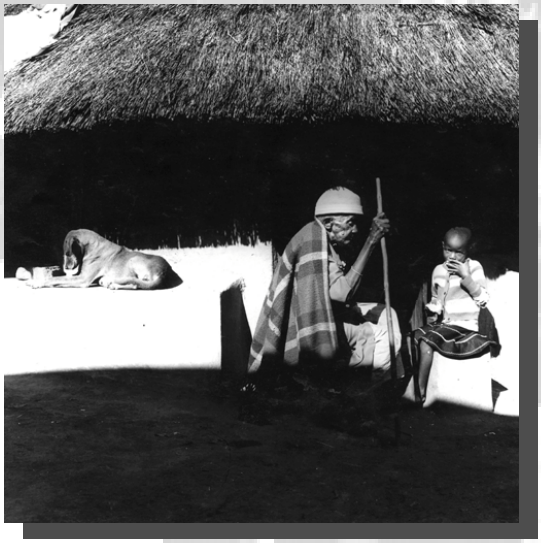
DECENTRALISING HEALTH SERVICES IN SOUTH AFRICA: Constraints and Opportunities

- a crosscutting report -



DECENTRALISING HEALTH SERVICES IN SOUTH AFRICA: Constraints and Opportunities

- a crosscutting report -

compiled by
The Local Government and Health Consortium

April 2004

The Local Government and Health Consortium is a programme of monitoring and research work, funded by Health Systems Trust, which was developed and conducted between 2001 and 2003.

HEALTH SYSTEMS TRUST

Centre for Health Policy

Health Economics Unit
University of Cape Town

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FOREWORD

THE ROLE OF THE LOCAL SPHERE IN THE NATIONAL HEALTH SYSTEM

This publication is timeous as it is published in the 10th year of freedom. It is therefore well placed to assess what has been achieved in the first 10 years of democracy with respect to one aspect of a massive project, that is the creation of a national health system (NHS). The project was first described in detail in the ANC's National Health Plan for South Africa (1995), and in an abbreviated form in the Reconstruction and Development Plan (1994). The frameworks presented in these documents were later included in a policy framework on the district health system (DHS) in 1995 and in the first major comprehensive policy paper of the Department of Health in 1997 – the White Paper for the Transformation of the Health System in South Africa.

The White Paper refers to the RDP in outlining the long term goals and role of the health district: "The goal outlined in the RDP is to have a single NHS, based on a district health system that facilitates health promotion, provides universal access to essential health care and allows for the rational planning and appropriate use of resources, including the optimal utilisation of the private health sector resources".

The White Paper listed 12 principles that should underpin the development of the DHS, proposed 5 implementation strategies and listed a range of functions for a health district. Critically the White Paper suggests that the package of health care services provided by a health district "will be subject to the outcome of negotiations between the province and a municipality in terms of the constitutional right of municipalities to render municipal health services".

Noting that a single governance model will not be possible in the short term for a variety of now well known reasons the White Paper provided three governance options for the DHS: the provincial option; the statutory district health authority option and the local government option. For the latter option to be realised two conditions were listed: (a) the boundaries of the municipality had to be the same as that of the health district; and (b) the municipality had to have the capacity to render comprehensive services.

This publication needs to be read against the backdrop of the project of the creation of the DHS as the foundation of the NHS. It should also be viewed against the challenges of massive transformation of the state and all of its organs of governance within a relatively short period of time by a cadre of relatively inexperienced (in governance and management) politicians and technocrats.

That an NHS is well on the way on, an admittedly bumpy, road cannot be denied. Rather sophisticated policies have been developed on a range of issues but it is often said by supporters of the party in power and its detractors that implementation has not been easy. A reading of this publication points to some of the reasons why implementation of the DHS in particular and the creation of an NHS in general has been difficult.

The publication calls for a review of the decentralisation vision with specific reference to issues of quality and the role of municipalities. It also reiterates the need to locate this project in the vision presented in Alma Ata in 1978. Given that planning and delivering health services necessarily involves multiple stakeholders within and outside of government, it is critical that this document is studied by all stakeholders and that it is used as a resource to review what has been achieved in the first 10 years of democracy and to plan what type of health system we should be developing in the next 10 years.

Dr Yogan Pillay
Chief Director: Strategic Planning
National Department of Health
6th March 2004

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The members of the LGH (Local Government and Health) Consortium participated in compiling chapters for this integrative or "crosscutting" report, based on the outcomes of their respective pieces of LGH research work. Particular mention is made of Lucy Gilson from Centre for Health Policy who compiled chapters 7 and 8 – the Synthesis and Recommendations.

Health Systems Trust (HST) staff edited and laid out this report. The Consortium members are particularly indebted to Fiorenza Monticelli and Halima Hoosen in this regard.

Mention should be made of HST's original two project champions – Dr David McCoy, the founding Project Manager, and Mr David Mametja, HST's Chief Executive Officer. We trust that this report, together with the research reports from which chapters 1 to 6 are drawn, are adequate reward for their vision, enthusiasm and contributions.

Finally, the work on which this report is based has involved many health workers, municipal officials and councillors from throughout the country. They have acceded to our requests for time and information, offering insights from their experiences, knowledge and wisdom. Without them our findings would be much the poorer!

ACRONYMS

CHC	Community Health Centre
CHP	Centre for Health Policy, University of Witwatersrand
CPS	Centre for Policy Studies, Johannesburg
DHC	District Health Council
DHS	District Health System
DM or Dist Munc	District Municipality
DPLG	Department of Provincial and Local Government
EHS	Environmental Health Services
HBC	Home-based care
HEU	Health Economics Unit, University of Cape Town
HST	Health Systems Trust
IDP	Integrated Development Plan
ISC	Inter-sectoral Collaboration
ISRDS	Integrated Sustainable Rural Development Strategy
LG	Local Government
LGH project	Local Government and Health project (see Preface Background - sixth paragraph)
LM or Loc Munc	Local Municipality
MCWH	Maternal, Child and Women's Health
Metro	Metropolitan (category A) Municipality
MHS	Municipal Health Services
MinMEC	Meeting between the national Health Minister and provincial Members of Executive Council for Health
NDoH	National Department of Health
NDoT	National Department of Transport
NGO	Non-governmental Organisation
NHA	National Health Act (awaiting President's signature)
NHB	National Health Bill (Sept 2003 version)
PDoF	Provincial Department of Finance
PDoH	Provincial Department of Health
PDoT	Provincial Department of Transport
PFI	Private Finance Initiative
PHA	Provincial Health Authority
PHC	Primary Health Care
PHRC	Provincial Health Restructuring Committee
PIMS Centres	the core element of a 'Planning and Implementation Management Support' system established by DPLG to support local municipalities
PPI	Public-Private Interaction initiative
PPP	Public-Private Partnership
Provloc	Provincial Local Government Associatrion
SALGA	South African Local Government Association
SANAC	South African National Aids Council
VCT	Voluntary Counselling and Testing (for HIV)

PREFACE

This report integrates the findings of a project monitoring the health decentralisation process in South Africa between 2001 and 2003. It is targeted at senior policy makers and health managers, although the report is also intended to offer middle managers insights into the situation.

Chapters One to Six are summaries of the individual studies, which together make up the project. Chapter 7 synthesizes the findings, including wider insights gained from the crosscutting nature of the project. Chapter 8 (the Recommendations) contains eight areas of importance for consideration in decentralising management within the health system on the basis of a newly promulgated Health Act.

Time-strapped readers are encouraged to move directly to the final two chapters, especially the recommendations (chapter 8), which constitute important reading for any role-player holding a position of influence in national, provincial or local government-linked health service delivery.

Background

Since 1994 the health system in South Africa has been undergoing reform. The national vision for health services is primary health care (PHC) through a decentralised, municipal-based, district health system (DHS). This is happening simultaneously with the restructuring of government into three spheres - national, provincial and local. The roles and responsibilities of each sphere are defined in the Constitution of 1996. The Constitution outlines how the three spheres of government are meant to relate to each other. The emphasis is on cooperative governance with independent, yet inter-dependent, spheres.

The demarcation of the whole country into municipalities and the local government elections of December 2000 completed the establishment of the local sphere of government – comprising metropolitan, district and local municipalities. The structures and systems for this sphere are legislated through Acts such as the Municipal Structures Act and the Municipal Systems Act.

International experience has shown that decentralisation of health services is a complex and fragile process. Care is needed to prevent increasing inequity, increased administrative costs, fragmentation, and avoid any weakening in strategic direction, national coordination and cohesion. (Collins and Green, 1993) In order to prevent this, the decentralisation process needs to be carefully monitored on an on-going basis.

The dual decentralisation processes referred to above have had a significant impact on health service delivery in the country. In the absence of a legislative framework within which to implement the DHS decentralisation activities have vacillated as likely policy has changed. Constitutionally municipal health services (MHS) are a local government responsibility, but the term was not defined. Early expectations were that MHS would include all of PHC services – firstly with and then later without Level 1 hospitals. Personnel at district level put great effort into implementing this concept. Recent developments however, pointed towards MHS being limited to a list of environmental health services only. Results on the ground were a feeling of futile endeavour and demoralized staff. The pending National Health Act ostensibly returns to provincial control 'the rest of' PHC, with the option to delegate or assign PHC functions to local government – now the only way of achieving the stated aim of a municipal-based district health system.

The Minister of Provincial and Local Government specified MHS as a district municipality responsibility, although much of the work is currently being performed by local municipalities. Provision is made for local municipalities to undertake the work on an agency basis and implementation is due in July 2004.

The monitoring and research project, "Local Government and Health in South Africa" (LGH), was established during the latter half of 2001 to monitor and track the impact of the policy to decentralise health services to local government. The name reflects the early trend that suggested the inclusion of more of the primary level services in the definition of Municipal Health Services (MHS). The project was established by a consortium of founding partners, involving the Health Systems Trust (HST), the Centre for Health Policy (CHP), University of Witwatersrand, the Health Economics Unit (HEU), University of Cape Town and the Centre for Policy Studies (CPS), Johannesburg. The LGH Consortium was fully funded by the Health Systems Trust.

Conceptually, the project used a framework of five policy-related themes – equity, local accountability and community involvement, inter-sectoral collaboration, inter-governmental relations, and public-private relationships - all relating to the sixth under-pining theme of improving service delivery and quality of care.

Methodological framework

While aspects of the research looked at the impact and process of decentralisation at a country and province-wide level, some of the studies focused on 'tracer' (or sentinel) sites. These sites acted as in-depth case studies and as 'windows' through which the complexities of health systems development and change could be viewed. Selection of the sites, one per province, aimed at covering the broad range of health systems and local government contexts and scenarios that exist in the country and included rural / urban; well resourced / poorly resourced; previous homeland / previous RSA; cross boundary district municipality and metro council.

Overview of the chapters

Chapter 1 includes at the current financing of health services and how these impact on equity of distribution. A macro view reviews the funding processes and distribution of funds from national and provincial levels. A micro analysis looks at resource allocation within three district or metro municipalities.

Chapter 2 explains the present system of distributing transport for health services and, some of the challenges that health officials face in ensuring that transport is available for delivery of health services.

Chapter 3 investigates vertical integration in service delivery, focusing on the changing relationships between spheres of government and the impact on service delivery, using HIV/AIDS services as a tracer.
The referral system and relationships between clinics and level 1 hospitals is also illustrated.

Chapter 4 looks at the role of local government in relation to health services and the accountability of local government councillors to the community, mainly through other governance structures.

Chapter 5 investigates the health content of a selection of Integrated Development Plans (IDPs) and the involvement of health officials in the IDP process.

Chapter 6 is an introductory analysis and overview of Public-Private Interactions (PPIs) in the South African health system.

Chapters 7 and 8 are the synthesis of the findings referred to in the preceding chapters. Chapter 7 reports on the progress of the decentralisation process whilst Chapter 8 looks ahead at future challenges.

The full reports of each of these chapters are available from the Health Systems Trust website (www.hst.org.za).

Chapter 1

Financing and Equity

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Background

Despite almost ten years of democracy there has been no research that evaluates comprehensively the distribution of funding of Primary Health Care (PHC) across districts. There are international fears that decentralisation may negatively impact on the fair distribution of such resources. This is especially concerning for South Africa given the legacy of apartheid and the importance of equity in Government policy. It is vital that decentralisation must be developed with equity in mind, protecting those in greatest need. This chapter evaluates the equity of PHC financing within the context of recent debates about decentralisation to local government. It draws together four reports which analyse the overall financing of, and need for, non-hospital PHC across districts and present findings from case studies of resource allocation within health districts (Thomas *et al*, 2003; Mubangizi *et al,* 2003; Khumalo *et al,* 2003; Okorafor *et al*, 2003). The different approaches and their findings are complementary and yield conclusions and recommendations to be implemented at different levels of government to improve the performance of the health system.

International experience of the interaction of decentralisation on health care financing is summarised. The objectives of and some discussion of methods used in the studies are discussed. Results detailing the overall financing of non-hospital PHC in relation to need are then presented as an exploration of budgeting practices in the case studies. Conclusions and recommendations follow.

The full report on this research, of which the chapter is a summary, can be downloaded in pdf format from www.hst.org.za

International Experience

Decentralisation, in its various guises, has proved to be a very popular reform in many developing countries (Brijlal *et al* 1998). Yet, it is often complex and characterised by political conflict between different spheres of government (Mills *et al* 1990; Collins 1996). Most importantly, one threat of decentralisation is to the equity of health care financing across geographical populations. As decentralisation progresses to lower levels of the system local sources of finance become increasingly important. If there is no effective vehicle for cross subsidy between wealthier and poorer populations, then inequities are likely to increase (Collins *et al*, 1996). While decentralisation may encourage additional resource generation at the local level (Collins *et al*, 1996), it may also result in fragmentation of funding with little overall coordination (Brijlal *et al* 1998, Mills *et al* 1990). All this points to the need for strong central oversight of financing to redress problems of inequity and manage, if not rationalise, fragmentation of funding.

Rationale and objectives

Without understanding how resources are allocated, and who effectively takes the decisions, it is difficult to pursue equity through effective policy change.

While much has been published on inter-provincial inequities (see Thomas et al, 2000; McIntyre et al, 1998; McIntyre et al, 1995), little is known about the equity of financing primary health care across health districts in South Africa. Further, given that PHC is a key government policy, it is vital for policy makers and planners to understand the current funding picture, its implications for equity and the changes that need to be made to move the health system closer to stated goals. Indeed, it is a goal of the National Department of Health to have every public PHC facility offer a comprehensive package of PHC services by 2004 (Makan *et al*, 2003). To provide a foundation for such an approach it is also important that policy makers are aware of the resource allocation practices on the ground, particularly in relation to intra-district budgeting.

Consequently, the objectives for the studies were:

Across the country:

- To map the financing of non-hospital primary health care within all local government areas
- To construct deprivation indices for the country as a whole and for each province to measure the need for health care services
- To analyse the equity of financing health care in relation to need across all health districts
- To propose changes to improve the equitable allocation of resources.

In case study sites:

- To document and evaluate the decision-making process and mechanisms at different levels of government that determine the allocation of resources within the local government areas
- To analyse how such decision-making processes impact on equity within local government areas
- To propose changes to resource allocation practices to improve equity across local municipality areas within a health district.

Methods

The studies used both quantitative and qualitative methods. A picture of financing was pieced together from data provided by Provincial Departments of Health, Provincial Treasuries, National Treasury and National Department of Provincial and Local Government in accordance with the funding flows described below. Deprivation data were calculated to reflect need for health care using key socio-economic indicators based on census data. Further semi-structured interviews were conducted with key officials and politicians from the

case study sites and the relevant Provincial Departments of Health. These methods are discussed briefly below. The study also built on earlier research on the options for financing local government health services (Mbatsha and McIntyre, 2002).

Outline of Funding Flows

The financing of non-hospital PHC services is currently quite fragmented. Indeed, the overall funding relationships in the public health sector are complex. To understand the methods used for data collection it is necessary to map out the funding flows. This is shown in Diagram 1.1. National Treasury allocates funds to provinces and local governments in the form of block grants (the equitable share) and conditional grants (for earmarked purposes) (National Treasury, 2002). Provincial Treasuries must allocate these funds across sectors, such as health, education and so on through their own budget process. Provincial Departments of Health then allocate the funds they receive from provincial Treasury to different activities, such as district hospitals, clinics and so on. There is no formal mechanism to protect funding of PHC activities at any stage in this resource allocation process.

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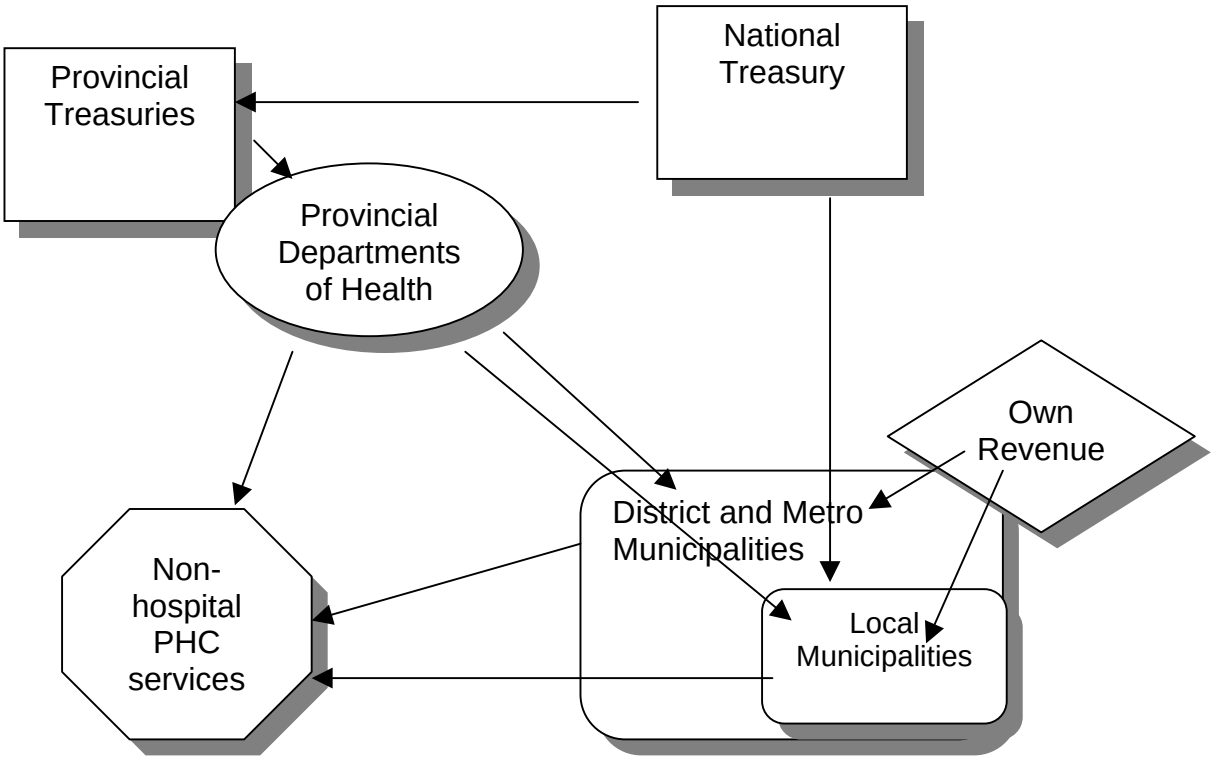
The substantial fragmentation of funding of non-hospital PHC makes coordination of equitable financing difficult.

Diagram 1.1: Representation of Funding Flows Relating to PHC



Provincial Departments of Health contribute to the funding of non-hospital PHC in two ways; through their direct expenditure on provincial health programmes and clinics and through transfers that they make to local government for such activities. These transfers can go to As (metropolitan councils), Bs (local municipalities) or Cs (district municipalities), though there are relatively few transfers to district municipalities at present. Transfers may take the form of contracts or subsidies (Mbatsha and McIntyre, 2002). The equitable share grant and conditional grants to local government currently go to the B level (local municipalities). Historically, these funds were not mandated for health care services but for the core

responsibilities of municipalities, including housing, water and sanitation. Nevertheless, there is some suggestion that some local governments may utilise these funds for health care. In addition local governments raise their own funds for health care through local rates and tariffs, and this has grown to be quite an important source of funding in some districts (Thomas *et al*, 2000). The substantial fragmentation of funding of non-hospital PHC makes coordination of equitable financing difficult, as will be explained.

Need and Deprivation Indices

Equitable funding may require a bias toward those in greatest need "unequal treatment of unequals".

Many previous studies on health financing in South Africa have relied on equal funding per capita as a basis of measuring equity (see for example McIntyre, Baba and Makan, 1998). While this is one approach it may not go far enough. Instead, equitable funding may require a bias toward those in greatest need or the endorsement of the notion of vertical equity, "unequal treatment of unequals" (Mooney, 1996; McIntyre, 1997). Therefore, to assist with measuring equity, composite indices of deprivation for district municipalities were constructed from 1996 census data. In this report both funding per capita and funding according to deprivation are explored as measures of equity.[2]

Census data for 1996 were utilised to build up a picture of need for health care services in each district. Data from the ward level were used in relation to variables that appeared relevant to socio-economic status. These are shown below in Box 1.1. The values of such indicators were weighted according to the respective population within each ward. A deprivation index score was calculated using principal component analysis.

Box 1.1

Key Socio-Economic Variables

- Proportion of black individuals in the population
- Proportion of children in the population
- Proportion of the population which is illiterate
- Proportion of the population which is unemployed
- Proportion of the population living in informal dwellings
- Proportion of the population with no access to telephones
- Proportion of the population with no electricity
- Proportion of the population with no sanitation
- Proportion of the population with no direct access to water

Case Study Sites

In each case study site a review of resource allocation processes and their impact on intra-district equity was conducted. The sites were chosen to reflect an appropriate urban-rural balance while also considering size of local government area and number of sub-districts. The case study sites chosen were Thabo Mofutsanyane District, Tshwane Metropolitan Area and Alfred Nzo District.

[2] It may be argued that sectors, other than health, also contribute to health status and the need for health care. While the authors accept this point an analysis of broader social sector spending goes beyond the scope of this research project. It is, nevertheless, an important area for future research.

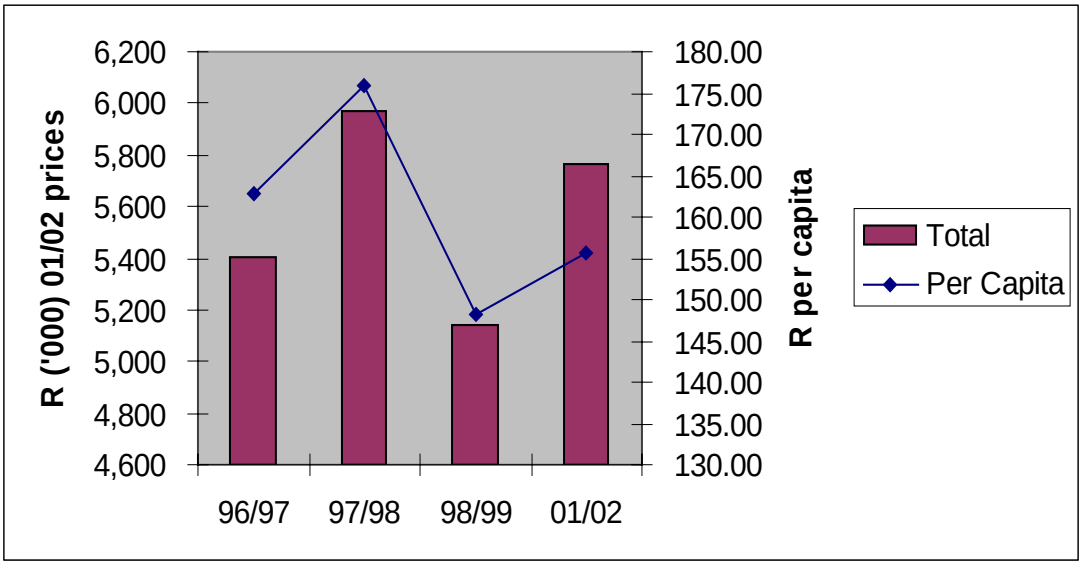
Results

Overall Financing

Almost R 5.8 billion was spent on non-hospital PHC in 2001/02 (see Graph 1.1). This is approximately 19% of the public sector health budget. To compare these estimates of PHC expenditure with earlier years, National Health Accounts data (Thomas and Muirhead, 2000) are analysed for 1996/97-1998/99. Transforming all data into 2001/02 prices gives Diagram 3.1, which shows that real expenditure peaked in 1997/98, just under R6.0 billion or R176 per capita. Since then spending on PHC has dropped both in real and per capita terms. There was a fiscal squeeze in 1998/99 which impacted on all public health sector budgeting. Further, it is also argued that some of the increases in the mid 1990s were related to high medical inflation and increased staff costs (Blecher and Thomas, 2003) and thus exaggerates increases in the quality and quantity of PHC service provision. Nevertheless, there was definitely a recovery in funding from 1998/99. However, real per capita expenditure on non-hospital PHC in 2001/02 was still lower than in 1996/97.

Further, the average amount spent on PHC per person is lower than required for the PHC package, over R200 per capita in 2001/02 prices – but there are some indications that PHC per capita funding levels have improved since 2001/02, albeit insufficiently to fund required services.

Graph 1.1: Total and per capita funding of non-hospital PHC in the public sector, 1996/97-2001/02 (at 2001/02 prices)



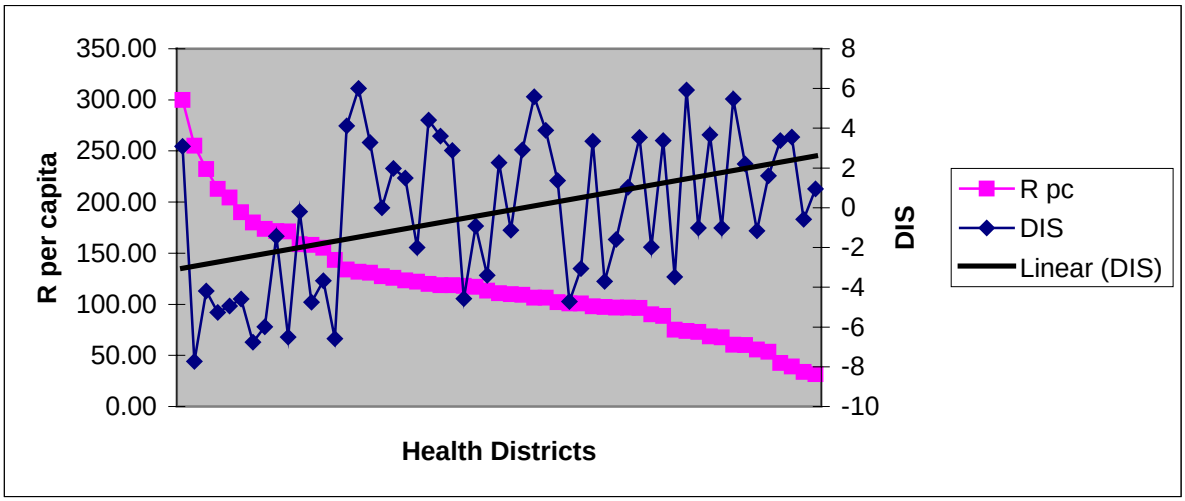
Financing and Equity

Summary results are highlighted in Graph 1.2. Here the financing per capita of non-hospital PHC services in each health district is compared with the need in each district, calculated using deprivation indices. Financing per capita ranges from a high of R300 to well under R50, and is shown by the curve from top left to bottom right. For each district, the deprivation score is also shown, ranging from +6 to almost –8. A trend line has been added to the deprivation scores to make the relationship clearer between financing and need. As can be seen, as financing

As financing per capita decreases there is an overall trend for the district to have a higher deprivation score. In other words the most needy districts get the least funding and vice versa.

per capita decreases there is an overall trend for the district to have a higher deprivation score. In other words the most needy districts get the least funding and vice versa.

Graph 1.2: Financing per capita vs. Deprivation across health districts in South Africa



***KEY:* DIS is the deprivation index score and Linear (DIS) is a linear trend line for the DIS.**

This general picture of an inverse relationship between need and financing is also highlighted in Table 1.1. However, this time the data refer to *relative* deprivation within each *province*. This means that the scores cannot be compared across provinces. Instead they indicate within any province the deprivation of a district relative to the other districts in that province. For instance, Nelson Mandela Metropolitan Area has a very low deprivation score in Table 1.1. This indicates that compared to other districts in the Eastern Cape it is relatively affluent.

As can be seen in Table 1.1, it is generally the case that the best funded districts, in per capita terms, are not those which are deprived. Conversely those districts that receive the least funding per capita tend to be those with high deprivation scores.[3]

[3] The socio-economic indicators used in calculating the deprivation index, shown in Box 1.1, indicate that there is unlikely to be any tangible impact of health funding on deprivation.

Table 1.1: Best and worst funded district municipalities, in per capita terms, with their deprivation scores

Best-Funded Districts		Worst-Funded Districts	
District	Deprivation Index Score	District	Deprivation Index Score
Eastern Cape			
Nelson Mandela (PE)	-1.54	DC 14	0.21
DC 12	-0.12	DC 10	-0.95
Free State			
DC 16	-0.15	DC 19	0.51
DC 17	-0.31	DC 20	-0.18
Gauteng			
Ekurhuleni (ER)	-0.13	CBDC2	0.73
Egoli (Jbg)	-0.28	CBDC8	0.26
Limpopo			
DC 33	-0.47	DC 35	0.28
DC 36	-0.44	CBDC4	0.25
KZN			
Durban Metro	-0.97	DC24	0.67
DC 22	-0.37	DC 29	0.37
Mpumalanga			
DC 32	0.26	DC 30	-0.21
Northern Cape			
CBDC1	-0.42	DC 8	0.1
North West			
DC 39	0.49	CBDC1	0.72
DC 40	-0.96	DC37	-0.13
Western Cape			
Cape Town	-0.61	DC2	0.09
DC5	0.35	DC3	0.45

Note:
Higher positive values indicate increased relative deprivation within a specific province. Comparisons cannot be made across provinces as the data are relative to each province.

Implications of the narrow definition of Municipal Health Services

The issue of how to finance PHC is particularly pertinent given the minimalist definition of Municipal Health Services contained in the National Health Bill.

The issue of how to finance PHC is particularly pertinent given the minimalist definition of Municipal Health Services contained in the National Health Bill. The definition basically gives district municipalities the responsibility for financing and providing Environmental Health Services only. The remainder of PHC services must be funded from Provincial Departments of Health. The implications of this definition are unclear at present. The worst case scenario from a sustainability perspective is that there will be a loss of funding for PHC of about R 1.0 billion, minus the costs of provision of Environmental Health Services - at maximum an 18% reduction in total public sector PHC financing. Key concerns relate to the responsibility for funding this potential short-fall. Nevertheless, others argue that the loss of funding may not be of too much concern. From an equity perspective they claim that the biggest loss of funding will actually occur in those districts where local government own revenue is high. It may be argued that such districts are those that are well off anyway and are currently “overfunded”. Taking this one step further, those who support a more equitable allocation of resources might argue that the removal of local government PHC funding might actually level the playing field between districts and reduce inequities.

To explore such issues it is worth re-examining the data to see whether such assertions have any validity. In particular it is useful to examine those health districts where:

- Own revenue is a high share of total PHC expenditure
- Funding appears to be far below that required to deliver a PHC package.

In essence this analysis examines issues around both sustainability and equity. It concentrates on the districts that appear underfunded yet also rely on own revenue funding. More precisely, our analysis explores those health districts where overall funding per capita of PHC is less than R100 per capita and between R100 and R120 per capita and where own revenue funding is important for PHC funding.

Several points arise from this analysis. First, there are a number of health districts where PHC is currently extremely underfunded in per capita terms where local government own financing is important. Hence, it is not just the well-funded health districts that will be hit by this redefinition.

DC30 and DC31 in Mpumalanga appear extremely vulnerable to loss of own revenue, with already low PHC funding per capita. In such cases, the amounts lost may not be large in Rand terms but the impact could be huge in terms of service delivery.

Interestingly, to fill the potential gap lost by the twelve health districts with less than R100 pc of PHC funding, which would be most affected by the definition, less than R100 million would be needed. For the fourteen health districts where PHC per capita funding is between R100 and R120, Table 1.1 shows that an extra R175 million would need to be raised to bridge the gap. In this latter grouping are the two metropolitan councils which appear most vulnerable to loss of own revenue funding, Tshwane and Nelson Mandela (Port Elizabeth). Consequently, the data imply that at least R275 million should be targeted to these 26 health districts to avoid serious impacts on health care service delivery in already under-funded contexts. Still such a strategy should be seen as merely disaster avoidance. The pervasive inequities in the system highlighted earlier in the chapter and the need to deliver a full PHC package in all health districts require further and more comprehensive action.

Key Findings from the Case Studies of Resource Allocation within Districts

Actors and their power in budgeting

Provincial institutions, such as the Department of Health and Treasury, are very powerful in the decision-making processes around how resources are allocated to and even within districts. The degree of decentralisation of finances to district municipalities and below is very limited, though the extent differs from province to province. Nevertheless, where there is a functional IDP process, local level politicians (and particularly District Mayoral Committees) can make a substantial difference in how capital funding of health care is allocated.

The degree of decentralisation of finances to district municipalities and below is very limited, though the extent differs from province to province.

Parallel Budget Processes

It appears there are two distinct and parallel processes for budget formulation. It is not apparent, though, how these resource allocation systems interact. One, the PDoH allocation of resources, is steered by provincial authorities, relates to health operational/recurrent funding and is quite top-down.

A lack of interaction between the two budgeting systems may produce inefficiencies and result in a squandering of scarce resources.

The other, the IDP, is directed by local politicians, makes decisions primarily on capital funding, is multi-sectoral in nature and is bottom-up (in that it consults with communities and attempts to identify their needs). Further, each budgeting cycle is out of line with the other –

financial years do not concur. Nevertheless, the decisions that are taken within each budgeting process will impact on the other. New capital projects will have recurrent cost implications. If these are not factored in to future budgets, then facilities risk being under-maintained and inappropriately staffed. A lack of interaction between the two budgeting systems may produce inefficiencies and result in a squandering of scarce resources.

Incremental Approaches

Across all case studies it was admitted that historical incremental budgeting was used far more than it should have been. Nevertheless, such a system perpetuates inequities and consolidates inefficiencies. Further, there is sometimes the confusion that needs-based resource allocation should be related to demand or utilisation of services. Nevertheless, the international literature shows that utilisation based funding does not adequately address need. Indeed this approach may well guarantee significant underfunding in needy areas, especially as low demand may well be a product of low quality caused by previous underfunding. Relatedly the interviews revealed that some Treasuries are keen to relate funding to perceived capacity to benefit, without attempting to improve the capacity to benefit of deprived areas. Distribution of resources by such criteria will only compound inequities in resource allocation.

Resource Allocation Criteria

In all the case study areas there were discussions that budgets should, take into account population bases and might also consider income and disease types (particularly HIV/AIDS). However, one province that pursued a formula for promoting a more equitable resource allocation across geographic areas met with opposition from stakeholders and the process has now been shelved. Problems may further be compounded by limited financial management and strategic planning capacity in some districts fuelling concerns about their “capacity to benefit”.

Problems may further be compounded by limited financial management and strategic planning capacity in some districts fuelling concerns about their “capacity to benefit”.

Effective communication and clear roles

Communication between stakeholders proved to be essential for effective budgeting at all levels and particularly between provinces and districts, districts and sub-districts and districts and local governments. With the evolution of parallel budgeting processes this communication and exchange will become increasingly important. Finally, roles and responsibilities in budgeting were often reported to be unclear – particularly between district and sub-districts and also between regions, where they still exist.

Conclusions and Recommendations

The results produced by these studies highlight the extent of inequities in health financing of non-hospital PHC across South Africa. In many ways they confirm the international picture that uncorrected decentralisation of health financing is no recipe for equity.

- **The financing of PHC is fragmented and there is no evidence of its coordination within the decentralisation process. Currently, no single institution has the mandate or authority for this role. Further, there has been no explicit national policy for PHC financing. Consequently, resource allocation for non-hospital PHC has been done with virtually no regard for equity.**

- **Need for health care and financial resources for PHC are inversely related. The least deprived health districts tend to get the most funds per person. Such results hold not only across the country as a whole but within most provinces.**

- **There are wide discrepancies in per capita financing of non-hospital PHC across provinces and districts. Four times as much money per person is allocated for these activities in the Western Cape as in Mpumalanga. Funding to individual health districts ranges from R300 to under R40 per capita. Indeed, 19 district municipalities receive less than R100 per capita for financing non-hospital PHC activities. Such amounts are far below those needed to deliver a PHC package.**

- **Relatedly, financial resources are highly concentrated in certain provinces and health districts; 3 provinces account for 60% of resources (KwaZulu Natal, Gauteng and Western Cape), but only 43% of the population, and the five best-funded health districts claim 43% of all non-hospital PHC funding, with only 28% of the population.**

- **The degree of financial decentralisation to local government levels is in most provinces limited. Provincial Departments of Health are the main funders of non-hospital PHC, averaging 75% of all finances. In Limpopo and North West around 90% of funds come straight from Provincial Departments of Health.**

- **Provinces are doing little to address inequities in the financing of PHC across their health districts. They are not using measures of need to guide budgeting (such as population based resource allocation). In general, they do not compensate for the differential revenue raising capacity of different districts and in some cases they exacerbate inequities.**

- **The relationship between IDPs and the provincial allocations to the health sector need to be resolved. Currently, the two processes are working in parallel, which may result in inefficient and ineffective allocation and utilisation of resources.**

- **It is clear that historical budgeting processes still determine the allocation of resources in and across many districts and is recognised as being inefficient and inequitable.**

Laying the Foundations for Equity

It is vital that the National Department of Health, in alliance with National Treasury and provinces, develop a PHC financing policy which guarantees equitable financing to support access to an agreed package of services. In this regard, research is needed to ascertain the actual costs of PHC service delivery in provinces, the quality and quantity of services provided and the additional financing requirements for delivery of a PHC package. Broad-based commitment to the provision of the PHC package is foundational for equitable financing of PHC.

While an appropriate understanding of the financial requirements for PHC delivery is important, other steps are also needed to ensure appropriate use of such funds, and these relate to:

- Improving absorptive capacity of local governments;
- Guaranteeing the efficient use of allocated resources through effective budgeting and decision-making
- Ensuring effective deployment of human resources to provide PHC services;
- Bolstering PHC capital infrastructure to improve access.

What is clear from the above is that to make redistribution work, to fund PHC more effectively and meet the needs of the population, substantially greater resources must be allocated to developing the decentralised health care system. A platform is needed for effective redistribution. Resources and strategies must be directed to this end to allow an equitable PHC system to emerge.

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Chapter 2

Transport - an Essential Resource for Health Services[4]

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Background

Equitable distribution of all resources for delivery of health services between and within health districts is required to achieve the Constitutional vision of universal access to health care. The challenges of equitable redistribution of financial resources are discussed in Chapter 1. There are, however, other essential resources for health services delivery, such as transport, that may require redistribution. Transport-related research, focusing on two main issues, was undertaken between April and June 2002. It aimed to understand, firstly, the present system of distributing transport for health services and, secondly, some of the challenges that health officials face in ensuring that transport is available for delivery of health services. Policy and other documents were reviewed, key informants were interviewed and discussions held with health service providers in three provinces, Gauteng, Limpopo and Mpumalanga.

This chapter provides an overview of the current systems for providing transport for public sector health services. These systems, together with the National Department of Transport's 2002/2003 strategic plans for managing the national government's motor fleet, and their possible implications for service delivery are discussed. Recommendations for further research and for improving transport for health services, based on experiences in other developing countries, are made.

The full report on this research, of which the chapter is a summary, can be downloaded in pdf format from www.hst.org.za

Hall, W. du Plessis, D. and D. McCoy D. Transport for Health Care Delivery. In: South African Health Review 2000. Durban: Health Systems Trust; 2002.
URL: ftp://ftp.hst.org.za/pubs/sahr/2002/chapter18.pdf

Transport is essential for health services delivery.
It is required for

- **Delivery of health services – mobile services, supervision visits to clinics and communities, school health services, support of DOTS and other community based health programmes**
- **Patient transfers – elective and emergency**
- **Support services – collection and delivery of supplies and drugs, general administration, attending meetings.**

Current Transport Systems for Public Health Service Delivery

Provision of transport for service delivery is dependent on complex inter-government and inter-sectoral linkages. Policies and management systems for the national government motor fleet for all sectors within national and provincial spheres of government are centrally determined and controlled by the National Department of Transport. These policies and systems do not apply to services delivered by the local sphere of government - i.e. the metropolitan areas, district municipalities and local municipalities.

Development of policies and management systems for transport for provincial health services are centralised in the National Department of Transport.

Table 2.1 lists the stakeholders and some of their roles and functions in the provision of transport for health.

Table 2.1: Stakeholders and their roles in transport for public sector health services

	Stakeholder	Roles and Functions
NATIONAL SPHERE	National Dept of Transport (NDoT)	Sets policy for all national and provincial government sectors. Transport for service delivery controlled and monitored by Government Motor Transport, Subdivision of Corporate Services Division. NDoT Strategic Plan 2002/2003 states for management of national fleet includes: - ▪ Implementation of private-public partnerships ▪ Improved reliability and availability of subsidised transport Monitoring of above strategies. Contracted Wesbank First Auto (RT460) as Fleet Management Service Provider. Negotiate Tender RT77 for purchase of new vehicles for all provincial and national departments.
	National Dept of Health (NDoH)	No role for provision of transport at service delivery level.
PROVINCIAL SPHERE	Provincial Dept of Transport (PDoT)	Implement national policy. Establish Motor Transport Advisory Committees – includes all provincial departments. Management of provincial fleet – purchase, licencing, repair and disposal – supported by Wesbank First Auto. Managing and monitoring PPPs in the province.
	Provincial Dept of Health (PDoH)	Hire of vehicles for health services from PDoT. Liaise with PDoT and Wesbank First Auto in fleet management. Allocation of vehicles to health regions, districts and sub-districts for service delivery. Financial accountability for transport – PFMA requirements.
LOCAL SPHERE	Local Government (LG)	Provision of transport for health within own area of jurisdiction – metro, district or local municipality who provide: - ▪ Finance for purchase and maintenance of vehicles ▪ Monitoring of the fleet ▪ Allocation to services Local policies, not subject to NDoT policies.
SERVICE DELIVERY	**Health Region / District / Sub-district**	Day to day management of vehicles allocated by PDoH. Allocation of vehicles for health delivery functions. Motivate to PDoH for vehicles for service delivery.

The role of the National Sphere of Government

The National Department of Transport (NDoT) determines policy and monitors implementation of these policies. Government Motor Transport, a subdivision of the Corporate Service Division, is responsible for transport in all government sectors within the national and provincial spheres. This department is required to "manage the national government's motor fleet", through strategies that ensure "an effective fleet management system with effective controls; (and) reduces fleet management costs" (NDoT 2002/3 Strategic Plan).

The NDoT has contracts for the purchase of new and replacement vehicles (Tender RT 77) and for a Fleet Management Service Provider (Tender RT 460). These tenders apply across all sectors in national and provincial government services.

The NDoT and the Provincial Departments of Transport (PDoT) purchase new vehicles through Tender RT 77 at reasonable prices from many manufacturers. Tender RT460 (Fleet Management Service Provider) is presently held by Wesbank First Auto. In terms of this tender First Auto is responsible for the monitoring and control of all government owned vehicles, which includes facilitating the repair and maintenance of the vehicles and providing a fuel tagging system to reduce fuel fraud. First Auto liases with the NDoT and the PDoT and provides them with electronic data on all vehicles in the fleet. Until recently there has been little or no contact between First Auto and the user departments, such as the Provincial Department of Health (PDoH), to assist with the management of their vehicles.

The National Department of Health has no role in allocating vehicles for health service delivery within the provinces.

The role of the Provincial Sphere of Government

Implementation of the NDoT policies is through the PDoT, who liase with the other provincial departments in supplying the required vehicles for service delivery. Coordination is through Motor Transport Advisory Committees, established according to the NDoT Transport Policy (Transport Circular No 4 of 2000). All provincial government sector departments, including the PDoH, are represented in this committee.

The PDoH is financially accountable, in terms of the Public Finance Management Act (PFMA), for the cost of transport used for delivery of health services. However, the PDoH is dependent on the PDoT to supply these vehicles (for which a hire fee is paid) and to coordinate licensing and repair and maintenance of the vehicles. New and replacement vehicles are purchased through the NDoT tender, RT 77. The PDoH may request specific vehicle models for service delivery, but the final decision for purchase of vehicles rests with the PDoT. The Provincial Department of Finance (PDoF) must confirm that funds are available for purchase, maintenance and repair of vehicles.

The health districts/sub-districts and health facilities are allocated vehicles by the PDoH for service delivery. Problems with availability of vehicles for service delivery are common, particularly in the more rural provinces of Limpopo and Mpumalanga.

In the three provinces in the study, the PDoT was found to be working closely with their user departments. Strategies to streamline the provision of transport for service delivery, including delegation of some of the PDoT functions to the user departments, are under discussion.

The role of the Local Sphere of Government

The NDoT policies do not apply within the local government sphere of government. The metros, district and local municipal councils determine their own policies and allocate transport for all services within their area of jurisdiction. The metropolitan areas and the larger local municipalities may have vehicles that are dedicated to health services, whereas in the smaller local municipalities vehicles are often pooled and shared between departments.

Local government presently has limited health responsibilities (environmental health and some primary health care services) and thus does not need as many vehicles for service delivery as is required by the health districts administered by the PDoH. Local government will need to increase the size of their fleet if more PHC services are decentralised to local government.

During the time of this research, local government health workers reported that they experienced very few problems with the availability and management of transport for health

service delivery. As noted above, the area of jurisdiction for local government is smaller than the provincial, and is often confined to a single local or metropolitan municipality.

Implications for Health Districts and Sub-districts

A complex relationship exists between the spheres of government (National and Provincial), sectors (transport, health and finance) and private sector (First Auto for fleet service management) in providing transport for health service delivery. The health service providers in the health districts and sub-districts rely on this complex system to work efficiently to ensure that there are adequate vehicles available for service delivery.

However, the reality often reflects a picture of inefficiency. There is a commonly heard cry from health workers in the provincially-run health services, that there is a lack of transport for timeous transfer of patients between levels of health care, for supervision and support of health workers and for the delivery of medicines, vaccines and other essential supplies to clinics. This is particularly true in the rural areas of the country. Problems with transport have been identified as a direct, avoidable cause of death in peri-natal and maternal death surveys. For example, the annual peri-natal care surveys in 2000 and 2001 identified problems with transport as a direct, avoidable cause of peri-natal deaths (2.6% in 2000 and 5.3% in 2001) (Medical Research Council, 2001) while lack of transport for moving patients between institutions accounted for 13.6% of maternal deaths reported in 1998 (Pattinson, B, 1998).

Reports of vehicles lying idle for extended periods of time or being without licences are not uncommon. Authority to issue new licences and for vehicle repairs to be carried out is required from both the PDoH and the PDoT. The Provincial Department of Finance (PDoF) must also confirm that funds are available. Time delays are experienced with the information being fed up and down the system. First Auto, as fleet service managers, does facilitate the process and improvements in some areas were reported. The planned decentralisation of some PDoT functions to the PDoH is designed to improve the current management system and will potentially decrease the delays being experienced in replacing, maintaining or repairing the current fleet of vehicles in the health services. However, it remains difficult for this protracted vertical system to respond timeously to the transport needs of the health workers in the health districts and sub-districts.

National Department of Transport Strategies

The management of the national government fleet, through the National Department of Transport's Strategic Plan for 2002/2003, includes strategies for:

- implementation of PPPs (private-public partnerships) where appropriate; and
- improved reliability and availability of subsidised transport.

Management of the national government fleet is not considered to be a core function of the NDoT and the strategy of privatising is therefore in line with the general government policy of outsourcing non-core functions. These policies are: -

- ***Subsidised car scheme (National Department of Transport Circular No 4 of 2001)***
  This is a scheme through which an official in the department purchases with a subsidy a vehicle for his/her official duties, thus supplementing the pool of vehicles available for service delivery. The department reimburses the official for work-related trips and at the end of the contract period the vehicle becomes the property of the official. To participate in the scheme the official must meet certain prescribed criteria that include requiring the vehicle as a work facility, traveling more than a prescribed distance each month and satisfying Wesbank's (the present private financial service provider) financing requirements. All applications to join the scheme are signed by the head of department and the NDoT monitors the scheme.

- ***Outsourcing***
  The NDoT's policy, as stated in the strategic plans for 2002- 2003, is to outsource fleet management for all government departments through public-private partnerships (PPP) with companies whose core business is fleet management. The private

company is then responsible for managing the government fleet and ensuring that vehicles are available at all times for service delivery. The National Treasury's Public Private Partnership Departmental Guidelines guide the process of setting up these PPPs.

These two policy approaches are designed to improve the efficiency of the management of the fleet and to improve the availability of transport for service delivery within all sectors. Theoretically they achieve this. In the subsidised car scheme the individual ensures that the vehicle is available for official use and may not use a government-owned vehicle. The scheme does potentially increase the availability of transport for carrying out official functions, but it requires good management to ensure that the criteria are adhered to and that the vehicles are only used for service delivery. The scheme is open to abuse. Fleet management for all national departments was outsourced in 1999 to Imperial Holdings (Press release, National Minister for Transport, 10 June 1999) and the entire Northern Cape government fleet is now managed through a PPP signed in November 2001 with Pemberley Investments (Pty) Ltd, comprising of Africa Kosini; Imperial Holdings (NDoT, 2002). Other outsourcing projects are planned.

There is no proof that either of these policies - outsourcing or subsidised car scheme - improve the delivery of health services. The impact on service delivery has simply not been investigated. The schemes are centrally developed and monitored and vertically implemented.

Three questions arise:

- What is the impact of outsourcing transport management and extending the subsidised car scheme on health service delivery? Are the policies, which might be good for some sectors, actually impeding health service delivery?
- How will these policies operate in a decentralised health system in which local government is not subject to national transport policies?
- How can the equitable distribution of transport for health service delivery be assured in a decentralised system?

Discussion

Lack of transport for health service delivery is not unique to South Africa - neither is the policy of decentralising health services to a local level, establishing the DHS and using the PHC approach. There is international experience and research that can be drawn on to assist with establishing a transport system that can respond to the needs of the health services.

TransAid Worldwide, an international Non Government Organisation (NGO), has been training transport managers in South Africa at all levels of the health system since 1996. The organisation has also undertaken a multi-country study on transport management in the health sector in four sub-Saharan countries – Ghana, Cote D'Ivoire, South Africa and Zimbabwe. This study demonstrated the importance of a functional transport system that includes policy, operational management, fleet management and management information supported by a comprehensive situation analysis and good human resources for ensuring the effective and efficient delivery of health services (Nancollas, S, 2001). This study showed that in Ghana the Ministry of Health has taken full responsibility for a transport system for health services. This move had a positive impact on availability of transport for service delivery. Ghana has a decentralised health system with districts and regions having budget responsibilities and the country scored the highest Transport-management Profile in this report. The report recommends that in South Africa the Department of Health should manage the health fleet in-house, as it does not get value for money from its relationship with the Department of Transport.

South Africa is moving towards a decentralised form of government through establishing an effective and efficient local sphere of government. The vision for health services is a municipal based DHS. Equitably distributed and efficiently managed support services that are responsive to local needs are required. Transport is a vital support service for health services.

There is some evidence that a locally managed, comprehensive transport system is very efficient and effective in ensuring transport availability for health service delivery in a decentralised health system. Currently transport for provincial health services is centrally controlled and managed through a vertical system that is dependent on complex intergovernmental relationships requiring good inter-sectoral collaboration at all levels of the system. A major concern is that new policies developed by the NDoT focus on the needs of government as a whole, and not necessarily on the needs of the service providers. In reality, lack of transport for service delivery is a common complaint at all levels of the service as the system is difficult to manage efficiently.

Conversely, policies for provision of transport for health services within the local sphere of government are locally determined, managed and controlled. There are few complaints from health workers in local government.

Recommendations

1. Undertake research to answer three pertinent questions:

- **What is the impact of outsourcing transport management and increasing the extension of the subsidised car scheme on health service delivery? Are the policies, which might be good for some sectors, actually impeding health service delivery?**
- **How will these policies operate in a decentralised health system in which local government is not subject to national policies for transport?**
- **How can the equitable distribution of transport for health service delivery be assured in a decentralised system?**

2. The national and provincial departments of health should take full responsibility for the provision of transport for health services. Policies need to be developed independent of the Department of Transport.

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Chapter 3

Governmental Relations and HIV Service Delivery[5]

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Background

This chapter reports on some of the main findings of a research project that examined inter-governmental relations in the health sector in South Africa (Blaauw et.al., 2003) The study focused on HIV/AIDS services with the intention of using HIV/AIDS as a tracer or probe of broader health system functioning. The main objectives of the research were to describe what HIV/AIDS services are provided, how the different functions are allocated between government actors, and how they are then coordinated.

Phase 1 was completed in the second half of 2002 and provided a broad National Overview of HIV/AIDS activities in the national, provincial and local spheres of government. Phase 2 was done in early 2003 and consisted of detailed Case Studies from three different study sites. The research methodology was mainly qualitative and exploratory and included literature review, document analysis and key informant interviews.

The key results of the project are presented by considering the following questions:

1. Why is coordination important in decentralisation reform?
2. How do we describe inter- and intra-governmental relations?
3. How are HIV/AIDS roles and responsibilities allocated?
4. How are HIV/AIDS services coordinated?
5. What are the strengths and weaknesses of the current arrangements?
6. What contextual factors influence these relationships?
7. What is the impact on HIV/AIDS service delivery?
8. How can governmental coordination be improved?

The full report on this research, of which the chapter is a summary, can be downloaded in pdf format from www.hst.org.za or from www.wits.ac.za/chp/
Blaauw D, Gilson L, Modiba P, Erasmus E, Khumalo G and Schneider H. (2004). Governmental Relationships and HIV/AIDS Service Delivery. The Local Government and Health Consortium, Health Systems Trust, Durban. 2003

1 Why Is Coordination Important In Decentralisation Reform?

Health sector decentralisation involves a shifting of power between central and peripheral levels (Mills, 1994). As authority is transferred from the centre towards the periphery, roles and responsibilities of each level of the system have to be re-aligned. The wider distribution of responsibility requires new mechanisms of coordination to ensure that all levels work together coherently to support service delivery and enable health system goals to be achieved.

Within a decentralised system the central level should retain functions related to setting national frameworks but give up responsibility for translating these policies into service delivery.

International experience indicates that a common problem of decentralisation reform is that the roles of the different levels may not be clearly or appropriately re-defined (Thomason et al., 1991). For example, within a decentralised system the central level should retain functions related to setting national frameworks but give up responsibility for translating these policies into service delivery. The central level also needs to change from a command style of management to a more facilitatory approach. However, the central level often fails to adapt to these new roles. By retaining too much authority the central level can undermine the attainment of decentralisation reform objectives (Mercado et al., 1996). On the other hand, if too much authority is transferred to the periphery, national goals of equity and coherence may be undermined (Collins and Green, 1994).

The fragmentation of responsibilities and authorities that results from health decentralisation are cited frequently (Kohlemainen-Aitken and Newbrander, 1997). How to address the problem and how to improve integration and coordination has, however, received much less attention in the health systems literature. One of the main objectives of this study was, therefore, to explore in more detail how activities are coordinated between different government actors within decentralising health systems such as South Africa.

Health sector decentralisation is not simply a technical exercise in organisational design. Socio-cultural factors such as the local socio-political context, organisational culture, and informal organisational relationships have been shown to have a significant influence on the impact of health decentralisation reforms (Atkinson et al., 2000).

2 How Do We Describe Governmental Relations?

Governmental relationships are extremely complex. It is difficult to talk about governmental coordination without developing some conceptual frameworks and definitions. One of the frameworks developed in this study is presented in Figure 3.1.

Figure 3.1 firstly summarises the key actors involved in HIV service provision. According to the Constitution, the government is divided into national, provincial and local spheres as well as the legislative, executive and administrative arms. Each of these divisions has some responsibility in relation to health system functioning. Of course, health functions are mainly allocated to the Health Departments at the national, provincial and local levels. Within the Departments of Health (DoH), both national and provincial HIV/AIDS directorates or units are primarily responsible for the provision of HIV services but have to work together with other health programmes, support staff and line managers in order to be effective. Figure 3.1 also highlights the important role of civil society and the private sector in HIV/AIDS and reminds us that the provincial sphere actually consists of nine different provinces and that the local sphere is made up of 6 metropolitan municipalities, 47 district municipalities and 231 local municipalities.

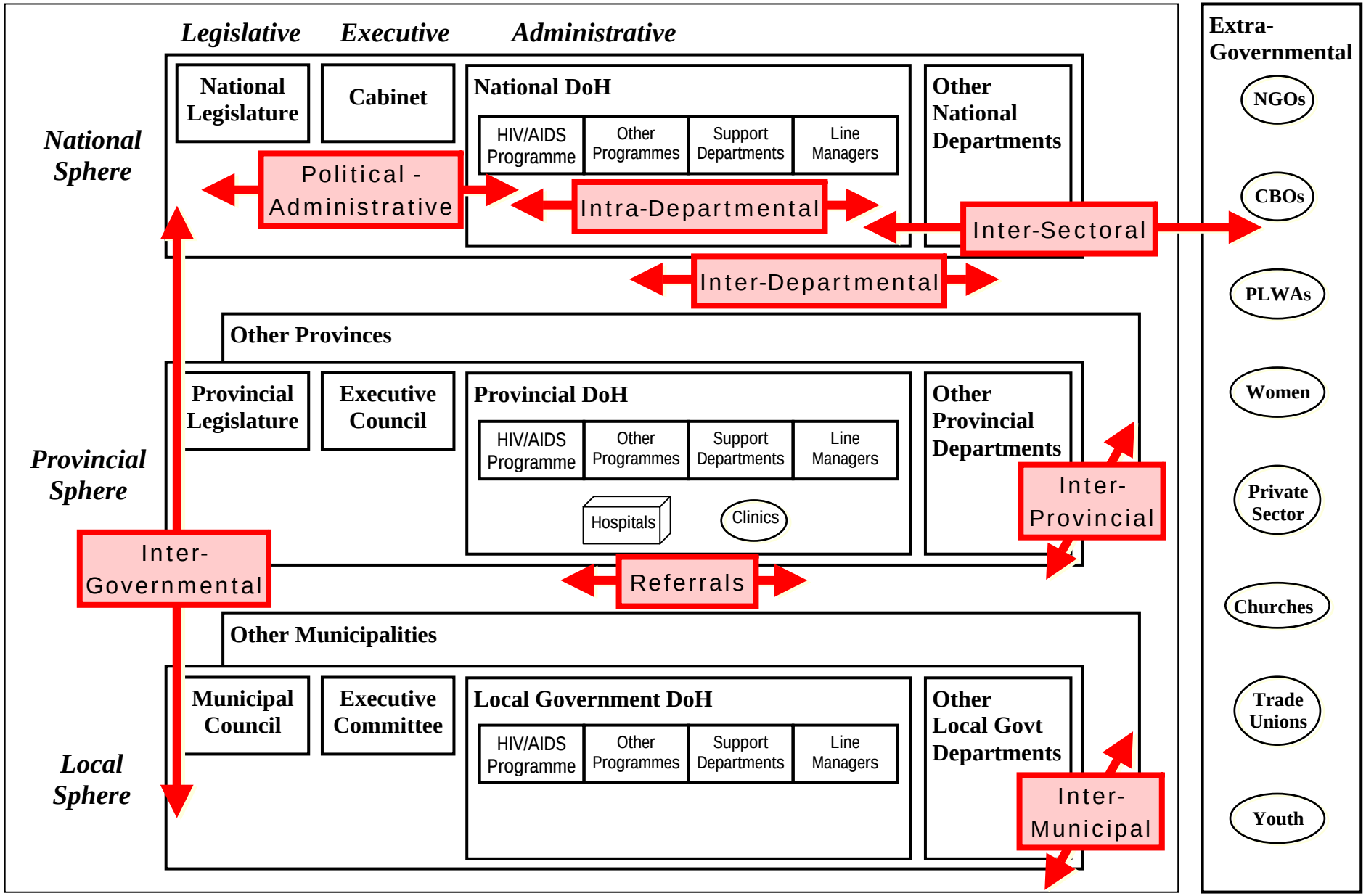

Figure 3.1: Framework for describing the main actors and main categories of coordination in HIV services

Coordination relationships are multi-faceted and can be described and categorised in a number of different ways. Some of the terminology used in this study is summarised in Table 3.1 below.

Table 3.1: Different ways of describing governmental coordination relationships

Characteristic	Description	Main Sub-Categories	
Dimension	Whether relationship is at same level or between levels	• Horizontal • Vertical	
Domain	Whether relationship is within government or with actors outside of government	• Internal • External	
Category	Main categories of governmental relationships on the basis of which actors are involved	• Inter-governmental • Inter-sectoral • Inter-provincial • Inter-municipal	• Political-administrative • Inter-departmental • Intra-departmental • Referrals
Mechanism	Means of coordination	• Coordination structures • Planning	• Meetings • Informal relationships
Channel	Which part of government is involved	• Legislative • Executive / Political	• Administrative
Nature	Nature of the relationship	• No relationship • Information sharing	• Consultation • Accommodation • Joint decision-making

3 How Are HIV/AIDS Roles And Responsibilities Allocated?

Both national and provincial respondents said that the main role of the Provincial Department of Health (PDoH) was to modify national policies according to provincial realities.

The Constitution allocates health responsibilities to all three spheres of government: general health services are shared between the national and provincial spheres, provinces are exclusively responsible for ambulance health services, and the local sphere is made responsible for municipal health services (MHS), but without defining what this might be. Although national policy is committed to the development of a municipal-based District Health System (DHS), the Health White Paper and earlier drafts of the National Health Bill focus on the functions of the national, provincial and district levels but are not clear on how this relates to local government. A decision of the Health MinMEC[6] in early 2001 suggested that the local sphere would ultimately be responsible for district governance and defined MHS as primary health care, implying a significant role for local government in the provision of HIV/AIDS services. In the final version of the National Health Bill submitted to parliament in September 2003 provides a definition for MHS which effectively reduces local government's direct health responsibility to a list of environmental health services. The Bill does, however, make provision for additional health functions to be delegated to competent municipalities.

The HIV/AIDS Strategic Plan is the most important blueprint for the government's HIV/AIDS strategy. It outlines a comprehensive package of interventions but is less clear on how the different responsibilities will be allocated and coordinated. The Plan is mainly concerned with involving other departments and sectors in the campaign against HIV/AIDS, and makes almost no mention of the different spheres of government. There was reasonable consensus among the respondents in this study about the roles of the different actors in relation to the HIV/AIDS programme. These are summarised in Table 3.2.

[6] Meeting of the National Minister for Health with the Provincial Members of the Executive Council (MEC) responsible for health in each province.

Table 3.2: Identified roles and responsibilities of key Actors

National DoH	Provincial DoH	Local Government DoH
• Leadership • Provide strategic direction • Policy development • Define norms & standards • Develop guidelines & protocols • Provide technical support to provinces • Training • Mobilise resources • Allocate resources • Provide resources for national programmes (conditional grants) • Funding of NGOs • Monitoring & evaluation • Coordination • International liaison • Research	• Adapt national policies programmes to provincial circumstances • Develop plans to operationalise policies and strategies • Provide appropriate environment for implementation • Training • Capacity development • Mobilise resources at provincial level • Allocate provincial resources • Hospital services • Establish and support inter-governmental coordination structures • Serve as channel to district, local government • Feed local dynamics up to national • Monitoring and evaluation of implementation	• Implementation • Clinic services • Prevention • Serve as channel to communities • Integrate local level resources • NGOs • CBOs • Infrastructure • Poverty alleviation

Hospitals	Clinics	NGOs	Other Government Departments
• Treatment of opportunistic infections • Providing post-exposure prophylaxis (PEP) • Providing palliative care in step-down facilities	• IEC and AIDS awareness • Treatment of opportunistic infections • Treating STIs • Providing VCT services • Linking with and supporting NGOs	• IEC, campaigns • Condom distribution • Counselling • VCT • HBC services • AIDS orphans • Counsellors, carers • Other NGOs • Health workers	<u>Social Development</u> • Social grants • Poverty alleviation • AIDS orphans • NGO support <u>Education</u> • Health education • Life skills training <u>National Treasury</u> • Resource allocation • Conditional grants <u>Public Service Administration</u> • Government workplace HIV programmes

The National Department of Health (NDoH) was seen to have a legitimate role in steering the HIV/AIDS programme. Both national and provincial respondents said that the main role of the Provincial DoH (PDoH) was to modify national policies according to provincial realities. Local government informants mentioned their role in the provision of clinic services, advocacy, training, home-base care (HBC), and NGO support. Hospitals and clinics were described as being responsible for clinical service provision, particularly the treatment of STDs and opportunistic infections. NGOs were mentioned as legitimate and important HIV/AIDS actors, particularly in the provision of home-base care (HBC) for AIDS patients, but also for education, counselling and training.

4 How Are HIV/AIDS Services Coordinated?

The HIV/AIDS Strategic Plan does not really address coordination between the three spheres of government.

The Constitution provides the broad legislative framework for inter-governmental relations and outlines a system of co-operative governance in which shared objectives and values are most important in coordinating relations between the three spheres. The Local Government White Paper and subsequent legislation also emphasise the need for cooperative inter-governmental relations and further suggest that local government can play an important role, particularly through the development of local Integrated Development Plans (IDPs).

Table 3.3: Main coordination mechanisms by category of coordination

Category of Coordination		Coordination Mechanisms
Inter-governmental	National – Provincial	• General structures: MinMEC, PHRC • National HIV meetings • National programme meetings • Consultation in policy development • Planning and budgeting processes • Conditional grants • Appointment of national staff to provincial level • HIV newsletter • Standardised guidelines, manuals • National reporting mechanisms
	National – Local	• Very limited engagement • General structures: (South African Local Government Association) SALGA reps on MinMEC & Provincial Health Restructuring Committee (PHRC)
	Provincial – Local	• Mostly ad-hoc and informal • General structures: Provincial Health Authority (PHA) • Planning processes: Participation in IDP development
Inter-departmental		• General structures: Cabinet, Executive councils, cluster committees • Dedicated coordination units • HIV-specific structures: IMCs and IDCs at national and provincial levels
Inter-sectoral		• HIV-specific structures: South African National Aids Council (SANAC), Provincial AIDS Councils (PACs), District Aids Councils (DACs) • Dedicated coordination units • Contracts with NGOs • NGO forums, consortia
Inter-provincial		• General structures: MinMEC, PHRC
Inter-municipal		• General structures: Provincial Health Authority (PHA), District Health Authority (DHA) • HIV-specific structures: PAC, DAC
Intra-departmental		• Management meetings • Direct engagement
Political-Administrative		• Direct engagement • Presentations to legislature

The major focus in HIV coordination has been on national-provincial coordination, inter-departmental coordination and inter-sectoral coordination. National–provincial coordination has been improved through mechanisms such as the Strategic Plan; regular meetings between programme directors from the two levels; specific conditional grants to support priority activities; and the appointment of national personnel at provincial level. A number of respondents noted that the framework provided by the Strategic Plan had been important in supporting HIV coordination. As one official noted:

> ***'..... we are guided by the strategic plan. There's something that gives us the direction of where we're going to… there is a sort of continuity, so that you don't find every year, you are suddenly doing something totally different, that there's some broad framework within which you can operate. And it gives everyone a sense of where they can slot into the different activities.' (National HIV programme official)***

Inter-sectoral and inter-departmental coordination have been facilitated by the establishment of the HIV-specific coordination structures as outlined in the Strategic Plan. Most of these structures are supported by dedicated personnel and secretariats within the DoH.

Coordination of HIV/AIDS services between provinces and local government has not been formalised. For example, some interviewees described how they were occasionally involved in campaigns or projects together, and attended each others' meetings when invited. Few respondents spontaneously mentioned broader coordination structures such as the Provincial Health Authority (PHA). The PHA was generally depicted as a political structure dealing with tensions related to DHS development and rather removed from day-to-day health service functioning.

A number of interviewees confirmed the importance of informal relationships as mechanisms of coordination within the HIV/AIDS programme. As one respondent said:

> ***'Sometimes it works far better to bypass channels and to phone a person directly and ask them for assistance. That is a very effective manner, although it's not always the correct way, but we do get things done in that manner.' (Provincial official)***

5 What Are The Strengths And Weaknesses Of The Current Arrangements?

Table 3.4. summarises the strengths and weaknesses identified by respondents in relation to what HIV/AIDS services are provided, how HIV roles and responsibilities functions are allocated, and how they are coordinated.

Table 3.4: Summary of strengths and weaknesses

	Strengths	Weaknesses
HIV/AIDS Service Package	• Comprehensive outline provided by 5-year HIV/AIDS Strategic Plan • Well-defined priority interventions (condom provision, VCT, HBC) • Progress with implementation of priority interventions	• Implementation too slow • Little on treatment • Neglect of broader systems and development roles
Allocation of Roles and Responsibilities	• General health roles are defined • Functions of different actors in relation to HIV/AIDS has evolved over time • Reasonable consensus on roles, particularly in relation to national and provincial levels • Some attempt to define roles of other departments and other sectors	• HIV roles and responsibilities of different actors not formally defined • Some tensions in role allocation • Role of local government unclear and unstable • Limited decentralisation of responsibility • Focus on directing and controlling rather than support and development • Limited attention to service delivery at facilities
Coordination and Integration	• Coordination of HIV/AIDS services is receiving attention and resources • Framework provided by Strategic Plan • Improvement in National – Provincial coordination • Inter-departmental and inter-sectoral coordination being addressed	• Objectives of coordination not clearly specified • Weak communication systems • Poor Provincial – Local coordination • Less attention to intra-departmental coordination • Reliance on structures for coordination • No coordination of coordination • Focus mostly on political channels of coordination

HIV/AIDS Service Package

Most of the officials interviewed were quite positive about the progress that has been made in the implementation of the HIV programme over the last year or two. They pointed to improvements in public awareness, condom provision, the expansion of voluntary counselling and testing (VCT) sites, the introduction of home-based care (HBC), and the strengthening of sexually transmitted infections (STI) and TB services. A number commented on the importance of the five-year Strategic Plan in providing a comprehensive and detailed plan of action.

However, some people felt that progress has been too slow while others argued that curative services have not had enough attention. Priority activities within the HIV/AIDS programme have generally become structured into separate, fairly vertical, sub-programmes - such as the VCT and HBC - with reasonably well-defined packages of interventions. This has facilitated implementation but has also served to divert attention from broader systems support and developmental issues. A provincial director explained:

> ***'…. if you look at it now from the Strategy it is only a health issue and yet when you look at HIV/AIDS it is a developmental issue.'***

Allocation of HIV/AIDS Roles and Responsibilities

The HIV Strategic Plan does not clearly specify the roles and responsibilities of the different spheres and actors with regard to HIV services. A provincial director noted:

> ***'The HIV Strategic Plan does not clearly specify the roles and responsibilities of the different spheres and actors with regard to HIV services.'***

Over time the respective roles of the national, provincial and regional/district levels have become reasonably defined in practice (Table 3.2). There has been some deconcentration of responsibility along the national–provincial–regional axis, but most of the strategic direction and authority within the HIV/AIDS programme remains at the centre. A number of respondents complained that the national and provincial levels were still too involved in programme implementation.

The role of local government in HIV service provision remains an important area of uncertainty. Though there is significant variation between municipalities, HIV activities at the local government level remain fairly limited and no HIV responsibilities have been specifically devolved to the local sphere. Many local government respondents felt that the resources and advantages of local government were not being adequately utilised in the government's HIV/AIDS strategy. They argued that the local sphere provided better access to communities and community based organisations, were better situated to mobilise and integrate local resources, and would facilitate a more developmental approach to HIV/AIDS.

HIV/AIDS Coordination

Many local government services function quite independently of the national programmes even when there is significant overlap of activities such as in the setting up of VCT sites or contracting with NGOs

Coordination and integration has clearly been identified as a priority within the DoH and the HIV/AIDS programme. Partly reflecting the priorities outlined in the Strategic Plan, most attention has focused on improving national-provincial coordination, inter-departmental coordination and inter-sectoral coordination. Other categories such as intra-departmental coordination and provincial-local coordination have received less attention. With regard to HIV services, interactions between provincial and local officials appear to be limited to very local initiatives and very specific issues. Many local government services function quite independently of the national programmes even when there is significant overlap of activities such as in the setting up of VCT sites or contracting with NGOs. In the absence of formal relationships local government managers often have to rely on informal and personal connections, which was not seen as ideal.

A number of different coordination mechanisms have been utilised. The Strategic Plan seems to have been particularly influential while coordination structures have varied in their effectiveness; some structures have played a critical role whereas others exist in name only. Nevertheless, the structures have tended to proliferate. In some instances, the establishment of new structures appears to have become an end in itself, hindering coordination rather than facilitating it. As one official complained:

'There is no coordination of the coordination'.

Many respondents suggested that simple communication would address many of the current problems.

Most coordination initiatives have focused on political channels of coordination which do not necessarily result in improved coordination of service delivery. Similarly, the nature of the coordination required is rarely specified. Many respondents suggested that simple communication would address many of the current problems. On the other hand, some provincial and local interviewees argued that there were lots of discussions about programme operations but little space for coordinated strategic thinking and problem-solving among senior managers.

6 What Contextual Factors Influence These Relationships?

The present context of public sector transformation in South Africa is reflected by inter-governmental relations and the coordination of HIV services. Some important factors include the current political pressures for service delivery; the prolonged process of local government restructuring; and the historical legacy of apartheid on municipal level capacity. Within this changing environment governmental relations are clearly still evolving and developing.

The current organisational culture of the public sector also influences these relationships. For example, bureaucracies tend to favour formalisation and structural solutions to coordination problems while the prevailing political culture tends towards accountability to politicians and the current centralisation tendencies within government.

At the DoH level, the policy process with regard to DHS development has been a key contextual factor. Prioritising the district level, as well as the uncertain and changing debate about the role of local government within the DHS, has definitely contributed to the poor integration and coordination with the local sphere.

Lastly, certain contextual factors contributing to the observed relationships and dynamics are unique to HIV/AIDS. HIV/AIDS is seen as requiring a broad, multi-sectoral response, which significantly increases the number of actors involved and the complexity of coordination. Also, the urgency of the HIV crisis in South Africa accounts for the preoccupation with implementation and service delivery rather than slower more developmental approaches.

7 What is the impact on HIV/AIDS service delivery?

Of concern is that the priority sub-programmes of HIV/AIDS have tended to become rather centralised and verticalised and are sometimes seen as ends in themselves.

The HIV/AIDS Strategic Plan has focused on the rollout of a series of national HIV priority sub-programmes, particularly VCT (Voluntary Counseling and Testing) and HBC (Home Based Care). There has clearly been progress in these areas and their implementation has been fairly well coordinated, at least between the national and provincial departments. Of concern is that the priority sub-programmes of HIV/AIDS have tended to become rather centralised and verticalised and are sometimes seen as ends in themselves. Although the department has prioritised the establishment of structures to support inter-departmental and inter-sectoral coordination, these have had limited impact on implementing the HIV/AIDS programme.

The Strategic Plan has been helpful and influential in determining the direction of the HIV/AIDS strategy. The danger, however, is that where the Plan is weak or deficient, so will the programme be. So, aspects such as supporting curative HIV services at clinics and hospitals, or improving provincial-local coordination or intra-departmental integration have been relatively neglected. A few officials voiced their concerns about the limited space for strategic engagement and review of current strategies and initiatives.

Many facility level managers interviewed seemed ill-prepared to take on the extra workload being allocated to them in relation to HIV services. Their concerns, related to basic infrastructure and broader systems support, are not adequately addressed within the current HIV/AIDS plan.

Informants outside the HIV/AIDS directorate commented on the poor coordination within the department on HIV issues. They also complained that HIV/AIDS was receiving a disproportionate share of the attention and resources and that other PHC priorities should not be neglected.

Lastly, the limited interaction and involvement of local government is understandable in the light of the uncertainty regarding DHS development, together with the concerns about municipal capacity and the arrangement of fiscal federal relations. Nevertheless, failing to

take full advantage of the resources and more developmental approach of local government may be particularly detrimental for HIV/AIDS services.

8 How Can Governmental Coordination Be Improved?

An acceptable balance must be found between the oversight and control role of the national and provincial spheres and their developmental and support responsibilities.

This study has explored the complexity of governmental relations and coordination. The frameworks and approaches developed in relation to the coordination of HIV/AIDS services are helpful in highlighting some of the tensions and tradeoffs that need to be considered in improving health system coordination in South Africa:

- There is a tension between achieving short-term delivery objectives - through mechanisms such as centralisation and verticalisation - and broader, more long-term developmental goals - such as the strengthening the local sphere of government. An acceptable balance must be found between the oversight and control role of the national and provincial spheres and their developmental and support responsibilities.
- Improved coordination requires that the roles of the different actors in the provision of health services be clarified, particularly within the local sphere.
- The coordination needs must be clearly defined. Some relationships simply need better communication and information sharing, whereas others may require joint decision-making.
- A more balanced approach to the different categories of coordination is necessary. Inter-departmental and inter-sectoral coordination are clearly important but more immediate priorities may be to facilitate integration within the DoH and to improve coordination between the provincial and local spheres of government.
- Political buy-in and leadership are critical to the success of health interventions, but administrative channels of coordination also need to be developed to ensure that coordination of actual service delivery takes place. The absence of forums for strategic engagement of senior officials from all three spheres of government is a particular concern. A further strategy would be to focus on improving political – administrative relationships.
- Formal structures are frequently seen as the solution to coordination problems though they have not been uniformly successful. There also needs to be more attention to the *"coordination of coordination"* which requires defining clear responsibilities and relationships between different coordinating structures. Other mechanisms of coordination, such as information dissemination or integrated planning, should not be neglected.
- There appears to have been little emphasis on developing shared values between the different spheres of government, the approach to cooperative governance outlined in the Constitution. Respondents spoke more of the competition and rivalries between levels than a shared aim of government delivery. Shifting to more financial mechanisms of coordination, such as conditional grants and service level agreements, may actually undermine existing cooperative relations.
- Process issues must be considered in designing inter-governmental relationships, for example by ensuring that actors affected by the changes participate in their development. Flexibility and learning through experience will probably be more helpful than technical expertise in organisational design.

Lastly, although coordination is important, it should be remembered that if coordination demands too much of the system (in terms of direct or opportunity costs) minimal interventions requiring reduced coordination might be more appropriate and effective than maximal interventions requiring excessive coordination.

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Chapter 4

Local Government's Role in Delivering Primary Health Care

Summarised from the original research done by the Centre for Policy Studies (CPS)

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Background

One of the Local Government and Health (LGH) project's seven research briefs was designed to explain and monitor how the structure, functioning and culture of local government is changing and how, over time, this impacts on the delivery of PHC through the district health system.

The broad areas of focus of the research were: -

- How is health organised in local government?
- Does local government have the capacity to successfully implement the new district health system?
- What is the pattern and accountability of local government councils and health institutions to local health users and other relevant structures / stakeholders?

This research report is drawn from interviews and focus group discussions in the following three districts and two metropolitan municipalities, conducted during 2002: -

- Mopani District Municipality, Limpopo Province
- Francis Baard District Municipality, Northern Cape Province
- Thabo Mofutsanyane District Municipality, Free State Province
- City of Cape Town, Western Province
- City of Tshwane, Gauteng Province

Most interviews were with local government councillors and officials; very few provincially employed health officials were included. It is acknowledged that the research was incomplete, but nevertheless it does give an indication of how stakeholders in health service delivery do relate to each other and how they perceive the future for health services.

Findings

The findings from the five study sites, as recorded in the Centre for Policy Studies (CPS) interim reports, are summarised below under the headings: -

- Geographic factors
- Governance structures
- Health services
- Councillor roles
- Accountability channels
- Expectations of decentralisation

The detailed findings per district municipality and metropolitan municipalities are presented in Table 4.1 and Table 4.2 respectively.

Geographical factors

Detailed geographic information, including population figures, land area and administrative history, are presented in Table 4.3.

The immense physical size of some districts and their dispersed population, such as Frances Baard, present their own challenges in delivering health services, as do the more densely populated areas.

The re-demarcation of health districts and health sub-districts is in itself a challenge for the communities to adapt to. The municipalities visited are unique in their topography, infrastructure and socio-economic development, resulting in different health needs requiring different solutions.

Cross-boundary municipalities, such as between City of Tshwane and North West Province, are problematic for referrals and equity of services.

The better-resourced municipalities, such as the metros, have a large tax base and are therefore better placed to address the challenges of improving services. The district municipalities do not have a sufficient tax base to deliver all PHC and must, therefore, rely on external sources of revenue. Their low tax base also limits the ability of the district municipalities to provide other basic essential services such as water and sanitation, thus presenting unique problems to the municipalities in improving the health status of their communities.

Governance Structures

To understand health delivery it is important to understand the nature of the structures responsible for this delivery.

Local government structures have a political and an administrative component. The mayor and municipal manager are the respective heads of these components, assisted by a team of councillors and officials respectively. The mayor and councillors are political appointees, whereas the management officials are usually professionals in their various fields. The Local Government Green Paper of 1997 and subsequent local government legislation (Local Government Structures Act of 1998 and Local Government Systems Act of 2000) make provision, however, for the municipal manager to be a political appointee.

The number of posts that are created and filled is determined by the budget and other factors. The rural district municipalities often have simple structures with the mayors taking greater responsibility for the strategic direction of the municipality and even for the administration. The metros and the more urban local municipalities have more complex structures.

The Cities of Cape Town and Tshwane have full hierarchies in place with qualified individuals appointed to all positions. Tshwane has an executive mayor, with a Mayoral Committee consisting of councillors dedicated to specific portfolios. In Cape Town the mayor chairs a multi-party executive committee of councillors responsible for specific portfolios. The mayoral powers in the metropolitan areas can be extensive, sometimes equivalent to that of the premier of the province. In contrast Mopani, Thabo Mofutsanyana and Frances Baard District Municipalities do not have sufficient income to sustain an elaborate hierarchy and the mayor works closely with a few district appointees and the portfolio committees.

Health Services

Although PHC services were reported to be "relatively accessible", this is arguably more a reflection of the respondent's acceptance of the *status quo* and limited knowledge of the national norm of basic health services being available within five kilometres of every person.

In the more rural municipalities of Mopani, Thabo Mofuntsanyane and Frances Baard the provincial departments of health provide most of the PHC services. In the metropolitan areas this responsibility is shared between the metro council and the province. As mentioned above, the rural district municipalities do not generally have the resources to run health services. Particular districts may have one or more local municipality with the necessary capacity and these could take on the function on behalf of the district. (e.g. Sol Plaatjies Local Municipality in Frances Baard District Municipality). The metros, apart from the funding, have the capacity to take on more PHC services and the political leaders in particular are keen to do so. The managers, and in particular the financial managers, are more cautious. The City of Cape Town officials expressed concern about the increasing number of people seeking health care through the public sector due to rising cost of medical aid. This is eroding into the City's budget and they will require additional funds in the future, especially if the city is to take on additional health services.

Concern was expressed about integrating services and establishing a viable referral system when there is more than one authority responsible for the services within a district. The metro municipalities, believing that it is easier for them to address problems of equity, want to take responsibility for all PHC services within their jurisdiction.

In summary, the two metro councils have organised structures for health service management and play a significant role in delivering PHC services. In contrast, the district municipalities currently have a limited role in providing health services and the provincial health department provides the bulk of the PHC services. Within the district municipalities there are some local municipalities that do provide significant PHC services.

Councillor Roles

Health professionals expressed some concern about the nature and extent of local government involvement in health and they fear the possibility of political interference in technical decision-making. However, councillors responsible for health generally expressed the wish to take on DHS at the municipal level in a responsible fashion and want to be well informed on PHC and other health services. Councillors reported consulting widely with health professionals, political leaders and joining relevant debates. In addition, they report consulting with communities on their health needs.

The councillors' main interest at health facilities was reported as seeing to improved infrastructure such as water supplies and providing moral support to the staff.

Provincial health officials and health portfolio committee members have developed close working relationships. The members indicated that they rely on the health professionals to guide them in decisions, not wanting to interfere in any technical decisions. In all municipalities the councillors indicated that they visit the health facilities and work closely with provincial health professionals. They will also discuss with health officials problems that community members have brought to their attention.

Accountability channels

Accountability to local communities is central to PHC and DHS. Elected councillors in all municipalities set this as a top priority. Clinic and ward committees are structures that are already functioning in most places and are used for community consultation. Some consider ward committees to be preferable to clinic committees, because the former extend into the community whereas the latter are concentrated around a specific facility and may not address the needs of the wider communities. In places, such as the City of Cape Town, ward committees are not well established. Health Committees are functioning, however, and form an integral part of community accountability channels through the health forums to the health portfolio committee.

In rural municipalities, such as Mopani, tensions between the elected councillors and the long established traditional authorities impact on leadership patterns and thus decision-making. Here certain senior health officials have developed good working relationships with both councillors and traditional leaders and, acting as a go-between, have managed to resolve health-related problems.

Expectations concerning decentralisation

The general expectation in all municipalities is that health services will be decentralised to local government. There is, however, no clear strategy as to how or when this will be done, nor precisely what will be decentralised to which level of local government. This uncertainty leads to tension between district and local municipalities, particularly where a local municipality is stronger than the district municipality.

Concluding Remarks

The overall impression of these limited snap-shot views is that the newly created municipalities are keen to take on the challenges of running PHC services. The newer, more rural councils appear to lack the necessary capacity. The metros, if given the additional funding required, appear confident and capable of taking on the services.

The relationship between the district and local municipalities needs to be clarified. The legislative framework and a strategic plan for decentralisation of health services and the establishment of the district health system are urgently required. This will alleviate the uncertainties and the confusions noted during the fieldwork for this study.

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Table 4.1: Summary of District Municipality Profiles

	Mopani DM	Frances Baard DM	Thabo Mofutsanyane DM
Geography and history	See Table 4.3		
Health services	Dist Munc = Health District Loc Munc = Health Sub-district Health Services – PHC – PDoH mostly – 7 dist hospitals, 63 clinics & 26 mobiles – LG in Greater Tzaneen and Letabo – 2 clinics – Dist Munc – some EHS only Management – PDoH appointed Dist and Sub-Dist Management Teams District Health Council – not established	Dist Munc = health district No subdivisions Health Services – PHC – PDoH mostly – 4 dist hospitals, 1 CHC, 15 clinics & 7 mobiles – LG – in Sol Plaatjie – 9 clinics & 1 mobile – Dist Munc – some EHS only Management – PDoH appointed Dist Management Team District Health Council – not established	Dist Munc = health district Loc Munc = Health Sub-district Health Services – PHC – PDoH mostly – 8 dist hospitals, 2 CHCs, 28 clinics & 26 mobiles – LG – in ex local authorities – 43 clinics – Dist Munc – some EHS only Management – PDoH appointed Health Manager and Team District Health Council – established
Municipal Structures ***Political***	Elected Mayor and Speaker Mayoral Committee of elected councillors, who are chairs of portfolio committees. Health is part of Social Development Services Most councillors – part-time Greater Tzaneen – strong Loc Munc with similar structures	Elected Mayor and Speaker Mayoral Committee of elected councillors, who are chairs of portfolio committees. Health is part of Social Development Services Most councillors – part-time Sol Plaatjie – strong Loc Munc with similar structures	Elected Mayor and Speaker Mayoral Committee of elected councillors, who are chairs of portfolio committees. Separate Health Portfolio Committee with 2 sub-committees – – Consultative Committee – Policy Committee = DHC Most councillors – part-time No strong Loc Munc
Administrative	Not established – Mayor responsible for administrative functions No appointed Health Manager	Emerging structure Appointed Municipal Manager No appointed Health Manager	Emerging structure Appointed Municipal Manager No appointed Health Manager
Strategy and expectations of decentralisation	PHC anticipated to be decentralised to Dist Munc – time frame not known. Health Portfolio Committee working closely with Provincial structures in preparation to decentralisation.	All PHC to be transferred to Dist Munc from April 2003 – Loc Munc responsible for EHS, Dist Munc balance of PHC Delayed due to lack of supportive legislation Technical Task Team – addressing issues of human resources, finances, health services, health information and legal/contract Interim PHA established	PHC services to be decentralised to Dist Munc, funded by province. Capacity building being undertaken in preparation for decentralisation Functional integration – encouraged to assist with establishing DHS District Council active in process

	Mopani DM	Frances Baard DM	Thabo Mofutsanyane DM
Relationships			
Between officials and politicians	Close working relationship, as well as with provincial officials. Councillors not involved with technical issues, but supportive of improving clinic services	Close working relationship developed – small, new unit offering support and guidance to each other	Mayor and Municipal Manager meet weekly and work closely with each other Meetings held with Provloc – to discuss intergovernmental interactions Possibly some tensions between new political and old administrative structures
Between district and local municipalities	Works closely with all local municipalities. Each local municipality is represented on the District Social Services Portfolio Committee	Relationship with Sol Plaatjie Loc Munc has some tension due to greater strength and experience in health services in the Loc Munc. Some suggestions that Sol Plaatjie should be responsible for PHC services, on agency basis for the Dist Munc – but this is contrary to Provincial strategies.	Good working relationship with all local municipalities.
Between local govt and community	Link with community through local municipality representation on District Social Services Portfolio Committee, ward committees and clinic committees. Some tension between political and traditional leadership structures Provincial health officials assist with mediating between the two structures	No close link with community, except in DMA. Loc Munc (e.g. Sol Plaatjie) closer relationship through Ward Committees and Clinic Committees. Form communication bridge between community and health services	Link with community is through The Health Forum, comprising the chairs of all clinic committees in the district.
Between district municipality and province	Collaborate on strategic planning issues. PDoH director for health in the district attends all Health Portfolio Committee meetings. Councillors visit clinics and reportedly have closer relationship with provincial health officials than with provincial politicians	Close working relationship to develop strategies and plans for decentralisation of PHC services. Close relationship also between Sol Plaatjie Loc Munc and Province – possibly adds to tension between the two levels of Loc Govt. Co-operate in appointment of staff	Developing strong inter-governmental relationships seen as priority by Premier of the Free State. Well-structured relationship developed between spheres of government. PHA meets quarterly with the DHC Councillors and district health management team work closely together Inter-sectoral collaboration evident in the ISRDS node

Loc Munc = Local Municipality
Dist Munc = District Municipality
PDoH = Provincial Department of Health
LG = Local Government

EHS = Environmental Health Services
PHA = Provincial Health Authority
DHC = District Health Council
CHC = Community Health Centre

ISRDS – Integrated Sustainable Rural Development Strategy
Provloc = Provincial Local Government Association

Table 4.2: Summary of Metropolitan District Profiles

	City of Cape Town	City of Tshwane
Geography and history	Previously part of Cape Province No previous homelands Long history of local government and PHC health services	Previously part of Transvaal Small portion ex homeland – Odi District Long history of local government and PHC health services
Health services	City of Cape Town – well structured health services Divided into eight health sub-districts District Health Authority established Services being integrated between two spheres Health Services – PHC – PDoH – 2 district hospitals, 47 clinics – City of CT – 109 clinics, EHS services Management – each sphere has own health management team, who meet regularly.	PHC services provided by City of Tshwane and PDoH, through regional office Municipal Council fulfils the role of the District Health Authority Services being integrated between two spheres Health Services – PHC – PDoH – 4 district hospitals, 4 CHCs, 22 clinics & 9 mobiles – City of Tshwane – 29 clinics and 3 mobiles Management – each sphere has own health management team, who meet regularly.
Municipal Structures ***Political***	Elected executive mayor Executive mayoral committee – members are full time councillors and each responsible for a portfolio committee Health joined with amenities and sport City divided into 16 sub-councils Established governance structures – Ward Committees and Health Forums Political power evenly balanced between ANC and DA	Elected executive mayor Executive mayoral committee – members are full time councillors and each responsible for a portfolio committee Health part of Social Development Portfolio Committee Political power dominated by ANC
Administrative	Established administrative structures Appointed Municipal Manager Appointed Health Manager with health management team	Established administrative structures Appointed Municipal Manager Appointed Health Manager with health management team
Strategy and expectations of decentralisation	Western Cape committed to decentralize PHC to City of CT Transfer was expected to start in June 2002, but delayed due to lack of legislative framework Anticipated that PHC will remain provincial responsibility, with the City being responsible for EHS only – this is welcomed by financial managers in the City because of the rising cost of PHC due to rising medical aid costs and urbanization.	Gauteng PDoH expects to decentralize PHC services to the Metros and Dist Munc City of Tshwane ready to accept the services provided there is additional funding. Councillors have been trained and are ready to accept the services.

	City of Cape Town	City of Tshwane
Relationships ***Between officials and politicians***	Close working relationship over many years. Health Portfolio Committee relies on officials for technical guidance, but members are not involved with technical issues. Health services managed by experienced health professionals. Political considerations – evident in appointment of three successive city managers within few years.	Councillors communicate directly with health officials for advise, but are not directly involved in technical decisions Health Manager and health team are all experienced health professionals. No major controversies between the two.
Between local govt and community	Structures for formal communication in place – – To the Health Portfolio Committee via the 16 sub-councils – To the Cape Metro Health Forum via the 11 District Health Forums Ward Committees not well established as formal accountability structures. Health Committees within geographical areas usually deal with health issues. Health Manager reported to have 'open door' policy with community and has established good relationships with the community.	There are few functional clinic committees used as accountability structures to the community Politicians consult communities through Ward Committees Clinic committees and ward committees are beginning to interact with each other.
Between metropolitan municipality and province	Close working relationship established 11 of the 47 provincial community health centres are run jointly. Regular meetings held between the two – ensuring common strategies for health service delivery Inter-government relations complicated by political turmoil in the province	Relationship is generally good. Have shared vision for decentralisation of health services – but Metro frustrated by delays. Councillors visit the health facilities and are familiar with national and provincial legislation and policies

Table 4.3 District Municipalities

District Municipality	Local Municipality	Population	Area (km2)	Pop Density (/km2)	Former Administrative Authority	Rural/Urban	Wards
Francis Baard	Sol Plaatjie	215857	1877	115	Former RSA	Mixed	27
Northern Cape	Phokane	62498	830	75	Mostly former homeland	Rural	9
	Dikgatlong	39056	2378	16	Mostly former RSA	Rural	7
	Marageng	23745	1541	15	Mostly former RSA	Rural	5
	Diamondfields District Management Area (DMA)	4819	5720	1	Mostly former RSA	Rural	0
	TOTAL	**345975**	**12346**	**28**			**48**
Mopani	Greater Giyani	257531	2967	87	Former homeland	Mostly rural	25
Limpopo	Greater Letaba	238217	1871	127	Former homeland and RSA	Mostly rural	23
	Greater Tzaneen	408849	3260	125	Mostly former RSA	Mixed	33
	Ba-Phalaborwa	129063	3000	43	Mostly former RSA	Mixed	14
	TOTAL	**1033660**	**11098**	**93**			**95**
Thabo Mofutsanyane	Maluti a Phofung	383337	4421	87	Mostly former homeland	Mixed	34
Free State	Setsoto	119112	5966	20	Former homeland and RSA	Rural	16
	Dihlabeng	116302	4739	25	Former homeland and RSA	Mixed	17
	Nketoana	69756	5611	12	Former homeland and RSA	Rural	9
	Phumelela	49151	7548	7	Former homeland and RSA	Rural	7
	Golden Gate National Park (DMA)	670	61	11	Former RSA		0
	TOTAL	**738328**	**28346**	**26**			**83**

Chapter 5

Assessing Health Content and Health Sector Participation in Selected Municipal Integrated Development Plans

Summary by Ross Haynes
From original research by Rene Moodaley[7]

Background

Enhanced inter-sectoral collaboration (ISC) is seen as a key potential advantage of decentralisation. Legislation, through the Municipal Systems Act of 2000, makes provision and calls for ISC and cooperative governance. Both approaches can contribute to improved health service delivery. However, there are no tools available for monitoring and evaluating ISC. Addressing the root causes of poor health, such as poverty, inadequate nutrition, poor sanitation, lack of potable water and poor housing, requires collaboration between a number of state service providers.

The Integrated Development Plan was identified as a possible tool to monitor how different sectors are working together within local government in addressing health needs in the community.

The full report on this research, of which the chapter is a summary, can be downloaded in pdf format from www.hst.org.za
Moodaley R, *Rapid Appraisal of the Health Content of selected Municipal Integrated Development Plans.* Health Systems Trust, 2004, Durban.

Methodology

The aim of this study was to review the Integrated Development Plans (IDPs) from selected municipalities in South Africa's nine provinces. One district or metropolitan municipality was selected per province, plus two local municipalities from within eight of the nine selected district municipalities and one local municipality from the ninth.

The main objective was to assess the quantity and content of health-related information in the IDPs and the involvement of the provincial and local health officials in the IDP process. The study looks at the first generation of IDPs which were to be adopted in April 2002.

The primary source of information was the IDP documents. However information was also gathered from reports and publications from government departments, health development agencies and a number of key informant interviews.

Summary of Findings

Budgeted allocation for health-related development projects as a percentage of the total IDP budget varied considerably (from 47% to less than1%) This variation could reflect the varying importance that municipalities assign to health issues, but could also reflect historic need or other more pressing needs in the municipal area which affected the prioritising process and thus the budget allocation.

Inadequate information prevented a reliable assessment of the health officials' participation in the IDP processes. Generally indications point towards inadequate participation, although some IDPs nevertheless contained good health information.

The nature of health projects undertaken by different municipalities varied greatly. Categorising these into infrastructural, curative and preventative type projects suggests that most projects fall into the first two categories. HIV/AIDS related projects, the main component of the third category, were given high priority, presumably as a result of corresponding emphasis in the Department of Provincial and Local Government (DPLG) IDP guidelines. These projects however, are frequently presented in isolation and do not link holistically with other health activities. In a similar vein, another national health priority programme, Maternal, Child and Women's Health (MCWH), which was not prioritised in the IDP guidelines, was not included in any of the IDPs.

Although the IDP document is meant to incorporate health care plans as one of approximately ten sector or service delivery plans, none of the IDPs assessed included such a plan. In most cases there appears to be little linkage between the health care plans compiled by the provincial structures at district level and the IDP development process.

The information contained in the IDPs was also not sufficient to draw conclusions about the degree of inter-sectoral collaboration in a particular area.

Note was taken of those IDPs reflecting good practice on the ground, such as meaningful community participation, vertical and horizontal coordination and alignment, good information exchange, effective communication channels and logical flow in the identification of projects.

A review of selected first generation Integrated Development Plans indicate little health content, and limited involvement of provincial and district health officials.

Conclusion

The health sector relies on all three spheres of government, NGO's and the private sector to realise its aims. Each sphere of government is responsible for providing different services. This study re-emphasises the inter-connectedness of health and development. Improvements in health, environmental and socio-economic issues require inter-sectoral efforts. Such efforts, involving education, housing, public works and community groups, including businesses, schools and universities and religious, civic and cultural organizations, are aimed at promoting sustainable development in the communities.

As a first time study, no benchmarks were available for purposes of comparison. At the same time, this study deals with the first round of IDPs in the municipalities. The study does, however, provide a baseline for future studies. Future IDPs should reflect the impact of service level agreements between provincial health departments, district municipalities and local municipalities with joint planning activities between province and district concerning health service delivery. The extent of services provided will vary according to the capacity of specific municipalities and service agreements set up between provinces and municipalities.

Although the DPLG IDP Guidelines[8] encourage the inclusion of sector specific plans, the Municipal Systems Act does not legislate for a health plan as a separate output in the IDP process. From this perspective health issues would arise and be included in the IDP through emerging as local needs and priorities – from a consultative process or as direct responsibilities. This would result in the role of health planning in the IDP process varying, depending on the type of municipality and the local context. From a health perspective, however, section 38 of the National Health Bill of 2003, likely to be promulgated in the near future, requires District Health Plans to be integrated into the respective IDP.

While assessing the health content of IDPs in selected municipalities, it is important to remember the changing context of decentralising health to local government, and therefore its impact, over the past few years. For both municipal and health officials, developing the IDPs in question took place during a time of great uncertainty with little assurance of who would be responsible for what. The Constitution, without defining it, makes municipal health services (MHS) a local government responsibility. Expectations about the final definition vacillated between the full basket of primary health care services to a selection of environmental health services, but always with the national vision of a municipality-based district health system as a backdrop. . Provisions in the National Health Bill of 2003 define MHS as a list of environmental health services (excluding port health, control of hazardous substances and malaria control) and make MHS a district and metropolitan municipality responsibility, although with provision to appoint local municipalities as implementing agents.

Good participation in the Eastern Cape sites demonstrates the value of a municipality actively reaching out to its communities and not only to those citizens who have the means, influence and power to participate but to those who normally do not have a voice. The study further suggests that it was frequently members of the community who had access to certain levels of information, or who had a particular interest in the affairs of the municipality, who actively participated in the IDP.

Successful exchange of information is a basic condition for effective coordination. Decision-makers require information in order to decide on priorities, select appropriate programmes and adapt them to changing needs.

Communication channels should be established or strengthened and formalised, mainly by regular meetings and reports (as described by the municipalities appraised in the Eastern Cape). At a project level, general meetings with the community, traditional leaders,

[8] DPLG (undated). *IDP Guide Pack – Guide V: Sectors and Dimensions.* Department of Provincial and Local Government, Pretoria

businesses and political organisations should be complemented by meetings at a sector department level. Properly organised meetings working to a prepared agenda and chaired by the person responsible for co-ordination produce the best results.

The study strengthens the notion that integrated development planning is a useful tool for promoting equity, inter-sectoral coordination and the optimal use of scarce resources.

Although the study was not particularly effective in assessing the exact role that the health sector played in development of the IDP's it does provide circumstantial evidence of increased prioritisation of health needs linked to greater health sector involvement. This supports the imperative for health officials to view the IDPs differently and support a sufficiently senior level of involvement. The provisions of the National Health Bill should provide the necessary leverage for those responsible for the IDP process, such as the Municipal Manager, to elicit adequate health sector participation.

Recommendations

1. **Promote a greater understanding of the IDP processes and the health management structures amongst**

   - health officials, especially the IDP's role in sourcing municipal funds for development projects and its potential in aligning sectoral resources towards achieving mutual aims. Such mutual aims could include ensuring that a new clinic has a road, water supply and sanitation facilities, electricity, and access to agricultural and welfare inputs - all aimed at promoting the development of a healthier community.

   - councillors and municipal officials require an understanding of the health management structures, including the emerging health legislation, and should press for the full involvement of health (and other sector-linked) officials in the IDP process.

2. **Promote health care plans as a tool for enhancing coordinated health services delivery by**

   - developing and sharing a standard version of a health care plan. This will assist all involved in using this as a tool in planning the overall development process within the respective municipal area

3. **Promote Community Participation by ensuring that**

   - municipalities proactively reach out to <u>all</u> the members of their community so as to draw on their local knowledge and to promote acceptance and ownership of the IDP.

4. **Ensure vertical and horizontal alignment**
   - thereby minimising duplication and maximising effective use of resources.

5. **Ensure effective communication**
   - through regular sharing of correct and relevant information along agreed communication channels.

Chapter 6

Public-Private Interactions in the South African Health Sector [9]

Haroon Wadee[1], Lucy Gilson[1], Duane Blaauw[1], Ermin Erasmus[1] and Anne Mills[2]

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Background

In many countries health sector reforms are designed to minimise the role of government and to increase that of the private sector in health service delivery, on the assumption that the private sector will improve the quality of service delivery, enhance efficiency and improve equity within the health system. This has been through either privatisation or out-sourcing.

The South African health system has a strong private sector that serves less than one-fifth of the total population. Before 1994 little attention was paid to the role of the private sector within the overall health system, leaving it to develop and grow in an unregulated way. Towards the end of the 1990s attention began to be focused on managing public-private interactions (PPIs) in ways to achieve health system goals.

There is a growing interest within government for the private sector to play a role in service delivery.

At the provincial level a range of PPIs are emerging. However, the role of private sector with proposed decentralisation of health to local government is unclear. Vague frameworks and ambiguous criteria for decision-making could result in unchecked growth in the type and content of PPIs.

The full report on this research, of which the chapter is a summary, can be downloaded in pdf format from www.hst.org.za
Wadee H., Gilson L., Blaauw D, Erasmus E and Mills, A. (2004): *Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National, Provincial and Local Levels*. The Local Government and Health Consortium, Health Systems Trust, Durban. 2004.

Methods

This study sought to map current PPI initiatives within provincial and local government as a basis for future planning. It looked at what constitutes PPIs, their range, the forces influencing their development and their potential implications.

The study used qualitative and quantitative methods. A review of health economics, health policy, public administration and privatisation literature provided insights into both national and international experiences of PPIs. A conceptual framework to describe and monitor health sector PPIs was developed. Document reviews, key-informant interviews, a national survey and a media analysis were undertaken to map PPIs, outline the policy environment and to understand PPI drivers. There was a low response rate to the survey, partly due to the complexity of the questionnaire and partly due to the lack of capacity in newly established municipalities. However, the information was useful for the mapping exercise and highlighted the difficulty of gathering evidence of the impact of PPIs.

Policy Context

The South African PPI experience pre-dates 1994 and includes a range of clinical and non-clinical contracting. For example, these PPIs included contracts with State-Aided hospitals such as SANTA and with Lifecare for tuberculosis and psychiatric care and the appointment of private clinicians as part-time district surgeons to improve access in under-resourced areas.

After the 1994 elections there was minimal policy development dealing with the private sector. The *White Paper on the Transformation of the Public Health System* (South Africa 1997) provides a vision for a unified health system that includes co-ordination between the public and private sectors. This provided the basis for the development of a coherent Private-Public Partnership (PPP) policy by the National Department of Health (NDoH) in 1999. The Limpopo (June 1997), Eastern Cape (April 1998) and Western Cape (August 1998) provincial departments of health developed PPP documents. These influenced the national policy document that was accepted in November 2000 by the Provincial Health Restructuring Committee (PHRC), less than three months after the National Treasury established a PPP unit.

In June 2000 National Treasury established a PPP unit to support and approve provincial government PPPs, and in September 2000 detailed PPP guidelines in line with the Public Finance Management Act (PFMA) of 1999 were finalised. Treasury-approved PPPs in health include the Nkosi Albert Luthuli private finance initiative (PFI) and the Free State hospital co-location agreements. These arrangements however are not fully covered in the NDoH PPP document. An NDoH PPI Working Group was established in early 2001 to address discrepancies between the narrower National Treasury PPP guidelines and the NDoH PPP document. This group presented a document at the National Health Summit in November 2001. PPIs were identified as a priority area at the Summit and in July 2002 a PPI Lekgotla with major stakeholders from all spheres of government, private funders, private providers and trade unions was held.

Within local government the Municipal PPP pilot programme was initiated in 1997 and by March 1998 the Municipal Infrastructure Investment Unit (MIIU) was established. By early 1999 landmark water privatisation contracts were signed in Dolphin Coast and in Nelspruit. The Municipal Structures Act of 1998 and Municipal Systems Act of 2000 endorse private sector partnerships to meet infrastructure backlogs and to improve service delivery. However, there are no guidelines to co-ordinate health-specific PPIs within the local sphere of government. The South African Constitution of 1996 allocates powers and functions to local government that makes it difficult for both National and Provincial health departments as well as National Treasury to enforce PPP guidelines at this level.

PPI policy development is a complex matter. The development of parallel guidelines and the gaps that have been identified in these puts PPI development at risk of being uncoordinated, and possibly undermining the health system.

Mapping health sector PPIs

Two broad sets of PPIs were identified:

- Those that *manage relationships;* include
  - interactions such as formal and informal dialogue,
  - policy and patient transfer protocols.

  For the most part, these facilitate discussion and engagement between the sectors, building trust and providing a foundation for service delivery PPIs.

- Those that *support service delivery;* include
  - Purchased services – refers to purchasing clinical services
  - Outsourced non-clinical services
  - Joint-ventures – can be either a lease or service model
  - Private Finance Initiative (PFI) – raising capital on private money markets for infrastructure investment through a private consortium
  - Other innovative interactions such as asset swap.

At local government level, most PPIs take the form of purchased services for primary care. These purchased services are primarily linked to individual providers, clinical support services (radiology, pathology) and some home-based palliative care involving a range of for-profit and non-profit private providers. The non-clinical outsourcing that occurs includes waste management and security services. There are a few examples of joint ventures such as sharing under-utilised public facilities with general practitioners in return for services beyond clinic operating times.

Non-clinical contracting is common at the provincial level and includes catering, security, laundry and porter services. These are primarily implemented at hospital level care and involve purchased services and joint ventures.

Service model arrangements range from Co-location Agreements (a form of lease arrangement in which spare public hospital capacity is leased to private providers) to the development of differentiated amenities within public hospitals (which may involve an agreement with private funders to allow insured patients to use the better amenities).

The nature of PPIs is all-encompassing and may include formal Treasury-approved PPPs, such as the Free State Hospital Co-location Agreements, alongside other forms of interaction that do not necessarily conform to the narrow prescriptions of Treasury's PPP unit.

The range of private agents involved in provincial PPIs is diverse, and includes hospital companies, private funders and specialist clinical and non-clinical companies. A new form of outsourcing that is emerging at provincial level focuses on general management functions at facility and other levels. Private 'transaction advisors' are being employed to manage the Treasury PPP process between provinces, Treasury and private investors/service providers. This is likely to increase as more provinces embark on PPPs that require Treasury approval.

PFIs were identified at all levels of government, although to a limited extent at the local government level where the term may have been misunderstood. In one case it was applied to private donations for infrastructure investment, which is different from the long-term contractual nature of the Treasury PFI approach. At provincial level, the provincial health department manage the PPIs with considerable support from the national level (Treasury and Health). These are used to revitalise and equip existing facilities, or to build and equip new

ones. This may include equipping facilities with the latest hi-tech medical and non-medical technology, such as the Nkosi Albert Luthuli Hospital PFI. Elsewhere the plan is to purchase non-medical equipment through a PFI.

The types and forms of PPIs being implemented vary quite considerably between areas and authorities. For instance KwaZulu-Natal is keen on PFIs, Western Cape prefers co-location and Gauteng is in favour of a combination of PFIs and differentiated amenities. One innovative form of PPI to emerge in the Western Cape is the 'asset swap' in which private investors are offered prime property owned by the province, and in return are required to rebuild and equip facilities in under-served areas.

The mapping analysis shows a wide range of PPIs in operation. Although some cases these interactions include Treasury-approved PPPs, this is not the dominant form of PPI taking place in the health sector.

Demonstrating the blurred boundaries

Service delivery whether publicly or privately owned involves a core set of functions with respect to financing, capital ownership and provision. But with PPIs these boundaries between the two sectors are blurred and may even overlap. Table 6.1 highlights this blurring, and hence the complex nature of PPIs. It considers two different forms of the 'purchased service' category of PPI, namely contracting session doctors and contracting renal treatment.

Table 6.1: Application of Technical Characteristics Analysis to Highlight Complexity of PPIs.

	Capital Financing	*Recurrent Financing*	*Capital Ownership*	*Healthcare Provider*
Session Doctors	**Public**	**Public (collective tax)**	**Public**	**Private/Public**
Renal Treatment	**Private**	**Public (collective tax)**	**Private**	**Private**

With session doctors capital and recurrent financing and ownership is public. However, the health care provider is both public and private. The individual is a private practitioner but works within a public facility. The case of the public sector contracting renal treatment from the private sector involves a different allocation of roles. Although capital ownership, capital financing and health care provider functions lie in the hands of the private sector, recurrent financing is provided by the public sector through its purchase of services.

This comparison illustrates that even within one PPI category, such as purchased services; public and private stakeholders may take responsibility for a different combination of functions. Managing PPIs is, thus, a complex task that requires careful consideration of the details of each PPI

What drives PPI development in the South African Health Sector?

In analysing the driving forces behind PPI development in the health sector it is important to understand the objectives of both the stakeholders responsible for initiating them, and of the PPIs themselves. These objectives provide a sense of why PPIs are being implemented, but do not assess whether they are achieving these objectives.

PPIs that manage relationships facilitate discussion between the public and private sectors, build trust and lay a foundation for service delivery PPIs, which have a wider range of objectives. Table 6.2 highlights the similarity and differences in objectives between PPI categories. Purchased services and joint-ventures may promote equity; while outsourced non-clinical services and PPPs promotes efficiency.

Table 6.2: Objectives of PPIs by Category

PPI category	Objectives
Purchased services	• Improve access • Improve quality of care • Improve service delivery in areas of need • Promote public health role of private practitioners. • Tapping into external expertise
Outsourced Non-Clinical Services	• Reduce costs • Improved access • Improved quality of care • Shifting risk of capital investment to private sector.
Joint-Ventures	• Higher quality services • Lower costs • Revenue generation • Improved access • Improved efficiency via improved resource use
PFIs	• Access to private sector finance and expertise • Value-for-money • Affordability • Savings to health care purchasers • Improved management • Addressing infrastructure backlogs
Treasury-Approved PPPs	• Risk transfer to private sector • Affordability • Value-for-money • Improved economies of scale • Improved service delivery
Other (Asset Swap)	• Improve access • Addressing infrastructure backlogs

Objectives also differ between stakeholders (see Table 6.3). For instance the NDoH is concerned with strengthening the health system, improving equity and containing costs, whereas the National Treasury emphasises the need to address infrastructure backlogs, get value-for-money and shift risk to the private sector. The public sector is more concerned with improving health system equity, whilst private hospitals and funders are concerned with generating a profit.

Linked to objectives are drivers, which are the key contextual factors influencing the range of objectives of the stakeholders. Like the objectives the drivers differ between stakeholders (see Table 6.3). For instance, the NDoH is concerned with cost escalation in the private sector, misdistribution of resources and budgetary constraints. Although the National Treasury is concerned with budgetary constraints as well, one of their major concerns is the backlog in infrastructure development.

Table 6.3: Comparative Overview of Objectives and Drivers by Four Key Stakeholders

Stakeholders	Objectives	Drivers
National Department of Health	1. Strengthening the health system 2. Cost containment in the health sector 3. Revenue Generation 4. Improving equity of financing and access **5. Improving efficiency**	1. Fragmented health system 2. Cost-escalation in the private sector 3. Budgetary constraints 4. Mal-distribution of resources across public/private sector relative to population served, leading to poor coverage and access for poorest income groups; as well as poor value for money of South African health system (as shown by low rating in World Health Report 2001) **5. Budgetary constraints; under-utilised resources within the system.**
National Treasury	1. Shifting risk to the private sector 2. Value-for-Money **3. Addressing infrastructure backlogs**	1. Budgetary constraints 2. Budgetary constraints **3. Infrastructure backlogs**
Private Funders	1. Reduce costs 2. Improve access 3. Improve efficiency 4. Strengthening the health system 5. Profit **6. Enhancing trust between the public and private sectors**	1. Cost escalation in private sector 2. Lack of access to medical insurance and private healthcare; declining market; market saturation 3. Under-utilised resources within system 4. Fragmented health system 5. Declining market; market saturation **6. Lack of trust between the sectors**
Private Hospital Companies	1. Enhanced efficiency 2. Improved perceptions of the private sector 3. Profit 4. Staff retention **5. Enhancing trust between the public and private sectors**	1. Duplication in health system 2. Negative perceptions of private sector by government 3. Declining market; market saturation 4. Personnel exodus abroad **5. Lack of trust between the sectors**

Differences between stakeholders have the potential to allow PPIs to generate negative impacts on the health system, leading to possible fragmentation of the services and generating additional costs. The confusing frameworks for PPIs have the potential to complicate their management. This in turn may result in poor management. There is a tension between the private sector profit motivation and the public sector equity objective. Strengthening the health system may emerge as a shared objective, but if this is not explicitly stated it may be undermined by a clash of motives, causing a lack of trust between the sectors and possible further fragmentation of the health system.

The PPI Working Group, the National Health Summit, the PPI Lekgotla, and provincial public-private forums have identified the need to bring stakeholders together to develop mutually acceptable frameworks in order to enhance mutual trust between the sectors.

Potential Problems of PPIs

During interviews public sector stakeholders raised a number of potential problems that may result from PPI implementation. These include:

- The lack of a legislative framework to guide provincial departments

- The lack of strong and specific capacity within all spheres and levels of the public sector to deal with the complex PPI negotiation processes, to ensure that the private sector does not take advantage of the public sector
- The difficulty of establishing measurable outcomes for inclusion in the contract
- The lack of adequate resources to support the necessary development of skills and systems
- The complexity of managing public perceptions around PPIs to avoid them undermining support for the public sector.

Private sector stakeholders raised the following concerns:

- Lack of trust between the sectors
- Lack of clarity or transparency around government decision-making processes
- Lack of national co-ordination in PPI decision-making requiring provincial engagement
- Risk-averseness on the part of the government undermining private sector willingness to enter into PPI
- Problems with government procedures such as timely payment
- Quality of care problems in the public sector
- The trade union opposition to privatisation.

Trade unions concerns raised include:

- PPIs leading to 'tiering' within the health sector;
- The private sector having no incentive to serve the poor;
- Lack of government capacity to fully analyse potential PPIs.

Conclusions

Three inter-linked conclusions can be drawn from this analysis;

I. There is a lack of clarity or vision around the potential and problems of PPI development within the health sector, and between and within spheres of government. This leads to diverse understandings and developments across the country. There are inadequate and confusing guidelines for policy development and implementation of PPIs. Some guidelines are health specific, whereas others, such as the National Treasury (2000; 2001) Public-Private Partnership (PPP) guidelines, are applicable to other sectors.

II. Managing PPIs is complex and challenging. A wide range of PPIs are being implemented with a range of different objectives. In the absence of coherent frameworks, the task of ensuring that PPIs strengthen the health system is difficult. Every PPI has a complex set of relationships between public and private stakeholders with respect to financing, provision and ownership.

III. Adequate capacity in contract negotiation, monitoring and evaluation is needed to effectively manage the process of developing health sector PPIs. This will ensure that health policy goals are realised, and not undermined, by PPIs.

The key dangers of uncoordinated action around PPIs is the risk of further fragmenting the health system and of generating additional costs and burdens for the public sector.

There is little knowledge and understanding of the range of PPIs being developed across the country and their cost and benefits to the health sector. The potential impact of PPIs on service delivery are not being monitored or evaluated.

Policy Recommendations

Implement the vision outlined in the 2001 National Summit PPI document. This seeks to strengthen the capacity of the public sector to develop and implement PPIs – including the capacity to choose not to implement PPIs.

Establish a PPI unit within the NDoH to
- communicate a unified vision,
- develop specific frameworks and guidelines,
- co-ordinate PPI development across government,
- support dialogue between the sectors,
- provide operational support to both provincial and local government management,
- offer relevant training and
- coordinate the monitoring and evaluation of PPI experiences and their impact on service delivery.

Secure funding and human resources for effective functioning of the national PPI unit.

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Chapter 7

The State of Decentralisation in the South African Health Sector, 2003

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Background

The central aim of this chapter is to assess the current (as at 2003) state of decentralisation within the health sector, and the key challenges facing it. It draws on evidence from all of the studies undertaken within this programme of work, and as briefly outlined in earlier chapters. The second section summarises the core findings, and the third section presents a more detailed justification of them.

This work was undertaken as the National Health Bill, and its recommendations concerning the future role of Local Government in health care management and delivery, were being finalised. Nonetheless, the conclusions presented here take as their starting point the National Health Bill's definition of the Municipal Health Services (MHS) to be provided by Local Government. These include a list of environmental health services. Other health services may be delegated or assigned to Local Government, per agreement between the municipality and the MEC for health.

Strengths and weaknesses of health system decentralisation 1994-2003

The evaluation of health sector decentralisation identifies five main achievements of the last ten years. They are:

- The creation of new provincial administrations and governance structures that can enable wider health system change
- Moves towards the adoption of an enabling and co-ordinating role by the national Health Department
- The consolidation of effective national-provincial co-ordination structures and the development of (generally) trusting relations between these two spheres of governance
- The development of structures, approaches and some informal relationships as means of co-ordinating and supporting service delivery throughout the country
- The emergence of a willingness, even in newly formed municipalities, to assume responsibilities for health service provision.

However, over this period two main problems have been experienced. First, there are continued geographical inequities in health system resource allocation, indicating gross inequities in the distribution of human resources and physical infrastructure between and within provinces. Second, only a limited degree of decentralisation in health sector management has actually been achieved. As a result, the promise of the early achievements of DHS development (Gilson et al. 1996) have been hard to sustain and build on.

Underlying these problems are four main sets of obstacles:

- Uncertainty over the role of local government in the health system, that is only now (2003) being resolved through the long-awaited framework of the National Health Bill
- Persistent capacity weaknesses in the health system, despite the great amount of training provided
- A hierarchical and rigid bureaucratic culture
- Some reluctance on the part of provincial governments and health departments to decentralise authority to lower levels

Yet some experiences over the last ten years also provide pointers about how these obstacles can be tackled. These experiences are considered in Chapter 8 (Recommendations).

The state of health system decentralisation in 2003

The achievements and obstacles outlined in the previous section are explained and justified here through three sets of analyses. They are:

- a review of health system performance across geographic areas
- a mapping of the room for decision-making at each level of government
- an explanation of the factors influencing this map of decision-space.

Health system performance

The five best-funded health districts claim 43% of national funding for primary health care activities which are provided outside of hospitals, although they are home to only 28% of the population.

As outlined in Chapter 1 (Financing and Equity), the study on resource allocation provides a comprehensive analysis of health resource allocations at municipality level within South Africa; the first time such an analysis has been undertaken. The chapter shows that budgetary allocations between municipalities are inequitable, in that those with least funding have greatest needs (as measured by populations weighted by deprivation) and those with most funding have the least needs. The five best-funded health districts claim 43% of national funding for primary health care activities which are provided outside of hospitals, although they are home to only 28% of the

population. These funding allocations are reflected in personnel allocations between and within provinces, which also do not reflect the distribution of population or needs. But provincial governments are doing little to tackle these inequities. They do not use measures of need to guide budgeting or personnel allocations, nor offset differences between municipalities in their capacity to raise revenue.

In addition, both Chapters 1 and 2 provide examples of continuing inefficiencies and problems with the way resources are used within the health system. Too little funding is allocated to primary care, although this level is better able to address the health needs of the majority of the population than other levels of service. The budgets of at least forty district municipalities in 2001/02 were, thus, too low (on a per capita basis) to fund the agreed primary health care package of services. This situation of under-funding may also get worse as a result of how Municipal Health Services are defined in the National Health Bill. The potential loss of local government own revenue to the health sector is estimated to be in the region of R1.0 billion per year in 2001/02 prices. In addition, other resources such as transport are often poorly managed, with duplication and waste in resource use.

Differences between provinces and municipalities in how activities are implemented may also make inefficiencies or inequities worse. Chapter 6 (PPI), for example, shows that there are considerable differences in the types of public-private initiatives (PPIs) being implemented in different areas of the country. As implementation of PPIs requires new management skills and systems it is also possible that PPIs will have unexpected and even negative impacts on the health system, especially in those areas with limited capacity.

Finally, some indications about the strengths and weaknesses of service delivery are provided through specific consideration of HIV/AIDS services (Chapter 3).

Respondents from across the health system suggest that there has been some progress in HIV/AIDS service delivery. A comprehensive five year plan has provided a useful framework to guide service development, and the range of services being provided has expanded over time (from condom provision to include strengthened STI and TB services, voluntary, counselling and testing and home-based care). Positive relationships between health care providers and NGOs as well as effective multi-sectoral action have been important to these achievements. Municipalities have expressed their readiness to take on some responsibilities for tackling the HIV/AIDS epidemic, especially since the Integrated Development Plan guidelines emphasize inputs in this area (chapter 5). Many municipalities have begun, informally, to co-ordinate their actions with provincial facilities and managers.

However, several common concerns about service delivery were also identified. Development of the HIV/AIDS service delivery package has been slow and has focussed more on preventive activities than treatment needs. Problems experienced in referral relationships between clinics and hospitals for HIV/AIDS patients, probably indicate a broader weakness in the health facility network. Other problems likely to cut across all services include weaknesses in clarifying cross-boundary responsibilities, limited availability of necessary equipment and supplies, and transport availability and management problems. Although not part of this research, it is common knowledge that a central weakness of service delivery relates to staff – their availability, retention and motivation. Uncertainty about the role of local government in the health system has made negative impacts on staff morale.

Mapping decision-space

Decentralisation within any governance system always involves the transfer of some set of decision-making powers from national to sub-national levels (Mills et al. 1991). However, the extent of decentralisation actually achieved within any system depends on how much power is transferred for certain decision-making functions. It is helpful to map how much freedom managers at different levels have to take decisions about their own work (Bossert 1998); having decision-making power is different from being responsible to undertake certain tasks. Although facilities may be implementing many activities, they generally do not have much room to make decisions about whether or not to perform those activities or how to implement them. Not having such room means they have little decision-making power.

Table 7.1 provides a picture of decision-making power for South Africa in 2003, drawing on the detailed evidence of the studies presented in earlier chapters of this report. In the table the term 'narrow' implies a very limited degree of decision-making power, compared with the 'wide' decision-space.

Although the table covers only a partial set of management functions, it highlights five features of health system management decentralisation. It indicates that:

- Little decision-making power lies at facility and district management levels
- Municipalities (before the National Health Act) had greater health management power than local managers employed by provinces (although this potential varies between municipalities)
- Provincial Health Departments have important roles in decision-making around health service delivery within provincial boundaries, including in relation to municipalities
- Local government often functions independently of provincial/national government, and even has separate legal and regulatory frameworks
- Centralising tendencies throughout government constrain both municipality and provincial managerial authority.

Table 7.1: Mapping management decision-space in the South African health sector, 2003

	Resource Allocation	Transport Management	Managing PPPs & PPIs	Managing Service Delivery
National treasury	**wide** *key role in allocating resources to provinces & municipalities*	**wide** *Treasury & NDoT set frameworks*	**wide** *Treasury sets national framework; DPLG sets own framework*	moderate *advises Cabinet on key issues e.g. HIV/AIDS*
National health depart-ment (NDoH)	**narrow-moderate** *some DM power via conditional grants e.g. for HIV/AIDS, but determined through consultation with PDoH & Treasury; weak attempts to develop guidance to promote RA equity*	**narrow** *outsourced through contract between NDoT & private provider*	**narrow-moderate** *in part due to weaknesses in ensuring PDoH compliance with NDoH PPI guidelines*	**moderate-wide** *responsible for setting national policy direction & support implementation; some funds & personnel to ensure implementation e.g. HIV/AIDS*
Provincial treasury	**moderate-wide** *works with national Treasury guidelines*	moderate ***implements national guidelines with PDoT***	moderate *initiates PPPs & manages implementation working within national guidelines*	narrow ***limited role, but influence via e.g. resource allocation power***
Provincial health depart-ment (PDoH)	**narrow-moderate** *decides budget allocations to geographic areas, levels of care (PHC) & transfers to municipalities for health care*	**narrow-moderate** *identifies needs, allocates vehicles within health dept & has financial accountability but works within provincial guidelines*	narrow-moderate *initiates PPPs & PPI & manages implementation working within national guidelines*	**moderate-wide** *responsible for adapting national policy to provincial needs, & ensuring service implementation (including co-ordination with municipalities)*
Provincially employed local managers	**narrow-none** *budgeting largely done on historical basis*	**narrow** *maintain & monitor vehicles; motivates to PDoH for new/replacement vehicles*	**narrow-none** *manage relationships with NGOs*	**narrow-none** *support implementation of provincial & national directions*
Municipality (incl. health dept)	**moderate-narrow** *depends on balance of funding between allocations from national Treasury, provincial transfers (for health care) & own revenue generation*	**wide** *if have own transport pool, manage independently (A & large B municipalities)* **narrow** *if using pool vehicles (smaller B and C municipalities)*	**moderate** ***sometimes initiate within DPLG guidelines***	moderate-narrow *depends on balance of funding provincial transfer vs. own revenue & historical role in health care provision*
Facilities (provincial or municipality)	**none** *budgeting largely done on historical basis*	**none**	**none** *may manage relationships with NGOs*	**none** *implement services according to guidelines*

The Constitutional allocation of powers suggests that the South African governance system can be characterised as a devolved system. It is intended that a substantial degree of decision-making power be transferred from national government to both provincial and local governments. For example, political representatives have a key role in approving budget allocations at provincial and local government levels. However, the key features of the

decision map outlined in Table 7.1 suggest that management within the South African health sector remains quite centralised at national/provincial levels. The implementation of political devolution is, therefore, limited by managerial centralisation. A key reason for this centralisation is the strong influence of the national Treasury over decision-making at all levels of government and in all sectors. The powers of provincial and local health departments are also limited by the dominant role of the national Department of Health in at least some areas of service provision. Even within provinces, there is little decentralisation to lower managerial or service delivery levels. As a result, the definition of MHS outlined in the National Health Bill has the potential to strengthen provincial control of primary health care delivery by centralising resource allocation decision-making powers at this level. Although this may protect the equity of resource allocations within provinces, such a positive impact is not guaranteed. Such centralisation could also prevent the health system from being able to respond flexibly and innovatively to local needs.

The views and perspectives of those working within the health system also demonstrate that they experience it as a highly centralised system. Health systems are often pictured as a pyramid, with the national level at the apex and the health facility network representing the broad base. However, using interview data from all LGH studies, Figure 7.1 shows that those working within the South African health system see it as a series of inverted pyramids.

People at every level, but particularly front line managers and providers, feel that they work in isolation from others at their own level, and face a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands.

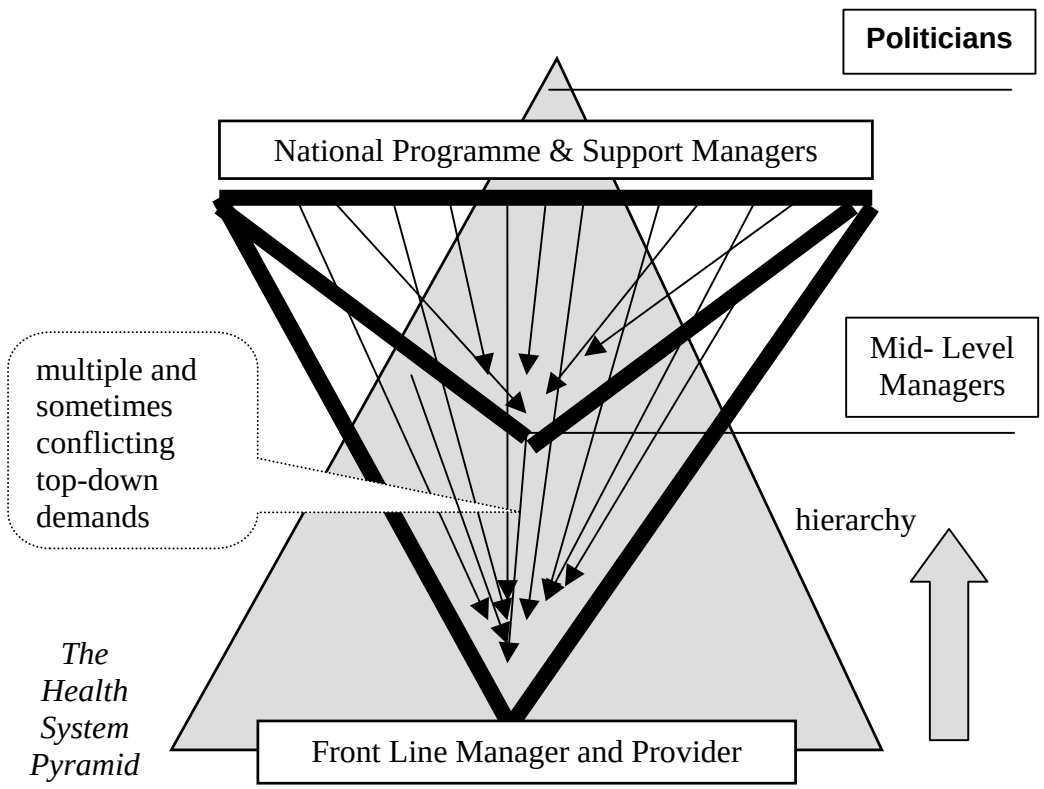

Figure 7.1
View from Below: The Inverted Pyramid Within the South African Health System

Explaining health system performance and decision-space

Evidence from the studies outlined in earlier chapters identifies three factors as explaining the current state of decentralisation within the health system:

- An environment that has not supported decentralisation
- The complexity of inter-governmental relations in the new South African state
- The focus on strengthening the health system by establishing new organograms and committees (the hardware), rather than changing the way people work together (the software).

A constraining environment

Despite the Constitutional commitment to a devolved governance structure, a variety of tensions and weaknesses have served to constrain the implementation of decentralisation within the health sector. The slow development of local government as a sphere of governance reflects and reinforces these tensions and weaknesses.

In some respects, decentralisation in the health sector appears mythical.

In some respects, decentralisation in the health sector appears mythical. From the earliest health policy documents, local government was identified as playing a key role in health care delivery. This policy direction is not, however, reflected in the views of government officials. Many people doubt local government's capacity to manage and deliver health services, and have therefore opposed decentralisation. The national Treasury and even some local government managers worry that municipalities do not have the funding or management capacity to provide even the basic services for which they are solely responsible (Pillay 2001). Some health managers fear a deterioration in the quality of service delivery if power is devolved to lower levels. In their view the technical needs of health care delivery require strong central roles in guiding and delivering health care. They may be reluctant to give away sectoral decision-making power and be concerned about working with people who are not health professionals.

Another feature of the constraining environment is that existing policy frameworks have not provided strong enough guidance for decentralisation. Engagement with other government departments in pursuit of health system decentralisation has been patchy. DHS development has been a separate unit within the national Department of Health rather than a strategy for all health system development and programming. PHC financing has remained fragmented and only weak efforts have been made to protect PHC funding levels from other health system demands. Within provincial Health Departments, facilities have been given almost no decision-making power. Where some national level actions (as in the area of HIV/AIDS) have a tendency to be too controlling, in other areas national action is too weak as a support mechanism (as in the case of PPIs).

This health sector experience reflects broader centralising tendencies within government. As Table 7.1 indicates, the national Treasury has had a dominant influence across spheres of governance. Sometimes its policy initiatives are seen positively in the health sector. However, where its policy frameworks are in tension with those of the national health department the differences can cause confusion for managers. For example, as the NDoH's PPI framework differs from the Treasury guidelines on PPPs, managers are not clear whether to apply them (Chapter 6). The centralising tendencies within government also ignore the peculiar needs of individual sectors. The health sector's transport needs are very different from other sectors, involving management of health facilities spread over great distances as well as the transport of patients and medical supplies. Yet all sectors are currently governed by the same set of guidelines.

Centralised management approaches are, moreover, written into the practices of the public sector as inherited from the apartheid era. In the LGH project studies, the need to wait for decisions 'from above' or to get approval 'from above' before acting were identified as undermining problem-solving at a local level and co-ordination in support of service delivery. Similarly, poor communication practices serve to confuse those working within the health system. They have contributed to the level of uncertainty associated with the debates over the

role of local government in the health sector. The feeling that you do not know what is happening to your job or to the system in which you work is itself de-motivating and undermines health managers' trust in their superiors and colleagues.

Translating policy statements into decentralised practices within the health sector has been hard because the environment was characterised by uncertainty, opposition and rigidity.

Complex inter-governmental relations

The complexity of inter-governmental relations (IGRs) as established within the South African Constitution has presented a second set of challenges to transforming the health system. Figure 3.1 of Chapter 3 clearly illustrates this complexity by mapping the categories of co-ordination necessary within the health sector. They include co-ordination:

- Across the three spheres of governance
- Within each sphere - between those with political and administrative authority, between departments, and within departments
- Within local government - between district and local level municipalities
- Within the health sector - between individual service delivery programmes, between service delivery programmes and support managers and between clinics and hospitals
- Across the nine provincial governments and, now, six metro, 47 district and 231 local municipalities
- Between governmental and extra-governmental actors (e.g. health facilities and NGOs).

Given this complexity, establishing certain functioning coordinating mechanisms (such as MinMEC[10] and PHRC[11]) between national and provincial levels within the health sector is an important achievement. These coordinating mechanisms have, to some extent, enabled improved service delivery. In the area of the HIV/AIDS policy framework, conditional grants and operational guidelines have allowed co-ordination across sectors and with actors outside government. At local levels, and despite the lack of clear policy guidance, there are also pockets of effective, often informal, co-ordination in problem-solving between provincial Health Departments and local government staff.

The absence of a national policy framework to guide health resource allocation within the fiscal federal structures helps to explain the continuing inequities in primary health care budgets, and it's under-funding.

But there have been problems in managing within the current governance structure of South Africa. The absence of a national policy framework to guide health resource allocation within the fiscal federal structures helps to explain the continuing inequities in primary health care budgets, and it's under-funding. Despite broad consensus on the general roles of national and provincial Health Departments in policy development and service delivery, clarity on who has authority to make what decisions within the health sector is lacking. In the area of HIV/AIDS such weaknesses, together with national funding and personnel appointments to provincial levels, have allowed the national level to become more involved in implementation than is acceptable to provincial Health Departments. Finally, relatively simple problems have impeded effective functioning in many of the co-ordination structures established within and across spheres. Examples include attendance by staff lacking the authority to make decisions, irregular attendance and poorly structured meetings.

Two particular problems have undermined co-ordination between national/provincial and local governments. These are the lack of coordinating structures and common policy frameworks. The White Paper on Local Government sees local government itself as the focal point and mechanism for co-ordinated action within government (Chapter 3). However, many provinces have not yet established functional structures to bring together provincial and local government officials. Secondly, differences in policy frameworks between national/provincial

[10] MinMEC – meeting between national Health Minister and provincial Members of Executive Council for Health

[11] PHRC – Provincial Health Restructuring Committee

and local governments have been obstacles to co-ordination. Parallel budgeting procedures ensure fragmentation of PHC financing within the country. Transport management differences prevent shared transport use. Differential human resource frameworks are a key barrier to the functional integration of health services.

Capacity weaknesses within the public service make these problems worse. At an organisational level these include poor systems of planning and management, very weak systems for monitoring and evaluating performance, poor communication procedures and staff shortages/personnel turnover. At a personal level they include weak development of the skills needed for specific areas of managerial responsibility (e.g. budgeting, PPI development) and for the negotiation and communication skills essential to effective co-ordination. Confidence shortfalls that result from such weaknesses can lead to a defensiveness in personal relationships that further impedes co-ordination.

The organisational culture of the civil service inevitably contributes to the problems. Hierarchy, and associated attempts to control other actors within the system, has blocked co-ordination within departments and between spheres of governance. It has also undermined trust between people and organisations. Communication weaknesses have sometimes undermined co-ordination, while issues such as race, gender and political credentials also influence relationships within and between organisations.

Hardware vs. software in health systems.

There has finally been a tendency to focus on hardware rather than software issues in health system development (Blaauw et al. 2003). Hardware issues include legal frameworks, structures, organograms, financing flows and technical skills development. Software issues cover management styles, communication approaches, relationships, problem solving approaches, building trust. Both are necessary to a health system, with one complementing the other. A focus on one over the other can limit change.

In some respects the focus on hardware in South Africa has been necessary. Establishing the legal framework for the District Health System was a critical step to service the new management structure and approach. On the other hand, national Treasury's focus on funding and financial accountability has reinforced this hardware focus. There have also been weaknesses in what hardware has been developed. For example, the MTEF (Medium Term Expenditure Framework) process has been seen as the primary mechanism of forward planning rather than a more integrated planning and budget process.

The LGH studies suggest that the reliance on informal mechanisms of co-ordination between provincial and local government over the last ten years has been a problem. Coordination has, for example, been seen primarily as a function of establishing a new structure, body or meeting (see Chapter 3). This approach ignores the critical role of shared values (such as mutual trust and good faith, as emphasised in the Constitution) in enabling coordination, and of guiding visions and frameworks.

A key casualty of the hardware focus has been the limited attention given to human resource management. Personnel shortages require urgent action. Training more staff or offering financial or other material incentives are seldom enough by themselves to tackle either migration or the problems of poor staff morale. Other software needs include building trusting personal relationships and developing the associated skills of communication, negotiation, and people management. Developing such skills will itself breed the personal confidence that is important to leadership throughout the health system.

Finally, a focus on hardware over software has left little room for innovation and creativity. It has reinforced top-down and hierarchical decision-making procedures. These have crowded out local-level problem solving and bottom-up approaches to service delivery.

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Chapter 8

Looking Ahead and Tackling the Challenges

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"There are no easy answers - If there were, we would have done it!".
Yogan Pillay 2003 PHASA conference

Background

Tackling the challenges of health system decentralisation is not an easy task, yet the challenges must be tackled in order to take forward the decentralisation process.

A newly promulgated National Health Act will provide a strong foundation for future action. In addition, the findings of the LGH studies point to eight other necessary steps. They are:

1. Communicating a clear and simple vision
2. Identifying an implementation body to support health system decentralisation
3. Developing a provincial mindset supportive of decentralisation
4. Capacity development
5. Strengthening co-ordination by clarifying roles and responsibilities
6. Developing planning as a co-ordination mechanism;
7. Strengthening monitoring and evaluation (M&E)
8. Encouraging leadership throughout the health system.

Taking action on the first four is an immediate requirement, whilst the last four can be implemented over a longer period. Each is discussed in more detail in this final chapter. The LGH studies indicate that for many of these actions there are some existing pockets of experience on which to build. This experience is briefly outlined here and demonstrates that the recommendations are feasible to implement.

1. Communicating a clear and simple vision

International experience of implementing change shows the important role that guiding visions play in providing a basis for common action towards shared goals (Lake et al. 2000). In South Africa, uncertainty about the future role of local government cannot continue. A new vision of the key features of a decentralised health system can now be built on the provisions of the National Health Bill. Strong, clear and quick communication of the broad outline of this vision and its goals is essential. Simple and consistent messages need to be developed and delivered to a wide range of audiences. These include public health professionals throughout the system, local government councillors, national level politicians, other government departments and the public. A wide range of communication channels and media should be used.

Strong, clear and quick communication of the broad outline of this vision and its goals is essential. Simple and consistent messages need to be developed and delivered to a wide range of audiences.

The findings of the LGH studies indicate that the new decentralisation vision must directly tackle two specific issues. Firstly, the tensions between the health service objective of quality health care delivery and the developmental role of local government. Secondly, the expectations that local government will soon begin to take responsibility for some health care functions. The vision must therefore spell out the future role of local government, as well as the steps that will be taken to build it (see also the following three proposed steps).

The Kopanong Declaration on PHC (August 2003) provides an excellent foundation for the declaration of this vision of health system decentralisation. Not only does it re-state the governmental commitment to primary health care and to the District Health System, but it also outlines roles for all three spheres of governance. A declaration on decentralisation should spell out more explicitly the one or two key roles and responsibilities envisaged for each sphere and for the facility level over the next 5 years. This would clearly indicate the intention to transfer some decision-making powers from higher to lower levels in that period.

2. Identifying an implementation unit to support health system decentralisation

Establishing a common vision is the first of four immediate tasks that must be initiated at the same time as the National Health Act is promulgated. The other three are: establishing a range of policy frameworks that are supportive of decentralisation; developing a new mindset within the health system that is supportive of decentralised functioning; capacity building throughout the system.

Implementation must show that the district health system is viewed, not as a vertical programme, but as a strategy for all health system development and planning. Ideally, more people, more energy and more political clout are needed.

The last two tasks are discussed in more detail below. The new policy frameworks that are needed include those addressing resource allocation and specifically, PHC financing, transport management and PPIs. It is also critical to ensure that the envisaged development of a single civil service supports decentralisation within the health sector. Establishing such frameworks will require engagement with the national Treasury and Department of Provincial and Local Government.

Implementing these tasks will require dedicated time, energy and commitment to enable change across the system. Providing support to decentralisation cannot be undertaken as just one of several tasks, and also requires a variety of skills as well as strong political backing (Gilson and Travis 1997). Although some units within the national Health Department have a reasonable track record of supporting change at other levels, not all units yet play such an

enabling role. In addition, the capacity of the existing national DHS directorate to implement these functions is limited by its organisational and staffing position. Implementation must show that the district health system is viewed, not as a vertical programme, but as a strategy for all health system development and planning. Ideally, more people, more energy and more political clout are needed.

One implementation unit could be tasked with all four tasks or several units could be charged with implementing different tasks. Structural options that could be considered are:

- Establish a new health unit at national level that has a dedicated team, to implement all tasks. The team should include staff with experience of working at provincial and local government levels. The structure could be established on a temporary basis but should have a relatively long life-span. The role and structure of the unit should also evolve in response to the changing needs of the decentralisation process over time;

OR

- Work in collaboration with the existing DPLG units that support municipality development (e.g. PIMS centres[12]). The units' main tasks would be to establish national frameworks supportive of health decentralisation and to develop local government capacity for health service management;

AND

- Charge the national DHS directorate with the task of supporting other national DoH units to adopt an enabling role towards lower levels. This work would involve establishing national policy frameworks supportive of health decentralisation, and developing new working procedures and practices within the national Health Department. Through the existing DHS committee, the directorate would also continue to facilitate coordination and discussion with provincial departments and organised local government.

3. Developing a provincial mindset supportive of decentralisation

Provincial Health Departments obviously have a critical influence of the future path of decentralisation. They must act responsibly towards lower levels, fulfilling their constitutional function of enabling local government development.

There is already much evidence of innovation in support of service delivery within the health system. The challenge now is to value and promote such problem-solving, rather than stifle it.

Acting responsibly towards lower levels begins from the understanding that all levels have different functions and must work together to enable service delivery. That is the essence of co-operative governance. Although health care professionals have particular areas of medical expertise, effective primary health care provision requires collaboration with those who represent or have knowledge of the community, and have skills of community mobilisation. Building trusting relations with municipalities under any decentralisation option is important.

Provincial Health Departments must also reassess how to work with their own facility networks. It is never possible to tightly control and monitor a health system from above. Local level staff can always ignore or change the instructions they receive. Protecting the quality of service delivery requires a careful combination of central guidelines and space for local level innovation. There is already much evidence of such innovation in support of service delivery within the health system. Nurses pay from their own pockets to transport laboratory supplies, or use their own vehicles to collect drugs or take patients to referral facilities; at a local level provincially-employed health workers are getting together with their counterparts in local government to solve operational problems. The challenge now is to value and promote such problem-solving, rather than stifle it. Managers at lower levels must receive real support and

[12] PIMS-Centres are the core element of a 'planning and implementation management support' system established by the Department of Provincial and Local Government to support local municipalities.

not just instructions. More support must be given to those areas with the weakest levels of capacity.

Provinces must also take action to counter the resistance to decentralisation that results from the rigid hierarchies of the civil service. The LGH studies provide evidence from several provinces (see Chapters 1 and 3) that such action is possible. There is evidence of good communication practices. Informal meetings between colleagues allow problem solving despite the barriers of formal organograms and structures. The 'Champions' approach of the Eastern Cape province, in which teams from the provincial health department visit local areas to listen to staff needs, challenges hierarchy.

From their position in the health system structure, provincial Health Departments have an important role in demanding accountability from the national level. They must motivate for changes in national frameworks that support decentralisation and in the way the national Health Department works. In this way, provincial departments can act as role models for other levels of the system in relation to challenging hierarchy.

4. Capacity development

Capacity building requires a clear vision of decentralisation that reduces the current uncertainty. Broader policy frameworks around human resource development and management are also needed.

Of all eight identified areas of necessary action, capacity development is perhaps the most critical.

Strengthening capacity development involves several tasks, including:

- Clear assignment of responsibility for this task to a unit or units
- Identification of the skill needs of different levels of the health system, based on their assigned roles and responsibilities
- Establishing priorities for the types of training needed and who should be trained
- Reviewing available training and mentoring options and their relevance to priority skill needs
- Development of innovative capacity development strategies to address priority skill gaps
- Regular monitoring of achievements and re-development of programmes as necessary.

It is important to note that some of the most important skills needed within a decentralised system are not technical, whether clinical or managerial. Rather they are those of problem-solving. These include having the confidence to challenge hierarchy and negotiate with other people, and the attitudes required to develop personal relationships.

The development of such skills cannot easily be taught but often comes from experience and learning on the job. Relevant approaches to 'training' include sharing experience with people working at similar levels of the health system who have similar problems. This can be undertaken through site visits, joint problem-solving workshops, informal exchanges and communication.

An example of an alternative, innovative approach is to use service level agreements between provincial Health Departments and municipalities as a mechanism for building the capacity necessary to allow the gradual transfer of responsibilities to municipality level. Such agreements are, in this form, an enabling mechanism rather than simply a tool for monitoring and penalising poor performance. In this form, service level agreements would ensure that provincial Departments act responsibly towards lower levels.

The approach and its feasibility are indicated by its use in transferring management and decision-making power for primary care delivery to First Nation governance authorities in Canada (Lavoie, personal communication). The transfer process has three stages. Initially First Nation authorities (read as municipalities in the South African context) apply to the governing body of the Canadian health system (say, provincial Health Departments) for funding for a pre-transfer process of one year. In this initial year they assess community health needs and prepare plans for health management and delivery. A second bridging

phase of nine months involves negotiation between the applying authority and Health Canada to establish agreement on how services will be managed and how accountability will be exercised. Finally, a contract of 3-5 years is established to govern the third phase of routine service delivery, including evaluation of implementation experience. The slow phasing of the process allows development of the capacity required to support service delivery and management and ensures that national authorities have opportunities to review and evaluate progress towards and in implementation. Similar processes of support and engagement often govern contracts for the delivery of social services between government and NGOs in the UK and elsewhere. The key element of such a process is the development of a service that meets the population needs, through negotiation, dialogue and capacity development.

5. Strengthening co-ordination by clarifying roles and responsibilities

The South African Constitution requires a co-ordinated approach to all aspects of health system development.

Such co-ordination will need clear delineation of the roles and responsibilities of different levels and groups within the system. Decentralisation always involves some combination of centralisation and decentralisation, and the pattern differs between functions. The LGH studies provide some indications of the needs of different management functions.

Funding PHC requires active central level action to establish the principles and frameworks of equity that can guide implementation. However, protecting equity does not require that budgeting is entirely controlled at national level. National and provincial financing frameworks to promote resource allocation equity can be combined with bottom up budgeting approaches in which even facilities can be actively involved. The reports of the 1996-97 District Financing Project provide suggestions about how to develop such approaches (e.g. Brijlal et al. 1997). A critical function of the national/provincial decision-making authority within bottom up budgeting is to communicate clearly and effectively what budget limits are, how they have been established *and* how they can be challenged by those at other levels.

Some aspects of transport management may also need to be centralised, such as the purchase of new vehicles through a single tender, to achieve economies of scale. But many tasks in transport management are better implemented at much lower levels. For example, the health district should determine the number and type of vehicles required within their district for delivery of services rather than just being allocated what is available from the Department of Transport.

In contrast, there is an important role for a strong national unit in developing health specific frameworks and guidelines around PPIs that can support decision-making across provinces. Skills and systems within provinces must also be built. The danger is that without such national level action, PPIs will be poorly managed and have negative impacts on the health system.

Finally, more effective co-ordination will also require a balance of formal and informal strategies. Stronger co-ordination with local government within provinces requires the establishment of more formal structures and mechanisms (such as service level agreements) to complement the largely informal approach currently adopted. But where existing structures are not working effectively then action must be take to strengthen them (such as clarifying who must attend to make the structure effective and getting their commitment, and planning meetings to allow for constructive engagement) as well as to establish the informal approaches that complement them. Personal relationships are often an important means of getting things done, and should be encouraged when in the best interests of health system development.

6. Developing planning as a co-ordination mechanism

Another strategy for strengthening co-ordination is to strengthen planning processes. Thus, the national DOH planning guidelines of April 2003 encourage district plans to be aligned both with provincial and municipal plans (IDPs).

For coordination, the opportunity of planning is that it requires people within the system to get together and think together.

However, to be effective, planning requires a combination of hardware (e.g. frameworks, links to budgets, information) and software (negotiation, dialogue and communication skills, effective personal relationships).

In addition, in the South African context, two elements of context must be tackled to enable planning. The first is the uncertain health system context, which can be tackled by establishing a decentralisation vision as outlined in the first step described in this chapter. The second is the rule-bound and hierarchical civil service bureaucracy. National and provincial managers must encourage local level actors to solve problems themselves, and champion those that do. They must also set examples for others - such as indicating clear and simple 3 or 5 point plans, sticking to them and using them as a basis for evaluating their own performance.

If the contextual issues are addressed effectively, the April 2003 planning guidelines provide a solid foundation for developing planning processes. They delineate who has what roles and responsibilities in planning. They provide guidance on how to link the planning process to the existing budgeting process and formats. They should be widely communicated.

However, it will be important to guard against the types of problems that can prevent planning from acting as a coordination mechanism. Two important dangers in this respect are that the:

- Focus of the process becomes the writing of the plan document rather than the problem-solving and coordination necessary to improve service delivery
- Development of a detailed plan document consumes so much time that routine management functions are neglected.

7. Strengthening monitoring and evaluation (M&E)

Monitoring and evaluation (M&E) can facilitate co-ordination by providing a focus for engagement and dialogue between the various people within the system that have to work together, and so allow better understanding of each other's needs and constraints. Most importantly, M&E can allow the health system to learn from past experience what is needed to strengthen future service provision.

Monitoring and evaluation is an important input into any planning process and has its own importance within management.

In South Africa, procedures for M&E of district health system development have been institutionalised in some provinces, with some benefits. However, the negative experiences include the isolation of the procedures from routine planning and management, and the lack of feedback to districts (Pillay 2001).

Clearly the national level has an important role in M&E. In some areas it has the leading role; for example, in relation to PPIs. In other areas it has initiated systems that allow other levels to conduct M&E. The development of the District Health Information System and Hospital Information Systems, thus, offer important entry points for M&E at all levels. But to enable learning, M&E must be conducted throughout the system and must use information beyond formal data.

Such M&E must focus more on the processes of health care delivery and management, than on their impacts. It also must move beyond a measurable set of indicators, to include the processes and forms of dialogue that allow such indicators to be used in problem-solving.

Indicators must be changed over time to reflect health system development. The roles and responsibilities of different levels must, again, be spelt out. It is critical that clear responsibilities are given to the lower levels of the system so that M&E becomes a strategy that encourages bottom up innovation. Yet higher-level leadership may be required to propose and champion such an M&E approach. It requires recognition throughout the health system of the importance of collaborative reflection on performance and joint problem-solving in pursuit of personal, team and, ultimately, health system goals.

8. Encouraging leadership throughout the health system

The final action in support of decentralisation is, therefore, to encourage effective leadership throughout the health system. Champions at all levels of the system need to be given the space to take the innovative action required to overturn the myth of health system decentralisation. Systems of accountability, such as M&E, need to be developed which allow those failing in their tasks to be challenged, particularly from below. National and provincial leaders need to accept their particular responsibilities but also allow those at other levels the authority to take on new responsibilities. They must offer consistent and strong leadership in their particular geographical areas. But local level managers and front-line health providers must also be given the opportunity to demonstrate their leadership qualities and the support necessary to develop those qualities. Above all, leaders throughout the health system have to act responsibly towards it and towards the population it serves. This implies that they must step outside their own personal concerns, challenge their own biases and speak for the values and needs of the system as a whole.

Leaders throughout the health system have to act responsibly towards it and towards the population it serves. They must step outside their own personal concerns, challenge their own biases and speak for the values and needs of the system as a whole.

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