

One size does not fit all:

Health services and local government

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Liela Groenewald

Researcher, CPS

Centre for Policy Studies

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Centre for Policy Studies
9 Wellington Avenue
Parktown
Johannesburg, South Africa

P O Box 16488
Doornfontein 2028
Johannesburg, South Africa

Tel (011) 642-9820
Fax (011) 643-4654
e-mail: admin@cps.org.za

www.cps.org.za

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Introduction

Health services in South Africa are fragmented and inefficient. A major reason for this is that the country's health dispensation is still based on legislation formulated in 1977, which is now substantially outdated.¹ Inter alia, health care has changed greatly over the past three decades, and a new political dispensation has been introduced involving different roles and functions for different spheres of government. New national health legislation is urgently needed to align health services with the new constitutional framework, and to make them more coherent and efficient.

The department of health (DoH) has been working on a new health bill since 1994. However, the legislation has been delayed because policy-makers cannot agree on how a district health system (DHS) – expected to be a central feature of the new health dispensation – should be governed. More specifically, they differ over whether a DHS should be controlled by municipalities or by provincial governments. Until now two drafts have been released, but disagreement continues, and there is still no clarity about when a final draft will be taken to parliament.

This paper presents some data gathered in the course of recent research on how local governments are currently managing health services, and the views of municipal councillors and officials on issues surrounding their current and future management. It does so in order to help inform decisions on whether some or all municipalities are capable of managing a DHS, or providing certain health services within a DHS.

Policy documents

Changes in health districts as well as the incomplete legislative process have been informed by several policy documents. The first is the ANC's highly ambitious *National health plan for South Africa*, released in 1994.² This plan was formulated with the assistance of the World Health Organisation (WHO) and informed, in turn, by a set of resolutions that emanated from the International Conference on Primary Health Care (ICPHC),³ held at Alma-Ata in the then USSR on 6-12 September 1978.

Delegates to the conference decided that district health systems (DHSS) were the best way of improving people's health status. DHSS are largely self-contained segments of national health systems that deliver primary health care (PHC)⁴ to commu-

¹ L Gilson, T Balfour, and V Goosen, *Towards well-functioning health districts in South Africa*.** [incomplete reference]

² African National Congress, *A national health plan for South Africa*, Johannesburg: African National Congress, 1994.

³ A resolution reaffirming the Alma-Ata commitment was passed at the world summit on sustainable development (WSSD) in Johannesburg in xxx xxxx. ** [date needed]

⁴ PHC emphasises a preventive approach and universally available essential care, but encompasses comprehensive quality health care.** [unclear] See Declaration of Alma-Ata, 1978, <http://www.who.int/hpr/archive/docs/almaata.html>, accessed April 2002; definition of progressive primary health care, <http://www.hst.org.za/pphc/phcdef.htm>, accessed August 2002.

nities, thereby improving the ability of health systems to address needs at the local level, and promote grass-roots input into their management.⁵ A declaration to this effect was issued at the end of the conference. Organisations which advocate the DHS include the WHO, the United Nations Children's Fund (UNICEF) and, by implication, the 134 states represented at the Alma-Ata conference.

In line with this, the *National health plan* strongly committed the ANC to introducing a DHS in South Africa once it had assumed power.

The second major policy document informing the legislation is the 1997 *White paper for the transformation of the health system*.⁶ While it described South Africa's proposed health system in the same terms as the ANC document, it did so far less ambitiously. It also advocated the introduction of a DHS, and provided three options for its governance - municipalities that had the capacity to do so, legislated District Health Authorities, or provincially appointed District Health Managers. Since then, the draft legislation has contained divergent approaches to this issue.⁷

Steps taken

Against this backdrop, but with no appropriate national policy in place, some steps have been taken to begin transforming South Africa's health system. These include the demarcation of new health districts, shifts in management priorities, and various attempts to integrate the health facilities falling under different authorities and providing different levels of service. In the absence of a clear policy, some provincial legislatures have passed their own health legislation based on their expectations of what the new national legislation will contain. These expectations have been informed by policy documents and public addresses that do not provide a consistent vision of a unified national health system.

In particular, as noted earlier, there is no consensus among politicians and government officials about the way in which a DHS should be governed. Many analysts believe local authorities are the obvious bodies for doing so, while others believe inequalities in health care could be more effectively addressed if DHSS were controlled by regional or provincial authorities.

This confusion has partly been caused by the fact that the constitution of 1996 refers to 'municipal health services' without defining the phrase. The constitution does not remove the responsibility for health care from other spheres of government. It stipulates that municipalities should be responsible for health, but not what type of municipality is referred to. Furthermore, it does not indicate how much health care, or what aspects of governance or administration, municipalities should handle. To complicate matters further, the form that local government would take

⁵ Declaration of Alma-Ata.

⁶ Department of health, *White Paper for the transformation of the health system in South Africa*, Pretoria, 1997.

⁷ Department of health, National Health Bill, <http://www.doh.gov.za/docs/index.html>, 2001, accessed November 2002.

in a democratic South Africa was anything but clear when the constitution was finalised. Therefore, the constitution left room for serious disagreements, which have indeed arisen.

More specifically, the new health bill is largely being delayed by the inability of the National Treasury, the Department of Local and Provincial Government (DPLG), and the DoH to agree on which institution or sphere of governance should assume strategic, financial, and administrative responsibility for a DHS.⁸ Put differently, the question is how ‘municipal health services’, the phrase used in the constitution, should be defined.

Two definitions

Policy-makers have vacillated between a broad and a limited definition of ‘municipal health services’; currently, a very narrow definition is in vogue in terms of which municipalities will only assume responsibility for environmental health services (including waste management, impact assessment, and food inspection).¹⁰ The DoH does not want the health sector to lose local government revenue currently spent on health by allocating all responsibility for a DHS to the provinces. However, the National Treasury is concerned about the unstable finances of local authorities, and the DPLG wants to protect municipalities against mandates that they cannot fulfill.

This has emerged from interviews conducted in the course of the research alluded to earlier; these concerns are also mirrored in the various drafts of the proposed legislation. The study on which this paper draws has been conducted by CPS researchers in collaboration with the Health Systems Trust (HST) and other organisations, on how the culture and structure of local government may impact on the implementation of a DHS. Interviews were conducted in two metropolitan areas: the executive capital, Tshwane, in Gauteng, and the legislative capital, Cape Town, in the Western Cape; and two rural areas: Mopani in Limpopo and Thabo Mofutsanyane in the Free State. Tshwane was chosen because it is a cross-border municipality, falling in both Gauteng and North West. When the interviews were conducted, Cape Town was the only metropolitan authority not controlled by the ANC. Thabo Mofutsanyane includes the former homeland of QwaQwa as well as several towns, while Mopani has very little experience of local government.

These municipalities were chosen to provide a cross-cutting sample. Given their small number, and also, as argued elsewhere, the considerable diversity between municipalities, the impressions recorded in this paper cannot be regarded as repre-

⁸ Representative of an NGO active in the health sector, briefing of CPS researchers, 17 June 2002.

⁹ This phrase appears in the South African constitution and municipal legislation, but is not defined.

¹⁰ Representative of an NGO active in the health sector; source A: interview with two senior health managers of a city in the Western Cape, conducted by the author and Fiona White, 22 July 2002; source B: interview with two senior financial managers of a city in the Western Cape, conducted by the author and Fiona White, 24 July 2002.

sentative of local governments throughout the country. Also, they are based on interviews with municipal councillors and officials, and could well change if a broader range of role players, particularly civil society actors, were interviewed. However, they do provide information which should be of value to policy-makers.

Diverse circumstances

Just as the health care system is fragmented, the four local authorities visited operate under diverse circumstances, including the strength of their administrations. As in the health sector, differences and similarities between local authorities are often determined by their socio-economic profiles, including skills profiles, the availability of resources, access to information, and other factors. Local authorities are ostensibly becoming more stable following the events of the past few years, which include the municipal demarcation process, the introduction of new local government legislation, and successful local elections.

Factors such as possible changes to the South African electoral system, tensions caused by the privatisation of municipal services, other strategic differences with the South African Municipal Workers' Union (SAMWU), and the evaluation of local authorities' financial viability may well lead to further changes. Nevertheless, NGOs in the health sector believe the stage has been set for local authorities to assume responsibility for a DHS.¹¹ The final phase of local government transition is purportedly under way, distinguished by the promotion of 'developmental local authorities' that form an independent sphere of government. Some municipalities are in fact managing health services with structures and approaches based on their own differing expectations and disparate capacity, not always in line with those of the province within which they fall. National legislation is the mechanism through which responsibility for a DHS will be assigned to the provincial or municipal sphere of government, and thus the only way in which the differing expectations of the local and provincial government with respect to responsibility for the DHS can be resolved. A decision in the form of new national health legislation is urgently needed.¹²

Parallel structures

In line with most governing systems, local authorities have two parallel structures, one political and the other administrative.¹³ Large cities often have large bureaucracies. Rural municipalities often have smaller bureaucracies, with senior officials often having to assume direct responsibility for providing strategic direction as well

¹¹ Health Systems Trust, *Local government and health in South Africa: a research and monitoring project*, Undated.

¹² F White, *The district health system: dying for a decision*, Johannesburg: CPS, 2002.

¹³ The political structures are headed by mayors, and the administrative structures by municipal managers. Ideally, they are assisted by teams of councillors and officials.

as monitoring service delivery. In some cases, the supporting administrations comprise no more than a few secretaries. Newly created district municipalities may not have sufficient income to sustain a more elaborate administration.¹⁴ Many positions in district municipalities also remain vacant either because personnel still have to be recruited, or because the division of powers and functions between different kinds of municipalities has not been finalised, and municipal managers are therefore not certain how many members of staff they will require.

The role of elected representatives

The public representatives who will control a DHS need to be sufficiently informed and engaged with their communities to take the appropriate strategic decisions. If local councillors are to govern health services, they will have to understand the relevant debates. On the other hand, based on experiences of political decisions on medicine or treatment policy in the national sphere, some NGOs in the health sector fear inappropriate political interference in technical health decisions¹⁵ in the decentralised districts that are intrinsically harder to monitor. For this reason, it is useful to look at councillors' views of their potential roles in a DHS.

Municipal councillors involved in health issues are generally keen for their local authorities to assume control of district health. They display a desire to do this responsibly by harnessing the necessary resources, promoting equity, and developing both access to basic services and the sophistication of health services close to communities. However, councillors interviewed did not seem interested in involving themselves in technical decisions in respect of health care.¹⁶ Concerns that municipal councillors may interfere in treatment policy therefore seem to be unfounded. Most councillors interviewed wanted to be well informed, and where capacity allowed, were busy equipping themselves for the task of taking forward the concept and implementation of a DHS.

PHC, encompassing preventive care, universally available basic or essential care, and higher-level or comprehensive care, is central to the philosophy of a DHS. Most of the councillors interviewed made a point of coming to grips with the phrase 'Primary Health Care', and have developed a finer understanding of the requirements for providing PHC as close to communities as possible.¹⁷ These councillors

¹⁴ Sources D and E: mayor and financial manager of a district municipality in Limpopo in which the ANC is the majority party, interviewed by the author and Tobie Schmitz, 27 May 2002.

¹⁵ Interview with two senior financial managers of a city in the Western Cape.

¹⁶ Source F: focus group session with health portfolio committee of an ANC-majority district municipality in Limpopo, including a provincially employed director of district health, conducted by the author and Tobie Schmitz, 28 May 2002; Source G: focus group session with executive councillor for health in a Western Cape city and three DA PR councillors on the health portfolio committee, conducted by the author and Fiona White, 3 July 2002; source H: focus group session with three ANC PR councillors serving on the health portfolio committee of a Western Cape city, conducted by the author and Fiona White, CPS, 22 July 2002.

¹⁷ Sources F, J, G, H.

are engaging with role players varying from in-house health managers and other health professionals, provincial employees who have a solid sense of the health system – either on the health profession side or the political debates around its management – to communities, which councillors are consulting about community health needs and perceptions.

In more than one district municipality, members of health portfolio committees have a close working relationship with the relevant provincial manager, who attends all portfolio committee meetings. In more than one city, councillors also obtain expert advice from in-house health managers.¹⁸ Members of health portfolio committees interviewed rely heavily on these health professionals for technical guidance. Often, these committee members also interact with health managers and visit health facilities.¹⁹ (In Thabo Mofutsanyane, where this is not common, there is a lack of funding for health, and councillors would also have to travel some distance.) Many of the councillors interviewed were continually familiarising themselves with current legislation as well as the national policy process.²⁰ When they communicate directly with health workers at clinics, the issues they addressed were improving access by keeping the facilities open for longer, providing water or security, or improving accountability.²¹ In the areas visited, the technical management of health services was largely left to health professionals who worked their way up the health system.²²

Ward and clinic committees

Accountability to local communities is another central tenet of a DHS.²³ The white paper as well as the drafts thus far of the national health bill envisage that this will be achieved via clinic committees.²⁴ Such committees already exist, although not everywhere. Currently, clinic committees comprise elected representatives of communities served by a given clinic; they consult communities directly or facilitate the consultation of communities by councillors on their health needs and their impressions of health service delivery.

In two local authorities visited controlled by the ANC, ward committees seem to be fulfilling that function. The ANC councillor responsible for health in one city regarded clinic committees as something that may have been necessary in the apart-

¹⁸ Sources A, G, H, I: interview with senior provincial PHC manager in the Western Cape, conducted by the author and Fiona White, 23 July 2002.

¹⁹ Source F.

²⁰ Source J: interview with councillor responsible for social development in a city in Gauteng with an ANC majority, conducted by the author and Fiona White, 26 June 2002; Source C.

²¹ Sources F, G, H.

²² Source K: interview with subdistrict health manager in Limpopo, conducted by the author and Tobie Schmitz, 28 May 2002; source A.

²³ *Declaration of Alma-Ata*; ANC, *A national health plan*.

²⁴ Department of health, National Health Bill.

heid era, when ward committees were not formally consulted by local authorities.²⁵ However, since ward committees are now being established almost universally, they could be consulted about health matters as well, making clinic committees superfluous. In Mopani, clinic committees exist and are consulted by councillors, but the health portfolio committees also use ward committees and ward councillors as a source of community input.²⁶ Ward committees are chaired by ward councillors, while the other members are elected by registered voters in the ward. The members each represent an interest group or village, and must be registered voters themselves. No municipal employee or proportional councillor may serve on a ward committee.²⁷ However, councils may exercise discretion on whether or not to establish ward committees, so that health policy-makers cannot rely on their existence as a means of canvassing the community's view on health matters.

Another concern around ward committees expressed during the research was the tension, especially prevalent in under-resourced rural areas, between elected councillors and traditional authorities. One health manager had developed strong relationships with both political and traditional leaders. She managed to overcome the challenge by eliciting input directly from both sectors, rather than expecting either one to represent the other.²⁸

Problems surrounding the use of clinic committees for community input as proposed in the draft legislation includes the fact that these committees are constituted in relation to existing clinics, and thus elected by communities where health facilities already exist. In other words, the structure by its very nature excludes those with the least access to the health system—individuals or communities whose voices need most to be heard by the developers and managers of the health system. This situation could effectively perpetuate inequality in health services.

At the time the interviews were conducted, this view was not supported by experiences in Cape Town, where the DA was in power. Ward committees were not well established, nor part of the formal accountability structures. The DA preferred to use subcouncils in which several wards could discuss their concerns together. In this metropolitan area, health committees, structures similar to clinic committees, take community concerns to the relevant institutions or authorities without limiting themselves to specific facilities.²⁹ 'While health committees generally call meetings at clinics, which local people can attend, their discussion is not limited to one facility. All the health issues in the geographic area are put on the table,' said one health

²⁵ Source J.

²⁶ Source F.

²⁷ N Steytler, and J Mettler, Proposals towards the establishment of ward committees, *Local Government Law Bulletin*, 3(1), [http://www.sn.apc.org/users/clc/localgovt/bulletin/01\(1\)ward.htm](http://www.sn.apc.org/users/clc/localgovt/bulletin/01(1)ward.htm), 1 April 2001

²⁸ Source K.

²⁹ Sources A, H; member of a health committee in a Western Cape city, interviewed by the author and Fiona White, 23 July 2002.

committee representative in a health forum.³⁰ Interested community members in various sections of the city elect health committees. Sixteen subcouncils must bring together the input from health committees and other mechanisms of community participation. However, health committees could also directly access councillors and council officials. While subcouncils are political structures with ward councillors serving on them, health forums are a purely community-managed mechanism.³¹

These experiences seem to suggest that accountability and participation are top priorities for municipal councillors dealing with health at the local authorities visited. Clinic committees have the disadvantage that they are structured around existing health facilities, so that the very people with the least access to health services may be excluded from the participation process. Health committees include anyone with an interest in public health care in a certain region. Ward committees or subcouncils are efficient mechanisms for participation, but cover a broad range of issues.

Geographic factors

In Tshwane, a cross-border municipality, inequality in services across the provincial border is apparent in terms of facilities, resources, and efficiency.³² The portion of Tshwane that falls in Gauteng has more resources, greater capacity, and more accessible health facilities. The city's health officials have experienced problems in integrating North West health services with those in Gauteng. Many clinics in Tshwane fall under one of the two provincial administrations, but the city has built a better working relationship with the Gauteng provincial administration, so that functional integration is more possible in the Gauteng part of Tshwane. Addressing inequity is high on the priority list of most municipalities, but again, this pursuit is much more possible when services fall under the same administration or civil service.

There is a marked difference between the urban and rural areas studied, in respect of water and sanitation, resources, readiness to implement a DHS, and the functioning of accountability structures. In both Tshwane and Cape Town, a relatively large proportion of households earn R18 000 to R72 000 a year, while smaller numbers earn less. Also, employment levels are relatively high. Conversely, in the two rural districts studied, a large proportion of households earn less than R18 000 a year, while levels of unemployment are far higher. Moreover, larger portions of the rural populations are younger than 15.³³

³⁰ Source L: interview with a member of a health committee in a Western Cape city, conducted by the author and Fiona White, 22 July 2002.

³¹ Source A.

³² Source C.

³³ Municipal Demarcation Board, Municipal profiles, http://www.demarcation.org.za/munic_profiles/new_layout/index.html, last updated July 2002, accessed July 2002.

These factors impact on the DHS because they determine the reliance on public health services as opposed to private health care.³⁴

The strength of the rates and tax base of a given municipality impact on its ability to expand the provision of potable water and efficient sanitation. These factors impact on the DHS in turn because they affect the health status of a population, especially the poorest people who rely on the DHS most. One rural community, during the integrated development plan (IDP) process when it was canvassed by the municipality, identified water and sanitation as its main health needs.³⁵ In another, where there is no shortage of water, most people nevertheless use public taps and pit latrines.³⁶ By contrast, the vast majority of people in cities have piped water and flush toilets in their homes.³⁷

Cities have their own problems. The rural—urban migration pattern is changing the size and profile of the urban population relying on state health services, as are and rising medical aid premiums, since households in ever higher income brackets are driven to also partially or entirely rely on state health services.³⁸

Nevertheless, rural municipalities often have the least resources and highest ratio of reliance on state health services, and simultaneously have many more problems to address than their urban counterparts in implementing a DHS. Many of these problems are not directly related to health services, although they affect health. Given the current emphasis on prioritisation in municipal budgets, building clinics and buying medicines may struggle to compete with the provision of water and sanitation.

The urgent need for a decision

Some people still have to travel further to health services than is ideal. However, the main concern of senior health workers in all districts studied is the co-ordination of the health services provided by different authorities or institutions, or the ‘functional integration’ of health services, in the words of senior national health officials, and the degree to which the current lack of cohesion may detract from referral systems. Despite the close working relationship between local and provincial authorities at some sites, interviewees consistently stated that health services needed to fall under one administration. ‘With the best will in the world, one manager is better than two,’ the executive councillor for health in Cape Town remarked.³⁹

³⁴ 1upinfo.com, South Africa: health care services, <http://www.1upinfo.com/country-guide-study/south-africa/south-africa70.html>, accessed August 2002.

³⁵ Sources F, K.

³⁶ Municipal Demarcation Board, Municipal profiles

³⁷ Unicity of Cape Town, *Demographics*, <http://www.capetown.gov.za/home/demographics.asp>, accessed June 2002; Municipal Demarcation Board, Municipal profiles.

³⁸ Source G.

³⁹ Ibid.

Until very recently, most respondents expected that new health legislation would lead to a DHS managed by local governments. As a result, many local authorities are expending scarce resources on developing a familiarity with the health sector. Should the transfer not materialise, it means these scarce resources will have been wasted.

Local authorities are also spending time and money on creating new or building existing accountability structures, which are created expectations among their communities. Similarly, should the transfer not materialise, these expectations will be thwarted.

This underscores both the urgent need for a decision on the locus of a DHS, and the need for all mandates to local government to be funded. While the emerging picture is one of disparate situations in which a one-size-fits-all approach will not be appropriate, indecision has not only contributed to creating the situation, but continues to worsen it.

In 2001, the Department of Provincial and Local Government (DPLG) surveyed more than 80 per cent⁴⁰ of local authorities in the country in order to monitor their development. The study showed that 30 per cent of local government staff needed comprehensive training, 33 per cent of local authorities failed early warning management indicator scores, and consumers owed more than R15,8 billion to municipalities, with R3,2 billion already regarded as irrecoverable bad debt.⁴¹ Under the circumstances, all local authorities are understandably concerned that their mandates should be properly funded. Local authorities would probably prefer to receive funding directly from the national treasury, rather than having them channeled through provincial authorities, but the central charge by those interviewed to policymakers is that funding for the DHS would have to be forthcoming from another sphere of government.

In Cape Town, municipal representatives and officials were aware of the latest developments in the national debate on the new health legislation,⁴² which has largely taken place behind closed doors. The provincial authority did not share the city's expectation that district health will be a provincial function. This discrepancy had negative effects, since the provincial authority has scaled down support for the DHS, while municipal finance managers were not keen to increase funding for a service that may not become the municipality's responsibility.⁴³ The lack of a decision may thus cause health funding not only to stagnate but also to decline.

In February 2001 an indication came that national policy-makers were in touch with the greatest grass-roots challenges. At that point, the committee comprising the minister of health and members of the provincial executive committees responsible for health (MINMEC) decided that the functional integration of districts should be

⁴⁰ Logistics prevented many Northern Cape municipalities from responding

⁴¹ Department of Provincial and Local Government (DPLG), Quarterly monitoring of municipal finances and related activities: summary of questionnaires for quarter ended September 2001, 2001.

⁴² Source B.

⁴³ Source I.

‘the immediate priority for DHS development’⁴⁴. However, this boils down to little more than a reassertion of the frustration articulated by those in the municipal sphere, and does not resolve any of the crucial questions around governance or financial responsibility. Two highlights of the picture painted by this research have been the close working relationship between local and provincial structures and communities in certain rural districts, and the apparent readiness of all metropolitan areas studied to implement comprehensive municipal health services.

As noted earlier, many municipalities have been gearing up for a municipally based DHS. While they caution that a DHS must be a funded mandate, they are already devoting human and other resources to preparing for this expected transfer. To summarise, councillors of all the local authorities visited seem eager to take on the role of strategic guidance and accountability facilitators in the DHS, and are equipping themselves for these roles. Councillors in rural areas place more emphasis on obtaining input directly from the community as one factor determining direction. They also have more pressing obstacles, such as a lack of water and sanitation, whereas the metropolitan areas seem to have the capacity to take on the responsibility for a DHS almost immediately. Resources are thus mostly going to ensuring that decision-makers are properly informed and accountable, rather than to providing additional health care. Even in Cape Town, where health is one of four top priorities in the current budget,⁴⁵ improvements have been made largely by rationalising and redistributing staff and facilities.⁴⁶

All this underlines the urgent need for passing new national health legislation. The absence of a clear policy is problematic not only in respect of the health sector, where fragmentation and stagnation are central problems, but also from the perspective of local government, whose scarce resources will have been wasted if current expectations are not realised. These resources could otherwise have been harnessed to provide potable water, improve sanitation, and improve local conditions conducive to good health. In the long term, this waste of local resources will compromise the health status of communities, and create more pressure on the health sector.

Conclusion

A theoretical perspective⁴⁷ and a series of interviews with local stakeholders both point to indecision by policy-makers and a lack of national leadership as the greatest crises of the South African health system. The main obstacle to functional integra-

⁴⁴ Y Pillay, Functional integration – let’s share lessons, <http://www.lists.healthlink.org.za/cgi-bin/lyris.pl?visit=dhs-lg&id=187716009>, accessed August 2002.

⁴⁵ Sources B; A.

⁴⁶ Sources A, G, M: interview with member of a Western Cape hospital board and a former health worker, conducted by the author and Fiona White, 24 July 2002.

⁴⁷ White, *The district health system: dying for a decision*.

tion, efficient referral, cohesive management, and the expansion of health services to address inequality is the lack of clarity on the governance of a DHS.

Types of decentralisation vary in terms of the range of responsibilities allocated to local authorities, financing arrangements, and approaches to governance and accountability. International experiences indicate that each of these forms of decentralisation pose difficult challenges.⁴⁸ The weaknesses of the different approaches have been manifested most clearly in increased inequality, higher administrative costs, less strategic focus, fragmentation, and general incoherence in health planning and management. The urgent need for proper planning is also underlined by the current inability of elected representatives to translate their communities' concerns into action in the health sector.⁴⁹ To avoid unwanted outcomes, the chosen framework for decentralisation must suit the local situation – and such insight requires research and rigorous preparation.

A one-size-fits-all approach – for instance legislating only district municipality governance – would be destructive. As shown, the divergent situations of different local authorities, particularly those in urban and rural areas, underscore the need to provide different options for governing a DHS. This was in fact proposed in both the *White paper for the transformation of the health system* and the first draft of the National Health Bill. Both documents proposed three options, namely municipal governance, provincial governance, or a statutory district health authority (DHA) comprising representatives of different spheres.

Provinces are obliged by the latest draft of the bill⁵⁰ to promulgate provincial health legislation to create DHSS. According to the most recent draft, a DHA will govern each district, and this DHA may be a municipality, a provincial department, or a body constituted by provincial health legislation. This effectively delegates the decision about the governance of DHSS to provinces.

Should this legislation be enacted, provinces will have to take a decision based on several factors. The draft legislation fails to give sufficient guidance in this respect. While municipalities are mentioned first in the bill, it states no preference on governance. The bill therefore fails to encourage the important principle of subsidiarity, namely that decision-making should occur as close as possible to the grass roots where the capacity exists to cope with it. This principle is central to the DHS. It is being contradicted in both respects, namely that even those local authorities that are capable of managing a DHA could potentially be denied the opportunity to do so by their relevant provincial authorities, or that municipalities without the necessary capacity could be given the responsibility for district health.

Decentralising for its own sake may break the backs of poorer municipalities struggling under the strain of too many responsibilities. Arguably, decentralised

⁴⁸ Health Systems Trust, *Local government and health in South Africa*.

⁴⁹ M Tsotetsi and F White, Health sector decentralisation in South Africa research and monitoring strategy: research protocol for brief V, unpublished.

⁵⁰ Department of health, National Health Bill.

management and accountability would both still be possible even if provincial departments constituted DHAS.

However, local authorities are intended by recent local government legislation to become developmental entities. Integrated development plans (IDPs) determine municipal budget priorities. These IDPs are in turn intended to be informed by community participation. Often, health services or health-related matters are identified as priorities in consultative processes. But local authorities that have no authority over a DHS will presumably not receive funding for it, and therefore be powerless to address their constituencies' concerns in this respect. Provincial accountability mechanisms are weaker and less direct than those in the local government sphere.

Nevertheless, providing more than one option allows a phased approach in which management and funding arrangements could be tested over time, and decentralised when viable. Any one option will be neither ideal nor immediately achievable for a large group of local authorities. Exactly what model would be ideal for which district should be determined on the basis of further research that takes into account the views of civil society organisations in the health arena, health care providers, and members of the public.