

UNIVERSITY OF CAPE TOWN
Health Sciences Faculty

Decentralised Resource Allocation and its Impact on Equitable
Health Care Financing

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To the Memory of my Grand Parents

Maggie Nowandile and Lawrence Dabula Mbatsha

University of Cape Town

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Abbreviation/Acronyms

ANC	African National Congress
DHS	District Health System
GEAR	Growth Employment and Redistribution Strategy
IDP	Integrated development plan
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
RSC	Regional Services Council

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Abstract

The main objectives of this thesis are to: (i) Map the financing of non- hospital primary health care within local government areas in South Africa; (ii) analyse the equity of financing health care in relation to need (iii) and document the process followed at provincial and local government level in decision making around budgeting for non hospital PHC services. The methods used in this paper are both qualitative and quantitative. Detailed interviews have been conducted with National and Provincial Departments of Health and Treasury officials as well as local government treasury and health officials in four provinces of South Africa. Further, an analysis of budgetary data has provided a picture of actual expenditure and revised allocations for local government health care. The study found that national policies oriented towards equity are undermined by provincial and local policies, politics, inappropriate resource allocation and historical budgeting. Still, a phased approach towards deprivation-led budgeting, through appropriate funding channels, may allow fairer allocations to, and expenditure in, deprived areas. This has to follow a concerted effort to build the capacity to absorb resources for the municipalities that do not have that capacity at present.

Chapter 1:

INTRODUCTION

1.1 BACKGROUND

No comprehensive assessment of inequities in the allocation of public sector health care resources within provinces and across district municipalities has previously been done in South Africa. Nor has any evaluation of equity in the allocation of local government health care resources been undertaken. Yet this is critical for the achievement of District Health System related policy. It was the government's original intent to see the full Primary Health Care (PHC) package being driven by Local Government, through the District Health System (DHS) (African National Congress Health Plan 1994, Pillay et al 2001 and Department of Health 1997). However, the National Health Act No 61 of 2003 shifts government's position. The powers for provision and funding of primary health care are given to the Provincial Government level. The Act allows Provincial Departments to get into service level agreements with Municipal government to provide primary health within their boundaries where capacity to do so exist. In South Africa Districts are demarcated along the Local Government boundaries (National Department of Health 1997, Pillay et al 2001). Given both the commitment to move to a district health system and the devolution of responsibility for health service provision to the local government through service level agreement, it is important that an evaluation of equity is undertaken at the district level.

In the mid 1990s in South Africa a needs based formula was used to guide health sector resource allocation (Gilson et al 1999). Between 1994 and 1996, each sectoral department had to devise its own formula to allocate resources to the different provinces. The needs based formula of the Department of Health favoured poor provinces. During this period additional resources were allocated to provinces that had major backlogs. Limpopo was one of the provinces that saw huge increases for

primary health care at that time but then experienced a huge decrease because of its inability to absorb funds (Okorafor et al 2003). This situation changed in 1996 with the introduction of fiscal federalism in South Africa (a process whereby provinces are given a global budget and each province's government can decide what the final budget allocation is to be to each provincial department (Gilson et al 1999). Provinces that had large backlogs in health service provision, i.e. the historically disadvantaged provinces, did not get increased health resources.

In the absence of a formula for resource allocation across and within provinces it has been very difficult to achieve equity across provincial and municipal levels. This has resulted in strong political leaders at provincial level getting more resources for their sectors. Indeed this system of fiscal federalism actually reversed some of the equity gains achieved between 1994 and 1996 (Gilson et al 1999, Thomas et al 2000).

Equity generally has been endorsed in principle in most government policies but not implemented in practice. In the National Department of Finance formula for allocating the global budget between provinces, 'catch up' for those most disadvantaged has been given only a very low weighting, in fact only 3% (McIntyre et al 2000).

One of the principles that guides health care provision in South Africa has been decentralisation. This has taken different shapes over the years. The provision and funding of primary health care services has been devolved to be a function of provincial governments. The district health system (DHS) has been seen as the vehicle to drive the provision of the PHC services. This deconcentration of PHC services to the DHS has resulted in services being provided closer to communities (National Department of Health 1997, Pillay et al 2001).

This thesis looks comprehensively at resource allocation mechanisms and the actual distribution of resources in relation to services that will in future be provided at health district level. It assesses health expenditures both by province and by local government between different local government areas. It evaluates how equitable these financial distribution patterns are relative to the need for health services in these areas. Finally it considers alternative mechanisms for promoting equity.

1.2 AIMS

The aims of this thesis are as follows: (i) Map the financing of non- hospital primary health care within local government areas in South Africa; (ii) analyse the equity of financing health care in relation to need (iii) and document the process followed at provincial and local government level in decision making around budgeting for non hospital PHC services and (iv) to indicate how to improve equity in public sector health care financing and expenditure between and within geographic areas in South Africa.

1.3 OBJECTIVES

- To document and evaluate the mechanisms for allocating nationally raised revenue to individual provinces and municipalities for health;
- In relation to the direct provision of services by the relevant spheres of government, to document and critically evaluate resource allocation processes in relation to the provincial health budget for local government and the provincial subsidies for health care across municipalities,
- To understand the circumstances that influence the decision-making processes within municipalities with respect to the allocation of both the local government's own revenue and national grants between sectors/departments;

- To critically assess the pros and cons of alternative financing mechanisms for local government health services;
- To measure the total health care expenditure in all municipalities in all provinces in South Africa, disaggregated by source of finance;
- To measure the expenditure of provincially-financed and -delivered district level health services within the boundaries of each municipality;
- To examine how equitably (i.e expenditure levels relative to indicators of need) health care resources are allocated between local governments.
- To recommend strategies for improving the equity of resource allocation in the South African context

1.4 ORGANISATION OF THE REMAINING CHAPTERS

Chapter 2 paints the picture of the context for the provision and financing of primary health care before and after 1994. The picture of services is skewed with better services for the minority group and worse for the majority of the population. The macro economic policy changes after 1994 and the health financing reforms that have taken place are presented. This chapter also looks at the decentralisation of the provision of health services in the country. The formation of districts and municipalities and the financing of health services at those levels is also looked at.

The detail of the concepts used in this thesis are set out in Chapter 3. The concepts of equity, efficiency, deprivation, decentralisation and primary health care are outlined.

Chapter 4 focuses on the methods used in gathering data for this thesis. The qualitative and quantitative methods used are spelt out.

Chapter 5 describes and analyses the actual expenditure data for non-hospital PHC services from all the provinces. It also measures the data according to need/deprivation across the country.

Chapter 6 looks at the process followed in resource allocation at provincial and local government level for primary health care services. The strengths and weaknesses of this process and an alternative financing mechanism are examined.

Conclusions and recommendations are presented in Chapter 7.

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Chapter 2:

CONTEXT OF DISTRICT LEVEL HEALTH SERVICES IN SOUTH AFRICA

The main aim of this chapter is to paint a picture of the context of the financing of South African non-hospital primary health care. In recent years South Africa has seen two main changes as far as macro economic issues are concerned. In 1994 the African National Congress came to office as the governing party with a developmental policy, called the Reconstruction and Development Programme (RDP), which became the Government of National Unity policy. This advocated more spending on social services (Gilson et al 1999). It spelt out implementation processes to be followed in building infrastructure that would provide basic services. It was a bold plan aimed at correcting both the mistakes of the past and the underdevelopment caused by the policies of the previous government. In the wake of the clinic upgrading and building programme that followed, the health sector, especially PHC, saw a major boost in resources, as the health sector programme received funds from the RDP budget (Govender & McIntyre 1997)

In 1996, the same year as the South African Constitution was introduced, the government also introduced a new macro economic policy called the Growth Employment and Redistribution Strategy (GEAR) (National Treasury 1996). GEAR is the macro-economic policy of South Africa. It advocates growth first and only second redistribution. After it was introduced, both government departments and the citizens of the country saw a time of financial belt tightening. The government changed from promoting social spending to cutting social spending and reducing civil servants. This was seen by many analysts as a self imposed structural adjustment programme. GEAR, and the introduction of the new constitution, brought with them a period

where most of the inter-provincial equity gains made between 1994 and 1996 were reversed. In essence this was because of the limits placed on spending and the lack of an equitable formula for resource allocation across provinces (McIntyre et al 1999, Gilson et al 1999).

"Economic growth has not matched the level of population growth, let alone the levels needed to address the enormous backlogs, which are a legacy of our past. Furthermore, government has adopted a tight macroeconomic policy framework (GEAR) which emphasises, inter alia, deficit reduction and a progressive reduction in the tax burden. This scenario impacts significantly on the health sector and our planning has to be rooted in this reality." (Dept. of Health 1999, Health Sector Strategic Framework 1999-2004)

The RDP was introduced at a time when the country was governed by an interim constitution, which allowed the central government to decide on resource allocation. The national treasury department was able to allocate money to the different sectors and the relevant national and provincial departments then decided together how much of the budget provincial departments were to get for the provision of services such as health services. During this period (1994-96) the national health department used a formula that saw resources distributed more equitably, with provinces with greater needs getting more (McIntyre et al 1999, Gilson et al 1999).

All this changed in 1996, when the new constitution gave powers to the provinces to decide on how they wanted to divide up their own budgets. The constitution introduced a fiscal federal system in South Africa. This meant that the National Treasury gave provinces a slice of the nationally raised revenue and thereafter provinces decide on their own, how much different sectors get. At provincial level

there does not seem to be an attempt to redistribute resources using any sort of explicit formula. Most provinces use historical budgeting. Departments get the same amount as the previous year with an addition of an amount for inflation (McIntyre et al 1999, Gilson et al 1999).

2.1 LOCAL GOVERNMENT HEALTH SERVICES

Local government health services delivered prior to 2000 fell broadly in two categories. Firstly, local governments have historically provided a limited range of preventive, promotive and rehabilitative primary care services. These were seen as the explicit responsibility of local government. Secondly, some local governments that had sufficient capacity provided additional services, such as curative primary health care services and ambulance services, on behalf of (or on an agency basis for) provincial and/or national governments. In addition, the 1977 Health Act makes provision for provincial and national health departments to appoint a local government to provide basic health services for an adjacent municipality, where the latter does not have adequate capacity to provide these services or to raise sufficient revenue for them. The Health Act No 61 of 2003 gives the responsibility of provision and funding of primary health care to the provincial health department. Municipal health services were narrowly defined to basically provide environmental health services. Furthermore, the Act allows the members of the Executive Council at provincial level to assign what health services should be provided by a municipality. These have to be stipulated in a service level agreement signed by the province and relevant municipality.

Funding of these two categories of services also took different forms. For services that were regarded as a core local government responsibility, local government 'own revenue' was drawn upon to contribute to the funding of these services. Municipal

health departments had to compete with other municipal departments (e.g. housing) for allocations from 'own revenue' through the normal budgetary process. However, a subsidy was also provided, initially from the national health department and more recently from the provincial health departments, to ensure adequate provision of these services. The level of these subsidy payments for municipal health services is largely at the discretion of the provincial health department.

In relation to local government health services that are provided on behalf of the provincial health department, or one of the former national health departments such as the House of Representatives' or House of Delegates' health departments, an agency payment was made to the relevant local government by the provincial or national government. Agency payments differ from subsidies in that provincial/national health departments were expected to cover the full cost of running these services (since the services are considered to be the responsibility of the national/provincial department) and municipalities could terminate the agency agreement and refuse to provide these services. These payments were frequently structured as salary payments for identified staff involved in the provision of these agency services. Sometimes part of the subsidies and/or agency payments took the form of free drugs paid for by the provincial government. This was a mechanism to ensure that local governments had access to low cost medicines (Mbatsha and McIntyre 2001).

In return for these subsidies and agency payments, the 1977 Health Act requires local governments to submit a quarterly report to the relevant provincial Department of Health on the health status of the population they serve, the services provided, and expenditure incurred. Once these reports are received, the next quarterly instalment of subsidies and/or agency payments is then released.

2.2 DECENTRALISATION: HEALTH DISTRICT

Up until 2003, in South Africa, there was a long-term commitment to integrated district health services being provided by local government (Pillay et al 2001, ANC Health Plan). Currently the bulk of health care service provision is the responsibility of Provincial Departments in South Africa. Provinces have been responsible for hospital services and curative primary care services. Local government health services have been limited to preventive, promotive and rehabilitative primary care services, with, prior to 1994, a concentration on communicable disease control and environmental health (Gilson et al 1999). Some local governments do provide integrated preventive and curative primary care services, but they tend to be the ones with better capacity and a larger resource base. Typically the reason why local governments do not provide or have very limited provision of health services is where they have weak health provision capabilities. Most of these are in rural areas, many formed only in 2000 and are still struggling to develop infrastructure and build the minimum capabilities to provide basic services.

In the National Constitution, municipal health services were not clearly defined. Where they have been was in the recent National Health Act (2003) and was only for environmental health services. In that same act the national department of health has undertaken to decentralise the management of health systems (Mbatsha and McIntyre 2002, NDoH 2003). That department is also planning for a full primary health care package to be provided at health districts, which are demarcated along the municipal boundaries. The Act encourages service level agreements between provincial department of health and district municipalities that have the capacity to provide primary health care services. The Act mandates the provinces to be the custodians of primary health care funding. This means that the funding of primary health care services provided by municipalities through the service level agreement

is still going to be channelled through provincial departments (Makan et al 2003, Thomas et al 2003).

The Health Act No 61 of 2003 also advocates for the provision of PHC services through the DHS within the boundaries of District municipalities. Section 25 (2) (L) of this act gives powers to the head of provincial health department to facilitate and promote comprehensive primary health services. Sections 32 (2) and (3) invoke the powers given to the provincial Member of the Executive Council (MEC) in section 156 (4) of the constitution of the Republic of South Africa. This power allows the MEC to assign certain health services which are the responsibility of the provincial or national department to be rendered by the district or metropolitan municipality. Consequently, provinces have given municipalities powers to provide primary health care services while holding on to the funding responsibility of PHC service. Other provinces have taken direct responsibility for providing PHC services and are busy taking over the municipal facilities that were previously rendering PHC services.

2.3 OVERVIEW OF LOCAL GOVERNMENTS AND THEIR FINANCING

According to section 151 of the constitution of South Africa, local government is recognised as a distinctive sphere of government. Municipal councils are vested with legislative and executive authority and, within the limitations of national and provincial legislation, are free to govern community affairs according to their own initiative. Section 151 (4) stipulates that national or provincial governments may not act as constraints on the municipality's ability to exercise its powers and perform its functions. Instead, the national and provincial spheres of government are required to work together with local government to create an enabling environment for municipalities. In particular, section 154 clearly indicates that the national and provincial governments should, by all means available to them, give support to and

strengthen the capacity of municipalities to manage their own affairs and to provide basic services to the community.

Section 155 of the Constitution of the Republic of South Africa sets out the different categories of municipalities:

- a. Category A: A municipality that has exclusive municipal executive and legislative authority in its area. An example of this kind of municipality would be Cape Town, Tshwane and Nelson Mandela Metro. These are economically active and viable municipalities.
- b. Category B: A municipality that shares municipal executive and legislative authority in its area with a category C municipality within whose area it falls. These would be municipalities that make up a C municipality. An example of this would be Umzimkhulu local Authority and Umzimvubu Local Authority which form part of a C municipality.
- c. Category C: A municipality that has municipal executive and legislative authority in an area that includes more than one municipality. Alfred Nzo District Municipality is an example of a Category C municipality, with Umzimkhulu and Umzimvubu two of the Category B municipalities within it .

There have been dramatic changes in the organisation of local governments since the 1994 elections. The number of municipalities has been reduced with an emphasis on amalgamating local authorities from former 'white' areas with those from former 'black' areas. This was seen as an important mechanism for promoting a redistribution of resources between the previously well off and previously disadvantaged areas. The process has placed a heavy burden on restructured municipalities, especially those where service responsibilities have increased but without new avenues for generating extra revenue. The process was also unable to create municipal structures with a uniform capacity to deliver services to their

communities. Capacity is particularly limited within those municipalities in provinces containing former 'homeland' areas and in which there has been a tendency for provincial departments to concentrate their efforts on building their own capacity at the expense of that of local government (Mbatsha and McIntyre 2002).

Local government generates its revenue through levying local taxes (e.g. the Regional Services Council (RSC) levy on payrolls) and property rates as well as from utility sales (e.g. charges for water and electricity) (Mbatsha and McIntyre 2002, National Treasury 2001).

In general, it is expected that municipal services will continue to be funded largely from locally-generated 'own revenue'. In 2000/01, transfers from the national level accounted for only about 7% of total local government expenditure (National Treasury 2001). However, given the differential ability of local governments to generate 'own revenue' due to differences in their rates and tax bases, there is a need for some nationally allocated resources to offset differential revenue raising capacity and try to ensure equitable provision of basic services by local governments. With the finalisation of local government boundary demarcations and the democratic election of local governments in late 2000, transfers of financial resources from the national level have been increased and a coherent mechanism for allocating these resources between municipalities adopted.

An equitable shares formula for the allocation of resources from the national Treasury to individual local governments was first introduced in the 1998/99 financial year. There are currently 3 components to this formula (National Treasury 2001, 2006):

- An institutional grant to support the overhead costs of municipalities which have a small rates and tax base relative to their population (i.e. where a high proportion

of residents are unable to contribute to rates and taxes). This component of the formula estimates the average overhead costs of municipalities, and deducts from this amount the rates/tax revenue that the municipality could generate, based on the number of households above the poverty threshold.

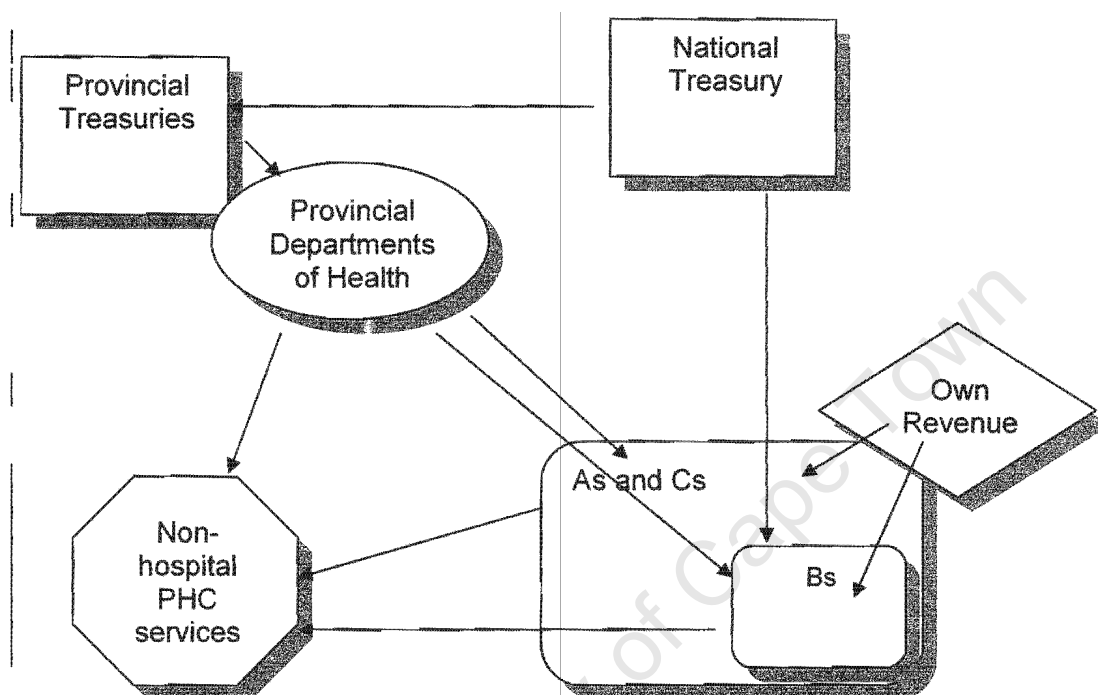
- A basic services grant to support the operating cost of basic services provided to low-income households. This component is based largely on the estimated annual per capita cost of providing basic municipal services multiplied by the number of people living in poverty in each municipality. The basic services included in this calculation are electricity, water, refuse and sanitation.
- An allocation to municipalities located in former 'homeland' areas that are taking over personnel from provincial government in what are termed R293 towns. (This will gradually be discontinued as these municipalities become fully functioning and have a full staff complement.)

In addition to the equitable shares allocation, there is a range of conditional grants that are "made to those municipalities that apply for or are selected to receive these funds" (National Treasury 2001, 2006). These grants are directed to capacity-building (to improve financial management, planning and project management capacity), restructuring (in order to move towards improved financial self-sustainability) and infrastructural development. These transfers were not earmarked for health service but some municipalities managed to tap on them for health service provision within their boundaries. However, the channelling of these transfer is going to change in the financial years coming after the 2006/07 to more the equitable share amount.

Apart from local government 'own revenue' and these transfers (equitable shares and conditional grants) to local government from the national revenue fund, the only other source of funding for local government is that of 'grants-in-kind'. The major 'grants-

in-kind' are the subsidies for municipal health services and agency payments for ambulance/emergency services, both of which currently take the form of transfers from provincial health departments.

Diagram 1: Representation of Funding Flows relating to PHC



Source: Thomas et al 2003 (As, Bs, Cs in the diagram refers to the categories of municipalities)

2.4 Funding of PHC

There are two streams to the money for PHC from the province as you can see on diagram 1. One is the money transferred from the provincial department of health as agent and subsidy payment to local governments for providing primary health care services on their behalf. Second, province does also provide primary health care services at the local government level or area. Thus, one sees the direct transfer of

funds from provincial level to the health district office and then the provincial facility at local government level.

Another source of funds is the equitable share for primary health care services at local government level which comes from the national treasury. This is money raised at the national level and allocated to all the provinces and local governments. This money is not specifically sent for health but can be used for health and other services provided at provincial and local government level. The own revenue contribution for health care services was obtained from data provided by the department of provincial and local government (Thomas et al 2003).

Summary

Historically, primary health care provision was fragmented; local government provided a limited range of preventative, promotive and rehabilitative services. Some local governments with sufficient capacity provided additional services, such as curative primary health care services and ambulance services, on behalf of provincial and national governments.

Major debate over the past 10 years has been around the proper definition of Municipal health services. This, resulted in the narrow definition of municipal health services to only entail environmental health services. Provincial level government ended up with the responsibility of providing primary health care services. The health Act 61 Of 2003 furthermore gives the financing responsibility for PHC services to provincial government, except for environmental health services. However, the provincial health department can get into a service level agreement with a municipality to provide the PHC services. The funding for the environmental services is the responsibility of municipal government.

Chapter 3:

LITERATURE REVIEW

3.1 Conceptual definitions of Equity

Concepts like equity, need and decentralisation are reviewed in detail in this literature review chapter as they form the basis of policy direction in most developing countries. This is done to give clarity and way forward on future policy direction.

3.1.1 Which Definition of Equity?

The equity concept has been used by different people in different societies to mean different things. Equity refers to justice or fairness in society. This is not the same as equality, which refers to everyone being treated equally. Equality refers to the equal allocation of resources equally amongst the population regardless of their starting levels. Treating people equally may not be fair or equitable. Key definitions of equity are dealt with in the following paragraphs.

3.1.2 Equality of Expenditure per capita

Equality of expenditure per capita looks at the distribution of the nationally raised revenue between regions for the provision of health care services (Mooney 1986). Are people in the population getting the same amount spent for the provision of health care services? This definition uses one of the concepts of need, which is the population covered by the resources.

3.1.3 Equality of inputs per capita

It relates to the fact that inputs like human resources and infrastructure may cost different amounts in different areas of the same country (Mooney 1986). This in reality shows that when one gauges the equity issues by looking at the equal expenditure per capita you may lose sight of the fact that the cost to provide

resources to different parts of the country can be different. For example, to attract health professionals in rural areas you need to have incentives that would be seen as top up to their salaries. A good example is rural allowances in South Africa (Department of Health 2004).

3.1.4 Equal access for equal needs

Equality of access means equal opportunities for use of health services for people with equal need. People should be afforded the same opportunity when they are ill with the same sickness whether or not they choose to use the services (Mooney 1994). This allows for the fact that people have different value judgments; for example they might decide not to use health care services on the grounds of cultural and other beliefs. It can also allow for the fact that people can have different reactions to treatments.

3.1.5 Equality of use for equal needs

Equality of use is based on the notion that people who have the same sickness should get the same treatment. Being ill is seen as need. Equality of use assumes that people's value judgments are the same. When people get sick they will choose the same treatment. Equality of use does not take into account that people have alternative ways of healing themselves based on cultural and religious beliefs. It fits in with the concept of horizontal equity, which favours the equal treatment of people with equal need (Mooney 1994).

3.1.6 Equality of Marginal met needs

This definition is related to issues of cost-benefit approach. A health authority with budget constraints would allocate its resources to activities for which ratios of benefit

to cost are highest. It is difficult to use it for health service provision costs differ with interventions required and their benefits also differ with different people in society.

3.1.7 Equality of Health

Equality of health looks at the end result of distribution. It focuses on the outcome. It does not look at the fairness of the process through which health resources are distributed (Mooney 1994). It perpetuates the assumption that all individuals in a society seek the same health end point. It also assumes that people will have the same values with respect to health. Equality of health represents an idyllic end point, which in reality does not exist. It does recognise that health is affected by other factors that health services might have no control over (Mooney 1994). Examples of this are education, housing and water and sanitation. In South Africa all these fall outside the powers or jurisdiction of the Minister and the department of health.

3.1.8 So which definition to choose?

It would seem that equality of access is the best definition of equity in that it fits in the imperfect environment in which we live today (Mooney 1994). It is the long term goal of most health system to provide equal access to health services to its citizens. However, it is very hard to gauge its success as one would need to first define access and look at the issues of need in a country. The definition that is most practical is the equal expenditure per capita in a country. Equal health is both too expensive and too elitist. It is too expensive because raising the health of those at the bottom from a fixed budget would be too great a sacrifice for those at the top - in terms of health. It is too elitist because it does not allow individuals or groups to exercise variations in preferences for health as compared to other aspects of life.

Equal use is too narrow in that it does not allow for varying preferences for either health or health care consumption.

3.2.1 Approaches to Equity

There are two approaches to measuring equity: **distributive** justice and **procedural** justice. Distributive justice looks at fairness of the outcome of the resources that were distributed. It concerns itself with looking at the endpoint. Was the outcome of the distribution fair? Distributive justice is linked to the concepts of equality of use and equality of health. It does not account for the fact that people have different value judgements or that people have different cultural backgrounds that might lead them to have different perceptions of health care services (Daniels 1982, Mooney and Jan 1997, Rasinski 1987).

Procedural justice looks at the fairness of the process through which resources are distributed. It favours the idea that the process of accessing health care should be fair even if the outcomes are not. Procedural justice accepts that individuals have different value judgements, that they have different responses to treatment. Procedural justice can be seen in terms of equal access according to equal need. People might need to be treated differently to achieve fairness. Procedural justice is the best concept to have in an environment in which people differ in their values regarding health and health care, because it allows for differences in the choices people make and therefore, the outcomes they achieve (Mooney and Jan 1997, Rasinski 1987)

3.3.1. Horizontal Equity

Horizontal equity is often interpreted in terms of equal treatment for equal need. This means equal opportunity of access to people with equal need (Mooney et al 1991). Most politicians and decision-makers tend to persist with only horizontal equity in an environment that is not a level playing field in the sense that needs do differ but 'either no or inadequate attention' is then given to what the policy response should be to different levels of need. Policy is constrained to using only horizontal equity even in societies where there are major inequalities. The reason for this might be that horizontal equity is less controversial. It may invoke less anger from those who have the wealth and voice in society. The rich and middle classes are organized and have access to resources and easy access to decision makers. They tend to challenge efforts by government aimed at distributing resources to the poor (Thomas & Gilson 2004). However, when horizontal equity is applied in an unequal environment, it will not bring adequate shifts in resources. When the starting point of health of members of a community is not the same, there is then the issue of the extent to which the society places more value in allocating scarce resources on a preferential basis on improving the health of the poorest members of the community.

3.3.2 Vertical Equity

The application of vertical equity (unequal but equitable treatment of unequals) has not been widely practiced in most countries. This form of equity is supposed to move the efforts of policy makers and decision makers in a direction where they will strategically allocate the limited resources of the country in a way that will raise the standards of those who were previously disadvantaged and systematically neglected (in the case of South Africa) (i.e. positive discrimination). This means targeting

relatively more health expenditure to the areas where poverty and deprivation are greatest (Mooney 1999, McIntyre 1997).

The practical application of the vertical equity principle is potentially challenging. There could be a tendency to explain or describe vertical equity as a way of lifting up the standards of the previously disadvantaged by lowering the standards of those that were previously advantaged. However, vertical equity favours the principle of maintaining the standard level of the best groups while putting every extra resource at your disposal to the upliftment of the poorest in the community. Vertical equity principles have not been applied in South Africa. The government concentrated its efforts on applying horizontal equity, which is not the right medicine for South Africa with its huge inequalities. This is the reason many people will say equity has not worked in South Africa and in most of the developing countries especially in Africa. Vertical equity principles are those required to bring about the needed change in resource allocation in South Africa (McIntyre et al 2000). When people talk about equity they need to be clear of the definition of equity and the right type of approach that must be applied. The application of horizontal equity across the board without differentiating for the different needs of poorer areas would fail to meet the equity goals, which are set by government departments. The concept of need is critical to understand as it is used by many as a measure of how equitable a society is.

3.4 Need

Need is defined differently by people in different fields. Even within health economics, there are many definitions and associated arguments (Asadi-Lari et al 2003, Culyer 2001 and Mooney 2003). The definition favoured by most economists is "the ability of people to benefit from health care provision" (Asadi-Lari 2003, p 2). More value is given to the capabilities of a person to gain more from the health intervention. This

section deals with the concept of need from the perspective of the individual, community and wider societal indicators of need.

3.4.1 Need

Issues of need have been explored both at the macro and micro levels. The first examines the needs of the general population and the second the needs of the individual. The latter is where issues of the relationship between the patient and their doctor come in, in the sense that in order for the patient to know and be aware of his/her health care needs he must be informed by the doctor.

3.4.2 Indicators of Need

Indicators of need have been looked at and the ones that most people seem to agree with are: population, socio-economic status, Age and sex, morbidity and mortality (Doherty and Van den Heever 1996, UK Department of Health and Social Security 1976). I explore each in turn.

Population size has been seen as a good indicator of need when distributing resources to different regions of a country. Efforts should be made to deliver resources according to the population that is served. For this to be effective a country would need to have good and regular census data available. If a country uses old data they would fall into a trap of providing inappropriate resources to a population that has changed. This will lead inadvertently to an unsuitable distribution and use of scarce resources.

Socio-economic status has been identified as associated with the health of the citizens of a country. The income bracket of a citizen can be linked with their usage of health services. The lower the income the more people would not be able to afford to pay for health care services. Further, poorer populations may be more susceptible

to disease. Therefore, the state would have to compensate by putting more resources where the region is dominated by a population that is poorer .

Age and the sex of the population have also been seen to be an indicator of need. The old and children have been identified as needing more health care attention than the younger and middle aged people. Further health seeking behaviour between men and woman is different for different health services (Doherty and Van den Heeden 1996, DHSS 1976). For instance, women of child bearing age need more maternity and family planning health services than men and older women. These indicators can tell what services are needed and where.

3.4.3 Morbidity and Mortality

Morbidity data is a good indicator of need, if one has access to good data. Nevertheless, collecting it can be expensive, which is a luxury developing countries cannot afford. In contrast, mortality data is more available and could be a way of getting around the difficulties with morbidity data (Doherty and Van den Heeden 1996, DHSS 1976). Yet, developing countries would have to make sure that data is accurate and updated regularly.

In a developing country context the choice of indicators to use is heavily affected by availability of data locally. Ideally one would have a combination of them in order to fully reflect the different aspects of need. However this is not often possible. One of the indicators of need that takes a wider social perspective in looking at need is deprivation

3.4.4 Deprivation

Deprivation is defined as a condition of noticeable and demonstrable disadvantage relative to the community or the larger society or nation to which an individual, family

or group belongs (McIntyre et al 2002). It refers to the adverse material and social state individuals and households find themselves enduring. Deprivation is different from poverty in that it goes beyond the inadequacy of income, to the material and social conditions experienced by an individual or a household compared to the rest of members of the community or the nation (McIntyre et al 2002). It provides an indication of broadly defined socio-economic status through combining a range of variables into a single index. A deprivation index may therefore be a useful measure of vertical equity, as it measures the lack of resources available to the poorest members of the population.

3.4.5 "Need- based Formula and Need"

A needs based formula is a process of allocating financial resources to the different regions of a country using measures of need for the appropriate population. This is done by identifying the relevant population and adjusting for the relative need of that population using indicators like age, gender and socio economic conditions in that area (Doherty & Van Den Heever 1996). The "need-based formula" is used in many countries as a way of allocating resources equitably to the population. It might not be a perfect way of allocating resources but is a starting point to meaningfully distribute resources in a fair and just way.

3.5 Primary Health Care

The definition of PHC is best seen in terms of the Alma-Ata Declaration: "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and

country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (Alma-Ata Declaration 1978. p.2).

Primary health care promotes the importance of equity in society. It is centred around community participation in decision making around the service provision and distribution of resources, although this is often absent in reality. In South Africa it is a legal requirement for Local Governments to get the views and direction from the communities before distributing resources and the provision of services. The national health act has given the responsibility of financing the health services and major component of primary health care to the provincial government, which is not legally bound to consult with communities about resource distribution (Thomas et al 2005). The health service financing and provision decisions are still made at a much higher office than the ones nearer to the communities that use the services.

The primary health care approach stipulates the provision of service through a multisectoral approach (Green 1999). It realises that there are other factors that are beyond the health department that affect health. This is one of the problems of policy making in South Africa, as sectoral departments that impact on health do not write policies in a coordinated manner (Sinanovic et al 2005).

This thesis limits itself to the understanding of only the financing of PHC services, not the broader definition of the PHC which includes both contributions from other sectors and the involvement of the communities in decision making. It does not look

at the technological input to PHC services as outlined in the Alma Ata declaration and Mahler (1981). Decentralisation is seen as one of the necessary structures that need to exist in order for some of the principles of PHC to come alive (Green 1999) and this is explored in the remainder of the thesis.

3.6 Decentralization

Decentralization is a transfer of authority, power and certain responsibilities from the central or national level to other spheres or lower levels of government (Brijlal and Gilson 1997, Bossert 1996). There are two approaches to decentralization that have been identified. One is a social development approach, which looks at decentralization as a major part of a policy. This approach comprises a set of strong components that are centred round socio-economic development and community participation. The other approach is that of the market, which sees decentralization as a vital element in the effort to improve efficiency by bringing market practices to the public sector (Collins 1996).

Decentralisation has been identified as a good way of governance and way of distributing resources because it allows governments to allocate resources according to the needs of the local consumers (Cerniglia 2003, Martinez-Vazquez and McNab 2003). This goes with the assumption of local government being nearer to the people; people's needs and preferences are identified and responded to. In reality this assumption is correct only where the voice of the communities is strong. When you look at the case of Bolivia, which started its decentralization in 1994 after a period of about 40 years of State led development, there was general development in the country and the strong presence of the Local Oversight Committees which made sure those resources was spent according to the needs and choices of the

community. The presence of good capacity at local government level contributed to the positive effects of decentralization in Bolivia (Faguet 2004)

However this was not the case in Indonesia, where there was a lack of community voice and capacity at a local government level to listen and deliver services according to the needs of the community. In Indonesia decentralisation widened the gap between the rich and the poor, public health services deteriorated from what they were before the initiation of decentralization. The poor communities were not well educated and demonstrated a lack a will to fight for their rights, whereas, on the other side the rich had a voice and were able to get the things they wanted done (Kristiansen and Santoso 2005). Therefore, the above evidence does show that decentralisation on its own cannot deliver on its objectives when there is no good and strong community voice and good local government capacity to deliver good services. In South Africa the policy to engage with the community is present but its implementation is lacking (Thomas, et al 2005)

In South Africa decentralisation came about as a result of political negotiation around the future landscape of the country before the democratic elections of 1994 (Friedman and Humphries 1993). South Africa has had parallel processes of decentralisation, one is the political process of giving power of provision and authority to the different spheres of government for example between provincial and local government. The other process is the one that takes place at provincial level giving responsibility of providing services to the health districts which are an extended office of the provincial department of health.

In this thesis two types of decentralization are examined. These are deconcentration and devolution. Deconcentration is the removal of power from central offices to regional offices of the same sector (Bossert 1996, Martinez-Vazquez and McNab

2003). This is a system whereby the central government moves the responsibility of provision of government services to regional and local offices. The central office still holds the responsibility of generating revenue and deciding how to divide the revenue generated centrally among the sectors of government.

With deconcentration very limited powers are given to the local level. Their main task in most environments is to manage the resources they are given by the central offices. In most cases lower offices do not have the power to hire and fire staff. They need to get approval on most things from the central office. This process has a tendency to weaken the lower levels. The district health system in most developing country including South Africa is arranged along these lines of authority.

Devolution is the removal of responsibility and authority away from central offices to other lower elected levels of government , for example provincial government and local government (Bossert 1996, Martinez-Vazquez and McNab 2003).). Central government transfers power to develop the budget and provide services to locally elected government spheres. An example of this in South Africa is the transfer of powers for allocating resources at the provincial level.

Without proper or careful planning decentralisation is unlikely to meet the goals of health sector reforms (Brijlal et al 1998). When a country decides to go the decentralisation route it needs to do the ground work in terms of levelling the playing fields. There should be a concerted effort made to build up the capacity of the lower levels of the system. Further equity and decentralisation have been proven to be difficult combination (Thomas et al 2003)

from the central office before firing or hiring a person, and this affects capacity. Getting authorisation from the Treasury before using the surplus budget affects capacity.

The task network relates to the coordination of organisation or departments that need to achieve the task. The lack of proper coordination between the department of health and water affairs department in South Africa, for example, has constrained the capacity of the departments to deal properly with sanitation and hygiene issues (Sinanovic 2005).

Organisation relates to the structure of the department and how it is managed. The effectiveness of managers is sometimes constrained or enhanced by the organisational structure. If organisations have too many layers employees may be constrained from performing efficiently (Hilderbrand and Grindle 1994). Other important organisational factors are the existence of clear policy goals and objectives and the buy-in of the implementing staff

The last dimension relates to issues of training and hiring of people with the right skills in the organisation. Furthermore, it relates to the creativity of managers and their ability to create an environment to make sure those people with the right skills stay within the organisation. The non existence of the right skills mix in Health Ministries of good financial managers has been seen as one of the early failures of the user fees in Ghana and Zimbabwe. Further a lack of legal expertise in the Ministry made things difficult in the contracting out of services for the health sector in Ghana (Mills, Bennett and Russell 2001)

Chapter 4:

THE STUDY METHODOLOGY

INTRODUCTION

The aim of this chapter is to outline the methods used in this study, the study design, sampling method, data collection methods, and data analysis. The data for this thesis are taken from two projects in which I have been heavily involved. The first was for a chapter Mbatsha and McIntyre (2002) in the 2001 South African Health Review, in which I was the principal author. In that study I did the literature review and the review of policy documents, drafted the interview schedule and conducted the interviews. With the co author, I did the analysis of the interview material and most of the write up of the first draft of the chapter. The second project was a review of the finances of non-hospital PHC in South Africa, looking across all district municipalities. In this project I did some of the document review, collected most of the quantitative data and collated all of them, worked with the principal author in the analysis of the data and contributed to the write up process of the report. For the thesis I re-edited the chapter from the first project as a chapter for the thesis, then took the data from the second project and did an analysis of my own. The data were collected in 2002/03 for the year 2001/02 and the write up of the thesis took place in late 2005 and 2006.

4.1 STUDY DESIGN

I would like to refer to the research as an analytic study as it investigates the causal relationship between decentralisation and equity in health. One is looking at the impact of decentralisation on health equity. The study uses a cross-sectional approach with information or data collected for a single point in time (Katzenellenbogen et al 1997). Interviews were done with people to get their views and knowledge at a point in time about the processes or mechanisms used to

allocate resources in provinces and the country. This thesis is based on both qualitative and quantitative research methods, as outlined below.

4.2 QUALITATIVE METHODS

Sampling Methods and Sample Size

Interviews were conducted in 2001 with key officials at all the three levels of government. Additionally relevant policy documents were reviewed. Interviews with key actors in national, provincial and local government Departments of Health and Treasuries were undertaken to document the current mechanisms for financing local government health care. The interviews were also used to get the views of the actors on these mechanisms. They were conducted in three provinces, namely Western Cape, Mpumalanga and Free State. The three provinces were chosen because they provided a representation of features that are common to other provinces. For example, Western Cape has provided features of a province dominated by an urban area, and that has a big metropolitan district municipality. Mpumalanga has features of a province with a small urban area and that charged patients a user fee for primary health care level. The Free State has features of a predominantly rural province. As it is important to canvass views in different categories of municipalities, Cape Town was included as an example of a major metropolitan council, Nelspruit as a town, and Tsepho/Kopano as a municipality in a rural area in the respective provinces. Officials at the National Treasury and at the national Department of Health were interviewed to get national views on current financing mechanisms, as well as alternatives, for local government health services.

Interviewee's profile

Level of Government	Position	Gender
National Department of Health	Deputy Director General	Female
National Department Health	Director of District Health	Male
National Department of Health	Director of Health Financing and Economics	Male
National Treasury Department	Chief Director of Intergovernmental Fiscal issues	Male
National Treasury Department	Director of Local Government Financing	Male
Provincial Department of Health	Director responsible for determining local government subsidies	Female
Provincial Department of Health	Director responsible for determining local government subsidies	Male
Provincial Department of Health	Director responsible for determining local government subsidies	Female
Local Government Treasury	Town Treasure	Male
Local Government Treasury	Town Treasure	Male
Local Government Treasury	Town Treasure	Male
Local Government Treasury	Town Treasure	Male
Local Government Health Department	Head of Health	Female
Local Government Health Department	Head of Health	Male
Local Government Health Department	Head of Health	Female
Local Government Health Department	Head of Health	Female

Officials from the provincial Department of Health and Treasury in all three provinces were interviewed to obtain information about the mechanisms used in determining

the allocation to the local government for the health services they provide on behalf of provinces (i.e agency and subsidy payments). Then officials from local government Treasury and Health departments were interviewed to outline the different sources and allocation of funds for health and their preferences about the best way of allocating the primary health care resources from the national and provincial level. All the officials interviewed were also asked about the strengths and weaknesses of two financing mechanisms:

- the present financing mechanism whereby decision and allocation of resources for primary health care provided at local government is done at a provincial level.
- an alternative financing mechanism with decisions being made in, and allocations coming from, the national Treasury.

To gain access, telephone calls were made to senior officials in all levels of government. Subsequent emails and faxes provided a brief summary of the research with contact numbers of the relevant researchers following which appointments were made with key officials. In-depth semi-structured interviews were conducted with all the interviewees to get beneath the surface responses (Bowling 2002). The advantage of using semi-structured questionnaires is primarily that it allows the respondent an opportunity to give more personal explanations and more detailed answers. It also allows the interviewer to draw out more detail while the interviewee is thinking and talking about the subject (Katzenellenbogen et al 1997). Separate questions were drafted for the three levels of government in the health and treasury departments (see appendix A). The interviews were tape recorded with an undertaking from the interviewer that the identity of the people interviewed would not be revealed and that the information would be used for research purposes only and not made available to others. The interviewees were also read, and signed, a letter

of consent. The recordings of the interviews were transcribed with the permission of the interviewees

4.3 ANALYSIS OF THE DATA

The transcripts were given to the two researchers involved in the study to analyse. Each researcher was given each transcript to review independently and identify the themes coming from the interviews. This was done to try to guard against biases as a result of one researcher 'seeing' themes and overlooking others. Then both researchers sat together to compare. They concurred on most of the themes emerging from the interviews.

Summary of the themes coming from the interviews

Health services provided by the Local Government
Process of allocating budgets from local government revenue
The Integrated Development Plans process
Views on the Provincial Allocations
Disadvantage of the present financing system
Advantage of the alternative financing system
Financial controls if money comes direct to local government
Control measures against councillors abusing the system

4.4 Document Review

Documents were also reviewed to get an understanding of local government in general and of the existence of decentralised health services specifically. The current status quo of financing local government health care services was looked for in the documents reviewed. This review provided insights into what powers exist at different levels of government, and the division of the nationally raised revenue to the different spheres of government. The 1977 Health Act and amendments were looked at to help to explain how funds are currently transferred from provinces to local governments. For the quantitative section data were obtained from provinces and national treasury department websites. Other sources were used to get more accurate data for the financing of primary health care at a district municipal level for the financial year of 2001/2002.

4.5 Quantitative analysis

To build up a picture of financing of Non-Hospital PHC in local government areas, an examination was made of different sources of funding for local government. This was done at the level of the district municipality for ease of analysis. Expenditure data for primary health care were requested from all the provinces. Transfers from national treasury department to district municipalities were collected from National expenditure reviews. District municipalities' own revenue data were received from the department of Provincial and local government. The expenditure data relate to the financial year 2001/2002. This year was chosen because it was the first financial year for which data were available after the demarcation process. Local government boundaries were drawn for the first time to cover all of South Africa. The expenditure data on primary health care at the local government level was thus compiled from different sources.

The focus of analysis for this project is the health district, which is taken to be all metropolitan areas and the district municipalities in all the nine provinces of South Africa. This constitutes currently 53 areas and accounts for all non-hospital PHC services in the country. Funds for non-hospital PHC are currently transferred to sub district municipalities in most provinces but some go directly to the district municipalities and provinces do provide these services directly within municipal boundaries through the health districts and regions. To allow comparisons to be made, the CPI index was used to inflate and deflate prices of data used in the Brijlal *et al* (2000) and Chitha *et al* (2004) studies, standardising to the 2001/2002 prices of the PHC package. These were conducted to determine the cost of providing a full package of primary health care services.

Per capita spending

The expenditure data were divided by the population from the 1996 census data projected to get a 2001/2002 estimate of the per capita expenditure i.e. for money spent for primary health care on individuals living in the district municipality. Adjustments were made for the population which belongs to medical schemes, as they do not use the public sector primary health care services. The per capita expenditure was then used to measure horizontal equity across the health districts.

The data used to assess need were deprivation indices and were calculated for the Primary Health Care Financing study by Thomas *et al* (2003). Such measures of need were done at a district municipality level, using the 1996 population data and drawing on the work by (McIntyre *et al* 2000), which conducted the first conceptualisation and measurement of deprivation. The need data when combined with the expenditure data represents a measure of vertical equity across the health districts.

Limitations, Action Taken and Suggestion for future research

The major limitations of the study related to data. Certain provinces did not keep data according to the format that was required for this study and were unable to provide the information needed. The candidate had to physically go to those provinces and work with relevant department officials to collate the data according to the format of the study. Further research is needed in this area to broaden the understanding of the concepts and difficulties in the actual implementation of equity in a fiscal federal system. Research should be done on absorptive capacity to see what is needed to be able to use extra resources allocated to the provinces and district health services.

University of Cape Town

Chapter 5

Distribution of Primary Health Expenditure

The aim of this chapter is to look at the degree of equity in financing from provinces to municipalities and health districts for primary health care services. Firstly, attempts are made to measure total health care expenditure in all municipalities in all the nine provinces (i.e. the expenditure of the local government and delivered district health services within the boundaries of each municipality). This allows an estimate to be made of the "own revenue" generation capacity of each municipality. Measurement of equity is undertaken by examining across geographic areas:

- allocation of expenditure per person (horizontal equity)
- the allocation of expenditure per person as compared to the deprivation index (vertical equity) .

Diagram 1: Proportion of PHC funding from different sources, 2001/2002

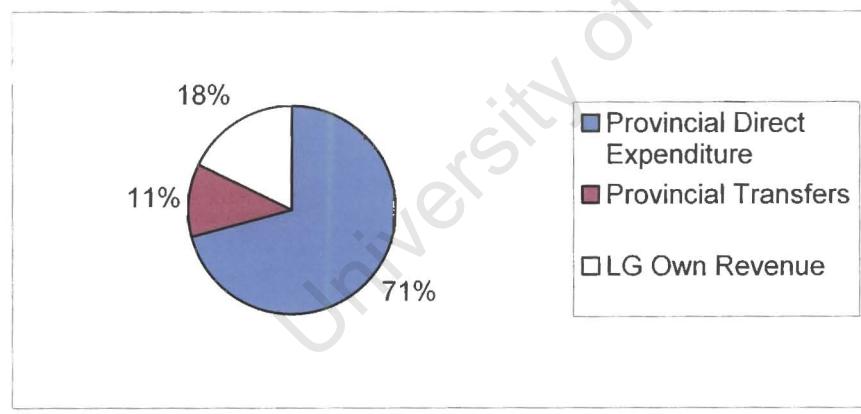


Diagram 1 shows the distribution of primary health care funds and their sources in South Africa. It brings out a number of issues. The major funding source for non hospital PHC is the provincial department of health, with 82% (when you add both

the provincial direct expenditure and the transfers) of the total funds,. Table 1 also shows that the provincial department of health provides the bulk of PHC services within districts This amounts to 71% of the money spent in district municipal areas across the country. This is counted as money used directly by the provincial departments to provide PHC services. The funding from the own revenue of District and Local Municipalities makes up only 18% of the total PHC expenditure.

Table 1: Expenditure by source for PHC

	Provincial Direct Exp %	Provincial Transfer %	Local Government Own %
E. Cape	80	11	9
Free State	62	26	11
Gauteng	57	14	29
KwaZulu Natal	77	6	18
Mpumalanga	74	9	18
N. Cape	88	5	7
Limpopo	97	0	3
North West	89	6	5
W. Cape	56	20	24
Average	71	11	18

Table 1 shows the disparities in the practice of funding primary health care across provinces. Some municipalities spend more from their own revenues for the provision of PHC within their boundaries than others. In most provinces, the money spent by municipalities to provide PHC from their own revenue is greater than the provincial transfer for the provision of PHC services at municipal level, including Western Cape, Limpopo, Northern Cape, Gauteng, KwaZulu Natal and Mpumalanga. However, the own revenue and transfer amounts are very small in Northern Cape and Limpopo and North West. The gap that would have to be funded by provinces because of the changes of the funding responsibility in the Health Act (National Health Act of 2003) is bigger in the four provinces that had strong municipalities, namely Gauteng, Western Cape, KwaZulu Natal and Mpumalanga. National Treasury has agreed to fund towards the replacement of the own revenue in the non metropolitan areas

(Interview Material). Still, the cover of the Treasury is not going to close the gap of providing the full PHC package. Thus, most of those areas need more funding to put them up to speed with the provision of the full primary health care package envisaged by the South African Government, as discussed earlier.

Table 2 PHC Expenditure Per Capita

	Provincial Direct Expenditure
EC	70
FS	47
GT	97
KZN	103
MP	40
NC	98
L	77
NW	141
WC	125
Average	90

Table 2 highlights the direct allocation expenditure by the province to provide PHC in their facilities. Mpumalanga and Free State provide very little funding compared to North West and Western Cape. Eastern Cape, Free State, Mpumalanga and Limpopo spend far less than the national average to directly provide PHC services in the health districts.

5.1 Local Government Service

There is a need to look at the different sources of financing in order to see who contributes the most for local government health services. When one looks at the allocation by source for local government health services, there are interesting results.

Diagram 2 PHC Per Capita expenditure by Source

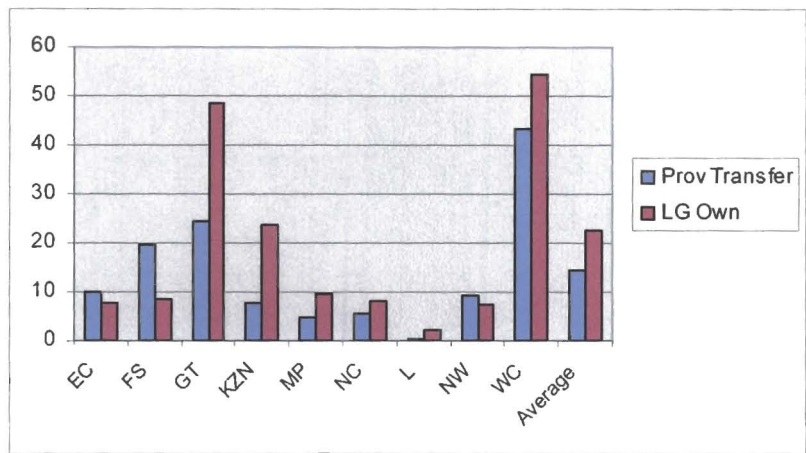
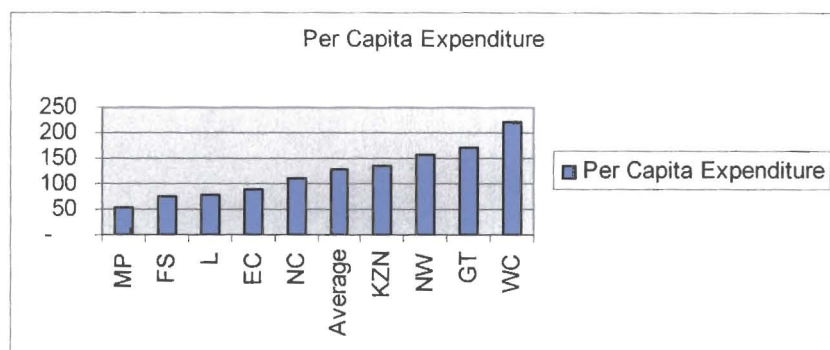


Diagram 2 shows the per capita expenditure by source to provide local government health services. In some provinces the provincial transfers are higher than own local government contribution. The provinces that had a strong local government system unsurprisingly have high own contributions from local government and higher than the provincial transfers. With the exception of Mpumalanga and Northern Cape the provinces that have more own local government revenue are the ones with Metropolitan areas. Northern Cape's higher own expenditure can be attributed to the strong local government of the Sol Plaatjie area which has the history of the diamond mine. Mpumalanga's higher own revenue contribution could be attributed to the fact that some local governments were still, illegally, charging user fees at their clinic facilities when most other provinces had implemented the abolition of user fees for Primary Health Care services.

Diagram 3 Total PHC Per Capita Expenditure (All Funding Sources)



Looking at Diagram 3, one can see that in South Africa, we are far from achieving geographical equity in the distribution of PHC funding. Four (Eastern Cape, Limpopo, Free State and Mpumalanga) out of nine provinces spend less than R100 on average on PHC. As the diagram above identifies, there is a huge gap between the highest and the lowest per capita expenditure. Mpumalanga spends around R55 on average whereas the Western Cape spends R223. The Western Cape is spending four times more than Mpumalanga for primary health care.

The total per capita expenditure figures show which provinces on average have better funding. Western Cape has the highest non-hospital PHC expenditure per capita. This is followed by Gauteng, North West and KwaZulu Natal. All of these provinces are above the national average for 2001/02 of R128 per capita expenditure. Nevertheless the per capita expenditure of the provinces above the national average are still far below the estimated resources required to provide the full PHC package of R172.4 and R224.8, according to Brijlal and Hensher (2000) and

R258.9, Chitha et al (2004).¹ Thus even the well resourced provinces will still need substantially more funding to be able to provide the full package of PHC.

In South Africa, even if the level of expenditure across provinces were to be equalised, this is unlikely to result in equal health outcomes or even what might be deemed a fair distribution of health services. This is primarily because the starting point of people is not the same. A concerted effort would need to be made to correct the inequities existing in the present system. Addressing inequities can be achieved more effectively if the overall budget is increasing. However, the real government health budget has hardly shown any increase from the mid-1990s until the early 2000s. Government budgets for health services have only been increasing since 2003/04 (McIntyre and Thiede 2007).

Table 3: Inequities within the provinces. Eastern Cape

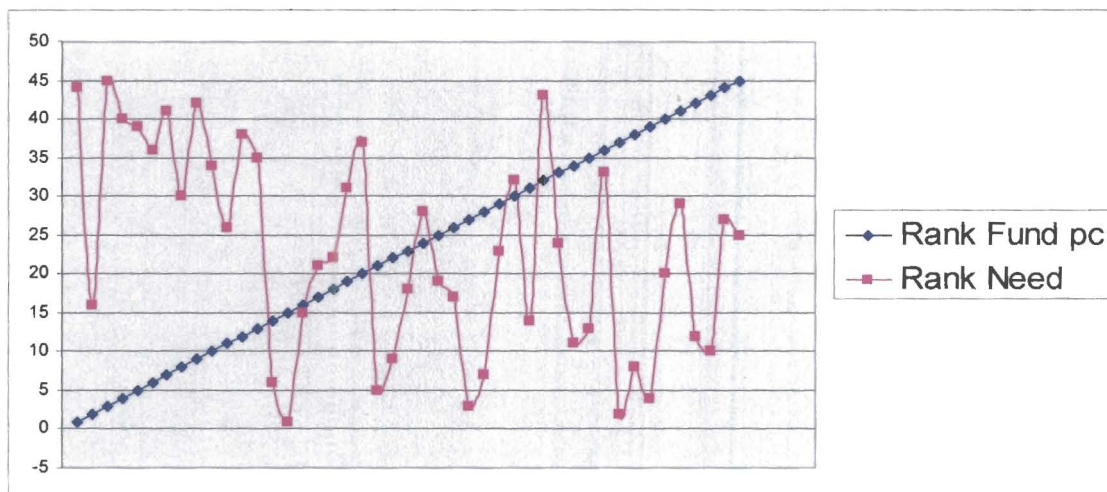
District	Per Capita Funding SA
Municipality	Rand Value
Cacadu	55.69
Amatole	110.87
Chris Hani	88.62
Ukhahlamba	39.28
O.R. Tambo	73.87
Alfred Nzo	60.55
Nelson Mandela	
Metro	118.15

¹ The main reason for the differences in the figures is that, the Chitha et al 2004 data includes the scarce skills and the rural allowances that were introduced for health professionals in South Africa. It also includes the cost of employing Community Health Workers at district level to help with home based care.

In addition, the inequities within provinces are quite another issue. An example is shown, in Table 3, which highlights the per capita expenditure in each district municipality within the Eastern Cape province. The inequities within the province are immediately apparent. Ukhahlamba District Municipality spends R39,28 compared to the R118,15 of Nelson Mandela Metro. The extent of inequities within provinces indicates that looking only at average provincial expenditures can be misleading. Redistribution across provinces will not in itself result in equal redistributions within provinces. Given more funds there is a real risk that the municipalities that are spending more now will get most of the extra funds. This is because of their greater absorptive capacity. Over the years these higher funded municipalities have built a solid foundation of skilled people and infrastructure that helps with the delivery of services.

Roads and water supplies are better in the strong local governments than the weaker ones. It will inevitably take time for the poor municipalities to gain the same level of skills. A concerted effort needs to be devoted to the poorer municipalities to build skills, to make it easier for them to attract skilled professionals to come and work with them and thereby to build absorptive capacity. A major difficulty with such a strategy is that most of the poorer municipalities are in rural areas and lack the sort of infrastructure that would attract skilled people to come and work there. Where there is a shortage of good schools, roads, electricity, network connection for mobile phones, shopping facilities and recreational facilities, it is hard to attract and retain skilled staff.

Diagram 4 Difference between Actual and Needs based Budgeting



Ideally, the two lines should move together, as they show per capita funding against deprivation across municipal districts in the country. Yet, Diagram 4 indicates an inverse relationship between the two. In general, the municipal districts that need the most are the least funded. This can be related to the budgeting practice in most provinces.

The use of historical budgeting does not help the pursuit of equity of funding at provincial level at all primarily because it does not allow provinces to allocate resources according to need. Simply adding each year of monies in line with the inflation rate, which is largely what the present system does (see Chapter 6), provides no opportunity for provinces to reallocate resources to areas where they are most needed.

Table 5:

Concentration of Resources				
	R ('000)	% of total	Population %	Over-Resourced By
Top 5	2,502,656	43	28	873 020
Top 10	3,258,955	57	42	857 620
Top 20	4,293,547	75	62	744 215
Top 5	Cape Town, JHB, Ekurhuleni, Durban and Amatole			
	(Tshwane is 6th)			

Resources are concentrated in just a few district municipalities in the country, as is shown in Table 5. The well-off district municipalities will continue to be the ones receiving most of the government funds until some real changes are made in the budgeting allocation system such as moving to a needs-based budgeting approach across the country.

Key issues raised in this Chapter

It can be clearly seen that the bulk of the provision of primary health care and funding comes from the provincial department, with 82% of the funding. When one looks at sources of funding across provinces one sees a different picture as resources varies across the provinces. There are huge disparities in the funding of PHC services between provinces. Diagram 3 highlights the alarming difference between the highest and lowest spenders (R40 in Mpumalanga and Western Cape spending just above R200). The expenditure across provinces for primary health care services is far lower than the funding required to provide the full primary health care package. The

discrepancies in funding are even worse when one looks at per capita expenditure across district municipalities within a province. Diagram 4 shows the inverse relationship between the actual expenditure and the deprivation index. In order for the expenditure trend to change government would need to phase in a needs based budgeting system in South Africa.

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Chapter 6

Actors Views on the Allocation Mechanisms

The aim of this second results chapter is to document current mechanisms of financing local government *health* services, particularly transfers from provincial health departments, and the views of key actors on these different mechanisms. In addition, it considers actors' views on the possibility of funding local government health services through direct transfers from national Treasury.

In recent years the dividing line between subsidies and agency payments has become blurred. Yet the historical experience of these different payment mechanisms, which were integrally related to whether a particular health service was regarded as the responsibility of local government or not, is of considerable relevance to the current debates on service level agreement between the municipalities and provincial departments of health. As municipal health services are narrowly defined to include only environmental health services as they are in the health act of 2003, district health services would constitutionally be regarded as a provincial function. It would still be feasible for local government to provide district health services, but this would then be on an agency basis for provincial health departments. In this case, finances for district health services would have to be allocated to provinces, which would then, through an explicit service level agreement, fund the full cost of these services as provided by local governments.

Thus, as this will continue to be the financing mechanism, this discussion indicates the importance of assessing the current system of provincial allocations to local government. It is also necessary however to consider the potential strengths and

weaknesses of direct funding from national Treasury, as this would be the most logical financing mechanism for environmental health services.

6.1 Mechanisms for determining provincial allocations to individual local governments

Interviews for this research indicate that over time the distinction between “subsidies” and “agency payments” has become blurred. For this reason all payments from provincial health departments to local governments will be referred to as “allocations” or “transfers” in the remainder of this chapter.

A range of mechanisms are used to determine provincial allocations for health services to individual local governments. In some provinces, there is a two-phase process whereby allocations are initially made from province to regions, and the regional office then determines allocations to the different local governments in that region. In other provinces, allocations to local governments are determined by the provincial head office.

Staff at two of the provinces visited indicated that, based on indicators of the relative need for health services in the different local government areas, they were making some, even if limited, attempt to introduce mechanisms for promoting an equitable distribution of resources. In one province the indicator used is the population size of each municipality. In the other province the size of the population not covered by medical schemes is the indicator.

Despite these two efforts to introduce an element of equity into the allocation process, all provinces indicated that historical distribution patterns still play an important role in determining the allocations to local governments. In one province, budgets for each local government's allocation were based entirely on historical

allocations (e.g. adding 6% as an inflation adjustment to the previous year's budget), with the final payments being adjusted to take some account of utilisation statistics and expenditure claims. In the two provinces that have introduced some indicator of need into the resource allocation process, the number of facilities and type of services provided still play an important role in determining allocations. While adjustments based on these factors are necessary to take account of historical agency agreements (e.g. to cover the additional costs of providing curative services in certain municipalities where this had been negotiated with the former House of Representatives), they do have the effect of perpetuating both historical patterns and existing inequities in service provision.

In those provinces that rely entirely on historical budgeting processes, payments to local governments are often still linked to individual staff posts. This creates two problems. Firstly, if the post becomes vacant and is not filled within a certain period, the cost of that salary is removed from the provincial allocation to the local government. If there is substantial staff turnover in a relatively poor municipal area where it is difficult to attract new staff, over time, the allocation to this local government will decline, hence exacerbating inequities between this and other better resourced municipalities. Secondly, this mechanism of determining allocations can heighten conflict with respect to salary scale differences between provincial and local governments. As noted by one local government official, *"province would negotiate that we will pay for 3 nursing posts, 4 nursing assistants ... at this clinic ... and it would be at provincial salary and you know you will pick up the difference."*

In contrast, allocations to local governments in those provinces that are attempting to apply a more equitable allocation process take the form of 'block transfers'. The funds are no longer tied to specific posts, but can be used, along with resources provided from the municipality's 'own revenue', for the general provision of health

services by that local government. However, some of these transfers may be earmarked for specific services (e.g. HIV/AIDS services). In addition, certain provinces have moved away from the unlimited provision of free drugs to local governments. Instead, part of the allocation is earmarked as a drug budget from which local governments can order drugs from the provincial depot. This funding mechanism makes explicit the hidden value of the subsidy local governments are getting from the provincial governments through free drug supplies and has been introduced to promote better management of drug utilisation by local governments. A local government manager viewed this as a positive move, offering the following explanation: *"Before, the laboratory costs, reproductive health services, family planning stuff and medicines, including TB medicines and obviously vaccines had all been free to local government, and we would just draw from the central store. Province had to pay ... and that means it was a bit like Father Christmas ... There was no motivation for us to manage what was going on ... We didn't know what was going on. So nobody had any idea what medicines were being used and what was happening, so it was a recipe for disaster."*

6.2 Strengths of the system of provincial allocations to local government health services

The majority of provincial officials interviewed indicated that the key benefit of the present financing mechanism is that it gives provinces some control over local government health care services. They see the need for such control in terms of ensuring that national policy is implemented within the local sphere of government. These views indicate some possible reluctance on the part of local government health departments' to provide health services in line with the national policy framework. This reluctance is exacerbated by the 1977 Health Act which makes provision for the national health department to issue directives to local governments

in relation to health service provision, reflecting a view of municipalities as a "lower level" of government. Ideally however municipalities, as a distinct sphere of government, should have relative autonomy in deciding on service provision within the parameters of national policy guidelines.

Strength of the current financing mechanism is that it facilitates appropriate interaction and referral patterns between the different levels of health services allowing for co-ordination of the provision of all health care services in an integrated manner. As one provincial health official noted, *"I think that the funding needs to be channelled via the provincial health department simply in order to try and ensure that the entire health system still hangs together. You can't have a primary care service which is running completely independently of the hospital services"*.

Some interviewees also suggested that the current financing mechanism enhances financial sustainability. This is because local governments have an indication that a certain amount of money will be provided by the provincial health department every quarter to enable it to provide the minimum basic health services to its communities.

Some local government treasury officials suggested that the current system is administratively easy as money is claimed on a quarterly basis from the provincial health department. There is a perception that it would be more difficult and time-consuming to interact with the national Treasury. Furthermore, a number of interviewees felt that it was easier for each province to deal with local governments within its geographical boundaries than for the national government to deal with all the 285 local governments in the country. However, these views do not take into account the fact that national Treasury already allocates resources directly to all local governments under the Division of Revenue process. Thus, systems already exist within the national Treasury. To use these would require simply the inclusion of

health services in the 'equitable shares' allocations from national Treasury to individual local governments.

Finally, some interviewees suggested that the current financing mechanism has the *potential* to allocate resources for local government health service provision in an equitable manner. It was argued that provinces are more aware than national Treasury of the 'own revenue' generation potential of different local governments and can more easily identify those with the greatest need for subsidy allocations.

6.3 Weaknesses of the system of provincial allocations to local government health services

Despite the numerous strengths of the current system of provincial allocations identified by respondents, provincial and local government interviewees also had considerable concerns about the existing mechanism. Both provincial and local government officials indicated that although there was the *potential* for equitable allocation of resources, currently equity goals are not adequately taken into account. This is due to the heavy reliance on historical budgeting. In particular, the needs of the communities in individual municipal areas are not appropriately considered in the present financing mechanism. Some interviewees argued that it was not only population size that should be taken into account, but also morbidity and mortality patterns and the socio-economic status of communities (which influences of course inter alia the local government's ability to generate its own revenue). One provincial official commented as follows: *"I think the weakness of focusing on history is that it overlooks some of the new developments, and maybe also if we could look at the disease profile of particular areas, maybe it would be better ... we need a tool to measure or decide what we can allocate to a particular local authority and also to look at the needs that are in that area, not only to focus on the number of facilities because*

when you focus on that number, are you sure that there is equitable distribution of those facilities amongst different local municipalities? So I think that is the weakness because mainly we will focus on history."

The historical budgeting system can promote inefficiency in that it rewards "bad managers" who incur high levels of expenditure in order to argue for higher allocations from provinces. This is clearly at the expense of those who control their spending. A national Department of Health official suggested that one way in which equity and efficiency could be enhanced is by provincial health departments gradually redistributing resources and strengthening capacity to ensure that each local government is able to provide a comparable package of primary care services.

The major concern on the part of provincial health department officials is that the current system does not permit adequate monitoring of local government health services. A provincial manager explained the problem as follows: *"... all these payments to local government are made in terms of the Health Act of 1977 and those few little clauses that are in there doesn't define how much is meant to be paid, it doesn't even really define what we are paying for. It doesn't define any monitoring mechanisms. All it requires is they put in a claim to say- that they have spent more than that amount of money and that's all that they prove to us that they have spent more than that amount of money"*. Some provincial officials claim that local governments do not use the provincial allocations only for health services but fund other sectors as well with these resources. This may well be the case given that provincial payments are made to local government treasuries rather than directly to local government health departments. In addition, the existing format for quarterly local government reporting, which is based on specifications in the 1977 Health Act, does not make provision for adequate monitoring of health services provided by local governments, or of health status. This format is very detailed but much of the information is not appropriate for

the purposes of monitoring. While provincial managers feel that the end result is that monitoring is inadequate, Klugman and McIntyre (2000) noted that some local government health managers feel it is not so much inadequate as inappropriate. This is because they are primarily accountable to their local councils. One interviewee in the Klugman and McIntyre study argued as follows: *"Province provide 17% of my total health budget so I can't be monitored by another authority who provides a small proportion of my budget"*.

From the perspective of local government, a number of concerns with the present system were identified. As the quarterly payments to local governments are paid in arrears, many local governments experience cash flow problems in relation to health service provision. This is exacerbated in some provinces where there are considerable delays in paying these quarterly instalments. One local government Treasury official indicated that *"In the past there has been a few problems and the [provincial] department also has got cash flow problems and then sometimes you have to wait for your money, and that means that the municipality must go into overdraft to subsidise the salaries of the people in the health department and maybe next year, after we have paid a lot of interest on the overdraft, we only get the money then"*. Local government officials indicated that there were particular problems with securing payment near the end of the provincial government's financial year. The quarterly payments were in some cases delayed even more than usual while in other instances the payment was arbitrarily cut by the province.

There was some agreement across interviewees that recent efforts to establish performance agreements between provincial and local government health departments were a positive step and would resolve some of the problems outlined above. From the provincial perspective, there would be improved monitoring of local government services as the agreements could specify a more appropriate set of

reporting requirements than under the 1977 Health Act. In addition, provincial obligations for funding contributions to local government health services would be specified, which might then promote greater security in this regard.

Summary of the strengths and weaknesses of the Provincial allocations

Strengths	Weaknesses
• Province have control over local government health care services • Facilitates appropriate interaction and referral patterns between levels of health services • It has potential to allocate resources in an equitable manner	• Equity goals are not adequately taken into account due to heavy reliance on historical budgeting • It does not permit adequate monitoring of local government services. • Cash flow problems

6.4 Key issues in relation to 'own revenue' funding of local government health services

While provincial allocations are an important source of funding for health services in some local governments, interviewees noted that in metropolitan areas, an average of two-thirds and as much as 90% of expenditure on local government health services are financed from 'own revenue'. Thus it is also important to consider the decision-making process for the allocation of 'own revenue' between the health and other local government departments.

The process followed by local governments was described by a municipal Treasury official as follows: *"We have certain guidelines which we get from Pretoria each year which tells us that your general cost may only increase by this, your maintenance may increase by this, and in total your budget may only increase by a certain percentage."*

And then during the budgeting process, all the departments can come to us and they tell us from this year's budget what they will need next year, which is basically in some instances a wish list, and then the moment when we go and put all those things together and we see that the municipality budget is growing say by 15% and the guideline is only 7%, then we will have to go back to all those directors and tell them "listen between the lot of you, you will have to cut X million" and then they will have to prioritise and cut where necessary to meet those standards that are laid down by the people in Pretoria". There is reportedly a heavy reliance on historical budgeting in determining the allocation of local government resources to the different sectors. The final stage is the approval of the municipal budget by its Council. The budgeting process is led by the local government treasury. However, the final decision is taken by the local government council.

Klugman and McIntyre noted that some health departments are under considerable pressure when competing with other departments for a fair share of their local government's budget. This departmental resource competition has been made more difficult by the continuing debates over the constitutional definition of municipal health services. As one local official explained: *"Departmental heads think provinces should just take over [health services] and pay. We think the municipality should pay more [towards health services] but the department heads don't like this. Politicians don't seem that aware of this issue."* A number of interviewees in the current study indicated that local government councillors are very unclear on what health services are the responsibility of and are provided by their municipality. This then limits their ability to make informed decisions about the allocation between health and other local government departments.

There was considerable concern that if municipal health services were defined as including all district health services, local governments would be expected to fund

these fully out of their 'own revenue' and would not be able to do so. However, this concern appears to be unfounded as the constitution explicitly makes provision for each sphere of government to receive an equitable share of nationally collected revenues to enable it to perform its constitutional responsibilities. A large portion of the future integrated district health services is currently funded through transfers from national Treasury to provincial governments. If district health services were to become the responsibility of local government, local government fears could be allayed through reducing the provincial share of national resources (by the value of current spending on district level health services) and increasing the local government share of national resources by the same amount.

The process of local government budgeting is set to change dramatically with the move towards Integrated Development Planning (IDP). The IDP is a participative process involving a range of stakeholders whereby municipalities develop a strategic development plan, which is intended to guide all planning, management and decision making in the municipality (Department of Provincial and Local Government 2001). The IDP covers a five-year period in line with the period that the council will be in office. It should explicitly outline the development priorities of the municipality, (which should be based on the needs of the community), and thus serve as a guideline for the strategic allocation of resources in pursuit of these priorities. The IDP should be reviewed annually to respond to changing needs and circumstances.

It is anticipated that the IDP process will promote a move away from historical budgeting processes towards a more equitable and rational allocation of local government resources to health services and to other local government services such as housing, water and sanitation provision (which also have important health effects). As one local government health official explained: *"We must remember that local Government, as it is now, is not the animal that it was three years ago. So before*

in a sense it was a big bureaucratic thing that basically delivered services itself. It took the refuse away and it got the water there, got the electricity and all that. Now it is very different and it is very developmental and it is driven by an Integrated Development Plan, which fits in perfectly with the kind of intersectoral approach of primary health care”.

Against this background on the prospects for the IDP process, it is noteworthy that, although preparation of an IDP by each local government is a legal requirement under the Municipal Systems Act of 2000, only one of the municipalities interviewed claimed to have an IDP in place.

6.5. ALTERNATIVE MECHANISMS OF FINANCING OF LOCAL GOVERNMENT HEALTH SERVICES

It is clear that there is considerable dissatisfaction among some local government officials with the current system of health care financing, particularly with respect to allocations from provinces. Local government officials interviewed in another research project raised the possibility of replacing the provincial allocations with direct allocations from the national Treasury by including health services in the 'equitable shares' formula (Klugman and McIntyre 2000). Direct allocations from national Treasury would be particularly relevant if municipal health services were ultimately to be defined broadly to cover district health services. The potential strengths and weaknesses of this alternative financing mechanism are considered below.

6.6 Potential strengths of direct funding from national Treasury

Direct financing of local government health services by national Treasury was regarded by some as being likely to reduce cash flow problems. Some local government officials indicated that they trust national Treasury more than provincial authorities to release the money that is due to them. This stems in part from the suspicion that regional politics influence the distribution of provincial resources to local governments and the perception that this would be less likely to occur in allocations from national Treasury. This is particularly so given that national allocations are based on a transparent 'equitable shares' formula. The relatively greater trust in the national Treasury also stems from the experience of arbitrary cuts in provincial allocations to local governments and frequent delays in payments. One local government official argued as follows: *"if you are running the money through the Province, there is a danger, and that is another reason why a national decision is better, because if Province is under-resourced or has constraints, it might want to try and steal from us, and it does presently. ... I think the reason why there is greater trust with national is a sense 'well they have really got the money' ... at least they won't go bankrupt"*. In addition, national Treasury would transfer the full amount budgeted at the beginning of the financial year, as opposed to the current process of quarterly payments in arrears from the provinces.

This financing mechanism could also improve the monitoring of expenditure by local government health managers. As these managers would know in advance how much they were to receive, they would be able to monitor routinely expenditure against the budgeted amount.

Interviewees indicated that another important potential benefit of direct funding of local government health services by national Treasury would be that it would simplify

financial administration and accountability. The local government treasury would only have to interact with the national Treasury around an integrated 'equitable shares' allocation. This is considerably simpler than the current process of engaging with national treasury for an allocation for basic services excluding health services, as well as with provincial health departments and treasuries for health service allocations. One interviewee indicated that they "*would prefer that the national government or national treasury puts the money directly into the coffers of local government for the purposes of running those services, because the transfer of funds to province and then from province to local, it is a lot of administration and I don't think it is necessary*". In addition, as national allocations occur at the beginning of the financial year, local governments would not need to submit quarterly reports to provinces to secure the next quarterly health service allocation.

Accountability mechanisms would also be streamlined. At present, local governments are required to account to the national Treasury for the 'equitable shares' allocation they receive for providing basic services, to the provincial Department of Health for health service allocations, and to their own Council for expenditure funded from 'own revenue'. Under the alternative mechanism, there would only be expenditure accountability to national Treasury and the local government Council. The role of Provincial government would then focus on monitoring the implementation of national policies, including health sector policies, as stipulated in the constitution.

One of the most important arguments presented by interviewees in favour of a change in the mechanism of financing health services is that it would promote comprehensive and integrated planning and would enhance local government's ability to deliver the full range of basic services. Consolidating financial allocations would appear to be an appropriate response to the stated policy of devolving

authority, particularly given that municipalities comprise the sphere of government closest to communities and are arguably in the best position to assess and meet the needs of the population in relation to basic services. This argument is strengthened by the legal requirement that local governments develop an IDP to ensure that resources are used to achieve identified priorities for the community served. Local governments would be held accountable for both the use of resources and the extent to which IDP priorities are achieved, not only by other spheres of government but also by the communities they serve.

Direct financing from national Treasury is also seen as being critical in speeding up the process of improved delivery of local government health care services, in terms of both the quantity and quality of services. There would be longer term planning under the IDP, strengthened by greater certainty about future allocations, which would enable local government health managers to plan for health service improvements well in advance and to have greater flexibility in responding to the changing needs of the communities they serve. They would not be constrained by the current bureaucratic system whereby permission has to be sought from the provincial health department to buy equipment or additional supplies that are needed for health care delivery. A number of local government interviewees complained of the lengthy process of submitting a request to the regional or district office which is then passed on to the provincial head office resulting in excessive delays in securing basic service delivery resources. Instead, local government managers would have full control, responsibility and accountability over the health budget and would be able to use it to respond to urgent service delivery needs.

The final argument put forward by interviewees in favour of direct funding from national Treasury is that it has considerable potential to achieve equity between local governments. Under the present system of provincial allocations, there is the

potential to achieve equity in local government health services *within* each province. However, each province has the autonomy to decide how much of the provincial health budget will be devoted to supporting local government health services. Thus, even if provinces moved away from a historical budgeting system to one that takes account of a full range of indicators of relative health need in each municipality and differential ability to generate 'own revenue', significant inequities would remain between local governments in different provinces. If the existing 'equitable shares' formula used by national Treasury for allocations to local government were revised to include a health services component, it would be feasible to promote equity in local government health services throughout South Africa.

6.7 Potential difficulties/weaknesses of direct funding from national Treasury

There were considerable concerns about changing the existing financing mechanism, particularly among provincial health officials as well as national Department of Health and Treasury officials. Some of these concerns were based on misconceptions about how the process would work. For example, most of the provincial interviewees raised the difficulty of monitoring local government health services if money were transferred directly from national Treasury. Most were of the opinion that this would mean that the national Department of Health would be responsible for monitoring their services, which would only be feasible through a return to the old system of regional offices of the national health department in each province. In fact if resources were allocated directly from national Treasury, local governments would be accountable for the expenditure through the normal government auditing processes. Additionally it is relevant that the constitution clearly stipulates that provincial government has an important role to play in monitoring the implementation of national policies.

Another misconception relates to the mechanism for allocating resources to local governments. Some provincial interviewees were concerned that national Treasury would allocate health service funds to both Category B and C municipalities. As explained by one interviewee, *"my understanding from the people in national treasury is that that then gets divided between all the local authorities whether the local authority is delivering a health service or not As you know especially in the rural areas you have got B and C municipalities which are covering the same area and it would be silly to be giving both Bs and Cs health money"*. However, the national Treasury clearly states in its 2001 Budget Review that the 'equitable shares' allocations "are made to all primary municipalities" (National Treasury 2001) and generally go directly to Category A and B municipalities. Allocations are only made to Category C municipalities when there is either no Category B municipality in a particular area falling under the Category C municipality, or where a Category B municipality is institutionally weak and as a result the Category C municipality provides basic services on its behalf.

Another concern expressed by provincial and national health department interviewees is that changing the financing mechanism could result in a lack of co-ordination and integration of service delivery between province and local government. Provincial interviewees were concerned that they would lose control over local government, as they currently use finances as a mechanism to ensure that local governments comply with their directives. In particular, it was indicated that local governments would provide services in an autonomous fashion, which might not be in line with the national policy, vision and goals. This suggests inadequate understanding of the constitutional framework which requires that local government policies must be in line with the policies of national and provincial government, and that the different spheres of government work together to deliver services to the

population. In addition, the IDP process stipulates that each municipality's IDP must be developed in consultation with the other spheres of government.

A further concern is that the potential for 'dumping' patients on, or inappropriate referral of patients between, health facilities administered by another sphere of government might be increased. One local government official argued that, *"particularly with the fact that we understand that there is going to be a potential cut of the academic funding and then you are going to start to see people pull back on the other resources potentially. And of course all the more worrying perhaps, when you do devolve the District Health system to the local government, will be that then it is seen as 'we' and 'them', and Province starts to think "oh well we can kind of put the financial pressure on local government because they can just meet it from somewhere else and we want to protect our services". ... What is the real downside of the District Health System is potentially this kind of playing off ... The Regional Hospitals kind of dumping patients back into the district hospitals or into the primary health care services"*. There is also the potential for the reverse to happen; local government clinics that are facing a budgetary crisis might refer patients with minor ailments to provincial hospitals, thereby cost shifting to another sphere of government.

The final concern from the perspective of national and provincial health department interviewees was the potential for local government health care services to lose out to other sectors in the municipal budget negotiations. If health services are included in the 'equitable shares' formula, the national Treasury would make a block grant to each primary municipality. This would be combined with 'own revenue' and each local government department would have to bid for a fair share of these resources. Interviewees fear that health might receive a relatively smaller budget than it does currently, while other local government departments might receive relatively higher budgets. However, some local government interviewees felt that the health

department would in fact be awarded a high priority in IDPs. They also pointed out that even if the health service budget declined, if the additional resources were allocated to services such as water, sanitation and housing this might ultimately translate into even greater health status improvements for the community served by that municipality. This was supported by one provincial manager who argued: *"I would think that if the local authorities have any spare money they should be pouring it into housing and basic services. I think that would have a far better outcome on health status"*.

There were two major concerns expressed by national Treasury officials about including health services in the 'equitable shares' allocation. Firstly, it would be logistically difficult to implement in the near future due to the information requirements. As there are considerable differences between municipalities in the type and range of health services provided, with some municipalities' not providing health services at all, detailed information on health service provision in each municipality would be required.

Secondly, national Treasury officials, as well as national and provincial health department interviewees, were concerned about local government capacity to provide health services. Treasury representatives expressed a very strong view that the process of restructuring local governments has been difficult and that many local governments have limited capacity and have inherited large debts. Local governments are struggling even to begin to put basic services in place and addressing the challenge of equitable provision of water, sanitation, housing, refuse removal and electricity should be the priority as these services are constitutionally specified as the main competency of local government. On this basis, it is argued that local government must be given adequate time to develop its capacity and to establish the above-mentioned basic services before they are expected to assume

full responsibility for all primary health care services. Decentralisation of district health services to local governments would be accompanied by a transfer of some provincial staff to local government which would enhance the capacity of local government level to deliver health services. However, there is still a concern that this added responsibility would detract from developing local government capacity to deliver water, sanitation and other essential municipal services.

One provincial interviewee highlighted that it is not only capacity for service provision that is required. *"I would say that ... the fact of the matter is that there is not yet capacity in local government, particularly to deal with such a big responsibility because it is a big responsibility once you say "transfer it straight to local government", but eventually that is how it is supposed to happen. In my opinion, eventually money must go straight to local government and local government must use the money, but before you do that there has to be capacity. We have to have people that will fight for this money and say "this money must be used for this. Health must get this chunk" and so on, but until we have that capacity I wouldn't feel comfortable saying money must go straight"*.

Chapter 7

Conclusion

The funding data outlined in the thesis reveal extensive inequalities across provinces and across municipalities in South Africa. There is a need for a concerted effort to build capacity and strengthen the existing capacity where it exists within Health Districts so that they will be able to use anticipated extra resources in the future. It appears that it would not help to give more money to areas which, because of a lack of management structures and basic infrastructure, cannot absorb such funds.

It also emerged that the process of signing Service Level Agreements has created some confusion in most municipalities. People working at local government health clinics are not clear where their future lies until the process has been finished. Both National and Provincial Departments of Health have to work very closely with Municipal Authorities to build the capacity of managers and providers at the District level.

There are diverse views on the pros and cons of the existing system of financing local government health services and of direct financing from national Treasury. Some interviewees in local government felt that it was administratively easier to deal with provincial authorities; others that it would be simpler to deal with national Treasury. Some felt that there was relative stability of funding from provincial health departments; others felt that this was not the case and that there would be greater security if resources were allocated from national Treasury.

Despite these divergent views, there does appear to be considerable support across spheres of government and cogent arguments in favour of integrating health service funding into the 'equitable shares' allocations from national Treasury in future. However, it will take time before this will be feasible. Given the vast differences in

health service provision by local governments, it is logistically difficult to gather all the data required to allocate appropriately health service resources between local governments from a national level at present. Possibly of even greater importance is that the National Treasury itself appears to be opposed to this change in financing mechanism. As they are the organisation that would have to implement this change, their support is critical. National Treasury have a valid concern about the capacity of local governments to improve basic services at the same time as taking on considerable responsibility for health service provision. However, it may be feasible to adopt a staggered approach to implementing direct financing of health services from National Treasury, starting with metropolitan municipalities where there is already greater capacity to deliver both basic services and a wide range of primary health care services.

In other municipalities, it will be critical, in close co-operation with the respective provinces, to expand gradually the amount and range of primary health care services provided. This will serve to ensure greater uniformity between municipalities in the package of health services delivered. Once this has been achieved, it will be logistically feasible for National Treasury to include health services in its equitable share allocation to local governments, as all municipalities will be providing comparable health services. The extent to which this will occur in the near future is heavily dependent on resolving debates about the definition of municipal health services and the future of district health services. If, or when, direct transfers for municipal health services from National Treasury are initiated, it will be essential to agree appropriate referral mechanisms between local government and provincial health services to prevent inappropriate cost-shifting between spheres of government.

There appears to be consensus among interviewees that there are considerable problems with the existing system of provincial allocations. Given that this system is likely to continue for the foreseeable future, efforts should be made to improve this system as a matter of urgency. In particular, there should be serious consideration of mechanisms for building equity considerations into the allocation process in all provinces, such as taking into account the relative needs of communities in each municipality for primary care services and the differential ability of local governments to generate 'own revenue'.

The gradual shifting of resources to historically disadvantaged areas should be accompanied by efforts to develop capacity at local government level to provide a more uniform package of primary health care services. The cash flow and administrative workload problems associated with quarterly payments in arrears could also be addressed through moving to a single payment at the beginning of the financial year, accompanied by explicit guidelines on reporting to ensure accountability and for monitoring purposes. Ultimately, all of these changes require a move towards the system of inter-governmental relations envisaged in the 1996 constitution, whereby a collaborative relationship between the three spheres of government exists.

Limitations, Action Taken and Suggestion for future research

The major limitations of the study related to data. Certain provinces did not keep data according to the format that was required for this study and were unable to provide the information needed. The candidate had to physically go to those provinces and work with relevant department officials to collate the data according to the format of the study. Further research is needed in this area to broaden the understanding of the concepts and difficulties in the actual implementation of equity in a fiscal federal system. Research should be done on absorptive capacity to see what is needed to be able to use extra resources allocated to the provinces and district health services.

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LOCAL GOVERNMENT HEALTH CARE FINANCING

INTERVIEW SCHEDULE

INTRODUCTION

The Health Economics Unit (HEU) at the University of Cape have been commissioned by the Health System Trust to undertake the above-mentioned study. This is a short term project running to the end of September 2001. The HEU and CHP research is primarily directed at compiling data for the 2001 South African Health Review (SAHR). The central focus of the project is on documenting current and future alternative health care financing mechanisms at local government level, with a particular emphasis on recording the views of key Department of Health and Treasury actors in the different spheres of government. Data collection will be undertaken at national level and in a sample of provinces and municipalities.

NATIONAL DIRECTOR OF DHS & Deputy Director General

- What is your interpretation of municipal health services mentioned in the constitution?
- Where do you see future of DHS?(is it with local government or provincial department of health)
- Is the local government approach feasible?(taking account of differential local governments capacity to provide health services in the short term)

- How long does the Department think it is going to take to align DHS with local government?
- The National DHS Committee: what is its role and power?
- What is your understanding of how local government health services are currently financed?
- What are the strengths and weaknesses of the current procedure of local government health care financing?
- In your opinion, what is the best mechanism for financing local government health care services in the future?
- What are the strengths and weaknesses of that mechanism?
- Is there a process of formulating norms and standards for municipal health services financing?
- How do you see the relationship between the three spheres of government?(In terms of ensuring co-ordinated and integrated health services)

National Health Director of Financing

- What is your interpretation of municipal health services mentioned in the constitution?
- What is your understanding of how local government health services are currently financed?
- What are the strengths and weaknesses of the current procedure of local government health care financing?
- In your opinion, what is the best mechanism for financing local government health care services in the future?
- What are the strengths and weaknesses of that mechanism?

- Is there a process of formulating norms and standards for municipal health services financing?
- The National DHS Committee: what is its role and power?
- Is the local government approach feasible?(taking account of differential local governments capacity to provide health services in the short term)
- How do you see the relationship between the three spheres of government?(In terms of ensuring co-ordinated and integrated health services)

NATIONAL TREASURY

- What is your interpretation of municipal health services mentioned in the constitution?
- What is your understanding of how local government health services are currently financed?
- What are the strengths and weaknesses of the current procedure of local government health care financing?
- In your opinion, what is the best mechanism for financing local government health care services in the future?
- What are the strengths and weaknesses of that mechanism?
- Could you tell me/us about the constraining and facilitating factors in the allocation of resources?
- Do you think it is feasible for local governments to be fully responsible for DHS?

- **PROVINCIAL HEALTH REPRESENTATIVE**

- What is your interpretation of municipal health services mentioned in the constitution?
- Could you tell us about the health services provided by municipalities in your province? (is it an integrated health care system or is still fragmented)
- How do you see the relationship between the three spheres of government?(In terms of ensuring co-ordinated and integrated health services)
- When deciding on the allocation of resources/subsidies for LG, how do you decide how much is set aside for LG health services?
- How is the allocation of these funds to individual LGs determined?
- What are the strengths and weaknesses of that procedure?
- How do you feel about the contribution from the LG own revenue for LG health services?
- In your opinion, what is the best mechanism for financing local government health care services in the future?
- What are the strengths and weaknesses of that mechanism?

LOCAL GOVERNMENT HEALTH PERSON

- What is your interpretation of municipal health services mentioned in the constitution?
- Could you tell us about the health services you provide?
- How do you see the relationship between the three spheres of government?(In terms of ensuring co-ordinated and integrated health services)

- What are your views on the provincial allocations (amount set aside for LG health services and allocation between LGs)?
- Is your department able to obtain a fair share from the LG own revenue?
- In your opinion, what is the best mechanism for financing local government health care services in the future?

What are the strengths and weaknesses of that mechanism?

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Appendix B

Interview Consent Form

Project: Financing Local Government Health Care Services in South Africa

I, _____ hereby agree of my own free will to participate in the interview with the research team from the Health Economic Unit on the above mentioned project. I have agreed to participate in this exercise with full understanding of my rights, as regards this interview, and acknowledge that:

- The information from the interview is to be used for the sole purpose of complementing the research project conducted by the HEU.
- I reserve the right to pull out from this exercise at any point.
- The sources of information for this part (interview) of the research project shall not be revealed; no names will be used in the report of this project.

Signature.....

Date.....

University of Cape Town