administration of the user charges and that it will also make it possible to reduce operating costs, by privatizing some of the services, freeing more resources for alternative uses. It might also happen that revenue collection will be more efficiently carried out at the central metropolitan level than at the decentralized one. However, as far as the property tax is concerned, its local management can help to establish the accountability of local officials and that will be lost with the centralization. Generally speaking, it seems that the service reorganization and the fiscal reform might help to implement the health care reform, producing more local revenues, but a closer look at the issues involved is necessary.

<sup>21</sup> Which explains why there is a discrepancy with the total population of GJB reported before.

<sup>22</sup> Among which, we visited the Hillbrown community health centre, an hospital transformed into a policlinic, which drains patients from all parts of the city.

<sup>23</sup> The Alexandra health centre, administered by an NGO but receiving subsidies from the province and which drains, as well, patients from many parts of the city.

### *Institutional set up of PHC delivery in Johannesburg*

What seems to have been more precisely defined than in other Local Governments of Gauteng is the institutional set up of PHC delivery in JB, even if many points still need clarification. As indicated in Table 5, it is planned that a central health unit located in the central administration will determine the overall primary health care strategy and allocate a budget to each of the 11 regional offices, which, through their regional health units, will operate the services. In other words, the central administration will retain the primary role in the financing of the services, through its own municipal funds directed to PHC and the administration of the provincial transfers, and in the articulation of PHC, carrying out planning functions (and notably determining the PHC package, together with the other levels of government) and “purchasing” functions, assuming that it enters into a contractual arrangement with the administrative units paying them for providing an established PHC package. It will also play a crucial role in supervising and monitoring the activities of the regions and an indirect role in the production of the services since it will formally “own” all PHC facilities and staff (which will be only operated by the regional units) and, consequently, should have the ultimate fiscal responsibility for them. The administrative regions, on the other hand, will have the main responsibility for operating the facilities (on average, 13 clinics and 340 staff per region<sup>24</sup>), including staff administration (under municipal rules) and the current administration of the health centres.

Three unresolved issues within this framework concern the transfer of funds from the central metropolitan structure to the regional one, the relative role of the regional health units and district health authorities and the extent of responsibilities attributed to the regional units.

**Transfer of funds from the Metropolitan Council to the regional structure.** The two main issues here are (a) under which specific form the funds will be transferred<sup>25</sup> and (b) how they will be distributed across the regions<sup>26</sup>. These choices will affect the type of purchasing function (for all the services as a whole, for each service individually as exemplified above), as well as its same implementation (an allocation according to historical costs or ex-post expenditure is not compatible with the introduction of contracting) and many possible outcomes (quality, coverage and equity of delivery).

**Relative role of regional health manager and district health manager.** This relative role is still not very clear. In principle the districts are operated by the regions, meaning that the primary responsibility for delivery lies with the regional health manager and then with the district manager. However, it is mentioned in some formal documents that the health budget should be directly administered by the district authorities, attributing them the main responsibility for the delivery. Giving autonomy to the health districts themselves might be a good idea but how to coordinate this with the role of the regional health units? Or do the district health managers coincide with the regional health managers? This is not very clear.

**Intensity of responsibilities transferred to the regional health units.** Finally, will the regional health units only strictly operate the PHC facilities, or will they also have a role in the

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<sup>24</sup> The demarcation of the areas of jurisdiction of the 11 administrative regions still needs to be done (the issue cannot be resolved until the outer boundary process of the city is complete), which makes it impossible to know the distribution of PHC facilities across the regions.

<sup>25</sup> As block grants covering the five main sectors that have been decentralized at the regional level, as specific transfers for each of the sectors, as general transfers with no pre-assigned use leaving the regional managers free to allocate the funds across the different sectors ?

<sup>26</sup> Use of performance incentives ? Any adjustment to local needs and poverty ? Fixed budgets ?

articulation of health care, notably determining which services should be provided beyond the essential package and other aspects of the service organization (including payment mechanisms, opening and closing times of the facilities, etc)? This delegation of responsibility from the central unit might be necessary to promote a delivery more suitable to local needs and characteristics, which is the first scope of decentralization.

## **B) The experiences of Chile, Colombia and Brazil**

**The process in the three countries.** In Table 7, we show the main characteristics of the decentralized model of primary health care delivery applied in Chile, Colombia and Brazil: three Latin American countries that decided to decentralize the responsibility for primary health care to the sub-national level and which, as mentioned in the introduction, share some common characteristics with South Africa.

In the table, we highlight the sub-national level involved, the institutional arrangements and capacity requirements, the financing and fiscal arrangements and the staff policy, as well as some political, administrative and fiscal characteristics of the countries.

### **Choice of the sub-national level, institutional arrangements and capacity requirements**

#### **Sub-national level**

**In the LAC case, the favorite option has been to transfer the responsibility for PHC delivery to existing elected Municipal Governments, making Local Health Districts (when in place) coincide with the geographic area covered by the Local Government**

These LGs, which are typically small in size (around 20,000 people, increasing, however, in urban areas, where they reach 200,000/300,000 or even 500,000 and more persons) have become responsible, to different extents, for the articulation (budget management, determination of local priorities, determination of payment mechanisms, etc) and production/operation (facilities and staff are owned, or, at least, managed by the municipalities) of PHC. They typically manage budgets which include both revenues transferred from other levels of governments and produced at the local level, which means that, in this sense, they also have a financing function.

#### **Institutional arrangements**

**In Brazil and Colombia municipalities do not really have the choice on how to manage PHC: they are supposed to operate PHC facilities directly, through the constitution of Local Health Departments or Secretaries run by Health Managers appointed by the Mayor. In Chile, municipalities had two possible options at the moment of the decentralization reform: they could either operate PHC services directly through the constitution of Municipal Local Health Departments, or do it through the constitution of non-profit maximizing Private Health Corporations**

As far as the institutional arrangements for service delivery are concerned, many different options are possible. Once Local Governments are given the responsibility for PHC, they should in principle be free to decide how to manage the services. They might even decide to give up operational control almost completely, retaining mainly articulation functions. That would happen, for instance, turning PHC and hospital facilities to independent corporations, like it is

currently being done in many German Local Governments. That would have the advantage of reducing fiscal responsibility for losses. This option, however, seems to be more easily applicable to hospitals than to PHC clinics.

In Brazil and Colombia, however, municipalities do not really have the choice on how to manage PHC: they are supposed to operate PHC facilities directly, through the constitution of Local Health Departments or Secretaries run by Health Managers appointed by the Mayor. Additionally, in Colombia, sub-national decentralization is being accompanied by an institutional decentralization which, in the PHC case, means attributing autonomy to the same Local Health Districts, so we get a parallel process attributing responsibilities to both the Local Health Departments and, to a still small extent, the Health Districts Authorities. In both countries, some flexibility in the daily management of the facilities is provided by the possibility of introducing innovatory payment mechanisms (which can produce purchaser-producer splits, even if the PHC facilities are still formally owned and managed by the municipality).

In Chile, municipalities had two possible options at the moment of the decentralization reform: they could either operate PHC services directly through the constitution of Municipal Local Health Departments, or do it through the constitution of non-profit maximizing Private Health Corporations, subject to the Mayor's authority. This latest option has the advantage of introducing more flexibility in the daily administration of the services as the Corporations are subject to private sector law for many operational aspects. However, most municipalities (with the exception of the ones in Great Santiago) opted for the direct operation of services.

### Capacity requirements

**In Brazil and Colombia, the actual transfer of the full range of PHC services to the municipalities was, firstly, preceded by a deepening of the political and fiscal decentralization process, secondly, and additionally, by a specific “certification” process which ensures that a set of stringent institutional and capacity requirements are met by the municipalities. In contrast, in Chile, the transfer was carried out without previous fiscal and political reforms and institutional and capacity requirements were not as explicitly stated as in the other two cases**

In order to take over these different functions, municipalities need to fulfill a number of political, institutional and fiscal requirements. These requirements will vary depending on the precise role of the municipalities: the wider and more complex the role, the more stringent they should be.

In Colombia, political decentralization was deepened in 1987 with the election of municipal governments and strengthened with the 1991 Constitution which, apart from providing the legal framework to political decentralization, also promoted higher levels of fiscal and functional decentralization. Some information on the political and fiscal framework is given in Table 7. These reforms provided the Colombian municipalities with a minimum set of conditions to be able to have a role in PHC delivery (own fiscal basis, central transfers, own elected government, etc). A further set of conditions (indicated in Table 7) are necessary to transfer the full responsibility for PHC to them, including full responsibility for budget and staff management and the determination of local priorities (subject to the existing central rules).

In Brazil, a deepening of fiscal decentralization (1988 Constitution), with particular focus on municipalities, preceded the 1993 health care reform which constituted the SUS (“Sistema Unico de Salud”, ie. Unified System of Health) and considerably extended the role of municipalities in health care delivery. As in Colombia, however, municipalities still have to fulfill a set of ad-hoc requirements to take full responsibility for the delivery of PHC (see Table 7).

In contrast, the Chilean transfer was carried out without previous fiscal and political reforms and institutional and capacity requirements were not as explicitly stated as in the other two cases. Responsibilities were almost immediately transferred with no gradual “certification” process. This lack of reforms and requirements can be partly explained by (but has also induced) the minor level of responsibility in PHC delivery transferred to the Chilean municipalities compared to the Colombian and Brazilian ones (see below).



Table 7: A characterization of the decentralized systems of primary health care delivery in Colombia, Chile and Brazil

	Some characteristics of the political, administrative and fiscal structure of the country – Legal framework	Sub-national level selected at the country level – Coordination with Local Health Districts (if existing) – Definition of PHC package	Main institutional arrangements and capacity requirements for the transfer of PHC	Financing and fiscal arrangements for PHC	Staff policy for PHC
Colombia	<p>Colombia is divided into 33 elected Departments and 1,060 elected Municipal Local Governments. Departments have on average 1,100,000 people, while 70% of the Municipal Governments have less than 20,000 people. Decentralized responsibilities and resources are established by constitutional law (1991 Constitution).</p> <p>Both levels of government have their own fiscal basis, which was deepened since the beginning of the 80's (mainly composed of local taxes, little use of service user fees). Municipalities also receive general transfers under the form of a sharing agreement in the current national revenues (PICN). The transfers are conditional insofar as they have to be allocated across precise uses (30% to education, 25% to health, etc). Departments also receive general transfers (Situado Fiscal) under the form of conditional block grants for education and health (60% should be allocated to education, 20% to health and the remaining 20% to one of these two sectors). Part of these transfers should be decentralized to the municipal level once municipalities are "certified". The SF represents 18% of the total public expenditure.</p> <p>The PICN is allocated according to historical levels, poverty indicators, fiscal effort and administrative efficiency. The PICN represents 13% of tot expenditure.</p> <p>The SF is allocated according to historical levels, population and fiscal effort. Historical levels have still too much weight. Other revenues: co-financing, natural resources "regalias", credit (excessively used).</p>	<p>PHC transferred to the Municipal Local Governments which head the Local Health Systems. There is an equivalence between the Local Health District and the Municipal Local Governments. The transfer of responsibility was officially stated in the 1991 Constitution.</p> <p>A PHC package was defined under the form of a Compulsory Health Plan (so-called "Plan Obligatorio de Salud"). Who defined it ?</p>	<p>Municipalities can manage all PHC services on their own, including PHC hospitals, once they are certified by the departments. These are some of the most important conditions for certification:</p> <ul style="list-style-type: none"> <li>-creation of a Local Health Secretary</li> <li>-creation of a Local Health Fund</li> <li>-process of autonomization of hospitals under way</li> <li>-development of a Local Information System</li> <li>-elaboration of a Local Health Plan</li> </ul>	<p>PHC is financed by a combination of different sources of funds. Main ones:</p> <ul style="list-style-type: none"> <li>-25% of the PICN</li> <li>-50% of the SF directed to health (at least in theory)</li> <li>-own municipal funds</li> <li>+ FOSYGA (which directly refunds the providers through the Empresas Promotoras de Salud (EPS) and co-finances the subsidized POS with the municipality).</li> </ul> <p>Relative share of each source in Total Health Care (1996):</p> <ul style="list-style-type: none"> <li>-15% PICN</li> <li>-30% SF</li> <li>-20% central funds (FOSYGA' s contributions to municipalities + ad-hoc financial assistance)</li> <li>-35% other (own revenues)</li> </ul> <p>% of PHC exp over tot exp in health care: 43%</p> <p>.Fiscal gaps: tackled .Horizontal equity: the allocation of the PICN takes into account poverty criteria but ends up being inequitably allocated. .Efficiency: both the formulas for the allocation of the SF and PICN take into account fiscal effort. But too complex to be really effective.</p>	<p>Certified municipalities manage all PHC staff, but subject to central rules on the determination of wages and firing procedures</p>

	Some characteristics of the political, administrative and fiscal structure of the country – Legal framework	Sub-national level selected at the country level – Coordination with Local Health Districts (if existing) – Definition of PHC package	Main institutional arrangements and capacity requirements for the transfer of PHC	Financing and fiscal arrangements for PHC	Staff policy for PHC
Chile	Chile is divided into 13 administrative Regions and 326 elected Municipal Local Governments. 70% of the Municipal Local Governments have less than 30,000 habitants. Municipalities have their own fiscal basis (local taxes), even if small. The main local taxes are the real estate tax (property tax), vehicle registration fees, and commercial and industrial patents. Little use of user fees. Very little use of credit. In all, own revenues represent approximately the 45% of all municipal revenues, of which 32% are constituted by local taxes. Main issue: lack of local flexibility in the determination of local tax bases and rates.		No specified requirements except for the fact that municipalities had to constitute either Local Health Departments or Private Health Corporations (non-profit maximizing and subject to the Mayor's authority) to manage PHC.	<p>PHC is financed by a combination of two main types of funds:</p> <ul style="list-style-type: none"> <li>-specific transfers to PHC from the Ministry of Health (FONASA) (approx. 70%)</li> <li>-own municipal funds (approx. 30%)</li> </ul> <p>PHC exp p/c: approx. 13,000 Chilean pesos per beneficiary (1996). Approx. 7,000 pesos p/c (including only the PHC clinics managed by the municipalities)</p> <p>Fiscal gaps: the specific transfers have not been enough to cover the operating expenditures. The resulting deficits had to be covered by the municipalities</p> <p>Horizontal equity: specific transfers are allocated across municipalities according to the number of beneficiaries of the PHC services adjusted by rurality and poverty levels + mechanism which redistributes money across municipalities (Fondo Comun Municipal)</p> <p>Efficiency: use of a capitation formula + use of "management agreements" fixing results to achieve in terms of inputs (number of medical services offered), outputs (improvement of nutritional indicators, mortality rate) or levels of quality of care</p>	Initially all staff was devolved to the municipal level with total municipal autonomy. The PHC staff was subject to private sector rules. From the beginning of the 90s, there was a partial re-centralization through the approval of a Statute which fixes minimum wages similar to the Regional Health services and introduces some notion of civil servant career relating the salary to variables of merit, training and seniority.

	Some characteristics of the political, administrative and fiscal structure of the country – Legal framework	Sub-national level selected at the country level – Coordination with Local Health Districts (if existing) – Definition of PHC package	Main institutional arrangements and capacity requirements for the transfer of PHC	Financing and fiscal arrangements for PHC	Staff policy for PHC
Brazil	<p>Brazil is divided into 26 elected States + 1 Federal District and 5,200 elected Municipal Governments. 67% of the Municipal Local Governments have less than 20,000 habitants (this proportion, however, covers only the State of Sao Paulo). The average size of a State is 5 millions habitants. Decentralized responsibilities and resources have been deepened with the Constitution of 1988. Both levels of government have their own fiscal basis and receive general transfers, precisely co-shared federal taxes, by the federal government. These transfers are allocated according to negotiation criteria and equity considerations. Municipalities receive general transfers from the States as well (25% of the tax on commercial transactions). Additionally, there are some ad-hoc negotiated transfers from the federal government to the States and Municipalities and from the States to the Municipalities. In 1991, 57% of the total revenues were managed by the federal level, 27% by the State level and 16% by the municipal level. The relative proportions of States and municipalities have increased with the 1988 Constitution. Approximately 37% of the total municipal revenues are constituted by own revenues.</p>	<p>PHC principally delivered by the Municipal Governments. The Local Health Systems are headed by the Municipal Governments.</p> <p>No formal minimum PHC package has been defined. A typical package would however include:</p> <ul style="list-style-type: none"> <li>-psychiatric consultations</li> <li>-rehabilitation</li> <li>-paediatrics and gynaecology obstetric</li> <li>-general surgery</li> <li>-dental consultations</li> <li>-preventive health</li> <li>-emergency care</li> <li>-basic investigations (x-rays and laboratory)</li> </ul>	<p>To have complete responsibility of the Local Health System (including public and private sector) and autonomy in managing health funds, municipalities have to reach the stage of municipality in “semi-full administration”.</p> <p>Main conditions for that:</p> <ul style="list-style-type: none"> <li>-have a Municipal Health Secretary</li> <li>-have a Municipal Health Council</li> <li>-have a Municipal Health fund</li> <li>-have a Municipal Health Plan</li> </ul> <p>But planning capacity remains low. Lack of effective local health plans.</p>	<p>PHC is financed by a combination of the following types of funds:</p> <ul style="list-style-type: none"> <li>-general transfers from the federal government and the States</li> <li>-transfers from the federal Social Security budget</li> <li>-municipal revenues (only approx. 12% of the total exp in health care is financed through these revenues).</li> </ul> <p>Fiscal gaps: transfers to the municipal level and the municipal fiscal basis have increased since 1988</p> <p>Horizontal equity: transfers from the SS budget are allocated according to a complex formula including indicators of service quality, technical and financial performance, population and epidemiological profile. Little care about equity. The general transfers are slightly redistributive.</p> <p>Efficiency: see above- the formula used for the allocation of the SS transfers includes some indicators which should enhance efficiency. However, its does not work properly.</p>	<p>Staff policy is quite autonomous. Municipalities hire and fire their staff with little interference of the other levels of government.</p>



## Main lessons for Gauteng :

What can we infer from these considerations that can be useful to the South African and Gauteng case ?

- It seems that the basic PHC strategy adopted in the three Latin American countries is similar to the one that will be applied in Gauteng: in all cases, the responsibility for PHC is given or will be given to the constituted Local Governments, with no distinction of size, with the objective of increasing the social efficiency of delivery ensuring, at the same time, a higher level of accountability of the new health care managers (appointed by the elected local authorities) to the population.
- In all countries, with the exception of Chile, Local Governments have a very heterogeneous size, fluctuating between approximately 20,000 habitants to several millions ! This PHC strategy implies that, as long as they have elected metropolitan Local Governments, small, medium and large cities are transferred the responsibility for articulating and producing PHC services. The absence of differentiation per size might create problems for both the very small municipalities, which might not have the sufficient capacity for assuming the new responsibilities, and large and average cities, which might be too big to provide health in a socially efficient way. This suggests that the strategy might need to be adjusted. In fact, in Colombia and Brazil, the “certification” process seems to have worked quite well for resolving the problems of the smaller municipalities since it makes it possible to decentralize responsibilities gradually or have municipalities with a different level of responsibilities according to their capacity. However, this system does not solve the problem of large cities and, additionally, has led to situations where the responsibility up-grading of municipalities was delayed for no apparent reasons by the intermediate levels of government<sup>27</sup>, creating conflicts. It is for this last reason that we can say that the Gauteng province is probably doing the right thing in no conditioning the transfer of responsibilities to a negotiation process and solving the small municipality problem by making it possible for municipalities with lack of capacity to make associations. A certification system, more objective and systematic than the Latin American one, might, however, have the merit of considering in a more explicit way the capacity requirements necessary to assume the responsibility for PHC (which it might be important to detect and assess also in large cities).
- As regards the institutional arrangements adopted to manage PHC, the three Latin American models did generally leave little choice to the Local Governments on how best to carry out their new responsibilities, with the consequence of leaving generally little choice to large cities (with some exceptions<sup>28</sup>). That might also explain why we did not find truly innovative experiences of service management. The Chilean option of running the services through private corporations, as well as the increasing autonomy given to the Local Health Districts in the context of a Local Government system in Colombia can, however, be considered as innovative experiences whose relevance to the case of Gauteng and Johannesburg will be examined while analyzing the cases of Santiago and Bogota.

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<sup>27</sup> Which, together with the Local Governments, have to manage the certification process.

<sup>28</sup> This is notably the case of Sao Paulo in Brazil, which passed a special law which allowed it to transfer the management of health to 14 cooperatives, constituting a true exception in the country.

## **Intensity of the Transfer of Responsibility**

The balance of power between the central and the local governments is not the same across the different countries: within the articulation and production functions, more or less sub-functions have been decentralized to the sub-national level.

## **Staff management**

**In Chile and in Brazil, medical and non-medical staff is managed with great autonomy at the municipal level (the staff is in fact defined as “municipal” staff), while in Colombia, this autonomy is limited by the application of central employment rules, which restricts local flexibility in dismissing medical staff and fixing salaries**

## **Lessons for Gauteng:**

- The problems that this lack of flexibility created in Colombia (see Vargas and Sarmiento, 1998) suggest that the Local Governments and, as a consequence, the large cities as well, should be free to manage the PHC staff with a minimum of central intrusions.

## **Type of PHC institutions transferred to the local level**

**In both Brazil and Colombia, a comprehensive definition of PHC districts was adopted and Local Governments were formally given responsibility for the administration of both PHC health centres (clinics and policlinics) and district hospitals (which mostly provide PHC outpatient and inpatient services). Only PHC services provided in some higher level hospitals are excluded. In contrast, in Chile, only PHC centres were decentralized, all hospitals of whatever level remaining the sole responsibility of the regional sections of the Ministry of Health**

## **Lessons for Gauteng :**

- As in Chile, in Gauteng as well it is planned to decentralize only the PHC centres to the municipal level. The main issue here is that the municipalization of PHC centres, excluding the district hospital, will lead to an artificial divide between level 1 hospital services and primary level care even where comprehensive health districts existed, producing a division between two symbiotic components of a single system as well as potentially blocking the ability of district health managers to use the hospital resources in support of district and PHC development. Additionally, there might be a referral problem produced by the incentive that municipalities might have in unduly referring their patients to the district hospitals, managed on a different budget, to save on costs. On the positive side, it is said that this separation will prevent the health centres from being dominated by hospitals, avoiding “hospicentric” health districts. The experience of Latin America seems to suggest that, at least in the long run, a comprehensive Local Health District is more performing than a less comprehensive one, even if more resources and skills are necessary to manage it.

## **Determination of the PHC package**

**In the Latin American case, this issue was not always tackled with the greatest clarity or logic. In Chile , the PHC package was adequately identified and specified but little freedom was left to the municipalities to complement it. In Brazil, the PHC package has not been adequately defined, leaving more freedom to the sub-national level, but also leading to more coverage disparities among areas. Only in Colombia, the package seems to have been adequately defined and the municipalities be also given the necessary freedom to complement it. The type of services generally included in the package varies across countries**

Within the framework of the principal-agent relation typically involved by the implementation of a decentralization model, the central level will in general establish a minimum PHC package that the local level will have to provide. This is to ensure a fair amount of equity among areas. The local level will have to commit to make this package available to its residents and will typically be free to complement this package with other services corresponding to local priorities. In the Latin American countries analyzed, however, this issue was not always tackled with the greatest clarity or logic. In Chile, the PHC package was adequately identified and specified in the special agreement stipulated between the regional sections of the Ministry of Health (the so-called Regional Health Services) and the municipalities. However, little freedom was left to the municipalities to complement the package (increasing lately, however). In Brazil, on the contrary, the PHC package has not been adequately defined, leaving more freedom to the sub-national level, but also leading to more coverage disparities among areas. Only in Colombia, the package seems to have been adequately defined<sup>29</sup> (even if it does not strictly cover only PHC services, creating some ambiguity in the responsibility of municipalities) and the municipalities be also given lot of freedom to complement this package.

### **Lessons for Gauteng:**

- On the basis of these experiences, and taking account of the important spatial socio-economic inequities that characterize all the countries under analysis, it seems adequate to fix a minimum PHC package and hold the Local Governments accountable for it to both the central level and the local population. However, it seems also adequate to give the necessary flexibility to the Local Governments to complement this package with services that specifically address local needs.
- The Latin American experience might also be helpful to Gauteng for determining the minimum PHC package. On one extreme, we have the case of Chile with a basic but well balanced package of services, on the other one, the case of Brazil with no minimum package but a standard package more comprehensive than the Chilean one (see Table 7). There might be a case for a comprehensive interpretation of the PHC package principally based on the referral issue mentioned above (a more comprehensive municipal system of PHC services will make referrals to other systems less likely even if it will not avoid them) but this option is more expensive and demanding than the other one, requiring a very careful assessment of the possible financing sources and the local available skills. A possible option would be to adopt a comprehensive version of the PHC package and transfer the whole responsibility for it to the Local Governments after a certification process similar, but more objective, than the one adopted in Colombia and Brazil. That would notably make it possible to transfer a more comprehensive PHC package to large cities, assuming that they will be the first to be certified. If and how this option could be effectively applied to the Gauteng case is a matter of discussion.

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<sup>29</sup> It is referred to as the “subsidized compulsory health plan” (subsidized POS), by opposition to the “complete compulsory health plan” (complete POS) which covers almost all possible health services.

## Budget allocation across PHC institutions

**In Brazil, municipalities are free to choose how to allocate their budget across the different institutions. Most of them introduced competition in their payment system, purchasing services from both the public and private sector. In Colombia, the range of options is more reduced. Finally, in Chile, the payment mechanisms are completely centrally determined**

Another important aspect of service articulation concerns the decision on the criteria and mechanisms for allocating the budget among the different PHC institutions. In Brazil, municipalities are free to choose how to allocate their budget across the different institutions. Most of them introduced competition in their payment system, purchasing services from both the public and private sector. In Colombia, the range of options is more reduced. The main limitation consists in the “obligation” to transform gradually most supply subsidies into demand subsidies, leaving little choice to municipalities. Finally, in Chile, no choice at all exists: the payment mechanisms are completely centrally determined. On the one hand, leaving this aspect of service articulation at the discretion of the Local Governments would have the advantage of making it more suited to the local conditions. The application of a competitive payment mechanism, for example, might be possible in large urban environments with a developed network of private and public providers and the skills necessary to articulate the competition among them, but not in other types of environments. On the other hand, however, having a common payment mechanism, for instance based on performance, might ensure minimum quality standards and a more equitable outcome.

## Financing and fiscal arrangements

**In the three countries, own revenues represent a relatively small proportion of the total financing of PHC, reflecting a Latin American trend. In Chile and Colombia, there is a lack of autonomy in determining most tax bases and rates. In all three countries, transfers come mostly from the Central Government and an attempt was made to incorporate equity and efficiency indicators in their allocation formulae. In both Colombia and Brazil, however, the lack of reliable information systems together with the insufficient supervision and monitoring have had negative consequences on the effective application of these allocation formulae**

The financing and fiscal set up is a crucial aspect of a decentralized system of health care. Transferring the responsibility for the delivery of PHC to the sub-national level implies tackling the financing of this new responsibility as well. “Unfunded mandates” are too common in the decentralization history. In the three Latin American countries considered, PHC delivery is financed by a combination between local revenues and revenues from other levels of government in varying proportions across the countries. The following table summarizes some basic information on the combination between different types of revenues and on the nature of these revenues across the analyzed countries.

Table 8 : A characterization of the health care financing sources in Colombia, Chile and Brazil

	Proportion of PHC financed by own revenues	Type of own revenues	Characteristics of the transfers	Conditions attached to the transfers	Allocation criteria
Colombia	Approx. 20% a/	Local taxes: Property tax, vehicle registration fees, commercial and industrial patents	-General transfers from the CG to the departments and municipalities (Situado Fiscal)	-60% to education, 20% to health, 20% to either education or health -50% of the SF	- allocated according to historical levels, population and fiscal effort. Historical levels



		Little user charges Credit		for education transferred to the “certified” municipalities  -30% to education, 25% to health	have still too much weight.  - allocated according to historical levels, poverty indicators, fiscal effort and administrative efficiency
Chile	Approx. 30%	Local taxes: Property tax, vehicle registration fees, commercial and industrial patents	Specific transfers from the National Health Fund to the municipalities	No conditions	Per capita, adjusted by poverty and rurality levels
Brazil	Approx. 12% a/	Local taxes: Commercial and industrial patents, real estate tax, vehicle registration fees, consumption and production taxes User charges Credit	-General transfers from the FG to the municipalities  -General transfers from the States to the municipalities (25% of the taxes on commercial transactions, a type of VAT)  -Specific transfers from the Federal Social Security Fund to the States and municipalities	No conditions  No conditions  No conditions for the States. Only the municipalities in semi-full administration can manage the funds directly	-allocated according to discretionary and equity criteria  -not specified  -formula including indicators of service quality and quantity, technical and financial performance, population and epidemiological profile

a/total health care

In all cases, own revenues represent a relatively small proportion of the total financing of PHC (even if these data should be carefully interpreted as they refer mostly to total health care and the proportion should increase considering only PHC). This is rather typical of Latin American countries. The fiscal reforms introduced in both Brazil and Colombia had the main purpose of increasing municipal revenues, either widening the municipal fiscal basis or, preferably, increasing the amount of transfers from other levels of government, notably through federal and national revenue sharing agreements. These general sources of revenues were then complemented by revenues specifically aimed at financing health care services, as illustrated by the introduction in Brazil and, to a lesser extent, Colombia, of specific transfers made from the federal (national) Social Security Fund to both States (in Brazil) and municipalities (in Brazil and Colombia). In Chile, municipalities only receive specific transfers for health which complement their existing weak fiscal basis.

A combination between own revenues, general and specific transfers might be a good option for financing health care, in spite of the fact that it introduces a high level of dependency of municipalities from the other levels of government, but it needs to be very carefully designed to foster an efficient and equitable health care delivery across areas.

### **The equity issue**

Complementing own municipal revenues with transfers might not only be necessary to close the financing gap but also to ensure a minimum level of equity across areas. In other words, if we want municipalities with a different revenue basis to be able to provide the same minimum package of PHC, it will be necessary to introduce some redistribution into the system, either designing general or specific transfers which incorporate the equity concern through the use of allocation formulae that take into account explicitly the poverty level and fiscal capacity of each of the areas, or using some other redistributive mechanism which makes it possible to introduce some financial compensation across areas. In both Colombia and Brazil, general transfers directed to the municipalities are allocated according to a formula which incorporates poverty levels. The complexity of the formula used in Colombia, however, complicates its effective application. In Chile, specific transfers for PHC are adjusted by poverty levels and levels of ruralness to make them slightly redistributive. Additionally, a Municipal Fund was constituted to introduce direct revenue compensation across municipalities. Which of the different options is preferable will ultimately depend on the result that we want to achieve. If the main concern is to promote an equalization of municipal revenues, irrespective of the use of these funds<sup>30</sup>, the use of general unconditional transfers with a redistributive component or of general revenues compensation schemes seems to be a good option. If, however, the main concern is to bring the municipalities to provide the same minimum PHC package, two better options are: the introduction of transfers specifically aimed at financing PHC with some component of redistribution, like in Chile and, to a lesser extent, in Brazil<sup>31</sup>, or the introduction of general redistributive transfers conditional on partial allocation to PHC like in Colombia. In any case, the PHC minimum package must be adequately costed and the amount of resources necessary to provide it be evaluated in the different possible environments. That was adequately done in Chile and Colombia but not in Brazil. Another important condition for the effective design of distributive transfers and mechanisms is the necessity of having a reliable central information system on local conditions and needs to prevent the possible “adverse selection” problem that can arise when allocating the funds according to equity criteria.

### **The efficiency issue**

Another problem that needs to be tackled is the possible negative impact that distributive transfers and mechanisms might have on local fiscal effort and performance. This leads us to the discussion of the efficiency issue. To prevent this negative impact and reward good performance, the transfer allocation formula might have to incorporate explicitly some performance indicators measuring improvements in technical, administrative and fiscal efficiency and in the quality and quantity of PHC, together with the equity indicators. This is what all three analyzed countries have tried to do, using different indicators and, in the Chilean case, also “management agreements”. However, the effective application of this type of formula can pose some complicated conceptual problems: how to measure technical and administrative efficiency? And service quality? Additionally, as and more than in the previous case, it is also very information intensive. In particular, little or no information on the “true” effort of the Local Governments (only proxied by the above mentioned outcomes) could lead to an erroneous allocation of funds if the LGs cheat on the central government, taking advantage of economic uncertainty and of its lack of information (“moral hazard” problem). In that case, a proper supervision and monitoring might turn up to be very important to make the “true” effort at least imperfectly observable. The use of intermediate expenditure targets might also constitute a way of observing, even if imperfectly, the effort. In

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<sup>30</sup> So that municipalities can have the same spending potential in general.

<sup>31</sup> Possibly also with the attached condition of spending a specified total minimum amount, financed on both transfers and own funds, on PHC.

both Colombia and Brazil, the lack of reliable information systems together with the insufficient supervision and monitoring have had negative consequences on the effective application of the allocation formulae.

### **Lessons for Gauteng:**

In the light of these considerations, what can we say of the Gauteng case ? These are a few, non exhaustive, comments.

- As far as the combination own revenues/transferred revenues is concerned, if approximately 30% of the PHC expenditures keeps on being financed by municipal revenues in Gauteng, that will locate it around the Latin American average (see Table 8). This is not a high proportion and will create a dependency from other levels of governments similar to the Latin American case, with the related financial uncertainty and loss of local accountability. The first issue can be tackled promoting a formal legislation of the transfers, by opposition to ad-hoc negotiated agreements. That was in fact done in Colombia and Brazil with good results. The second issue is more difficult to deal with and would in fact require an increase in the proportion of own funds. This might be obtained in several ways. Our Latin American cases are not necessarily a good example as the local revenue bases, except in the case of Brazil, are traditionally weak with several taxes with small bases mostly fixed by higher levels of government, little autonomy in fixing the tax rates and little use of user charges. Only in Brazil, in spite of their persistent dependence from the centre, Local Governments have more autonomy in determining tax bases and rates and have access to more consistent user charges. On the basis of these experiences, we can say that it might be better to concentrate on a few revenue sources, like property taxes and user charges<sup>32</sup>, than on too many different sources, and have high levels of autonomy in determining bases and rates. However, determining the ideal proportion between own and transferred funds is very difficult and it might well be that one third of expenditure financed by own funds be enough to reach a satisfactory level of local accountability (see the case of Santiago).
- No standard receipt seems to exist on the issue of transfers, equity and efficiency. The main clear difference between Gauteng and the three Latin American countries examined is that it is envisaged that in Gauteng PHC will be financed by a combination between own funds and provincial transfers, making the Local Governments agents, with more or less intensity, of the province, while in the LA countries practically all transfers come directly from the central level, building a direct principal-agent relationship with the centre. A principal-agent relationship built around the province might have the advantage of improving the working of the transfer mechanism as a consequence of the better information on local conditions of the province compared to the centre and its closer supervision. This is, as pointed out before, a very important point, considering the problems that both Colombia and Brazil had in allocating their transfers across Local Governments. The referral mechanism between levels of care might as well be working better since the province will have the will and the possibility of using the transfer mechanism to give the right incentives to the LGs. However, going through the province might add a more political less objective flavour to the whole process<sup>33</sup>, which might be more impartially and equitably managed from the centre. This trade-off makes it difficult to formulate a definite opinion. A centrally based transfer mechanism would probably confer more power to large cities since they would be now dealing directly with the centre with no interference of the province.
- Turning to the specific characteristics of the transfers, we can reiterate that the Latin American option of specific or general conditional transfers allocated according to specific formulae taking into account both equity and efficiency indicators is a correct one if the main objective is to get a minimum and efficiently produced PHC package across municipalities. In that respect, according to the current debate (see section on

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<sup>32</sup> Complemented, for instance, by consumption taxes on specific goods (alcohol, cigarettes, etc) like in Brazil.

<sup>33</sup> As it happened in Colombia with the transfer of the Situado Fiscal from the departments to the municipalities.

Gauteng), Gauteng seems to be moving in the right direction. The Latin American case offers no experience on the allocation of fixed budgets (except for hospitals), but provides some on the application of the capitation option (Chile) and of fiscal/financial effort indicators (Colombia and Brazil). The application of the “management agreements” in Chile might also be an interesting option to look at. However, the main issue might not concern so much the precise allocation formula but how it can be effectively implemented. This requires an amount of information and supervision proportional to the complexity of the formula suggesting (a) to keep the formula simple and (b) to build a clear inter-governmental cooperative structure where, for instance, deconcentrated structures of government, like the Regional Health Services in Chile, assist the central government in implementing the formula. In Gauteng, this role could be fulfilled by the existing administrative Health Regions, assuming that PHC services keep on being financed by provincial transfers.

### **Role of large cities in PHC: the cases of Belo Horizonte, Bogota and Santiago**

What about the role of large cities in PHC in the three analyzed countries ?

In Table 9, we provide a quick characterization of this role within the current decentralized system of health care delivery. We then describe in more detail the role of the three selected large cities: Belo Horizonte (Brazil), Bogota (Colombia) and Santiago (Chile).

Table 9: A characterization of the role of large cities in the decentralized system of primary health care delivery in Colombia, Chile and Brazil

	Role of large cities in PHC and main requirements	Case Study: Some political, administrative and fiscal characteristics of the large city	Case study: the role of the city in PHC
Colombia	Insofar as they are elected Local Governments and are not subdivided into minor Local Governments, they directly manage PHC. The requirements are the same than for ordinary Local Governments (see Table 7).	Bogota: the city counts with 7,000,000 habitants, it is considered as both a Municipality and a Department with an elected Mayor and is, in turn, divided into 19 Municipal Governments, headed by appointed local Mayors and elected local councilors, of approximately 350,000 habitants on average. It does have its own revenue basis (mainly local taxes) and receives transfers from the centre (SF + PICN). The 19 Sub-Municipalities do not have revenue basis.	<p>Bogota: PHC has been transferred to the primary responsibility of the municipality of Bogota, through its newly created District Health Secretary. The main responsibilities of the Secretary cover the articulation, financing and production of PHC. A deconcentration process made it possible to transfer some responsibilities in the articulation and production areas to the 19 sub-municipalities which, in fact, coincide with the Local Health Districts. As a department and following the deconcentration process, the role of Bogota is also to regulate many aspects of PHC delivery.</p> <p>All funds for PHC are formally part of the District Financial Health Fund.</p> <p>Main financing sources of PHC in Bogota (approx.):                      -SF: 16%                      -PICN: 51%                      -FOSYGA (funds administered centrally): 8%                      -own funds: 25%</p> <p>% of funds for PHC over tot exp: 35%</p> <p>Habitants per PHC centre: approx. 47,000</p>
Chile	The only large city (Santiago) does not have any particular role in PHC, due to its political and administrative structure.	Santiago: the city counts with approximately 6,000,000 habitants and is divided into 51 elected Municipal Governments of approximately 200,000 habitants on average and 6 Regional Health Services. No fiscal basis at the city and regional level, only the municipalities have one.	<p>Santiago: PHC has been transferred to the 51 elected Municipal Governments (with a few exceptions), all with a local health department or a private health corporation (corporations are very common in Santiago). The role of the city as a whole is not specified. No particular role.</p> <p>Main financing sources of PHC in Santiago:                      -specific transfers: approx. 65%                      -own funds: approx. 35%</p> <p>PHC exp p/c: approx. 20,000 Chilean pesos per beneficiary (1996)</p>

			Habitants per PHC centre: approx. 35,000
	Role of large cities in PHC and main requirements	Case Study: Some political, administrative and fiscal characteristics of the large city	Case study: the role of the city in PHC
Brazil	Insofar as they are elected Local Governments and are not subdivided into minor Local Governments, they directly manage PHC. The requirements are the same than for ordinary Local Governments (see Table 7).	<p>Belo Horizonte (in the State of Minas Gerais) : approx. 2 million. Fiscal basis at the city level which also receives federal and state transfers.</p> <p>Salvador (in the State of Bahia): approx. 2 million. Fiscal basis at the city level which also receives federal and state transfers.</p> <p>Relative share of funds: -own revenues: 42% -state transfers: 35% -federal transfers: 17%</p>	<p>Belo Horizonte (in “semi-full” administration): the elected Municipal Government is responsible for the delivery of primary health care, including the first referral hospital (providing both PHC and some SHC), through the Municipal Health Secretary which heads the Local Health System. All aspects of delivery (financing, articulation and production) are included. The State of Minas Gerais has a strong role in the coordination of the municipalities and in the establishment of mechanisms of control and evaluation of the municipal health systems.</p> <p>Main financing sources of PHC (including some SHC) in Belo Horizonte: -federal transfers (social security): 88% -own revenues: 12%</p> <p>PHC (including some SHC) p/c: 58 reales de 1996</p> <p>Habitants per PHC centre: approx. 13,000</p> <p>Salvador (in “partial” administration): the elected Municipal Government is responsible for aspects of the delivery of PHC through the Municipal Health Secretary: control and evaluation of ambulatory and hospital services, introduction of preventive health, planning of PHC processes and of the authorization of hospitalizations, staff contracting, etc. It will move on to semi-full administration when ready.</p>

## 1. Belo Horizonte: A Case of a Centralized Metropolitan Government

**Belo Horizonte is a city of approximately 2 million habitants, with its own elected Municipal Government and its own fiscal basis complemented by transfers received by both the State and the Federal Government. Through its appointed Municipal Health Secretary, it runs, with great autonomy, the Local Health District System, composed of 142 health centres, 4 mixed units and 1 general hospital. This centralized model of PHC delivery has the advantage of providing a centralized planning, financial and technical management which takes advantage of economies of scale and of the institutional and fiscal capacity present at the central metropolitan level. Its main and strong disadvantage, however, is that it does not take into account preference diversity and does not promote local accountability**

In Brazil, all large cities have some level of responsibility in the articulation and production of primary health care. This actual level of responsibility depends on the formal stage of the city in the decentralization process: incipient, partial or semi-full administration. In 1996, only approximately 3% of the country's municipalities, i.e. 137 municipalities, were at the stage of semi-full administration, but these 137 municipalities represented 16% of the overall country's population and included 11 State capitals. In fact, almost all the largest cities, with some exceptions, are in semi-full administration, meaning that they have extensive responsibilities in the financing, articulation and production of PHC.

### **Basic political and fiscal characteristics of Belo Horizonte and its role in PHC delivery**

A typical example of a large city in semi-full administration is provided by Belo Horizonte, the capital of the State of Minas Gerais. As indicated in Table 4, Belo Horizonte is a city of approximately 2 million habitants, with its own elected Municipal Government and its own fiscal basis complemented by transfers received by both the State and the Federal Government. Like all Brazilian municipalities, Belo Horizonte directly manages the real estate tax, commercial and industrial patents, vehicle registration fees and the existing production and consumption taxes, with great autonomy in the determination of the rates and of the fiscal basis of these taxes. Additionally, it is free to charge user fees on most public services and to contract loans.

Within this political and fiscal framework, all the more favourable the larger the municipality, and having satisfied all the necessary criteria (see Table 7), Belo Horizonte negotiated with both the Federal Government and the State its incorporation in the status of municipality in semi-full administration in 1994. In concrete terms, that means that, through its appointed Municipal Health Secretary, the city runs the Local Health District System, composed, principally, of 142 health centres, 4 mixed units, with both outpatient and short-stay inpatient care and 1 general hospital which provides both primary and non-complex secondary health care.

The city has complete autonomy in managing all the Local Health District's staff and facilities and determines the PHC package to be offered as well as the relation between the public and the private sector, which involves the use of contracting principles. To carry out all these functions, it manages freely an health care budget composed of revenues from the Federal Social Security Fund (88% of total PHC financing) and own revenues (12%).

Thus, we have a case of a centralized elected metropolitan government which directly operates PHC services in its geographical area. Its important fiscal and institutional capacity makes it capable of managing an extensive network of PHC providers (with some SHC, as well) and also

assume an extensive role in the planning and purchase of services, including the purchase of services from the private sector network present in the capital<sup>34</sup>.

### **Advantages and disadvantages of the model**

This model has the advantage of providing a centralized planning, financial and technical management which takes advantage of economies of scale and of the institutional and fiscal capacity present at the central metropolitan level. Its main and strong disadvantage, however, is that it does not take into account preference diversity and does not promote local accountability, since the metropolitan government is far away from the voters considering the large size of the city. There is no formal rule on the ideal size of a Local Government and of the corresponding size of the Local Health District (assuming that both coincide, which does not need to be the case), but a size larger than 500,000 habitants seems to be inadequate to comprehensively reflect local preferences and foster local accountability.

To illustrate this, if it is true that the development of the PHC network<sup>35</sup> and a slight reduction of hospitalizations<sup>36</sup> indicates a satisfactory management performance of Belo Horizonte, some evidence also shows (see Instituto de Saude (1998)) that local resource mobilization was much lower<sup>37</sup> and the reduction in hospitalizations less marked than in other smaller municipalities, indicating that there was little involvement of the population, little fit with their needs and little local accountability of the managers compared to smaller municipalities.

Thus, the Brazilian model of gradually decentralizing the direct responsibility of delivery of PHC to the existing small, average and large municipalities and have it managed through centralized Health Secretaries seems to be more adequate for small municipalities<sup>38</sup> (smaller than 500,000 habitants) than for average (smaller than 2,000,000 habitants) and large (2,000,000 or more habitants) municipalities. These, however, are free to operate a deconcentration of the responsibility for PHC services within their Municipal Health Secretary, which could lead to the creation of smaller and more responsive local health districts. This solution, however, has not generally been chosen by Brazilian municipalities, which preferred a centralized to a decentralized management.

## **2. Bogota: A Case of a Deconcentrated Metropolitan Government**

**Bogota is a city of approximately 7 million habitants, with its own elected Metropolitan Government and its own budget which includes own fiscal and non-fiscal revenues and revenues transferred by the national Government. It is in turn divided into 19 Sub-Municipal Governments of approximately 360,000 habitants on average, which are headed by 19 appointed Mayors. Through its newly created District Health Secretary, the city runs,**

<sup>34</sup> The “contracted” private sector network represents only approximately 12% of outpatient and short-stay inpatient PHC provided in health centres and mixed units but 53% of all hospitalizations (including short-stay inpatient PHC provided in hospitals).

<sup>35</sup> The proportion habitants/PHC institutions lowered from 15,000 habitants per PHC institution in 1994 to 13,000 in 1996.

<sup>36</sup> Which can probably be related to the higher coverage and “resolution” of the PHC network.

<sup>37</sup> There was even a clear crowding-out of local funds by the federal transfers.

<sup>38</sup> Very small ones will probably end up having only partial responsibility on PHC delivery, while the other ones will probably end up having the primary responsibility of their networks with the right local health district size.



**with great autonomy, a network composed of 130 health centres and 8 PHC hospitals. Since 1992/93, two main processes are under way: the transfer of more administrative autonomy directly to the Local Health District Authorities and, above all, a gradual deconcentration of the responsibility for PHC to the 19 sub-municipalities. This deconcentrated model of PHC delivery is more socially efficient than the centralized one because it is better suited to take account of the different needs and preferences of the population. However, it might be little conducive to local accountability compared to a two-tier metropolitan model where the primary responsibility for PHC delivery lies with elected Sub-Municipal Governments with individual fiscal bases**

In Colombia, the role of large cities depends as well on the PHC decentralization model applied at the national level and on the political and fiscal structures of the cities.

### **Basic political and fiscal characteristics of Bogota and its role in PHC delivery**

The largest city is Santafe de Bogota, with 7 million habitants. The city has its own elected metropolitan government (equivalent, in fact, to both the government of a Municipality and of a Department) and its own budget which includes own fiscal and non-fiscal revenues and revenues transferred by the national Government under the form of general conditional transfers (the Situado Fiscal and the PICN). It is in turn divided into 19 Municipal Governments of approximately 360,000 habitants on average, which are headed by 19 Mayors appointed by the General Mayor of Bogota and by local councils elected by the population. This hybrid political-administrative structure makes Bogota's situation quite unique in the country. In fact, these 19 localities, which have no autonomous revenue basis, are not characterized formally as municipalities and this explains why we are referring to the case of Bogota as a case of deconcentrated metropolitan structure in contrast to a two-tier metropolitan structure.

As a consequence of this structure, the exact PHC decentralization pattern that was being applied in the country of making the Local Health Districts coincide with the geographical coverage of the elected municipalities, unifying their administration, could not be applied. While the Local Health Districts of Bogota were formally made to coincide with the 19 localities, their administration was, in many respects, centralized at the central metropolitan level (which, legally, is the only truly elected municipal government). In fact, the complete responsibility for PHC delivery (including both health centres and first-referral PHC hospitals) was formally given to the metropolitan government of Bogota through its newly created, in 1991, District Health Secretary<sup>39</sup>. Being both a Municipality and a Department, Bogota, through the certification process, was enabled to have the complete responsibility of both PHC and higher levels of care. Before this process, all health care services were in fact co-managed with the Sectional Health Service, deconcentrated structure of the national Ministry of Health, located in Bogota. In concrete terms, and concentrating on PHC, this means that Bogota runs a network composed of 130 health centres and approximately 8 PHC hospitals and cumulates the functions of both a municipality and a department. As a municipality, its main responsibilities include articulation<sup>40</sup> and production functions<sup>41</sup>, financed by a combination of own revenues, which include all the local taxes indicated in Table 8, and general

<sup>39</sup> Which surged from the fusion of the previous Sectional Health Service (deconcentrated entity of the Ministry of Health) with the previous District Health Secretary.

<sup>40</sup> Planning and the decision on payment mechanisms are made at that level, even if the basic PHC package and the gradual transformation of supply subsidies into demand subsidies has been fixed centrally.

<sup>41</sup> All facilities and staff have been formally transferred to the city of Bogota, even if the staff remains subject to central rules.

central transfers (the PICN and, at least in theory, 50% of the SF), all centralized in the District Health Financial Fund<sup>42</sup>.

Now, as and more than in the Belo Horizonte case, carrying out all these functions at the central metropolitan level can be highly socially and even technically inefficient due to the very large size of the city. In view of that, two processes have developed in the city since 1992/93: a gradual deconcentration of the responsibility for PHC to the 19 sub-municipalities which, as we have seen, coincide geographically with the Local Health Districts and a tendency towards the transfer of more administrative autonomy directly to the Local Health District Authorities. These two processes are proceeding rather slowly and are not always compatible one with the other. In general, however, the main tendency has been towards giving more and more autonomy to the 19 sub-municipalities in the planning of the local health policy and in the management of staff and facilities, decentralizing, even if with very much caution, some budget at that level. The gradual transfer of autonomy to the Local Health District Authorities aims mainly at promoting greater levels of self-management and self-financing.

The deconcentration process (but in fact also the “functional” decentralization one<sup>43</sup>), if continued and strengthened, should make it possible for Bogota to assume some of the typical functions of a department in PHC which, otherwise, do not have much meaning in the context of a department which, being a municipality as well, directly operates its PHC system. As a department, Bogota should have an important regulatory and, to a lesser extent, “articulatory” role, which mainly consist of a coordination role, technical assistance role, supervision role and, even if to a lesser extent, a redistributive role. Through its coordination role, a department should promote common activities and collaboration across municipalities in areas where there are important economies of scale and spillovers across the local borders (public health, some areas of preventive health). The deconcentration of PHC planning at the sub-municipal level would leave this role to the District Health Secretary of Bogota. Through its technical assistance role, a department has to assist municipalities in several areas, including financial management and the technical aspects of delivery. Again, deconcentrating the operation of PHC facilities at the sub-municipal level would require the city to assume this role. Through its supervision role, a department has to check that the conditions that the municipalities had to fulfill for assuming the responsibility of PHC remain valid and fulfilled and that the existing central rules are respected. The deconcentration of PHC responsibilities to the sub-municipal level involves some form of informal certification carried out by the city’s District Health Secretary that creates scope for this role as well. Finally, the Secretary should allocate the budget across the sub-municipalities according to equity criteria to compensate for the different socio-economic conditions and needs.

### **Main advantages and disadvantages of the model**

Thus, Bogota is a case of deconcentrated metropolitan government, where the main responsibility for PHC delivery lies with the metropolitan municipal level and some delivery functions are being decentralized to the sub-municipalities, hybrid between political and administrative units. This

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<sup>42</sup> We should point out that Bogota, both as a municipality and a department, is also responsible for the enrollment of its population in the Social Insurance Companies (called “Empresas Promotoras de Salud”, EPS) that articulate health care delivery (purchase services) on behalf of their contributing beneficiaries and, as a municipality, for the partial financing of the Social Insurance Companies that purchase a “subsidized” health care package (basically, the PHC package) for the lower class people (which have to be detected by the municipality as well, taking advantage of local information).

<sup>43</sup> i.e. the transfer of autonomy to the Local Health District Authorities.

model stands between a two-tier metropolitan structure, with two elected levels of government within the city, and the centralized metropolitan model seen above.

#### *Deconcentrated metropolitan government vs centralized metropolitan government*

Compared to the centralized metropolitan model, where the complete responsibility for PHC lies with the centralized metropolitan government, this model has the small disadvantage of relying more on local skills<sup>44</sup> and of reducing the scope for economies of scale in the production of some of the services<sup>45</sup>. It might also be more difficult to handle since issues of responsibility sharing will be raised by the introduction of the second level of administration of the services. However, it does have the advantage of being more socially efficient because it is better suited to take account of the different needs and preferences of the population. This better fit should also enhance local involvement and resource mobilization for PHC. The model should also be more technically efficient as it should make it possible either to save on inputs or to maximize the output following technical choices more suited to local characteristics.

#### *Deconcentrated metropolitan government vs two-tier metropolitan government*

Compared to a two-tier metropolitan model where the primary responsibility for PHC delivery lies with the elected municipalities constituting the city<sup>46</sup>, this deconcentrated structure, combined with the fewer responsibilities transferred to the sub-municipalities, might, however, be little conducive to local accountability. This concern follows from the fact that the local mayors which are responsible for the local health processes are appointed by the centre and not elected, the sub-municipal units have no own revenue basis and the distribution of responsibilities between the levels is not very clear cut: within this framework, the local mayors and other appointed managers might not consider themselves accountable to the local population and this same population will be less prone to participate in the health care process. This might lead to a low level of ownership of both managers and the population on the PHC process leading to poor administrative and technical choices, poor maintenance of the facilities<sup>47</sup> and little resource mobilization in spite of the deconcentration process. A positive feature of the deconcentrated model compared to the two-tier one, however, is its potentially weaker negative impact on inter-area equity. The only negative impact that might be expected on the distribution of the access to PHC and its quality will be related to the different local managerial skills which might lead to more or less adequate planning and production decisions. This impact should be attenuated by the technical assistance provided by the metropolitan level. In the two-tier metropolitan model, the coexistence of several local fiscal bases, each one associated with a different local government, within the city, will more easily lead to inter-area inequity if, as expected, the size of these fiscal bases is proportional to the socio-economic situation of the areas. In that case, some appropriate redistributive mechanisms have to be designed to correct these inequities.

#### *A preliminary assessment*

Given these considerations, it is very difficult to make a thorough evaluation of the case of Bogota. A positive result has been the increasing contribution of the municipality to the financing of PHC

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<sup>44</sup> Which be might be weaker than the ones present centrally.

<sup>45</sup> This is however generally not a big problem in PHC.

<sup>46</sup> That could have been the case of Bogota if the sub-municipalities had had the legal and political status of the other country's municipalities, assuming, thus, after certification, the main responsibility for PHC delivery.

<sup>47</sup> All the more considering that the facilities are owned by the city and not by the sub-municipal units.

(25% of PHC financed through local revenues), higher than some years ago, indicating a noticeable mobilization effort probably produced by the deconcentration process. However, the share of PHC in the health care expenditure is still too low (35% in 1999) and the PHC network increased only slowly, as indicated by the fact that the proportion between the population and the PHC institutions decreased from approximately 50,458 habitants per PHC institution in 1992 to approximately 47,000 habitants per PHC institution in 2,000<sup>48</sup>. This might indicate weaknesses in the planning and prioritization process due to a still too centralized management.

As far as the equity dimension is concerned, the only available data on the distribution of the proportion habitants/PHC institutions (which can be taken as a proxy for service coverage) across the 19 localities of the city are 1992 data, which means that they reflect a situation where Bogota had just assumed the complete responsibility for PHC and no deconcentration had still been implemented. We notice from Table 10 that, quite surprisingly considering the centralized management of PHC delivery, there is an apparent high heterogeneity in the proportion of habitants per health centre across areas, not always justified by the different socio-economic conditions, indicating inequities in coverage. We might fear that these inequities have increased with the deconcentration process but this does not need to be the case if adequate technical assistance has been provided and the budget adequately allocated across areas. In fact, the inequities might have been caused by the deficient information of both the Ministry of Health, represented by its local Health Section, and the previous Health Secretary of Bogota, on the socio-economic characteristics and needs of the localities. If this is the case, the deconcentration might on the contrary have improved the distribution of resources, increasing coverage where it was more necessary. Unfortunately we have no data to comprove this.

Table 10: Distribution of PHC centres per sub-municipality in Bogota (1992)

	Habitants per health centre
Municipality 1	40,392
2	64,221
3	24,800
4	65,522
5	18,221
6	33,964
7	44,267
8	45,600
9	42,378
10	52,664
11	84,716
12	41,741
13	186,000
14	40,141
15	63,327
16	67,667
17	19,223
18	32,733
19	26,165

<sup>48</sup> Still high, even if this proportion should take into account the actual beneficiaries of the public health PHC services and not the habitants as a whole.

### 3. Santiago: a case of jurisdictional fragmentation

**Santiago is a city of approximately 6 million habitants divided into 51 municipalities of approximately 200,000 habitants, each with its own elected Local Government (since 1992) and its own, even if small, fiscal basis. The city does not have any central metropolitan government or revenue basis. In this jurisdictional fragmented structure, the responsibility for the delivery of PHC has been transferred to the 51 municipalities which run, on average, 4 health centres. The main advantage of this fragmented model of PHC is that it is quite sensitive to citizens' preferences and emphasizes local accountability. Its main disadvantage is the lack of a central structure capable of providing centralized coordination and planning, as well as equity corrections, when necessary**

Finally, in Chile, there is in fact only one large city: Santiago, whose role in PHC delivery is, again, dictated by the PHC decentralized delivery system implemented in the country and the political and fiscal structure of the city.

#### **Basic political and fiscal characteristics of Santiago and its role in PHC delivery**

Santiago is a city of approximately 6 million habitants divided into 51 municipalities of approximately 200,000 habitants, each with its own elected local government (since 1992) and its own local fiscal basis, even if small. The city does not have any central metropolitan government or revenue basis, illustrating the absence of intermediate levels of government in the country. In this jurisdictional fragmented structure, and following the applied decentralization model, the responsibility for PHC delivery has been transferred to the 51 municipalities constituting the city<sup>49</sup>. In concrete terms, that means that each municipality has to run, on average, 4 health centres and is responsible for the operation of these health centres (staff and facilities have been formally transferred to the municipalities through specific agreements<sup>50</sup>) and, but to a lesser extent, for some articulation aspects of service delivery.

The fewer responsibilities transferred in the Chilean case with respect to the Colombian and Brazilian cases are a reflection of the authoritarian regime and of the weak political and fiscal capacity of municipalities, together with the fact that no gradual certification process existed in Chile but all responsibilities were transferred at the same time. The responsibility in financing of the municipalities has increased in time due to the decrease, at least up to the beginning of the 90's, of the central transfers, reaching the point where 35% of PHC is financed through local revenues in Santiago, in spite of the generally low municipal fiscal capacity. Finally, in contrast to the rest of the country, most of the Santiago's municipalities have decided to manage PHC services through Municipal Private Corporations, leading to a more autonomous administration of the services. Given this, there is no role in PHC for Santiago as a whole. Supervision and regulation of municipal services are provided by the 6 Regional Health Services, deconcentrated structures of the national Ministry of Health, in which Santiago is divided. These Services are also in charge of some preventive health measures together with the municipalities. Financing and articulation, as we have seen, are a co-shared responsibility between the Ministry of Health and the municipalities.

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<sup>49</sup> Even if, at the moment of the transfer, in the early 80's, the number of municipalities was slightly smaller and they were still not elected.

<sup>50</sup> In Santiago as well as in the whole country, all infrastructure was given in comodato for a renewable five year term and all personnel was transferred after payment of severance payments and other benefits by the Ministry of Health.

## Main advantages and disadvantages of the model

Thus, this fragmented model provides still another model of urban PHC delivery. Its main advantage is that it is quite sensitive to citizens' preferences and emphasizes local accountability. Its main disadvantage is the lack of a central structure capable of providing centralized coordination and planning, as well as equity corrections, when necessary. The complete reliance on local skills might be another concern.

In fact, the Santiago case seems to be quite a successful one. Judging from the fact that up to 35% of PHC is financed through local taxation in the context of a developed and developing network of PHC<sup>51</sup>, it seems that there was an important local mobilization effort in PHC, as well as the will and capacity to develop a comprehensive network. Additionally, disparity in access to PHC, as measured by the proportion of beneficiaries per health centre across the 6 Regional Health Services, does not seem very much of a problem since this proportion seems to reflect the socio-economic situation of the regions (proxied by infant mortality), being consistently higher in the poorest areas than in the richest ones (see Table below). If we assume that poorer people are prone to use health care facilities more frequently than richer ones, this distribution seems reasonable<sup>52</sup>. In the end, the real problem seems to be the unequal distribution of skilled managerial and medical human resources across municipalities.

Table 11: Distribution of PHC centres per Regional Health Service in Santiago (1999)

Regional Services	Habitants per health centre	Beneficiaries per health centre	Infant Mortality (per thousand habitants)
Regional Service 1 (eastern)	54,000	21,000	7.6
Regional Service 2 (central)	52,593	21,000	7.5
Regional Service 3 (western)	16,913	12,087	9.6
Regional Service 4 (northern)	20,262	12,000	9.6
Regional Service 5 (south-eastern)	23,106	10,112	8.4
Regional Service 6 (southern)	24,824	14,600	9.1

## Lessons for Johannesburg:

From the experience of these three large cities, we can extract some general and more specific lessons relevant to the Johannesburg case.

Generally speaking, the three cases confirm that the role of large cities tends to be the result of the combination between the decentralization model applied at the country level and the

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<sup>51</sup> Consisting of approximately 35,000 habitants per health centre, or 20,000 beneficiaries per health centre if we consider that approximately 60% of the Santiago's habitants are users of the public health PHC services.

<sup>52</sup> However, this distribution does not show us the disparities among the municipalities themselves and could possibly hide important size and quality differences among the health centres, produced by the different revenue bases. In any case, the combined action of the Municipal Common Fund and the equity criteria applied in the allocation of the central transfers among municipalities produces a slightly progressive distribution of health care expenditure per beneficiary (see Carciofi, Cetrangolo and Larranaga, 1996).

political/administrative/demographic characteristics of the city. This suggests that determining the role of a large city in a decentralized system requires, firstly, a careful understanding of the model under implementation and, secondly, a good knowledge of the city's characteristics. Innovative options will be generally possible only within the margins of autonomy left by the model and, always, respecting the city's general characteristics.

Given this, we have reviewed three different models of health care delivery with the advantages and disadvantages that have been explained above. The first two models are in fact still applicable to the Johannesburg case, since the exact political/administrative structure of the city has still not been defined, as well as some of the characteristics of the decentralized health care delivery model implemented in Gauteng<sup>53</sup>. If the deconcentrated regional structure ends up not being created, PHC might end up being operated directly by the central health manager similarly to the Belo Horizonte case. If it is created, the health care delivery model will look like the Bogota case. The Santiago model, finally, is not applicable anymore in its general characteristics but might produce some recommendations on more specific aspects.

### **Which model for Johannesburg ?**

**Option 1: centralized PHC delivery model.** It is unlikely that the management of PHC will remain centralized at the city level since this would make it impossible to satisfy consumers' needs in an adequate way, considering the large size of the city. The difficulties faced by Belo Horizonte, smaller than Johannesburg, in promoting popular involvement and resource mobilization are another indication that, in spite of some advantages, a centralized model of PHC delivery is not adequate to large cities. The public contract approach applied in Belo Horizonte would, however, be interesting to look at.

**Option 2: deconcentrated PHC delivery model.** As mentioned in the section on Johannesburg, the more likely option up to now for the city is the creation of a deconcentrated metropolitan structure which will be in charge of the operation of PHC services. That would imply that the city would be divided into local health districts of approximately 350,000 habitants, exactly as it is the case in Bogota, managed by 11 deconcentrated regional offices, which would correspond to the 19 sub-municipalities of Bogota<sup>54</sup>. A closer look at the experience of Bogota would then be highly recommendable. The assessment that we have made of this experience has shown a series of advantages but also disadvantages of the model, these ones principally related to the little local accountability of the administrative units, that should induce some careful thought. In the light of this experience, it is anyway recommended to confer a high level of autonomy in the production and articulation of PHC to the regional units of JB (higher than the autonomy conferred to the sub-municipalities of Bogota): that could produce a higher level of decentralization and local involvement than in the case of Bogota and, as long as the functions of the different levels are very precisely identified, have a positive impact on local accountability. An alternative option could consist in attributing the management of PHC delivery to 10 or 15 sub-councils committees established by the metropolitan council (the creation of sub-councils is a currently debated, even if not very popular, option in JB). That would make the model even more similar to the one of Bogota because of the hybrid political/administrative nature of the sub-councils, with beneficial effects on local accountability. However, this is not very likely to occur.

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<sup>53</sup> Model, which, additionally, is not too dissimilar from the models implemented in the LA countries.

<sup>54</sup> Which, however, are hybrid between administrative and political units.

**Option 2-bis: deconcentrated and functionally decentralized PHC delivery model.** Another option of PHC delivery structure, which would be feasible within the deconcentrated administrative structure, might be the one, applied in Bogota as well, of a transfer of high levels of autonomy in the provision of PHC services to autonomous Local Health District Authorities (denominated above “functional” decentralization). That could have definite advantages on the social efficiency and, even, local accountability side as long as the district authorities are representative of the district population<sup>55</sup>. As shown in the Bogota case, this option would not necessarily be alternative to the other one. However, in this case, the relative functions of the regional units (which, in this case, would become more centered on monitoring tasks) and of the district health authorities (centered on the operation of the facilities) should be very carefully defined, contrary to what has happened in the same Bogota. In any case, but above all in the absence of a deconcentrated structure, that would require the central metropolitan structure to adopt a strict regulatory role. It is not clear, however, if the option of “functional” decentralization is still open to Johannesburg since Gauteng chose to attribute the main responsibility of PHC services to the Local Governments and not to district health authorities. That might be possible if the model is interpreted with flexibility and Local Governments, once they become formally responsible for PHC, are free to adopt any institutional arrangement they want, including the one of giving up quite a lot of control on PHC services.

**Option 3: fragmented or two-tier PHC delivery model.** The Santiago model is the only one which it will not be possible to adopt any more since the Municipal Structures Act, which promoted the unicity structure in the whole South Africa, has to be compulsorily applied. As mentioned before, that means that the current two-tier structure of the city which, with some adjustments (increasing, notably, the number of local councils), would have made it possible to apply a sort of Santiago model, will be dismantled leaving all functions and resources to a single metropolitan council<sup>56</sup>. Our assessment of the Santiago model has been generally positive highlighting, in particular, its positive impact on social efficiency, local accountability and resource mobilization. As a result, the proportion of inhabitants per PHC centres decreased quite a lot during the 80’s and 90’s reaching a figure of 35,000 inhabitants per health centre not too dissimilar from the 26,000 inhabitants per health centre of Johannesburg (even if both proportions are still too high according to international standards) and this proportion is lower in the poorest areas than in the wealthiest ones (see Table 11)<sup>57</sup>. These considerations might suggest that keeping the current political/administrative structure of JB, with more numerous and institutionally and financially strengthened local councils, might not have been a bad option on the health care delivery side. This is all the more true if we consider that, in spite of several drawbacks<sup>58</sup>, the current PHC delivery model applied in JB seems to have worked in fact reasonably well, combining some degree of local accountability through the local councils with some degree of central coordination and management through the province and the upper tier of government. At least, this appears to

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<sup>55</sup> That would happen if they take the form of health district councils with appointed and elected officials.

<sup>56</sup> The set of sub-councils committees which might possibly be established by the metropolitan council could not be comparable, by any means, to an autonomous second tier of government.

<sup>57</sup> It is true that a fragmented metropolitan structure can have a negative impact on intra-city equity making service delivery dependent on different revenue bases which might either lead to services of very different quality and/or cases where the minimum PHC package cannot be produced or to different tax rates, with an additional impact on locational decisions. However, it was shown in the Santiago case that, even without a first tier of government and in the presence of important socio-economic differences among municipalities, these inequities can be quite efficiently tackled through the determination of minimum PHC packages, redistributive central transfers and, even if that might be more debatable on efficiency grounds, the acting of an inter-municipal fiscal equalizer.

<sup>58</sup> The main ones being the horizontal segmentation, which produces referral problems within the PHC sector and cost duplication, and the weak institutional capacity of the current local councils.



be the case judging from a proportion of habitants per health centre reaching 26,000 pers/hc<sup>59</sup> and a distribution biased in favour of the poorest area, the southern district (a bias considered too strong by some - See Table 6). An innovative feature of the Chilean and, particularly, Santiago model that could still be applied to Johannesburg is the administration of the primary health care services by private non-profit corporations. In the JB case, that might be applied giving the option to the regional offices of either directly manage the services or contract them out to private corporations. The high management flexibility of these institutions<sup>60</sup> produced quite satisfactory results in the Santiago case.

In conclusion, the current transformation towards a more centralized health care delivery model in JB has to be very carefully assessed in the light of all the possible advantages but also disadvantages of the model, and options of institutional arrangements for making service management more socially efficient have to be detected and carefully designed. A simple deconcentration of PHC articulation and production functions might not be enough requiring a truly “functional” decentralization of these two functions. Otherwise, it is important that the regional units be as autonomous as possible in the execution of their responsibilities and the central unit be able to concentrate on a supervision, coordination, technical assistance and redistributive role. It is essential that the current political and fiscal transformation, started for reasons exogenous to the health sector, combined with the on-going health care reform, be able to promote a more efficient use of resources without losing on social efficiency and quality grounds.

## 2.2 Decentralization in the articulation of health care and role of large cities

As indicated in Table 1, another type of decentralization, less frequent, involves the transfer of responsibilities to sub-national units in the mere area of articulation of health care services (in general, both primary and higher levels of care). The sub-national units would then typically act as intermediaries, organizing the consumption of care with no direct responsibility in the production of the services. The Latin American experience does not provide any explicit case of such a model. Such a model is, however, provided by the UK and New Zealand cases, described in Table 12, where this type of responsibilities have been attributed to autonomous health authorities.

In England, with the reform of the 1990's, District Health Authorities no longer manage hospitals or community care units but are responsible, as purchasing organizations, for assessing the health needs of their area population, determining the priority health services required and contracting with the National Health Services and private providers to deliver these services. In New Zealand, since the beginning of the 1990s as well, the Regional Health Authorities, which act as agents for the consumers, are responsible for assessing and monitoring the need for health care and purchasing health services for their populations, as well as ensuring the fulfillment of purchase contracts with providers.

**Could large cities undertake this role ?** We will just mention a few points that should be taken into account when discussing this issue. The “intermediary” role is very different from the one of service delivery and, typically, will presume that the sub-national units become skilled at writing, negotiating and monitoring the implementation of contracts. In other words, they need a deep knowledge of the medical care process. Additionally, there must be more than one provider, so that a purchaser can demand price concessions and back that up with the credible threat to go elsewhere if the provider does not offer lower prices. Thus, at first sight, this role is likely to be

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<sup>59</sup> Still above international standards but considered too low by some people who think that a rationalization of the PHC network is necessary.

<sup>60</sup> Which, however, respond ultimately to the Mayors.

more attractive to large cities with substantial technical capacity and whose health care systems are extensive enough to offer a number of alternative providers for the city to choose among. However, at second sight, a large city might represent too many individuals to be capable of effectively fulfilling individual preferences and responding to the different individual needs, suggesting that it might be better to divide it into a few purchasing authorities with potential access to all the providers of the city. This is for instance the case of London, which has been divided into approximately 17 purchasing District Health Authorities with access to all the providers of the city. Another similar case, where the purchasing units are even smaller (around 200,000 habitants), is provided by the one of Stockholm in Sweden<sup>61</sup>.

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<sup>61</sup> See Meneguzzo (1996) and Raffael, Marshall (1997) for a detailed treatment of the Stockholm case.

Table 12: A characterization of the decentralized systems of health care delivery in the UK and New Zealand

	Sub-national level selected at the country level	Main institutional arrangements and capacity requirements for the transfer of the articulation responsibility	Financing and fiscal arrangements	Staff policy
UK	The District Health Authorities (105 in all) cover 600,000 hab on average and are responsible for purchasing primary, secondary and tertiary health care from competing semi-autonomous and private providers.	The DHAs must be managed by eleven members with only five non-employee board positions. Renewed importance of the Councils (statutory bodies established in most districts in 1974) in representing the views of health service users.	The DHAs are financed by National Health Service transfers allocated according to the district population, taking into account the age, sex and health-risk factors of the population and geographic differences.	Staff managed at the institutional level but subject to central rules.
New Zealand	<p>In 1990, there was a remodeling of the system which created four government-owned purchasers, the Regional Health Authorities, of approximately 875,000 habitants, which received funding for the purchase of primary care, hospital care and public health services from both semi-autonomous and private providers.</p> <p>The RHAs have geographical monopolies and determine the services to be provided within the government budgets and policies. They have extensive obligations to consult with communities over changes to services and service planning.</p> <p>From 1996: the 4 RHAs were funded in the Health Funding Authority. A much stronger accountability framework has been developed for the Fund. The HFA standardised the measurement units used across New Zealand to enable prices and service levels to be compared across distinct populations and providers. Was this reform really successful ?</p>	The RHAs must be managed by boards of directors.	The RHAs are financed by transfers of the Ministry of Health allocated according to a formula based on the regional population.	Staff managed at the institutional level but subject to central rules.

### **Lessons for Johannesburg:**

As a consequence, the application of such a model to the JB case might require to transfer this responsibility to a set of sub-units covering each a fraction of the city's population, as for the case of the decentralization of production and articulation of PHC. This role could for instance be attributed to the 11 regions that it is planned to establish. This would require the central administration of the city to play a role similar to the one of a Ministry of Health in the UK and New Zealand cases allocating a budget across the regions which would then be responsible for the health status of their respective populations and contract with competing providers to deliver the required services. Within this model, the health institutions would typically have a lot of operational autonomy, while some operational functions (particularly the ones that involve important economies of scale) would be maintained at the national level<sup>62</sup>. This model is an attractive one. Among other advantages, removing the health providers from the management control of the sub-national units makes it easy for them to adopt a truly "objective" purchasing role since they do not have the ultimate fiscal responsibility for the management of services anymore and can feel free to place contracts with providers of their choice rather than simply those under their own management<sup>63</sup>. However, as we have seen above, the model requires that a number of stringent conditions be met, concerning in particular the sub-national units' technical skills and the existence of competing autonomous or semi-autonomous providers. These conditions do not seem to be currently met in JB suggesting that, at this stage at least, a decentralization model like the one applied in the analyzed LAC countries seems more suitable. This model would also seem more suitable to secondary and tertiary health care levels than to primary health care.

### **2.3 Institutional decentralization and role of large cities**

Finally, another type of decentralization, often called "autonomization", refers to the transfer of responsibilities in the provision of the services directly to the health institutions (primary and higher levels of care institutions). This type of decentralization is being more and more applied based on the conviction that giving more autonomy to the health institutions is a necessary conditions for producing efficiency and quality gains in health care delivery. We will not discuss here the general characteristics of such a decentralization process and the specific characteristics that it takes in the countries where it is under implementation (notably in Colombia, UK and New Zealand), as this is beyond the scope of this paper. Detailed information on the Colombian case, which involves a partial "autonomization" of the production and articulation of health care (through the creation of the "Empresas Sociales del Estado" and of the "Empresas Promotoras de Salud") can be found in Bossert and others (2000) and Londono, Jaramillo and Uribe (1999). While an analysis of the UK and New Zealand cases, which involve the "autonomization" of hospitals through, respectively, the creation of the NHS Trusts and the Crown Health Enterprises, is provided by Raffel (1997), Scott, McKenzie and Webster (1999) and Ham (1999). We will just focus on the consequences that such a model is likely to have on the role of large cities in health care delivery.

The main effect will be that, whatever the previous role of the city in health care delivery, its main role will become one of a regulator since a system which becomes more open and diverse

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<sup>62</sup> In this sense, it would commonly adopt the form of a "non-traditional fully decentralized model" (see Table 1).

<sup>63</sup> The "conflict of interest" created by the co-existence of production and articulation functions at the sub-national level within the framework of an attempted public contract model can be exemplified by the Brazilian case.

through institutional decentralization (and competition) will need a strengthened regulatory function which will need to be shared by the centre and the sub-national levels. In other words, if the city had previous responsibilities in financing, articulation and/or production, these ones will diminish following the transfer of responsibilities operated by the institutional decentralization, while its regulatory functions will increase.

**In what should consist this new or strengthened regulatory role of the city ?** Within the context of an institutional decentralization, regulation should be interpreted in a broad way and involve setting, implementing and monitoring the rules of the game for the health system, as well as providing it with strategic direction. Among its regulatory functions, the city might be well placed in helping with the implementation and monitoring of centrally fixed criteria and standards for the assessment of performance of the articulating organizations<sup>64</sup> and institutional providers of services acting on its territory. It might do so through the management of accreditation procedures and regular reporting mechanisms. It might also help in the implementation of the formulae for resource allocation among non-governmental articulating organizations and/or institutional providers and introduce and manage compensatory and targeting mechanisms to correct any undesired equity consequence of the institutional decentralization. Finally, it might collect and offer public information about the performance of providers and insurers (if the articulation is undertaken by non-governmental organizations) to protect the consumers.

### **Lessons for Johannesburg:**

What would this mean in the JB case ? As regards primary health care, the city's central and regional administrations would become less involved in the direct provision of services and more in the regulation of such provision requiring other types of skills. In other words, a complex and effective regulatory framework would need to be constructed involving the different available levels to ensure that the institutional decentralization is in line with the consumers' interest and capacity to pay. As regards higher levels of care, a process of autonomization of the main hospitals would confer to the city a specific role also in the delivery of this type of care (in contrast to the current situation-see Annex I) by attributing it the regulatory functions discussed above. In fact, the recent attempts of autonomization of some tertiary health care hospitals could require JB to take up some of these new functions.

### **SOME CONCLUDING REMARKS**

The Latin American cases analyzed offer some practical experience on the design and implementation of systems of decentralized health care delivery at both the country and city level which provides some useful point of reference for Gauteng and Johannesburg. In particular, at the city level, the analysis has shown that the case of Bogota in Colombia seems to be a particularly useful case to look at given the reforms currently planned in JB. In the longer run, the experience provided by the current reforms in the UK and New Zealand, in particular the ones on the separation between articulation and production, would also be worth looking at.

In more general terms, we have seen that there is a wide range of roles for large cities in primary health care delivery. Box 1 illustrates in a very simplified way some possible models of PHC delivery, going from cases of high involvement of the central metropolitan level (and its deconcentrated levels) in all the functions of the delivery, including the direct production of the services, to cases of little or, even, no involvement. In general, for large cities, it will be

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<sup>64</sup> If the articulation functions have been transferred to ad-hoc non-governmental organizations.

preferable to move from high levels of involvement in all the main functions of PHC delivery to lower involvement levels largely focused on regulatory functions (technical assistance, supervision, redistribution) and, to a lesser extent, financing and articulatory ones. The main reason for this is that lower levels of government, the local health districts and the PHC institutions themselves will be usually in a better position to respond to the specific needs of the population and do it in a more accountable way. The functional and institutional decentralization cases as well as the Santiago and London cases illustrated in Box 1 exemplify this type of decentralized PHC delivery models in urban environments. However, as shown throughout the paper, which role will be eventually adopted by the city will depend on the decentralization strategy adopted at the national level and on some main characteristics of the city itself. Among the city's characteristics relevant to the selection of a PHC delivery model, the following could be identified:

**-the political and administrative structure** of the city: centralized, deconcentrated, two-tier or jurisdictionally fragmented metropolitan structure. The more decentralized the metropolitan structure, the more likely it is that the main responsibility for PHC delivery will be attributed to lower independent levels, leaving little role to the central or centrally controlled metropolitan government.

**-the fiscal capacity** of the city, measured by the existence and size of the local revenue basis, and the distribution of this fiscal capacity among the existing levels of the metropolitan structure. The higher the local revenue basis and the more centralized is its administration, the higher will be the role played by the central metropolitan level in the financing of PHC delivery.

**-the institutional capacity** of the city and of the existing levels of the metropolitan structure to undertake the different functions constituting health care delivery. The stronger and centralized this capacity, the higher will tend to be the role of the central metropolitan level in health care delivery.

**-the demographic structure** of the city, in particular the size of the population and its distribution within the city according to socio-economic status. The larger the city, the smaller will generally tend to be the role of the central metropolitan structure, favoring decentralized models of PHC delivery. However, the higher the level of socio-economic segmentation within the city<sup>65</sup>, the more extensive will generally need to be the role of the central level (either through a more centralized model of delivery or an active redistribution policy).

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<sup>65</sup> In other words, the lower income population is concentrated in certain areas and the higher income in others.

**Box 1: Different models of PHC delivery in cities**

**Belo Horizonte**

	Central metropolitan level	Second level within the city	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**A typical case of institutional decentralization**

	Central metropolitan level	Second level within the city	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**Johannesburg – after the reform**

	Central metropolitan level	Second level within the city (*)	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**Johannesburg - before the reform**

	Central metropolitan level	Second level within the city (**)	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**Bogota**

	Central metropolitan level	Second level within the city (*)	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**Santiago**

	Central metropolitan level	Second level within the city (**)	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**A typical case of functional decentralization**

	Central metropolitan level	Second level within the city	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

**London**

	Central metropolitan level	Second level within the city	Local health district authorities	PHC institution
Regulation				
Financing				
Articulation				
Production				

A less intense color means a weaker role in the function.  
 (\*) Refers to a deconcentrated level. (\*\*) Refers to a second tier of government.

## ANNEX

### Decentralized systems of secondary and tertiary health care delivery and role of large cities

#### 1. Decentralization in the articulation and production of health care and role of large cities

Now, the main focus of the paper is on PHC services, provided both in health centres (clinics and policlinics) and PHC hospitals, but the decentralized structure of SHC (and THC) delivery is worth examining briefly as well for three main reasons:

-firstly, the distinction between PHC and SHC hospitals is generally not clear cut: in most generally considered SHC hospitals, PHC services are being provided as well and, vice-versa, some SHC services can be provided in usually denominated PHC hospitals. The first issue makes it necessary to analyze the SHC hospital situation as well.

-secondly, one of the very important issues in health care delivery and an issue that has to be faced by the decentralization process is the referral issue. In theory, the PHC network should be used as the first contact point with the health care delivery system and, if necessary, refer the patients to higher levels of care. This requires a well-working vertical coordination between levels of care, which could be made more difficult with the decentralization process, even if not necessarily so.

-thirdly, for completeness, it is useful to determine if large cities could in fact play a role in higher levels of care as well.

#### A) The experience of the Gauteng province and Johannesburg

**The current situation.** In the whole Gauteng province, including Johannesburg, all SHC and THC is currently managed by the Province, through the Gauteng Department of Health. This includes also the few SHC services that are provided in the district hospitals. In fact, the province manages, in all, 7 central hospitals, providing SHC and THC, 8 regional hospitals, providing SHC (and some PHC) and 8 district hospitals, providing mostly PHC<sup>66</sup>. The hospitals are mostly financed by national revenues transferred to the province (equitable share grants + conditional grants) and, to a minor extent, user fees. To induce cost-containment, the funds are assigned under the form of pre-determined budgets negotiated on the basis of a number of services that the hospitals have to provide.

Within such a framework, which gives the direct responsibility for the SHC and THC delivery to the province, the role for large cities is in fact minimal. As one of the five administrative regions constituting the province, i.e. Central Wits, JB is also an health region<sup>67</sup> (which, as seen, coincide with administrative regions). However, contrary to the case of PHC where the regions have at least a role of intermediary in the transfer of funds from the province to the Local Health Districts, in the case of higher levels of care, the funds are directly transferred from the province to the hospitals, leaving no role to the region except the one of having to coordinate the different health services in the health region and to ensure, in conjunction with the other health regions and the provincial health authority, effective referrals systems.

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<sup>66</sup> It also manages a few psychiatric and specialised hospitals.

<sup>67</sup> But, the Regional Health Authorities are distinct from the GJ authorities, with little connection as the Regional Authorities are appointed by the province.



**Should there be a role for large cities ?** Now, the on-going reform does not plan to undertake any change of responsibility in secondary and tertiary health care, leaving it entirely with the province.

Should the city have a larger role in SHC and THC delivery ? And, in this case, which role ? Would it be convenient to transfer the responsibility for the management of the district hospitals and, even, regional and central hospitals to the city (meaning that the city would have to manage 1 district hospital and 4 central ones)? Which conditions would be necessary for that ? On the one hand, the city might be more responsive to local preferences than the province, covering a smaller population and geographic area. Additionally, within the context of the planned PHC reform, a global decentralization at the city level might make it possible to avoid the vertical segmentation between levels of care that will result from the decentralization of PHC to the municipal level while hospitals remain provincial. On the other hand, however, it might not be technically feasible and convenient for the city to manage some types of hospitals and the organization of a city-based delivery of secondary and tertiary health care (while the province keeps on managing the hospitals of the smaller cities) might break the regional health system constructed around the province. These issues will be further developed in the next section in the light of the Latin American experience and some general considerations.

**The referral issue.** In any case, if the delivery of SHC and THC is kept centralized at the provincial level, the vertical segmentation that will result from the ongoing PHC reform might complicate the referrals between PHC centres and hospitals, since the PHC centres, now managed and partly financed by the Local Government, might have the incentive to refer the patients to more complex institutions or levels of care to save on costs. This is all the more worrying if we consider that even now there is a referral problem<sup>68</sup> in Gauteng and Johannesburg. This is supported by the fact that, in Gauteng, it is estimated that around 50% of the patients could be treated at a lower level of care. In some cases, the deficient working of the referral system might be explained by the lack of PHC units (and district hospitals), in others, however, by the ineffectiveness of the health regions in supervising referrals between levels of care. Again, the discussion is postponed to next section.

## **B) The experiences of Chile, Colombia and Brazil**

The process in the three countries. In Table A.1, we summarize information on the main characteristics of the decentralized system of secondary and tertiary health care delivery in the three analyzed countries.

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<sup>68</sup> Which consists either of undue referrals of PHC units to higher levels of care or of auto-referrals.



Table A.1: A characterization of the decentralized systems of secondary and tertiary health care delivery in Colombia, Chile and Brazil

	Sub-national level selected at the country level for SHC hospitals	Main institutional arrangements and capacity requirements for the transfer of SHC	Financing and fiscal arrangements for SHC	Staff policy
Colombia	SHC and THC hospitals are managed by the Departments, which, after certification, have complete autonomy in the delivery of SHC and THC (with the exception of some nationally managed THC hospitals).	Departments need to be certified as well to have complete autonomy on SHC and THC. Some of the conditions for certification include:  -fusion between the previous Sectional Health Service and Departmental Health Secretary into a unique Departmental Health Secretary -creation of a Departmental Health Fund -elaboration of a Departmental Health Plan -process of autonomization of hospitals under way	SHC (and THC) is financed by a combination of different sources of funds. Main ones:  -50% of the SF directed to health (at least in theory) -own departmental funds (including consumption taxes (denominated “transferred funds”) and other minor local taxes and revenues) + FOSYGA (which, through the EPS, directly refunds the provider) and co-payments	Certified departments manage all SHC and THC staff, but subject to central rules on the determination of wages and firing procedures
Chile	SHC, THC and PHC hospitals are managed by 26 Regional Health Services, deconcentrated structures of the national Ministry of Health headed by an appointed director and covering approximately 600,000 persons.  Some THC hospitals are still managed at the national level.	No particular capacity requirement. RHSS headed by a director appointed by the President of Chile.	All levels of care hospitals are financed by funds coming from the Chilean National Health Fund (FONASA), which are allocated across RHSS’ according to wage bills and services rendered (now, in fact, according to Diagnostic Related Groups, covering the full cost of services). As part of the recent reforms, and as in the case of PHC, an annual service agreement between the MOH and each HSR is signed for periodic and systematic review of quantity, quality of service, effectiveness and efficiency of resource use by the HSR. User fees constitute another financing source as well as some capital financing provided by the MOH or the FNDR.	Personnel administration is undertaken autonomously by the director (permits, promotions, hires), but the pay scale is fixed centrally as well as the structure by profession of the personnel hired. Firings difficult.
Brazil	Most SHC and THC hospitals are managed by the Federal Government and, above all, the States. Some SHC services also managed by the municipalities. In fact, 48% of all inpatient health care institutions (hospitals and health centres) and 80% of all outpatient health centres were part of the municipal network in 1995. However, inpatient municipal structures are typically small and oriented on PHC services, as indicated by the fact that municipal beds represented only 7% of total beds in 1995	To have the complete responsibility of their health systems (including public and private sector) and full autonomy in managing health funds, States, as municipalities, have to reach the stage of States in “semi-full administration”.  Main conditions for that:  -have a State Health Secretary -have a State Health Council -have a State Health fund -have a State Health Plan	State SHC and THC hospitals are financed by a combination of the following types of funds:  -general transfers from the federal government to the States -transfers from the Federal Social Security budget to the States -State own revenues (mainly, taxes on commercial transactions (IVA)) + user fees	Staff policy is quite autonomous. States hire and fire their staff with little interference of the other levels of government.

## **Choice of the sub-national level, institutional arrangements and capacity requirements**

We notice that the three examined Latin American countries have chosen to transfer the responsibility for the delivery of SHC and THC (with the exception of some nationally managed THC hospitals) to decentralized or deconcentrated sub-national units larger in size than in the case of PHC. The sub-national units have an average dimension which fluctuates between 600,000 persons in Chile to 5,000,000 in Brazil. These figures hide in the cases of both Colombia and Brazil important disparities, since, in a few cases, the States of Brazil are not bigger than an average city and the Departments of Colombia than a small one. However, the size of these sub-national units is generally big enough to capture the economies of scale that exist in the delivery of secondary and tertiary health care and provide the concentration of managerial and technical skills necessary for the delivery.

Given this difference, in both Colombia and Brazil, the decentralization pattern adopted for SHC and THC is in fact quite similar to the one adopted for PHC. In both cases, the selected intermediate entities have elected governments in place and have their own revenue basis, as the municipalities do. In both cases, these intermediate levels of government have to go through a certification process to acquire full autonomy for the delivery of the services. In contrast, in the Chilean case, in the absence of a proper intermediate level, it was decided to create ad-hoc deconcentrated structures of the Ministry of Health at the sub-national level (the so-called Regional Health Services (RHSs)) and to give to these new administrative entities the responsibility for managing SHC, THC and PHC hospitals. That makes this decentralization process quite different from the one applied to the PHC health centres which was a truly political decentralization with the complete transfer of facilities and staff to the elected municipalities.

## **Fiscal and financing arrangements**

As far as the fiscal and financial arrangements of the decentralized system of SHC and THC delivery are concerned, they turn out to be, again, quite similar to the ones adopted in the PHC case, except for the inclusion of users' co-payments among the financing sources.

In Brazil, most SHC and THC hospitals are financed through a combination of general federal revenues, specific revenues coming from the Federal Social Security Fund and State revenues, all administered by the States, complemented by co-payments. In Chile, hospitals are financed through the specific revenues of the National Health Fund<sup>69</sup> transferred to the RHSs, complemented by budgeted funds under the Ministry of Health's normal investment programs or under the Regional Development Fund (FNDR) and co-payments (which represent, however, only 5-6% of total RHS's income). Finally, in Colombia, SHC and THC hospitals are financed through a combination of general national revenues (Situado Fiscal) and departmental revenues administered by the Departments, complemented by revenues of the National Health Fund<sup>70</sup> administered by the EPS (Empresas Promotoras de Salud) and co-payments.

The discussion of the funded/unfunded mandate issue and of the equity and efficiency of delivery one is similar to the one previously made for PHC.

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<sup>69</sup> Which includes funds coming from national budget allocations and payroll contributions of workers not affiliated with the private sector insurance companies.

<sup>70</sup> Which includes funds coming from national budget allocations and payroll contributions.

### **Lessons for South Africa and Gauteng:**

To conclude this first part, we can point out that the South African experience seems to be quite in line with the Latin American ones. In all cases, the responsibility for SHC and THC hospitals is attributed to intermediate semi-autonomous or autonomous territorial structures with no specific role given to Local Governments. In all cases, these intermediate structures have extensive responsibilities in the provision of the services, even if this is more true of the cases of Colombia and Brazil than of the cases of Chile and South Africa where the deconcentrated provinces and the RHSs have no financial autonomy and are more strictly subordinated to national rules. In South Africa, as in the Latin American countries, the fiscal and financing arrangements adopted for SHC and THC hospitals are similar to the ones adopted in PHC.

**The role of large cities in SHC and THC.** Now, what can we say about the role of large cities in SHC and THC delivery ? In Table A.2, we provide a quick description of this role. In the three countries analyzed, it seems that only Bogota, as a municipality and a department at the same time, directly manages the SHC and THC hospital network. In Chile, as we have seen, hospitals are managed by the RHSs. This deconcentration structure is also reflected at the level of Santiago, which is divided into 6 RHSs covering, on average, 1 million habitants. In Brazil, most of the SHC and THC network is, as we have seen, administered by the States, with the consequence of leaving no specific responsibilities to large cities.

Table A.2: A characterization of the role of large cities within the decentralized system of secondary and tertiary health care delivery in Colombia, Chile and Brazil

	Role of large cities in SHC and main requirements	Case study: the role of the city in SHC
Colombia	Only Bogota, as a department, directly manages SHC and THC hospitals. No particular role for other large cities.	<p>Bogota: SHC and THC hospitals are managed by Bogota, through its District Health Secretary. The main responsibilities of the Secretary cover the articulation (budget management, planning, payment mechanisms), financing and production (all infrastructure and staff have been transferred to the city level, after the fusion between the Health Sectional Service and the previous District Secretary).</p> <p>All funds for SHC and THC are formally part of the District Financial Health Fund.</p> <p>Main territorial financing sources of SHC and THC in Bogota (approx.):</p> <ul style="list-style-type: none"> <li>-SF: 27%</li> <li>-own funds: (including the “transferred sources of revenue”: consumption taxes on liquor, lottery, etc): 73%</li> </ul>
Chile	No particular role for large cities.	<p>Santiago: All levels of care hospitals are managed by the 6 RHSS, of approximately 1 million habitants on average, in which Santiago is divided.</p> <p>The regions are responsible for the management of all public infrastructure and personnel, as well as managing a pre-determined budget.</p> <p>The role of the city as a whole is not specified. No particular role.</p>
Brazil	No particular role for large cities, except in the management of the SHC services included in their network.	<p>Belo Horizonte: only 1 general hospital with PHC and SHC is managed at that level. The State of Minas Gerais (in “semi-full” administration as well) manages most SHC hospitals and determines the health regional policy. It also participates in the financing with own revenues, which complement the general and specific transfers.</p> <p>The city also purchases SHC services from some private contracted hospitals (which represented 52.3% of inpatient stays in 1996)</p>

## **The logic behind the model and alternative options**

As mentioned above, the decentralization models applied in all three countries have the purpose of attempting to preserve a certain minimum dimension of the sub-national unit responsible for SHC and THC delivery, transferring this responsibility to intermediate levels of government or deconcentrated structures.

Another option, which was however rarely adopted in the Latin American context, would have consisted in adopting a differentiated pattern of decentralization according to the dimension of the cities, making it possible for large (2 millions or more habitants) and, possibly, average (500,000 to 2 million habitants) cities to become responsible for the delivery of SHC and THC services, while attributing this responsibility to intermediate levels (departments, States, RHSs) for small cities. This option would make it possible to involve cities above a certain size more closely making health care delivery more responsive to local preferences and increasing local accountability. Considering that the responsibility of delivery is already being given to States, departments or RHSs which have the size of average cities, no capacity problems should prevent cities above a certain size to take up responsibility for most health care delivery, with the possible exception of complex THC institutions traditionally run by the centre. This is all the more true if they have to go through a certification process.

However, apart from complicating the process itself introducing different treatments according to size, this pattern of decentralization might complicate the construction of the coherent regional health systems that might be required by the demographic and geographic structures in which the cities are located. For instance, if the city is surrounded by a series of smaller urban and rural centres within a geographic distance bigger than the one included in the perimeter of the extended city but small enough to make the city reachable, it might make sense to see the geographic area as an integrated one and to plan the location of SHC and THC hospitals in a coherent way within this geographic area<sup>71</sup>. Decentralizing the responsibility of delivery to the city, while maintaining the smaller centres under the responsibility of the intermediate level structure, might break this required integration and lead to inadequate planning and locational decisions and/or referral system. Thus, if the territorial disposition of the large, medium and small centres makes the construction of regional health systems advisable, decentralizing the responsibility for service delivery at an intermediate level which coincides geographically with the regional health system seems to make more sense than decentralizing it at the city level. In fact, in Brazil, the States should not only manage the main SHC and THC hospital network but also establish an effective and comprehensive regional health policy to make the best possible use of this network<sup>72</sup>. In Colombia, as well, the departments are given the responsibility for managing the SHC and THC hospital network within a coherent regional policy. In Chile, this role was given to the ad-hoc RHSs, which have the responsibility of managing the whole hospital network of a certain geographic area which, except in the Santiago area, covers a main city and a number of surrounding urban and rural minor centres.

### **Lessons for Gauteng and Johannesburg:**

Coming back to the case of Gauteng and Johannesburg and in the light of these considerations, it might probably make sense to keep SHC and THC hospitals at the provincial level to articulate a

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<sup>71</sup> For instance, locating the complex hospitals only in the main city, ensuring they are above a certain size, and establishing an effective referral system between the PHC institutions located in the surrounding small centres and the PHC and SHC facilities of the city.

<sup>72</sup> Unfortunately, this is not always the case in practice.

consistent provincially based regional health system which makes good use of the available health care institutions. The demographic structure of the province, however, articulated around three important cities of which two with well established central hospitals, would make it probably more rational to organize the system around two main regional health systems, one articulated around Central Wits and one around Pretoria. That would lead to a better distribution of patients among the central hospitals (over-crowded in Central Wits) and a more rational use and location of the regional hospitals. In any case, a decentralization of the hospitals to the cities themselves would not be advisable in such a system. This system would also imply the replacement of the five existing health regions, which, up to now, did not work effectively, with the two mentioned above.

### **A discussion of the cases of Santiago, Bogota and Belo Horizonte with emphasis on the referral issue**

Thus, as in the PHC case, the role of large cities in SHC and THC delivery reflects the decentralization pattern adopted.

#### **1. Santiago**

In Chile, the division of the country into regional health systems of a moderate size is in fact applied also in Great Santiago where different types of municipalities are grouped together into 6 regional health systems. The 6 established regional systems are manageable in size. They include, on average, 1 THC hospital, 3 SHC hospitals (including some PHC clinics linked to the hospitals ) and 1 PHC hospital. They also include, on average, 34 PHC centres managed by the different municipalities in which they are divided. As mentioned above, the organization into regional health systems makes it possible to optimize the use and location of SHC and THC, facilitating as well the referral process. This system seems to have worked rather satisfactorily in Santiago, even if not necessarily equally well across the 6 RHSs.

*Referral issue.* However, as far as the referral mechanism from the PHC centres to the higher levels of care hospitals is concerned, the deconcentration process combined with the municipalization one led to a vertical segmentation between the levels of care<sup>73</sup> which, at least initially, hampered the smooth working of the referral mechanism. In fact, taking advantage of the vertical segmentation and faced with increasing financial deficits, the municipalities were increasingly fostered to refer the patients to the higher levels of care administered on a different budget by the RHSs, or to the generally more comprehensive PHC clinics linked to the SHC hospitals, leading to the over-congestion of the RHSs structures. The gradual recuperation in the real value of the transfers combined with the 1992 local elections led then to an alleviation of this problem because of the better financial situation of the municipalities and the higher local involvement and resource mobilization which led to an increasing PHC municipal network. Additionally, to alleviate this problem in the Chilean case is the fact that, as noticed, some PHC services are offered within the institutions managed by the RHSs, avoiding the vertical segmentation issue. This is, however, not a valid option, since the co-existence of PHC services managed by different sub-national levels breaks the local health district concept leading to inefficiencies and duplications in the organization of PHC delivery, which it is better to avoid by solving the horizontal segmentation problem. The way to solve the referral problem created by the vertical segmentation seems to go more through the establishment of performance incentives, which foster the local health districts to maximize the amount of solved cases. In fact, the per-

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<sup>73</sup> In spite of the fact that, formally, all levels of care are part of the regional health system.



capita mechanism introduced at the beginning of the 90s introduced some incentives in the right direction, as well as the management agreements signed between the municipalities and the Ministry of Health. Finally, there is generally a lack of effective coordination mechanisms between the municipalities and the RHSs that makes referrals and contra-referrals not fluid enough.

## 2. Bogota

In Colombia, Great Bogota heads the SHC and THC network, as well as the PHC one, because, as a department, it works itself as a regional health system. The overall public network of SHC and THC of Bogota (excluding the national hospitals) consists of 5 THC hospitals and 8 SHC hospitals, complemented, as we have seen, by approximately 8 PHC hospitals and 140 PHC health centres. In contrast to the case of Santiago, the whole network of hospitals and health centres is formally managed by Bogota, even if the administration of the PHC network is partially deconcentrated at the sub-municipal level. In fact, the decentralization reform of the beginning of the 90's led to the end of the previous segmentation between the hospitals depending on the Sectional Service of the Ministry of Health and on the District Secretary of Bogota and to a unique health care network managed in complete autonomy by the city. The overall network of Bogota, including the national and private hospitals not managed by the city, was re-organized into 4 specific operative levels of care: a first level constituted of the national and private reference hospitals, a second one of the tertiary health care hospitals of the Secretary, a third one of the secondary health care hospitals of the Secretary and a fourth one of the primary health care institutions divided itself into 4 levels of complexity<sup>74</sup>. This organization by level was combined with a deepening of the vertical integration between these levels within 4 networks corresponding to 4 specific geographic areas of the city and size of the potential markets.

*Referral issue.* This overall system greatly facilitated referrals from the lower levels of care to the higher ones within the same vertical network, contributing also to a reduction of health care delivery costs. One of the main unresolved problems of the Bogota case, however, is the persistent lack of PHC health centres (in spite of the existence of some, even if small and very underutilized, PHC hospitals) and their still unequal allocation across areas. That complicates the smooth working of the referral process, since the lack of health centres will either induce the patients to skip this level of care seeking care directly in SHC hospitals or the PHC health centres themselves to refer the patients to other institutions to reduce the burden of work. In fact, the high proportion of unjustified referrals or auto-referrals to SHC units was considered as a very serious issue at the beginning of the 90's and is still likely to be an issue nowadays considering the little reduction in the proportion population/PHC institution, even if the whole referral and contra-referral process became smoother with the reform and perverse financial incentives reduced by the fusion between the two systems. Thus, paradoxically, if, on the one hand, a municipalization process which produces an institutional and operational separation between the PHC network and the SHC and THC network can hamper the referral process, on the other hand, it can improve it if, like in the Chilean case, it promotes an important increase in the PHC network.

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<sup>74</sup> Grade 1: basic health care units; grade 2: primary health care units; grade 3: urgency health care units; grade 4: primary health care hospitals.

### **3. Belo Horizonte**

In Brazil, large cities like Belo Horizonte and other State capitals are formally part of the regional health system but leave the main responsibility for its management to the States themselves, as head of the systems. As we have seen, Belo Horizonte manages autonomously a comprehensive PHC network, including some SHC services provided in the general hospital.

*Referral issue.* The referral process works quite smoothly between the different levels of complexity of the PHC level up to the SHC services offered in the hospital. In fact, due to the development of the PHC clinics and to a closer control of the municipality on hospitalizations, the proportion between hospitalizations and habitants decreased by 13% between 1994 and 1996, suggesting an improving referral system. However, no evidence exists on the working of the referral process between the municipal network and the State SHC and THC network. A segmentation between the two health care systems has always existed but was less marked due to the smaller municipal system and the co-management of many functions of this system with the State. Thus, the main issue is if the complete separation between the State and the municipality health care networks promoted by the recent reform had a negative impact on the referral process. The combination of the increase in the municipal PHC network, a financing process very reliable on transfers with little local fiscal responsibility, the adoption of performance incentives in the allocation of the specific transfers and the effective control of the State on its hospitalizations makes it likely that there is no big referral problem. However, that should be adequately checked.

### **Lessons for Gauteng and Johannesburg:**

On the basis of these experiences, we can conclude that the referral issue created by the decentralization process can indeed be a serious matter but that options of appropriate corrective devices exist. Appropriately designed regional health systems, accompanied by the design of effective incentives, can help to solve all types of coordination problems among health care institutions. In the Gauteng case, it will be necessary to reorganize the health regions so that they can effectively facilitate the communication and some sort of integration between PHC centres, district, regional and central hospitals in spite of the institutional segmentation. This role could be attributed to the existing five health regions or, better, to the two new regions mentioned above. In fact, these regions could in turn be divided into a few networks, easier to coordinate and supervise, following the case of Bogota. Many options are possible. Most networks would cut across the administrative regions included in the new health regions. As far as the design of incentives is concerned, it would be important that the funds transferred by the province to the Local Governments be allocated according to some performance criteria which reward the effort for capturing and curing patients. In Gauteng, the fact that the funds are channeled through the province which also manages the hospitals should make this incentive mechanism easier to apply than, say, in Chile, where the RHSs do not control the funds going to the municipalities.

**2. Decentralization in the articulation of health care and role of large cities** (*see section 2.2 of the main paper*)

**3. Institutional decentralization of health care and role of large cities** (*see section 2.3 of the main paper*)

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