



SALGA

South African Local Government Association

Position Paper on the Provincialisation of Personal Primary Health Care Services

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Provincialisation of Personal PHC

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Acronyms

ANC	African National Congress
CEO	Chief Executive Officer
DHA	District Health Authority
DHIS	District Health Information System
DHS	District Health System
ECPHC	Eastern Cape Provincial Health Council
GPDoH	Gauteng Provincial Department of Health
GPHC	Gauteng Provincial Health Council
IDP	Integrated Development Plan
MDG	Millennium Development Goals
MHS	Municipal Health Services
MOU	Memorandum of Understanding
NHA	National Health Act
OSD	Occupation Specific Dispensation
PHA	Provincial Health Authority
PHC	Primary Health Care
PHC	Provincial Health Council
SALGA	South African Local Government Association
SDWG	Social Development Working Group
SLA	Service Level Agreement
WHO	World Health Organisation

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Executive Summary

Background

Primary health care (PHC) was internationally accepted in 1978 as the preferred system for health care. It is defined in the Declaration of Alma Ata and includes essential care, which is appropriate, available and affordable to the community and the country. It is health care delivered as close to the community as possible with full participation by the community. It forms part of the national health system. In 1986 the World Health Organisation declared that the most appropriate vehicle for delivery of PHC is the district health system (DHS). The DHS is based on a defined geographical area with a defined population and includes all health care services within that area.

The PHC approach for health care was re-affirmed in 2008, the 30th anniversary of the signing of the Declaration of Alma Ata. The World Health Assembly in May 2009 endorsed this by saying, "...[we] strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multi-sectoral action, decentralisation and community participation as the basis for strengthening health systems".

Following the democratic elections of 1994, South Africa adopted PHC through the DHS as the basis for the national health system. All health policies and legislation since then have affirmed this approach. A decentralised approach is favoured and ultimately for the services to be rendered through a municipal based DHS, under one management authority. To attain this has been a difficult and long road as fragmentation of the services had to be overcome before the new system could be fully established.

The Constitution of South Africa designates national and provincial government as responsible for "health care" and local government as responsible for "municipal health services" (MHS), but does not define these two competencies. The Constitution requires, in terms of Section 156(4), provinces to assign to local government any competency where there is capacity and willingness to deliver the service. This includes "health service."

Notwithstanding the lack of definitions in the constitution and local government and other legislation, the department of health has made strides in establishing a DHS and the PHC approach for health care. Each province has developed their own policies, based on national policies and guidelines, and implementation plans for PHC and DHS. This initially was through a process of functional integration with health services historically run by municipalities.

There were long delays in finalising health legislation to support the policy direction of PHC and the DHS. The concurrent development of local government legislation influenced decisions made in health policy implementation. The White Paper for the Transformation of Health Services of 1997 guided the national health MinMEC and in 2002 the MinMEC decided that the district and metropolitan municipalities would be the level at which the DHS would be developed. Confusion around the definition of MHS continued until the National Health Act of 2003 confirmed a minimalistic definition of some elements of environment health. This meant that the balance of PHC, ie personal PHC remained the responsibility of the provincial government.

At that time there was a move towards decentralising PHC to metropolitan and some district municipalities who were already delivering the services. However, fragmentation of the services remained. In 2005 the National Health Council (which had been set up in terms of the National Health Act) took the decision to provincialise all personal PHC services. This decision was taken in the interest of bringing the services under one authority, the province, and consolidating the services until 2015 when the decision would be reviewed. The plan for 2015 is to delegate or assign PHC functions to municipalities which have the capacity and willingness to provide the services. This delegation or assignment will be in terms of signed Service Level Agreements between the province and the municipality concerned. The decision was accepted and endorsed by Provincial Health Councils and other relevant bodies.

This decision by the NHC took local government and SALGA by surprise as they felt there had not been adequate consultation with all stakeholders. There is one local government representative on the NHC, but it appears that information was not freely shared within local government structures.

Provincial health departments have tried implementing the decision with varying degrees of success. Opposition has come particularly from the metropolitan municipalities and SALGA. In November 2007 SALGA placed a moratorium on further transfers from municipalities to provinces for staff and assets and an impasse appears to be in place.

Developing a Position Paper on Provincialisation of PHC

In May 2009 National SALGA contracted the Centre for Municipal Research and Advice to assist them to develop a position paper on the provincialisation of PHC so as to seek a way forward.

This paper has been developed through a research process of primary and secondary documentation, policies and legislation. Stakeholders in the process of provincialisation within SALGA and department of health at national, provincial, district and municipal levels were interviewed in six provinces. Their views were used to gain deeper understanding of the impact of the impasse and uncertainties have on those responsible for implementation of decisions made by higher levels within the service.

The limitations of the study were the short time span for the background research, the long process of contacting and interviewing relevant stakeholders and the difficulty of obtaining data and some documents.

Findings

A review of processes followed and the current position in each province is included in the main report. Each province has approached the challenges differently and has made varying progress towards provincialisation of PHC. The Free State is the only province to report completion of the process.

In summary, the research has shown the greatest resistance to provincialisation comes from the metropolitan municipalities. The metros have historically provided some PHC services, initially mainly preventative and promotive health services. The scope of services provided has increased over the years to include most PHC services. These services are co-funded by the province and the municipality. Funding from the province is as a subsidy which is insufficient to pay for all services provided. Most district municipalities are supportive of provincialisation of PHC as they do not have the capacity to manage the services. An asymmetrical approach is generally supported.

From the interviews the main concerns expressed by the SALGA and local government officials were lack of political leadership in the process, lack of broad consultation and clear communication of the decisions and the possible impact it may have on community participation and service delivery. The health department officials were more accepting of the decision but find the process very confusing and frustrating.

Impact on human resources, especially related to conditions of service, remuneration and hours of work are discussed. The possible financial implications for provincial and local government need careful assessing and calculation for each municipality.

The legal implication of the transfer of the functions and how these can be affected is central to any decision as to the position SALGA and local government takes. Functions and powers of spheres of government, legislative definition, judicial interpretation, assignment of PHC, subsidiarity and the legal status of the NHC 2005 resolution are discussed in depth in the report.

Capacity of municipalities to provide PHC services is a major discussion point in the whole issue of provincialisation vs delegation of assignment to municipalities. There is no clear understanding of what "capacity" involves and includes. There is no standardised definition or concept of what is required. This is discussed, but requires further clarity before the decision is made as to whether a municipality has capacity or not for the function.

Recommendations

Finally, on the basis of an assessment of the current position, the research undertaken and listening to the voices of some of the stakeholders, two options are proposed for SALGA to consider.

Option 1: challenge provincialisation, assert constitutional authority over primary health care

Option 2: support provincialisation but insist on the progressive decentralisation to municipalities that have the capacity

With either option it is important to ensure there is

- Political buy-in for the option chosen
- Adequate broad stakeholder consultation
- Clear communication to all stakeholders
- Strengthening of links between health and municipal governance structures.

1. Background

1.1. International

Primary health care (PHC) has been recognized internationally as the preferred basis for health care for the past 30 years. In 1978, the Declaration of Alma Ata was signed at the International Conference on Primary Health Care held in Alma Ata. The Declaration states, *inter alia*,

- *The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector*
- *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*¹

The Declaration formed the basis for the development of the World Health Organisation (WHO) "Health for All by 2000" campaign. Initially there were some difficulties and delays in implementing the plan and in 1986 the WHO promoted the District Health System (DHS) as the vehicle for delivery of PHC. This is defined as

"A district health system based on primary care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area, whether governmental or otherwise. It therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, communities, the health sector, and related social and economic sectors. It includes self-care and all health care personnel and facilities, whether governmental or nongovernmental, up to and including the hospital at the first referral level, and the appropriate support services, such as laboratory, diagnostic and logistic support. It will be most effective if coordinated by an appropriately trained health officer working to ensure as

¹ World Health Organisation; Declaration of Alma Ata; 1978

comprehensive a range as possible of promotive, preventive, curative and rehabilitative health activities."

The objectives of "Health for All by 2000" have not been met. There, however, are countries such as Brazil² and Thailand³ which have made good progress and there are areas of good practice. In 2000 the General Assembly of the United Nations adopted the United Nations Millennium Declaration and the Millennium Development Goals⁴ (MDGs). Three of the eight goals are directly related to health issues and are planned to be attained by 2015. Progress is slow and few countries are likely to reach these goals. New approaches to health care, health systems and implementation of health programmes have been proposed. However, the principles of PHC remain the most effective way of delivering services in developed and developing countries. The World Health Report 2008, "*Primary Health Care: Now more than Ever*" affirms this. The report proposes four broad, interlinked policy directions to guide countries in making health system and health development decisions. These are:

- Universal coverage reforms – to improve health equity
- Service delivery reforms – to make health systems people- centred
- Public policy reforms – to promote and protect the health of communities
- Leadership reforms – to make health authorities more reliable⁵

This was further indorsed by the Sixty-second World Health Assembly on 22 May 2009, in saying "*...strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multi-sectoral action, decentralisation and community participation as the basis for strengthening health systems*". ⁶

1.2. Development of PHC and DHS in South Africa

Since 1994 the South African health policies have embraced PHC as the basis for health services and the DHS for delivery of these services. The vision has been for a decentralised system which is municipal based. The African National Congress Health Plan in 1994 states that everyone has a right to achieve optimal health and that health services be restructured through the PHC approach, with full community participation and inter-sectoral collaboration. Services were to be decentralised to the lowest level possible, to be people-centred and be delivered through a DHS.⁷ The Bill of Rights in the 1996 Constitution of South Africa stresses the right to life, the right to health care and the right to emergency health care. The Constitution assigns

² World Health Report 2008; Country Examples; Brazil's Family Health Programme,

³ World Health Organisation: World Health Report 2008; Country Examples – Thailand' Health Promotion Programme

⁴ United Nations, Millennium Development Goals available at <http://www.un.org/en/>

⁵ World Health Organisation: World Health Report, 2008: *Primary Health Care; Now More Than Ever*

⁶ Sixty-second World Health Assembly; Agenda Item 12.4; Primary Health Care, including health system strengthening. 22 May 2009

⁷ A National Health Plan for South Africa; 1994. Available at <http://www.anc.org.za/show.php?doc=ancdocs/policy/health.htm>

“health services” to national and provincial government, ambulance services to provincial government and “municipal health services” to local government. The Constitution, however, does not define the terms “health services” or “municipal health services”.⁸ The 1997 White Paper for Transformation of Health Services emphasises that PHC through a DHS will be the focus of the national health system and that health care services be decentralised to municipal level.⁹

The Constitution and these early policy documents formed the basis for development of health services in all provinces during the first decade following the change of government in 1994. The aim was to improve health service delivery and overcome the effects of the apartheid state in which health services were fragmented and inequitable. In the absence of any legislation to support these policies, provinces developed different structures and systems to deliver the services.

The core of the health system was PHC to be delivered through DHS based on geographically defined health districts. The White Paper provided 12 principles on which the DHS should be based, namely:

- overcoming fragmentation
- equity
- comprehensive services
- effectiveness
- efficiency
- quality
- access to services
- local accountability
- community participation
- decentralisation
- developmental and intersectoral approach
- sustainability

In addition three possible governance structures are presented to allow for district variations across the country:

1. The provincial option, i.e. the province would be responsible for all district health services through the district health manager. (This option could be exercised where there was insufficient independent capacity and infrastructure at the local level.)
2. The statutory district health authority option, i.e. the province, through legislation, would create a district health authority for each health district. (This option could be exercised in instances where no single local authority had the capacity to render comprehensive services.)
3. The local government option, i.e. a local authority would be responsible for all district health services. (This option could be exercised if a local authority,

⁸ The Constitution of the Republic of South Africa, 1996.

⁹ White Paper for the Transformation of Health Services in South Africa, 1997.

whose boundaries were the same as that of a health district, had the capacity to render comprehensive services.)

The White Paper includes proposals for implementation of the health policies.

The White Paper formed the basis for developing the various drafts of the National Health Act and to guide policy decisions by the National Health MinMEC¹⁰ until the Act was finalised. The transformation of local government with changes in its structures and functions were concurrent with the changes in health structures and systems. These changes influenced decisions made in implementing the DHS and developing PHC services. In February 2002 the Health MinMEC recommitted themselves to primary health care delivered through a municipal based district health system, to include the 12 principles listed in The White Paper. In summary their decisions were:

- District and metropolitan council areas to be the focal point for health service coordination and delivery
- Provincial departments of health to coordinate the planning and delivery of PHC within the districts in collaboration with local government
- A Provincial Health Authority (PHA), comprising the MEC for Health and councillors responsible for health from each district and metropolitan councils in the province, would be set up in each province. The role of the PHA was to be advisory to the MEC for Health.
- The MEC would facilitate the establishment of District Health Authorities (DHA).
- The long term goal would remain to capacitate municipalities for deliver the full range of district health services, although initially district hospitals would be excluded
- Municipal Health Services (MHS) should be defined to include the following:
 - Environmental health services
 - Provision of clean water and sanitation
 - Prevention of infectious and communicable diseases
 - Health promotion and education
 - Provision of community rehabilitation services
 - Treatment of minor injuries and diseases
 - Provision of essential medicines for primary care

This initial definition of MHS was an attempt to retain at municipal level those services that were already being delivered by some municipalities and to facilitate the later extension of these services to include the whole basket of PHC services in the spirit of the constitution to assign services to local government where there is capacity and willingness to manage the services. This definition of MHS was open to interpretation. A change was required for MHS to have a minimalist definition of environmental health only, or be widened to include all PHC services, including district hospitals.

¹⁰ National Health MinMEC was chaired by the National Minister of Health and included the nine provincial MECs for Health, the National Dept of Health DG and DDGs, Heads of Dept of Health from the provinces and representation from SALGA and municipalities.

Since municipalities had no experience of running hospitals or the capacity to take these on Health MinMEC agreed in July 2002 to a minimalist definition of MHS as elements of environmental health. This was supported by legal experts and National Treasury. The MHS function was assigned to district and metropolitan councils. This decision had profound impact on PHC as all personal PHC remained the constitutional responsibility of the provincial government.

To overcome the uncertainties that arose until the promulgation of the National Health Act in 2004 the National Department of Health introduced a strategy of functional integration between provincial and municipal health services to facilitate the DHS and PHC delivery. Functional integration was defined as: *“structured co-operation and collaboration between provincial and local government health rendering authorities for the purpose of decreasing fragmentation and duplication, enhancing integrated service provision, increasing efficiency and quality of primary health care. This takes place in the absence of legal, financial and administratively integrated governance and management structures”*¹¹. It was to be an interim strategy until 2009 when a single public service was expected to be in place. Functional integration was designed to bring managers and health workers from province and local government closer together in order to bring understanding of an integrated health service. This worked well in some districts and provinces, but caused frustration among health workers in other parts of the country.

The promulgation of the National Health Act (NHA) in 2004 brought legal basis and certainty for establishing the DHS. Chapter five of the Act is devoted to the establishment of the DHS. The minimalist definition of MHS in the Act formalises the responsibility for personal PHC to be with the provincial government. The Act, however, in line with the Constitution and local government legislation, provides for assignment of personal PHC to municipalities if the municipality has the capacity to deliver the full basket of services and is willing to do so. The Act requires health districts to be coterminous with local government district and metropolitan municipal boundaries. The MEC for health in the province can, in consultation with the MEC for local government, divide these health districts into sub-districts.¹²

The NHA calls for the establishment of a National Health Council (NHC), a Provincial Health Council (PHC) in each province and a District Health Council (DHC) for each health district. The DHCs are to be established by the MEC for Health, in consultation with the MEC for local government. The key functions of the DHC are:

- To promote cooperative governance between spheres of government;
- To ensure coordination and integration of services within the health district; and
- To advise the MEC for Health, through the Provincial Health Council, of any health matters relevant to the health district.

¹¹ Pillay Y., Leon N., Guidelines For Functional Integration, (2003); National Dept of Health.

¹² National Health Act, no 61 of 2003.

The DHC must also advise the municipal council on these health matters. To date few DHC in the country are reported to have been constituted or active.

Annual District Health Plans are to be prepared by the district management team. These are to be in line with national health policies and with the Integrated Development Plan (IDP) of the relevant municipality. The plans are to include a human resource plan and a budget that is in line with the national budget cycle i.e. from 1st April to 30th March.

In terms of the NHA the National Health Council (NHC) has been established. This council consists of the Minister of Health, who is the chairperson, the deputy Minister of Health (if there is one), the MECs for Health of the nine provinces, a councillor representing local government, the Director-General and Deputy Director-Generals of the National Department of Health, the Heads of the Health Departments in the nine provinces, the head of the South African Military Health Services and an employee representing the South African Local Government Association.

The NHC's functions are to advise the Minister of Health on:

- any matter of policy related to the health of South Africans;
- legislation pertaining to health matters
- norms and standards for health establishments
- guidelines for the management of the district health system
- the implementation of national health policy
- national and provincial health plans
- strategy for health research

The provinces have made unequal strides in restructuring their services to be in line with NHA and towards establishing the DHS as set out in Chapter 5 of the NHA. Some of the progress made in the provinces is discussed later in this report under Provincial Summaries.

In August 2005, in the interest of advancing the establishment and functioning of the DHS and in improving service delivery, the NHC made certain resolutions. These included:

- There should be no delegation of personal PHC services to municipalities for the next 10 years.
- All municipal staff and services, if possible, should be absorbed into provincial services ("provincialised").
- Provinces should decentralise PHC services within provincial structures.
- In each district the province should appoint a district health manager with authority to act; this district health manager should have instructions to work closely with municipal officials.
- These policies should be reviewed in 2015 and amended or reversed if by then a single public service had been well established.

- In 2015, if it was appropriate to delegate responsibility for personal PHC to a municipality, then consideration should also be given to delegate responsibility for district hospitals.
- In metropolitan districts municipal health staff and services should, wherever possible, be absorbed into provincial structures and co-funding of personal PHC should be phased out over a period of three to five years.

Reasons given for this decision are, in summary

- The current lack of capacity in many, but not all, municipalities to render the services
- To bring the PHC services under one management authority so as to eliminate fragmentation
- To consolidate PHC services
- To plan for full delegation of PHC services to municipalities who have the capacity to rendered the services and are willing to take them

The ultimate goal to establish a municipal-base district health system for delivery of a comprehensive, integrated PHC service has not changed. A deconcentration of health management to district level through current provincial department of health structures, working closely with municipal structures, is proposed to establish a well functioning DHS until full delegation or assignment of PHC to municipalities can be realized.

Although represented on the NHC, local government and SALGA generally feel they were not adequately consulted when this decision was made. This in particularly applies to the metropolitan municipalities and those municipalities directly involved with rendering health services through local government systems and structures. There has, therefore, been a resistance to comply and challenges have been made as to the legality of and reasons for the decision.

Some provinces set up task teams to plan and implement the provincialisation of the PHC services, starting with district and local municipalities. In other provinces little or no progress has been made. The task has been difficult, in part due to the frustration and at times anger felt by municipal officials responsible for health services. These feelings were expressed by some of the stakeholders during the interview process for this current project. No PHC services have to date been provincialised from any metropolitan municipality in the country.

BOX 1:**Kopanong Declaration – August 2003**

Resolve that the key focus of the agenda for strengthening primary health care over the next five years will include:

1. Concrete strategies and processes, with clear targets, to reduce inequities in the allocation of resources for primary health care with a focus on both horizontal and vertical equity over the next 10 years.
2. Committed funding and budgets for sustaining community involvement in health through, *inter alia* regular area summits leading to provincial summits.
3. Strengthening the health system by focusing investment of resources on priority health programmes and by accelerating the implementation of the DHS including its various components.
4. Develop, implement and monitor the implementation of coherent human resource plans at district, provincial and national levels based on national guidelines including the strengthening of recruitment and retention strategies.
5. Re-invigorated committed to the principles of the PHC approach by all partners with effective national and provincial leadership.
6. Strengthening of PHC through the development of intersectoral forums at every level but especially at the facility and district levels.

We will use the performance management system of government and the accountability mechanisms in each municipality, province and nationally to assess and report on progress each year on the six areas listed above.

Birchwood Declaration – April 2008

Resolve that the revised and revitalized primary health care strategy for South Africa will include:

1. Advocating for an increase in the resource allocation for primary health care, by at least doubling the current per capita expenditure over the next ten years.
2. Better alignment at district level of key interventions that impact on health, notably provision of water and sanitation, early childhood development, recreational programmes, health education and other activities that focus on encouraging healthy lifestyles especially amongst the youth in particular.
3. Strengthening the role, responsibilities, authority and accountability of the district health management team so as to achieve improved health outcomes.
4. Strengthening the health information system to generate good quality data for monitoring health outcomes and informing decision making.
5. Strengthening national and provincial support to districts as well as ensuring that provincial managers are accountable for primary health care outcomes.
6. Strengthening various models including those that focus on a catchment population and further explore a South African model for the delivery of comprehensive primary health care services.
7. Maximize the benefit of political leadership in supporting the provision of health care and the positive impact of healthy lifestyles.
8. Ensure that Primary Health Care provided by the private health sector is made more affordable to the public.
9. Improve the provision of support by hospitals to comprehensive primary health care to strengthen continuum of care.
10. Re-orientate all health workers and managers to the Primary Health Care approach.
11. Include the PHC approach in the training of health workers to ensure their appropriate professional socialisation.

In December 2007 the South African Local Government Association (SALGA) placed a moratorium on any further provincialisation of personal PHC and a stalemate between the provincial and local spheres of government appears to be in place. SALGA has now sought assistance with developing a position paper on

provincialisation of health services. This position paper is expected to provide guidance to SALGA on how to proceed and how to support municipalities in this process.

As discussed above, primary health care has been the focus of National Health Policy for South Africa since 1994. This has been affirmed several times. The Kopanong and Birchwood Declarations, adopted on the 25th and 30th anniversaries of the signing of the Alma Ata Declaration in 1978 respectively, again affirmed the ideals of PHC in South Africa. (See Box 1)

Further to these two declarations, the National Department of Health commissioned a position paper for the revitalisation of primary health care in South Africa. The proposed core principles of a revitalised PHC approach are:

- A population orientation, focused on meeting the priority health needs of geographically coherent populations in a comprehensive manner including prevention, promotion and good quality, essential care
- An outcomes focus, aimed at reducing mortality and morbidity from the major causes of ill-health
- Integrated, efficient and well supported Primary Health Care teams, guided by and accountable to communities
- A well functioning District and Sub-District Health System. ¹³

The position paper advocates for horizontal integration of PHC functions at district and sub-district level, a vertical integration of roles and responsibilities and a common vision and priority for PHC. *“A decentralisation of authority and responsibility, a review of the role of the centre, investment in improved and more open monitoring systems, and implementation of political and community accountability structures”* ¹⁴are also envisioned.

The vision of a decentralised DHS is affirmed. However, there is no mention or discussion in the position paper on whether it is envisioned that PHC will remain a responsibility of provincial government or if PHC will, in the future, be delegated or assigned to local government.

The National Department of Health and the government's commitment to providing a health system based on the primary health care approach and delivered through a municipal-based district health system are abundantly clear. Attaining this vision in the context of current, and often changing, legal and policy frameworks has proved to be a difficult and long road.

¹³ Schneider H., Barron P.,(2008) Achieving the Millennium Development Goals in South Africa through the Revitalisation of Primary health Care and a Strengthened District Health System

¹⁴ ibid

2. Development of a Position Paper for SALGA on the Provincialisation of Primary Health Care Services

2.1. Problem Statement

In 2005, the National Health Council resolved that PHC would be a provincial responsibility, and Municipal Health Services (MHS) comprising selected components of the Environmental Health package of services remaining as a municipal responsibility. In terms of the 2005 resolution, municipal clinics were to be transferred under the provincial health structures, in a process known as 'provincialisation'. This policy will be reviewed in 2015 and may be amended or reversed if by then a single public service has been established.

Following this resolution, the process of provincialisation started, with different levels of progress made per province. However, on the 11 and 12th of October 2007 the National Consultative Meeting of SALGA held in Sandton Convention Centre resolved to halt all further transfers of PHC from municipalities to the provincial government until such time that there is clarity on what constitutes Primary Health Care and research done on whether municipalities, especially Metros, are not best placed to effectively and efficiently provide the primary health care services. This resolution was later endorsed by the National Executive Committee Meeting of 6 and 7 December 2007.

In May 2009 National SALGA appointed the Centre for Municipal Research and Advice to interrogate this problem and to assist SALGA to develop a position paper on provincialisation of primary health care services.

2.2. Methodology

A team comprising of a Team Leader, a Senior LG Researcher, a Primary Health Care Expert, a Local Government Policy Expert and a Local Government Legal Expert was set up. The Primary Health Care Expert and Senior Local Government Researcher acted as primary researchers.

A two stage approach to data collection was used.

2.2.1. Desk top research

A desk top research of primary policy and legislative documents was undertaken. Information was supported by secondary data supplied by interviewee or accessed through internet.

2.2.2. Primary research

A qualitative study with a descriptive and cross-sectional design was under taken. The assessment coverage of the study included a sample of six provinces and national, provincial and municipal stakeholders. The selection of the sampled provinces was determined by SALGA status quo reports and distribution of rural/urban, poor resourced/well resourced municipalities, and led to the following sample:

- Eastern Cape
- Gauteng
- Mpumalanga
- Northern Cape
- North West
- Western Cape

In each province, the Provincial Departments of Health, SALGA Social and Development Working Group (SDWG) Provincial Chair and SALGA Deputy Chief Executive officers (CEO) were approached. Two district or metropolitan municipalities and two health districts per province were randomly sampled, and occasionally purposively sampled through a snowball strategy. Telephonic semi-structured interviews were conducted with available stakeholders.

Annexe 1 provides a list of the stakeholders interviewed

2.3. Limitations of the Study

- The time frame for the project was too short for full interrogation of the current position in each province and for interviewing an adequate cross-section of stakeholders to elicit their experiences, roles and understanding of the process to date.
- Quantitative data on municipal managed versus provincial managed clinics and community health centres was not readily available, even from provincial and district offices. The District Health Information System (DHIS) was accessed for national indicators per district and per facility; the system, however, does not identify the managing authority of each facility i.e. municipal or provincial. Some data was available from the health department and/or municipality and is commented on per province.

3. Findings

3.1. Provincial Summaries

This section provides a brief overview of the current position in the provinces, in particular as this relates to the National Health Council Resolution of August 2005 to provincialise all personal primary health care services.

3.1.1. Eastern Cape Province

The Eastern Cape Province has diligently strived to provide quality health care in line with PHC and the DHS across the province. Following the MinMEC decision of June 2002, the Eastern Cape Provincial Health Council (ECPHC) resolved in June 2004 to delegate PHC services, in a phased approach, to the six district municipalities and one metropolitan municipality in the province. MHS was to be devolved to the district municipalities and metro by June 2005. A task team comprising of

representatives from department of health and local government was set up to plan, implement and oversee the process.¹⁵

In response to the change of direction introduced by the NHC resolution of August 2005, the ECPHC rescinded their resolution of June 2004. The ECPHC further resolved on 9th February 2006 to provincialise all local government staff in local and district municipalities and to investigate delegation of PHC services within the metro. A combined task team was set up and all stakeholders informed of the decisions. Despite a lengthy process of negotiation between the department of health and SALGA little progress has been made.¹⁶

In February 2009, In order to take the process forward, the ECPHC proposed two options for discussion:

1. The establishment of interim District Health Authorities (DHA) for each district in the province and the signing of Service Level Agreements (SLA) between the province and the DHAs. An amendment to the Provincial Health Act of 1999 would be required. This, in effect, would establish in the province the third option (the local government option) originally proposed in the National Health White Paper of 1997, but would be contrary to the NHC 2005 resolution.
2. The ECPHC should, with the assistance of the provincial cabinet, establish a forum for discussion between the department of health, SALGA and local government; a Memorandum of Understanding (MOU) between the health department and SALGA be signed and the technical task team be reconvened to take the process forward.¹⁷

The district and local municipalities in the Eastern Cape are generally quiet on the issues and accept provincialisation of the services as being in the best interest of PHC and establishing the DHS. These municipalities acknowledge that currently they do not have the capacity to take on the additional services. Certain districts, however, have raised concern about how the process of provincialisation has been undertaken and the extent to which the interests of municipal personnel as well as the municipality has been compromised in the process. So, while there is consensus on the rationale for provincialisation, there is deep concern for the manner in which it has been implemented.

The Nelson Mandela Bay Metro (NMBM), however, has been vocal and has challenged the legality of the proposals made by the provincial government, as well

¹⁵ Discussion Document on a proposed solution for the provision of primary health care services in the Eastern Cape Province, February 2009

¹⁶ *ibid*

¹⁷ *ibid*

as the legality of previous proposals.¹⁸ (These are discussed more fully under Legal Implications below)

In response to the provincial ECPHC endorsement of the NHC resolution of November 2005, the NMBM proposed that the metro would continue to provide personal PHC at their current level on a delegated basis for five years. During this time a process for monitoring and measuring the capacity of the metro to deliver these services would be put in place. The metro would continue to co-fund the services for the five years. Thereafter, if capacity has been proven, the province would assign the function, with the required resources in terms of Section 154(4) of the Constitution. No final agreement was made on this proposal, hence the current stalemate between the province and the metro.¹⁹

The current position in the Eastern Cape²⁰ is

- No transfers of personnel or assets has occurred –total number of staff and clinics was not immediately available at time of the interview
- Co-funding of the personal PHC within the districts and metro continues
- MHS is not fully devolved from province to municipalities

Challenges are

- Continued fragmentation of the services as these are under two authorities
- Financial
 - Different salary scales; in particular the recently introduced Occupational Specific Dispensation (OSD) for provincial employees. This has resulted in municipal employed nurses resigning to take up a post with the province.
 - Funding flows from province and national for PHC services
- Change of leadership in the department with new government

Data for the Eastern Cape was accessed through the DHIS and from the Nelson Mandela Bay Metro. From these data sources a comparison of the utilisation indicators for provincial and municipal health faculties within the metro was possible. See Table 1 and 2 (next page).

Table1: the utilisation rates suggest higher usage of the municipal clinics by the community than the provincial clinics; higher work load for the municipal nurses; more municipal employed staff than provincial staff. It is not possible, however, from these figures to comment on the quality of service provided.

Table 2: The provincial managed community health centres show higher utilisation rates, except for the under 5 year olds. The provincial services have five community health centres within the metro, three of which are open 24 hours per day; the

¹⁸ Response of Nelson Mandela Bay Metro to “Discussion Document on a proposed solution for the provision of primary health care services in the Eastern Cape Province.” February 2009

¹⁹ *ibid*

²⁰ Interview with official of EC Dept of Health: chair of Technical Task Team for Provincialisation of PHC

municipality manages two community health centres, one of which is open 24 hours per day.

Table 1: Nelson Mandela Metro - Clinics

	Municipal clinics	Provincial Clinics	Not specified	Total
Clinics	37	3	3	43
Nursing staff	177	34		211
Utilisation Rate	4.6	2.9	3.2	4.3
Utilisation <5yrs	5	2.9	4.2	4.6
Utilisation >5yrs	4.6	2.9	3.1	4.3
Nurse clinic load	55.2	34.7	42.2	50.7

Table 2: Nelson Mandela Metro – Community Health Centres

	Municipal CHC	Provincial CHC	Total
CHC	2	5	7
Nursing staff	31	150	181
Utilisation Rate	3.5	3.6	3.6
Utilisation <5yrs	5.3	1.8	2.8
Utilisation >5yrs	3.3	3.8	3.7
Nurse clinic load	52.8	41.3	44.6

3.1.2. Free State Province

The Free State was not included in the primary research for this project.

Full provincialisation of PHC is reported to be complete in all districts. There is no metro in the province.

3.1.3. Gauteng Province

Gauteng is a predominately urban province with three metropolitan municipalities and three district municipalities. There is a long history of engagement between the

Gauteng Department of Health (GDoH), local government and SALGA in addressing issues of health service delivery and establishing a DHS for delivery of PHC.

In November 1998 a Declaration of Intent (the Vaal Declaration) was signed by political leaders in support of the local government option for health services – i.e. for decentralisation of the function to local government where there is capacity for and a willingness to provide the services. Co-funding of the services continued. In 2000 the Gauteng Provincial District Health Systems Act was promulgated. This made way for implementation of the local government option for the DHS, through signed service level agreements. The National Health Act of 2003 assigned MHS to local government and personal PHC to provincial and national government.

In 2005 the Gauteng Provincial Department of Health (GPDoH) allocated additional funds to two district municipalities to assist with the continued delivery of PHC in those districts. In the same year, consultants were engaged to undertake a Due Diligence Study to quantify health expenditure and assets. The study showed financial and human resource gaps in the municipality services, and the need to improve the infrastructure of the clinics so as to provide a full comprehensive PHC service.²¹ The Due Diligence Study did not show that health services would deteriorate if managed by the municipalities; adequate funding and resources were required.

On 6th December 2005, following the NHC resolution to provincialise all personal PHC services, the three metros in Gauteng met with the Chairperson of SALGA Gauteng SDWG and made recommendations to GDoH that delegation of PHC services to the metros was the preferred option. They further proposed the closure of the funding gap be negotiated between the parties and that service level agreements be signed. On 27th November 2006 the Gauteng Provincial Health Council (GPHC) decided to proceed with provincialisation without further consultation with local government and the metros despite their expression of preference for delegation of PHC services to the metros.²²

Joint planning and consultation between GDoH and local government continues through the Provincial Health Council, the Provincial Health Council Technical Committee, the District Health Councils and the District Health Council Technical Committees. There, however, is a feeling that local government and SALGA have not been fully engaged in the process and on 1st June 2007 the municipalities were instructed by the PHC to provincialise the services.

On the 10th March 2008 the PHC endorsed the resolution of the Premier's Coordinating Forum (PCF) that provincialisation of personal PHC continue. This was discussed on 11th June 2008 by the Joint Task Team for Provincialisation with a view to clarify various outstanding issues and improve the working relationship between the

²¹ Gauteng Department of Health power point presentation on Provincialisation of PHC – undated. Accessed from Gauteng Department of Health Website – www.health.Gauteng.gov.za – May 2009

²² Interview with City of Tshwane official

GDoH and SALGA. Despite objections and reservations raised by SALGA the decision of the PHC and PCF remained in force for full provincialisation of PHC. The joint task team was tasked with taking the process forward.

The Gauteng Department of Health proposed an implementation timetable²³ for provincialisation of PHC to start from 1st June 2007 – as follows:

District Councils (GDoH takes full funding responsibility and operational control from 01 April 07)

- Metsweding - transfer of staff + assets – Apr 07 - Jun 07
- West Rand - transfer of staff + assets – Jul 07 – Mar 08
- Sedibeng – transfer of staff + assets – Jul 07 – Mar 08

Metro Councils

- 2007/8 - strengthen collaboration / joint planning
- 2008/9 – Improve service delivery / communicate and consultation on transfer of services
- 2009/10 – Start transfer in City of Tshwane
- 2010/11 – Finalise transfers in City Tshwane
- 2011-13 – Start transfer in Ekurhuleni and City of Johannesburg

This time-line is supported in the 2006/07 annual report for the department – provincialisation was due to start in April 2007. The 2007/08 annual report is not available on the website to follow-up progress made. Officials from the Gauteng Department of Health were not available for interview during the research process to confirm the current position.

Table 3: Total Headcount at City of Johannesburg PHC Facilities according to managing authority

Authority	2006 /2007		2007/2008	
	Number	Prop by authority	Number	Prop by authority
LG	2,838,419	51.6%	3,088,774	53.8%
Province	2,359,466	42.9%	2,325,651	40.5%
NGO	300,144	5.5%	330,701	5.8%
Total PHC headcount (COJ integrated)	5,498,029	100.0%	5,745,126	100.0%

The City of Johannesburg is vocal in their support of delegation of personal PHC to the metro. They are confident they have the capacity to manage the function. In 2008 the City of Johannesburg had 97 PHC health facilities (87 fixed clinics, 1 satellite

²³ Gauteng Department of Health power point presentation on Provincialisation of PHC – undated. Accessed from Gauteng Department of Health Website – www.health.gpg.gov.za – May 2009

clinic and 9 mobile units).²⁴ The provincial health services manage 30 PHC health facilities (7 community health centres and 23 clinics) within the metro. Table 3, taken from the annual routine data report of the City of Johannesburg for 2007/08, shows that the number of attendances at the municipal clinics is increasing and is greater than the number of attendances at the provincial clinics.

The Council in the City of Tshwane has not made a final decision on the provincialisation of PHC. The City of Ekurhuleni was not included in the primary research.

3.1.4. Kwa-Zulu Natal Province

KwaZulu-Natal was not included in the primary research for the project.

KZN halted the process of provincialisation following the SALGA National Consultative meeting resolution on the 11th and 12th of November, later endorsed by the NEC Meeting on the 6th and 7th of November 2007.

In a recent communication from the KwaZulu-Natal Local Government Association to SALGA²⁵, a request for a final resolution on the issue of provincialisation was posed.

Currently services are reportedly affected due to the subsidies from the province to municipalities that have been stopped as service level agreements have not been signed, as well as employees in municipalities not receiving salaries on par with their provincial colleagues. Municipal clinics have been assigned to hospitals for supervision.

It is reported that the majority of municipalities are in favour of transferring the service with the exception of Umhlathuze, Ethekwini Metro and Msunduzi who in terms of the previous agreement with the department of health would have continued rendering the service subject to the signing of a service level agreement.

Number of clinics and staff to be transferred is not known.

3.1.5. Limpopo Province

Limpopo was not included in the primary research for this project.

Memorandums of Understanding have been signed between the provincial department of health and all local municipalities in the province. Assets and staff have been transferred to the province in 8 of the 12 local municipalities. In the remaining four, no action has taken place in two, in one district there is a dispute and in the last one the assets have been verified, but no transfer has yet taken place.

Number of clinics and staff to be transferred is not known.

²⁴ City of Johannesburg: Health Portfolio Committee, Analytical Report on Annual Routine Data 2007/08.

²⁵ Letter Kwanaloga, Municipal Institutional Development, to SALGA, June 3rd 2009

3.1.6. Mpumalanga Province

The process of provincialisation of primary health care services in Mpumalanga commenced in November 2008. A total of 13 municipalities were affected. To ensure that the process was implemented in an equitable manner, the decision was made to effect the transfer in two phases. The transfer of staff was prioritized, followed by the transfer of assets.

To date, the transfer of staff in six clinics has been completed. The transfer of assets in respect of these clinics is still on-going. Initially, it was anticipated that the transfer of all affected clinics would have been completed by now. However, because of the resolution of the National Executive of SALGA on 6-7 December 2007 to halt any further transfers, the process has come to a standstill.

The remaining seven clinics therefore continue to provide primary health care services. Not all of these municipalities have signed service level agreements or memorandums of understanding in terms of which they deliver the service.

3.1.7. Northern Cape Province

The Northern Cape is mostly rural, with low population density spread over vast areas.

The Northern Cape has a long history of developing a DHS. The process began soon after the demarcation of the new provinces in 1994. Prior to 2005 there was good communication, coordination and consultation between the provincial and municipal health departments. A decision to provincialise all PHC was taken early and all local authority health services, staff and assets were transferred to the province as early as 1998. These transfers were all done with agreement from the Department of Local Government and SALGA in the province and the process managed by a task team.

The only exception was Sol Plaatjie Local Municipality in the Francis Baard District Municipality, which includes Kimberley, the provincial capital. A general resistance to cooperate is felt by the provincial health structures in the district municipality and at the provincial level.

There is no metro in the province. Three other local or district municipalities who were contacted as part of the research agreed that provincialisation of the PHC services was good as they, the municipalities, lacked capacity to render the services.

The provincial department of health favours provincialisation as it reduces fragmentation and duplication of services. The impact on service delivery is positive, except in the one resisting local municipality where it is difficult to monitor the services or get access to information, or even to the facilities. Training is offered by the provincial department and all municipal staff are invited to attend the training.

Despite reservation expressed by provincial and district health structures the Sol Plaatjie LM continues to render PHC services and expresses confidence in their own

ability to take on the full package of PHC, provided they are given the finance and other resources required. There are a total of 10 clinics in Sol Plaatjie, of which 6 are managed by the municipality and 4 by the province. There is one provincially managed community health centre in the municipal area. The clinics are managed by municipal appointed staff and run with nursing staff seconded from the province. There is co-funding of the services. Table 4 (next page), taken from information supplied by Sol Plaatjie LM and data from the DHIS, shows that utilization rates are higher in provincially managed facilities. The nurse workload is higher in the municipal clinics. Overall the province employs more nurses than the municipality. It is not possible to comment on the quality of care offered by the two authorities from this data.

Table 4: Sol Plaatjie Local Municipality – Clinic

	Municipal facilities	Provincial facilities	Total
Clinics	6	4	10
Staff	10	73	83
Utilisation	3.2	4.2	3.6
Utilisation <5yrs	4.5	8.5	6.1
Utilisation >5yrs	3.1	3.7	3.3
Nurse work load	36.2	22.7	30.8

Currently there are six municipal clinics and ten professional nurses (all in Sol Plaatjie) to be transferred to the province.

3.1.8. North West Province

The North West has a long history of developing a DHS. In certain districts such as the Dr Ruth Segomotsi Mompati District the transfer of the function to the province was conducted in a seamless process. The transfer in this district commenced in August 2007 and was completed by May 2008.

To date, the full transfer of the function has been effected in five municipalities. There are still seven municipalities which continue to render primary health care services. However, not all of these municipalities have signed service level agreements with the department of health in terms of which they render the service. The resolution of the National Executive of SALGA in December 2007 to halt any further transfers has, in addition, created uncertainty around the process. As a result, of this uncertainty, municipal personnel have in certain instances opted to resign from municipal posts to join the provincial department.

3.1.9. Western Cape Province²⁶

The Western Cape Province has distinguished itself from other provinces in respect of the leading role that it played in implementing the provincialisation of primary health care services pursuant to the National Health Council Resolution of 2005. In particular, the formal structures created for the purpose of constructive engagement between the various stakeholders such as the provincial department of health, SALGA, the City of Cape Town and district municipalities have created good intergovernmental relations that continue to inform the engagement between these stakeholders today. Importantly, trade unions were also included in the consultation processes that preceded provincialisation.

The success of the process in the Western Cape is attributable in part to a bi-ministerial task team (BMTT) which was established and operated between 1997 and 2000. The task of this BMTT was to assess where primary health care services should best be placed for equitable service delivery. In 2000, the BMTT recommended that all primary health care services be delegated to the City of Cape Town and all category B municipalities in the province. This recommendation was confirmed by a provincial cabinet resolution in 2001. Various capacity and staff audits of all district municipalities were conducted by this task team and contracted consultants.

In July 2002, the Health MinMEC made the decision to narrowly define municipal health services as "environmental health services" in the draft Health Act. Based on this narrow definition and the shift in the national position in relation to the delegation of primary health care to local government, the provincial leadership took the decision to pro-actively implement the narrow definition of municipal health services.

The National Health Act of 2003 was enacted in 2005, confirming the approach adopted by the provincial leadership. Pursuant to this enactment, in February 2005, the Western Cape MEC, Pierre Uys together with the executive of SALGA concluded a framework agreement in Cape Town governing the transfer of personal primary health care services previously provided by nonmetropolitan municipalities to the Western Cape government. A phased approach to this transfer was adopted.

Various task teams were established to consult on the key issues involved in the transfer process. A provincial technical team undertook an audit of all staff members impacted by the transfer. Asset audits were undertaken as a priority. A finance task team was set up to ensure compliance with the Public and Municipal Finance Management Act. All of the role players comprising these task teams, met on a regular basis to work through the issues at stake in the provincialisation process in a very detailed and comprehensive manner.

²⁶ The history of the political decisions leading up to the implementation of the National Health Resolution of 2005 in the Western Cape is documented in the 2008 draft report by Peter Barron "The Phased implementation of the District Health System in the Western Cape Province- A case study".

All of these various processes culminated in the full transfer of personal primary health to the province. From 1 April 2005, the province fully funded personal primary health care services. On 1 March 2006, the province took operational control of these services in the non-metropolitan areas as stipulated in the framework agreement.²⁷

The consolidation of the district health system in the Western Cape has furthermore been strengthened by the adoption of the service delivery plan known as Health Care 2010. Health Care 2010 is a detailed plan that aims to shape and direct service delivery in the Western Cape with a view to strengthening the DHS, improving access to services by communities and ensuring that the DHS is integrally linked to regional and tertiary hospitals. This would ensure a continuum of care and services that is easily accessible to communities.

The City of Cape Town is the only municipality that continues to deliver PHC in the Western Cape. This is done in terms of a service level agreement concluded with the province. They also have a co-funding arrangement with the province. While there are good intergovernmental relations in the Western Cape that contribute to the synergy between the province and the metro, the current service level agreement and co-funding arrangement is not based on an assignment or delegation of the function to the metro. It is therefore vulnerable to change if political leadership changes or the approach to provincialisation in the province changes.

The current position in the Western Cape is:

- All non- metro municipalities completed the transfer of both assets and personnel to the province before the deadline of 31 July 2007.
- Numerically, 23 municipalities have transferred the function with 542 individual staff members transferring to the provincial department of health;
- The metro continues to provide the service on the basis of a co- funding agreement with the province;
- The metro currently fulfills primary health care services in 98 clinics. The focus of these clinics is mainly promotive and preventative and certain curative aspects of health care for children under 13 years of age.
- The metro also runs four comprehensive community health centres.

Challenges:

If the function is provincialised, much work will have to be done to ensure that the transfer of personnel and assets takes place in an equitable manner;

If provincialisation is pursued, the metro strongly advocates for the assignment of the function on the basis of section 156(4) of the Constitution. In terms of such an

²⁷ Communication by the Department of Health (Provincial Government of the Western Cape) (2006) *Historic framework agreement between the Western Cape Department of Health and SALGA* : The Directorate of Communications, accessible at <http://capegateway.gov.za/eng/your_gov/3576/news/2006/jul/137415/> accessed on 25 May 2009.

assignment, new and equitable funding arrangements for the function would have to be put in place.

District Health Councils, an integral component of the District Health System have yet to be implemented in the Western Cape. A draft bill to establish these councils has been released for comment.

Lessons learnt:

Peter Baron, in his draft report on the provincialisation process in the Western Cape, succinctly details the factors which aided the smooth transfer of primary health care to the province.²⁸ These factors are important considerations that could assist other municipalities that are either currently engaged in the process or which have yet to embark on the process;

- Clear political leadership;
- Clear implementation frameworks;
- Buy-in from all stakeholders;
- Effective communication strategy;
- Baseline staff audit;
- Physical asset audit;
- Staggering of implementation (not all districts were transferred simultaneously);
- Phased transfer (operational transfer, followed by asset transfer, with staff transfer last); and
- Top management oversight.

3.2. Voices of stakeholders

Stakeholders in the provincialisation process of PHC were randomly selected in six provinces. The randomisation was often dependent on availability of a person to be interviewed during the time of data collection. Managers were selected from national, provincial, municipal and health district levels. There was no attempt to interview front line health workers or community members.

This section briefly summarises the key points made by the participants in the interviews.

3.2.1. Political support

Strong leadership and political support is required to drive the process forward. This sentiment was expressed by several interviewees, from SALGA, the metros, national and provincial health managers. There is new leadership in national and provincial government. Some MECs for health, for example in the Eastern Cape, have already been briefed on the current impasse and officials expressed hope that there will soon be clarity for the way forward.

²⁸ Barron, P (2008) *The Phased implementation of the District Health System in the Western Cape Province- A case study*, (Draft report) at 24-25.

3.2.2. Consultation with stakeholders

Stakeholders acknowledge that local government, through SALGA, is represented on the NHC where the decision to provincialise PHC was taken. The consultation, however, did not extend downwards to the level of service delivery. This was particularly noted by the metropolitan managers who expressed frustration at being sidelined in a decision that affects them more than the other municipalities. A national SALGA manager noted, in acknowledging some internal problems with consultation within their own structures, *"I don't think that SALGA was adequately consulted. Those representing us did not really engage with the working group adequately..."* Interestingly, most interviewees feel that in the past when the National Health Act was being discussed, consultation between the spheres of government and between the affected departments was good.

3.2.3. Communication with stakeholders

The decision to provincialise PHC was generally not well communicated to those who would be responsible for implementing the decision. Most municipal and health managers said they were *"just told"* to provincialise and, local government structures in particular, were *"taken by surprise"* at the decision. Some provinces and metros were proceeding towards delegation of PHC to the metros when they received the national mandate that the status quo applied and they were to proceed with provincialisation. No implementation plan or guidelines appear to have followed the decision. Some provinces appear to have done very little, whereas others have developed their own plans with task teams in place and have made strides towards provincialisation of PHC, in particular from the district municipalities within their respective province. Provincialisation has not taken place in any of the metropolitan municipalities to date.

3.2.4. Community participation

Community participation in development and delivery of services is a pillar of PHC and developmental local government. SALGA and municipal managers all expressed the view that PHC should be at the local level as they are closest to the people and have strong governance structures, such as ward committees, through which to work with community members. Some national and provincial health managers are not convinced by this argument and expressed the view that the provincial health services were close to the community in providing the services. The disagreement in this regard may continue. However, there is general consensus from all who were interviewed that the needs of the people receiving the services is the most important and that it is essential for local government and health governance structures to find ways of working together.

3.2.5. Capacity, financial, human resources and legal implications

These are discussed below.

4. Human Resource Implications

The transfer of personnel from municipalities to the province is problematic. The two spheres of government offer employment with different conditions and service, remuneration (including pensions) and working hours. In addition many personnel have felt frustrated, demoralised and even angry with the uncertainties around frequent changes in policy between decentralisation and provincialisation of the PHC services. A clear policy and process for transfer of staff, if it is to happen, is essential.

The research shows that many of the bottlenecks encountered in the provincialisation process to date, relate to problems concerning the transfer of personnel. Before embarking on any course of action it is necessary to conduct an audit of all personnel impacted. On this basis, a standardised process, which complies with the dictates of the Labour Relations Act, must be adopted.

Key issues to be addressed in this regard are measures to create parity between the different salary scales used to remunerate personnel at the municipal and provincial level. The implications of the OSD must also be taken into account. Similarly, different conditions of service for personnel must be standardized. The lessons learnt during the amalgamation of different municipal administrations should be applied. The experiences where this has been successfully done, such as the Western Cape, should be drawn on.

Another important stakeholder that must be party to decisions relating to personnel, are the trade unions. Importantly, the collective agreements concluded by the trade unions must be respected. Engaging the unions constructively at an early stage of the process will guard against costly and time-consuming disputes at a later stage of the process. This line of engagement with labour was followed in the Western Cape Province with good outcomes.

5. Legal Implications

5.1. Functions and Powers

“Municipal health services”, in keeping with the developmental mandate of local government, is listed as a Schedule 4B function in the Constitution. It therefore follows that local government has full executive and legislative authority over this function (section 156(1) and (2)). The manner in which functions are currently listed in the Schedules to the Constitution, however, sheds very little light on what these functions practically entail. Overlapping powers and functions have in the past led to duplication, inefficiencies and in certain instances, turf battles between provincial departments and municipalities.²⁹

²⁹ Steytler, N, and Fessha, Y (2007) *Defining Provincial and Local Government Powers and Functions SALJ Vol 124: 320–338.*

Given the importance of health care as an essential service and constitutionally entrenched right, confusion and unclear mandates in respect of the delivery of this function can be ill-afforded. The negative impact of uncertainty in respect of which sphere of government is responsible for providing personal primary health care threatens to undo some of the gains achieved in the health sector in post-apartheid South Africa. In this background section, we will examine the legislative definition of municipal health services, the judicial interpretation thereof as well as the Constitutional framework regulating the assignment of functions and powers. This will be followed by a summary of the legal options which SALGA may pursue in attempting to resolve the bottlenecks occasioned by this uncertainty.

5.2. Legislative definition

The National Health Care Act 61 of 2003 has defined municipal health services as: “...for the purposes of this Act, including]—

- water quality monitoring;
- food control;
- waste management;
- health surveillance of premises;
- surveillance and prevention of communicable diseases, excluding immunisations;
- vector control;
- environmental pollution control;
- disposal of the dead; and
- chemical safety,

From this definition it appears that municipal health care excludes the personal health aspects of primary health care. This interpretation is in keeping with the executive policy decisions and frameworks that preceded the promulgation of the Act.

5.3. Judicial interpretation:

In the case of *Independent Municipal and Allied Workers Union and Others versus President of the RSA and Others* 3298/2006 it was argued that the definition of municipal health care in section 1 of the Act is unconstitutional because it does not include “primary health care services” which were an integral component of municipal health care prior to the enactment of the Act.

The Court examined the current definition to determine whether it has the effect of limiting municipal health services to what the applicants considered to be the “narrow” function of environmental health services. In examining this definition, the Court placed particular emphasis on the expansive use of the word “includes”. The Court therefore found that the list of functions in the definition in the Act is by no means a closed list, but is rather inclusive of primary health care services.

Importantly, the Act does not create watersheds between primary health care and municipal health care. While it defines municipal health care it does not explicitly define primary health services as being a Schedule 4A function. This left the door

open for the Court to conclude that primary health care may in fact form part of municipal health care. If the Act had specifically defined primary health care as part of the Schedule 4A competency, the Court would not have been able to reach this conclusion.

The Court furthermore looked at the transitional arrangements that were contemplated by the Act. Section 34 of the Act provides that:

“Until a service agreement contemplated in section 32 (3) is concluded, municipalities must continue to provide, within the resources available to them, the health services that they were providing in the year before this Act took effect.”

On the basis of section 34 and the definition in the Act for municipal health services the Court made a declaratory order to the effect that:

“municipal health services within the meaning of section 1 of the National Health Act 61 of 2003 includes health services ordinarily provided by municipalities at the time the Act came into operation”

While this judgment confirms that the definition of municipal health services in the Act includes “primary health care”- it appears to give and take with the same hand. Despite the fact that the content of “municipal health services” is now certain, strangely, the Court continues to approve the removal of authority and resources related to primary health care from municipalities to provinces. The position of the Court is thus that:

- municipalities have the authority over primary health care and;
- national and provincial health governments have the power to remove that authority from municipalities.

The judgment therefore provides very little certainty in respect to how municipalities should approach this function. This judicial interpretation of the function however, remains unchallenged. Practically, it means that those municipalities, who are in favour of retaining personal primary health care, have a window of opportunity to challenge an attempt by provincial government to take the function away.

5.4. Assignment of primary health care:

If we are to accept the interpretation of the court that municipalities are entitled to deliver PHC as part of their original function and power as listed in Schedule 4B, it creates a legal misnomer to engage in discussions around assignment of the function. It is unnecessary for an original power to be assigned to municipalities by way of service level agreements or memorandums of understanding. Municipalities should have executive and legislative authority in respect of this function and should be able to fund the function by means of own revenue and its portion of the equitable share. As will be discussed under option 1 below, practical considerations do not make this route the preferred course of action.

Alternately, if it is argued that PHC is not an original function of municipalities, and is in fact a provincial competence, then there are strong arguments in favour of assigning the function to municipalities.

5.5. Subsidiarity:

The established principle of subsidiarity advocates that “public responsibilities should be exercised by those elected authorities who are closest to the people”. In recognition of the developmental mandate of local government, the Constitution provides that national or provincial government “must” assign certain functions to a municipality if certain, specified circumstances are met.

“The national government and provincial governments assign to a municipality, by agreement and subject to any conditions, the administration of a matter listed in Part A of schedule 4 which necessarily relates to local government, if:

- a) the matter would most effectively be administered locally and
- b) the municipality has the capacity to administer it.”

The assignment framework set out in the Municipal Systems Act is very detailed and aims to ensure that municipalities are not engaged in unfunded mandates. The service level agreements and memorandums of understanding in terms of which municipalities currently fulfil primary health care, do not seem to comply with the rigorous standards of the assignment framework as set out in the Systems Act.³⁰ See Annex 2 for the legislative framework.

5.6. Legal status of the National Health Council’s 2005 resolution

It is important to note that, legally, the National Health Council’s resolution of November 2005 amounts to policy, and not to law. The National Health Council is an intergovernmental forum. It is not tasked with executive decision making. Executive decision making surrounding health matters is the task of the national Minister and of each of the nine provincial MECs for Health.

This is not to say that the resolution is irrelevant; clearly, it has determined much of the course that is being followed currently and its policy implications continue to resonate throughout the health sector. However, for purposes of a legal analysis, the resolution should not be elevated to law.

6. Financial Implications

There are diverse financial implications for the different stakeholders in this process, namely municipalities, provincial departments and the personnel who are party to the provincialisation process. However, the focus of this discussion is on the financial implications for municipalities.

³⁰ See further discussion of the assignment framework under the heading “financial implications” below.

The limited scope of this research did not permit a full costing of the provincialisation exercise. However, there are certain standard financial implications that municipalities should expect to contend with. To get an accurate overview of the financial implications of provincialisation, an assessment will have to be conducted on a district-by-district basis.

For municipalities that are not currently providing PHC, there are no cost implications. For municipalities that are providing PHC and that hand the function over, there are transitional costs involved. Once the hand-over has taken place however, there will be a reduction of cost on the municipal budget.

Other municipalities may continue to contribute to the PHC delivery, as the metros currently do. Their costs would however be dependent on the terms of the service level agreement that is concluded.

Importantly, the *ad hoc* funding arrangements which currently exist for metros in respect of their funding of the PHC function must be resolved. The current uncertainty about their mandate to fulfil the function impacts on the ability of metros to budget adequately and in certain instances, has negative financial implications for metro budgets.

An audit of assets to be transferred on provincialisation must also be undertaken on a district by district basis. Once this assessment is completed, the provincial department must enter into an agreement with municipalities to provide equitable compensation for these assets. The cost of transferring staff must also be audited and budgeted for.

If the decision is taken to assign primary health care to municipalities, the financial safeguards built into the assignment framework must be adhered to. A full cost-analysis of the assignment of the function must be undertaken, including engaging the National Treasury and Financial and Fiscal Commission on:

- The future division of revenue raised nationally between the spheres of government as required by section 214 of the Constitution;
- The fiscal power, fiscal capacity and efficiency of the particular municipality; and
- The transfer of employees, assets and liabilities.

The assignment framework as outlined in the Constitution, Municipal Systems Act and National Health Act must be fully complied with.³¹

³¹ See Annexure A.

7. Capacity

7.1. Capacity of local government:

A key factor underpinning the decision to provincialise personal primary health care is that of the capacity, or rather the lack of capacity, on the part of local government to adequately fulfil the function. Desktop research as well as the outcomes of the interviews reveals that there is no standardized concept in respect of what “adequate capacity” entails. While there are certainly conditions which point to the ability of a municipality to fulfil a function in an efficient and equitable manner, there is no exhaustive constitutional and/or legislative definition which defines capacity.

7.2. Role of capacity in the subsidiarity debate:

Arguments around capacity constraints are often raised in response to calls for powers and functions to be decentralized to the local level. The established principle of subsidiarity however, strongly advocates that “public responsibilities should be exercised by those elected authorities who are closest to the people”. Section 156(4) of the Constitution entrenches this principle by mandating that national and provincial government **must** assign a function to municipalities if the matter would most effectively be administered locally and the municipality has the capacity to administer it.”

Capacity should however, not be the sole arbiter of where a function is located. Functions and powers need to be assigned on the basis of where it is most appropriately placed for service delivery. Funding and capacity, of necessity, will then follow the function.

The assignment framework as outlined in the Municipal Systems Act seems to give effect to this argument. Section 10A of the Systems Act provides that if a Cabinet member, MEC or other organ of state initiates an assignment of a function or power to a municipality in terms of an executive act, it

“...must take appropriate steps to ensure sufficient funding, and such capacity-building initiatives as may be needed, for the performance of the assigned function or power by the municipality if—

- (a) the assignment of the function or power imposes a duty on the municipality;
- (b) that duty falls outside the functional areas listed in Part B of Schedule 4 or Part B of Schedule 5 to the Constitution or is not incidental to any of those functional areas;
- (c) the performance of that duty has financial implications for the municipality.

If section 156(4) of the Constitution required capacity to be a pre-requisite to the assignment of a function, then section 10 A of the Systems Act would be superfluous.

These debates around the role of capacity in the context of decentralization are also reflected in international jurisprudence on the matter. The United Nations Capital Development Fund, in advocating for capacity building at the local level to achieve the millennium development goals, argues that capacity is not an essential prelude to decentralization;

"In many countries and within many donor agencies there is a tendency to see capacity building as an essential prelude to decentralization- the argument being that local governments should not be given wide responsibilities until local capacities have been fully strengthened. However, local development practice experience strongly suggests that this view is often misplaced....in practice the devolution of responsibilities and functions usually acts as the necessary demand driven stimulus for local government and other local organizations to acquire capacities...Indeed it is increasingly realized that...planning and management are skills that are far better learned by doing than by listening to an instructor." ³²

In the context of the district health system premised on local accountability and accessibility to local communities, primary health care is best located at the local level. Inasmuch as capacity is indeed an important factor, it is argued that a principled and conceptual approach towards the ideal distribution of powers is necessary. Even though the challenges around local government capacity are tremendous, to permit capacity to dictate the outcome of a review of where the function should be located would be counterproductive. Undue emphasis on capacity as an impediment to devolution can result in a "chicken-and-egg" dilemma, whereby capacity is not developed as long as the function is absent. Secondly, the capacity argument is attenuated by the notion that, on a properly executed devolution scheme, resources and finances follow the function.³³

7.3. Capacity assessments in the context of the provincialisation process:

In the context of the provincialisation of primary health care, there does not appear to be any standardized policy framework or approach which was used to assess municipal capacity. Almost all interviewees agreed that capacity assessments were not conducted on a case-by case basis in respect of municipalities affected by the decision to provincialise PHC. It appears therefore that the conclusion that capacity does not exist to fulfil the function was derived from general assumptions about the

³² United Nations Capital Development Fund (2006) Delivering the goods- Building local government capacity to achieve the Millennium Developmental Goals, A practitioner's guide from UNCDF experiences in least developed countries.

³³ De Visser, J and Christmas, A (2007) *Developmental Local Government: Determining Appropriate Functions and Powers*. The full paper is accessible at <<http://www.communitylawcentre.org.za>>.

capacity of local government as a sphere, and not, on a detailed assessment of whether capacity exists within a particular municipality to deliver the function.

Interviewees conceded, however, that in certain rural district municipalities where institutional problems and other impediments to basic service delivery make it difficult to fulfil their basic service delivery mandate, under-capacity is not contested. These municipalities acknowledge that that they are currently under-capacitated and that the challenges to overcoming these impediments will remain for the medium to long-term. These districts do not challenge the fact that capacity assessments were not conducted in their municipality.

The metros on the other hand all categorically claim to have the financial, human resource and institutional capacity to fully deliver primary health care. This fact is largely acknowledged by their respective provincial counterparts. The approach to assessing capacity of the metros has however not been clear. In Nelson Mandela Bay Metro, for example, an agreement was reached with the provincial department of health to evaluate its capacity to deliver the function over a five-year period.³⁴ Despite continued qualitative service delivery, this process was not completed due to an about-turn change in the political approach to provincialisation.

In accordance with the strategic recommendations of this paper, it is strongly recommended that adequate capacity assessments be conducted in the metros and that on that basis, an asymmetrical view be taken in respect of fully assigning primary health care to the metros and those district municipalities who have the necessary capacity to fulfil the function.

7.4. How do we build capacity in the run-up to 2015?

7.4.1. Indicators for assessing capacity- a bird's eye view

While capacity is not a finite concept, there are indicators which point to the prospects of a municipality being able to fulfil its service delivery functions, such as sound financial management, a well-functioning institutional establishment and adequate financial and human resources. In addition, the extent to which municipalities are able to fulfil their current functions, is indicative of whether they would be able to take on the added responsibility of primary health care. Annual capacity assessments conducted by Treasury as well as the Municipal Demarcation Board can assist in obtaining an overview of the efficiency of a municipality.

In respect of financial management, National Treasury has developed an assessment of municipalities linked to their ability to implement the requirements of the Local Government: Municipal Finance Management Act.³⁵ Municipalities are allocated high, medium or low capacity status for the implementation of the Municipal Finance Management Act. Generally those municipalities with the largest

³⁴ Response of Nelson Mandela Bay Municipality on "Discussion document on a proposed solution for the provision of PHC services in the Eastern Cape province" at 3.

³⁵ Local Government: Municipal Finance Management Act, 88 of 2003.

budgets tend to be regarded as having high capacity levels. Municipalities which believe they have the necessary capacity levels are able to apply to have their status upgraded.³⁶ Sound financial management systems are therefore a good indicator of the ability of municipalities to fulfil their functions.

The Municipal Demarcation Board conducts annual assessments of the capacity of district and local municipalities to fulfil their functions. An annual report is compiled which details the baseline information that would inform possible capacity shifts in municipalities. The report is also the basis of recommendations for consideration by the MEC for Local Government for the adjustment of powers and functions for the district municipality and associated local municipalities for the period. It also assesses each municipality's capacity to perform specific powers and functions, and not the internal organisational matters which, in the short and/or long- term, may affect the performance of a municipality. The trends recorded in the performance of functions, however, can be used by both Provincial and National Government as an early warning system. It may, for instance, identify a municipality which has consistently demonstrated poor capacity for the rendering of a number of functions in five capacity assessment periods. Thereafter, the Provincial Department of Local Government may opt to intervene to identify possible causes and institute measures to correct identified inadequacies.

The continued success of initiatives such as Project Consolidate and various other capacity initiatives, training programmes and interventions are also useful tools in evaluating how capacity evolves in municipalities.³⁷

7.2.2. Developing a sector-specific capacity framework:

The Department of Health in conjunction with SALGA can determine an appropriate framework and benchmarks that municipalities should progressively achieve in order to build capacity to fulfil primary health care. An example of such a sector-specific framework is the accreditation framework which is used to determine whether municipalities can act as service deliverers of the housing function.

The requirements for accreditation are outlined in the National Housing Code.³⁸ While the framework for accreditation is quite detailed, it has not proved to be a suitable mechanism for the devolution of the housing function to local government.

The difficulties encountered in the accreditation process represent the first hurdle that municipalities have to overcome even before leaving the starting blocks. One such challenge relates to a lack of understanding of the application process³⁹ and the arguably high threshold requirements for accreditation. For example the

³⁶ Dr. Mcebisi Ndletyana, Dr. James Muzondidya and Mr. Vinothan Naidoo, 2008 "Local Government: Strengthening Capacity – A Review of Measures Taken in the Last Fifteen Years" Democracy and Governance Programme, Human Sciences Research Council, Pretoria

http://www.thepresidency.gov.za/docs/reports/15year_review/governance/local_government.pdf

³⁷ Ibid.

³⁸ Part 2, Chapter 2, National Housing Code.

³⁹ Resolution of the KwaZulu-Natal Housing Summit: 2005.

“proven track record” requirement stipulates that “the Council’s proven track record of initiatives and involvement in housing provision and/or community development in its area of jurisdiction will be a recommendation”. In respect of capacity, it is a pre-requisite that the municipality should have “financial, administrative, professional and technological capacity to fulfil its housing responsibilities and to administer the National Housing Programmes.” It is therefore difficult to conceive of many municipalities who currently have that level of infrastructure. As argued above, the appropriate kind of capacity is unlikely to emerge without the existence of authority. SALGA and the department of health can therefore set indicators such as good management systems, sound financial management and human resource systems etc. However, in the absence of having the authority and resources to fulfil the function, it would be unfair to expect any more than that.

7.2.3. Building local capacity within the District Health System (DHS):

The DHS is intended to be the most decentralised structure responsible for the governance and management of the health system established by the National Health Act. As such, this system must be rooted in the local municipalities and communities whom it serves. A key institution of the DHS that would involve municipalities is that of the District Health Council. Local municipal representation on this Council is meant to extend to local councillors who in turn, are accountable to their local municipalities and the communities which they serve. A survey conducted by Schneider and Barron reveals that these key institutions have not been established in District Health Systems⁴⁰

“The National Health Act vests the governance of the DHS with provincial government, which is required to pass subsidiary legislation to establish appropriate resource allocation processes, structures (such as district councils and clinic committees) and cooperative governance arrangements with local government. None of the provinces have passed the envisaged legislation and [only] two provinces have draft legislation. Therefore most health districts do not function as envisaged in the Act...formal mechanisms of accountability such as District Councils and Clinic/Community Health Centre Committees are either absent or do not play a meaningful role.”

In the absence of functioning district health councils, municipalities are unable to exercise oversight over the delivery of primary health care and are effectively removed from the policy processes around this function. The possibility of local representation on district management teams in these DHS's is therefore also highly unlikely.

There are however exceptions to this status quo. In the Dr. Ruth Segomotsi Mompati District Municipality, interviewees reported a strong and well-functioning District Health Council;

⁴⁰ Schneider, D, Barron P and Fonn, S (2007) *The promise and the practice of transformation in South Africa's Health System* State of the Nation- South Africa 2007 at 9.

“The health councillor from the district municipality – is not merely a councillor. She forms part and parcel of our district management team. When we have appointments – the health councillor is part of that process. If there are issues which the community complains about at the municipal level, she approaches us and often tells us to pull up our socks. Councillors from each local municipality form part of the district management team. The Councillor at the district municipality has been integrally involved in primary health care from when it was initially decided that primary health care should be a district municipality function. She has therefore “grown” into her portfolio in primary health care”

Involving local councillors in district health councils and district management teams ensures that not only is local oversight and accountability to municipalities maintained, but it allows institutional knowledge of the policy process and implementation of primary health care to be retained at a municipal level. In the absence of this type of local involvement, in 2015, municipalities will have no knowledge of the primary health care system. In that context, it would therefore make little sense to devolve the function to the municipal level.

A foreseeable challenge that SALGA and provincial departments may have to contend with is getting municipal administrators to continue to be part of processes over which they no longer have an implementing mandate. The only way to circumscribe this challenge would be to ensure that their involvement is not limited to a representative role, but that they are equipped to constructively engage and shape the processes and decisions of these structures.

Another key challenge raised by Schneider and Barron⁴¹ relates to “reversing the current pattern of upward accountability where actors constantly respond to demands from above, to a process of downward accountability, in which senior managers spend more time engaging with and responding to needs from below; and implementing integrated processes of communication between national and provincial structures.”

To this end, the integration of local integrated development plans into district and provincial health plans must not simply be an exercise that amounts to a chase for compliance. Lastly, local government must contribute to the formulation of new policies which relate to primary health care and the district health system.

⁴¹ Schneider, D, Barron P and Fonn, S (2007) *The promise and the practice of transformation in South Africa’s Health System State of the Nation- South Africa 2007*, at

8. Recommendations

8.1. Two options

Two options are presented to SALGA for consideration.

Option 1: challenge provincialisation, assert constitutional authority over primary health care

The Constitution provides that municipalities have authority over “municipal health care” (Schedule 4B). The National Health Act essentially defines “municipal health care” as environmental health care, thereby excluding primary health care from local government’s constitutional mandate. However, the Pretoria High Court in the *Imatu* judgment⁴² has ruled that the National Health Act’s definition may include primary health care. Therefore, legal uncertainty as to the proper interpretation of the Schedule 4B competency “municipal health care” remains. There is still scope for the argument that, constitutionally, municipalities have the authority to perform the primary health function. In this line of argument, the provincialisation process, including the National Health Council resolution of 2005, the DHS framework in the Health Act and the actions taken in terms of this framework could be challenged by SALGA.

The difficulty with this argument is that it presupposes a one-size-fits-all approach. The assertion (through an amendment of the Health Act or court judgment striking down the Act) that municipal health care includes primary health care would mean that all district municipalities have the authority (and obligation) to provide primary health care. The reality, as indicated again by the field research, is that many district municipalities do not have the capacity to provide primary health care. These municipalities would then have to enter into service level agreements with the relevant provincial governments in order to see the service delivered in their districts on their behalf. This scenario will be extremely disruptive and, it is suggested, is undesirable.

Moreover, the constitutional framework does not provide for ‘assignment’ from a municipality to a province. The municipality could only engage provincial department on the basis of agency agreements. Therefore, the municipality would not be able to divest itself of the responsibility to monitor and oversee the function, a function for which many do not have capacity.

⁴² *Independent Municipal and Allied Workers Union and Others versus President of the RSA and Others* 3298/2006

Option 2: support provincialisation but insist on the progressive decentralisation to municipality that have the capacity

Leaving the abovementioned uncertainty over the content of “municipal health care” aside, SALGA could opt to support provincialisation but focus its advocacy on the progressive decentralisation of primary health care to municipalities that have the capacity to fulfil the function.

This position would be in line with the constitutional framework for the division of powers and functions. If it is accepted that primary health care is a Schedule 4A function and the provincialisation is therefore supported, the Constitution (s 156(4)) instructs national and provincial governments to assign the function to municipalities that have the necessary capacity. Furthermore, this position would be in line with the National Health Act, which provides that the Provincial Executive “must assign such health services to a municipality in his or her province as are contemplated in section 156 (4) of the Constitution” (s 32(2)). The Health Act thus provides that provinces must assign primary health care services to those municipalities that have the capacity to perform the function.

This option would not result in uncritical support for the provincialisation process but in an insistence that it is implemented in line with the Constitution and the Health Act.

The resolution, taken by the National Health Council, is contrary to this position. It refers to the decentralisation of primary health care to local government but uses criteria that are at odds with the Constitution. For example, the provision that no decentralisation will take place during the first ten years is effectively a moratorium on assignments. This violates section 156(4) of the Constitution. Section 156(4) of the Constitution instructs national and provincial governments to approach the assignment of Schedule 4A and 5A function on the basis of substantive arguments. These substantive arguments relate to two issues, namely capacity and being best placed to deliver the service. It does not permit a moratorium on assignments of Schedule 4A functions and does not permit national government to use the lapse of time as the singular criterion to lift a moratorium on assigning the primary health care function. It would be legally coherent (but not necessarily tenable) to argue that no municipality is currently able to deliver the service. However, it is not legally coherent, in the context of the injunction of section 156(4) of the Constitution, to argue that no municipality may receive the function for a period of ten years.

It is suggested that for SALGA to support the provincialisation of primary health care *without decentralisation* is therefore also not an option. First, this option contradicts the Constitution. Section 156(4) of the Constitution *demand*s asymmetry, namely the decentralisation of Schedule 4A functions to those municipalities that have the capacity to deliver the service and that are best placed to do so. Secondly, the research indicates that this position would contradict the interests of adequate service delivery in those municipalities that have been performing the function.

The research shows that there is not a great appetite for holding on to primary health care as a Schedule 4B, original constitutional function. This is not the municipality's primary concern. In fact, most municipalities, even those that deliver primary health care, are not opposed to the provincialisation of primary health care, particularly because provincialisation creates the platform for a more transparent funding arrangement. This is particularly relevant for those municipalities that are currently providing the service. Most often, those municipalities provide the service, based on a large contribution from the municipal budget, complemented by provincial transfers. These provincial transfers are not only insufficient but, more importantly, unpredictable as there is no coherent funding arrangement. Primary health care is provided on the basis of agency agreements, usually renewed annually. These agreements put the municipality in the position of a contracted service provider, outside of the transparency and predictability of the intergovernmental fiscal environment of the Division of Revenue Act. The primary concern for those municipalities is thus be the continuation of the provincialisation process as long as it results in the function being assigned or delegated by the provincial government to those municipalities that have the capacity to deliver the service.

In some instances, provincial governments appear to have an interest in delaying the provincialisation of primary health care services. For example, Nelson Mandela Bay Municipality reports a dilatory department of Health that is not following through on the provincialisation process. A cynical interpretation may be that the current uncertainty and patch-work configuration enables the department to exercise full control over funding streams pertaining to primary health care because the municipality has no recourse to any predictable funding arrangement in absence of a delegation or assignment. The completed provincialisation, followed by the decentralisation of the function to NMBM, would mean that the provincial department has to part ways with the 'flexibility' of the agency agreement and replace it with the 'rigidity' of a delegation or assignment platform, including the municipality's recourse to a predictable funding arrangement.

8.2. Proper provincialisation is good for local government

It can be argued that the provincialisation of primary health care, as laid out in the National Health Act creates sufficient opportunities for local government.

For those municipalities that do not have the function, it provides for primary health care delivery through deconcentrated entities that work in close consultation with district municipalities. This should facilitate a constructive relationship between the deconcentrated entities at district level and the relevant district municipality, including a platform for integrated planning.

For those municipalities that will receive the function through the decentralisation framework, it provides for a more coherent and predictable funding framework. The current situation where (metropolitan) municipalities provide the primary health care function on the basis of hazy legal mandates, complex agency agreements and

unpredictable funding arrangements would be replaced by a more coherent delegation framework.

However, the problem is that on both scores, the provincialisation process is often not followed through. The deconcentration of primary health care to district management authorities is often incomplete and operational decision making is still located at the level of provincial departments. In many provinces, the district health councils and provincial health councils are entities that exist in name only. Municipalities and district health authorities therefore do not benefit from dynamic relationships at municipal level that facilitate coherent and joint planning. Similarly, the option of decentralisation to municipalities with capacity to deliver, which is part and parcel of the provincialisation concept, is not taking place.

8.3. General recommendations

Whichever option SALGA selects it is recommended that cognizance of the following general principles be included in the way forward to establishing a comprehensive, integrated PHC through the DHS, as envisioned by the National Government Health in all health policy and legislation. These recommendations take note of views expressed by stakeholders interviewed during the research process for this paper.

- Ensure political buy-in and leadership from the top for the process
- There is broad stakeholder consultation with managers at all levels within the department of health, local government and SALGA.
- A communication strategy is in place to inform stakeholders of what, why and how the process towards strengthening PHC and establishing the DHS is to be taken forward
- Links between health and municipal governance structures are developed

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Annexure 1

List of stakeholders interviewed.

In each province, the Provincial Departments of Health, SALGA Social and Development Working Group (SDWG) Provincial Chair and SALGA Deputy Chief Executive officers (CEO) were approached. Two district or metropolitan municipalities and two health districts per province were randomly sampled, and occasionally purposively sampled through a snowball strategy. The overview below contains the stakeholders who availed themselves to be interviewed within the set timeframe.

National

	Position	Name
Treasury	(Municipal Finance Management)	Mark Bletcher
DoH	DDG	Dr Yogan Pillay
	Chief Directorate: PHC	Bennett Asia
SALGA	ED: CD	Antonette Richardson
SALGA	ED: IGR	Johan Mettler

Gauteng

Province	Position	Name
SALGA SDWG	National and GP SDWG Chairperson	Cllr Nandi
Metros	Position	Name
City of Tshwane	Executive Director: Health Care	Mr. Joseph Nkosana
City of Johannesburg	Executive Director: Health and colleagues	Dr. Bismilla
District	Position	Name
West rand District	Executive manager Health and Social Development	Ms Kelina Ndlovu

Eastern Cape

Province	Position	Name
EC	GM: District Health Services	Maureen Botha
Metro	Position	Name
Nelson Mandela	Acting Director Health Municipal Manager	Dr Hussein Adv Richards
District	Position	Name
Ukhahlamba		
DOH	District Health Manager	Mrs. Nobahle Ndabula
LG: District	Director Community Services	Fiona Sephton

Western Cape

Province	Position	Name
PDOH	Deputy Director General Department of Health	Dr. Joey Cupido
Metro	Position	Name
Cape Town	Executive Director: City Health	Dr Ivan Blomfield
Districts	Position	Name
LG: District	Director Community Services	Mrs Oppies

North West Province

Province	Position	Name
SALGA	SDWG Chairperson NW	Cllr Mmoni More
SALGA	Deputy: CEO	Ms. Shirley Molema
District	Position	Name
Bophirima		
DoH	District Health Manager	Mr Matsepe
LG: District	Director Community Services	Mr H. Bezuidenhout
Southern		
LG: District	Director Community Services	Mrs. Motshoenyane

Mpumalanga

Province	Position	Name
SALGA	Deputy: CEO	Mr Felani Ndebele
PDoH	Provincial Chief Director PHC/DHS & Hospitals	Mrs Melanie Wolmarans
District	Position	Name
Nkangala		
DOH	District Health Manager	Mr. Joshua Mohlamme

Northern Cape

Province	Position	Name
SALGA	SDWG Chairperson NC	Mr Gaonyadiwe Mathobela
PDoH	Director: District Health Services	Mrs Mthunsi

Frances Baard (District)	Position	Name
DoH	District Health Manager	Ms Gumbu
LG: District	Community Development Officer	Kagiso Pholoholo
Sol Plaatjie (LM)	Manager Personal Health	Johan Britz
Dikathlong Plaatjie (LM)	Director Community Services	
Magareng (LM)	Director Community Services	

Annexure 2

Legislative framework for the assignment of functions⁴³

Process

Memorandum to Minister and National Treasury:

Section 10 of the Municipal Systems Act requires that even prior to an assignment; a memorandum must be submitted to the Minister for local government and the National Treasury or the relevant provincial treasury (if it is a provincial organ of state). This memorandum must:

- (a) give at least a three-year projection of the financial implications of that function or power for the municipality;
- (b) disclose any possible financial liabilities or risks after the three-year period; and
- (c) indicate how any additional expenditure by the municipality will be funded.⁴⁴

Approval of the National Treasury

Before requesting the recommendation or advice of the Financial and Fiscal Commission, the organ of state intending to assign a power or function in terms of law to a municipality must first obtain the written approval of the National Treasury (if it is a national organ of state) or of the relevant provincial treasury (if it is a provincial organ of

state).⁴⁵ If the relevant treasury refuses to give its approval (based on its appraisal of the memorandum), the proposed assignment may not be proceeded with.

The Fiscal and Financial Commission

If the assignment is proceeded with, the relevant organ of state must then notify the Financial and Fiscal Commission of the fiscal and financial implications of such assignment on

- (a) the future division of revenue raised nationally;

⁴³ Local Government: Municipal Systems Act 32 of 2000, Financial and Fiscal Commission Act 99 of 1997, and Fiscal Intergovernmental Relations Act 97 of 1997.

⁴⁴ S 10(1)(a)–(c) Municipal Systems Act.

⁴⁵ S 3 (2D) Financial and Fiscal Commission Act.

(b) the fiscal power, fiscal capacity and efficiency of the particular municipality;
and

(c) the transfer of employees, assets and liabilities, if any.

The Commission must then be requested to furnish its recommendation or advice regarding such assignment. The failure to procure and consider the advice or recommendations of the Commission are severe, as the assignment has no legal force in the absence of such consideration.⁴⁶ The assigning organ of state must not only consider the recommendations but also indicate the extent to which it has considered the recommendation or advice of:

(a) the Commission;

(b) the municipality to which the power or function is to be assigned;

(c) the National Treasury; and

(d) any other functionary responsible for authorising the assignment.⁴⁷

Local Government Budget Forum

The assigning organ of state must also consult the Local Government Budget Forum if the proposed assignment of a power or function to municipalities has a financial implication for local government.⁴⁸

Guidelines on Allocation of Additional Powers and Functions to Municipalities

In addition to the Constitution and Municipal Systems Act, *Guidelines on Allocation of Additional Powers and Functions to Municipalities*⁴⁹ were recently promulgated by the Department of Provincial and Local Government. These Guidelines attempt to infuse the assignment process with the necessary safe-guards that would protect the interests of all parties to the assignment. Importantly, functions can be assigned either to individual municipalities or to local government as a sphere. A

⁴⁶There is however a caveat to this provision. The organ of state which requests the Commission to provide recommendations or advice about an assignment is not compelled to wait indefinitely for their response. If the Commission fails to make a recommendation or give advice within 180 days, the organ of state intending to assign the power or function may proceed with the assignment provided that the National Treasury is consulted and the assignment takes into account the financial and fiscal implications of the assignment on the matters referred to in s 3(2A)(a) of the Financial and Fiscal Commission Act. Item 24 sch 1 *Assignment and Delegation Guideline* (2007), Department of Provincial and Local Government.

⁴⁷ S 3(2A)(d) Financial and Fiscal Commission Act.

⁴⁸ S 6(b) Intergovernmental Fiscal Relations Act.

⁴⁹ Department of Provincial and Local Government (2007) *Guidelines on Allocation of Additional Powers and Functions to Municipalities* (Pretoria: Department of Provincial and Local Government).

differentiated approach to assignment is therefore possible and appropriate, given the variety in capacity, economic and spatial realities present in municipalities.