Briefing note on local government health service financing and expenditure and moving towards monitoring equity in local government health services

Prepared for Health Systems Trust by
Di McIntyre, *Health Economics Unit, University of Cape Town*

Introduction

At present, some (but not all) municipalities provide health services. There is considerable diversity between municipalities in relation to the range and extent of health service provision. Historically, local government health services have been restricted largely to the provision of preventive, promotive and rehabilitative primary care services, with particular emphasis on communicable disease control and environmental health. In addition, some municipalities provide ambulance services on an agency basis for the respective provinces (i.e. ambulance services have historically been a provincial responsibility, but in most cases provinces pay municipalities to provide these services on their behalf). In an effort to reduce fragmentation of health services, some municipalities are increasingly providing integrated preventive and curative primary care services.

With the move to create a functioning district health system, there is a long-term commitment to integrated district health services being provided by the local government sphere, although there is still considerable debate about the constitutional responsibility of municipalities for health service provision. However, given the differential capacity across municipalities to provide health services, there will continue to be variable district health organisation across the country, ranging from district services being fully devolved to local government level in some areas to district services being fully provided by provincial health departments in other areas.

The purpose of this document is to provide a brief overview of what is currently known about health care financing and expenditure at local government level. It also outlines what is required to obtain accurate baseline information on financing sources, expenditure levels and resource allocation decision-making processes and information requirements for evaluating and monitoring the equity of local government health care financing and expenditure.

Local government health care financing

Historical perspective

Until 2000, there were two major sources of finance for local government health services, namely local government ‘own revenue’ and transfers from provincial health departments. Local governments can raise their own revenue through levying local taxes (e.g. the RSC levy on payrolls) and property rates and from utility sales (e.g. charges for water and electricity). ‘Own revenue’ has been supplemented in some municipalities through lump sum allocations from the national (and provincial) level, although these have been relatively small until recently. Municipal health departments have to compete with other municipal departments (e.g. housing) for allocations from ‘own revenue’ (and resources from national/provincial transfers) through the normal budgetary process.

Provincial health department allocations have traditionally taken two forms; payments for agency services (particularly ambulance services) and subsidies for municipal health services. Although the line between these two types of payments is sometimes blurred, it is useful to understand the

distinction between them. In the case of agency payments for ambulance services, provincial health departments *have* to cover the full cost of running these services as these services are effectively the responsibility of the province and municipalities could terminate the agency agreement and refuse to provide these services. In contrast, the level of subsidy payments for municipal health services is largely at the discretion of the provincial health department.

The mixture between 'own revenue' and provincial health department transfers varies considerably between municipalities. In metropolitan areas, 'own revenue' accounts for the biggest share of municipal health care funding, while in small towns and rural areas, those municipalities that do provide some health services are heavily dependent on provincial transfers.

Current financing of local governments

Although municipal health services continue to be funded in the manner described above, there has been an important recent development in the overall local government funding mechanisms that creates an opportunity to change the way in which municipal health services are funded (namely direct transfers from national level rather than from provincial health departments). With the finalisation of local government boundary demarcation and the democratic election of local governments in late 2000, transfers of financial resources from the national level have been increased and a coherent mechanism for allocating these resources between municipalities adopted. An equitable shares formula for the allocation of national resources to local government was first introduced in the 1998/99 financial year, but the size of the budget allocation for the local government equitable share increased dramatically in the 2001/02 financial year.

In general, it is expected that municipal services should continue to be funded largely from locally-generated 'own revenue'. In 2000/01, transfers from the national level only accounted for about 7% of total local government expenditure (National Treasury 2001). The differential ability to generate 'own revenue' between municipalities translates into a need for national revenue transfers to ensure equitable provision of municipal services. Thus, national transfers are based on an 'equitable shares formula'.

There are currently 3 components to the equitable shares formula:

- An institutional grant to support the overhead costs of municipalities which have a small rates and tax base relative to their population (i.e. where a high proportion of residents are unable to financially contribute to rates and taxes). This component of the formula estimates the average overhead costs, less the rates/tax revenue that the municipality could generate, based on the number of households above the poverty threshold.
- A basic services grant to support the operating cost of basic services provided to low-income households. This component is based largely on the annual per capita cost of providing basic municipal services multiplied by the number of people living in poverty in each municipality. The basic services included in this calculation are electricity (estimated to cost R36 per person per annum for 2001/02), water (R20), refuse (R20) and sanitation (R10).
- An allocation to municipalities located in former 'homeland' areas that are taking over personnel from provincial government in what are termed R293 towns (this will gradually be discontinued as these municipalities become fully functioning and have a full staff complement).

In addition to the equitable shares allocation, there is a range of conditional grants that are "made to those municipalities that apply for or are selected to receive these funds" (National Treasury 2001: 251). These grants are directed to capacity-building (to improve financial management, planning and project management capacity), restructuring (in order to move towards improved financial self-

sustainability) and infrastructural development.

Apart from these transfers (equitable shares and conditional grants) to local government from the national revenue fund and local government 'own revenue', the only other source of funding for local government is that of 'grants-in-kind'. The major 'grants-in-kind' are the subsidies for municipal health services and agency payments for ambulance/emergency services. Some stakeholders argue that the funding of local government should be further rationalised and integrated by including municipal health services in the equitable shares' basic services grant (i.e. replacing provincial health department payments with direct transfers from national government). Some arguments for and against this recommendation are briefly considered in the next section, which draws extensively on the 2000 Women's Budget (Klugman and McIntyre 2000).

Should the financing of local government health services be changed?

There are a number of perceived problems with the current mechanism of 'grants-in-kind' from provincial health departments for local government health services. From the perspective of both the provincial health departments and *some* municipal health departments, there is a concern that the grants or subsidies follow historical funding patterns and that equity considerations are not adequately taken into account. While some provinces are trying to allocate subsidies on the basis of relative need for municipal health services, this is hampered by lack of information on the availability of 'own revenue' for funding these services. Thus, while provincial health departments can come up with some estimates of 'needs-based indicators' (such as population size, demographic composition, mortality etc.) for each municipality, they cannot estimate the differential tax/rates base of municipalities and thus their ability to fund health services from their own revenue. Provincial interviewees participating in the Women's Budget study indicated that contributions to health services from local government own revenue are *'a state secret'* (Klugman and McIntyre 2000).

However, lack of transparency in financial affairs occurs equally in the other direction. Local government health managers are not provided with information on expenditure at provincial facilities within the boundaries of their municipality, which hinders rational planning for health service delivery. Managers at the local government level are also concerned about the lack of transparency in grant/ subsidy decision-making, both in terms of what proportion of provincial health resources are set aside for these grants and in relation to the distribution between different municipalities in the province.

There is considerable insecurity for local government health managers under the current grant/subsidy arrangement. When confronted with increasingly constrained provincial health budgets, local government grants/subsidies are frequently a 'soft-target' and may be cut arbitrarily during a financial year. This is one of the key reasons that local government health managers would prefer health service transfers to be incorporated with the equitable shares allocation from national level. It appears that there is considerably greater security in the budgets allocated by local government councils. When asked whether their budgets were arbitrarily cut during a financial year (as happens in some provinces), one local government health manager explained that *'Council doesn't function that way'* (Klugman and McIntyre 2000).

Another important motivation for favouring national transfers is the problem of dual, and sometimes conflicting, lines of accountability created by provincial health department grants/subsidies. Local government health managers are expected to be accountable to the provincial health departments as well as to their own councils. This is particularly problematic in metropolitan areas, where provincial health department subsidies are a small proportion of total health expenditure on municipal health services, and where health managers feel that they should be primarily accountable to their council and should not be monitored by and expected to report to the provincial health department as well.

A related issue is that the current funding mechanism exacerbates power imbalances between provincial and local government. A local government official explained this issue as follows: *'It's imperative that local council services work and you can't work when someone else is pulling the purse strings'* (Klugman and McIntyre 2000). This means that local government and provincial health departments are not equal partners in discussions about how to rationalise and integrate health services at a district level.

The dual funding of local government health services, and the continuing confusion over the constitutional definition of "municipal health services", also jeopardises health managers' ability to argue effectively for a 'fair share' of 'own revenue' in their municipalities. Heads of other municipal departments argue that provinces should be subsidising health services entirely and that the health department should thus not have a claim on 'own revenue' resources.

Despite the above problems, provincial managers generally favour continued subsidisation of local government health services through the provincial health department route. However, they want routine information on local government own revenue contributions, and improved accountability for expenditure funded through provincial subsidies. At present, some feel that local governments are *'doing whatever they want to do with the budget [subsidy]. This is not being controlled by provincial government'*. The national Department of Health is developing guidelines for 'service agreements' between provincial and local departments. Several provincial managers agreed that *'the service agreements will be useful – we'll sign them and that will oblige people [local governments] to provide certain services'* (Klugman and McIntyre 2000).

There is likely to be continued heated debate about whether or not the current funding mechanism for local government health services should change. The issue of control over resources is a major impediment to a 'partnership' approach in moving towards an integrated district health system. However, even if agreement were reached that subsidies for local government health services should be included in the equitable shares formula, it will be technically difficult for national treasury to do this in the foreseeable future. Given that not all municipalities provide health services, and the considerable variation in package of health services provided by different municipalities, it will be difficult to incorporate health services in the basic services grant component of the equitable shares formula.

Local government health care expenditure

There is extremely limited data available on health care expenditure at the local government level. The most comprehensive and recent data are available in the National Health Accounts (NHA) report. However, it should be noted that the NHA database is incomplete at local government level, and that it contains limited disaggregated data according to expenditure by type of service.

REFERENCES

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