10 CHAPTER

Developments towards a district health system

The Minister of Health and Members of the Executive Council (MEC's) for Health of the nine provinces have reiterated the vision of a district health system (DHS) being the cornerstone of a national health system. They have also reiterated the view that the final home of the DHS is with local government. Therefore, the developments that took place in the local government sector in the year 2000 have had and will continue to have, a profound impact on the establishment of the DHS.

One of the major developments in 2000 was the demarcation of new local government boundaries. The total number of municipalities in the country was reduced from 834 to 285. Health district boundaries are being re-aligned to correspond with the boundaries of Metropolitan and District Councils. Although this will ensure that all government departments have the same managerial area of operation, it has caused major disruptions in terms of staff who have been working in the interim health districts. It is also a problem in terms of the concept of the DHS – many of the new "health districts" are now too large to be manageable and will have to be divided into smaller sub-districts. These problems are further elaborated on in this chapter.

Community participation and inter-sectoral collaboration are cornerstones of the DHS. This chapter looks at how the pursuit of these goals in the functioning of local government will facilitate their expression in the district health system. The issue of municipal financing is also discussed.

In addition, a number of key unresolved issues in local government which will affect the establishment and functioning of the district health system are highlighted. These include the necessity for a strategic framework to guide the implementation of the DHS, the role of national and provincial Health Departments, and capacity development within the newly created municipalities.

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This chapter discusses the developments towards establishing a district health system (DHS) that took place during the year. It discusses key aspects of local government transformation as well as developments in the health sector. Finally it attempts to analyse some of the obstacles to the implementation of the DHS. It should be read in conjunction with the chapter on "Establishing the District Health System" in the 1999 South African Health Review.[1] Many of the principles relating to the district health system, such as the purpose of the DHS, the size of a health district, the relationships between the three spheres of government, the role of the district hospital and the governance of the DHS were covered in that chapter.

It is important to remember that the DHS is a means to an end - the end being the rendering of equitable, effective, efficient health care of good quality and the implementation of a primary health care approach. The essence of the DHS is the organisation of health care according to the geographic sub-divisions of South Africa.

There are two tracks of transformation which impact on the DHS. The one is transformation of the health sector and the second is the transformation of the local government sector. During 2000 there were developments relating to both these tracks but unfortunately these developments do not run in neat parallel lines. They sometimes meander away from each other and sometimes criss-cross. This messy transformation has caused much confusion, wasted effort and time and has had a serious impact on the morale of health workers at the primary care level. This in turn has negatively impacted on the extent and pace of improvements in primary health care.

This confusion should not have been unexpected given the scale of transformation of both the health and local government sectors. With both sectors experiencing a large turnover in political and administrative leadership the weight of the challenges to the leadership has resulted in not enough attention being given to the realities and complexities of the DHS.

Developments in local government

In this section some of the key developments in local government that are relevant to the establishment of the DHS are highlighted.

The Transformation process

In 1996 the role and function of local government was formally laid out in the 1996 Constitution. According to the Constitution,[2] local government is no longer subordinate to provincial and national government, but has legislative and fiscal capacity. The Constitution also refers to a process of co-operative governance between the three spheres of government.

Municipal Demarcation process

The demarcation of new local government boundaries was undertaken by the Municipal Demarcation Board which was established in terms of the Local Government Municipal Demarcation Act 117 of 1998. The Demarcation Board divided up the entire country into new municipalities. This process reduced the number from 834 to 285 municipalities in total. Every area in South Africa is now part of a municipality, including all farming areas and areas which fall under traditional leaders.

The final phase of the transformation of local government commenced with the local government elections on 5 December 2000. At these elections 285 brand new municipalities came into existence. These fall into the following types:

- 6 Category A municipalities (Metropolitan Councils)
- 47 Category C municipalities (District Councils)
- 232 Category B municipalities (Local Councils).[a]

Metropolitan Councils

The Category A Metropolitan Councils are Durban, Cape Town, Port Elizabeth, Tshwane, (Pretoria), Johannesburg and the East Rand. In these areas all the powers and functions of local government are vested with the Metropolitan Council. These include municipal health services.

District Councils

Forty seven Category C District Councils, including seven Cross-Border District Councils, were demarcated. A number of principles were used in determining these district councils. The criteria for demarcation included that they should be of manageable size. To ensure this, the following were taken into account:

- The geographic size in km.
- The population numbers
- The population density.

However, because of the geographical differences in the country and the differences in population densities, there is a wide range between District Councils, eg. District Council 12 in the Eastern Cape has a population of 1 657 373 people whilst District Council 5 in the Western Cape has population of 56 167. This has implications for the organisation of the DHS.

The distribution of District Councils is shown in Table 1.

a The term "municipalities" is used interchangeably with the term "councils". Therefore a "metropolitan municipality" is the same as a "metropolitan council". The same applies to district municipalities or councils and local municipalities or councils.

Table 1: Distribution of District Councils by province

Province	Number of district councils
Eastern Cape	6
Free State	5
Gauteng	3
KwaZulu-Natal	10
Mpumalanga	4
Northern Cape	5
Northern Province	4
North West	5
Western Cape	5
Total	47*

* The total of 47 includes the 7 cross-border district councils which for the purpose of this table have been allocated to one of the provinces which they straddle.

Local Councils

Within these District Councils, two hundred and thirty two Category B Local Councils including seven Cross-Boundary Local Councils were demarcated. The basis of the demarcation included:

- Manageable size
- Resource sharing between "weaker" and "stronger" areas
- Functional linkages.

The category B municipalities have been divided into 6 gradings by the Demarcation Board based on their potential capacity. Grading 1 has significant and large municipalities with large budgets of over R300 million per year and with the management capacity to collect revenue and govern on their own initiative. Category 6 municipalities have budgets of less than R10 million. They are primarily former Bantustan areas where building capacity and the development of a tax base are high priorities. There are also huge differences in the population numbers of Local Municipalities. For example, within District Council 12 of Eastern Cape, Local Municipality 125 has a population of 682 287, whilst Local Municipality 128 has a population of 24 801.

The capacity grading of Category B municipalities is shown in Table 2.

Table 2: **Category B Municipalities, analysed by province and capacity**

Province	Capacity Grading						Total
	1	2	3	4	5	6	
Eastern Cape	1	1	2	5	9	20	38
Free State	1	1	4	10	4		20
Gauteng	1	1	4	3			9
KwaZulu-Natal	1	4	1	14	7	24	51
Mpumalanga		2	2	12	2	3	21
Northern Cape		2	1	8	7	11	29
Northern Province		1		10	3	9	23
North West		2	4	7	4	7	24
Western Cape		3	5	13	1	2	24
Total*	4	17	23	82	37	76	239
South Africa *	4	17	22	79	35	75	232

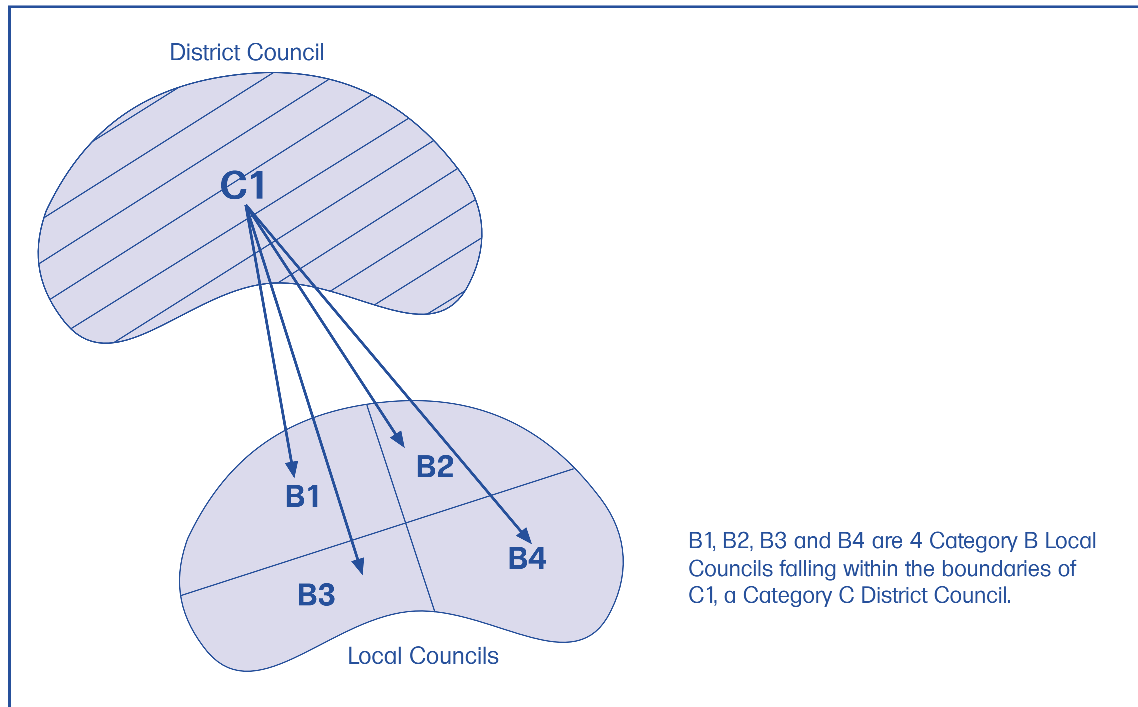
* The numbers for the total column and the numbers for South Africa have a difference of 7 due to the cross-border local councils being counted twice in the provincial lists – for both provinces they straddle.

Eighty one percent (81%) of all Local Councils (gradings 4, 5 and 6) will require assistance from District Councils and/or other levels of government to perform the range of functions expected of them.

Division of Functions and Powers between District and Local Municipalities

As Local Councils (Category B Municipalities) fall within the boundaries of District Councils (Category C Municipalities) these municipalities serve the same population (see Figure 1). Therefore the functions and powers of local government have to be shared between them. The aim of this shared authority is to ensure redistribution and sustainability of municipal services.

Figure 1: Schematic representation of District and Local Councils



Section 84 of the Municipal Structures Act 117 of 1998 creates a framework for the division of functions and powers between District and Local Councils by the Minister of Provincial and Local Government based on the recommendations of the Municipal Demarcation Board.

Section 85 of the Act permits an adjustment of this division by the MEC for Local Government in the event that the municipality in which the function or power is vested lacks the capacity to perform that function or exercise that power.

The Local Government Municipal Structures Amendment Act of 2000 allocates the function of Municipal Health Services to District Municipalities. The allocation of powers and functions are to give effect to the new and central role that District Municipalities must play in seeking to achieve the integrated, sustainable and equitable social and economic development of its area as a whole.

Local government restructuring and the DHS

In the Municipal Systems Act No. 32 of 2000, two issues are given prominence. The issues of community participation and intersectoral collaboration are of great importance to the envisaged development and role of local government. They are also two pillars on which the Primary Health Care Approach is built and are therefore of importance to the DHS.

A full chapter of the Act is devoted to the establishment of mechanisms for *community participation*. It advocates the building of a culture of community participation and imposes an obligation on local government to provide information and mechanisms for community participation as well as a contribution to capacity building to make this participation meaningful.

Implicit in the concept of *Integrated Development Planning* is the notion that different departments will plan together for the best good of the community concerned. As an example, in planning to prevent future cholera outbreaks the Health, Sanitation and Water sectors

need to put their heads together. Integrated development planning is a legal requirement for all municipalities and will therefore be an essential link to health planning in the district. The Act specifies the developmental orientation of this planning process and the requirement of community input into the plan.

The Integrated Development Plan (IDP) of a municipality is required to be aligned with and complement the development plans and strategies of other affected municipalities and other affected organs of state. The Act also gives effect to the Constitutional provision that local government participates in national and provincial development programmes. Provinces are required to assist and support municipalities in the development of their IDP's.

The *performance management system* of a municipality is based on these two pillars of community participation and IDP. Firstly, it has to be derived from its Integrated Development Plan thereby ensuring implementation of the Development Plan. Secondly, the municipality is required to involve the local community in the development, implementation and review of the performance management system particularly in setting key performance indicators and performance targets for the municipality.

An annual report comprised of a performance report, annual financial statements and the audit report must be submitted to the media, community, MEC for Local Government and the Auditor-General.

Municipal Finance

As the financing of health services is a key to the development of a DHS the current status of municipal finances is of importance. The financing of many municipalities will be a significant challenge to the success of the new local government system. Firstly, many municipalities were neglected during the apartheid era, resulting in serious backlogs that now need to be addressed. Secondly, the payment of rates and services is very low in certain areas. Thirdly, financial management has been poor in many municipalities, and lastly, the process of transforming local government has in itself been costly.

In addition, many municipalities will now be expected to take on and fulfil functions which have previously been carried out by national and provincial departments. An example of this is the DHS. This will require funding and unfortunately many questions around funding remain unclear. How will the DHS be funded, by whom, via what route and by how much are some of the questions that need answering.

Financing policy to meet the needs of local government is still in the process of development. Section 10 G of the Local Government Transition Act No. 203 of 1993 has therefore been retained until such time as financial policy and legislation are finalised. The provisions of the section relate to municipal budgeting, investments, raising of loans and levy allocations. The power to levy and claim a regional services levy and regional establishment levy is given to Metropolitan and District Councils. The Municipal Systems Act permits municipalities to generate income by means of user charges. This has the potential to be in conflict with the policy of Free Primary Care.

Developments in the health sector

The Minister of Health and the Members of the Executive Council (MEC's) for Health of the nine provinces in their MINMEC policy making structure reiterated the vision of a DHS being the cornerstone of a national health system. They also reiterated the view that the final home of the DHS is with local government.

The MINMEC has also resolved that health district boundaries would be re-aligned to correspond with the boundaries of Category A and C municipalities (Metros and District Councils). Although this is highly desirable in terms of getting all government departments to have the same administrative divisions and is essential for inter-sectoral co-operation, it has two serious implications for developments within the health sector. Firstly the process of drawing health district boundaries has had to restart in many provinces with the 174 health districts in place in 1999 now having to be brought into line with the 6 Metropolitan and 47 District Municipality boundaries. This has major implications for health workers who have been working in interim structures for some time. Secondly it has implications for the concept of the DHS, as many of these new "health districts" are very large in terms of population numbers. It is likely that these new "health districts" will have to be sub-divided to make them manageable in terms of the Primary Health Care Approach.

At provincial level, different provinces followed different routes in pursuing the development of a DHS. The Free State took the lead and in February 2000 published the Free State Provincial Health Act.[3] This Act spells out the functions and responsibilities of the still to be created District Health Authority that would be the governing body of the health district. In the Western Cape a bi-ministerial task team comprised of officials from provincial and local authority Health Departments has produced a detailed document setting out the way forward to transferring primary health care services rendered by the province to local government.[4] At the time of writing (January 2001) this document has still not received the necessary political endorsement for any action to take place.

However, on the whole there has not been much progress towards the establishment of district health systems in the provinces, largely because of the widespread uncertainty that resulted from the local government transformation.

Unresolved issues

Clear vision and strategic framework

The establishment of the DHS requires a close working relationship of at least the three Ministries of Health, Local Government and Finance. It also requires fundamental change to both the Health and Local Government sectors, and it is likely that a cabinet resolution is required to set the policy framework in place. To turn this policy framework into action will in turn require new legislation, as the current Health Act of 1977 is inadequate to set a strategic framework for the DHS.

This strategic framework needs to define the concept of Municipal Health Services by specifying the health functions which are allocated to the local government sphere. There are a number of ways which (in terms of the Constitution[2]) additional health functions can be distributed between the different spheres of government. These include devolution by assignment or delegation of national or provincial powers and functions, or an agency agreement between two spheres of government. In order for the DHS to come into existence some arrangement, in terms of these Constitutional options, needs to take place. The choice of option is complex and is contingent on further clarity on the definition of Municipal Health Services. It is also contingent on getting consensus on financing mechanisms between national, provincial and local government, and Treasury approval.

It is not likely that one option will cater for the different circumstances and state of development of all the health districts around the country. The strategic framework should also indicate the degree of flexibility and specify interim arrangements to be made whilst

moving towards the overall vision. So for example in the more remote rural areas, where local government is basically starting from scratch, it is likely to take at least two years before the DHS concept even reaches the policy making table, and much longer before it is implemented at local government level.

Municipal Health Services - the options

Schedule 4B of the Constitution[2] identifies Municipal Health Services as a local government competence. Four options have been identified to define this basket of services.

- **Minimalistic Approach**: This is comprised of environmental health services and related preventive and promotive services. This is the approach advocated by the Department of Finance.
- **Flexible Approach**: This would be negotiated individually for each municipality. This approach has Municipal Health Services being defined as services currently provided by the particular municipality.
- **Core Primary Health Care Package:** This comprises the full basket of primary health care services, but excludes District Hospitals.
- **DHS Package:** This includes the Core Primary Health Care package and District Hospitals.

The final definition of municipal health services has not yet been reached, but as an interim, pragmatic arrangement the health sector has agreed that the flexible approach will be followed. An intergovernmental workshop is planned for early 2001 to reach consensus on the definition.

Financial arrangements

For the DHS to be properly established adequate financial arrangements will have to be in place to ensure that there are sufficient funds for the decentralisation process. Also required are sufficient funds for the setting up of a district health authority, the district health management team and the support structures such as drug supplies and transport. The quantity of funds and the mechanisms by which they reach the various local government districts will need to be guaranteed somehow, as there are grave concerns in the local government sector regarding "unfunded mandates". Put simply, "unfunded mandates" occur when functions are decentralised and responsibility to carry out these functions is given without provision of the necessary resources.

Attention to the centre

As a parallel process to the decentralisation of health services and the setting up of a DHS, attention needs to be given to the changing role of the national and provincial Health Departments. In particular their role in various areas will need to be greatly strengthened if the DHS in particular, and the health system as a whole is to thrive. These areas include:

- Strategic planning for overall direction of the DHS
- Planning and resource allocation
- Support and monitoring and regulation of the DHS.

To fulfil this role, structures at the centre will have to change and new systems will have to be put in place and new values engendered. In this sense, the delivery of primary care will always be a joint (concurrent) responsibility of all three spheres of government.

Communication

There is a need for those affected by the setting up of the DHS, a completely new system of primary care delivery, to be adequately informed of the introduction of the new structures and the likely changes that will occur. Health workers need to know how their work will be affected and what will happen to their personal benefits. Other stakeholders such as unions, government departments, communities and individual users will be affected directly by the decentralisation process and it is vital that they are kept up to date with the processes.

Capacity development

Most of the newly created municipalities will not have the capacity to enable them to cope with the challenges and demands of a DHS. Plans need to be made and the necessary staff acquired and adequately trained in order for there to be orderly decentralisation without adversely affecting service delivery.

Conclusions

During 2000 there were major developments within the local government sector culminating in the elections for 285 new, rationalised municipal councils in December. This means that one of the fundamental building blocks for the DHS is now in place.

However, it is inevitable that much of the focus in local government in the near future will be on the internal changes required for the creation of the new system of local government. New relationships have to be established, new organisational identities have to be created, new management structures need to be established with new organograms and new goals with new lines of communication. These factors need to be taken into account in deciding on the pace of the decentralisation process. Because all the attention of decision makers is being focussed on the structures of local government, it has meant that the Health and Local Government Departments have not been able to synchronise their policies and strategic frameworks around the creation of a DHS.

For the decentralisation of primary health care services from provincial to local government level to take place and achieve a DHS in a relatively smooth way without service delivery being compromised, a wide range of factors need to be addressed and taken into account. Many of these factors (e.g. ensuring an overarching strategic framework with clear funding mechanisms, adequate communication, legislation) have been discussed in this chapter.

The successful implementation of a DHS rendering primary level services could have a significant impact on improving the quality of life of many South Africans, especially the poor. For success to be achieved, clear leadership is required by decision-makers in Health and Local Government at all three levels of government. Only once there is a clearly articulated strategic plan that covers all the main elements and potential obstacles can pragmatic decisions to implement be taken.