Financing Local Government Health Services

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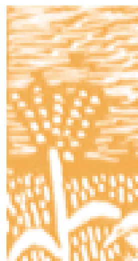
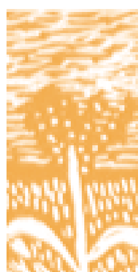
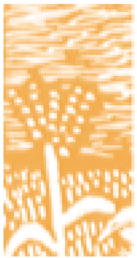



Given the stated commitment to decentralising district health services to local governments, it is becoming increasingly important to evaluate the current financing of local government health services and to evaluate whether this should be changed in future to ensure that decentralised services are adequately and appropriately funded. This chapter summarises the views of health department and treasury officials from national, provincial and local governments on these issues. The present system of subsidy and agency payments from provincial health departments to local governments has certain benefits, but also numerous problems. In particular, many interviewees indicated that equity considerations are not adequately taken into account in determining allocations to local governments, given the heavy reliance on historical budgeting. From the provincial perspective, the current arrangements do not permit adequate monitoring of local government health services, while local governments are particularly concerned about the cash-flow problems arising from quarterly arrear payments by provinces. There was general agreement that the current system can be improved, but somewhat less agreement about whether there should be fundamental changes in the financing mechanism. In particular, some interviewees argued that if 'municipal health services' (as specified in the constitution) are defined to include all district health services, local government health services should ultimately be funded through direct transfers from national Treasury. Once again, there will be considerable benefits from such an approach, but also potential problems particularly in relation to ensuring appropriate referral mechanisms between health service levels. It is unlikely that direct transfers from national Treasury will be implemented in the near future. Thus, it is important that improvements to the current system of provincial transfers are urgently introduced, while at the same time examining ways in which a future move to national Treasury allocations for local government health services can be operationalised effectively.

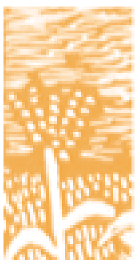
Introduction

The issue of local government health care financing is becoming increasingly important in the light of efforts to create a functioning district health system. Local government, as the sphere of government closest to communities, is seen as the most appropriate avenue for the provision of basic services, including primary health care services. 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.



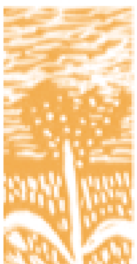
At present, some (but not all) municipalities provide health services. There is considerable diversity between municipalities in relation to the range and extent of health service provision. Historically, local government health services have been restricted largely to the provision of preventative, promotive and rehabilitative primary care services (mainly provided by nurses), 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. while ambulance services are a provincial responsibility (both historically and in terms of the 1996 constitution), 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.

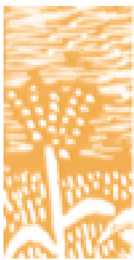
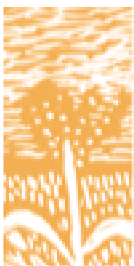
If all municipalities will ultimately be expected to provide comprehensive district level health services, some local governments will have to expand the range and type of health services they provide while others will have to develop the capacity to provide health services. It will be critical to ensure that these services are adequately and appropriately financed. This chapter briefly considers current and potential future mechanisms for financing local government health services.

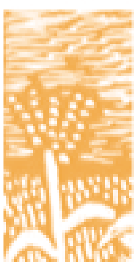
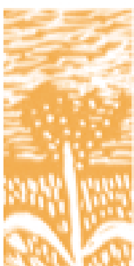


Overview of local governments and their financing

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



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

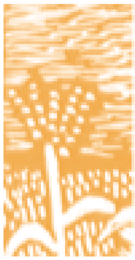
There have been dramatic changes in the organisation of local governments since the 1994 elections. The number of municipalities has been reduced with an emphasis on amalgamating local authorities from former 'white' areas with those from former 'black' areas. This was seen as an important mechanism for promoting a relative redistribution of resources between the previously well-off and previously disadvantaged areas. The process has placed a heavy burden on restructured municipalities, especially where service responsibilities have increased without new avenues for generating extra revenue. The demarcation process was unable to create municipal structures with a uniform capacity to deliver services to their communities. Capacity is particularly limited within municipalities in provinces containing former 'homeland' areas, where there has been a tendency for provincial departments to concentrate their efforts on building their own capacity at the expense of building local government capacity.[1,2]

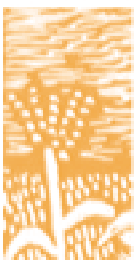
The main source of local government finance is that of 'own revenue', which is raised through levying local taxes (e.g. on payroll levies) and property rates as well as from utility sales (e.g. charges for water and electricity). 'Own revenue' has been supplemented through lump sum allocations from the national (and provincial) level, although until recently these have been relatively small.

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.[3] However, given the differential ability of local governments to generate 'own revenue' due to differences in their rates and tax bases, there is a need for some nationally allocated resources to ensure equitable provision of basic services by local governments. 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 resources from the national Treasury to individual local governments was first introduced in the 1998/99 financial year. There are currently 3 components to the equitable shares formula:[3]

- An institutional grant to support the overhead costs of municipalities which have a small rates and tax base relative to their population (i.e. where a high proportion of residents are unable to contribute to rates and taxes). This component of the formula estimates the average overhead costs of municipalities, and deducts from this amount the rates/tax revenue that the municipality could generate, based on the number of households above the poverty threshold.



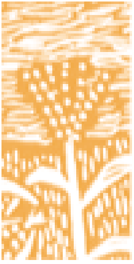


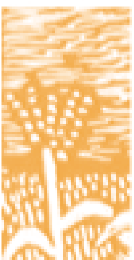
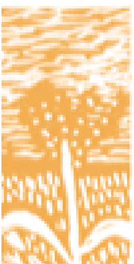
- A basic services grant to support the operating cost of basic services provided to low-income households. This component is based largely on the estimated annual per capita cost of providing basic municipal services multiplied by the number of people living in poverty in each municipality. The basic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

In addition to the equitable shares allocation, there is a range of conditional grants that are 'made to those municipalities that apply for or are selected to receive these funds'.[3] 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 local government 'own revenue' and these transfers to local government from the national revenue fund (equitable shares and conditional grants), the only other source of funding for local government is that of 'grants-in-kind'. The major 'grants-in-kind' are the subsidies for municipal health services and agency payments for ambulance/emergency services, both of which currently take the form of transfers from provincial health departments. 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 Treasury).

The purpose of this chapter is to document current mechanisms of financing local government *health* services, particularly transfers from provincial health departments, and the views of key actors on these mechanisms. In addition, it considers actors' views on the possibility of funding local government health services through direct transfers from national Treasury. It is based on interviews with key actors in national, provincial and local government Departments of Health and Treasuries. These interviews were conducted in three provinces, namely Western Cape, Mpumalanga and Free State. As it is important to canvass views in different categories of municipalities, Cape Town was included as an example of a major metropolitan council, Nelspruit as a town, and Tsepho/Kopano as a municipality in a rural area in the respective provinces.



Current financing of local government health services

Local government health services delivered prior to 2000 fell broadly under two categories. Firstly, local governments have historically provided a limited range of preventative, promotive and rehabilitative primary care services, which were seen as the explicit responsibility of local government structures. Secondly, some local governments that had sufficient service provision capacity provided additional services, such as curative primary health care services and ambulance services, on behalf of (or on an agency basis for) provincial and/or national governments. In addition, the 1977 Health Act makes provision for provincial and national health departments to appoint a local government to provide basic health services for an adjacent municipality, where the latter does not have adequate capacity to provide these services or raise sufficient revenue for them.

Funding of these two categories of services also took different forms. For services that were regarded as a core local government responsibility, local government 'own revenue' was drawn upon to contribute to the funding of these services. Municipal health departments had to compete with other municipal departments (e.g. housing) for allocations from 'own revenue' through the normal budgetary process. However, a subsidy was also provided, initially from the national health department and more recently from the provincial health departments, to ensure adequate provision of these services. The level of subsidy payments for municipal health services is largely at the discretion of the provincial health department.

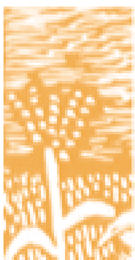
In relation to local government health services that are provided on behalf of the provincial health department, or one of the former national health departments such as the House of Representatives' or House of Delegates' health departments, an agency payment was made to the relevant local government by the provincial or national government. Agency payments differ from subsidies in that provincial/national health departments were expected to cover the full cost of running these services, (since the services are considered to be the responsibility of the national/provincial department) and municipalities could terminate the agency agreement and refuse to provide these services. These payments were frequently structured as salary payments for identified staff involved in the provision of these agency services.

Sometimes part of the subsidies and/or agency payments take the form of free drugs paid for by the provincial government. This was a mechanism to ensure that local governments had access to low cost medicines.

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

Although in recent years the dividing line between subsidies and agency payments has become blurred, the historical experience of these different payment mechanisms, which were integrally related to whether a particular health service was regarded as the responsibility of local government or not, is of considerable relevance to the current debates about the definition of municipal health services. In particular, if municipal health services are defined broadly to include all district health services, these services will be regarded as the constitutional responsibility of local government. This implies that they need to be funded from local government 'own revenue' and through some form of subsidy arrangement. Such subsidies can either be provided via provincial health departments, as at present, or could quite legitimately be included in the equitable shares allocations to local governments by the national Treasury. The latter approach would be in line with the constitution, which indicates that provincial and local governments are entitled to an equitable share of nationally collected resources to enable them to perform their constitutional functions. In contrast, if municipal health services are narrowly defined to include only a limited set of preventive, promotive and environmental health services, district health services would constitutionally be regarded as a provincial function. It would still be feasible for local government to provide district health services, but this would then be on an agency basis for provincial health departments. In this case, finances for district health services would have to be allocated to provinces, who would then need to fund the full cost of these services as provided by local governments through an explicit agency agreement.

Thus, it is important to assess the current system of provincial allocations to local government as this will continue to be the financing mechanism if municipal health services are narrowly defined (see the next 3 sections). It is also important to consider the potential strengths and weaknesses of direct funding from national Treasury (see page 61), as this would be the most logical financing mechanism if municipal health services are defined to include district health services.

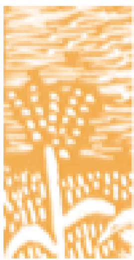


Mechanisms for determining provincial allocations to individual local governments

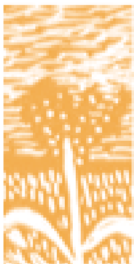
Interviews for this research indicate that the distinction between 'subsidies' and 'agency payments' has become blurred over time. For this reason all payments from provincial health departments to local governments will be referred to as allocations in the remainder of this chapter.

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

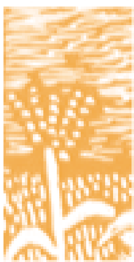
Two of the provinces interviewed indicated that they were attempting to introduce mechanisms for promoting an equitable distribution of resources, based on indicators of the relative need for health services in the different local government areas. In one province the indicator is the population size of each municipality. In the second province the size of the population not covered by medical aid is the indicator.



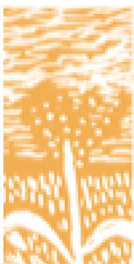
Despite these efforts to introduce an element of equity into the allocation process, all provinces indicated that historical distribution patterns still played an important role in determining allocations to local governments. In one province, budgets for each local government's allocation were based entirely on historical allocations (e.g. adding 6% as an inflation adjustment to the previous year's budget), with the final payments made on the basis of utilisation statistics and expenditure claims. In the two provinces that have introduced some indicator of need into the resource allocation process, the number of facilities and type of services provided still play an important role in determining allocations. While this adjustment is necessary to take account of historical agency agreements (e.g. to cover the additional costs of providing curative services in certain municipalities where this had been negotiated with the former House of Representatives), it does have the effect of perpetuating historical patterns and existing inequities in service provision.



In those provinces that rely entirely on historical budgeting processes, payments to local governments are often still linked to individual staff posts. This creates two problems. Firstly, if the post becomes vacant and is not filled within a certain period, the cost of that salary is removed from the provincial allocation to the local government. If there is substantial staff turnover in a relatively poor municipal area where it is difficult to attract new staff, over time, the allocation to this local government will decline, hence exacerbating inequities between this and other better resourced municipalities. Secondly, this mechanism of determining allocations can heighten conflict about salary scale differences between provincial and local governments. As noted by one local government official:



"Province would negotiate that we will pay for 3 nursing posts, 4 nursing assistants ... at this clinic ... and it would be at provincial salary and you know you will pick up the difference."



In contrast, allocations to local governments in those provinces that are attempting to apply a more equitable allocation process often take the form of 'block transfers'. The funds are no longer tied to specific posts, but can be used along with resources provided from the municipal 'own revenue' for the general provision of health services by that local government. However, some of these transfers may be specifically earmarked for specific services (e.g. HIV/AIDS services). In addition, certain provinces have moved away from the unlimited provision of free drugs to local governments. Instead, part of the allocation is earmarked as a drug budget from which local

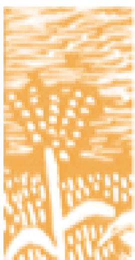
governments can order drugs from the provincial depot. This funding mechanism makes explicit the hidden value of the subsidy local governments are getting from the provincial governments through free drug supplies and has been introduced to promote better management of drug utilisation by local governments. A local government manager viewed this as a positive move offering the following explanation:

"Before, the laboratory costs, reproductive health services, family planning stuff and medicines, including TB medicines and obviously vaccines had all been free to local government, and we would just draw from the central store. Province had to pay ... and that means it was a bit like Father Christmas ... There was no motivation for us to manage what was going on ... We didn't know what was going on. So nobody had any idea what medicines were being used and what was happening, so it was a recipe for disaster."

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

The majority of provincial officials interviewed indicated that the key benefit of the present financing mechanism is that it gives provinces some control over local government health care services. They see the need for such control in order to ensure that national policy is implemented within the local sphere of government. These views indicate some uncertainty about local government health departments' willingness or ability to provide health services in line with the national policy framework. This uncertainty is exacerbated by the 1977 Health Act which makes provision for the national health department to issue directives to local governments in relation to health service provision, reflecting a view of municipalities as a 'lower level' of government. The Health Act (No. 63 of 1977) has yet to be revised to reflect the new constitutional reality in which local government is an independent sphere of government, alongside the national and provincial spheres. Municipalities as a distinct sphere of government, should have relative autonomy in deciding on service provision within the parameters of national policy guidelines.

A strength of the current financing mechanism is that it facilitates appropriate interaction and referral patterns between the different levels of health services allowing for co-ordination of the provision of all health care services in an integrated manner.



As one provincial health official noted:

"I think that the funding needs to be channelled via the provincial health department simply in order to try and ensure that the entire health system still hangs together. You can't have a primary care service which is running completely independently of the hospital services."

Some interviewees also suggested that the current financing mechanism enhances financial sustainability in the sense that local governments have an

indication that a certain amount of money will be provided by the provincial health department every quarter to enable it to provide the minimum basic health services to its communities.

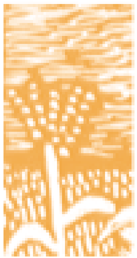
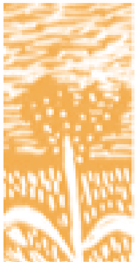
Some local government treasury officials indicated that the current system is administratively easy as money is claimed on a quarterly basis from the provincial health department. There is a perception that it would be more difficult and time-consuming to interact with the national Treasury. Furthermore,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

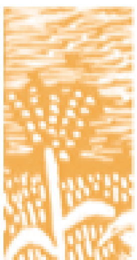
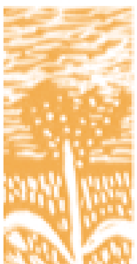
Finally, some interviewees suggested that the current financing mechanism has the *potential* to allocate resources for local government health service provision in an equitable manner. It was argued that provinces are more aware than national Treasury of the 'own revenue' generation potential of different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

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

Despite the numerous strengths of the current system of provincial allocations identified by respondents, provincial and local government interviewees also had considerable concerns about the existing mechanism. Both provincial and local government officials indicated that although there was the *potential* for equitable allocation of resources, equity goals are not adequately taken into account due to the heavy reliance on historical budgeting. In particular, the needs of the communities in individual municipal areas are not appropriately considered in the present financing mechanism. Some interviewees argued that not only population size should be taken into account, but also morbidity and mortality patterns, as well as the socio-economic status of communities which influences the local government's ability to generate its own revenue. One provincial official commented as follows:

"I think the weakness of focusing on history is that it overlooks some of the new developments, and maybe also if we could look at the disease profile of particular areas, maybe it would be better ... we need a tool to measure or decide what we can allocate to a particular local authority and also to look at the needs that are in that area, not only to focus on the number of facilities because when you focus on that number, are you sure that there is equitable

distribution of those facilities amongst different local municipalities? So I think that is the weakness because mainly we will focus on history."

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

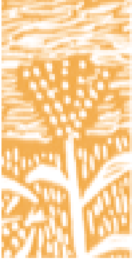
The major concern on the part of provincial health department officials is that the current system does not permit adequate monitoring of local government health services. A provincial manager explained the problem as follows:

"All these payments to local government are made in terms of the Health Act of 1977 and those few little clauses that are in there doesn't define how much is meant to be paid, it doesn't even really define what we are paying for. It doesn't define any monitoring mechanisms. All it requires is they put in a claim to say-that they have spent more than that amount of money and that's all that they prove to us that they have spent more than that amount of money."

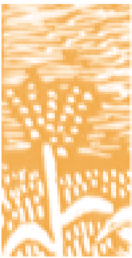
Some provincial officials claim that local governments do not use the provincial allocations only for health services but may also fund other sectors with these resources. This may be the case given that provincial payments are made to local government treasuries rather than directly to local government health departments. In addition, the existing format for quarterly local government reporting, which is based on specifications in the 1977 Health Act, does not make provision for adequate monitoring of health services provided by local governments, or of health status. The monitoring format is very detailed but much of the information is not appropriate for monitoring purposes. While provincial managers feel there is inadequate monitoring, Klugman and McIntyre[4] noted that some local government health managers feel such monitoring is inappropriate as they are primarily accountable to their local councils. One interviewee in the Klugman and McIntyre[4] study argued as follows:

"Province provide 17% of my total health budget so I can't be monitored by another authority who provides a small proportion of my budget."

From the perspective of local government, a number of concerns with the present system were identified. As the quarterly payments to local governments are paid in arrears, many local governments experience cash flow problems in relation to health service provision. This is exacerbated in some provinces where there are considerable delays in paying these quarterly instalments. One local government Treasury official indicated that:



"In the past there has been a few problems and the [provincial] department also has got cash flow problems and then sometimes you have to wait for your money, and that means that the municipality must go into overdraft to subsidise the salaries of the people in the health department and maybe next year, after we have paid a lot of interest on the overdraft, we only get the money then."



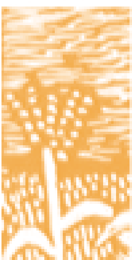
Local government officials indicated that there were particular problems with securing payment near the end of the provincial government's financial year. The quarterly payments were in some cases delayed even more than usual while in other instances the payment was arbitrarily cut by the province.

There was some agreement across interviewees that recent efforts to establish performance agreements between provincial and local government health departments were a positive step and would resolve some of the problems outlined above. From the provincial perspective, there would be improved monitoring of local government services as the agreements could specify a more appropriate set of reporting requirements than under the 1977 Health Act. In addition, provincial obligations for funding contributions to local government health services would be specified, which may promote greater security in this regard.

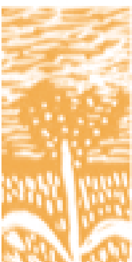
Key issues in relation to 'own revenue' funding of local government health services

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

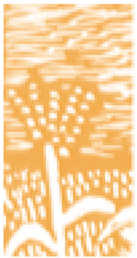
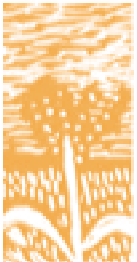
The process followed by local governments was described by a municipal Treasury official as follows:

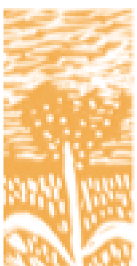


"We have certain guidelines which we get from Pretoria each year which tells us that your general cost may only increase by this, your maintenance may increase by this, and in total your budget may only increase by a certain percentage. And then during the budgeting process, all the departments can come to us and they tell us from this year's budget what they will need next year, which is basically in some instances a wish list, and then the moment when we go and put all those things together and we see that the municipality budget is growing say by 15% and the guideline is only 7%, then we will have to go back to all those directors and tell them "listen between the lot of you, you will have to cut X million" and then they will have to prioritise and cut where necessary to meet those standards that are laid down by the people in Pretoria."



There is reportedly a heavy reliance on historical budgeting in determining the allocation of local government resources to the different sectors. The



final stage is the approval of the municipal budget by its Council.

Klugman and McIntyre[4] noted that some health departments are under considerable pressure when competing with other departments for a fair share of their local government's budget. This departmental resource competition has been made more difficult by the continuing debates over the constitutional definition of municipal health services. As one local official explained:

"Departmental heads think provinces should just take over [health services] and pay. We think the municipality should pay more [towards health services] but the department heads don't like this. Politicians don't seem that aware of this issue."

A number of interviewees in the current study indicated that local government councillors are very unclear on what health services are the responsibility of, and are provided by, their municipality, which limits their ability to make informed decisions about the allocation between health and other local government departments.

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

The process of local government budgeting is set to change dramatically with the move towards Integrated Development Planning. Although preparation of an Integrated Development Plan (IDP) by each local government is a legal requirement under the Municipal Systems Act of 2000, only one of the municipalities interviewed claimed to have an IDP in place. The IDP is a participative process involving a range of stakeholders whereby municipalities develop a strategic development plan, which is intended to guide all planning, management and decision making in the municipality.[5] The IDP covers a five-year period in line with the period that the council will be in office. It should explicitly outline the development priorities of the municipality, (which should be based on the needs of the community), and thus serve as a guideline for the strategic allocation of resources in pursuit of these priorities. The IDP should be reviewed annually to respond to changing needs and circumstances.

It is anticipated that the IDP process will promote a move away from historical budgeting processes towards a more equitable and rational allocation of local government resources to health services and to other local government services such as housing, water and sanitation provision (which also have important health effects). As one local government health official explained:

"We must remember that local government, as it is now, is not the animal that it was three years ago. So before in a sense it was a big bureaucratic thing that basically delivered services itself. It took the refuse away and it got the water there, got the electricity and all that. Now it is very different and it is very developmental and it is driven by an Integrated Development Plan, which fits in perfectly with the kind of intersectoral approach of primary health care."

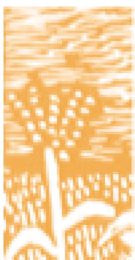
Alternative mechanisms of financing local government health services

There is considerable dissatisfaction among some local government officials with the current system of health care financing, particularly with respect to allocations from provinces. Local government officials interviewed in another research project raised the possibility of replacing the provincial allocations with direct allocations from the national Treasury by including health services in the 'equitable shares' formula.[4] Direct allocations from national Treasury would be particularly relevant if municipal health services are ultimately defined broadly to cover district health services. The potential strengths and weaknesses of this alternative financing mechanism are considered below.

Potential strengths of direct funding from national Treasury

Direct financing of local government health services by national Treasury was regarded by some as being less likely to lead to cash flow problems. Some local government officials indicated that they trust national Treasury more than provincial authorities to release the money that is due to them. This stems in part from the suspicion that regional politics influence the distribution of provincial resources to local governments. There is a perception that this would be less likely to occur in allocations from national Treasury, particularly given that national allocations are based on a transparent 'equitable shares' formula. The relatively greater trust in the national Treasury also stems from the experience of arbitrary cuts in provincial allocations to local governments and frequent delays in payments. One local government official argued as follows:

"If you are running the money through the province, there is a danger, and that is another reason why a national decision is better, because if province is under-resourced or has constraints, it might want to try and steal from us, and it does presently. ... I think the reason why there is greater trust with national is a sense "well they have really got the money" ... at least they won't go bankrupt."



In addition, national Treasury will transfer the full amount budgeted at the beginning of the financial year, as opposed to the current process of quarterly payments in arrears from the provinces.

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

Interviewees indicated that another important potential benefit of direct funding of local government health services by national Treasury is that it will simplify financial administration and accountability. The local government treasury will only have to interact with the national Treasury around an integrated 'equitable shares' allocation. This is considerably simpler than the current process of engaging with national treasury for an allocation for basic services excluding health services, as well as with provincial health departments and treasuries for health service allocations. One interviewee indicated that they:

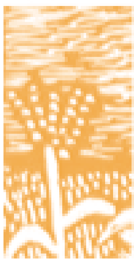
"Would prefer that the national government or national Treasury puts the money directly into the coffers of local government for the purposes of running those services, because the transfer of funds to province and then from province to local, it is a lot of administration and I don't think it is necessary."

In addition, as national allocations occur at the beginning of the financial year, local governments will not need to submit quarterly reports to provinces in order to secure the next quarterly health service allocation.

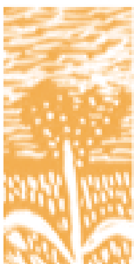
Accountability mechanisms would also be streamlined. At present, local governments are required to account to the national Treasury for the 'equitable shares' allocation they receive for providing basic services, to the provincial Department of Health for health service allocations, and to their own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

One of the most important arguments presented by interviewees in favour of a change in the mechanism of financing health services is that it would promote comprehensive and integrated planning and would enhance local government's ability to deliver the full range of basic services. Consolidating financial allocations would appear to be an appropriate response to the stated policy of devolving authority, particularly given that municipalities comprise the sphere of government closest to communities and are arguably in the best position to assess and meet the needs of the population in relation to basic services. This argument is strengthened by the legal requirement that local governments develop an IDP to ensure that resources are used to achieve identified priorities for the community served. Local governments will be

held accountable, for the use of resources and the extent to which IDP priorities are achieved, not only by other spheres of government but also by the communities they serve.

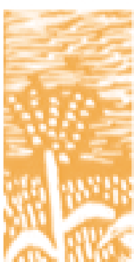


Direct financing from national Treasury is also seen as being critical in speeding up the process of improved delivery of local government health care services, both in terms of the quantity and quality of services. There will be longer term planning under the IDP, strengthened by greater certainty about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

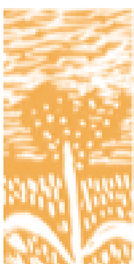


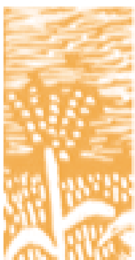
The final argument put forward by interviewees in favour of direct funding from national Treasury is that it has considerable potential to achieve equity between local governments. Under the present system of provincial allocations, there is the *potential* to achieve equity in local government health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

Potential difficulties/weaknesses of direct funding from national Treasury



There were considerable concerns about changing the existing financing mechanism, particularly among provincial health officials as well as national Department of Health and Treasury officials. Some of these concerns were based on misconceptions about how the process would work. For example, most of the provincial interviewees raised the difficulty of monitoring local government health services if money were transferred directly from national Treasury. Most were of the opinion that this would mean that the national Department of Health would be responsible for monitoring their services, which would only be feasible through a return to the old system of regional offices of the national health department in each province. In fact if resources





were allocated directly from national Treasury, local governments would be accountable for the expenditure through the normal government auditing processes, and the constitution clearly stipulates that provincial government has an important role to play in monitoring the implementation of national policies.

Another misconception relates to the mechanism for allocating resources to local governments. Some provincial interviewees were concerned that national Treasury would allocate health service funds to both Category B and C municipalities. As explained by one interviewee:

"My understanding from the people in national Treasury is that that (health service funds) then gets divided between all the local authorities whether the local authority is delivering a health service or not .... As you know especially in the rural areas you have got B and C municipalities which are covering the same area and it would be silly to be giving both Bs and Cs health money."

However, the national Treasury clearly states in it's 2001 Budget Review that the 'equitable shares' allocations 'are made to all primary municipalities'[3] and generally go directly to Category A and B municipalities. Allocations are only made to Category C municipalities when there is either no Category B municipality in a particular area falling under the Category C municipality, or where a Category B municipality is institutionally weak and where the Category C municipality provides basic services on its behalf.

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

A further concern is that the potential for 'dumping' patients on, or inappropriate referral of patients between, health facilities administered by another sphere of government may be increased. One local government official argued that:

"Particularly with the fact that we understand that there is going to be a potential cut of the academic funding and then you are going to start to see people pull back on the other resources potentially. And of course all the more worrying

perhaps, when you do devolve the District Health System to the local government, will be that then it is seen as 'we' and 'them', and province starts to think 'oh well we can kind of put the financial pressure on local government because they can just meet it from somewhere else and we want to protect our services'."

"What is the real downside of the District Health System is potentially this kind of playing off ... The regional hospitals kind of dumping patients back into the district hospitals or into the primary health care services."

There is also the potential for the reverse to happen; local government clinics that are facing a budgetary crisis might refer patients with minor ailments to provincial hospitals, to transfer the cost to another sphere of government.

The final concern from the perspective of national and provincial health department interviewees was the potential for local government health care services to lose out to other sectors in the municipal budget negotiations. If health services are included in the 'equitable shares' formula, the national Treasury will make a block grant to each primary municipality. This will be combined with 'own revenue' and each local government department will have to bid for a fair share of these resources. Interviewees fear that health may receive a relatively smaller budget than it does currently, while other local government departments may receive relatively higher budgets. However, some local government interviewees felt that the health department would in fact be awarded a high priority in IDPs. They also pointed out that even if the health service budget declined, if the additional resources were allocated to services such as water, sanitation and housing this may ultimately translate into even greater health status improvements for the community served by that municipality. This was supported by one provincial manager who argued:

"I would think that if the local authorities have any spare money they should be pouring it into housing and basic services. I think that would have a far better outcome on health status."

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

Secondly, national Treasury officials, as well as national and provincial health department interviewees, were concerned about local government capacity to provide health services. Treasury representatives expressed a very strong view that the process of restructuring local governments has been difficult and that many local governments have limited capacity and have inherited

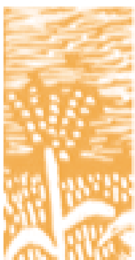
large debts. Local governments are struggling to even begin to put basic services in place and addressing the challenge of equitable provision of water, sanitation, housing, refuse removal and electricity should be the priority as these services are constitutionally specified as the main competency of local government. On this basis, it is argued that local government must be given adequate time to develop its capacity and to establish the above-mentioned basic services before they are expected to assume full responsibility for all primary health care services. Decentralisation of district health services to local governments would be accompanied by a transfer of some provincial staff to local government which would enhance the capacity of local government level to deliver health services. However, there is still a concern that this added responsibility would detract from developing local government capacity to deliver water, sanitation and other essential municipal services.

One provincial interviewee highlighted that it is not only service provision capacity that is required.

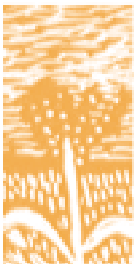
"I would say that ... the fact of the matter is that there is not yet capacity in local government, particularly to deal with such a big responsibility because it is a big responsibility once you say 'transfer it straight to local government', but eventually that is how it is supposed to happen. In my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

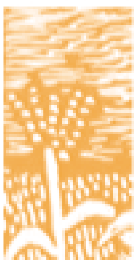
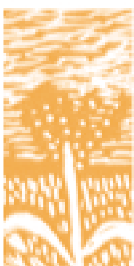
Conclusion

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



Despite these divergent views on a number of issues, there does appear to be considerable support across spheres of government and cogent arguments in favour of integrating health service funding into the 'equitable shares' allocations from national Treasury in future. However, it will take considerable time to reach a point where this will be feasible. It is logistically difficult to gather all the data required to appropriately allocate health service resources between local governments from a national level at present, given the vast differences in health service provision by local governments. Of even greater



importance, though, is that the national Treasury appears to be opposed to this change in financing mechanism; as they are the organisation that would have to implement this change, their support is critical. National Treasury have a valid concern about the capacity of local governments to improve basic services at the same time as taking on considerable responsibility for health service provision. However, it may be feasible to adopt a staggered approach to implementing direct financing of health services from national Treasury, starting with metropolitan municipalities where there is already greater capacity to deliver both basic services and a wide range of primary health care services. In other municipalities, it will be critical to gradually expand the amount and range of primary health care services provided, in close co-operation with the respective provinces. This will serve to ensure greater uniformity between municipalities in the package of health services delivered. Once this has been achieved, it will be logistically feasible for national Treasury to include health services in its equitable share allocation to local governments as all municipalities will be providing comparable health services. The extent to which this will occur in the near future is heavily dependent on resolving debates about the definition of municipal health services and the future of district health services. If, or when, direct transfers for municipal health services from national Treasury are initiated, it will be essential to agree appropriate referral mechanisms between local government and provincial health services to prevent inappropriate cost-shifting between spheres of government.

There did appear to be consensus among interviewees that there are considerable problems with the existing system of provincial allocations. Given that this system is likely to continue for the foreseeable future, efforts should be made to improve this system as a matter of urgency. In particular, there should be serious consideration of mechanisms for building equity considerations into the allocation process in all provinces, such as taking into account the relative need of communities in each municipality for primary care services and the differential ability of local governments to generate 'own revenue'. The gradual shifting of resources to historically disadvantaged areas should be accompanied by efforts to develop capacity at local government level to provide a more uniform package of primary health care services. The cash flow and administrative workload problems associated with quarterly payments in arrears could also be addressed through moving to a single payment at the beginning of the financial year, accompanied by explicit guidelines on reporting to ensure accountability and for monitoring purposes. Ultimately, all of these changes require a move towards the system of inter-governmental relations envisaged in the 1996 constitution, whereby a collaborative relationship between the three spheres of government exists.

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