

https://dspace.org/

Decentralized co-operative governance of the public health system in South Africa

Plaatjies, Daniel

2008-08-27T07:02:27Z
http://hdl.handle.net/10539/5568

Downloaded from a DSpace repository. https://dspace.org/

DECENTRALIZED CO-OPERATIVE GOVERNANCE OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

Daniel Plaatjies

April 2008

UNIVERSITY OF WITWATERSRAND

SCHOOL OF PUBLIC DEVELOPMENT MANAGEMENT

DECENTRALIZED CO-OPERATIVE GOVERNANCE WITHIN THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

Dissertation submitted in fulfilment of the requirements for a doctoral degree in Public and Development Management at the University of Witwatersrand, South Africa

Daniel Plaatjies

April 2008

ABSTRACT

The design of the decentralized co-operative governance system, conditioned and regulated by the South African constitution is of critical importance for policy design and implementation. The division of powers falls within a unitary form of government. This study, which is about the processes, mechanisms and modalities of public policies design and implementation uses the public finance and health sectors, as a case study or lens through which policy design and implementation is examined within a decentralized and cooperative governance system. The study is *per se* not about the public health system, but rather a review and an analysis about how the decentralization and cooperative governance nature, practice and dynamic of government system, influences and condition the policy processes and practice on finance and health, separately and collectively within the public health system.

In its attempt to unbundle the health function, but also reform the public health system, central and provincial governments have introduced a number of reforms. These reforms were ostensibly driven by different policies and programmes originating either from the public finance or public health sectors with significant consequences for the provinces. Moreover, these different policies also outlined structural and functional responsibilities and authority among the central and provincial government departments. The implementation of these policies was at times based on different interpretations of policy design and implementation responsibilities and authority between the central and provincial governments within co-operative governance system.

The argument of this study is that despite intentions implicit to public policy, co-operative governance system is contested at a central government level within the public health system, as well as between levels of government and the public health and finance sectors. This dissertation explores the nature of the relationship between the central and provincial governments by exploring co-operative governance in the health sector on policy and financing processes and mechanisms. The central question is how does decentralized co-operative governance really work in the public health system?

A case study method was used to conduct this research. Data was collected over a four and half year period using a variety of data collection methods, including semi-structured in-depth interviews; documents and reports analyses; policy content review and analyses; and revenue and expenditure reviews and analyses.

The study's findings are:

a) the functional and structural decentralization of policy-making and implementation within the co-operative governance system contributes to undermining the co-operative governance relationship between the public finance and health sector and central and provincial governments;

b) the central government is using its overriding powers to "impose co-ordinated solutions" to problems within the co-operative governance system, leading to situations where 'imposed co-ordination' is considered as 'co-operative governance';

c) the theory provides a classical distinction between state control, supervision and interference models. This dissertation shows that, depending on the policy context and circumstances, the uniqueness of South Africa's co-operative governance system allows the central government to mobilize any of these models to achieve its policy intentions, whether written or unwritten; and

d) the classical arguments of decentralization, particularly within a devolved system of co-operative governance where greater autonomy and authority are given to sub-national governments, are found wanting within the South African governance system, given both the policy-making and fiscal resource strength of the central government relative to the provinces.

This dissertation leads me to conclude that the South African practice of co-operative governance in the health system is actually imposed co-ordination and that provinces are de facto administration outposts of central government policies, programmes and service delivery responsibilities. Therefore in reality there is no autonomy and independence of the provinces from the central government as envisaged in the Constitution of the Republic of South Africa. In fact, provinces only exist, in terms of their

constitutional competencies as far the central government allows it to exist given its plenipotentiary powers over both micro and macro matters affecting institutions, fiscus and social policies.

ACKNOWLEDGEMENTS

To my dissertation supervisors, Professor Anne McLennan and Professor Pundy Pillay: Thank you for your support and intellectual guidance. I am extremely grateful to you for helping to boost my morale and energy so that I could finish this body of work. I am grateful to that you stepped in and agreed to supervise and support me in completing this dissertation.

I would like to thank Trevor Manuel for always intellectually, technically and politically stimulating my thoughts and for unwittingly helping me to grapple with provocative questions. Your inspirational leadership during my discussions with you on policy and service delivery matters has indeed allowed me to only see at time the public service through a lens of a political leader.

I would also like to thank Maria Ramos, John Kruger, Ismail Momoniat, Jan Hattingh, Jeffery Smith, Hennie Swanepoel, Kuben Naidoo, Andrew Donaldson and Lungisa Fuzile for their support. You all have allowed me to learn and develop and have indirectly contributed to the completion of this dissertation.

To Angie Kapelianis, Julia de Bruyn and Celeste Phillips for reading through a number of drafts of this research study.

To all my friends that have supported me over time and have accepted that “I am busy”: Mark Burke, Mark and Suraya van der Ross, Anthony and Lydia Jardine, Selwyn Jehoma, Jean Booysen, Nicky Florence, Chevon Erasmus, Omano Edigheji, Ivan and Delia Mabotha, Lydia and William Hess, Ricky and Edwina van der Burg, Philip Balie, Vernon and Lynne Weitz, Ian and Sadie Bull, Nico Solomons, John Bailey, Steven and Illse Lang, Veronica Strydom, Gershwin Jacobs, Chantal Hoffman, Charles and Jacqui Januarie, John and Nelli Tsalamandris Graham Williams, Stanford Webster –thank you all.

Thanks go to my families, especially my mothers Leentjie Plaatjies and Getruida Padiachy for your love, care, encouragement and support.

To my daughters, Leandre, Danelle and Lidian: I am eternally indebted to you for all your love, care, patience and support over the years.

Lydia-Anne, you have shown through the years, yes, through “dik and dun” that you are indeed my soul mate. You have supported me in my endeavours and have served as a critic and my advisor in various matters. I thank and love for all your support.

DEDICATION

I dedicate this work to my mother, Leentjie Plaatjies and the community of Netreg in Bonteheuwel, Western Cape Province of South Africa.

My points of reference when I am required to make public policy and finance inputs and interventions that contributes to shaping the life and conditions of society.

DECLARATION OF ORIGINALITY

I, Daniel Plaatjies, hereby declare that this dissertation is my own work and has not been submitted previously for any degrees at any university.

Daniel Plaatjies

LIST OF TABLES

Chapter 3

Table 3a: Decision-Space Functions…..…….page 98

Table 3b: Data Collection Method…….…….page 111

Chapter 5

Table 5a: Adaptation and Application of the Decision-Making Space Functions in the Hospital Strategy Project ……..page 156-157
Table 5b: Adaptation and Application of the Decision-Making Space Functions in the White Paper for the Transformation of the Health System……..page 163 -164
Table 5c: Adaptation and Application of the Decision-Making Space Functions on the Policy for the Development of a District Health System.....……..page 170 -171
Table 5d: Adaptation and Application of the Decision-Making Space Functions in the National Health Act, 2003.....….....page 182 - 183
Table 5e: Adaptation and Application of the Decision-Making Space Functions in the 2000 -2005 HIV and Aids/STD Strategic Plan for South Africa, 2000 .....page 190 - 191

Chapter 6

Table 6a: Equitable Share Formula…..…….page 211
Table 6b: Distributing the equitable share percentage by province……page 212
Table 6c: Calculation of health component……..page 217
Table 6d: Medium term expenditure framework and division of revenue……..page 227
Table 6e: Trends in health conditional grants, 2000/01 to 2007/08…….page 232
Table 6f: Provincial and national health expenditure, 1996/97-2004/05…….....……...page 238
Table 6g: Provincial and national expenditure as a percentage of Gross Domestic Product, 1996/97 to 2007/08……page 239
Table 6h: Provincial health expenditure in real terms (2004 prices), 1996/97 to 2004/05…….page 242
Table 6i: Provincial health expenditure, 1996/97 to 2004/05…….page 243
Table 6j: Provincial health: Conditional grants and equitable percentage share, 2000/01 to 2006/07…….page 247
Table 6k: Provincial health percentage share by programme, 1996/97 to 2004/05…….page 256
Table 6l: Provincial health expenditure by selected programmes on subprogrammes…….page 260

Chapter 7

Table 7a: Eastern Cape health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……..page 271
Table 7b: Free State health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……..page 278

Table 7c: Gauteng health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……..page 285

Table 7d: KwaZulu-Natal health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……page 293

Table 7e: Limpopo health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……...page 303

Table 7f: Mpumalanga health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08…..……page 307

Table 7g: Northern Cape health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08……..……page 314

Table 7h: North West health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08…..……page 320

Table 7i: Western Cape health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08…..……page 327

Chapter 8

Table 8: Unitary and Federal Elements Co-Exists in Public Health Financing System: The Conundrum ..……page 338

LIST OF GRAPHS

Chapter 6

Graph 1: Division of Revenue: Percentages of shared total……..…….page 228
Graph 2: Equitable share allocations...……page 230
Graph 3: Division of Revenue: Excluding the Conditional Grants from Provincial Allocations – Shares Total…….……page 234
Graph 4: Relationship between NHE and GDP: 1997/98 TO 2007/08……page 240
Graph 5: Provincial health expenditure by economic classification……page 245

Chapter 7

Graph 5a: Eastern Cape health expenditure by selected programmes: 2005/06……page 269
Graph 5b: Free State health expenditure selected programmes……page 274
Graph 5c: Gauteng health expenditure by selected programmes:2005/06……page 282
Graph 5d: KwaZulu-Natal health expenditure by selected programmes: 2005/06……page 291
Graph 5e: Limpopo health expenditure selected programmes……page 300
Graph 5f: Mpumalanga health expenditure by selected programmes:2005/06……page 306
Graph 5g: Northern Cape health expenditure by selected programmes: 2005/06……page 311
Graph 5h: North West health expenditure selected programmes……page 317
Graph 5i: Western Cape health expenditure by selected programmes:2005/06……page 323

LIST OF DIAGRAMS

Chapter 6

Diagram 1: Division of Revenue: 2005/06……page 235

Diagram 2: Division of Revenue: 2005/06…… ……page 235

Chapter 5

Diagram 5a: Eastern Cape health expenditure by selected programmes: 2005/06.....page 268
Diagram 5b: Eastern Cape health expenditure by selected programmes: 2006/07.....page 269
Diagram 5c: Free State health expenditure by selected programmes: 2005/06.....page 273

Diagram 5d: Free State health expenditure by selected programmes: 2006/07.....page 274
Diagram 5e: Gauteng health expenditure by selected programmes: 2005/06.....page 280
Diagram 5f: Gauteng health expenditure by selected programmes: 2006/07.....page 281
Diagram 5g: KwaZulu-Natal health expenditure by selected programmes: 2005/06.....page 290
Diagram 5h: KwaZulu-Natal health expenditure by selected programmes: 2006/07.....page 290
Diagram 5i: Limpopo health expenditure by selected programmes: 2005/06.....page 299
Diagram 5j: Limpopo health expenditure by selected programmes: 2006/07.....page 299
Diagram 5k: Mpumalanga health expenditure by selected programmes: 2005/06.....page 304
Diagram 5l: Mpumalanga health expenditure by selected programmes: 2006/07.....page 305
Diagram 5m: Northern Cape health expenditure by selected programmes: 2005/06.....page 310
Diagram 5n: North-West health expenditure by selected programmes: 2006/07.....page 316
Diagram 5o: Western Cape health expenditure by selected programmes: 2005/06.....page 322
Diagram 5p: Western Cape health expenditure by selected programmes: 2006/07.....page 323

LIST OF MAPS

Map1: Republic of South Africa.....page 118

LIST OF FIGURES

Figures 1.1 Power and Authority in the public public policy process in the public service: influence; text production and practice System.....page 6

Figures 1.2 Decentralized Cooperative Governance within the South African Public Health System.....18

Figures 1.3 Decentralized Cooperative Governance of Public Policy: A Theoretical Framework.....page 68

Figures 2.2 Conceptual Framework Model……..page 83

LIST OF APPENDICES

Appendix A: Eastern Cape Economic Classification of Expenditure….pages 370-377

Appendix B: Free State Economic Classification of Expenditure……...pages 378-386

Appendix C: Gauteng Economic Classification of Expenditure……..pages 387-395

Appendix D: KwaZulu-Natal Economic Classification of Expenditure…pages 396-404

Appendix E: Limpopo Economic Classification of Expenditure……..pages 405-413

Appendix F: Mpumalanga Economic Classification of Expenditure..….pages 414-422

Appendix G: Northern Cape Economic Classification of Expenditure.. pages 423-430

Appendix H: North West Economic Classification of Expenditure……..pages 431-438

Appendix I: Western Cape Economic Classification of Expenditure…..pages 439-447

KEY ACRONYMS

AIDS……Acquired Immune Deficiency Syndrome
ANC……..... … African National Congress
CHB……Chris Hani Baragwanath Hospital
CHS……...CHS
CODESA..... ……Convention for a Democratic South Africa
DHS……..……DHS
DORA……..……Division of Revenue Act
DP……..……Democratic Party
EC……..……Eastern Cape
EMS……..EMS
FFC……Financial and Fiscal Commission
FS……Free State
GDP……..……Gross Domestic Product
GEAR……...Growth Employment and Redistribution
GFS…….. Government Finance Statistics
GP……Gauteng Province
HFM……...HFM
HIV……...Human Immunodeficiency Virus
HSP……..…Hospital Strategy Project
HSP……Hospital Strategy Project
IFP……Inkatha Freedom Party
IGFR……...Intergovernmental Fiscal Review
IMF……...International Monetary Fund
KZN……KwaZulu-Natal
LP……...Limpopo Province
MEC……..…Member of Executive Council
MINMEC……...Minister and Members of Executive Council
MP……..Mpumalanga Province
MTBPS……Medium Term Budget Policy Statement
MTEF……Medium Term Expenditure Framework
NACOSA..... ……National AIDS Coordinating Committee of South Africa
NC……Northern Cape
NCOP……National Council of Provinces
NHA……..…National Health Act
NHC……National Health Council
NHE……..National Health Expenditure
NP……National Party
NTSG……National Tertiary Service Grant
NW……North West
PFMA……..Public Finance Management Act
PHC……..Primary Health Care
PHRC……Provincial Health Restructuring Committee
PHS……...PHS
PMTCT ……Preventing Mother-to-Child Transmission
RDP……..Reconstruction and Development Programme
SACP……South African Communist Party
SCOA……Standard Chart of Accounts
SDDS…….... Special Data Dissemination Standard
SMT…….. Strategic Management Team
STD……Sexually Transmitted Diseases
WC……Western Cape
WHO……World Health Organisation

CONTENT

ABSTRACT iii
ACKNOWLEDGEMENTS vi

DEDICATION viii
DECLARATION OF ORIGINALITY ix
LIST OF TABLES x
LIST OF GRAPHS xii
LIST OF DIAGRAMS xii
LIST OF APPENDICES xiv
KEY ACRONYMS xv

CONTENT XVI

CHAPTER ONE: DECENTRALIZED CO-OPERATIVE GOVERNANCE OF PUBLIC POLICY: - A CONUNDRUM WORTH SOLVING? 1

Introduction 1
Decentralized co-operative governance in the public policy process 2
Primary and Secondary Arguments 11

Research Problem Statement – Elements of a Conundrum 16

How structures of intergovernmental relations interact between and within public health and finance sectors 19

Purpose of Study 21

Public Health System as the Case Study 22

Significance of the Study 22
Research Question 23

Methodology of the Study 24

Organisation of the Dissertation 25

Chapter Summary 25

Organisation of Study – An Overview 25
Chapter Two: Literature Review and Relevant Research on Decentralization and Co-operative Governance: Shedding Light on the Conundrum 26
Chapter Three: Research Design and Methodology 26
Chapter Four: Geographical, Political and Economic Environment of the Public Finance and Health Sectors 26
Chapter Five: Decentralization and Co-operative Governance of Public Health Policies 27
Chapter Six: Decentralized Co-operative Governance of Public Finance of Policies: Principal-Agent Relations 28
Chapter Seven: - Review of Public Health Revenue, budgets and expenditures within the Provincial Government 29
Chapter Eight: Decentralization and Co-operative Governance between Central and Provincial Governments - Imposed Co-ordination or Inclusivity through Provincial Budgets and Expenditures 29

CHAPTER TWO: - LITERATURE REVIEW AND RELEVANT RESEARCH ON DECENTRALIZATION AND CO-OPERATIVE GOVERNMENT: SHEDDING LIGHT ON THE CONUNDRUM.....31

Introduction 31

The design of the conceptual framework.....31

The public policy trajectory.....34

Levels of policy-making 37

Systemic, programmatic, organisational, and instrumental levels of policy-making 37

Policy as text production.....40

Policy as practice 42

Decentralization and Co-operative Governance.....43
Models, Forms and Dimensions of Decentralization.....46
Institutional environment and arrangements 49
The principal-agent relations, decision making and accountability.....61
Revenue, Budgets and Expenditure.....69

Summary on literature review and relevant research on decentralization and co-operative governance 74

Conceptual Framework on Decentralized Co-operative Governance 77
The configuration of the conceptual framework.....84
a) Institutional Environment.....84
b) Principal-agent relationships, decision making and accountability.....86
c) Revenue, budgets and expenditure 89

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY 93

Introduction 93

Researcher as participant in data construction and review.....93

Design of Study 95
Decision- making space analytical approach.....96

Research Approach - Public Expenditure Review.....101
Assumptions of the PER.....102

National Health Accounts Model as a Public Expenditure Review Approach.....105

Overview of revenue and expenditure data collection.....109

Data Collection Techniques 111
Research Sample and Expert interviews – Senior Public Service Policy Managers 111
Semi-structure Interview Schedule.....113

Method of Data Analysis.....115

The Case Study and Limitations of Research Methodology **115**

Chapter Summary **117**

CHAPTER FOUR: PUBLIC HEALTH SYSTEM CONTEXT FROM A PUBLIC POLICY PERSPECTIVE: – DEMOGRAPHICS; POLITICAL AND ECONOMIC CONTEXT PUBLIC POLICY 118

Introduction **118**

The national context of South Africa – geography, demographics and health context **118**

National Political Context **120**

Macro-economic and Fiscal Context **121**
Fiscal Governance and Regulatory Context 125
History of public health governance 128
Constitutional reform and its influence on decentralized co-operative governance of the public health system 131

Chapter Summary **133**

CHAPTER FIVE - DECENTRALIZED CO-OPERATIVE GOVERNANCE OF PUBLIC POLICIES: DECISION-MAKING AND ACCOUNTABILITY 135

Introduction **135**

Public policies impacting on the public health system **137**
Transformation of the Public Health System 139
The role of central and provincial governments in the policy process 143
Post-apartheid policies in the transformation of the public health system and expansion of services 146

Hospital Strategy Project, 1996 ..... **148**
Implementation of Hospital Restructuring through Public Financing 152
Table 5a: Adaptation and Application of the Decision-making Space Functions in the Hospital Strategy Project 157
Total Decision-making Space 158

White Paper for the Transformation of the Health System in South Africa, 1997 ..... **159**
Table 5b: Adaptation and Application of the Decision-making Space Functions in the White Paper for the Transformation of the Health System 164
Total Decision-making Space 165

A Policy for the Development of a District Health System in South Africa, 1996 ..... **166**
Table 5c: Adaptation and Application of the Decision-making Space Functions on the Policy for the Development of a District Health System 171
Total Decision-making Space 172

National Health Act, No. 61 of 2003 ..... **173**
Table 5d: Adaptation and Application of the Decision-making Space Functions in the National Health Act, 2003 183
Total Decision-making Space 184

2000-2005 HIV/AID/STDs Strategic Plan for South Africa, 2000 ..... **185**
Total Decision-making Space 192

Conclusion **193**

CHAPTER SIX: DECENTRALIZED CO-OPERATIVE GOVERNANCE OF PUBLIC FINANCING OF POLICIES: PRINCIPAL-AGENT RELATIONS 202

Introduction **202**

Background on the financing of public health **203**

Overview of revenue and expenditure data collection **205**

Public Health Financing **206**
Provincial equitable share 210

Costed norms approach in public financing of provinces **216**
Health component of the provincial equitable share 218

Contesting the equitable share **221**
The Division of Revenue – The Vertical Division Policy Practice 226
Role of conditional grants as a funding mechanism for public health 232
Gross Domestic Product and Real Expenditure of Public Health 240

Regulatory Framework for Budgeting and Expenditure **248**

Provincial health expenditure by selected programmes **252**

Expenditure by Health Programme **255**
Expenditure Trends in Health Programmes – connecting with public health policies and national priorities 256

Conclusion **265**

Chapter Summary **267**

CHAPTER SEVEN - DECENTRALIZED CO-OPERATIVE GOVERNANCE AT PROVINCIAL LEVEL: REVENUE, BUDGETS AND EXPENDITURES 268

Introduction **268**

Eastern Cape Province - Health Service Expenditure **268**
Expenditure by health programme 268
DHS 271
EMS 273

Free State Province - Health Service Expenditure **274**
Expenditure by health programme 274
DHS 276
EMS 280
PHS 280

Gauteng Province - Health Service Expenditure 281
Expenditure by health programme 282
DHS 283
EMS 284
CHS 288
HFM 290

KwaZulu-Natal Province - Health Service Expenditure 291
Expenditure by health programme 292
DHS 292
EMS 296
PHS 296
CHS 298
HFM 299

Limpopo Province – Health Service Expenditure 299
Expenditure by health programme 299
DHS 300
EMS 301
PHS 302
CHS 302

Mpumalanga Province – Health Service Expenditure 305
Expenditure by health programme 305
EMS 307
HFM 309
DHS 309

Northern Cape Province – Health Service Expenditure 310
Expenditure by health programme 310
HFM 311
DHS 312
HIV and Aids Programme 313
EMS 314
PHS 316

North West Province - Health Service Expenditure 317
Expenditure by health programme 317
DHS 318
EMS 320
PHS 322

Western Cape Province - Health Service Expenditure 323
Expenditure by health programme 323
Central Hospital Programme 325
DHS 325
Central Hospital Programme 327

Conclusion 329

CHAPTER EIGHT – CONCLUSION: INTERACTION BETWEEN DIFFERENT PUBLIC POLICIES - IMPOSED CO-ORDINATION OR INCLUSIVITY THROUGH WITHIN THE PUBLIC HEALTH SYSTEM 332

Introduction **332**

Implications for decentralized co-operative governance within unitary public health system **337**
Findings from the Study 340

Implications for future research **351**

REFERENCES **354**

APPENDICES **369**

Chapter One: Decentralized Co-operative Governance of Public Policy: - A Conundrum Worth Solving?

Introduction

From the time he was appointed Finance Minister, Mr. Trevor Manuel has tabled the South African Budget every year in the month of February as a single government macro-economic and fiscal policy document. This document is to give effect to various fiscal and service delivery policy priorities but also to stimulate macro-economic growth and development including, where appropriate, changing the fiscal structure of services and the introduction of a range of social policy changes. Manuel's budget speech also confirms the government as a single entity. But, whenever he presents his annual Intergovernmental Fiscal Review, he always asks – *is our inter-governmental system working?* In reality, the management and governance option of decentralization has not only been in vogue but has also become popular within public fiscal and health policy reforms.

While this statement raises questions of the relationship between the central and provincial governments, I have often wondered if Manuel is paying lip service to the inter-governmental system. Is he questioning the status quo of the central-provincial government relationship, or being cynical? Is he confirming that there is only one government and the provinces are simply extensions? Could he also be confirming the constitutional existence and competencies of provinces relative to the central government? The different ministers responsible for health and social development have also respectively mentioned in public forums, especially when laying out the annual 10 point multi-year plan for its specific sector, that they have a national department and provincial departments that will deliver on their plans. This statement particularly reflects an understanding of a single government and a department with nine geographically based sub-national departments. These complex intra- and intergovernmental relationships are at the heart of this dissertation.

This chapter outlines the research context and questions that inform the examination and analysis of public policies, i.e. finance and health, that enter the decentralized co-operative governance public health system in South Africa.

Decentralized co-operative governance in the public policy process

The decentralized co-operative governance system conditioned and regulated by the South African constitution (Republic of South Africa 1996) is of critical importance for policy design and implementation. The country's constitution provides for the division of powers and authority within the unitary form of government. Decentralized co-operative governance of fiscal and health responsibilities has emerged as a primary objective of the constitutional, unitary national government within South Africa, particularly between the central and provincial governments and the public finance and health sectors. Yet there is little empirical evidence on the potential benefits of this structural and functional intervention on public policy process within the public service. This dissertation explores these public policy processes and policy texts using the public finance and health systems policy and finance as a lens. Public health is a concurrent function of the central and provincial governments, thus making both the central and the lower levels, which are nine in total, responsible for the public policy process in the public service.

The public health system is the case study to explore public policy processes that take within in the public service between the central and provincial governments and the between the public finance and health sectors. The public health system is of critical importance and serves as the context for studying the design, financing and implementation of public health and financing policies. The case study is the lens through which public policy processes are examined in the decentralized cooperative governance system.

The dissertation is not *per se* about the public health system, but is rather a review and an analysis of how the decentralized cooperative governance government system influences the public policy processes and, by implication, the public health system. The dissertation suggests that the positive effects of decentralized co-operative governance on the public policy process are greater where the institutional environment allows for co-operative public policy-making; where principal-agent relations are clearly defined; where location of decisions and accountability arrangements allows for the promotion of autonomy, partnership and interdependence between levels of governments and different sectors; and where a confluence exists of public finance and fiscal policies on the one side and public health policies on the other.

The author's 11 years experience in public policy design and implementation has revealed that public policy decentralization in co-operative governance system is a contested terrain. As such, decentralized co-operative governance may not only constrain the policy processes between levels of government, but also between the different sectors. On the other hand, decentralized co-operative governance has the potential to create co-ordination channels between the sectors and the levels of government. While a number of national and international studies (Ter-Minassian 1997; Bossert 2000; 2002; and Collins and Green 1994) have helped to understand the positives and negatives of decentralization, the magnitude of its impact on the policy processes, compounded by the constitutional imperative of co-operative governance, remains unquantified.

In their attempt to unbundle the health function, but also reform the public health system, central and provincial governments have introduced a number of reforms. These reforms outline structural and functional responsibilities and authority among the central and provincial government departments. While the reforms contributed towards influencing the institutional arrangements of the public policy processes within the public service, the design and implementation of policies were at times based on different interpretations of responsibilities and authority between the central and provincial governments and the different public sectors. According to Hanekom (1987: p20), cited in Cloete, Wissink and de Coning (2007: p31):

> An initiative for public policy making is derived from legislative institutions, public officials and interest groups. Other sources of information pertaining to public policies are the Cabinet, select committee, the Caucus and commissions of enquiry. The political office bearers, the ministers of state and the appointed public officials are, however, the most important participants in the policy-making function: the ministers because of being appointed by the State President to administer the state department(s) assigned to them, and the public officials because of their expert knowledge, as career officials, of the issues dealt with in specific departments. Public officials, especially at the top and middle levels, act as advisors on policy, policy formulation and policy implementation (execution), and also as policy monitors, i.e. comparing results with intentions.

These interpretations attached different meanings to the policy design and content – therefore, making the policies contested within the public health system. This dissertation explores the nature of the relationship between the central and provincial governments by

exploring co-operative governance in the health sector on policy and financing processes and mechanisms. The central question is how decentralized co-operative governance on policy in the public service really works in the public health system.

Proponents of decentralization from the time decentralization first became a top debate, emphasise the role of lower levels of government in providing differentiated public goods in response to heterogeneous preferences (Tiebout 1956; and Oates 1972). According to Oates (1993), decentralization of government is driven by the theorem that each public service should be provided by the jurisdiction having control over the minimum geographical area that would internalise the benefits and costs of such provision. Within both the public finance and health sectors, decentralization of finances and responsibilities within the public health system has emerged in the agenda of national governments and international organisations. Khaleghian (2003:2) mentions that "…devolving some of the centralized responsibilities to local levels is expected to improve both technical efficiency and allocative efficiency." The decentralization of the provision of the health system and services is based on the belief that lower levels of government will utilise resources more effectively. It is hoped according to Jack (2000: p1), that

> …lower level autonomy over health care provision can lead to enhanced allocative efficiency (better matching of services provided to those required/demanded) and to greater production efficiency, such as by ensuring compliance by providers with government requirements (e.g., showing up for work).

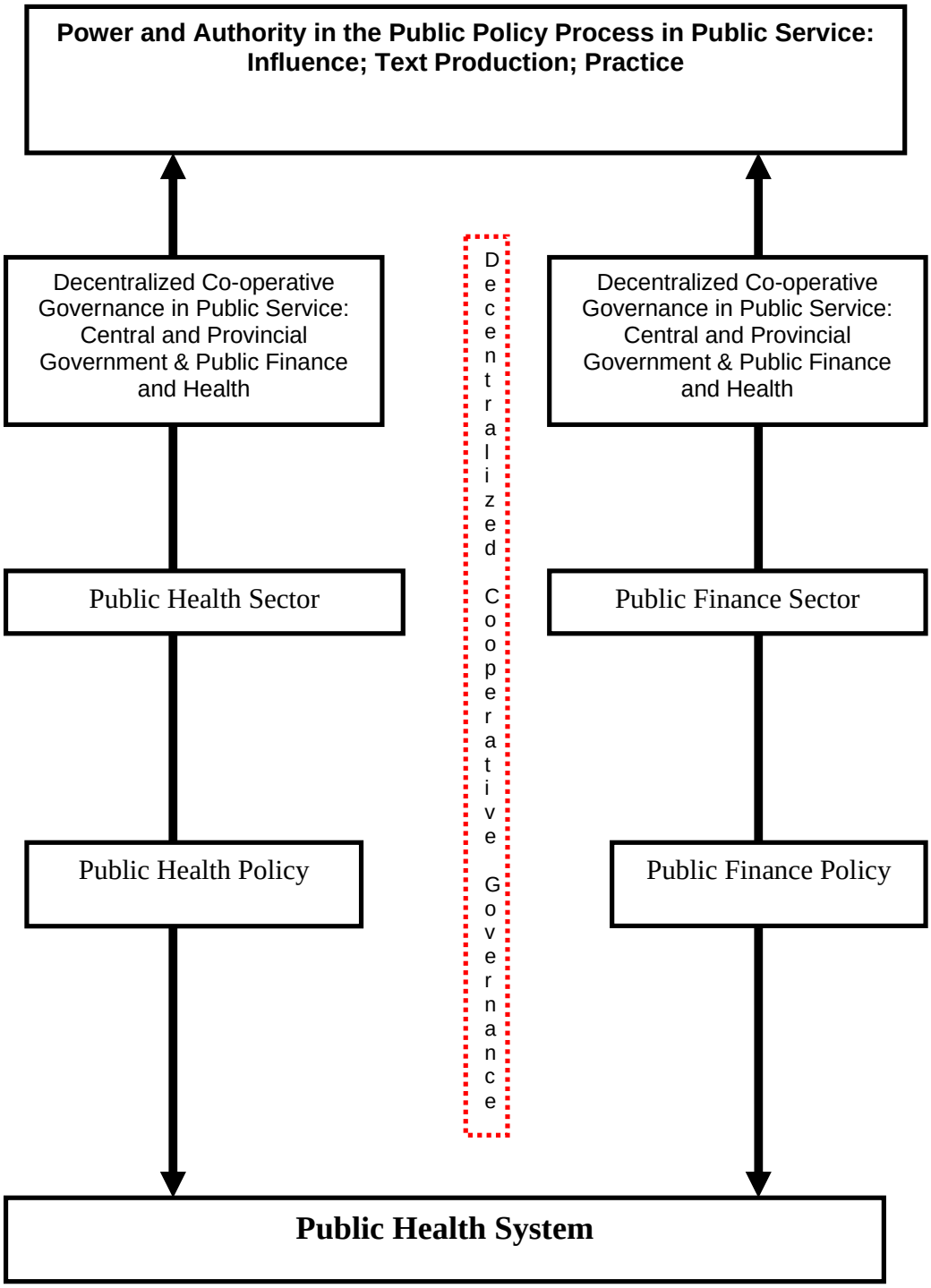
In order to achieve both allocative and productive efficiencies, closer collaboration and collegiality are required within the public policy processes to avoid a mismatch between the finance and fiscal policies and the health policies that impact on the public health system.

The arguments are also that the centre exercises a great deal of power through fiscal control (Das Gupta and Rani 2004) based on competition across jurisdictions and informational disadvantages at the sub-national governments (Khemani 2001), especially on policy control and implementation management and resources. Khemani (2001) suggests that a more political economy analysis of the incentives in the public sector has placed political accountability at the crux of the debate on decentralization. Litvak and Seddan

(1991) mention that decentralization as a set of policies that encompass fiscal, political and administrative changes can impact virtually all aspects of development.

Decentralization is defined within this dissertation as the presence of public policy responsibility and regulatory authority; decision making and accountability; and budget, revenue and expenditure responsibility on the part of the provincial government. More concretely, decentralization is about the distribution, allocation and transfer of power and authority between the levels of government. The power and authority are over public policy making, resources, decisions and service delivery. “Power and authority” refers to the competencies, exclusive and shared, which are distributed, allocated and transferred either through or both the constitution and legislative system (Bahl 1999; Dilinger and Fay 1999; Shah 1999). Both the constitutional and legislative systems formalise decentralization, thus making decentralization a rule-bound system. The constitutional and legislative systems also set the framework for a rule-bound governance system.

Figure 1.1: Power and authority in the public policy process in the public service: influence; text production and practice



The practice of decentralization is not only influenced by national and regional political contexts, but also the macroeconomic and fiscal policy frameworks. The rule-bound nature of the decentralized system, political context and the frameworks condition the environment, practice and system of decentralization. The conditionalities regulate the public policy interactions, decision making, accountability for policy implementation, service delivery and the management of fiscal resources between levels of government.

South Africa has a constitutional unitary system of government and state. The unitary system comprises sub-national governments: provincial and local. The constitutional decentralized unitary system, as a form of legal decentralization, locates authority to a level of government either over the whole or part of a public policy process without the diminution of central functions or prerogatives (Furniss 1974). This allocation of responsibilities means that each sphere has different authority and power. The practice, processes and system of decentralization are made more complex by a constitutional obligation of co-operative governance between the different levels of government. Co-operative governance requires the levels of government within the unitary system to operate in partnership with each other, even though the governments are autonomous and interdependent, especially regarding shared or concurrent competencies. The system of co-operative governance encourages co-ordination, partnerships and consensus between the different spheres of government (Pimstone 1998). The primary intention is to hold together the central and sub-national governments in pursuit of promoting and protecting the unitary system. Co-operative governance also has an in-built qualifier that any public policy made by the central government that affects and impacts on the competencies of the provinces must be developed in unison with the provincial administrations and governments.

The policy process and practice allows for the different sectors to develop their policies involving the central and provincial governments. For example, when the public health sector in the public service intends to develop a policy, especially when it has an impact on provincial competencies and responsibilities, the central government department managing the policy process is obligated to carry out province-wide consultation. Figure 1.1 shows the public policy process driven by delegated authority that is factored into the sector-specific policy processes; and devolved power, which is constitutional in terms of the autonomy of provinces and interacts with and impacts on the public health system. The assumption is that different sectoral and provincial-interest and resource-allocation authorities influence

and drive the public policy text-production processes. At a policy practice level, these influences which might be of common or conflicting nature, even if tentatively resolved, continue to influence the policy outputs and nature of the requisite policy inputs at the level of the public health system. The figure also assumes that during the sector- specific policy processes, interaction takes place between the sectors and the levels of government and that the final public policy, either for public finance or health, interfaces at the public health-system level. The public health system is considered as the context of public policy practice within the public service.

The public policy consultation that takes place includes the provincial departments of health and is followed by consultation with the provincial and central government departments responsible for public finance and fiscal policy. A similar policy process practice is followed within the public finance sector, especially when the components and elements of the fiscal policy have a direct impact on the provincial governments and both the central and provincial government health sectors. However, the reality within the fiscal and public finance and health processes is that the added effects of these public policies are only felt and observed when they enter the public health system. This is because of the varying power and authority of the sectors and the central to provincial government during the public policy consultation processes. The effects are also felt when the different sector-originated specific policies either converge or are in conflict with either the macroeconomic and fiscal policy trajectory or the expansionary, equity-driven public health policies within the public health system. The effects of the policies have the potential to contribute to a classical disjuncture between policy design and policy as resourced.

The concern of this dissertation is the effects of decentralized and co-operative governance and the dynamics and processes related to public policy processes on public finance and health. The decentralized public policy process within the public service has components and elements of both devolved and delegated competencies and responsibilities. The concern is how these decentralized components and elements within a broadly decentralized co-operative governance system interact in the production of policy on the public health system within the public service.

The dissertation also investigates how the public finance policies and public health policies interact and influence the configuration of the public health system. Both concerns are

premised on the understanding that the public finance sector led by the treasuries and the public health sector led by the departments of health have distinct but complementary policy mandates, which are interdependent. These policy mandates are also premised on the assumption that each of the sectors has different incentives to promote and protect the unitary public health system. It is at this intra-governmental or intersectoral level where there is a contestation between the sectors about the policy process, outputs and systems.

Similarly, given the integrated, but competing competencies within the mandates of central and provincial governments within the concurrent functions, a different set of incentives drives decentralization and co-operative governance in order to avoid any distortions within the public service delivery and financing industries or markets. At the consolidated central and provincial government levels, competing and complementary priorities and mandates, the policy processes and outputs of the different sectors are considered equal to those of other sectors. There is a one dimensional look at central and provincial government at public policy processes, which is different to the intra-sector or bilateral policy interaction between sectors. It at this intergovernmental level that contestation exists on the public policy processes and systems.

The intergovernmental and intrasectoral contestation in the public policy process requires exploration and analysis of: the institutional environment; principal-agent relations; decision making and accountability; and budgets, revenues and expenditures. These factors have an implicit connection between the decentralized and co-operative governance environments within the public policy process. The literature shows that decentralized co-operative governance environment are shaped by the institutional environment, the relationship between central and provincial governments and sectors, decision making and accountability; and revenue, budgets and expenditures.

This examination and analysis of factors that shape the decentralized co-operative governance system is for the purpose to predicting the likely consequences of the decentralized co-operative governance processes on the public policy process. Also, if the public policy process that unfolds between the central and provincial government and the public finance and health sectors is accepted as proxies of other concurrent public services, the analysis could illuminate the broader effects of decentralized co-operative governance on public policy processes within the public service. Co-operative governance, in principle,

is predicated on the common goal of agreed and inclusive public policy making in determining priorities of national[1] interest delivery priorities.

Co-operative governance in the context of a unitary decentralized system recognises the collegiality of policy development, decision making and resource allocations especially between the sectors. An appealing argument in this vein is that power and authority are vested equally in each of the sectors. Jones (1997) suggests that for collegiality to occur there must be awareness of the different strengths of each government sector and between the levels of government in order to capitalize on them; and a willingness to learn from one another, trust one another, treat one another with respect and courtesy, and to behave ethically or in terms of the rules of the system (Jones 1997). It is at a vertical level of the policy processes within the public service where there is recognition that there are different levels of power and authority as an outcome of the configuration of the unitary decentralized government and state. Collegiality within the system is built on decentralized competencies, collaborative public policy processes and constructive co-operation between the sectors and levels of government.

In this dissertation, I argue that the ongoing changes in the decentralized co-operative governance system are better understood as instances or factors of institutional and organisational learning; principal-agent relations; of decision-making and accountability; and of revenue, budgets and expenditures in response to the limits of a evolving constitutional governance system and a unitary government in transition.

Decentralized co-operative governance in this dissertation is defined as the presence of collegiality in the public policy process within and between the central and provincial governments and the different sectors in pursuance of the benefits of decentralization and co-operative governance. This type of governance recognises varying powers and authority on public policies, decisions and accountability, and public resources within the public health system between the levels of government.

[1] National in this dissertation refers to all nine provinces and the central government and cuts across provincial boundaries.

Primary and Secondary Arguments

The dissertation argues that the South African constitutional intentions of co-operative governance within a unitary and devolved decentralized system are to create harmony, uniformity and standardisation within the public health system. The underlying assumption is that co-operative governance will lead to policy design and implementation cohesion between central and provincial governments and between the public finance and health sectors within the public health system. However, the nature and extent of the form and practice of decentralization within the governance system, the policy design and implementation processes within the public finance and health sectors, and the revenue distribution and expenditure practice have led to a variation in the interpretation and execution of responsibilities and authority between central and provincial governments and public finance and health sectors. This variation has also contributed to tensions between central and provincial governments within the public health system. This tension, it is argued, undermines co-operative governance and the possibility of health reform and effective financing and management of service delivery.

The central argument of this study is that public policy implementation within the co-operative governance system is not only contested at a central government level within the public health sector, but also within and between levels of government and sectors.

The overall contention of this study is that the functional and structural decentralization of policy making has contributed to the undermining of the co-operative governance relationship between the public finance and health sector and central and provincial governments. Moreover, it has contributed to central government using its overriding powers to impose coordinated solutions to problems leading to situations where imposed co-ordination is disguised as co-operative governance. As a result, pressures have been building to change the governance arrangement. These pressures lead to three sets of dynamics and outcomes between the spheres and sectors: a) Tensions between central and provincial government regarding an interpretation of shared responsibilities for public health; b) a contested policy implementation process that leads to different and incompatible public health and finance policy outputs; and c) an emerging inverse relationship between central and provincial governments within the public health and finance sectors. These are discussed below.

a) Tensions between central and provincial government regarding an interpretation of shared responsibilities for public health

The contention here is that the horizontal and vertical articulation of common and varied policy interests between the spheres of government and within and between the sectors gives rise to the notion and practice of co-operative governance becoming a contested terrain. This study argues that the common and varied policy outlooks of different sectors and between central and provincial government produces a system of functional (public finance and health) and structural (between the different levels) decentralization. Given the functional and structural decentralization process operable within the co-operative governance system and the prevalence of both common and varied policy considerations and interests, co-operative governance has also produced alliances, which vary from strong to fragile depending on the policy intentions, despite the 'intention and spirit' of the constitution and the nature of a unitary state. Co-operative governance has in many instances led to central and provincial departments of health openly revolting against the treasury's fiscal and finance policy positions on hard budget constraints on public expenditure. In other instances, it has also led to a provincial government being the collective entity for both health and treasury and questioning the validity of a national policy decision taken by the central government departments of health and treasury. This occurs especially in instances where the financial implications and the resourcing levels of a public policy have not adequately been analysed and evaluated for a specific province relative to others. It is therefore conceivable that alliances on policy design and implementation might exist within functional areas (public health or finance) and respectively, but independently across the sectors at a central and provincial governments level.

b) A contested policy implementation process that not only leads to different and incompatible public health and finance polices outputs

The contention is that national policy decisions take place at a central government level for implementation at provincial level. This has contributed to variations in the outputs of implementation processes that intersect public finance and health policy decisions. This study argues in dealing with the policy trajectory that the policy design and implementation processes or practices have contributed to the financing of public policy decisions for

implementation in a way that does not necessarily contribute to strengthening of co-operative governance within the public health system.

c) An emerging inverse relationship between central and provincial governments within the public health and finance sectors

The principle of decentralized co-operative governance is operationalised through the allocation of concurrency powers between the central and provincial governments and sectors. The co-operative decentralized public policy process within the public service has the primary intention of ensuring a seamless public policy process that allows for different sectors to influence each other's policy texts, including the implementation of the text. However, the public policy processes and practices in the decentralized co-operative governance system have, particularly on concurrent competencies such as health, created tensions within the public health system. This reality has contributed to the contestation of the functional and structural configuration of decentralized co-operative governance.

Given the location of fiscal responsibility and authority and compliance requirements within the context of macro-economic stability and hard budget constraints on the part of central government, it is the contention of this study that an unequal relationship favouring the public finance sector exists between the central and provincial government. This, the dissertation argues, has undermined the fiscal policy decision-making and autonomy of provinces in the distribution of budgetary allocations in the overall scheme of public health financing. Moreover, the co-operative governance system in conjunction with the decentralised government strategy confirms a stronger link between the kind of macro-economic policy pursued by the central government and the fiscal resource space undertaken to implement both public finance and health policies. The dissertation also argue that this policy link has contributed to an uneasy relationship between sectors; that is, between those responsible for public finance policy and expenditure allocations, essentially treasuries, and those responsible for public health policy making and implementation, the health departments.

The knowledge and perspectives of the general direction, assumptions and characteristics in the theory and practice of decentralization – governance, public policy, public finance and health functions and systems – serves as a framework for making qualitative judgements of

the extent of policy design and implementation. The decentralization theorem also provides a basis for a framework to review and analyse the public policy structures, processes and mechanisms in a decentralized co-operative governance system. The conceptual framework provides the context of the review and analysis of policy processes – that is, policy design and implementation. This review and analysis are instructive in the analyses in a unitary decentralized co-operative governance system.

This dissertation leads me to conclude that the South African practice of co-operative governance in the health system is actually imposed co-ordination and that provinces are de facto administration outposts of central government policies, programmes and service delivery responsibilities. Therefore, in reality, there is no autonomy and independence of the provinces from the central government as envisaged in the Constitution of the Republic of South Africa. In fact, provinces only exist, in terms of their constitutional competencies, as far the central government allows them to exist given its plenipotentiary powers over both micro and macro matters affecting institutions, fiscus and social policies.

The conceptual framework argues that the public policy process within a decentralized and co-operative governance system is a dynamic process of incremental and continual change and growth, with each change being informed by the interactions and dynamic balance achieved between the different factors. This point of dynamic balance will be tested throughout the dissertation, is central to the conceptual framework and, therefore, will be a major focus of this study.

In seeking to understand what happens in a decentralized co-operative governance system within the policy domain in the public service, it is necessary to examine the factors that promote sound governance and a sound relationship between central and provincial governments and the verifying competencies for the different sectors within the public health system. The ongoing development and practice of decentralization and co-operative governance appear to constitute a precondition for the public policy process and content, given the different interrelated factors. The practices of decentralization and co-operative governance systems are referred to in this dissertation as ‘decentralized co-operative governance’. The conceptual framework discussed in the next chapter shows the interdependent relationships of the factors within decentralized co-operative governance system: institutional environment; principal-agent relations; decisions and accountability;

and revenue, budgets and expenditures. These factors and their relationships with the policy processes are tested in this dissertation.

The constitutional unitary system within South Africa promises a devolved decentralized system of government. The constitution creates a devolved system comprising three levels of government to co-operate within each other on concurrent or shared competencies. The three levels of government are central, provincial and local government. The constitution imperative is that these three levels of government, while interdependent and autonomous, must work in partnership with each other. The obligations associated with co-operative governance include: cooperation with each other in mutual trust and good faith by fostering partnerships; informing and consulting each other on matters of concurrent interests; co-coordinating actions and legislation and avoiding legal action against others (Republic of South Africa 1996; Pimstone 1998; and Department of Provincial Affairs and Constitutional Development 1998).

In this study co-operative governance is considered as a mode of governance where the central and provincial governments participate and co-operate in a more or less durable mix of public finance and health policy networks, in which the definition, formulation and implementation of public policies are dependent on the outcome of a process of meaningful consultation, negotiation, exchange and communication. This study also assumes that the main thrust of co-operative governance is about the ability to manage within a unitary, but quasi-federal, system the processes of centralization and decentralization. In addition, decentralized co-operative governance is about:

a) Inclusive and integrated public finance and health policy making and implementation in the public health system between the sectors and central and provincial governments;
b) Cooperation between sectors and levels of government to address the classic problem of optimum demand and supply of public services, programmes and resources; and
c) The demarcation of competencies with respect to public policies and programmes between sectors and spheres of government, both horizontal and vertical.

Co-operative governance is perceived as not only “the only means by which government resources can be harnessed in an integrated and coherent manner so as to address the social and economic needs” (Pimstone 1998:8), but also as the means of harmonising

different policy orientations and perspectives. Furthermore, the notion of decentralised co-operative governance is that the propensity for conflict between the central and provincial governments, as an outcome of competing interpretations on public policy and public resources, can only be contained and overcome through and within the context of co-operative governance.

Firstly, decentralized co-operative governance system has either facilitated or impeded structures or processes of interaction between the different spheres of government to regulate public and private goods. Secondly, it has created policy and decision-making dialogue on matters of public interest such as governance, location and competencies of function and public policies specific to a particular sector. Thirdly, the constitutional ideal of co-operative governance has also systematically reinforced a perception that the different instruments and mechanisms, essentially legislatures and departments, of spheres of government, though autonomous, operate in unison with each other in the context of exclusive and shared competencies.

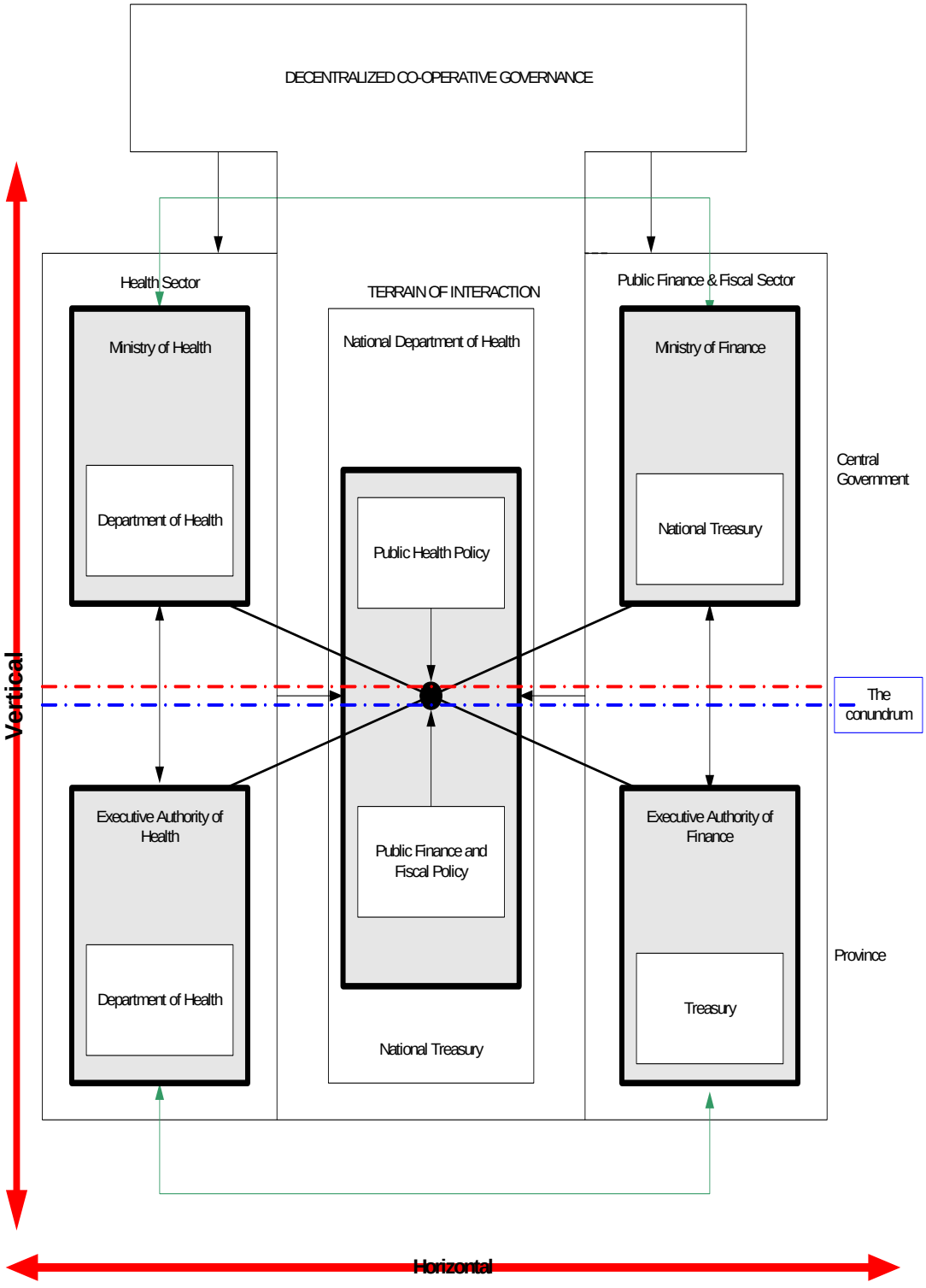
Research Problem Statement – Elements of a Conundrum

The public finance and health policies, including the different sector-specific programmes, have introduced since 1996 a number of new governance, policy and financing arrangements of both a structural and functional nature within the public health system. These policies, in the context of public health as a shared responsibility between central and provincial governments, have introduced a new dynamic to the health function and services in the public health system. This has led to different interpretations of responsibility and accountability for content, implementation and resourcing of health. At an operational level this decentralized co-operative governance system allows for policy design and implementation between the different levels of government and between sectors. Co-operative governance encourages partnership, uniformity, standardisation and harmonisation within and between the provincial and central governments and within and between the public health and finance sectors. However, within the arena of policy process and practice the differing competencies have led to vertical and horizontal separation and integration of the public policy processes within the public health system.

Autonomy and interdependence in the public policy processes in South Africa have led to varying interpretations of intent of public policies. The different policy processes and outputs from the public finance and health sectors, this study argues, have contributed to an environment where there is not only an unfettered autonomy but also a gradual mandate creep within the public health system from either the public finance or health sectors. The collective and compounding effects the level of government and sector autonomy and interdependence have led to mandate shifts and scope creeps by either the central and provincial governments or the public finance and health sectors. These dynamics have not only led to structural and function facilitators and impediments of effectively operationalising the decentralized co-operative governance system but also to an undermining of the overall system.

This dynamic of policy autonomy and interdependence has led, it will be argued to the existence of a conundrum within the decentralized co-operative governance of the public health system (see Figure 1.2 below). This conundrum is firstly a result of the nature of decentralization that characterises the functional and structural location of responsibilities, and, secondly, the nature and practice of the unitary state and government and its imposition on what constitutes decentralized co-operative governance. An initial analysis of the location of the health function suggests that only the public health sector – that is, different ministries and departments of health – are responsible and accountable for the health function within the public service. However, given the institutional functions, which consist of regulations, financing, articulation and production, even though the public health sector is primarily responsible for health services, the overall responsibility for the public health system is not that of the public health sector alone. The different levels of government as a block and the public finance sector have a considerable and sometimes decisive influence on the public health system, through policies and resource allocations. The responsibility for the overall health care system is a shared competence between the public finance sector - the treasuries and public health sector and provincial and central governments.

Figure 1.2: Decentralized Co-operative Governance within the South African Public Health System



The mandate drifts complicates not only authority over certain parts of the function but also, in practice, policy design and implementation. Vertical public policy articulation takes place between central and provincial governments within a function or sector, for example, national treasury to provincial treasury or national department of health to provincial department. Horizontal articulation happens between sectors or functions at a central level and at a provincial level, for example, National Treasury to the national Department of Health and from provincial Treasury to provincial Department of Health.

How structures of intergovernmental relations interact between and within public health and finance sectors

The varying interpretations of public policy responsibility and articulation, as shown in Figure 1.2 show the vertical and horizontal process of interaction between central and provincial governments on sector specific matters. The interaction, as illustrated in Figure 1.2, takes place in the manner described in the paragraphs that follows.

a) As a result of the shared responsibility for policy, implementation and monitoring between central government and provinces, policy articulation takes place within and between the finance and health sectors and between the levels of government. However, the interaction between the sectors does not of necessity make it an approved public policy. This policy gets further deliberated on in the central and provincial governments, where the sector where the policy originates from is merely another policy player. It is here, that the sector's autonomy and authority on public policy is further contested relative to the policies and priorities of other sectors within the public service.

b) Within the public health sector interactions on policy, governance and management, performance, on service delivery and financing take place between the political principals (Minister and the nine members of the Executive Council) and senior public officials (heads of departments). Within the public health sector these structures are referred to as a 'MinMEC' (Minister and Members of Executive Council) and Provincial Health Restructuring Committee (PHRC), which comprises the heads of departments of health called the Public Health Restructuring Committee. The political structure is responsible for policy decisions while the technocratic structure gives policy advice,

influence, and text production. The structures interact on the national public health policy framework, service delivery and administration and management of the public health system

c) In a similar way, within the public finance sector, policy articulation will take place between the political principals (Minister and the nine members of the Executive Council, officially named the Budget Council) and senior public officials (heads of departments). The political structure is responsible for policy decisions while the technocratic structure gives policy advice. The structures would interact on the macro-economic policy framework, public finance and fiscal policy, especially on social-service spending such as: public health; the management and governance of the public finance system; division of revenue between the different levels of government and any matters related to budgets and expenditure management within government and the different sectors such as public health.

d) Horizontal articulation happens between the structures at central and provincial government level, where credibility and feasibility of a particular policy are tested between the provincial counterparts (provincial health departments and treasuries) and likewise between the central government counterparts (National Treasury and Department of Health).

e) Formal and structured interaction also takes place between the public finance and health sector ministries and respective treasuries and departments of health. The forum of the public finance and health sectors interaction called the 10x10 (central government department and nine provincial departments), further amplifies the integration of responsibility for the function, but also the interconnectivity between the sectors to ensure closeness between finance and health sectors within the health function and system. This forum is responsible for public policy, policy priorities, expenditures and service-delivery trends in public health system. The discussions drive policy articulation, which is about the “organisation and management of care consumption and involves the key activities that follow financial resource flow to the production and consumption of health care” (di Gropello 2002:2). This form of interaction is a measure of decentralized co-operative governance and management between the sectors and central and provincial governments. Depending on who one ‘talks to’, the forum is also considered

as both a reporting and accounting session of the public health sectors', and provincial governments', performance to the treasuries.

f) The National Treasury's quarterly monitoring and supervisory meeting with the provincial government, particularly the provincial treasuries and departments also allows for a monitoring and supervisory role on both the provincial treasuries and health departments. This interaction allows for a direct engagement between the provincial health departments and the National Treasury to discuss the health departments performance against central government policies and programmes, management and administration of finances, service-delivery trends, and overall consumption of health care. The same type of interaction between the central government health department and provincial treasury is non-existent.

Despite Figure 1.2 showing a number of permutations of interaction that might take place between and within the public health and finance sectors to realise the ideals of decentralized co-operative governance, contestation occurs on public health policy and the resourcing of certain policies. For example, during the 2003/04 fiscal year, the provinces of KwaZulu-Natal and Western Cape publicly refused to implement a central government Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV and Aids) policy against the rollout of the anti-retroviral drugs. Clearly, given the co-operative governance imperative, a multi-variant and complex web of policy formulation and implementation articulations exist between the levels of government and line functions.

Purpose of Study

The purpose of this study is to investigate the manner in which the decentralized co-operative governance system influences and shapes public policy implementation within public health system in South Africa. At a secondary level, the research study intends to:

1) Examine decentralized co-operative governance between and within the central and provincial governments and the public finance and health sectors within public health system;
2) Analyse the interconnectedness between public health policy pronouncements and intentions and budgetary allocations; and

3) Comment on possible strategic and operational matters that may improve the interaction between public finance and health policies within the co-operative governance system.

Public Health System as the Case Study

The study uses a case study method. The public health system is of critical importance and serves as the arena and context for studying the design, financing and implementation of public health and financing policies. The case study is the lens through which policy design and implementation are examined within a decentralized and cooperative governance system.

The study is not about the public health system but is, rather, a review and an analysis of how unitary, decentralized cooperative governance influence and condition the policy processes and practice in the public service and, more specifically, in and between the public finance and public health sectors, separately and collectively within the public health system.

The study also focuses on how the sector-specific policies and the interaction between the levels of government not only influence what happens in the public health system, but also how the different factors mentioned above contribute to or impede the decentralized co-operative governance policy processes and the resourcing implications of the different policies.

Significance of the Study

Decentralized co-operative governance within and between the central and provincial governments and public finance and health sectors is viewed both from constitutional and governance perspectives as essential in optimising the link between policy intentions and what is eventually implemented and financed. Policy implementation within the decentralized co-operative governance context has placed more emphasis on joint public health policy statements between central and provincial governments, yet little attention has been paid to the public policy processes, dynamics and production of policy text and resource practice within the public service.

The exercise of the division of policy process responsibilities within the public service has raised questions about the requisite institutional capacity and competencies of sectors and the different levels of governments. Where responsibilities are shared, the role of each of level of government must be clarified. The constitution does not do this and it has left this clarification role to the different levels of government and sectors through complementary and varying policies. Policy making and budgetary-reform efforts have sought to alter significantly the way public policies are designed.

Measured through the conceptual framework of decentralized co-operative governance within the public-policy context, the dissertation contributes to knowledge and empirical evidence of policy design and implementation, governance and public financing. The study also considers the ways in which policy process could be strengthened between central and provincial governments and public finance and health sectors in a system of decentralized co-operative governance.

Research Question

The main purpose of this study is to analyse the decentralized co-operative governance public policy processes and practices within the public health system. Responding to this research focus, specific questions were considered. The central question of this study is:

Given the different rationales and contexts for the adoption of public finance and health policies within both the central and provincial governments, how do decentralized co-operative governance public policy processes and practices in the public service really work and how does the policy content and practice support decentralized co-operative governance?

Research Sub-questions

The research sub-questions are:

(a) How do central and provincial governments define and determine each other's responsibilities regarding public finance and health policy and practice within the context of a the public health system?

(b) How does the system of decentralized co-operative governance within and between the central and provincial governments, public finance and health sectors facilitate or impede agreed-upon public health and provincial finance policy processes and products?

(c) How and in which ways do public finance policies, on the one hand, and public health policies, or the other, influence or constrain each other within the public health system?

(d) How do the national policy imperatives or delivery obligations resonate within budget policy choices and the financing of public health within provincial governments?

Methodology of the Study

The study adopted descriptive, analytical, qualitative and quantitative methodologies, employing a multi-site case study approach. What is important to the choice of the qualitative approach of the current study is that the data focuses on naturally occurring, ordinary events in the natural setting of the public health system. The qualitative data presented in the study provides a helpful research text that invites "completion by the reader and acceptance by him or her, of the text's message and the construal of the meaning of the thesis" (Barone 1998: p.154). A detailed description of the methodology is presented in Chapter 3.

Qualitative data, according to Miles and Huberman (1994: p10) cited in Ashleigh (2005: p10) have the potential for "richness and holism", thus revealing complexity and "providing thick description that are vivid, nested in a real context". Qualitative data have the potential for 'richness and holism" revealing complexity and providing thick descriptions that are vivid, nested in a real context" (Miles and Huberman, 1994: p.10). The quantitative approach deployed in the form of the public expenditure review is used because of its ability to assist in the analysis of the overall composition of public health expenditure. The public expenditure review argues that the higher the proportion in favour of the provincial government resource and expenditure decision-making, the greater the degree of financial decentralization. The converse would represent a greater degree of centralization.

Organisation of the Dissertation

The dissertation is divided into nine chapters. Following this introductory chapter, the second chapter reports on the literature review. The review examines literature that is related to the focus of this study and provides an account of empirical research related to the research questions. The chapter concludes with an outline and exploration of the conceptual framework through detailed discussions of the factors relating to decentralized co-operative governance - institutional environment; relationships, decisions and accountability; and revenue, budgets and expenditures.

The research design and methodology, including discussions on data collection techniques and the data analysis method used, are discussed in Chapter three. Chapters four, five, six and seven are used to present, analyse and discuss data related to the implementation factors identified in the conceptual framework. The specific findings related to the four key research questions and general finding are presented in chapter eight. This chapter also looks at the conclusions and recommendations for further research.

Chapter Summary

The focus of this study, decentralization and co-operative governance of public finance and health policy processes was defined and explored in the section “national unitary public health system”. Within this exploration, particular emphasis was placed on the complexity of the horizontal and vertical system and practice of decentralized co-operative governance between and within the intra- and inter-governmental system and public health and finance sectors; the dynamic of differing and similar public health and finance policy processes and structures; the structural and functional system and relations between the central and provincial governments on the one hand and the public finance and health sectors on the other.

Organisation of Study – An Overview

This dissertation is further organised into the following chapters:

Chapter Two: Literature Review and Relevant Research on Decentralization and Co-operative Governance: Shedding Light on the Conundrum

This chapter argues that there is a theoretical link between the discussions of governance and decentralization. In order to understand the notions of decentralized co-operative governance, deeper insight is necessary to inform the dissertation's coverage of the theoretical and practical orientations of governance and decentralization. This coverage specifically seeks to inform the theoretical base of the different models of governance and how these models influence policy design and implementation within the context of a co-operative governance system. The chapter also locates the co-operative governance debate within a decentralized system of government, drawing on international literature through key arguments and principles underscoring the notion of decentralization.

These theoretical discussions on governance, decentralization, principal-agent relationship, public policy and public finance set out in the chapter provide a broad theoretical framework for analysing the interaction between central and provincial government. Chapter Two, through a review of the literature on decentralization, governance, policy processes and finance, is inadequate to explain the nature of co-operative government in South Africa. Instead it is necessary first to create linkages between the different literature orientations, which then need to be applied to the internal workings of policy processes, governance and decentralization models and forms with the practice. The literature framework serves as a "toolbox" for the investigation of decentralized co-operative governance within the public health system.

Chapter Three: Research Design and Methodology

The chapter sets out the research design, methodologies and data collection techniques.

Chapter Four: Geographical, Political and Economic Environment of the Public Finance and Health Sectors

This chapter provides a description of the geographical, political and economic environments within South Africa. Its intention is to sketch the varied influences on the public policy processes, including an understanding of the various structures and geo-political and economy of the public policy process context. The chapter also argues that the

key arguments and principles of governance and decentralization further inform the principal-agent relation that ostensibly exists between different levels of government. Chapter Four also claims that before firming up the theoretical exposition of the dissertation through the literature review, it is necessary to review the South African macro-economic policy trajectory and its influence on the public health system. This review was required to particularly understand the influences that the macro-economic policy context exercise on public finance and health policy within South Africa.

Chapter Five: Decentralization and Co-operative Governance of Public Health Policies

The different approaches to and the location of decision-making competencies for policy and practice between the public finance and health sectors, in addition to the location and responsibility for revenue and spending decision making, have contributed to complex and varied policies and competencies. This chapter argues that the central government has used its authority to systematically enlarge its responsibility within the processes of policy design and implementation. The central government has used a range of co-operative governance instruments and tools at its disposal such as control, supervision, influence, and interference to enhance its influence over the design and implementation of public health policies that intend to push equity and efficiency.

In addition, provinces as the implementing agents of public health policies have not merely been passive recipients of national policies and programmes but have actively engaged with the central government about the nature, extent and obligations of these policies. This policy design and implementation process has contributed to separation of different responsibilities and accountability for the health function between the central and provincial governments.

The chapter also argues that the policy content analysis also demonstrates a gradual expansion of public health services and programmes juxtaposed against requisite provincial government capabilities. Chapter Five argues that, depending on the policy content and, by implication, the obligations it confers, the relationship between the different locations of policy design and implementation lead to national public health policies either being an imposition or a voluntary coordinated policy solution within the shared health function. This is made more complex by out of annual official budget-cycle public policy statements, on the provinces by a central government minister. This chapter argues that it is the different policy

responsibilities and accountability that have led to varied interpretations of policy content and its associated obligations, thus leading to the undermining of the intentions of co-operative governance.

Chapter Six: Decentralized Co-operative Governance of Public Finance of Policies: Principal-Agent Relations

The financing of the public health system by both the central and provincial governments is a both powerful phenomenon in testing levels of commitment and the scope and scale of public health policy implementation. This chapter argues that the identified national public health policies discussed in the previous chapter predetermine the budgetary and resource allocation process within provinces. This policy design and implementation practice, which is articulated through different public health expenditure programmes, has pushed overall budgets and expenditure. This chapter not only argues, but also confirms, that the intention of the identified public health policies' proportional distribution of power and authority between the central and provincial governments strongly steers internal shifts between services within the health system.

While at an aggregate level the national public health polices have pushed expenditure, at a disaggregate level it data categorisation and classification have made it difficult to determine the impact of these policies. This chapter also argues that given the dominant role of the central government public finance sector embodied within the National Treasury, has pushed for a uniform, rule-based and coordinated public finance policy practice within the public health system. The practice has led to a hard budget constraint approach within the public finance sector, which has contributed to the simmering tensions with the public health sector as a result of its expansionary and equity-orientated policy approach.

This chapter also argues that further tensions are added to the policy-process practice discussed in Chapter Five as an outcome of: differing policy-design and implementation practices within and between the public finance and health systems; the implementation of different financing mechanisms such as transfers; and policy creep of central government within the policy implementation domain of the provincial government. These tensions have led to differing forms of policy design and implementation between and within the public finance and health sectors at both the vertical and horizontal levels of governments. The differing forms push uniformity and inclusivity on the one hand and, on the other, separate

and create exclusivity in responsibility and accountability. The varied finance and fiscal policy-implementation responsibility and accountability between the sectors and central and provincial government, this chapter argues, has added to an undermining of the intentions of co-operative governance, but also contributed to co-operative governance becoming co-operative management of expenditure within public health.

Chapter Seven: - Review of Public Health Revenue, budgets and expenditures within the Provincial Government

This chapter continues with the discussion on public finance started in Chapter Six. It argues, through the tracing of budget policies and expenditure trends, that public health policy has had a determined effect on resource allocations within the provinces. The tracing of public expenditure on provincial health is done through a review and analyses of financing and expenditure trends of major selected public health programmes. The resource and expenditure review is also done to assess the influence that central government health policies and programmes exert on the budget-allocation process within the provincial public health sector. The intention is to assess the nature and extent of the interaction between the public finance and health sectors in the determination of resource allocations and its influences on the decentralized co-operative governance approach.

Chapter Eight: Decentralization and Co-operative Governance between Central and Provincial Governments - Imposed Co-ordination or Inclusivity through Provincial Budgets and Expenditures

The chapter argues that from the perspective of public policy design and implementation, and revenue allocation and distribution, and public finance expenditure that the constitutional imperatives of co-operative governance are under threat. Moreover, Chapter Eight argues that the existing features, components and elements of decentralized co-operative governance practice within the public health system are not able to hold together the co-operative governance system. The chapter sets out a number of observations and conclusions that demonstrate the inability of the co-operative governance system to enforce and hold together uniformity and standardisation at both vertical and horizontal levels within the public health system between the public finance and health sectors. It argues for a new system of co-operative co-ordination or management within the public health system between the public finance and health sectors, which speaks integration rather than a

different form of governance. It is in this way that the chapter further argues for tailored universalism on policy responsibility and accountability at an implementation level relative to overall provincial capabilities, resource allocation and distribution process for the public health function, and the diminishing governance role at both policy-design and implementation levels of the provincial governments.

Furthermore, study argued that given the empirical evidence and analysis, provinces are de facto provincial administrations of central government policies. This deposition is strengthened by the argument that given the increasingly strong role of the central government within the unitary decentralized governance system, this increasing strong role has led to a systematic revoking of the devolved authority to either a delegated or deconcentrated system within the public health system, depending on the nature of the public policy in the interest of efficiency, effectiveness and equity.

Chapter Two: - Literature Review and Relevant Research on Decentralization and Co-operative Government: Shedding Light on the Conundrum

Introduction

The literature review for this study, shows that in many centralized countries all politics are central and national and that the centre is politically and economically strong and powerful. Lower levels of government politics are marginal. This contributes to the overall political orientation of people towards the central government. The overall strength of central government has in many countries led to competencies of lower levels of government systematically being reduced, leading to conditions where participation in local affairs is perceived as inconsequential, ineffective, and even ephemeral (Kalaycioglu 2000:p2). In fact, local politics exists only to the extent that the centre is willing to delegate some power to the provincial, city, town or village administrations (Kalaycioglu 2000).

The assumption of this study is that within a South African context, each provincial government has its own specific priorities, including service delivery pressures, which influence how, it as a single government that incorporates all sectors, interacts with sector-specific polices and expected levels of resourcing. The specific priorities are in addition to maintaining existing services and its administration. The singular or complimentary policy influences of the public finance and health sectors have an impact on the health system and its management and administration.

The design of the conceptual framework

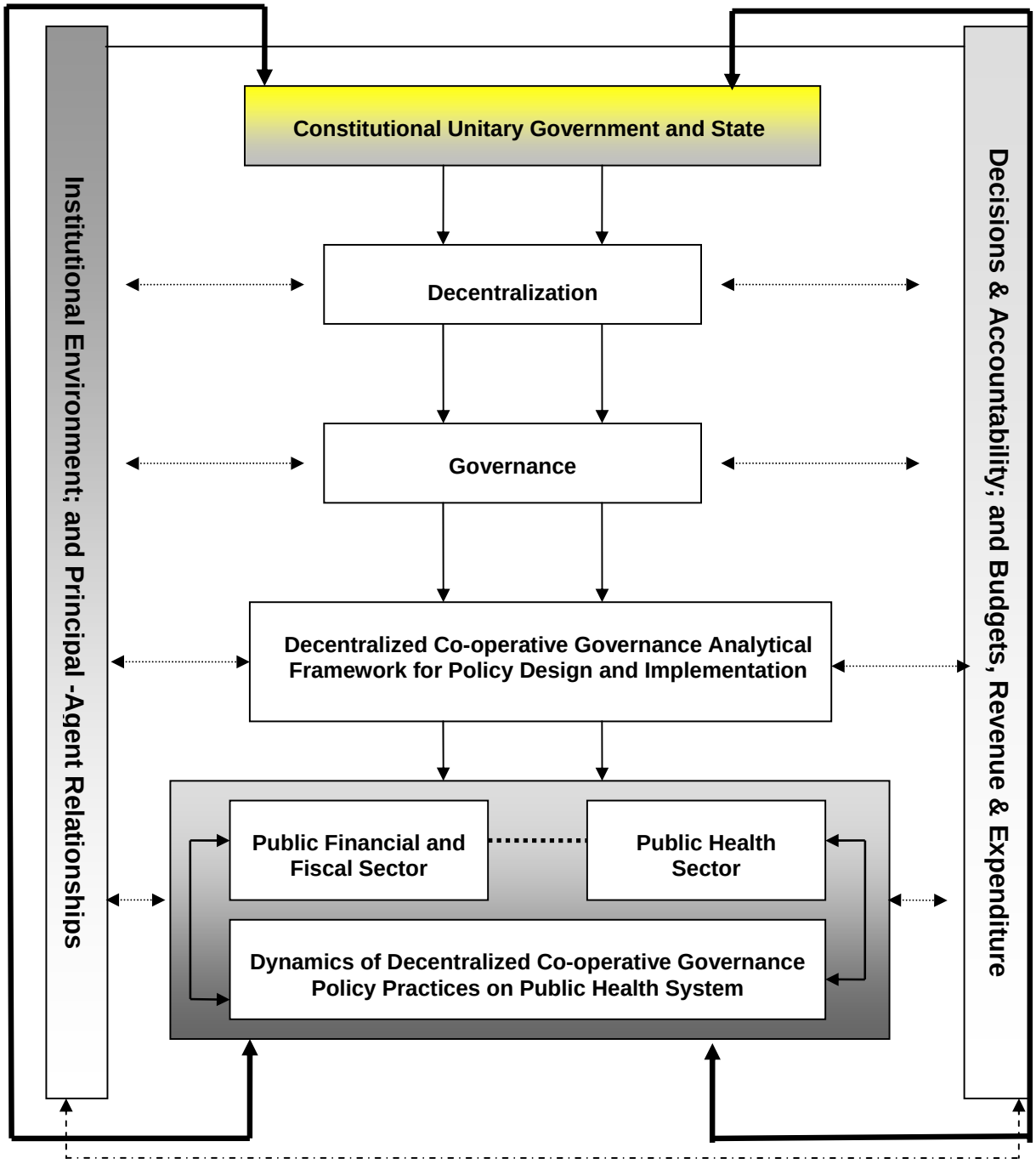
This chapter focuses on the incorporation of findings from the literature review into the design of the conceptual framework for the study, as demonstrated in Figure 2.1. The literature review starts with a discussion of policy processes and their linkages to the constitutional and unitary government and state. The chapter ends with a conceptual framework that serve as the building blocks towards an analysis of the decentralized co-operative governance public policy process. The literature as the key driver behind the conceptual framework identifies the institutional environment and arrangements, principal-agent relationships and decision making and accountability, and revenues, budgets and

expenditure as key dynamics or factors of the decentralized co-operative governance system that influences the design and implementation of public policy within the public service.

More concretely, the chapter locates the public policy processes of between the central and provincial governments and between the finance and health sectors within the constitutional unitary government and state. The primary intent is to develop a theoretical and conceptual framework of analysis. This is preceded by a literature review on the unitary government and state policy process in the public service. This policy review focuses on Stephen Ball's (1990; 1993) model of policy text and trajectories, which comprises policy as influence, policy as text production, and policy as practice. This model, which also focuses on policy as discourse, is used because its political orientation of the public policy-making process in the public service.

Figure 2.1 shows the conceptual flow of the literature review in the design of the conceptual theoretical framework of the study. The development of the conceptual theoretical framework is done through a literature review of decentralization and governance. The literature review of decentralization and governance leads to a definition of decentralized co-operative governance within the context of the public policy process. The literature review also contributes to the identification of factors that either influence or constrain the system of decentralized co-operative governance on the policy process within the public service.

Figure 2.1 Decentralized Co-operative Governance of Public Policy: A Theoretical Framework



These factors are: the institutional environment and arrangements; principal-agent relations; decisions and accountability; and revenue, budgets and expenditure. The literature review on decentralization and co-operative governance together with these factors eventually led to the design of the decentralized co-operative governance analytical framework for policy design and implement, the public policy process. The analytical framework serves as the lens through which the policy processes within the public finance and public health sectors are analysed. The study place great emphasis on the emerging dynamics of the decentralized public policy practices on the public health system. These dynamics in conjunction with the different factors are discussed in chapter 5, 6 and 7.

The public policy trajectory

Ball (1993:p10) suggests that, in analysing policy, we need a "toolbox of diverse concepts and theories rather than a pure one". This is so, he argues, because of the nature and complexity of different orientations to public policy. The notion of "toolbox" refers to a mix of policy tools, mechanism of both the public service policy context, including the application of several of the policy theories. The toolbox includes theoretical debates on differential competencies – that is, power and authority – between the levels of governments and functional or sector mandates. It also includes outputs of a discourse on functions, responsibilities, relations and policy processes. The toolbox in this study also includes the decision-making space tool, the revenue and expenditure review and the interviews to enable analysis of the identified polices, inputs and outputs. Hanekom (1987: p45) cited in Cloete, Wissink and de Coning (2007: p31) further mentions that:

> In public policy making, theories are utilised to explain the policy-making process. Furthermore, simplification of policy making is enhanced by using models to present problems in acceptable dimensions, while it appears that the various perspectives on policy making could also contribute towards greater clarity of the process. Although no universally accepted or agreed-upon theory of the policy-making process exists, it appears that a useful model should include at least the phases of goal identification, authorisation, public statement of intent, implementation and evaluation.

The policy process is a confusing swirl of events and there is no linear and sequential order of different policy moments. As such, different moments in the policy cycle could be skipped and others could happen simultaneously or follow a different order. A single moment in the

policy process is inadequate to capture the different environmental or systemic factors. Within each policy moment, different dynamics are at play, which reflect different values and perceived intentions and what ought to be the level of service provision of the policy and the context of policy interpretation. The policy process influenced by the different responsibilities implies that those involved in the policy process, at any moment, bring different orientations to what constitute an appropriate policy and how such a policy relates to the overall macro-policies of government. The public policy process must be considered in terms of "high politics issues" (Barker 1996: p6), "which matter to everyone and which involve the long-term objectives of the state or those in power, and those micro policies, or low level politics issues, which involve more localised, that is, sector, interests". Barker (1996: p6) writes:

> …a low politics issue can shift and become a high politics issue over time. It is important to remember that even apparently mundane sectoral policies are usually based on networks of decisions which themselves involve high politics issues. The policy maker has to be aware of these constraints, and has to develop a sense of what is possible. Each policy decision is made within a web of decisions, some of which are contingent upon the highest level of political decisions within a society, and upon the whole approach of that society to the way in which wealth and power are distributed.

The policy discourse within the sectors and the central and provincial government help to unravel the location of various policy responsibilities and inputs to be delivered in the realisation of the policies. The intended aim of reading and analysing of the selected policy texts is, therefore, to identify the key roles and responsibilities of the provinces, and how they impact on the co-operative governance system. By reviewing and analysing the selected public policies, the study identifies the functions and responsibilities that indicate the nature of the principal-agent relations, if any, between the central and provincial governments and the sectors.

Given the slippery nature of policies, and that "it is sometimes extremely difficult to pinpoint a particular decision to operate in a particular style because an overt decision may never have been made" (Barker 1996: p5), combined with the notion of a shared health competency or function and the vagueness of different policy texts that have entered the public domain, public policies have contributed to an intentional ambiguity about the location of public health care service delivery and public financing responsibilities. Without understanding the fluidity, complexity and contradictions that characterise the policy process it is difficult to anticipate how a particular policy may be diluted, diverted or even aborted by different interests and stakeholders. Barker (1996: p5) agrees that:

> Sometimes things are done in a certain way for historical reasons or by virtue of inertia, rather than because anyone has made a decision about them. Sometimes those with power actually use it to prevent the instigation of an overt decision-making process, because they have no good reason to want to share their decisions with, or to have to justify them to, others. Often decisions are not single identifiable entities but the result of an incremental process. This complexity in the nature of decisions makes it difficult to say that a decision is ever purely technical, or lacking in political content.

This statement by Barker (1996) suggests that gradual or incremental policy changes occur as a result of various ideological, political and economic dimensions within the policy-process machinery. Policy process, accordingly, is also influenced by an asymmetry in the policy process, given the varying powers and authority held by different policy actors. The asymmetry is also as a result of informational advantage and potential resources that one group, sector or level of government has over the other. This acknowledges that different forces and actors are not necessarily operating in concert to enhance the overall objectives of a particular public policy. The embedded processes have the potential to facilitate or impede the functional and structural features of decentralized co-operative governance of the public policy. There are similarly parallel and conflicting strategies at play within the policy process. At the formulation and design policy junctures, an attempt is made to make sense of a complex and often puzzling set of circumstances and intentions. These puzzling circumstances originate from different policy perspectives and from different macro and micro policy interactions, but also from different sector interests in order to realise the macro policies of the central government. The researcher argues that these processes are not by default or coincidental, but by design, given the central government's strong policy role and its overall, but unfettered responsibility to protect the ideals of the Constitution.

The policy process has produced the potential of fragile alliances within and between different sectors and levels of governments on specific policy positions. According to Cibulka (1994:116) the fragile alliances in the public policy domain originate not from "what they had in common ideologically but what they opposed from their different perspectives." The fragile alliances occur as a result of public policy oscillation, given the redistributive interests for equity of both sector specific and overall macro-policies. Ball's (1990:p16) intervention on these circumstances seems to be appropriate when he writes that:

> While the construction of the policy text may well involve different parties and processes to the implementation process, the opportunity for reforming and reinterpreting, the text means

> policy formation does not end with the legislative 'moment' and that for any text a plurality of readers must necessarily produce a plurality of meaning.

Public policy processes and levels of policy making

The public policy process comprises different processes in the public policy discussion, including: a) policy initiation or influence, where initial ideas regarding policy conceptualization are considered; b) policy drafting, where dominant ideas and objectives are drafted into a policy text, also reflecting policy compromises; and c) policy implementation. Ball (1993) claims that the policy-making process comprises three policy contexts – that is, policy influence; policy text production; and the context of practice. The context of policy influence is about the how the policy-initiation debate took place as a result of economic, political and social forces that have influenced the emergence and the development of the policy. According to Bowe, Ball and Gold (1992:p19) "[it] is here that discourses are constructed, interests parties struggle to influence the definition and social purpose…" of an appropriate public policy or how a public system such as health ought to be constructed. It is within this context where different interested parties compete to influence the public policy but it is also where policy actors within the public service engage in representations of sector interest. The context of policy influence has a symbiotic and an uneasy relation to the context of policy text production.

Levels of policy-making

The different policy contexts are distinct, interrelated, and draw on and reflect insights generated from each other. The policy process (Barker 1996:p7-8) operates at systemic, programmatic, organisational and instrumental levels within the public service. Barker (1996:8) maintains that the "types of policy which are possible at the programmatic, organisational and instrumental levels will depend on the systemic context..."

Systemic, programmatic, organisational, and instrumental levels of policy-making

The systemic level of policy refers to the main features shaping the public health system. At the programmatic level, policy decisions are made about priorities for health care, the actual nature of health care programmes and the way in which resources should be allocated. The organisational level considers the way in which resources are used productively to provide a

high-quality service. At the instrumental level, various instruments of good organisation, such as human resource development and information systems are managed. The systemic context is regarded as the co-operative governance system between the public finance and health sectors, and between the central and provincial governments.

Within the context of the systemic level, policies are viewed as rational activities to resolve the allocation of resources and values. The purpose of policy is to bring about cohesiveness, order and functionality of singular and plural governance. Public policy is considered an exercise of power, control and authoritative allocation of values, representing either divergent interests within a context of pluralistic government or the dominance of a singular, homogeneous state.

The systemic contexts of the public finance and health policies have the potential to create "legislative and administrative mandates that are deliberately vague and nonspecific" (Lee, Silver and Benjamin 1992: p1165). Lee, Silver and Benjamin (1992: p1165) note that:

> Intentional ambiguity is likely to characterize legislation or program implementation when (1) there is little apparent national consensus on the nature of the problem addressed, the goals to be achieved or the methods used in implementing policy; (2) suggested alternative policies are thought to be politically controversial, making it risky to establish an unambiguous policy choice; or (3) a measure passed by one political party is then implemented during the administration of another party with differing policies and priorities.

The potential of intentionally ambiguous policies contributes to tensions and differences in the interpretation of policies or legislation. In this instance the common and varying interpretation of policies has created leeway and flexibility for the different levels of government to implement public policies within their own legislative and service delivery institutions, thereby allowing for innovation and creativity.

Public policy models

Cameron (1991: p144) identifies two policy models – classical and integrationist – in order to identify key roles and responsibilities of policy actors. The classical model, which is top-down in nature, suggests that policy making and implementation are two distinct processes. According to this model, based on the theory of political dichotomy, legislators make policy, while bureaucrats or officials passively implement the intended policy. This model suggests

that policy formulation is the domain of politicians and that their representative institutions are independent of the government bureaucratic machinery. In this model, policy is interpreted as a rational, technical and administrative activity of a politically neutral bureaucracy. This model assumes that the implementation of public policy is unproblematic and that it takes place as intended. The classical model holds that the outputs of a policy are the same as the intended policy text. The model also assumes that the behaviour of government officials is inconsequential as they are only uncritical implementers of policy.

The integrationist model, however, assumes that policy formulation and implementation are linked, or (Wallace 1996:p109) "interpenetrate". The integrationist model argues that policy is continuously reconstructed or refined when assessed or evaluated for implementation. This is, it is argued, because conflicts or tensions that were unresolved during the text production require resolution during implementation. The argument is that key policy decisions are also made during practice when more facts are available to the implementers and, as such the implementers are better equipped than anyone else to make key decisions. Cibulka (1994:p112) asserts that:

> Since policies frequently lack clear goals, it will not do to argue that implementers are the culprits who subvert policy … these implementers often reconcile design flaws and conflicting statutory objectives … that people … created at a policy's inception, a process of adaptation that makes the democratic process work better than it might otherwise.

While interpretation of the intentions and goals of a public policy might confirm that implementers have an explicit role in the design of policies, a number of obstacles (Cameron 1991:p153-157) can severely jeopardise successful policy implementation, such as: policy goals being multiple, conflicting and vague; implementation depend on the cooperation of other implementing agencies, which hinders successful execution; ineffective implementation being due to poorly framed policies rather than implementation *per se*. Other obstacles are policies that sometimes make bad choices based on faulty premises and the often faulty communication between policymakers and bureaucrats. If bureaucrats do not know what they are supposed to do, this could lead to ineffective implementation; and legislation is often framed in a broad fashion, allowing policy implementers plenty of scope to influence policy content. Barker (1996:25), therefore, argues that "a policy may change in the process of implementation; the intended outputs and outcomes may not at all be those which result, and those who were intended to benefit from a particular policy are not always

the people who do benefit." Policy implemented as intended is therefore just as contested as the processes of policy initiation and drafting and is, therefore, not an automated process of transmission of policy content into practice. Public policy decisions are made based on the environmental context, including the administration and fiscal resource capacities. Although policy decisions influence or directs choices about resource allocations, the potential implementation of these decision are policy context-bound, that is, the implementation level. `The planning of policy implementation creates further opportunities for different influences. Barker (1996:p27) emphasises the integral link between policy and planning:

> In the planning process, policy preferences become expressed in terms of overt choices about the allocation of resources, ambitions to do and achieve certain things become tied to a time-frame; through the process of budgeting we count the cost.

Whitty and Edwards (1994:p14) suggest that different concerns can reflect different notions of who the 'powerful' are and how power is exercised within both policy process and planning. They suggest that such differences could also "involve different perceptions of rationality in policy making. This suggests that policies are, therefore, not only perceived as rational activities to resolve the allocation of resources and values, but that their purpose is also to bring about cohesion, order and functionality. On the other hand, policy is also an exercise of an authoritative allocation of values that is affirmed in public health policies.

Whitty and Edwards (1994:p14) further claim that:

> If the official view is taken, albeit with some skepticism, then policy is handed down in legislation and regulations by politicians and government officials to be implemented at street level. This is to overplay the role of central government, and downplay what happens before and after legislation. It risks assuming a unity and clarity of purpose among the "makers" of policy that may well dissolve under scrutiny. And it is almost certain to exaggerate the extent to which the policymakers can predict the consequences of their reforms by channeling the actions of those charged with implementing them. As judged by its real effects, policy is often made in the process of implementation.

Policy as text production

The policy text production is basically the writing of the main policy paper and subsidiary documents. Bowe, Ball and Gold (1992:p21) indicate that policy is not completed at the legislative moment but that "it evolves in and through the texts that represent it." This context is considered the most contested and messiest given the varied policy interests and

agenda, struggles, alliances and compromises to be reached in finalising the policy text. The context of practice refers to the arena of implementation and policy practice. It is in the practice arena that the policy processes include interpreting and implementing the policy texts. It is also here where the "parts of the texts will be rejected, selected out, ignored, deliberately misunderstood, responses may be frivolous, etc" (Bowe, Ball and Gold 1992:p22). The implicit public policy contestation is as a result of how the policy implementers interpret and implement the policy text in relation to fiscal resources, experiences, values and interests. This fits with Ball's (1993) views that the interpretation of the public policy is characterised by struggle or contestation and that those who wrote the policy text cannot control its meaning. The argument goes further, that the policy text will be recontextualised as some interpretations and meanings of the policy will be foregrounded while others will be considered insignificant.

Hatcher and Troyna (1994) assert that because many policy text analyses often fail to acknowledge the role of the state or the influence it exercises in policy interpretation and meaning, they contribute to limited textual analysis. These authors suggest that when one analyses policy texts, the role of the central government and the power it wields are critical to public policy interpretation and implementation. The view is that the state consists of a number of entities – public service departments and statutory authorities of various kinds – which often have conflicting interests (Taylor 1997) or as a set of publicly financed institutions, neither separately nor collectively necessarily in harmony, confronted by certain problems deriving from the state's relation with capitalism (Dale 1999: p57). Taylor and Dale both conceptualize the complexity of the state and that it is often in conflict with itself. The structures of the state and government (Taylor 1997) are considered the terrain in which policy structures, mechanisms and policy actors would struggle to achieve particular policy outputs and outcomes. It is these complexities that characterise the politicised nature of the public policy processes. Moreover, Taylor (1997:p29) mentions that

> …contestation is involved right from the moment of appearance of an issue on policy agenda, through the initiation of action to the inevitable trade-offs involved in formation and implementation. Contestation is played out in regard to whose voices are heard and whose voices are organised or 'authoritatively allocated' in the policy and which groups ultimately benefit as a result of the policy.

The separation of these different elements of Ball's policy process is artificial. In order to understand and interpret a policy, according to Silver (1990:p213) writes:

> The analysis of policy… is concerned with its origins and intentions – the complexities of competing and conflicting values and goals, the explicit and inexplicit representations of objectives which spring from diverse economic and social realities. It is concerned with the policy choices that are made, the decisions made – by whom, with what timing and with what authority. It is concerned with the guidelines, the rules, the regulations, the machinery of information, the interpretation in practice, the outcomes. At its most theoretical the analysis is concerned with what happens and why; at its most pragmatically historical it asks what, in known instances, seems to have happened.

Policy as practice

Ball (1993:10-13) argues that when any policy enters the domain of implementation, the original policy drafters no longer have control over its meaning and what gets implemented. He asserts that

> … the simple point is that policymakers cannot control the meaning of their text. Parts of the text will be rejected, selected out, ignored, deliberately misunderstood, responses may be frivolous, etc." It is in the implementation process where policy outputs as intended are dependent on the responses, reactions and contexts of implementation and resourcing.

The researcher opted for this approach of policy as textual interventions because it:

a) Draws, at a technical level, on policy formulators and implementers' perspectives of how policies facilitate or impede the separation and allocation of responsibilities and the process of co-operative governance between the different levels and sectors;
b) Draws primarily on information from different policy texts and documents in the public finance and health sectors; and
c) Draws from content of interviews with selected interviewees in order to further deepen knowledge about the operability of the decentralized co-operative governance system within the shared responsibility function.

The sector-specific policy considerations by the provincial or central governments as a whole require the implementers to interpret the text for meaning so as to facilitate implementation. This interpretation is affected by contextual realities within the province as the level of implementation. The contextual realities comprise institutional capacity, location

of decisions and accountability, relations between the formulators and implementers and the resourcing anchor. This complex reality has contributed to complex and varied policy meanings of public policy, including a protracted asymmetric public policy contestation in the public service. The schism between the formulators and implementers of policies within governments dates back to configuration of unitary and federal states and its public service. Every sector or functional unit within the configuration of government has a significant mandate and relation to each other. For example, a dominant public health sector or finance sector with no counterweight would shift the power and authority between public finance and health systems or between the levels of government. The relative determinant influence and political strength of either would reverberate through the whole public health system and finance systems.

Furthermore, the dominance over power and authority over the public policy process would influence the grand debate on public policy among politicians, legislatures and technocrats in the public service about the future decentralized co-operative governance policy making. A severely retrograde form of decentralized co-operative governance would be seen to have defeated imperatives of a unitary, constitutional government and state. The significance of the public policy process in the model of decentralized co-operative governance requires an amphibious support from both central and provincial governments and the public service sectors. The factors identified in this study to assess the effect of decentralized co-operative governance on the public policy processes are critical in realising the system. Given these scenarios, how are policy and budgetary choices made? How do these policy and budgetary choices influence and reconcile with provincial decision-making processes and choices?

Decentralization and Co-operative Governance

Decentralized co-operative governance is advocated on the grounds that it has the potential to improve allocative and technical efficiencies. In the public sector, both types of efficiencies are pursued for political considerations. This political dimension intersects with macro-economic and social factors at policy and governance levels. The decision to design and implement a system of co-operative governance in a decentralized system is a political issue that not only involves the distribution of political power within the state system, but also the access of social and political groups to the political decision-making process and the allocation of public resources (Collins, 1994: p67). Decentralization, according to Shah

(1994: p3), refers to the process of devolving political, fiscal and administrative powers to sub-national units of government.

The choice of decentralized co-operative governance between levels of government is therefore a political decision and a reform programme, motivated by non-technical considerations. Gilson, Kilima and Tanner (1994: p452) mention that the potential benefits of administrative decentralization are: greater participation by implementers and community decision-making; leading decision making that better reflects local needs and conditions; and quicker and more flexible decision making that results in a more responsive government. Araujo (1997: p110) mentions that the political issues surrounding decentralization are:

Decentralization

According to the public administration approach, decentralization deals with the allocation and transfer of power, authority and responsibility to make policies and decisions, to carry out management and administrative functions, and the utilisation of resources including the most effective means of service delivery (Bossert, Chitah, Simonet, Mwansa, Daura, Mabandhala, Bowser, Sevilla, Beauvais, Silondwa and Simatele, 2000; Cheema and Rondinelli, 1983; Collins, 1994). Decentralization involves the transfer of resources, decision making, planning, and management functions within government (Kolehmainen-Aitken, 1999).

The literature identifies a number of common arguments in favour of decentralization. These include the redistribution of power by bringing decision making closer to citizen, thus allowing for greater participation, which contributes to the sharing of power. Decentralization also contributes to efficiencies through a process and product that allows for decision making “closer to field-level providers of services and hence making it more appropriate”, thereby allowing “greater participation by implementers and communities in decision making” (Gilson, Kilima and Tanner (1994: p452). Decentralization is geared towards enhancing cost-effectiveness through a more efficient deployment and management of resources and services. The quality argument has to do with the improvement of quality to overcome the gap between public needs and the services provided by the system.

Decentralization is, therefore, perceived as a feasible way of supporting public service delivery if it matches lower levels of needed government capacity. Increasing responsibility at sub-national levels should therefore be commensurate with an increase in resources to build needed and appropriate capacity (Shah 1999).

Decentralization is a political issue that not only involves the distribution of political power within the state system, but also the access of social and political groups to the political decision-making process and the allocation of public resources (Collins 1994: p67). Decentralization therefore provides a means of maintaining political stability and for the conceding of power within a formal, rule-bound decision-making system (Dillinger and Fay 1999: p1). Within a rule - bound system (Bahl 1999), decentralization can improve the efficiency and responsiveness of the public sector by bringing government and its delivery institutions closer to the public. It helps to alleviate the decision-making bottlenecks created through central bureaucracies and the control of important economic and social activities. In this way, it contributes to simplification of bureaucracies.

Shah (1999: p1) is of the opinion that the decentralization of systems offers a greater potential for improved macro–economic governance than centralized systems because it acquires greater clarity in the roles of various players (centres for decision making) and transparency in rules that govern their interactions to ensure fair play. Decentralization is also linked to reducing the central or federal government fiscal weight by downsizing the central budget and to devolve responsibilities to states and localities supported by a presumption that over-expansion and excessive centralization are inherent in the political processes of a country (Musgrave 1976).

The experiences of countries suggest that there are different causes and effects of decentralization. In Kenya (Kolehmainen-Aitken 1999: p28-37) the health cost-sharing programme, through the structural adjustment programme of the 1989-93 Health Reform Policy paved the way for increased decentralization. One of the driving forces for cost-sharing has been slow economic growth, which caused a crisis in government funding and a drop in per capita government spending for health. In the Philippines (Kolehmainen-Aitken: 1999) decentralization was driven by public funding of health services that included comprehensive revenue allocation and by a funding formula driven by demographics. The policy of decentralization has not devolved the financing of health services but, rather, by

delegated financial responsibility and revenue-generating capabilities to local authorities. The Argentinean experience shows that the primary objective for decentralization was “the alleviation of the fiscal burden at the central level, rather than a quest for efficiency or equity” (Burki, Perry and Dillinger 1999: p78). Decentralization in Mexico mainly constituted attempts to reduce central state power by sharing political power with state governments by reducing the fiscal burden at central level and by rationalising the supply structure of public goods and general improvement in management.

Models, Forms and Dimensions of Decentralization

This public administration approach identifies different forms of decentralization: deconcentration, delegation, devolution and privatisation (Bossert et al. 2000). The public administration approach defines the appropriate levels for decentralizing functions, responsibilities, and authority to regions, district and local communities.

Deconcentration

Deconcentration, a dominant model before the 1980s, is defined as the transfer of authority and responsibility from central government to peripheral offices within the same administration structure. Within the deconcentration system, there are functional systems of field administration where field officers possess vertical links with the centre for all or for specific services. Deconcentration reflects an “integrated perfectoral system” (Collins 1994: p70). Accordingly, multifunctional but subordinate levels of regional/district/local administration are set up in regions, provinces, departments and/or districts with a prefect, which could be a commissioner or regional manager appointed by and accountable to the central government.

This prefect represents the channel of communication between the centre and the periphery. Deconcentration is, therefore, about the transfer of authority from the centre to the periphery with ultimate control by the central government. The ultimate is, therefore, about policy cohesion and hegemony, together with central planning, control, and allocation of resources. This form of decentralization is closely associated with the state control model. Khaleghian and Das Gupta (2004: p10) write:

> The advantage of this approach is that it preserves inter-jurisdictional consistency and prevents local neglect of invisible services (or those that do not bring in more votes); but its disadvantage is that bureaucratic rigidity frequently set in and local adaptation fails to materialize. The lack of this frequently center around a lack of managerial autonomy …

Delegation

Delegation is about the transfer of authority and responsibility to semi-autonomous agencies not directly under the control of central government. For Rondinelli (1983: p188) delegation is about the

> … transfer of functions to regions or functional development authorities, parastatal organisations, or special project implementation units that often operate free of central government regulations concerning personnel, recruitment, contracting, budgeting, procurement and other matters, and that act as an agent for the state in performing prescribed functions with the ultimate responsibility for them remaining with the central government.

The transfer of functions to different entities, who act as agent, explicitly sets the functional and structural context of the principal and agent relationship. The agent, according to Rondinelli (1983) acts on prescribed delegated functions with the overall control over the function still that of central government. This form of decentralization requires a "vertical dissection at the central level itself and the formation of separate and possibly parallel hierarchies within the public sector" (Collins, 1994: p79). Collins (1994: p79) also refers to this type of decentralization as a "system of indirect administration as there is no direct supervision of the agency."

Devolution

Devolution is about the shift of responsibility from central government to separate administrative structures or "lower level, autonomous units of government through statutory or constitutional provisions that allocate formal power and functions" (Partners for Health Reformplus 2002: p2-3). Devolution implies the "existence of quite distinct levels of government" (Collins 1994). Devolution systems are according to Collins (1994: p72) characterised in the following manner:

a) Statutory recognition of the right to conduct their own budget arrangements;

b) A clear legal existence with corporate status;
c) A multifunctional role;
d) The authority to take decisions on the allocation of resources, involving revenue raising and expenditure, personnel management, logistics management;
e) Legal and legitimate geographical boundaries; and
f) Appointment and election of key representative members from a different constituency to higher levels of government

Collins (1994: p72), however also asserts that on "paper, a system might formally appear to be devolution while in reality the local government units are closely controlled or functionally restricted by central government". Mills, Vaughan, Smith and Tabibzadeh (1990:p20) suggest that within the overall health system, because "health makes heavy demands on recurrent expenditure" the propensity exists that the "devolution may complicate efforts to construct a logical hierarchy of health service and to set up regional structure". These argue that due to the limited tax base of lower levels of government, lower levels of government are unable to absorb the increasing costs of public health serves. This, they claim, has led to shift of health services ownership and or financing out of local government hands. The phenomenon of increasing health costs has, in many developed countries, led to the resource squeeze of other service responsibilities of lower levels of government. This has led to central government intervention through the block grants to lower levels of government, resulting in a "heavy dependence of local government on central government and a likely corresponding reduction in local autonomy" (Mills et al. 1990: p20). Moreover, Mills et al (1990: p20) refer to this as "a means of cynically claiming to decentralize while retaining the crucial financial power in central hands". Khaleghian and Das Gupta (2004: p10) put it this way:

> …devolutionary policies, sometimes as part of structural adjustment efforts – has been to compensate for local control of the EPHFs [essential public health functions] by retaining a measure of central influence through financial controls, e.g., grants-in-aid or earmarked funds. This is typically a "second best" solution implemented after the EPHFs have been devolved, because reversal of decentralization policies seldom occurs … and it faces a number of implementation problems in developing countries, not least of them being the difficulty faced by central health authorities – themselves reduced in strength and number by decentralization policies that typically reduce the size of central government – in monitoring the activity of local governments. So while formal devolution makes adaptation more likely, it makes central oversight more difficult and in turn can have a negative impact on the effectiveness of surveillance, health promotion and other efforts.

Privatisation

Privatisation is about transfers of operational responsibilities and in some cases ownership to private providers, usually with a contract defining what is expected in exchange for public funds (Bossert 2000). This system evolves as an outcome of government's introduction of markets into the public sector and an attempt to partially replace public sector planning decisions on the allocation of resources by mechanisms of the market (Collins, 1994:p79). The market dimension to decentralization further proposes that the shift of responsibility for functions from the public to private sector must be done through privatisation and de-regulation. Collins (1994:p79) is of the opinion that

> …essence of any market is that those who demand a particular service and good will come together with the suppliers or providers and make transactions. In order to be able to operate in these market conditions it is therefore necessary to decentralize decision-making authority to purchasers and providers in the market.

Within each of the different forms of decentralization, significant power and authority remains with the central government. Burki, Perry and Dillinger (1999:3) mention that although in practice, the deconcentration, delegation, devolution and privatisation models can be employed simultaneously, "their political, fiscal and administrative implications are quite different". However, the typology of decentralization only serves as a descriptive framework and lacks analytical tools for analysing the extent of decentralization within the public health system. Bossert (2000) asserts that the typology does not provide much guidance for analysing the functions and tasks that are transferred from one institutional entity to another and it does not identify the range of choice that is available to decision makers at each level.

Institutional environment and arrangements

Ansell and Gingrich (2006) mention that in unitary states, where spending by lower-level government ultimately remains the responsibility of the national government, one can expect top-down decentralization reforms to be of particular concern when it comes to efficiency.

Ajam (1997) argues that a decentralized system such as the one envisaged by the South African Constitution requires a re-examination of the revenue-sharing mechanisms; in

particular, the vertical division of resources between national and provincial spheres. Ajam's argument is that the functions of central government are not delegated to sub-national governments on a temporary basis and then withdrawn. Institutional arrangements surrounding intergovernmental transfers are required to reflect the permanent nature of such delegation and systems should be designed for the possible long-term adjustment on the side of the provincial governments. The degree of strength of provincial government interests in central government, therefore, has a key bearing on how co-operative and decentralized health governance is institutionalised.

It has been argued by Ajam (1997) that political forces and technocrats in government, especially the Ministry of Finance, are driving the emerging fiscal arrangements. Accordingly, the consequence has been that revenue assignment has preceded expenditure assignment. This effectively contradicts the traditional fiscal federalist approach of matching revenue with expenditure responsibilities – that is, where assigned responsibilities must be followed by a flow of resources (Dillinger and Fay, 1999; Dillinger and Webb, 1999; Ajam 1997). Dillinger and Fay (1999) suggest that the issue is not necessary about whether governments should decentralize or not, but rather about how to accommodate underlying political pressures so that the development potential of decentralization can be realised and risks minimised. A critical factor is the establishment of institutional arrangements through rules for the decentralization of the governance. According to Dillinger and Fay (1999), such rules must include the division of political power between national and sub-national interests; the functions and resources assigned to lower levels of government; and the electoral rules and other political institutions that bind local politicians to their constituents.

Bird (2000a; 2000b), Dilinger and Fay (1999), Shah (1994) agree that rules (through the form of public policies and legislation) are essential for an efficient and effective decentralization system. Rules are required to regulate levels of service delivery, administrative and financing responsibilities, including finance arrangements and transfers. Rules are also required to institutionalise the balance of power between the non-state actors and government, and similarly between the central and sub-national governments. These rules should be made explicit, reasonably permanent or stable and self-enforcing to reduce uncertainty and provide a common ground for all players in the political process (World Bank: 2000).

The World Bank (2000) mentions that clear, explicit and binding rules within a decentralized system of government enable sub-national governments to co-ordinate a defence against an over-assertive central government while restricting their ability to bargain. Furthermore, the substance of a rule-bound system must address the broad areas of the division of national political power between national and sub-national governments and the structure, functions, and resources assigned to sub-national governments.

Other pitfalls surrounding decentralization are those associated with inequities within and across lower levels of government, “particularly when it is linked to local resource generating mechanisms” (Green 1992:p65). Prod’homme (1995) argues that there is no clear evidence that decentralization has increased equity. He argues that it instead accentuates inequities and increases the risks of compromising macro-economic stability, which is could be attributed to the absence of a mechanism to transfer resources from regions with strong fiscal bases to poor regions.

Decentralization, therefore, has the potential to create fiscal imbalances or inequitable sharing of revenue between rich and poor sub-national governments. Estache and Sinha (1995) suggest that a good way to offset the impact of decentralization on spending is to increase the imbalance of revenue and spending assignments in favour of the former. However, if an imbalance between revenue resources and expenditure assignments persists it inevitably threatens to reduce the performance of sub-national governments.

The problems in overall administrative and technical capacity at a lower level are often associated with the lack of skilled personnel, the lack of information, or the loss of economies of scale and of control over scarce financial resources, which counteract efficiency gains from devolution. Such weaknesses may also further impose constraints on the implementation of national policies and can lead to co-ordination channels being complex across regions as the role of the central government “shifts towards supporting decentralized service delivery, central-level regulation and oversight skills that are often in short supply” (Partners for Health Reformplus, 2002:p7).

Chhibber (1997:p19) blames decentralization especially in instances: where there are gaps between regions and the rich and poor within a country; where national government loses control of macro-economic policy as a result of provincial and local government fiscal in-

discipline which leads to frequent bailouts from the centre; and where local governments fall under the sway of special interests, which may lead to the misuse of resources. Prud'homme is of the view that decentralized systems are not the most effective in reducing interjurisdictional disparities as opposed to a centralized system, and that a centralized system would be able to distribute income from richer to poorer areas, even under regressive tax and expenditure systems in which per capita expenditures or benefits increase as per capita income rises. According to Prud'homme (1995:p203)

> The conclusion that emerges from analytical and empirical research is that national budgets tend to reduce regional disparities. Any reduction in the importance of national budgets relative to those at the sub-national level (a definition of decentralization) therefore increases interjurisdictional disparities by reducing the impact of national policies designed to correct regional inequities.

The design of a decentralization system hinges on the political and governance system of a country. The political system not only provides the context but also influences the outcome and nature of the governance system, which, in turn, determines and influences the establishment of its governance and decentralized system. The organisation of the governance and public health system, therefore, reflect the general trends of the political system. It is the nature of the political system that allows politicians and public policy makers to decide about “the nature of decentralization, the degree of authority of decentralization, the roles of the public and private sectors and the speed with which the decentralization will take place” (Kolehmainen-Aitken 1992: p12).

Models of governance

The governance model, which also finds inscription within the legal frameworks of countries and its overall political system, is an inherent aspect of the decentralized systems of governments. The legislative frameworks, but more specifically country constitutions, dictate discretion, responsibility, and accountability between the different spheres of government. However, while both the political system and governance model certainly have strong influences on the decentralized system, it is necessary to take account of why countries opt for decentralization as a policy option.

The governance system determines the role of the central government relative to sub-national governments and semi-autonomous units. Governance comprises structures, mechanisms and processes through which power and authority are exercised between and within different levels and organs of the government and state. The premise of the governance system also influence and serves as a determining factors in the form of decentralization a country decides and implements.

State control

Kooiman (1993) distinguishes three models of governance: state control, state supervision and state interference. In terms of this dissertation, the state control model is a normative system of rational decision making. Within the public service sector, the state control model concerns itself with the designing of the objectives and the regulations of the public health system through the public finance and health sectors. It is in this way that the public finance and health sectors, singularly or collectively, maintains and continues to exert control over all major public health functions and responsibilities, including the policy, finance or administrative behaviour of lower levels of government. Control, furthermore, happens at a political or administrative level through an occasional strong central state. The overall intention and aim of the model are to maintain and enforce hegemony within a decentralized governance system. The attainment of hegemony happens through coercive rule and, through this, the central state increases its capabilities to enforce its national political development project without consent. An application of this model by either the public finance or public health sector would mean that the decentralized co-operative governance of the public health system were entirely created by the central government and almost completely controlled by it and that anything that did not confine itself to the political agenda of the centre would be certainly repressed.

State supervision

In the state supervision model, the central government supervises the lower levels of government through a regulatory framework. This regulatory framework ensures a high degree of accountability. Within this model, the reformist role of the central state is recognised. The central government, through either the public finance or public health sectors, would set the overall policy objectives and regulations of the public health system,

monitor the achievement of these objectives and, thereby, determine the rules that guide the behaviour of the sub-national governments so as to maximise the chances of achieving decentralization objectives. In most state supervision models, governance systems are well established and supervision is only required to modify and ensure greater efficiency. In this model, lower levels of government are expected to produce the output that central government wants them to produce, through the use of regulation directives, fiscal resources, and through incentives which are embedded within the public policy system.

State interference

In the state interference model, central government interference occurs when sub-national governments become sites of opposition to central government policies. The opposition a public policy perspective, for example, occurs when policies are subverted or just simply ignored. The non-provision of from fiscal and other forms of resources for the implementation of the public policy are examples of such opposition. When these forms of opposition or undermining of public policies occur, central government intervenes. In many developing countries, central government interference occurs whilst autonomy of the sub-national governments remains the official policy. In Argentina, for example, provinces are well-established rivals of the central government and command strong local loyalty. In Colombia, lower levels of government are former outposts of the centre (Dillinger and Webb 1999:p24). Accordingly, their nascent independence is part of the central government executive's strategy to enhance the legitimacy of the formal government in the face of challenges from guerrilla and para-military groups.

Within the state interference model, central governments have been able to use their strong or overriding powers to impose a co-ordinated solution to intergovernmental public policy conflicts and tensions. This, according to Watts (1998:p6), leads one to question whether the practice is “imposed co-ordination" or genuine "co-operative governance". This model holds that the central state re-establishes its political hegemony through intervention within sub-national governments. A corollary of this is Section 100 of the South African Constitution that allows for interference based on objective conditions in provinces and direct central government monitoring, supervision and intervention in provincial affairs under specific instances. This model has the potential to undermine sub-national government autonomy and decision making.

Although the three models are not ends in themselves, but rather a continuum of governance systems, they provide an indication of the nature and extent of relations within and between the central state and lower levels of governance. All three governance models have difficulty in accommodating divergent and conflicting interests. Clearly, any governance model for South Africa should at least be able to accommodate different and conflicting interests between organs of the state and civil society. The above models do not acknowledge that no single actor has the possibility of solving the problems alone. Given that the state is a contested terrain, what is required is a process and governance model that accommodates conflicting and divergent interests in and within the state. Also, given that the government comprise different levels, a governance system ought to hold the different levels of government together.

Co-operative governance

Cloete, Moja and Muller (1995) refer to 'self-binding', a process of co-determinations where a set of accommodations is reached between opposing interests groups that realise that they have competing and complementary interests in the state. This would in practice mean the building of trust within and between organs of the state, which would lead to a shared accommodation of the state's role and programmes. In an intergovernmental context the shared accommodation is about how central and provincial governments interpret their constitutional, legislative and policy responsibility and authority. It is also about how central and provincial governments accommodate each other in the value proportion of the public health function and the policy process within the co-operative government system. Moreover, it is about how the processes of self-binding are articulated in the allocation and determination of separate and different responsibilities and accountability within the policy value chain.

Given its history, politicians in South Africa as a result of conflicting past between government and civilians, but also the outcome of a negotiated constitutional settlement, opted for a co-operative governance model that promotes the state as a shared commodity between competing interests. Co-operative governance, according to Pimstone (1998), reflects the complexity of the constitutional order, the existence of concurrent powers by the

different levels and the competition between the levels. The principal idea is that the levels of (Pimstone 1998: p7):

> …government must co-operate with one another in mutual trust and good faith by fostering friendly relations; assisting and supporting one another, informing one another on matters of common interest; coordinating their actions and legislation with one another; adhering to agreed procedures and avoiding taking legal proceedings against one another.

This model contributes to the process of reconciliation between opposing interests within the state, thereby ignoring the systemic roots of conflicting interests in the state. The model provides a platform for depoliticising the nature and extent of decentralized co-operative governance of public policies.

There are, however, elements of the other systems present within the co-operative governance model. Ostensibly, both in theory and practice, the model is a hybrid of the other three models, reflecting elements of the central state control, supervision and intervention models. In fact, given its constitutional responsibilities relative to those of lower levels of government and governance, the central government is still constitutionally and legally strong. It is within the internal operations of the co-operative governance model, where the central government dominates, determining policy, finance, and administration of the health system. However, because of the complex public policy role of the central government, it does not mean that an analysis of the decentralized co-operative governance of the public health system is entirely dependent on the political and governance system; it also hinges on the patterns of health system decentralization and organisation.

However, other than providing for a description of the application of the decentralized co-operative governance model, the literature reviews limitation is, that it does not provide the tools to analyse the impact of decentralization within the health system. Also, the intention of this dissertation is to unbundle the health function to get deeper insight into the location of responsibilities and authority between the levels of government as they unfold within the co-operative governance's arena of practice. By doing this, the research would allow for analysis of each of the responsibilities associated to the health function. It is therefore not inconceivable to suggest that certain health responsibilities and authority associated to the

health function could reflect the practice of the different models. This is especially possible where the health function is a shared responsibility between the central and provincial governments.

The South African decentralized public health and finance systems also reflect extensive asymmetry between responsibilities and expenditure assignment on the one side, and own revenue sources on the other. This has resulted in a severe fiscal gap for the provincial governments, which are the main deliverers of public services, such as public health. The researcher is of the view that the asymmetrical arrangements in the public finance system within South Africa are primarily determined by political and macro-economic policy considerations. The contention is, therefore, that the central government's key concern will be its ability to: maintain and macro-manage public health policy implementation through norms and standards; manage the macro-economic and fiscal policy processes and their implementation; and ensure uniform levels of decentralized public health administration. An asymmetric approach would, therefore, allow the central government either to delegate or devolve certain competencies to certain provinces that have the capabilities to deliver a full range or some parts of public health services. Clearly, such a practice allows central government to distinguish between strong and weak provinces and to assess which functions ought to be delegated or devolved to provinces.

Given the reasons for asymmetry and its applicability in the South African decentralized governance model, the level of political and economic developmental conditions demand both a strong centralist approach for one set of economic and political objectives and, within a decentralized system, another set of economic and political objectives. It is generally accepted among politicians and scholars of governance that a province such as KwaZulu-Natal is an example of asymmetry, due to political considerations, and the Eastern Cape Province, in turn, a classic example of fiscal, administration and service delivery considerations for capacity reasons. Although the two approaches have inherent tensions, they have also exacerbated tensions in the decentralized intentions of central government in the domain of policy, finance, and administration of the public health system because of the differential treatment of provinces. These tensions have, however, in an odd way brought about benefits to the provinces to the extent that a substantial part of public expenditure occurs at the provincial level. The composition of the expenditure could, therefore, be tailored for provincial service-delivery responsibilities and, possibly, facilitate an alignment

between the intended services to be provided and the preferences of the people living in the provinces.

At face value, it seems that the intention and practice of decentralized co-operative governance influence impose a common national purpose between the spheres of government. It is assumed that this common purpose ensures that central government plans and priorities are influenced by and characterise the interests of sub-national governments. Central government makes the rules under which sub-national governments operate by setting norms and standards. Dillinger and Fay (1999) argue that the power of sub-national interests in the central government has a key bearing on how intergovernmental or principal-agent relations are institutionalised. These authors argue that giving too much power to provincial and local interests makes it difficult to defend national interests above regional ones when the two are in conflict. On the other hand, too strong a central government stifles the political openness, service-delivery, governance and management innovations and efficiencies intended by decentralization. The South African Health Review (1999:p139) mentions:

> Experiences from other countries show that decentralization is nearly always resisted by central officials. Conditions that contribute to the continued centralization of resources, authority and power include the centralizing of finances and the hierarchical culture of the civil service. In addition, officials at the periphery of the health system are usually lower ranked than officials in the centre – therefore, while there is a decentralization of responsibilities and activities, there may not be a concurrent decentralization of authority and seniority within the health system, especially at district level.

Certainly, the public policy approach to decentralization has amplified the constitutional competencies of the provincial governments in public health service delivery, in spite of the organisational, infrastructure and resource weaknesses within certain provinces, inequitable access and the distribution of resources between central and provincial governments, and the horizontal distribution of resources between provincial governments. Moreover, provincial governments have increasingly demanded more resources, powers and functions by requesting either asymmetric or subsidiary decentralization, in spite of varying organisational, financial and service-delivery capabilities. The researcher is of the view that the transformation challenge is whether there should be situational or comprehensive interventions at a provincial government level on policy implementation, systems

development, financial and human resources management, and service-delivery capacity building.

For macro-economic reasons, central governments prefer to maintain control over the major national tax bases for their own budget (Bird 2000a; 2000b). By allowing such a policy stance on the function, the centre therefore exercises a greater deal of power through fiscal control. This has also happened, according to Das Gupta and Rani (2004:p3), in post-independence India where the tradition is

> …a strong centralized planning and policy making and decentralized implementation, and the relative financial control of the central government – rooted in constitutional fiscal provisions – has given it significant leverage to determine the end use of its devolved funds to the states.

The provincial and local levels of government are in this way kept on a tight fiscal leash and the autonomy provided for within the law is more apparent than real. Das Gupta and Rani (2004:p3-4) illustrate this with reference to public health functions:

> Using its financial and political leverage, the central government can persuade the states to work towards specific health objectives and priorities, and provide the necessary technical support.

Prud'homme argues that the inability of a decentralized system to pursue effective redistributive policies sees regional disparities as an abnormal phenomenon resulting from accidental shocks that will be reduced and be eliminated automatically by the movement for goods, capital and labour. Prud'homme (1995:p202) emphasises that

> Poor people are poor anywhere and should be aided irrespective of their place of residence. There is no guarantee, however, that transfers to low income areas will effectively benefit poorer residents. And although it is often maintained that reducing income disparities will automatically reduce disparities among regions, this argument is not compelling for several reasons.

Efficiency argument of decentralization

The literature holds that central governments should have the responsibility for macro-economic stabilization and finance redistribution and should provide national public goods, which involve substantial economies of scale. On the other hand, lower levels of government should provide services, which are consumed locally, so that public services could be "tailored to the preferences and circumstances of the various geographical constituencies that comprise the nations" (Oates, 1998: p XIV). The assumption is that preferences vary among localities and that resources allocated by decision makers will fit local preferences better than would a standard national package. According to Litvak and Seddan (1999: p10):

> The benefits of decentralization (that is, greater allocative efficiencies) can only be realised if local leaders have flexibility to respond to local needs and desires of their constituencies; if they have the financial and human resource capacity to respond effectively; if they are accountable to their populations as well as to the central government (for services delegated to local governments); and if local and central governments can obtain information and monitor services for which they are ultimately responsible.

An example of Litvak and Seddan's (1999), statement is South Africa's Limpopo Province, where central government places strong emphasis on housing in the allocation of funds, yet housing was not a priority for this province because of its rural nature (Department of Provincial Affairs and Constitutional Development, 1998). This example appeals to economic efficiency, which argues that if the mix of public services differs across sub-national governments and if externalities are not present, then provincial welfare can be maximised if it is based on the preferences of voters. This form of adherence to preferences of voters for services is also called benefit matching. Ter-Minassian (1997:p36) mentions that decentralizing spending responsibilities can bring substantial welfare gains, and that "[g]overnment resources can be allocated most efficiently if responsibility for each type of public expenditure is given to the level of government that closely represents the beneficiaries of these outlays".

The efficiency argument assumes that public services should fit the diverse expectations of the public and that bringing government closer to the people, better and appropriate services could be provided. The efficiency argument proposes that if preferences for public

services differ across sub-groups of the population, and if externalities are not present, then national welfare is maximised if local communities vote their preferences and provide the level and mix of public services that they want (Bahl, 1996; Shah, 1994). The efficiency argument also assumes that public services are provided more efficiently by the jurisdiction having control over the minimum geographic area that would internalise benefits and costs of provision. This refers to geographical area matching. The results of decentralization are such that: a) the mix of services provided will match the demands of the local population; b) government officials will be become more accountable for the quality of services they provide; and c) that local populations will be more willing to pay for public services, since their preferences will be honoured, especially if they have been involved in the decision making for delivery of these services. Bahl (1999: p2) mentions

> …when preferences among voters are diverse and local governments have responsibility for delivering those services that do not have major external effects, the potential benefits include better public services, better accountability on the part of government officials, more willingness to pay for services, and hopefully development from below.

The efficiency argument implies that through decentralization the revenue base could be expanded, thereby contributing to an increase in the overall revenue mobilisation. This is possible through shifting certain taxing responsibilities to sub-national government. The argument is that lower-level governments not only know their tax bases, but also have better access to information on opportunities for revenue mobilisation and can capture those taxes that escape through the national government tax net. Freinkman and Yossifov (1999) also maintain that the gains may be derived from comparative informational and wider contextual validated planning advantages of sub-national governments, which are better positioned to reflect recipients' preferences in the process of service delivery.

The principal-agent relations, decision making and accountability

The design of public policies, which: (a) unbundles the shared responsibility for the health function between the central and provincial governments; (b) differentiates between the types of public health care services, both preventative and curative, which are to be provided and by which sphere of government; and (c) clarifies what constitutes primary,

secondary and tertiary health care to be provided by the different public health care institutions and governance structures, including both management or technical and political decision-making processes in the public health sector, have been uneven. Different policy developments, such as the provision of “free health care”, the development of the district health system and the building of clinics and community health centres have “occurred ahead of other streams, notably hospital sector reforms” (Schneider, Cabral, Gilson, Cele, Laubser and Magongo (1997: p1). Schneider et al. also note in their brief report of July 1997 that “legislation and procedures for key public service functions at provincial level have yet to be finalized, and decision-making in certain areas is still highly centralized nationally”.

Developed and developing countries have made significant shifts to increase the competencies, responsibilities and authority of lower level governments. These shifts have been necessitated to a large extent by the need to improve government and governance and to improve the implementation of good administrative and service-delivery systems in response to the needs of citizens. The shifts are not only seen as critical to sustainable democratic transition and economic growth but also to ensure a closer correspondence between quantity, composition, and quality of public goods and services provided by lower levels of government. The intention is both to create and ensure allocative and technical efficiencies within the government system. According to Mills et al. (1990: p12), since the 1970s and 1980s governments within developing countries felt “sufficiently secure to contemplate relinquishing part of their tight control on power and decision-making”. Bossert et al. (2000: p2) are of the view that

> In some cases, this shift redefines the functional responsibilities so that the centre retains policy-making and monitoring roles and the periphery gains operational responsibility for day-to-day administration. In others, the relationship is redefined in terms of a contract so that the centre and periphery negotiate what is expected from each party.

The decentralization of public health policy and implementation is further complicated by a set of principal-agent relationships between the central and provincial governments. According to Burki et al (1999:22) it is within this set of relationships that “sub-national governments act both as agents of higher levels of government and as principals (or more precisely as agents of their constituents) in the delivery of local services” In this type of relationship central government has acted as the principal of policies, thereby not only setting the service-delivery and financing agenda for the provinces, but also determining the

norms and standards against which delivery and efficiency are measured, including resource allocations.

Given the resource limitations of the provinces, central government has funded provincial service delivery obligations with transfers from the national fiscus. In many ways this practice has highlighted the dominancy in policy determination, fiscal and financial, and administrative issues of the decentralized health system. The provincial governments have to fulfil, or rather attempt to fulfil, the responsibility of being the implementing agent to central government in terms of service delivery, management, administration and the financing of the health system. Although the agent responsibility in this instance is congruent with the element of benefit matching – that is, the services are provided to and the benefits are accrued by those individuals in a given province that fund (user fees and other revenues) those services – it limits the flexibility of the provinces as the agents to provide services other than those pronounced in policies. On the other hand, benefit matching provides the opportunity to the agents to reduce the "tendency for residents to view additional government spending as if it were free or costless to society" (Turnbull 2002:p8).

Within this principal-agent relationship, the central government has often delegated and devolved health policy implementation and service delivery responsibilities to the provinces. This has sometimes happened without the requisite resources, resulting in unfunded policy mandates. The nature of this type of relationship, where provinces are given additional responsibilities without resources, has not only led to conflict in policy implementation between the spheres of government, but also contributed to a further unbundling of service-delivery responsibilities in the public health system. Placing this relationship in the context of decentralized co-operative governance requires a re-examination of public policy, finances, and the overall implementation of decentralized responsibilities, given the vertical and horizontal division of fiscal resources between the national and provincial spheres.

Fitting in with the benefit-matching element of the agent responsibility of the provinces has also been a comparative advantage regarding information about "boundary-matching" (Turnbull 2002:8) issues related to service delivery over which public health extends. The boundary-matching approach provides provinces with comparatively a better understanding of disease patterns, hence the potential of different public health priorities relative to those of central government. Furthermore, agents have their own interests and preferences that

could diverge from their principals. This leads to agents also having information that principals don't have, thus introducing information asymmetry and rigidities within the system. This asymmetry emerges potentially from different perspectives and ostensibly different responsibilities for specific functions, which consequently flow from fundamentally different approaches to public policies and financing. The typical principles and conditions from which an asymmetry originates from are:

a) The power, authority and decision making capabilities between the central government and the provinces, based on comparable fiscal capabilities, which could serve as the driving force behind public policies;
b) The macro-economic responsibility, which lies with the central government to ensure stability and proper controls, particularly the location and process of macro-economic and fiscal policy production;
c) The fiscal and social policy (for example, public health) co-ordination and implementation;
d) Competing budgetary priorities and service-delivery priorities between the central and provincial governments, where claims are made that the provinces do not follow public policy imperatives of their own making and bear the budgetary brunt (Greenstein 1997);
e) The horizontal and vertical interaction within the decentralized co-operative governance system at a provincial level, where, asymmetry of a different kind is experienced; and
f) Budgetary and administrative functions, which have been decentralized and the consequence of reducing available national fiscal resources, and thereby expecting local level accountability (Lethbridge 2004).

As regard point e) above, variation in the administrative and service delivery capacity coupled with competing budget interests also take place between different obligations and sectors. The competition for budgets and other resources in the public service where there are competing service-delivery demands and priorities such as between additional resources for primary health care as opposed to tertiary health institutions.

A key thrust of central government would, therefore, be to influence how public goods and services are provided locally by setting policies with clearly determined norms and standards for delivery. The responsibility for the implementation of these policies has been closely associated with the role of central governments. The intention of having common norms and

standards is to reduce inter-regional barriers to factor and goods mobility and thereby contribute to efficiency gains. However, the difficulty of succeeding with this is the absence and or lack of requisite information needed to develop the cost estimates within the South African context. Also, costed norms are more appropriate for reviewing policy proposals prior to sector budget approvals.

The achievement of minimum norms and standards for public services across different states can be encouraged through different grants to equalise sub-national governments' capacities. The grants are favoured because they are "unobtrusive, allowing state governments to spend grant monies as they choose as long as they meet certain minimum standards of service and access" (Shah 1994: p29). The responsibility of the central government or the level of government providing the grant is to monitor and evaluate compliance with the standards. In support of equalising grants, Ter-Minassian's (1997: p36) mentions:

> The central government can influence how these goods and services are provided locally by setting policy guidelines for their delivery, by transferring resources to sub-national governments to equalise their capacity to meet these guidelines, and by controlling ex post the level and quality of services.

There are various problems (Partners for Health Reformplus, 2002: p6-8) that are frequently experienced in the design and implementation of decentralization. These problems include a mismatch between authority and responsibility, where lower levels are responsible for health care spending but do not have the requisite revenue-raising authority to absorb escalating health costs, such as the supply of the latest drug or appropriate technology for higher levels of care to citizens. Others include tensions and conflicts among decentralization objectives, particularly in shifts in service mix away from priority services. These tensions normally occur in cases of devolution where health providers such as lower levels of government respond to local preferences for curative rather than preventative and primary health care services. Khaleghian and Das Gupta (2004:p6) suggest that

> [the] very decentralized provision of goods by governments, in which local citizens push for choices given a budget constraint, will often lead to a revealed preference problem similar to the one that leads to the necessity for public provision to begin with. Small governments will tend to vote to provide the goods which citizens reveal preferences. They will therefore

> tend to spend on private goods types such as curative care clinic visits rather than on public goods type services such as health education and communicable disease control. Small governments may, therefore behave too much like individuals, with residents not receiving their preferences for public goods but in fact for private goods provided publicly.

The unresolved policy interests within principal-agent relations are reflected on occasion through shirking (for example the provincial governments could be required to implement a programme of HIV/AIDS/STD, but prefer to use the resources for infrastructure investment), stealing (where grants are claimed for one purpose, but used for other services), different delivery deadlines (the provincial governments may not have the luxury of time to implement a project compared to central government because of a difference in basic infrastructural needs and capacity,) and different risk preferences (the provincial governments may be able to take bigger risks compared to what central government is prepared to take).

While these changes ought to improve technical efficiencies within the overall public health system, Khaleghian and Das Gupta (2004:p6) warn that such independent behaviour, as a consequence of autonomy built into the overall public health system, "can be a dangerous thing, leading not only to policy fragmentation and self-serving behaviour…but also high transaction costs". Also, if such autonomy is not properly managed between the central and provincial governments, it could lead to unresourced and unintended spillovers into adjacent provinces, but also affect the manageability of adjacent districts.

The government-sanctioned *Provincial Review Report* (Department of Public Service and Administration, 1997) is of the view that different central government departments formulate public policies without exploring how the different provinces will implement these policies. The Report holds that the "unwritten expectation is that provinces will make the necessary financial and organisational arrangements. There appears to be an assumption at a national level that policy will automatically become activity" (1997:p14). The remuneration levels of medical personnel are an example of how central government sets the national policy framework, while the provinces are responsible for its delivery, administration and financing. The policy practice where decisions are taken at one level and implemented at another has, in many instances, contributed to tensions and potential disarticulation between policy mandates, functions and financing obligations, leading in various ways to mandate drift.

Greenstein (1997) eloquently asserts that central government "hardly plays any role in implementation and delivery of services … and it does not carry its own policies. It thus bears no responsibility for seeing them translated into concrete programmes of action, nor is it accountable for its failures". This practice could suggest an unequal role in policy design and perception that, because the provinces implement policy, they are de facto conveyor belts of central government policy implementation.

The assignment principle, encapsulating the assignment of functions and responsibilities, expenditure and revenue generation, argues that because of differing technical characteristics of various public services and revenue sources, different levels of government are better equipped to administer certain services. The decentralization strategy of a country should therefore guide the assignment of expenditure functions, suggesting that each level of government should be provided with control over the minimum geographical area that would internalise the benefits and costs of public service provision. It is therefore important to distinguish whether sub-national levels of government determine the allocation of spending or whether national government mandates spending and that these levels simply execute spending (Litvak and Seddan 1999: p19). Litvak and Seddan further note that "both theory and experience strongly suggest that expenditure responsibilities need to be stated as clearly as possible to enhance accountability and legal challenges" (1999: p19).

According to Bird (2000a), even in the most decentralized countries, lower levels of government remain dependent, to a large extent, on central financing and are almost inevitably subjected to a certain degree of central influence, monitoring and in some instances, control. For Ter-Minassian (1997), separating the expenditure authority from revenue-raising responsibilities, obscures the link between the benefits derived from public expenditures and their price – that is, the taxes levied to finance them. The alternative preferred by most countries is, according to Ter-Minassian (1997: p37):

> … one that provides for the assignment to each level of government of its own sources of revenue in combination with various types of intergovernmental transfers to bridge any resulting gap between revenue and expenditure assignments.

The South African Constitution, Section 214 (2) (a to j), provides for the criteria for the division of revenue, including the principle of decentralization on the expenditure side and

the assignment of substantial responsibilities to the provinces. Although the division of competencies between the spheres are set in the Constitution's Schedules 4 and 5, the overlaps between the concurrent and exclusive responsibilities are not always that clear. The 1997 Public Service Commission, in particular, mentioned that the separation of these functions between the spheres was not self-evident. The Department of Finance (1999a:p12) also mentions that:

> The exact functions of the national and provincial departments continue to evolve and are based on a practical interpretation of the Constitution and political agreement reached through forums such as technical committees.

The exclusive functions assigned to provinces are that provide provincial benefits. The concurrent competencies or functions are those shared with central and sub-national governments. Several of the expenditure assignments in South Africa, such as health expenditure, are assigned concurrently to the central and provincial governments. However, because of the shared responsibility for health, conditional grants were introduced in 1998 are allocated to address the spill-over effects. It is expected, for example, that as a result of these grants residents living outside provinces with academic hospitals will have access to these tertiary health care services.

According to Chellian (1999), the majority of central governments have the powers to levy the most important and reproductive taxes. Therefore, this arrangement requires central government to transfer a substantial proportion of its revenue to the provinces to enable them to fulfil their expenditure responsibilities. This centralization of taxing powers is derived from the Constitution in the interests of the integrity of the national economy, equity, economic efficiency (non-distortion in the allocation of resources and the minimisation of costs) and administrative ease. Chellian (1999: p2) argues that revenue decentralization is limited for several reasons, including administrative capacity.

The accountability principle suggests a ‘‘link between the benefits of public expenditure and their price, that is, the taxes levied to finance them” (Ter-Minassian 1997: p8). Accountability in a decentralized system requires the close scrutiny and enforcement of rules contained in a country’s constitution and related policies and legislation. The literature suggests that accountability could be attained through: (a) designing transfers so that these transfers do

not motivate lower levels of government to neglect revenue collection, overspend and divert their energies to 'game playing' in order to attract supplementary funding from the centre (Ma 1997); (b) encouraging competition wherever possible between sub-national governments as a spur to efficiency; (c) making performance information accessible and relevant (Bird and Vaillancourt 1998); and (d) encouraging public scrutiny.

Revenue, Budgets and Expenditure

The principle of expenditure assignment argues that the responsibility for expenditure should be assigned to the level of government that corresponds most closely to the geographical area of social benefit. Devolving expenditure autonomy to sub-national governments is a critical aspect of decentralization. This is to be expected because expenditure responsibilities require a determination of what level of government is to provide a particular service and the responsibility for public expenditure. Such expenditure assignments lead to efficient allocation of resources and thus increase welfare by ensuring expenditure priorities reflect the preferences of locals. Allocative efficiency claims that public expenditure made by a level of government that is closer and more responsive to a local constituency is more likely to reflect the demand for local services than decisions made by a remote central government. The claim is that people become more willing to pay for services than respond to their priorities, especially if they have been involved in the decision-making process for the delivery of these services.

In a complementary way, the central government would be responsible for functions where the benefits extend nationally or where economies of scale are important. Two broad types of expenditure decentralization can be distinguished. The first is delegated responsibility, especially where lower levels of government are responsible for central government policy implementation, thus acting as agents of the central government. The second is devolved expenditure responsibilities, where lower levels of government have discretion in making allocation decisions and the ability to determine how services will be delivered, thus allowing expenditure to accurately reflect the needs of the locals.

Dillinger and Webb (1999: p12-13) suggest that, without lower levels of government having autonomy over their expenditure, there is really no decentralization. The argument is that responsibilities should be assigned to the lowest level possible without compromising the

effective provision of the public service. The spin-off is that decentralization will improve efficiency in resource allocations and social welfare and that the greater the share of public expenditure assigned to provinces and municipal governments, the greater the need to involve them in the pursuit of any needed fiscal adjustment. The expenditure assignments to provinces may be based on “efficiency of public service provision and responsiveness to local needs and concerns even though it may be in conflict with national equity and efficiency objectives” (Shah 1999: p28). The expenditure assignment principle supports the proposition that it is best that the central or federal government perform the redistribution role of the public sector.

According to Chellian (1999), the level of political and economic development within South Africa indicates that decentralization should be confined to the expenditure side and that the provinces be allowed to benefit from the autonomy that the decentralization of expenditure brings. Arguably, the decentralization of expenditure alone could give autonomy to the provinces only to alter the composition of expenditure if the transfers are not conditional. Anwar Shah’s (1994) view is that the decentralization of responsibilities and the rationalisation of intergovernmental transfers should be supported in strengthening local institutional capacities. The intention of intergovernmental transfer is therefore to “correct” the decision-making process of local governments.

Revenue

The enhancement of the revenue-mobilisation capacity of lower levels of government is also in support of decentralization. Revenue assignment addresses what level of government has the right to levy, collect and retain taxes, user fees, and other forms of revenue, including the methods and administration for collection. Some taxes are not only suited to local and provincial governments because their assessment and collection requires familiarity with the local and population, but also because they are perceived as quasi-benefit charges that finance local services. The appropriate structure of sub-national finance, Burki et al (1999: p27) argue, “depends on the functions that have been assigned to each tier of government. This is because different sources of revenue have different effects on behaviour and different patterns of incidence.” However, to effectively address the allocation or devolution of revenue responsibilities, four key questions must be addressed: a) which taxes are to be devolved to sub-national governments; b) are sub-national

governments going to be allowed to set their own revenue collection rates; c) must the base for a revenues be uniform or can it differ between regions or sub-national governments; and d) who will be responsible for the revenue administration?

Policy actors disagree about which taxes should be assigned to the various levels of government. Both distributional and macro-economic management considerations argue against arrangements assigning all or most taxing powers to sub-national governments, with upward revenue sharing, especially if the sharing formula is renegotiated frequently (Ter-Minassian 1997: p37). According to Ter-Minassian (1997: p37) upward revenue sharing arrangements can only be viable in countries that have a long established tradition of close policy co-ordination among different government levels and loose confederations and have in common economic areas in which responsibility for stabilization policies continues to rest primarily with state members. Furthermore, by devolving taxation one promotes fiscal accountability to appropriate levels of government for the benefit of citizens. It is through devolved taxes that sub-national governments are allowed to differentiate the levels of services provided, thereby enhancing accountability between all the levels of expenditure. Spending at sub-national level will therefore be in line with sub-national priorities and local citizen preferences.

Transfers

The transfer principle denotes that intergovernmental transfers should be managed so as to defend national interests for macro-economic stability and for equity. The simple logic according to Hubbard (2001) is that the allocation and accountability principles suggest that, where possible, revenues to finance sub-national government services should be raised locally for local provision of services. However, these principles ignore that intergovernmental fiscal relations, which are of increasing importance as transfers from the centre, grow to finance the excess of sub-national government expenditures over revenues.

Transfers have the potential to generate limits on the extent to which own revenues can provide for increased expenditure responsibilities in sub-national governments. The assumption of transfers is that they should not adversely affect the sub-national government's incentive to raise its own revenue or to manage its expenditures effectively. Transfers are a form of revenue sharing directed towards rectifying the imbalances between

revenue and expenditure assignments, thereby encouraging redistribution of resources. Transfers can, however, encourage sub-national governments to under utilise their own tax bases and budgets – for example, putting them on a matching-fund basis and subject to clear, enforced rules with hard budget constraints. The worst distortions result from unconditional, discretionary transfer to fill gaps between sub-national government expenditure and revenue, thereby encouraging the lack of control over revenue and expenditure. China, for instance, suffers from 'gap filling' transfers arrangements, resulting in poor local control over revenue and expenditure, over-reporting of deficits, and strategic lobbying (Ma, 1997). The problem is also widespread in transition economies. In these economies both central-province (state) and province-municipality (local) require major restructuring and the transfer funds allocations are usually arbitrary and discretionary (Shah, 1994:p45).

Decentralization enhances revenue mobilisation, because some revenue collection initiatives such as levies, user fees and the like are better collected by the administration closer to the communities because of the familiarity with its revenue collection base. There are a few taxes that are buoyant and easy to administer at sub-national government level but broad–based buoyant taxes, such as VAT, are best managed by the central government (Hubbard 2001). However, the principle that underpins transfers is that they should not adversely affect the sub-national government's incentives to raise its own revenues or to manage its expenditures effectively.

Transfers are either unconditional or conditional, reflecting the philosophies regarding sub-national and central government roles. It is therefore important that (World Bank 1994: p76):

> When national [central] governments make transfers to the sub-national level to offset inter-regional inequalities in resource mobilisation capacity, these transfers should remain transparent. Transfers that are not clearly publicised to local users can undermine local government accountability and jeopardise the improvement incentives sought from decentralization.

Transfers consist of revenue sharing and grants. Transfers are not only the glue that holds a decentralized governance system together, but are also the primary source of revenue for sub-national governments in most developing countries Shah (1994: p24). Bahl (1996) suggests that intergovernmental transfers are a compromise solution in the debate over the division of revenue-sharing authority and expenditure responsibility. The design and

implementation of transfers are crucial for efficiency and equity of local and provincial public services and the fiscal well–being of sub-national governments. The distribution of resources is particularly important for public functions in relation to health services and provision in reaching vertical and horizontal equity. Horizontal equity refers to the distribution of resources in the health provision across the provinces, whilst vertical equity is about the distribution of financing for public health between the central and provincial governments. Both have therefore, an implication for the deployment of fiscal resources in the public health system and the lines of accountability for public health functions.

Transfers make central government arrangements more managerially complex and introduce common pool and principal-agent problems. This is so since sub-national government is concerned with the welfare of the geographical area and as the conditions demand and at the expense of the centre (De Mello 2000:p373). These problems could result in destabilising national budget deficits and increased inequity between localities unless the central management of transfers adequately defends national interests.

Conditional Transfers

Conditional grants reflect an expenditure-led approach, based on the assignment of spending responsibilities to levels of government and using transfers to close gaps between resources and responsibilities. The proponents of the expenditure-led approach argues that sub-national governments are faced with expenditure consequences of national policies for good or ill and that an expenditure-led framework is needed to ensure that they can cope with those consequences (Davey and Devas 1996:p234). Conditional grants support functions that have a high national priority, but may have a low sub-national government priority.

The system of conditional grants is a deficit move towards fiscal decentralization because it finances sub-national governments services, but the degree of autonomy it gives sub-national governments in making their budget decisions depends on the structure of the grant system (Bahl 1996:p5). Unconditional transfers are revenue–led (Davey and Devas 1996:p234). The philosophy is that governments at all levels should determine their own expenditure responsibilities.

Summary on literature review and relevant research on decentralization and co-operative governance

While the different models provide a structural orientation of, they ignore the functional aspects of decentralization and governance. Similarly to the structural orientation, the distribution of functions is either vertical or horizontal. Further clarity in the structural and functional orientation of governance and decentralization is provided by di Gropello (2002:p2-7) through an identification of: the level of integration of institutional functions (regulation, financing, articulation and production); the level of integration of populations (horizontal integration or segregation); the level of territorial decentralization of the main functions; and the level of institutional decentralization of the main functions as the dimensions that characterise public health system.

Within the public health system, the level of integration of the main functions is about the level of vertical integration or separation of the main functions constituting health care delivery. di Gropello (2002) is of the view that the current trend in public health care system reforms is to promote a separation of regulation, financing, articulation and production. At this level, the separation of financing and production and the separation of financing and articulation are considered to be critical characteristics. The separation of financing refers to the mobilisation of fiscal resources from different sources, while the production function refers to "the combination of inputs into the production process that takes place in a particular organisational structure and leads to a set of outputs" (di Gropello, 2002:p2). Accordingly, the separation "involves the end of budgets assigned in advance to public providers and the introduction of negotiated competitive contracts which force health institutions to compete and, hopefully, to increase the quality of efficiency of health care delivery" (di Gropello, 2002: p2).

The separation of financing and articulation refers to the organisation and management of care consumption where articulation is meant to convey the notion that the function pulls together and gives coherence to various components of health care. This separation also involves key activities that (di Gropello, 2002: p3):

> allow financial resources to the production and consumption of health care, like determining service specifications (type of service, price, volume, quality), carrying out

> population/epidemiological needs assessment of the population served, enrolling populations into health plans, determining a strategy to assure quality health care, selecting providers that are qualified to provide services, selecting the payment mechanisms of the providers, and contracting for services.

The level of integration of populations is about the extent that different groups are allowed access to every institution in the health system. This level of integration is at the heart of equality and equity considerations as key values. These values find particular expression in the public policies of governments. According to di Gropello (2002: p3):

> At the end of the dichotomy is segregation, whereby different segments of the population are segregated into the different health care institutions, and at the other end is 'horizontal integration' where all groups in the population have potential access to all institutions.

While territorial decentralization is about the geographical location of responsibility – that is, the transfer of responsibility to sub-national territorial units such as provincial and local governments – institutional decentralization is about the transfer of responsibility directly to institutions. di Gropello (2002) mentions that this type of decentralization intends to enhance the quality and efficiency of service delivery through a better responsiveness to consumers and thereby increasing accountability. The advantage, according to di Gropello (2002: p4), is that by distancing the providers from government's entities prevents politicization of decision-making and contributes to ensuring a much more flexible organisation in service-delivery to citizens.

The knowledge and perspectives of the general direction, assumptions and characteristics of the theory and practice of decentralization and governance, public policy, public finance, and health functions and systems serves as a framework for making qualitative judgements about the extent of policy design and implementation. It provides a basis for a framework to review and analyse the public policy structures, processes and mechanisms in a decentralized co-operative governance system. The conceptual framework sets the parameters for the review and analysis of the nature and extent of the policy processes; that is, policy design and implementation. It is instructive in analyses of a unitary decentralized co-operative governance system.

The literature review explored different propositions and counter propositions relating to decentralization and governance systems. On the one hand, the intention was to identify the

different assumptions, features and permutations of decentralization and governance. On the other, the review was about finding points of integration of common and diverse theoretical perspectives between the notions of decentralization and governance. The argument is about how the different theoretical perspectives of decentralization work together within the ambit of co-operative governance. The notions of governance and decentralization are, therefore, used as organising tools to set the theoretical orientation of the study.

When one looks comprehensively at the public policy process in conjunction with the accountability, expenditure, revenue and transfer principles, the principles provide an overview of how governance and decentralization could be analysed in the public health system. Clearly, the principles steer the creation of categories of decentralization to direct one to the determination of the location of functions, associated responsibilities and related competencies to realise the challenges presented by the functions. Put differently, the principles provide both an analytical and descriptive framework to analyse public policies that drive the decentralized co-operative governance of the public health system.

In this dissertation, decentralized co-operative governance captures: the inter-relations between the different models of governance; and the principles and forms of decentralization in the process of unbundling the health function, services and responsibilities and financing. Decentralized co-operative governance in the context of this dissertation is therefore understood to be an interplay of the different propositions and counter propositions that prevail in the self-binding process of creating inter-dependence, autonomy and partnership between the levels of government. Co-operative governance through this self-binding process between the spheres of government is also understood to be the exercise of constitutional, political, fiscal, economic and institutional power at play in the policy design and implementation arena between the levels of government and the different sectors.

The integration and synergy of the different theoretical perspectives are principally driven by this dissertation's understanding of decentralized co-operative governance. The integration and synergy of the different propositions collectively informed the theoretical orientation of this dissertation and as such it draws on:

a) The discussion on decentralization in order to understand and analyse the nature of the relationship, involving a determination as to whether the format of the relation is deconcentrated, delegated or devolved. This characterisation of decentralization provides the tools for determining the power relations within the decentralized co-operative governance system.

b) The concept of governance, comprising state control, supervision and interference models for the purpose of capturing and analysing the complexity and challenges that inform the policy design and implementation relationship between the central and provincial governments. This conceptualisation of governance is also used to capture the political and institutional governance relationship between the central and provincial government within the public finance and health sectors. The dissertation accepts that decentralized co-operative governance comprises the mechanisms and processes through which power and authority are exercised.

c) The dynamics of the political and institutional relationship which is concretised through a myriad of principal-agent relations and is central to the decentralization debate between different spheres of government, especially regarding competencies and resources.

d) The efficiency, assignment, accountability and transfers forms, which forms the theoretical underpinnings of decentralization as key principles. These principles are closely linked to an understanding of co-operative governance and the forms of decentralization. These principles are critical to understanding the different rationales that justify either comprehensive or asymmetric decentralization. This is particularly important given that no central or federal government has been seen to surrender total control over exclusive or concurrent competencies.

Conceptual Framework on Decentralized Co-operative Governance

The primary purpose of policies within the public service is to intervene or regulate a public good, such as the public health system. The public policy articulates the intervention to be made either through a service, programme or structure. The policy also identifies the distribution of power and authority between levels of government or institutions within the

public service. The power and authority that derive from the policy direct the structural and functional competencies of the levels of government and the public institutions.

Decentralization refers to how the public policies analysed within this dissertation articulate the location of varying responsibilities, power and authority, and service and programme delivery obligations to the different levels of government and the public sectors; that is, to finance and health. Decentralization is also about the allocation and transfer or even the contraction of power and authority over the institutional environment and arrangements; principal-agent relations; decision making and accountability, budget, revenues and expenditures of levels of government and public sectors. Decentralization is a "political reform designed to reduce the extent of central [government] influence and promote local [provincial] autonomy" (Khaleghian 2003: p2).

Decentralization in the description and analysis of the public policies in this dissertation is considered as deconcentrated, delegated and or devolved power and authority within the public service. Deconcentration through the public policy is viewed as (Khaleghian 2003:p2) "an administrative reform that can actually strengthen central control over the peripheral areas." It is through the public policy description and analysis in this study that deconcentration will be considered as "centralization in disguise". This disguise by means of public policy "extends the geographic and policy reach of the central government that community [public sector] participation, accountability, innovation or any other proposed benefits of decentralization will materialise" (Khaleghian 2003:p2). The analysis of the different public policies is an appropriate mechanism to whether the institutional environment and the policies preserve the consistency and parsimony of centralized decision making and whether, as a consequence, it maintains the relative ease of central government policy implementation. The decision-making space tool, described in Chapter Three, serves as an ideal tool to examine deconcentration but also delegation and devolution within public policies.

The interpretation of delegated authority is considered that of a temporary nature, either through a policy practice or programme decision during the public policy process between either the levels of government or public sectors. This delegated authority and power given by the principal to the level of government or public sector that is authorised to implement and manage the delegated function. In the decentralized co-operative governance system

the central government is considered as the principal. The receiving level of government or public institution or sector is considered the agent of the delegated function. The delegated authority by its nature can therefore be withdrawn, or changes could be mandated to it, and/ or the delegated authority could be undermined and ignored by the principal.

Devolution as a form of decentralization is a permanent feature of allocation and transfer of power and authority between the levels of government. Allocation and transfer are enabled by firstly, the Constitution and, secondly, requisite and appropriate legislation. While this form of decentralization provides permanency in the decentralized arrangements of the public policy process, it also sets the rule-based nature of the governance system. Both the delegated and devolved forms of authority and power in the public process have compounding implications for public finance and health policies and programmes in the public health system. Co-operative governance within the unitary government system serves as the panacea for dealing with contesting degrees of power and authority within the policy arena.

Co-operative governance in this dissertation is, therefore, considered as the mechanism to resolve potential conflicts and policy tensions between the levels of governments and the sectors. It is also considered as the structural and functional policy impetus for interaction between the levels of government and the sectors to ensure equilibrium in the policy process. It is this search for a policy equilibrium that must ensure continuity between the policy design and its implementation. It is also this equilibrium which must generate a synergy between the public finance and health policies and sectors. Decentralized co-operative governance of the public policy processes between the levels of government and public sectors is about the collective management of public policies and their implementation. It is also about how the decentralized co-operative governance system lends itself towards common understanding of the varying public policy competencies between the levels of government and the public sectors.

Maintaining the decentralized co-operative governance – in particular, securing public policy collaboration, collegiality and consensus – is probably the most acceptable rationale for macro-economic and fiscal policy and health policy consensus for a decentralized unitary government. Theoretically, it is argued that enforcement of decentralized co-operative governance of policies that impact on the health system in the public service being a public

good, its provision can only be materialized through collective action, consensus and respect for delegated and devolved powers and authority of the different levels of government and of the different sectors. Empirically, several studies on Australia, Brazil, Canada, Mexico (Ter-Minassian 1997) have drawn correlations between the nature and extent of decentralization, measures of economic and policy compliance performance, and fiscal resources. Yet, countries differ greatly in the extent to which the practices of decentralization allowed, either devolved or delegated, and the rules governing the practice of decentralization. Several pieces of empirical evidence suggest, in particular, a strong positive association between the institutional arrangements, relationships, decision and accountability; and budgets, revenues and expenditures.

Moreover, decentralized co-operative governance is about how the different national and sector-specific public policies as intended get reflected within the arena of practice, which is the public health system in this dissertation. It is in this interconnectedness between the intended policy and the policy as practice, through the system of allocation and transfers of powers and authority, that the effects of decentralized co-operative governance on public policy decentralization are measured. This is premised on the understanding that the greater the degree of decision making and accountability at the level of provincial government, the agent on budgets, revenues and expenditure, the greater the degree of decentralization.

Through an examination of decentralized co-operative governance, public policy relationships can help to predict the likely consequences of decentralizing processes. Most of these consequences (Khaleghian: 2003) originate as political decisions outside the public health sector. The implication of the policy content analysis emphasis the importance of the commitment mechanism to ensure enforcement of a rule- and policy-bound system. The argument of this dissertation is that the absence of such commitment may induce lower investment of resources by the provincial government and a higher degree of implementation by policy default and rent-seeking. The lack of commitment could also contribute to lowering of national norms and standards as set through the different public policies from the public finance and health sectors.

The dissertation addresses the assumption of the varying public policy responsibilities between the central and provincial governments and between the public finance (treasuries) and public health (departments and ministries of health) within the health system (the case).

What it proves is that what eventually becomes a central or provincial government policy, including fiscal resource decisions and allocations, does not necessary reflect a consensus between the specific sector (finance or health) and / or the specific level of governments. The processes of reaching public policy and resource decision consensus between the levels of governments and the different sectors, are essentially about how the decentralized co-operative governance system impacts on the vertical and horizontal policy process practice and the varying powers within the public service and how either the levels of government or the competing/complementary sectors impose or ensure policy consensus – the political economy of the policy process within the public service created by the constitutional system of decentralized co-operative governance.

The study is primarily concerned with the attempt to explore and analyse dynamics and processes related to the design and implementation of public policy finance and health within a decentralized and co-operative health system. The conceptual framework for this research is based on theoretical writings and research findings relating to the four factors of decentralization and co-operative governance in the design and implementation of policies within the public health system: institutional environment and arrangements; principal-agent relationships; decision-making and accountability; and revenue, budgets and expenditure.

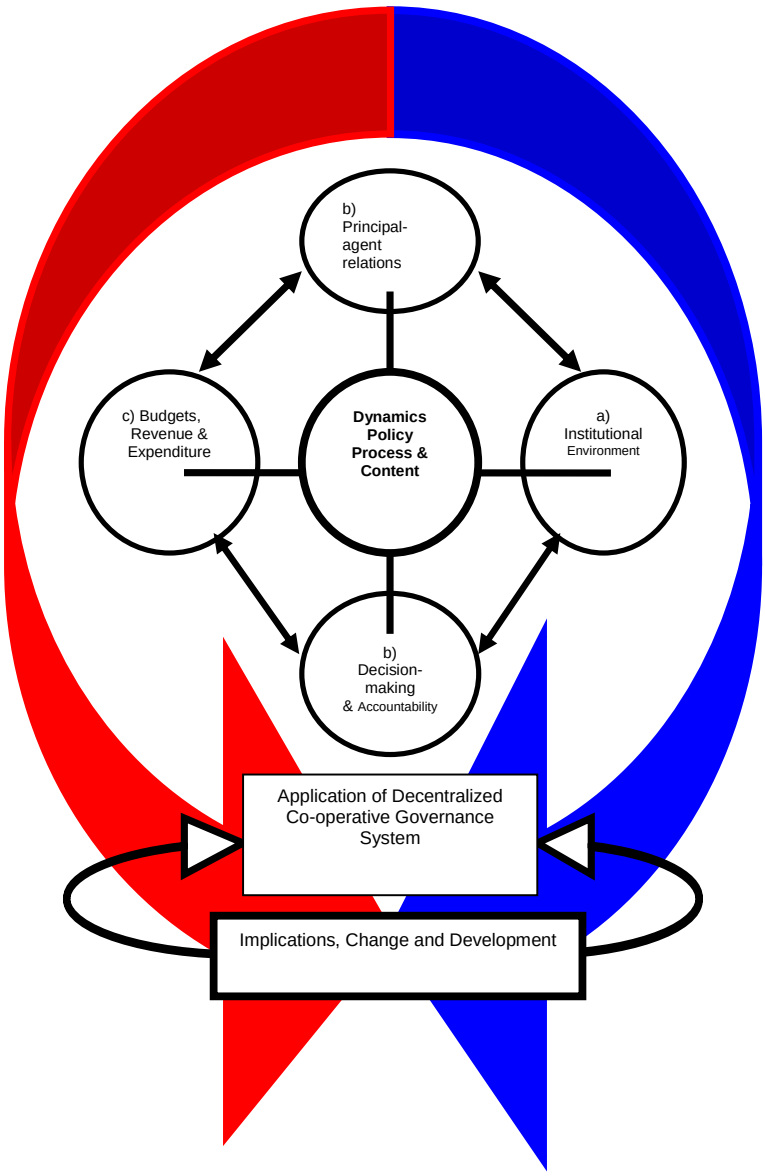
The literature discussed in this chapter shows an implicit connection between the institutional and decentralized governance environment and the positive effects for genuine decentralized cooperative governance. The literature shows that the developing decentralization and co-operative governance environment is shaped by the provisioning of resources, both physical and human, the institutional environment practices, and the shared or singular mandates and the relationships promoted and practised between the levels of government and public sectors. The ongoing development of the decentralized co-operative governance institutional environment, as with the other key factors of implementation, appears to constitute a precondition for the other factors of implementation. The conceptual framework shows the interdependent relationships of the core factors of implementation: institutional environment and arrangements; principal-agent relationships; decision making and accountability; and revenue, budgets and expenditures factors. These factors and their relationships are tested within the study.

The conceptual framework argues that the public policy process within a decentralized and co-operative governance system is a dynamic process of incremental and continual change and growth, with each change being informed by the interactions and dynamic balance achieved between the factors institutional environment and arrangements, principal-agent relationships, decision making and accountability, and revenue, budgets and expenditures. This point of dynamic balance is also tested throughout the dissertation and is central to the conceptual framework and, therefore, will be a major focus of this study. In seeking to understand what happens in a decentralized co-operative governance system within the policy domain in the public service, it is necessary to examine the factors that appear to promote a sound governance and relationship between these factors.

The thinking behind the framework recognises the work of Bahl (1996; 1999), Ter-Minassian (1997), Dillinger and Webb (1999), Bird (2000), Ball (1990; 1993), Bossert (2000), Kooiman (1993), Shah (1994) who all advocate the importance of a decentralized rule-bound system set through the articulation of its institutional arrangements and, thereby, reinforcing a holistic approach where prime importance is placed within a network of principal-agent relationships that exists among seemingly discrete parts. The idea of a network of relations (intra- and intergovernmental) is important to this study because it implies a continuous cycle of growth and redesign between and among the public policy sectors of the decentralized co-operative governance system. The identified factors acquire inputs from the external environment the implementation factors respond to this input through interaction. The interaction between and among the factors leads to a dynamic redesign, which allows for ongoing growth and development of the decentralized co-operative governance system.

The public policy process and content is diagrammatically presented in Figure 2.2. The figure shows an interplay and interconnectedness between the different factors and the resultant application of these factors within the decentralized co-operative governance system. The interplay between these factors creates a certain dynamic within the public policy process, where the content of each of these policy factors has an impact on each other. It is this influence, exercised through the interaction and the influences that each of the factors have on the public policy process and content, that has an impact on the configuration and practice of decentralized co-operative governance within the public policy terrain of the public health system.

Figure 2.2. Conceptual Framework Model



The argument presented in this dissertation is that the compounding effect of these factors operating within the policy process and policy content has not only implications for how the decentralized co-operative governance system operates, but also has the potential to

influence changes in and the development of the system. The point here is that both the design and practice of public policies and the different factors can have the combined effect of reproducing the system of decentralized co-operative governance.

In addition, the external policy environment provides inputs that result in the need for institutional arrangements to be implemented. This could be the result of the introduction of norms and standards for the implementation of the decentralized co-operative governance system. The inputs from the policy environment effects and are processed through each of the four factors. The interdependent relationship between these factors is seen as creating a process of dynamic balance.

The balancing results in the modification of the relationships of the key factors which, in turn are converted into planning and action. For example, the introduction of a new policy directive by either the public finance or health sectors for affects the public health environment, and, in turn, has implications for the level of resourcing for the health system, institutional arrangements, decision making and accountability, relationships between and among the actors within policy centres, and for budgets, revenue and spending priorities. The appropriate action taken is informed and directed by the interaction of the policy process within the decentralized co-operative governance system enabling the public health system, to respond to policy change, directive and priorities impacting on service delivery and, thereby, promoting institutional and organisational reform and growth. Senge (1994: p84) cited in Ashleigh (2005: p41) allows for an organisation or institution to “continual expand its capacity to create its future”.

The configuration of the conceptual framework

The conceptual framework of this study is based on four interdependent policy process factors within a decentralized co-operative governance system. The factors are: the institutional environment and arrangements; principal-agent relationships, decision making and accountability; and revenue, budgets and expenditure.

a) Institutional Environment

The analysis of the public policy leads to an assessment and identification of the functions, roles and responsibilities – that is, the competencies – of the levels of government. The

competencies, if clearly articulated, set the policy design and implementation mandates. It is within the policy as designed and intended where the assigning of functions, structures, revenue and expenditure responsibilities are located. The assignment of functions, structures and responsibilities collectively contribute to the rules and regulations of the governance system. The rules and regulations determine the role of the levels of government and public sectors in the production of public goods and services. It is in doing so, that the structural and functional roles and responsibilities of the levels of government are determined. The role and responsibilities of the levels of government and public sectors articulated within the public policies and legislation, not only have a bearing on the principal-agent relationships, decision making and accountability, and revenue, budgets and expenditures, but also forms the architecture of the institutional arrangements.

The institutional environment and arrangements are formulated through legislation and sector-specific policies form an integral and mutual dependency link with each other. It is this link, between identified public policies and the legislative framework, that creates the institutional environment. Given that the institutional environment contributes to the determination of functional and structural arrangements, it will in a multitude of ways have an effect on public policy design and implementation. In a similar manner, the policy as intended has not only an effect on the institutional environment of the public policy process, but is also pre-emptive in setting the rules and regulations of the institutional environment.

The institutional environment and arrangements also has implications for the flow of information and the relationship management between the levels of government and the public sectors. This flow of information and relationship management go to the heart of avoiding a situation of incoherence across and between government policy development and advice. The institutional environment and arrangements and, in particular the institutional arrangements, within a decentralized co-operative government lend themselves to a synchronisation within the public process between the varying competencies between the levels of government and the public sectors. This synchronisation implicitly thrives on generating incentives through the principal-agent relations and decisions and accountability arrangements. What characterises the institutional environment and arrangements, that is created by the legislation and public policies is the division of functional and structural responsibilities. Within the context of the division of responsibilities, especially in a

constitutional unitary government and state, the central government makes the rules under which provinces operate.

Simultaneously, the institutional environment and arrangements also encourage each level of government and public sector to concentrate on its own role and responsibility rather than that of the whole of government – central and provincial. While this is a commonly encouraged practice within most governments for line functionaries, it holds a different sway and practice for the public finance – that is, treasuries. This difference in mandate, which is transversal for treasuries, is based on the policy practice that the public finance sector is responsible for the macro-economic and fiscal policy and stability of a country. This transversal policy and economic stability responsibility recognises the treasury's competence to provide the entire government advice on economic growth and fiscal issues. The power and authority of provincial governments and central government agencies, like the public finance and health sectors, have a direct and key bearing on how the public policy mandates are designed and implemented. This division of functions and responsibilities comprise a complicated set of principal-agent relations.

b) Principal-agent relationships, decision making and accountability

The notion of principal-agent relationship suggests that there is an ownership over a competency and an allocation of responsibility for the many responsibilities within the public health function to be performed. The setting of public policies and legislation helps avoid a situation of allocation of tasks or responsibilities being "exogenous" or a situation where "many of the tasks that are to be performed, and the underlying objectives, are difficult to describe," (Jack 2000: p2). Jack (2000: p2) warns that "it might be relatively easy for a central government to renege on specific aspects of a contract (e.g. revenue sharing formulae), yielding finely-tuned contracts open to renegotiation." The answer to this complexity lies within the rules and regulations and broadly the appropriate public policies.

The distribution of competencies is articulated through public policy and provides for the vertical and horizontal separation and integration of functions and responsibilities. The public policies also give expression to the separation of responsibilities, decision making, and authority and accountability between the levels of government and public service institutions or sectors. The separation allows for the appropriate level of government and

public service or sector to understand its policy, service delivery and public financing mandate. This separation of function and responsibility and the power and authority associated within it contribute to the degree of autonomy and independence of provincial governments. This separation also has implicit within it the de-linking of policy competencies between the levels of government and the sectors. However, within the shared or concurrent function arrangement, the levels of government and its departments or sectors are expected to work together in the design and implementation of public policies. This is especially so in a constitutional, unitary, and decentralized co-operative governance system.

This form of decentralized co-operative governance system obligates the different levels of government and public sectors to work together on public policies that impact on each other's competencies. It is through this working together on public policies between the levels of government and sectors that a process of functional and structural integration emerges. This integration of functional responsibilities between the sectors, in particular, ought to enhance the processes and practices of decentralized co-operative governance on public policy. The integration should also allow for a stronger link between the varying public policy responsibilities, power and authority between the levels of government and sectors within both the central and provincial governments. The linking and de-linking of policy responsibilities between the levels of government and the public sectors is at the heart of the decentralized co-operative governance discussion within this dissertation.

Decision making and accountability within the decentralized co-operative governance system requires from the different public policies an explicit articulation of responsibilities in order to determine the nature of decision making and the degrees of accountability. The separation of responsibilities for decisions should not be taken to mean that policy implementation and resourcing happens in a vacuum. Given the expression that policy as designed and policy as implemented "interpenetrates" those responsible for the design, resourcing and implementation of policy, needs information to make appropriate decisions. The differential and complementary policy responsibilities suggest that both the principal and the agent of the public policy have the appropriate capacity – decision making authority, proper due diligent accountability arrangements, and resources – to make policy decisions. It is assumed that through this capacity, articulated through public policy, that competing views on policy issues and the role of the different levels of government and public sectors would be resolved.

A resolution of competing views on the policy mandates and the obligations identified within the public policy would avoid a situation of public policy traction certain levels of government or sectors. The resolution of conflicting views and policy traction are at the heart of policy co-ordination, decision making and accountability within the decentralized co-operative governance system. This is so because policy co-ordination in the public service tends to be sector based, is often concentrated on coordinating the process rather than the policy, and its reactive rather than focused on achieving coherence. Accountability for decisions at the provincial government level or sector is also about the extent to which objectives of policy decisions for implementation and resourcing purposes coincide with of the central government or its sector-specific policy priorities.

Decision making and being accountable for decisions at appropriate levels of government can potentially facilitate or impede the operationalisation of institutional arrangements of decentralized co-operative governance. The potential influence – positive or negative of levels of government being accountable for decisions – is based on the pretext that the legislation and public policy could be intentionally ambiguous, thus leading to differences in the interpretations of location of decision making and accountability. Conversely, the decision-making power and authority are also premised on the understanding that there is no ambiguity about the principal and agent intended to realise or implement a function and service. Furthermore, clarity in the separation of responsibilities lends itself to an analysis of whether the policy process, including the obligations at different levels of government and public sectors, was intended to reduce the alleged capture of the policy from the centre by the provincial governments. This capture of decision making, which ostensibly is located at a different level of government from the one that does the capturing leads to mandate drift. More concretely, the capture of decision-making authority from either the province or central government of each others function and responsibility has the potential ingredients of mandate drift and capture.

The public-policy and decision-making capture, including interference in the autonomy of another level of government, has the hallmark of constraining the system of decentralized co-operative governance. The challenge of capture to decision making within a decentralized co-operative governance system is that the two centres of public policy design and implementation raise questions and concerns about the relative autonomy and

interdependence of the central and provincial governments. The policy-process capture also raises concerns about separation and integration of functional and structural responsibilities between the levels of government and its potential spill-over effect into the arena of the public policy process between the public sectors. This spill-over has potentially an impact on how the institutional environment is configured, but also on how the different public policies facilitate or impede budgetary, revenue-allocation and expenditure decisions.

The level and degree of decision making and accountability articulated and practised through the principal-agent relationship, as identified through a myriad of public policies and legislation, clarifies the location of authority. It is this location or distribution of power and authority through the public policies and control over fiscal resources that lead to a policy function asymmetry. This public policy asymmetry brings to the forefront the varying competencies and resourcing capabilities for public policy between the levels of government and the sectors. It is also this public policy asymmetry that has a direct bearing on the policy inputs and outputs of the public health system. The asymmetry and capture, if and when they work together, forms a potent dynamic that contributes to a practice of policy practice and resources rent-seeking between the provincial and central governments and its public sectors.

The definition of decentralized co-operative governance and the conceptual framework within this dissertation is premised on understanding that the public policy process, compounded by the elements of rent-seeking behaviour and the asymmetry and policy capture of public policy responsibilities, contributes to the relative strength of different levels of government and sectors. It is the compounding effect of these elements that contributes to the solidifying of the varying competencies for resourcing public policy. These elements form the foundation of the principal-agent relationship.

c) Revenue, budgets and expenditure

Institutional environment and arrangements, coupled with the factors of principal-agent and decision making and accountability factors, have a determining impact on how budgeting, revenue allocations and expenditure take place within the public service system. While the different factors and the dynamics of decentralized co-operative governance affect the public policy process in a multitude of ways, they also have an impact on the structural and

functional nature of the budget and revenue-and-expenditure policy processes. The institutional environment, in particular, sets the rules of the public finance and fiscal policy framework. In fact, it sets the economic and fiscal constitution of a country. The institutional environment also sets the rules for the public finance flows, including the incentives for the purchasing of public and private goods and the associated accountability arrangements.

The outflow of the principal-agent scenario, on the other hand, helps to determine what functional and structural competencies, responsibilities and services are located with the different levels of government. It is within the principal-agent relationships articulated through policies and practice that assignment and allocation, including the control of public finance and fiscal resources, happen. The different policies and legislation, which set the regulatory framework for macro-economic and fiscal policy behaviour, also determine the degree to which provincial or central governments have independence and autonomy over the revenue or tax bases. It is particularly the control over the revenue bases that influences that ability of the lower level of government to contradict or act contrary to the wishes of the central government in its policy implementation or subversion. The fiscal resources and the distribution of power and authority over these fiscal resources between the levels of government are the vexing questions within the public policy design and implementation debate.

The vexing question within the context of responsibility and accountability for policy design and implementation in conjunction with control over resources creates challenges to the separation, integration, and management of a shared or concurrent responsibility such as the public health system. In addressing this question, this researcher holds that an unbundling of the public health function is necessary but that also the public policy process and system must be rule bound. Moreover, in an authoritative account based on country studies, Ter-Minassian (1997: p6) writes:

> … for the bulk of non-interest spending, there is no uniform pattern of assignments. Moreover, the legal framework regulating these assignments is not always clear, allowing the persistence of ambiguities regarding the respective roles of the various levels of government in the formulation of policies, the financing, and the delivery of shared expenditures ….

The public policies and programmes from both the public finance and health sectors are key cost drivers parallel to financing of the maintenance of the public health care system. It is the key cost drivers like policies and programmes, combined with maintenance public funding of the public health system that can lead to unfunded mandates. The notion of unfunded mandates particularly occurs in an institutional environment where the level of government responsible for service delivery and spending has no control over the revenue envelope. This type of expenditure-led practice without the requisite fiscal resources potentially contributes to fiscal dependency between the centre and lower levels of government. Consequently, to avoid this fiscal imbalance between expenditure responsibilities and revenue availability, public policies and programme must be appropriately funded. Anwar Shah (1994: p9) mentions that "assigning responsibilities for spending must precede assigning responsibility for taxation, because tax assignment is generally guided by spending requirements at different levels and cannot be determined in advance." Shah (1994: p9) suggests further that in a decentralized institutional environment of allocation of responsibilities it might be "desirable to decentralize taxation at the same time as decentralizing spending, so that sub-national governments will not have to rely exclusively on grants from higher levels of government".

The fiscal imbalance as a result of a potential disjuncture between the expenditure and revenue also occurs as a result of a possible information disadvantage of the costs of public policies and programmes relative to maintaining the core business of the public health system before new programmes or policies are introduced. Corry (1997: p109) notes that the approach in the financing of public policies and programmes:

> …needs to be interactive because the centre tends not to have enough information to assess what is practically and politically feasible within detailed expenditure fields. It has to be iterative (try, try again) because of the difficulty of getting the balance right and because of uncertain changes in the constraints such as economic variables and in spending on 'demand-determined programmes'. As a government gains experience it can reduce the iterations and adopt a more top-down approach, in which spending proposals closely flow initial guidelines.

The new and old public policies and programmes, which in many ways are an add-on to the existing service delivery and public financing of the public health system, suggest a review of existing financing or fiscal policy arrangements. What is also required out of this review is an assessment of whether additional funds for programme differentials and specialised fees

or programme funding increases are required. This review forms the basis of determining whether mandatory cost increases or decreases are required to give effect to the different public policies entering the public health system. Taken together, the location and authority for revenue, budgets and expenditure suggest a double feedback relationship between economic development and the interdependence and autonomy on the resourcing of public policies, in particular, indicating that affluent economies and the institutionally capacitated levels of government with additional fiscal resources are likely to more exert power and authority over public policy decisions.

Chapter Three: Research Design and Methodology

Introduction

This chapter looks at the research design, methodology, data collection and analysis based on the conceptual framework discussed in Chapter Two: *Literature Review and Relevant Research on Decentralized Co-operative Governance.*

Researcher as participant in data construction and review

As the researcher of this doctoral study, I have worked in the post-apartheid government public service since 1997 within the policy design and implementation arena. Between 1997 and 2001 I was employed by a provincial Department of Health within its strategic policy, planning, and development function. It is during this period that I developed a very keen interest and real practical experience in the design and implementation of public health policy and revenue generation within the public sector. During these years my interaction with experienced policy researchers and implementers within the tertiary education sector and government provided the opportunity to better understand and explore the linkages between public policies and various facilitators of and impediments to implementation. It was also during this period that I got involved with public health policy development between central and provincial government. My access and participation in policy development at a national level happened through the National District Health Service Team, especially the technical working group responsible for community participation and governance.

This professional involvement with public policy continued through an appointment as director for social security and welfare services at the National Treasury department of central government. It is especially here where I more vigorously explored and analysed the linkages or disjunctures between policy design and implementation, and public policy financing. This appointment, which lasted from 2001 to 2005, was followed by an appointment of head of a branch responsible for strategy, policy and business development at a central government agency within the public sector and service. All the previously posts held, including the current senior manager position in central government have placed me at the coal face of the institutional and organisational sites and dynamics of public policy, budgeting, and financing in the public service.

The experiences, knowledge and skills acquired have also enhanced my public policy design and implementation theory and my knowledge of policy within the public service. More specifically, the collective experiences were gained through:

a) Compiling and drafting of intergovernmental fiscal reviews (IGFRs) and estimates of national expenditure (ENE) chapters, including the cleaning of financial and non-financial data and tables on social services within the National Treasury.

b) Submission of inputs into annual budget reviews and provincial benchmarking for multi-year budgets and expenditures for provincial government treasuries and line departments. This annually happens through bi-lateral budget policy benchmarking between central and provincial governments.

c) Submission of reviews on policy, service delivery and expenditure trends through intergovernmental structures such as the Technical Committee on Finance; Budget Council; Minister's Committee on the Budget; Minister and Members of Executive Councils (MinMECs); Chief Financial Officer's Forums; 4x4 and 10x10sintergovernmental structures between central and provincial governments treasuries and other service delivery departments.

d) Inputs into the design and development of uniformed budget structures and strategic planning formats for the different social services departments.

e) Inputs into or drafting of conditional grants frameworks and multi-year financing levels of these frameworks.

These experiences in central and provincial governments' public policy-practice in the public service sectors led me to continuously and critically explore the link or disjuncture between how policy processes and design happen and how policy resourcing and implementation happen. The inadequate levels of resourcing of the policies and programmes, given inappropriate costing of the public policies, has been a source of huge frustration and introspection about policy as designed and policy as implemented.

There is an assumption that if you are part of a sector within the public service, a voice for a particular sector(s) or a particular interest, you are not objective and, therefore, should not produce research that contributes to policy debate. In my experience, being part of the public sector has informed me of the internal functioning of the public service sector and given me the ability to articulate trends and patterns that may make a difference in policy debate. In fact, the inside knowledge and capabilities developed did not only contribute to greater insight of the political economy of policy processes within the public service, but also about how policy imposition of certain dominant policy actors occur.

Design of Study

The study design comprises four stages:

A literature review on the theory and practice of governance, decentralization, including public policy and the extent of health decentralization with regard to public policy, fiscal and finance and administration. The outcome of the literature review is the development of a theoretical exposition on the extent of public health governance and decentralization in term of public finance and health policies and the key meanings that the literature attaches to these. The literature review and exposition are discussed within *Chapter Two: Literature Review on Decentralized Co-operative Governance.*

The policy content analyses explore both the theory and practice of policies within the government system. The analyses draw on policy practices within the public service and provide not only a theoretical policy exposition and also contribute to methodology in policy analysis.

The resource and expenditure analyses consider not only the flow of funds and trace the effects of funds flow, sources and uses of funds and how these maximise or impede decentralized co-operative governance in the public policy processes. The analyses include a public finance policy analysis and its implications for the public health system.

Interviews with senior policymakers and implementers examine their understanding of and the meanings they attach to the policy process and practice within a decentralized co-operative governance system.

Policy research design, methodology, data collection

The approach of this study is to determine: a) how the relationship between principal and agent is expressed in public health and finance policies; b) the nature of the interaction between the central and provincial governments following from policies in the context of the co-operative governance system; and c) the overall resourcing of public health, originating from the selected, but different, policies identified in this study.

The importance of this approach is its ability to assist the analysis in what is contained in identified health and public finance policies and how this content impacts on co-operative governance between the financial and health sectors, and between the different spheres of government. Cohen and Manion (1997) and Firestone (1987) believe such an approach acknowledges that the reality of policy formulation and practice is socially constructed. The research approach draws on knowledge derived from interactions and semi-structured interviews with policymakers and implementers, policy texts, and uses the decision-making space model. This approach targets senior policymakers and implementers from firstly, different departments and, secondly from the nine provinces of the country.

This type of targeting not only brings to the fore the question of common and/or divergent interests in co-operative governance from a public policy perspective, but also the interests of power and control in the terrains of policy implementation. Both power and control are directly linked to the structural and functional approaches of decentralized co-operative governance and therefore, contribute to how best to provide resources to give effect to decentralization within the context of co-operative governance. The approach privileges efficiencies and effectiveness and, therefore, concentrates on how the form of decentralized co-operative governance in the health sector gives effect to public policy and the provision and distribution of resources.

Decision- making space analytical approach

The decision-making space analytical framework (Bossert *et al.,* 2000; Bossert 2000; Bossert and Beauvais 2002) is based on the principal-agent theory. According to this theory the central government sets the goals and parameters for public health policy and programmes. By considering the different forms of decentralization, either the policies and legislation or central government then transfers authority, power and resources to lower

levels of government originating from the policies. This approach also accepts that the central and lower levels of government "have at least partially differing objectives" (Bossert 2000: p4). Just like the general thrust of the decentralization theory, the framework also assumes that the lower levels of government have distinct preferences with respect to the mix of activities and expenditures to be undertaken, and they respond to a differing set of stakeholders and constituents than national-level principals (Bossert 2000). The framework is also build on the assumption that the lower levels might have incentives to evade the mandates established by the central government. Moreover, because agents have better information about their own activities than the principal, they have "some margin within which to 'shirk' centrally defined responsibilities and pursue their own goals" (Bossert 2000: p4).

Bossert and Beauvais (2002: p16) argue that a major mechanism that could influence agents or lower levels of government is to "selectively broaden the formal decision-space or range of choices of local agents [lower levels of governments], within the various spheres of policy, management, finance and governance". This is done through the voluntary assignment of functions in order to promote the overall objectives of governance through decentralization and public health objectives. Central governments, according to Bossert (2000: p2) also seek to

> …establish incentives and sanction that would effectively guide agent behaviour without imposing unacceptable losses in efficiency and innovation. Diverse mechanisms are employed to this end, including monitoring, reporting, inspections, performance reviews, contract, grants, etc.

Bossert *et al.* (2000) mention that the degree and nature of the transfer of powers and authority differ by case and that powers and authority also influence and shape the principal-agent relationship within the health function and the decentralized system as a whole. The premise of Bossert's (2000) decision-space is that the form of decentralization, whether deconcentrated, delegated or devolved, originates from a degree of discretion allowed within a policy framework to make technically efficient decisions. The decision-space framework in link to the conceptual framework as it allows the researcher to determine the nature of the principal-agent relations, location of decision making and accountability arrangements and the determination of responsibility for the financing of certain functions.

Table 3a: Decision-Space Functions

Decision-Space Functions	Description of Functions
Finance and Expenditure Functions	
Revenue Sources	Choices about where sources come from: i.e. Will local authorities be allowed to assign their own source of revenue to health?
Allocations of Expenditure	Choices about how to allocate funds: I.e. Will local authorities be allowed to assign funds to different priority programmes? Hospital vs. primary care.
Income from Fees	Choices about local charges: i.e. will local authorities be allowed to set fees at all? If so, are they allowed to determine the levels and change them?
Service Organisation Functions	
Hospital Autonomy	Will local authorities grant hospitals autonomy and select the degree of autonomy allowed?
Insurance Plans	Will local authorities create, manage and regulate local health insurance plans?
Payment Mechanisms	Will local authorities select different means of paying providers? E.g. *per capita*, salary or fee-for-service?
Required Programmes and Norms	To what degree will the central authority define what programmes and services the local health facilities provide?
Service Standards	To what degree will the central authority define service standards, such as quality standards for facilities?
Vertical Programmes, Supplies and Logistics	Are vertical programmes continued under the control of the central authority or are they transferred to local control? Are drugs and other supplies provided by the central authority or do they become the responsibility of local authorities?
Human Resource Functions	
Salaries	Will local authorities be allowed to set different salary levels and determine bonuses?
Contracts	Will local authorities be allowed to contract short-term personnel and set contract terms and payment levels?
Civil Service	Will local authorities be allowed to hire and fire permanent staff without higher approval? Can staff be transferred by local authorities?
Access Functions	
Access Rules	Will local authorities decide who has access to facilities and who is covered by insurance?
Governance Functions	

Decision-Space Functions	Description of Functions
Governance Rules	Are local officials accountable to the electorate? Will local authorities have choices about: size and composition of hospital boards; size and composition of local health offices; size, number, composition and rule of community participation?

Source: Bossert, June 2000, Table 1, p.4.

While “allocated efficiencies” refers to the distribution of services, such as through the determination of a prioritised package of public health services distributed in accordance to need, Bossert (2000: p9) suggests “technical efficiency asks whether decision-makers are able to increase the outputs for the same level of inputs or able to reduce inputs for the same level of outputs”. As a result, allocative efficiencies are mainly achieved by a greater level of discretion and decision-making capabilities at the central government level and if, the argument goes, the allocative efficiency decision is made at a provincial government level it could result in poorer health outcomes as national public health priorities may be skewed away from the required health services. Given these arguments, technical efficiency can be achieved in an allocatively inefficient distributive system of health services. Also, in order to achieve greater levels of technical efficiency, greater decision-spaces at a provincial level are required in order to optimise an input mix for a given set of outputs.

Table 3a above from Bossert (2000) gives a summary of the different areas in which to achieve technical efficiency decisions. The decision-making space functions are *finance and expenditure,* which cover revenue sources, allocations of expenditure and income from fees; *service organisation functions,* which deal with payment mechanisms, insurance plans, hospital autonomy, required programmes and norms, service standards and vertical programmes, and supplies and logistics; *human resource functions*, which deal with salaries, contracts and civil services, thus assessing the nature and scope of human capital management decisions without recourse to a central government; *access functions,* which relate to access to public health facilities, including consideration of private out-of-pocket payments (fees), means tests and insurance cover; and *governance functions* that essentially focus on oversight and supervisory decision-making processes on most aspects of the public health system.

The decision-making space function mapping of the forms of decentralization in the health system and the nature and extent of decision-space for each function of the central government relative to the provincial governments are shown in an adaptation and application of the decision-space functions for each public health policy discussed. The criterion of the decision-space is applied to these policies, indicating whether the scope provided is narrow, moderate, or wide. The decision-space of these policies is defined for

the various functions and activities over which the central and provincial governments have increased choice, giving an “estimate of the range of choice or discretion” (Bossert 2000: p12).

The decision-space not only shows “the functional areas in which choice is granted to the agent by the mechanisms of central control and the degree of choice allowed in each case”, but also allows for a disaggregation of the “functions over which local officials have defined discretion, rather than seeing decentralization as a single transfer of a block of authority and responsibility” (Bossert 2000: p12). Clearly, there are strong similarities between the decision-space range of choices and the components of decentralization, discussed earlier. The components of deconcentration, delegation and devolution resonate closely with the decision-space range of narrow, moderate, and wide choices. The completion of the decision-space in each policy is based on policy content analyses, assessment of interviews from policy experts, and theoretical exposition of the study on decentralized co-operative governance. A combination of these different policy tools helps to clarify the decentralization picture for the public health system.

Research Approach - Public Expenditure Review

The public expenditure review (PER) approach is used because of its ability to assist in the analysis of the overall composition of the public health expenditure. The PER argues that the higher the proportion in favour of the provincial government resource and expenditure decision making, the greater the degree of financial decentralization. The converse will be a greater degree of centralization.

The PER was further utilised as the tool to review and analyse revenue allocation and its links with national government policies, programmes and budgets and expenditure priorities over multi-year periods. The PER also assists in analysing multi-year expenditure trends with a view to determine variations in both consolidated expenditure, real and nominal, and province-specific revenue allocations and expenditure. This dissertation is of the opinion that although provincial governments’ consolidated fiscal capacity is significantly weaker than that of central government it is responsible for almost all public health service delivery. Budgetary allocations to provincial governments are notionally based – firstly on the vertical division of revenue, referred to in fiscal documents as the ‘national division of revenue

between central, provincial and local governments'; and secondly on a horizontal division of revenue between the provinces as an outcome of the equitable share formula.

Provincial allocations also consist of conditional grant allocations that are vetted and modified between line functionaries from central government line ministries as part of an overall national budgetary policy formulation and co-ordination process. It is to be expected that central government would tightly monitor, in terms of the policies (e.g. the 1999 Public Finance Management Act, annual Division of Revenue Acts and Treasury Regulations) related to the division of revenue and both allocation and distribution of the resources to the provinces.

Moreover, the usefulness of the PER is demonstrated through an analysis of the relative revenue and expenditure growth patterns in order to measure both the nominal and real expenditure commitments by provinces. It also assisted this study in both analysing and determining the relative strength of central to provincial government. It is through these analyses that this chapter explores in which ways the system of decentralized co-operative governance influences the determination of technical and allocative efficiencies as indicated through the policy content analysis. It was through an analysis of public finance budgets, expenditure and fiscal policies that an nexus is formed with the public health policy analysis discussion covered in the previous chapter. It is at this nexus where a link is formed with the allocative and technical efficiencies analysis of the different policies.

Assumptions of the PER

The PER framework holds that the starting point for any expenditure analysis is the macro-economic framework (Pradhan 1996; Mokoro Ltd 1999). The claim is that the aggregate level of overall public expenditure must be aligned to the macro-economic framework. If and when this does not happen, according to Pradhan (1996: p3), high or rising budget are deficits will result in macro-economic imbalances. The inability to maintain macro-economic control, which concerns the government's ability to control public expenditure in pursuit of overall macro-economic objectives and to set and achieve expenditure targets (Mokoro Ltd 1999) is considered to be critical. The theoretical supposition is that macro-economic stability is a prime economic management objective and that unless sector spending (for example health expenditure) is based on tight fiscal constraints, it is likely to generate an

unfunded shopping list of expenditures. More concretely, this means that an overall ceiling of expenditure is required, which can then be broken down into resource envelopes showing sustainable expenditure levels for each sector. Mokoro Ltd (1999) claims that a PER concerns itself with operational efficiencies and effectiveness to be achieved through the strategic allocation of resources for specific uses. Therefore, by determining the strategic allocations of fiscal resources made through the different funding mechanisms by the central government one ought to observe both the expenditure allocation trends and the degree of provincial decision making. Operational efficiencies not only help to determine specific budgetary programmes to which funds have been allocated but also, through economic classification, the particular use of the funds, such as compensation of employees or expenditure on capital assets.

The PER approach comprises resource allocation, distribution and expenditure analyses. Filmer, Hammer and Prichett (2000: p201) mention that:

> [t]he effect of an increase in total expenditure on health depends on how that increase is allocated across health inputs. An equal increase in expenditure on all inputs will have a very different effect from an increase in expenditure on only the most effective interventions.

This approach required an analysis of all nine budgetary structures, programmes, provincial budgets and expenditures. This type of analysis provided knowledge about: the amount of funds spent across the nine provinces; under which programmes; and the flow and pattern of expenditure. Furthermore, the PER allowed for an analysis of the aggregated as well as disaggregated expenditure within the public health sector. This took place through identification of major programmes or sets of expenditures with relatively homogeneous benefits. The assumption is that the PER approach will allow the strategic interventions of particular allocations to be discerned, thereby directing the research approach to a particular public health policy output or either a national public health service delivery priority set by the central government.

The PER approach also allowed for disaggregating economic classification of expenditure across provinces through the separation of capital and recurrent expenditures and or administration, personnel, and health-programme expenditure. The expenditure analysis further enhanced “integrated analysis of capital and recurrent expenditure”, serving as a

"check on distortionary and ineffective expenditure composition" (Mokoro Ltd 1999: p15). It is this type of expenditure analysis where, on the one hand, it is assumed that operational and technical efficiencies and effectiveness are achieved and, on the other, that allocative efficiencies are achieved of the resources allocated. This includes an assessment of the expenditure allocation trends on a particular programme or policy.

The analysis of expenditure and resource allocations assisted in identifying: the level and composition of public expenditure, including an assessment of intersectoral and intra-sectoral resource allocations and expenditure; and the financial and non-financial information, the structure of governance and, the financing of public institutions (World Bank 1999). The expenditure analysis provides the opportunity to "follow expenditure issues from allocation to implementation and impact" (Mokoro Ltd 1999: p15). The potential of public expenditure analysis is that it not only adds value to the understanding budgetary problems but also to how expenditure between the central and provincial governments contributes to decentralized co-operative governance.

Moreover, an expenditure analysis recognises the importance of the institutional framework for public expenditure management, because "many misallocations are the predictable result of the way public expenditure management systems are set up" (Mokoro Ltd 1999:p15). Mokoro Ltd suggests that

> Assigning responsibility for investment and recurrent expenditures to separate agencies makes it much more likely that investment expenditure will be pushed beyond the point where its recurrent costs are sustainable; resources are likely to be inefficiently used if responsibilities are not clearly assigned, and if resource managers cannot predict in advance what resources they will have.

In order to overcome misallocation, expenditure analyses tend to search for systemic reasons for the expenditure patterns that are detected, including examination of budget preparation and management. However, doing such a PER analysis could be difficult when the quantity or quality of data is poor. The unavailability of data or poor data in this study is addressed by undertaking field surveys, including interviews with senior policy and finance managers in the appropriate central and provincial government departments to find out the veracity of public health expenditure and levels of decision making and how it influence decentralized co-operative governance.

The PER approach also offered a distributional analysis, which is a key feature of expenditure and resource allocation analysis. Distributional aspects of public health expenditure have assisted this study in its approach to measure how the resource allocation matches policy implementation and how the funding resource input balance between central and provincial government and across and between provinces and national government. In addition, the distributional analysis assisted the study to determine the incidence or the per capita expenditure and intra-provincial spread. This is done through an analysis of revenue distribution among the central and provincial governments, between public health programmes within the budget structures at both the central and provincial levels.

This distributional analysis assisted in matching allocations to public health policies and national priorities as far as they affect provincial funding allocations and distributions. The distributional analysis also looks at vertical and horizontal equity in the maximisation of decentralization. The study also considered key techniques presented by the national health accounts model as a key approach in determining the flow of public health funds.

National Health Accounts Model as a Public Expenditure Review Approach

Given the specific health resource and expenditure data requirements of this study, the National Health Accounts (NHA) model is an information system designed to provide such data. This system, according to Poullier, Hernandez and Kawabata (2002), constitutes the systematic, comprehensive and consistent monitoring of resource flows in the public health system. The NHA model provides a framework for measuring the levels of financial activity and the level of health. In this manner it provides a framework for the complex interactions that occur from the moment that the funds are allocated to the health system until they reach provincial governments. Moreover, NHA estimates can significantly influence policy and, as such, provide policymakers and implementers with a holistic picture of the public health system financing by showing the total actual expenditure.

The use of expenditure models, especially the NHA estimates (Magnoli 2001), assist in analysis of the public health system, including designing a policy, monitoring implementation, and evaluating reform. According to Magnoli (2001: p20) the NHA has the ability to:

> …influence policies because they provide decision makers with a holistic picture of the health sector, highlighting the concentration of expenditure and makes evident uses and roles of different payers. They also provide a framework for modelling reforms, and for monitoring the effects of changes in health financing and service provision. Lastly, NHA allow policymakers to evaluate policies in detail.

The NHA model relies extensively on periodic financial data (resource allocation and expenditure) requirements. Periodic data allow for a better understanding of structural change and are required for forecasting. The advantage of periodic data is that they allow for the usage of the NHA model as a standard measurement tool for situation analysis, planning, monitoring and evaluation purposes (Poullier, Hernandez and Kawabata 2002: p3). The NHA addresses four basic questions which are: From where do resources originate? To where do they go? What kind of services and goods do they purchase? Whom do they benefit?

The strength of the NHA (Magnoli 2001: p6) is that, as a method utilised over a defined period of time it not only provide a clear overview of the financial functioning of the health system but also identify its main agents (sources, financing intermediaries and providers), pinpoint financial flows, break down the expenditures – total and main components on health, detect behaviour of providers and consumers, maps resource allocation, and when conducted, and it can be used to measure changes resulting from policy reforms in health financing.

The NHA model has assisted this study to trace public financial flows over a period of time and across provinces through the public health system. This approach provides the study with space to review the source and distribution of health resources and expenditures that are channelled through the central and provincial departments of health. This allowed the study to show how the decentralization of the public health function and services responsibilities has contributed either to a decline or an increase in resource allocation and expenditure. This method also contributed to the determination of whether the transfer of public health functions and associated responsibilities from the central to provincial governments was a direct outcome of central government policy obligations. If the transfer is indeed a direct outcome of policy obligations, a greater share of government resource allocation would be in the provinces and aligned to the national policy imperatives of decentralization. The transfer of the function and responsibilities would result in the expenditure target being shifted from the central to the provincial governments. The

expectation was further that the relative share of the central government's resource allocation ought to decline with a concomitant fiscal resource increase in the provinces.

Berman (1996:p8) argues that there are two major aspects of national health expenditure estimation: the scope of national health expenditure estimates, the categories and definitions to be used, and the analytical framework; and the methods used to derive estimates for individual items of expenditure. The scope of the national health expenditure estimates can be articulated over a spectrum of departments such as labour for occupational health and education for nutritional programmes. This study is concern with expenditures that come via the central and provincial Departments of Health (benefit matching).

The study looks at the providers of resources, functions and types of health care expenditure services, economic expenditure categories and standard line items, and the provinces as geographical categories for resource allocation and expenditure. On the analytical front, the study focused on the calculation and presentation of consolidated and provincial-specific health expenditure estimates through budget programmes, sub-programmes and the economic classification of medium-term expenditure tables. In this analytical framework, health expenditures are examined in a flow of funds framework and presented in the form of expenditure tables that link expenditure resources and financing mechanism with a variety of breakdowns for the uses of expenditure. Within this approach sources and uses can be contrasted with the tabulation of separate accounts for sources and uses of expenditure (Berman 1996: p9). This writer argues that the sources and uses method imposes an important burden on the national health expenditure analysis, which typically consists of separately compiled estimates of expenditure by sources and providers, such as hospitals.

The approach therefore requires that all expenditure estimated by the different sources should be allocated to specific uses. Similarly, Berman (1996: p10) argued, "all expenditures reported by specific uses, such as expenditure on government hospitals, must be traceable to the specific sources" and traceable to a public health policy option and a national priority. The approach requires analysis of not only the subtotals and their aggregates, but also an understanding of the flow of funds through the public health system and, as such, insists on a need to know, in an integrated way exactly who pays, why, how much and for what?

According to this study, it is conceivable that an analysis of “who pays” ought to assist in determining the nature and scope of the financial leverage of the public health policy. The analysis includes where the function and service are located and the conditions, if any, that are attached to the funding inputs. Such an analysis also contributes towards an understanding of the dynamics in the relationship between the transfer and the recipient of the funds. “Why” the funds are given directs the study not only to the rationale, which could include the political and technical imperative for the fund allocation, but also to whether the funds are in terms of the particular policy and the rules of the public finance system. The allocation of funds could also be as a result of regulatory obligations to finance and deliver a public health function, service or priority. In terms of “how much”, questions are raised about whether a service or policy was costed and the amount or level of funds to be allocated, issues about multi-year financial flows and whether funding is full or partial. These questions are clearly linked to the “and for what purpose”. It is therefore conceivable that the imperatives or intended consequences of the funds might be based a common public expenditure policy agreement. It is through these analytical linkages that the impact of policy and the co-operative government in health is measured.

The methods used to derive estimates for individual items of expenditure, which build on the advantages of the source and use approaches, argue for greater disaggregation of funding sources beyond the general categories of public and private. However, the resource and expenditure table or matrix approach permits disaggregated analysis of expenditure and provides an understanding of the flow of funds in the health system. As such, every financial flow is quantified in a systematic and integrated way. The dimensions of the NHA model on expenditure (Poullier, Hernandez and Kawabata 2002: p6) comprise the definitions set out in the paragraphs that follow.

a) *Financing sources* are viewed as resources are that initially entered into the health system for health goods and services whether from tax-based, social security or other external funding for private and public health funding. However, in this study funding sources are viewed as public funds that flow through the public health system and are captured in the health revenue and expenditure data. Tax-based funds within the system are essentially conditional and unconditional funds.

b) *Financial agents* are defined as institutions that receive and manage funds from financing sources to purchase health goods and services. In this study funding agents are defined as both the central and provincial governments. These agents are also concurrently responsible for purchasing and providing goods and services to the public.

c) *Providers* are entities that receive financial resources and use those resources to produce health goods and services, which include basic health-care and service-provision institutions.

d) *Functions* are the categories of goods and services such as inpatient services, ambulance services and public health institutions. These goods and services are reflected by programme prescriptions, functional areas, and budgetary programme analysis.

e) *Cost of factors production (line items)* is the type of resources that are allocated to health care. It includes variables such as labour, drugs and medical equipment. In this study, line items are analysed only to the levels of economic classification and sub-programmes.

f) *Beneficiaries* are defined as recipients of outputs in the health system and services. While beneficiaries are important, this study only briefly reflects on per capita expenditure and only as a means to determine distribution and possible inferences on the equity distribution across the provinces.

Overview of revenue and expenditure data collection

This chapter draws on national and provincial data on health financing and expenditure, documentary analysis of financing and expenditure for public health services delivered by the nine provinces, sourcing and expenditure trends analysis and their connections with policy decisions and statements, and interviews with senior policy and finance official within health departments and treasuries. This is presented in chapters Six and Seven.

The research question directed the study towards a method of tracking the flow of funds within the health system, from sources of funding programmes and services that originates

not only from public health policies. The study explores service delivery priorities determined by central government by focusing on the flow of funds, the composition of funds, and an alignment between policy and funding trends over a multi-year period. The theoretical exposition points towards determining measures of inputs, costs and the financial trends in order to estimate how central government policies and priority-setting pressures have impacted on the nature of decentralized co-operative governance.

The revenue sources and expenditure data on budget allocations and expenditure from 1997/08 to 2007/08 are utilised to measure the effects of the public health policy on the financial decision-making capabilities of the provinces. As a result, the research approach in this chapter is one of a PER with the primary objective to track the public health policy implementation or to measure the "commitment" by the provinces to adhere to the national public health service delivery policies, programmes and priorities.

The revenue and expenditure data is presented in tables, graphs and diagrams in chapters Six and Seven. The tables, graphs and diagrams depict overall trends within revenue allocation and expenditure, and the funding mechanism, that is, equitable share or conditional grants. The data is also presented through the public health uniform budget structure programme as regulated by the National Treasury guidelines in chapters Six and Seven. The uniform and standardised budget structure for health comprises programmes and sub-programmes. The data is also presented in chapters Six and Seven through an analysis of financial data at an economic-classification and standard-expenditure item level. The expenditures at the levels of both the programme and classification levels are then linked and analysed in relation to the policy content discussed in chapter Five. The intention here is to determine the linkages between the mandatory and discretionary cost drivers within the policies, as well as growth patterns in revenue and expenditures. The mandatory cost drivers refer to the financing of health policies and priorities, interests on government debt, and payments required under government-guaranteed loans. Discretionary cost drivers, in turn, include personnel and capital expenditure. The expenditure on wages, interests, inflation and exchanges are all part of discretionary cost drivers.

This study focuses on the financing resources, financial agents and functions in order to analyse co-operative government and decentralization within the policy process and financing of the public health system. The view held by the researcher is that the enhanced

approach of the PER through components of NHA model accommodated analysis and expression of public finance and fiscal policies. This enhanced approach assisted in showing how the policies have an effect on the public health system. The enhanced approach to PER also assisted in an analysis and expression of public finance policy affecting the public health system through an analysis of: a) per capita expenditure; b) public health expenditure to Gross Domestic Product (GDP) to central government expenditure to GDP; c) the provincial health expenditure as a percentage of total expenditure; d) health as a percentage of provincial expenditure; e) transfers from all levels of government as a percentage of total provincial revenues and grants; f) the percentage of provincial revenue as a percentage total of national revenue; g) the distribution of resource allocation across programmes; and h) actual provincial health expenditure to budgetary allocations.

Data Collection Techniques

This study uses a combination of research approaches to address the research question. These are illustrated in Table 3.1 and are described below.

Research Sample and Expert interviews – Senior Public Service Policy Managers

The choice of study methods was influenced by the research questions and the public health system as the unit of analysis. Given the number of senior policymakers and implementers within both national and provincial governments, i.e. treasuries and provincial departments, it was felt that a selected sample would be most appropriate. The choice of such a sample relies on the researcher's personal knowledge of the context to be investigated and knowledge about the key policymakers and implementers within both provincial and national governments. The choice of the sample is according to the researcher's judgement or experience (Cohen and Manion: 1997; Neuman 1994) in public policy processes, knowledge about senior managers in provinces and national Government involved in decentralized co-operative governance: policy, finance and fiscal and administration. Non-probability sampling was chosen, because of the researcher's previous and current involvement in public policy analysis at both a provincial and national government level. The sample of respondents also allows for an evaluation of the public health function decentralization in terms of policy, financing and administration by people who know the system well from within and, as such, the "reported perceptions of those well-

placed to assess a given issue can lead to robust findings" and "subjective data is the only data that is evenly potentially informative" (Khaleghian and Das Gupta 2004:5-6).

The view is that by choosing both the public health and financial sectors and related policy, and financial administration as key focuses areas have provided the researcher the added advantage of easier access of government documentation, policymakers, and implementers within both provincial and national governments. The sample creates the opportunity to: a) generalise about the extent and effect of policy, fiscal and administration decentralization within the health system; b) generalise whether implementation of systems of fiscal decentralization and co-operative governance were able to optimise decentralization policies within the health system; and c) assess how senior public policymakers and implementers interact with policy, the nature of such interactions between the different spheres of government and how resource allocation and expenditure decisions are made, thereby allowing generalisation about governance and intergovernmental decentralization in practice.

Table 3b:- Data Collection Method

Data Collection Source	**Details from source required**
1. Literature review on decentralization including a review of secondary data on health decentralization	a) Theory and practice on policy, financial and fiscal; and administrative decentralization b) Published and unpublished documents or reports on health system decentralization; financial and fiscal decentralization c) Related policy documents on the decentralization of the health system
2. Policy review and analysis	a) Policy theory and practice b) Review and analysis of the identified health policy documents c) Identification of key concepts and categories as espoused by the policy documents
3. Expenditure and Resource Review and Analysis	a) Review of finance and fiscal decentralization – policy and practice b) Review and analysis of fiscal resources and uses and interconnectedness to policy and administration decentralization – budgets, expenditure and annual reports c) Review and analysis of funding distribution and funding flows
4.Interviews	a) Interviews with: b) A senior manager from the nine provincial Treasuries and health departments (9x2 =18 in total) c) Three senior managers from national Department of Health d) Three senior managers from National Treasury responsible for health – national and provincial financing and fiscal policy matters

Furthermore, the interviewees for the sample were drawn from all nine provinces (treasuries and health departments) and national government (National Treasury and Department of Health). The interviewees were chosen on the basis of: a) their historical and professional involvement in health decentralization and finance management and administration; b) their management and leadership responsibility for policy formulation and implementation; and c) their knowledge about public health policy, fiscal and finance and administrative decentralization. Such a non-probability sample drawn from the nine provinces and the national Departments of Health and the National Treasury creates the opportunity to:

a) Generalise about both the health and public finance sectors understanding and implementation of decentralized co-operative governance;
b) Generalise about the health and public finance sectors' interaction with and implementation of policy, finance and fiscal administration within the public health system; and
c) Explore and reveal the extent of comparative orientations of the effects and or outcomes of policy, fiscal and finance, and administrative decentralization and co-operative governance in practice

Semi-structure Interview Schedule

A list of the numbers of interviewees who made up the sample is presented in Table 3.1. Field visits were undertaken to interview central and provincial governments's senior managers responsible for health policy, fiscal and finance administration and management. Given the size of the sample and the time factor (tight time schedules and work responsibilities of the senior managers), the decision was taken to conduct semi-structured interviews would be conducted. Semi-structured interviews with policy makers and implementers from director level to head of departments responsible for policy and programme design and implementation within both public finance and public health sectors were conducted to examine the context of policy practice of public-finance and health-policy decentralized co-operative governance. Semi-structured interviews were also conducted with selected policy designers and implementers from the central and provincial government departments of health and finance. A series of questions was produced in order to develop a semi-structured interview schedule. The questions are:

1) What are the key features from a Treasury or Health perspective of decentralized co-operative governance of the public health system, especially in relation to functions and services? (Your understanding of decentralized co-operative governance of function and responsibilities, public policies and financing?)

2) In discussions between provinces and National Treasury, the national Department of Health is promoting or reintroducing the debate on centralized (block grant allocation) budgeting for Health to “fast-track equity”. What are your views of this policy debate? Does it contradict the current fiscal policy regime of an equitable share?

3) To what extent have financial decentralization and administrative decentralization either contributed to or impeded equity between districts, regions and provinces within the overall health system?

4) So, how do both provincial and national treasuries and departments of health go about managing national policy, national priorities, national budget within the provincial budgets and service delivery? Also, to what extent have provincial health priorities and financing conflicted with those at national level?

5) Are decisions about national policy priorities a de facto determination of provincial health budgets? (Is the autonomy given to provinces more apparent then real? – Are provinces kept on a functions and fiscal leash? If so, why?)

6) To what extent does the policy and intergovernmental practice through the system of decentralization of functions, services, finances and administration facilitate concurrency and decentralized co-operative governance in public health system?

7) To what extent do intergovernmental fiscal transfers – that is, conditional grants and the equitable share allocations contribute – facilitate or impede an integrated national and co-operative public health system? (Do we still have 1 or 9 or 10 public health systems? What is your opinion as a policy expert and activist?)

Method of Data Analysis

The study utilises different types of data analyses: policy content including secondary and primary documentation, expenditure and resource allocation, and interview. Policy content analysis (Firestone, 1987; Cohen and Manion, 1997) is a method that constructs categories of explanation of the data collected. The use of content analysis helps to identify appropriate categories that reflect the purpose of the research. The generation of these categories serves as the basis for organising the data. The categories also provide a general descriptive sense of the content of the data and how an analysis of it is to be pursued. Policy textual analysis is a key piece within the data collection activity. During the investigation, the researcher reviewed and analysed the content of the policies identified within chapter Five. This process allowed the researcher to parallels between the different texts and the literature on decentralization. The policy text analysis also relied on additional documentation, published and unpublished, which should further illuminate the meanings and understanding attached to the policies in the context of practice. Integral parts of the textual analysis are the key arguments that unfolded during the literature review.

In addition to a review and analysis of resource and expenditure secondary and primary data, the researcher intended to develop tables of funding sources and uses as presented in chapter Six and Seven. This should provide the study with aggregated and disaggregated resource and expenditure data and an understanding of the flow of funds through the health system at national and provincial levels. The identified funding sources and funding users for analysis further assisted by relating public health resources and expenditure activities to appropriate policies and programmes that relate to the public policy process of decentralization.

The Case Study and Limitations of Research Methodology

This study is located in both the qualitative and quantitative (financial data analysis) research paradigms. It utilizes a case study, which is the public health system, as the unit for the research. The advantage of the case study is that it allows the researcher access to the particular phenomenon in its natural setting. Given the complexity and dynamics of the co-operative governance of the public finance and public health sectors, the case study approach also allow for an in-depth, multi-method account of co-operative governance's

operability into the complex public finance and public health sectors, but also its overall implications for the public health system. This study uses a variety of data collection and data analysis techniques, such as in-depth individual interviews, assessment and analysis of reports and documents, budget and expenditure data analysis. The case study thus draws on both qualitative and financial statistical data. The study identified a number of limitations of research approach and the methods used. The limitations are set out in the paragraphs that follow.

One of the limitations of this study is the possibility that researcher bias could have been introduced related ethics, reliability and validity concerns. In order to overcome this possible bias, the dissertation made use of a variety of strategies, such as using multiple sources of data collection, to establish chains of evidence in order to confirm the credibility of the information and narrative account. The interviews with respondents were audio-taped and, where necessary, detailed notes were taken, such as in instances where there were time limitations on the part of the interviewees.

Case studies provide little basis for making scientific generalisation and can, therefore, not be used to make broad generalizations. However, according to Yin (1994:10) a case study may be "generalisable to theoretical propositions" but not to all areas within the public health system. In addition, the research study resulted in a huge volume of data that needed to be managed and suitably secured. Both electronic and manual databases were created and stored for easy reference. The main limitations of the study are following:

a) The dissertation focuses on the public health system, which will make it difficult to generalise about decentralized co-operative governance nationally, but also about other sectors for which there is a joint responsibility between central government and provinces.

b) The study draws on a selected sample. This makes it difficult to interpret or generalise the findings of the study to all policy actors within other sectors where there is shared responsibility between central and the provincial governments.

However, generalisation can be made about central and sub-national governments' policy interpretations and implementation; and the projected impact on the system of

co-operative governance and fiscal decentralization within the public health system, because of the authoritative positions that the members of the sample hold within the public service. All are at the level of senior management and are responsible for the efficient and effective functioning of the overall health system, in all its facets.

c) Interviews with policy actors and implementers (those selected) reveal a high degree of common interpretation of the policy processes within the public finance and health sector, respectively. While this homogeneity exists between the sectors at a vertical level, the same cannot be said at a horizontal level between central and provincial government departments regarding the policy design and implementation processes.

Chapter Summary

The focus of this chapter, research design and methodology, explored in the design, methodology, data collection techniques and analyses. Within this exploration, particular emphasis was placed on the researcher as participant, policy content, and revenue and expenditure reviews and analyses, and semi-structured interviews. The chapter also reviewed the decision-making space and the public expenditure review as analytical approaches to public policy content and public finance analyses. The chapter also argued for the utilisation of the case study method as the lens through which decentralized co-operative governance of public health policy and public finance are analysed. The public health system is case study of this dissertation.

The research design and methodology utilised in the collection and analysis of data is applied to the case study in chapters Five, Six and Seven. Chapter Four, provides a review and analysis of the public health system context, specifically focusing on the demographics, and political and economic contexts of public policy making and implementation in South Africa.

Chapter Four: Public Health System Context from a Public Policy Perspective: – Demographics; Political and Economic Context Public Policy

Introduction

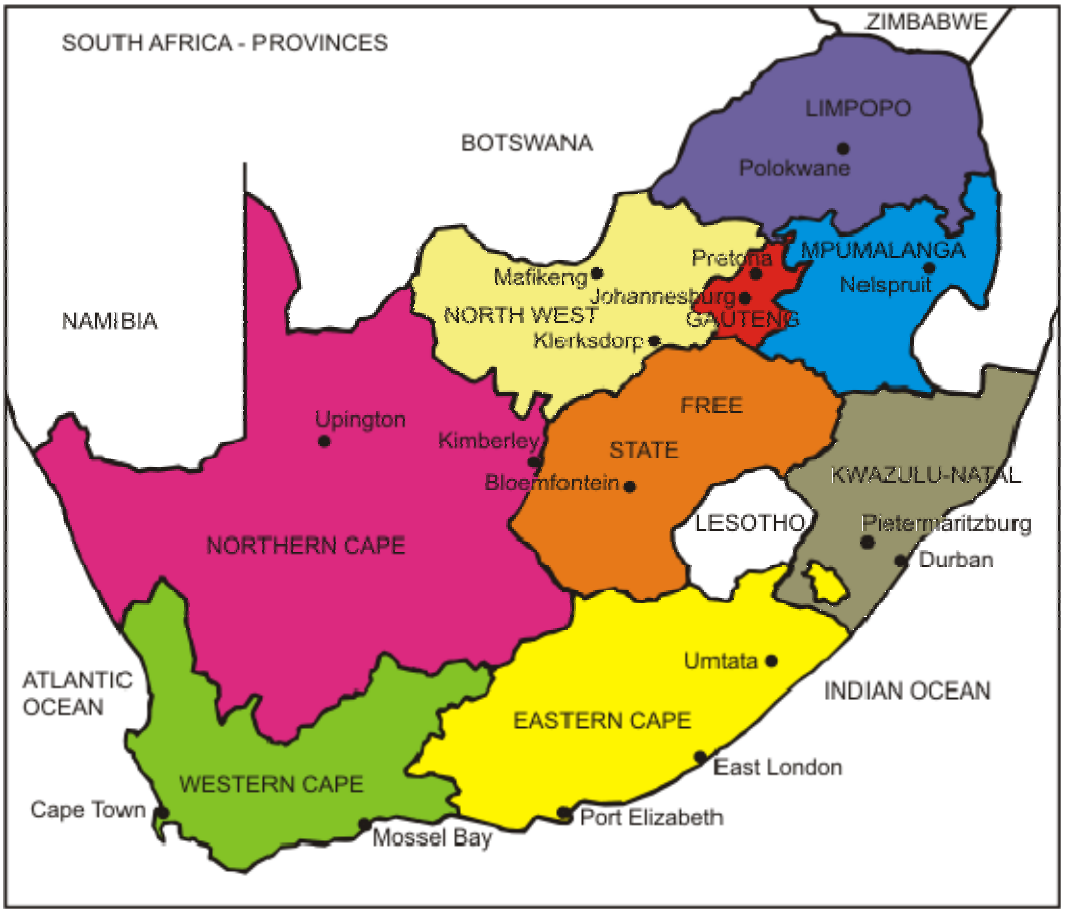
The chapter looks at the demographic, political and economic environments within South Africa that have influenced and impacted on the decentralized co-operative governance of the policy context on the public health system.

The national context of South Africa – geography, demographics and health context

The Republic of South Africa (referred to as South Africa), as shown in the Map below, consists of nine provinces with widely variant distribution of land and population. The provinces are the Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North West, Northern Cape and Western Cape. South Africa is a country of over 1.2 million square kilometres (or over 470,000 square miles). There are, according to Statistics South Africa (2006), about 47.4 million people in South Africa split into four basic groups. Blacks, termed “Africans”, comprise 79.5 per cent of the population. The next largest group is “Whites” at 9.2 per cent, “Coloured” at 8.9 per cent and “Indians” at 2.4 per cent. The gender split is almost even at 51 per cent female and 49 per cent male.

According to Statistics South Africa (2006), the Eastern Cape has 13.9 % of the land, with 14.6 % of the population. The Free State has 10.6 % of the land, with 6.2 % of the population (May 1998). May (1998) also mentions that Gauteng has only 1.4 % of the land, but is densely populated at 20.1 % of the people. KwaZulu-Natal has 7.6 % of the land but again has a dramatic density difference, at 20.9 % of the population. Limpopo has 10.2 % of the land and 11.3 % of the population. Mpumalanga has 6.5 % of the land and 7.4 % of the population. North West has 9.8 % of the land and 7.1 % of the population. In contrast to Gauteng and KwaZulu-Natal, Northern Cape has 29.5 % of the land but is sparsely populated at only 2.3 % of the population. Finally, Western Cape has 10.6 % of the land and 10.1 % of the population.

Map 1: The Republic of South Africa



South Africa has one of the highest income inequalities in the world, with a Gini co-efficient of .58 (World Bank Indicators Online, 2006). With rural areas accounting for 50 per cent of the total land, 72 per cent of the poor, representing 76 % of the Total Poverty Gap, are found in rural areas. The highest poverty levels (May 1998) are found in the provinces of the Eastern Cape, Free State, and Limpopo. These provinces together have 36 per cent of the population but 51 per cent of the total poverty gap. Poverty also impacts differently on the various racial groups, with 61 per cent of the African population, the overwhelming majority, living in poverty (Statistics South Africa 2006). The group is followed by the Coloured population at 38 per cent, 5 per cent of Indians, and only 1 per cent of Whites. The overall official unemployment rate is about 25.6 per cent. The life expectancy is about 49 years for males and 53 years for females. The overall life expectancy has decreased considerably over recent years with HIV and AIDS as a significant factor. The HIV positive rate was

approximately 11 per cent in 2006. Fifty per cent all new HIV infections in 2001 were in youth aged between 15 – 24 years (Statistics South Africa 2006).

National Political Context

According to Chapter 6 of the Constitution of the Republic of South Africa, Act 108 of 1996 (Republic of South Africa 1996) provinces are all constitutional geographical areas, each with its own politically autonomous authority, which comprises a provincial legislature and an executive council. The executive council or provincial cabinet is provided with technical assistance, support and delivery on its constitutional and legislative mandates by a public service staffed by public servants. The public service within this study refers to the central and provincial departments of health and the treasury departments in all nine provinces and central government. The public service comprises individuals employed by the government at central and provincial levels whose primary function is to assist and implement policies, programmes and deliver services as directed by the different executive authorities and accounting officers. An "executive authority" within the South African context refers to the political authority and the "accounting officer" refers to the most senior employee or public servant within a government department or public entity.

At a national level, South Africa is governed by a Parliament, the national legislature which consists of two houses, namely the National Assembly with national democratically elected public representatives and a National Council of Provinces (NCOP) which comprises provincially elected and delegated representatives. The NCOP, from both a public policy and finance perspective, protects the interests of provinces within the context of national political governance. The overall political management of the country is the responsibility of the central government Cabinet, which consists of the State President, Deputy State President and Ministers appointed by the President.

Decentralized co-operative governance in South Africa follows a strong political and constitutional approach. This approach was the outcome of the 1990 to 1994 negotiated constitutional settlements. The view of this dissertation is that co-operative governance within a unitary decentralized government is in essence an approach to hold the different parts of decentralized constitutional governance together. The view is also that the existence of constitutionally autonomous provincial governments could possibly lead to strong provincial government with a weak central government. The nature of decentralized

cooperative governance, it can also be argued, in the unitary state context was to ensure a strong central government with elements, of functions devolved to the provinces.

Chapter 3, section 41 of the Constitution identifies principles for co-operative governance which include the provision that all levels must "exercise their powers and perform their functions in a manner that does not encroach on the geographical or institutional integrity of government in another sphere". The Constitution delineates the distribution of power. The decision to pursue co-operative governance and decentralized system of government was mainly political. During the constitutional negotiations, in the early 1990s, referred to as the Convention for a Democratic South Africa (CODESA), the African National Congress (ANC), the South African Communist Party (SACP) and their negotiating partners advocated a centralized state, while the National Party (NP), Democratic Party (DP) and Inkatha Freedom Party (IFP) proposed a federalist approach of governance. Similar to the case of most developed and developing countries that emerged from a dispensation of political and governance conflict, the South African Constitution reflects an accommodation of underlying political pressures so that the development potential of co-operative governance and decentralized government could be realised and risks minimised.

The key imperative in support of the constitutional arrangement was to uphold political stability through a negotiated process that not only set the rules for co-operative and decentralized governance but also for how the system operates. According to Dillinger and Fay (1999) such rules include: the division of political power between central and sub-national interests; the functions and resources assigned to sub-national governments; and the electoral rules and other political institutions that bind local politicians to their constituents. The phenomenon of political polarisation also serves as an impetus for decentralization, where governments consciously choose to enter into a political compromise with adversaries as a means of dealing with the polarisation by devolving more authority to the regions as an attempt to diffuse dissent (Lauglo 1995).

Macro-economic and Fiscal Context

The South African economy recovered from the downward economic growth spiral of the early 1990s as a result of economic growth and investment. The growth in the economy has to date, however, not provided sufficient jobs, making the growth inconsequential to the

unemployed and the poor. Brown and Fölscher (2004: p xii) mention that the "number of jobs has grown, but not yet as fast as the number of those seeking them". The inability to address unemployment and poverty could be considered as a structural crisis originating from within the economy (Fourie and Burger 2003: p2). These writers also argue that this crisis was as a result of "intrinsic underdevelopment problems, large discrepancies in the distribution of income, wealth opportunities caused *inter-alia,* by apartheid, and large backlogs in the availability of basic social services" (Fourie and Burger 2003: p2).

A deeper understanding of the crisis requires a deeper analysis that is not only economically orientated, but also explores the different and divergent socio-political features on the South African social economic context. The economic crisis experienced during the 1990s obligated all spheres of governments to provide a social protection safety net for the unemployed and poor through public services such as health. Brown and Fölscher (2004: p xi) also argue that in addressing the crisis of unemployment, poverty and inequality a common theme within the government's response has been the constant effort to maintain stability, whether macroeconomic or socio-politically.

The response to the crisis, which is referred to as the "second transformation of the economy" (Fourie and Burger 2003: p2) from 1996 to 2000 was to ensure sustainable development, defined as

> …development that meets the needs of the present without compromising the ability of future generations to meet their own needs. The best expression of such a response is generally found in a country macro-economic, fiscal, development policies, but primarily the developmental policies that include resource use, health and social welfare …

According the Brown and Fölscher, the South Africa Government's argument is that "macroeconomic stability and growing confidence will see the economy entering a period of higher growth, providing resources to meet people's needs, given no further disastrously destabilizing international shocks" (2004: pxii). Content analyses of the different policy documents on economic growth and empowerment and the economic growth (National Treasury 2002a; 2005a; 2005b) suggest that South Africa has experienced three broad periods of fiscal policy since 1990. In the period between 1990 and 1995, the fiscal policy was an outcome of extraordinarily tough political and economic conditions. This period saw

a conservative fiscal policy stance to raise taxes and cut public spending. The fiscal policy was also intended to integrate the new South African economy into the globalized one. This period was characterized by a decline in the Gross Domestic Product (GDP) by 2, 1 percent (Department of Finance 1998: p2). The period was also characterized by a severe drought, which forced the government to push millions of South African Rands (currency) into drought relief. All this happened during a period of a weak international economic demands and a constrained domestic economy. The outcome of these factors was that the deficit reached over 7 percent in 1992, principally as a result of a decrease in tax revenue, increased spending, and increasing costs.

The second period of fiscal policy can be described as the Growth, Employment and Redistribution (GEAR) plan from 1996 to 2000. Although GEAR had all the hallmarks of what a South African market economy should be like, it was essentially a "neo-classical macro-economic stabilization policy along the lines of the so-called Washington Consensus with its key main objective to ensure fiscal sustainability" (Fourie and Burger 2003: p2). During this period, fiscal discipline curbed government spending, revenue performance improved and public borrowing declined. The budget deficit also declined due to higher economic growth. The overall tax burden rose due to efficiency gains and there were tax policy changes as well as tighter controls on spending. The budget was reduced from 4, 6 percent in 1996/7 to 2 percent in 2000/01 (Department of Finance 2000). During that period, the second democratically elected government experienced tough economic and fiscal constraints with debt service costs peaking and ever increasing pressures to expand existing spending levels with little fiscal credibility. The GEAR policy, pronounced the elimination of dissaving to release more resources for public and private investment, with a preference for the latter (Department of Finance 1996: p2; Fourie and Burger 2003: p5).

The third period of fiscal policy was introduced with the 2001 Budget and ran to the 2004 Budget. According to the national government, fiscal policy contributed significantly to achieving macro-economic stability. *The 2003 Medium-Term Budget Policy Statement* (National Treasury, 2003a) mentions in particular that the third term was characterized by significant increases in non-interest spending. This was financed by an increase in the tax to GDP ratio and a very dramatic decline in debt service costs. During this period economic growth averaged 2,6 per cent and gross taxes as a percentage of GDP increased from 24,1

percent to 25,7 percent. Debt cost fell from 5, 1 percent of GDP to 3, 9 percent (National Treasury, 2001a).

There are different views at the macro-economic, fiscal and governance level, about the varying effects of the evolution of the fiscal policy over the three periods. The differences particularly stem from the implementation of measures of "fiscal discipline relative to development" and the demand for expansionary economic and expenditure policies to deal within unemployment and poverty. The study holds that these views reflect a dialectical discourse in the co-operative governance system. This dialectical discourse enables the exchange of propositions and counter-propositions about the effects of the macro-economic and fiscal policies and governance concerns on matters of social policy, such as the concurrent health function between central and provincial governments. It is within this dialectical discourse context that Fourie and Burger (2003:p9) claim that:

> The government view proclaims a causality from disciplined fiscal policy to economic growth and then to development. The Cosatu view argues that causality runs in the opposite direction. These differences mean that the two sides ascribe very different operational priorities to development and sustainability. Because government emphasises fiscal sustainability, it does not want its expenditure to grow faster than GDP.

The dialectical discourse particularly encourages this exchange of propositions about the health function, health services in relation to roles, responsibilities and authority embedded within the context of the health function, which is constitutionally the concurrent responsibility of both the central and provincial governments. The dialectical discourse also enables a resolve of the central government as opposed to provincial government within the context of the co-operative governance system. The co-operative governance context and system, therefore, do not enable a process for the synthesis of opposing assertions regarding the concurrent health function but also enhance the instutionalisation of the processes of social discourse between the central and provincial governments.

These differences discussed in chapters Five, Six and Seven, also spilled over into public policies and programmes with regard to the method and distribution of fiscal resources between the central government and the provinces, i.e. the vertical division, and between the provinces, namely the horizontal division. The outflow of the division of revenue is particularly linked to levels of financing public goods to address inter- and intra-provincial inequities. In this study public health as a public good means that they are non-rival (i.e.

consumption by one person does not preclude consumption by another) and non-exclusionary (i.e. their benefits accrue to the entire population and can not be restricted to a discrete group). This is distinct from a private good – e.g. cancer treatment – which, as with most commodities is both rival and exclusionary (Khaleghian and Das Gupta 2004). It is in the cooperative governance context of policy design and practice that the provincial and central governments protect the general interest of health as public good to society. The nature and extent of cooperative governance also require both central and provincial governments to not only work in partnership with each other but to uphold the element of interdependence in the maintenance and provision of public health.

Fiscal Governance and Regulatory Context

The constitutional approach dealing with the fiscal gaps of the provincial governments is through intergovernmental fiscal flows that include: a) revenue-sharing arrangements of specified nationally collected taxes (personal income tax, value-added tax and national fuel levy); b) conditional and unconditional grants; and c) tax-base sharing. The Constitution Section 214(1) also states that revenue collected must be distributed equitably between the spheres of government. Also, the provincial share must be divided equitably between the provinces and other allocations may be made from the central government share, with or without conditions.

The South African Constitution provides significant powers to provinces to establish their own political structures and powers. However, the co-ordination and monitoring role, macro-economic stability and the achievement of national policy objectives and obligations are located with central government. Burki et al. (1999:21) argue that

> [the] central government is assigned responsibility for stabilization on the grounds that local economies have no access to an independent monetary policy and are too open for effective countercyclical measures. The income redistribution function is also assigned to the central government, on the grounds that local attempts to address income disparities are likely to provoke higher income groups to move to low-tax areas and low-income groups to move to high-benefit areas.

Although the locations of these roles to central government are in line with international best practice, the roles of central government limits provinces, in the domain of public policy formulation, finance, and administration of the health sector. Institutional arrangements of decentralized governance are primarily addressed within the Constitution and within legal

and regulatory frameworks such as the 1997 Intergovernmental Fiscal Relations Act (IGFRA), 1999 Public Finance Management Act (PFMA), and the annual Division of Revenue Act (DORA), and health legislation.

The Interim Constitution (Act 200 of 1993) and the Final 1996 Constitution (Act 108 of 1996) provided for the establishment of the Financial and Fiscal Commission (FFC). The FFC position within the intergovernmental fiscal framework, according to the National Treasury (2005b: p4) is that of

> an independent and impartial statutory institution, accountable to the legislatures, with the objective of contributing towards the creation and maintenance of an effective, equitable and sustainable system of intergovernmental fiscal relations, rendering advice to legislatures regarding any financial and fiscal matter which has a bearing on intergovernmental fiscal relations.

Intergovernmental Fiscal Relations Act (1997) provides the framework in which revenue is shared between the three spheres of government. The FFC is (National Treasury 2005b:p4-5):

> …an independent constitutional body that oversees the division of revenue process. It makes recommendations to government for the vertical division of revenue among the three spheres of government and the horizontal division of revenue between provinces and municipalities. When tabling the national budget, government must show how the division of revenue for that year takes the FFC's recommendations into account. Government's response is captured annually in the explanatory memorandum to the Division of Revenue Bill, which meet the requirements set out in section 10 (5) of the Intergovernmental Fiscal Relations Act, 1997.

Recommendations from the FFC are about: a) the vertical division of centrally raised revenue; b) the horizontal division of the provincial share amongst all nine provinces; and c) other allocations (grants) to provincial and local governments from the central government share and the conditions that may apply to such other allocations (grants). The FFC is also required to take into account the local and provincial governments' fiscal capacities, fiscal performance and their efficiency of revenue utilisation and needs. The 1997 Intergovernmental Relations Act not only formalises a process for dealing within intergovernmental budgets and related issues, but also gives effect to sections 41 and 214 of the Constitution. The sections set out the process for revenue sharing and promotion of co-operative governance, respectively.

The 1997 Intergovernmental Fiscal Relations Act requires consultation with the provinces government before a decision is taken on the final allocations and that a Division of Revenue of Act (DORA) must also be tabled with the annual budget. Both the DORA and the annual budget, which are embodiment of policies, priorities and programmes for the Medium-Term Expenditure Framework (MTEF) period, are presented to the South African Parliament indicating intergovernmental transfers, including the equitable shares and any conditional grants or agency payments.

In 1997 the national Budget Council (Department of Finance, 1999b) devised a revenue-sharing formula to ensure the equitable distribution of resources. According to the formula, the total national revenue budget, after expenditure on standing appropriations, debt service costs, and new policy reserve, is shared (formula based) on two splits. A vertical split between central and sub-national governments, and horizontal splits between sub-national governments. Horizontal splits between provinces are based on four categories: a) conditional grants b) unconditional grants c) tax share grants based on provincial tax collection; and the d) equitable share formula.

The equitable share allocates the largest portion of available funds to provinces to meet their constitutional mandates. The equitable share between the spheres is determined after a process of expenditure review and policy analysis. The provincial share reflects a political decision on the priority of provincial functions relative to those of central and local governments. The provincial equitable share is divided between the provinces, known as the horizontal division, by using a formula based on provincial demographic and economic profiles and an anticipated demand for the major services provided by the provinces. The revenue-sharing mechanism is intended to compensate provinces for the gap between expenditure responsibilities and revenue sources and to redistribute resources among provinces (Department of Finance 1999c). The health share is based on the proportion of the population without access to medical aid. More specifically, the Department of Finance (1999c:p14) mentions that:

> The use of an objective formula helps to achieve redistribution objectives and, in conjunction with the three-year budget allocations, introduces certainty in provincial revenues, consistent with international best practice. Although the formula incorporates components to reflect national demands for health, education, and welfare services and infrastructure backlogs across provinces, it does not imply any condition on the use of these resources.

Intergovernmental transfers make up approximately 95% of provincial budgets, which effectively creates a situation of fiscal dependency on the part of provinces. Agency payments are the third type of transfers, which is a basic refund for services provided on behalf of central or local government. The Department of Finance (1999b) acknowledges that some degree of confusion exists between conditional and agency grants payments, and the policy basis on which central departments decide what constitutes a conditional grant and what an agency payment.

History of public health governance

South Africa's apartheid history, which was characterized by racial and class divisions, with structural and organisational impediments to efficient and equitable public and private sector service delivery and institutions, had a significant impact on conceptualization and implementation of governance systems, state institutions and public life. Within the public health sector, prior to the 1994 election, the health system was fragmented into fourteen health departments at central government (Department of Health 1999). It consisted of the Department of National Health and Population Development, three Tricameral "own" affairs Departments of Health and the health departments of the former "Bantustans". Bantustan were, in the era before the first democratic elections, a tribal and ethic geographical reserve for indigenous Africans born and living in the geographical boundaries of South Africa. The apartheid government's 1983 Constitution introduced three separate Houses of Parliament, i.e. House of Representative (Coloureds), House of Delegates (Indians) and the House of Assembly (Whites). Each House was responsible for the administration of the "own affairs" of a particular racial group. No structure existed for the majority of Africans, whose needs were regarded as general affairs.

In addition, the former provinces of the Cape, Orange Free State, Natal and Transvaal each had a health department, and an estimated 400 local authorities had their own health departments. During this period the Department of National Health and Population Development functioned as an administrative central command and control post, by specifying policies and regulations to ensure that the public sector health outputs delivered by the then national, provincial and local government departments complied with separate human development.

Van Rensburg, Fourie and Pretorius (1992) confirm the excessive fragmentation of control of health services and a lack of central policy control, which led to misallocations of resources and wasteful duplication of services. The ***National Health Plan of 1986*** attempted to align the health system organisationally with the 1983 constitutional reforms (Rensburg, *et. al* p74 – p82). The division of health services, which was a continuation of the National Health Service Facilities Plan of 1980, was fundamental to the National Health Plan. Rensburg et al. (1992: p77-79) further indicate that the National Health Plan made provision for additional functional and structural arrangements that included:

a) The new **Department of National Health and Population Development** (formerly the Department of Health and Welfare) was entrusted with overall national policy formulation and central control of health services at first level of government. Provision was made for the delegation of executive functions to second and third tier authorities, *e g*, the provincial and local authorities, on an agency basis.

b) The first three levels of health care (i.e. those of the provision of basic subsistence, health education and primary health care) were entrusted to the three own affairs departments of Health Services and Welfare, while the Department of National Health and Population Development would manage these services on behalf of blacks but with delegated execution of such services by the provincial administrations.

c) The three remaining levels of health care (i.e. provision and control of community, regional and academic hospitals) fell under the control of either the Department of National Health and Population Development or the Own Affairs Departments of Health Services and Welfare, depending on the composition of the clientele of these hospitals. The actual management of hospital services is likewise delegated to the respective provincial administrations, which then manage these services as agents, on behalf of the other authorities.

d) The overall management of hospital services, as well as that of preventive services, was transferred to the **Co-ordinating Board of Provincial Administrators** in terms of the National Health Plan. The council operated under chairmanship of the Minister of National Health and Population Development. In respect of health matters in their

provinces the provincial administrators are assisted by the members of the executive committees entrusted with health services. Blacks also serve on these committees and in this way obtain a say in the formulation of policy.

e) The **Health Matters Advisory Committee** was likewise retained in the National Health Plan, but in restructured form so as to incorporate the three own affairs departments of Health Services and Welfare. Henceforth this committee would consist of: (i) the director-general of National Health and Population Development (as chairperson); (ii) functionaries of the Department of National Health and Population Development; (iii) functionaries of the three own affairs departments of Health Services and Welfare; (iv) functionaries of the second- and third-tier authorities; and (v) the surgeon-general of the South African Defence Force. For its part, the Health Matters Advisory Committee functions by means of a number of subcommittees entrusted with specific portfolios.

Following these reforms, new reforms (Rensburg et al 1992) were introduced by the apartheid central government through the **1990 National Policy for Health Act** (1990) and the **1991 National Health Service Delivery Plan for South Africa**. Rensburg et al. (1992: 84-89) also mentions that the National Policy for Health Act introduced three government bodies, which replaced existing bodies. The new bodies were:

a) The Health Matters Committee, which replaced the Health Matters Advisory Committee that was established in 1977 and considerably altered in 1986. The functions of this committee were to investigate matters pertaining to health at their own instigation or at the request of the minister, the own affairs ministers or the Administrator's Council; to consider such matters and to make the necessary recommendations; also to take actions which promote the objectives of this Act (1990) and the Health Act of 1977.

b) **Administrators Health Council,** which replaced the Co-ordinating Board of Provincial Administrators instituted in 1986. The functions of this council were to consider, on its own initiative or at the request of the minister of National Health and Population Development or that of any other minister responsible for health, a matter or a draft proclamation concerning health and to make recommendations in respect of such to the minister in question.

c) **Health Policy Council** replaced the National Health Policy Council established in 1977. The function of this council was to consider all draft legislation pertaining to national health policy, and also recommendations by the Health Matters Committee or other matters, which the minister or the council may deem necessary, and to make recommendations concerning such matters to the minister of National Health and Population Development or another minister of health in question. The following must, however, be noted: a significant stipulation of the 1990 legislation is that the provincial administrations have lost representation in the Health Policy Council and, so also, a direct and true say in matters pertaining to policy making, while the minister's decision is also binding in the case of the provinces. In this respect the powers of the provincial administrations were somewhat curbed.

This apartheid policy practice in the public health system and sector not only created duplication and wastage in the development of health policies, governance structures and resources, but also ravaged the public health delivery system and mechanisms in both the historically advantaged and disadvantaged sectors. McIntyre, et al. (1994: p7), maintain that "the effect of this fragmentation has been, not surprisingly, a gross lack of co-ordination in the development of health service infrastructure and inadequate health planning at the national level." Although the apartheid system succeeded in its political objective of determining separate public health services and development needs for the different racial groups, it created a chaotic governance system of public health and a system of financing of the public health sector, which bore no resemblance to public health needs or the development of curative and preventative health services.

Constitutional reform and its influence on decentralized co-operative governance of the public health system

The earliest contestation of the reforms to be implemented came from the African National Congress (ANC) arguing that South Africa is a unitary State and favoring a strong centre. The ANC preferred devolving functions to the periphery and viewed the provincial and local levels as the instrumentation arm of the central government (Pillay: 2000). Pillay (2000:2) mentions that according to the African National Congress (ANC):

> South Africa shall be a unitary state in which there shall be government at local, regional and national levels … parliament shall determine what powers a region should have, taking into consideration that certain functions are best performed at a regional level, provided the overriding authority of the central parliament is recognised. Powers of the regional and local government should be harmonized with the powers of central government bearing in mind that in case of conflict the constitution and national legislation should prevail. In essence regional government will have to function broadly within the framework of national policy. Regional government should not be able to contradict national policy as expressed in the laws of the country, but should rather influence the shaping of these policies and play a significant role in developing mechanisms for implementation.

During the five years after the first democratic election, the central government was responsible for maintaining and continuing to improve public health service delivery, and fast-tracking the improvement of access to historically disadvantaged groups and communities. On the other hand it had to establish a new public health system by integrating the various "apartheid government's health departments", consolidating the establishment and operation of the old and proposed new public health system, and by designing processes to standardize the system across the country.

More concretely, according to Pillay (2000), the establishment and operation of the public health function took the form of creating a central government's department of health and nine provincial health departments. In carrying out this task this processes occurred concurrently: (a) the integration in provinces of a multitude of existing administrations; and (b) the decentralization of functions from the central department of health to the nine provincial departments. The project was a central-government-driven agenda for the country, though the implementation of integration occurred at the provincial level, in all its forms it was led and co-ordinated centrally. This occurred while the central department itself underwent transformation to discharge its changing role.

Structurally, transforming the public health system was politically and technically administered and managed by a committee called the Minister and Members of the Executive Council (MECs). This committee was established to provide political and policy direction to the transformation process. At a technical level, a Provincial Health Restructuring Committee (PHRC) of the most senior health officials representing each province was created to focus on the implementation of Public Health Policies. The Provincial Health Restructuring Committee (PHRC) was set-up to: a) ensure that the provinces restructure in similar ways to maintain the integrity of the health system; (b) share experiences as the process unfolded; (c) provide national leadership; and (d) ensure effective co-ordination.

Each province, in turn, established a Strategic Management Team (SMT), comprising officials from the existing bureaucracy and mainly academics and members of non-governmental organisations lead the integration process at provincial level. At both the national and provincial levels various technical committees, again consisting of bureaucrats, academics and NGO representatives, were established to provide technical input into the process.

Since 1994, much attention has focused on the modernization of the public sector and its associated governance arrangements within a post-apartheid South Africa (Helmsing, Mogale and Hunter, 1996). The Constitution (Republic of South Africa,1996), introduced a decentralized government system, comprising three distinct, independent and autonomous spheres, i.e. central, provincial and local government. Chapter 3 of this constitution provides the foundation for a system of co-operative government. Section 40(1) of chapter 3 of the Constitution states: “In the Republic, government is constituted as national, provincial and local spheres of government which are distinctive, interdependent and interrelated.” Section 41 of Chapter 3 spells out the principles of co-operative government and intergovernmental relations. Schedule 5 of the Constitution specifies that certain expenditure responsibilities should be developed at the provincial and local government spheres, while others are administered jointly as stated in Schedule 4 of the Constitution. Provincial legislation, in terms of Schedule 5 of the Constitution takes precedence over national legislation, except when national legislation is needed to establish national norms and standards.

In terms of the South African Constitution health services are listed as a concurrent competence of national and provincial government. This means that national government may pass legislation setting national norms and standards for the provision of health services and that section 146 of the Constitution will apply if there is a conflict between the national legislation and the provincial legislation.

Chapter Summary

This chapter provided a description of the geographical, political and economic environments within South Africa. Its intention was to sketch the varied influences on the public policy processes, including an understanding of the various structures and geo-political and economy of the public policy process context. This exploratory description of

the decentralized co-operative governance constitutional structures and the central macro-economic and fiscal policy influence together create the environment within which public policy in South African operates. It also forms the common platform from which the policy process operates and, as such, a practice context of decentralized co-operative governance policy decision making and accountability. The political and economic influences and contexts described in this chapter show that the constitutional unitary state and government of South Africa have element and component of both a delegated and devolved decentralized system.

The next chapters that flow locates the policy content and revenue and expenditure analyses within this demographic, political and economic context of public health system in South Africa.

Chapter Five - Decentralized Co-operative Governance of Public Policies: Decision-Making and Accountability

Introduction

The pace of governmental, structural and public sector reform in South Africa has raised concerns about the appropriateness and coherence of public policies. Donaldson (1991) remarks that when many things are changing at once, societies run the risk of change getting out of control and there is a loss of coherence and balance in the socio-economic order. The 2002 Budget Review (National Treasury 2002b: p140), however, acknowledges that "health policy and services have a key role to play in social and economic development and in support of programmes that reduce poverty and vulnerability within communities". Change must be managed within a governance and policy framework. According to this study, any reforms, whether through policies or programmes, in the health sector have to fit closely with the new governance and decentralized framework. This framework, by implication, conditions future policies, programmes and priorities in the public health sector.

After 1996, public health functions in South Africa were decentralized to newly established provincial governments through a range of policies that include the White Paper for the Transformation of the Health System in South Africa (Department of Health 1997); the Policy for the Development of a District Health System for South Africa (Department of Health 1996a); and the National Health Act, No.61 of 2003 (Department of Health 2003a). These three policies and the Strategic Plan on Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome and Sexually Transmitted Diseases (HIV/Aids and STD) are the also form the focus of this study.

The different approaches to and the location of decision-making competencies for policy and practice between the public finance and health sectors, in addition to the location and responsibility for revenue and spending decision making, have contributed to complex and varied policies and competencies. This chapter argues that the central government has used its authority to systematically enlarge its responsibility within the processes of policy design and implementation. The central government has used a range of co-operative governance instruments and tools at its disposal such as control, supervision, influence and interference to enhance its influence over the design and implementation of public health

policies that intend to promote equity and efficiency. The chapter also argues that at an implementation level, provinces as the implementing agents of public health policies, have not being passive recipients of national policies and programmes and have actively engaged the central government about the nature, extent and obligations of these policies.

In addition, provinces as the implementing agents of public health policies have not been passive recipients of national policies and programmes and have actively engaged the central government about the nature, extent, and obligations of these policies. The policy design and implementation process has contributed to separation of different responsibilities and accountability for the health function between the central and provincial governments. The chapter also argues that the policy content analysis also demonstrates a gradual expansion of public health services and programmes juxtaposed against requisite provincial government capabilities. The chapter argues that depending on the policy content and, by implication, the obligations it confers – including out of annual official budget cycle public policy statements – on the provinces, the relationship between the different locations of policy design and implementation lead to national public health policies either being an imposition or a voluntary coordinated policy solution within the shared health function. This chapter argues that it is these differences for policy responsibility and accountability that have led to varied interpretations of policy content and its associated obligations and the undermining of the intentions of co-operative governance.

A plethora of public policies, in both health and finance, such as the Hospital Strategy Project (Department of Health 1996a) and the Medium-Term Expenditure Framework (Department of Finance 1997a) Medium-Term Expenditure Framework (Department of Finance 1997a) acknowledge either explicitly or by implication that South African hospital care has been over-extended and over-resourced relative to primary health care. It is through these policies that a conscious decision was taken by the central and provincial governments to strengthen primary health care by developing a district health system. The objective of this public policy stance is an explicit acceptance that primary health care has to expand. Implicitly, this has meant a potential shift and rationalisation of public health resources from hospital care to primary health care. This chapter looks at different policies that have entered the public health domain with the intention of asserting how the identified policies confirm different responsibilities between the central and provincial governments.

The study looks at how different policies confirm the location of authority and implementing responsibilities.

Public policies impacting on the public health system

What follows is policy content analysis of the selected health policies and its interconnectedness with the public finance policies and legislation. The exploratory and descriptive analysis identifies aspects in the different policies that create obligations for the provincial governments. Put differently, it identifies from a public policy perspective the content of the principal-agent and decision making and accountability arrangements, and the institutional environment, and revenue, budgets and expenditure factors. These factors, it's the contention of this dissertation, originate from the public policy content analyses. The analyses are informed by data gathered in open-ended interviews with selected policy actors. The interviews allowed for probing and clarification of the different policies, that is, a) within and between the central and provincial governments; and b) within and between the public finance and health sectors.

The overall policy content analysis in the study is retrospective in terms of the different waves of policy development in the public system from 1994 to 2004/05. The public finance part of the study includes both a retrospective and forward-looking analysis of revenue and expenditure, indicating the implications of national policies and priorities set on past and future trends of expenditure in the provincial public health sectors. The public policies were chosen because they direct or guide the restructuring of the public health sector, which has led to different health services, systems and governance reforms in South Africa. Moreover, the policies were selected because they have driven reforms in the public health sector. The selected public health policy has specifically contributed towards:-

a) Confirming proportional distribution of power and authority between the central and provincial governments;
b) Shifting health service provision from a hospital-centric system to that of delivering primary health care through a district health system;
c) Steering the health service reorganisation, administration structural reforms and public financing;

d) Determining broad health system policy objectives, choices and priorities that have guided resource allocation, particularly at a programme and health service delivery level, such as between the tertiary, secondary and primary levels;
e) Guiding expenditure and the allocation of resources to fund health programmes and different functional areas in the health sector; and
f) Guiding the composition of consolidated programme expenditure and spending inputs to produce health services in terms of the different economic classifications.

This study assumes that policy changes relate; firstly, to the establishment and operation of the new governance system, which gives effect to a decentralized, but co-operative governance public health system; secondly, to systematic reforms of the public health service delivery system to establish a district health system, which is the cornerstone of the new public health system based on a primary health care approach, thereby systematically shifting the resource envelop away from secondary and tertiary hospital care; thirdly, to a decentralized management system for hospital services; and fourthly to an overall uniformed and integrated public health care system consisting of nine autonomous and independent spheres of provincial governments responsible for implementing national health policies and a central government responsible for policy design and oversight of policy implementation through the setting of norms and standards.

The different approaches to and the location of decision-making competencies for policy and practice between the public finance and health sectors, in addition to the location and responsibility for revenue and spending decision making, have contributed to complex and varied policies and competencies. This chapter argues that the central government has used its authority within the decentralized, but unitary, governance system to systematically enlarge its responsibility within the processes of policy design and implementation. The central government has used a range of co-operative governance instruments and tools at its disposal such as control, supervision, influence and interference to enhance its influence over the design and implementation of public health policies that intend to promote equity and efficiency.

This policy design and implementation process has not only unbundled the relative responsibilities and accountability for the health function between the central and provincial governments, but has also raised financing obligations. The chapter also argues that the

policy content analysis also demonstrates a gradual expansion of public health services and programmes juxtaposed against requisite provincial government capabilities. However, this chapter argues, that depending on the policy content and, by implication, the obligations it confers on the provinces, including out of annual official budget cycle public policy statements, the relationship between the different locations of policy design and implementation lead to national public health policies either being an imposition or voluntary coordinated policy solutions within the shared health function.

Transformation of the Public Health System

The introduction of the *White Paper for the Transformation of the Health System in South Africa* (Department of Health, 1997:p1) is particularly strong in setting its mission for central government to deal with the past governance of health:

> … to provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary health care approach.

It is with the above in mind that the government of 1994, elected before the above-mentioned statement was made, implemented structural and functional reforms. These reforms have been embedded in the macro-organisational and economic framework, which includes systematic governance, public policy and fiscal reforms since the 1994 democratic elections. This framework, in particular, is underpinned by policy stances on equity, access and responsiveness to the needs of the public. The framework also directs behavioural change among the different constitutional parts of the governance system, and entrenches, through the location of the macro-policy decision-making competency, the relative strength of central government in relation to the provinces. This relative strength of central government arises from the fact that the “centre exercises a great deal of power through fiscal control” (Das Gupta and Rani: 2004) and creates the impression that the decentralized co-operative governance programme is a vertically orientated project. Nevertheless, public health sector policy reforms were achieved, including the: provision of universal primary health care; free health care for pregnant women and children under six years of age; and the development of an integrated, comprehensive national health service and a clinic-building programme for primary health care policy. How is commitment to these policies

being measured in the provinces? How were these central government policy decisions implemented and sustained from 1997 to 2004?

Notwithstanding the role that these reforms played in delivering uniform public health services in an equitable manner to all South African citizenry, complexities in public health policy design of these services, implementation and financing have resulted in tensions developing between central and provincial governments. These tensions, which were also the result of uncertainties about the roles and the integration of the previously fragmented system, were in some instances articulated in intergovernmental forums regarding the division of responsibility for public policy, financing and fiscal arrangements, including governance of the public health system. Pillay (2000:p6) mentions in connection with the public health policy and governance process:

> This process [the negotiating process of drafting policies] was used essentially to interpret the constitution within the context of transformation (on the understanding that the functions will be reviewed as provinces developed capacity and competencies). Like other centres, the national department had initially been ambivalent about relinquishing some functions. This is illustrated by complaints from provinces about the national department overstepping its mandate and that the national department sometimes interferes in provincial affairs and most graphically when officials from the national and provincial departments were drafting the National Health Bill and had to deal with provincial and national powers. Interestingly, this contestation repeated itself when the issue-involved division of functions between provinces and local government with the national departments' officials called on to act as mediators!

At the centre of the tension described by Pillay (2000:p6) are divergent views about what are the different components of the health function are as a constitutionally shared responsibility between central and provincial governments. It is the opinion of this study that the divergent views are attributable to a lack of clarity relating to:

a) The location of the different components of the health function;
b) Policy design and implementation competencies;
c) The scope and scale of services to be provided as a natural outcome of the location of different and specific components of the health function;
d) Resourcing of the component function as opposed to only the required public health services to be delivered to the public; and
e) The governance arrangements.

As regard this point, in the absence of an unbundling of the health function to direct different responsibilities between the central and provincial governments, the impression has been created that due to competing political and technical interests the provinces are kept on a tight public health governance, policy and fiscal leash.

A compounding output of this unbundling is the difference between a public health service and a public health function. These two concepts have been used interchangeably, even though their meanings differ. Khaleghian and Das Gupta (2004: p1-2) state that: "[t]he service-function distinction is not always made clear in the literature [*and in public health policy documents*] but is of considerable practical relevance when it comes to questions of management and financing". The significance of this distinction is because

> [m]any traditional public health services – immunization, std clinics, TB control etc. -are merit goods; the public health functions, however - policy-making, disease surveillance, population health assessment, health education etc. - are almost all public goods. Public health services are often relatively easy to measure, e.g. with indicators such as the number of children immunized or the number of TB cases treated. This makes them easier to manage and provides a wider scope for innovation in service delivery compared to public health functions, whose public good nature of complexity measure pose special challenges. As such, the public health functions are more akin to "core government functions (Khaleghian and Das Gupta 2004: p2).

Using the Essential Public Health Functions framework to analyse public health systems, Das Gupta and Rani (2004: p1) suggest that the core public health functions pertain to "assuring health sanitation monitoring; disease surveillance; health promotion; public health regulations; community partnerships; development of policies and planning; access to and quality of services; human resource development; and reducing the impact of emergencies on health".

Tapscott (1998) argues that the demand for greater power and autonomy from provinces remains a source of discontent. It is for this reason that Simeon (1998) recognises the need to achieve a balance between the horizontal and vertical division of powers and the devolution of powers and functions. The proposition here is that by balancing power and functions, central government interference is avoided in the provinces. The balancing of power and functions between the central and provincial governments are related to the nature of exclusivity and concurrent responsibility, which is linked to the scramble for financial and fiscal resources, which operates acutely between central and provincial

governments. This balance of power, the argument goes, ought to be maintained within a context of co-operative governance. However, it can only be solidified if there is a collective basis of as to where understanding where exclusive responsibility begins and ends for a particular sphere and where it ends within the context of shared responsibilities.

The balancing of power and functions also contributed to tensions about the deliberate macro-economic and fiscal policy of central government and the governance arrangements associated with the decentralized co-operative governance system. According to the Department of Finance (1999a: p7)

> Direct national control over expenditure responsibilities within concurrent functional areas has largely been relinquished, although national government retains responsibility for policy development. Provinces are almost entirely funded by transfers from national government, but have discretion over the allocations of funds between programmes. This separation of the functions of policy and expenditure management has created a double-edged sword of moral hazard and unfunded mandates.

A particular characteristic of the tension has been the location of health policy determination at central government level, while provincial governments, particularly the provincial treasuries, in terms of the fiscal devolution approach, essentially determine the level of financing of these policies. The devolution approach, according to the "neo-liberal agenda sees the devolution of authority from a central (monopolistic) authority to multiple authorities as a necessary step in creating a competitive market" (Ansell and Gingrich 2006: p140), thus creating multiple and competing jurisdictions, which could produce an efficient provision of public services.

This fiscal approach is not without problems, because it proclaims a causality from a central government fiscal policy determination to revenue collection and from division of revenue to provinces, supposedly based on the location of function for service delivery, previous years' spending patterns, and the relative demand for services, based on the equitable share formula. However, at a provincial level, the FFC (2001) has consistently argued, through its costed norms approach, that this form of causality runs in the opposite direction and that the location of competencies for particular functions, namely service delivery demands and obligations on the provinces, must inform the vertical and the overall division of revenue. What are the linkages between the equitable share allocations to provinces and their health spending requirements? On what basis are allocation decisions made in provincial health budgets? What factors are considered in the distribution of funds across the different

budgetary programmes? What is the link between the budgetary allocations for the different health programmes and the policy decisions?

Within and between these broad policy processes, “policy” is considered to be: a) public statements made by authoritative figures in the central and provincial governments, such as the Ministers and the Heads of Departments in both the public finance and health sectors; b) texts, such as different published and unpublished documents; c) draft and approved legislation, such as Bills and Acts (for example, the National Health Bill and the Mental Health Act, 2002); and d) different official circulars or statements of intent about particular public health policy matters, such as the roll-out of antiretroviral treatments for people infected with HIV. This understanding of policy is supported by Barker (1996:p8), who suggests, “ policies are expressed in a whole series of practices, regulations and even laws which are the result of decisions about how we will do things.”

The role of central and provincial governments in the policy process

The central and provincial Departments of Health have had to carry out the transformation agenda described above by continually assessing and negotiating their roles. The role of the central government department is to provide leadership with regard to developing the framework for transformation during the first five years (1994 to 1999). Pillay (2000) also suggests that many policies were adopted by a process of negotiation with the provinces, in structures established for this purpose (the MINMEC and the PHRC).

It is common knowledge in the South African public health sector that the MINMEC and the PHRC serve as forums to allocate functions between the central and provincial Departments of Health (Pillay 2000). The central government department is responsible and accountable for the following primary roles: (a) leadership, strategic planning and policy making; (b) drafting norms and standards for service provision, including inputs such as human resources; (c) negotiating with the National Treasury, previously known as the Department of Finance (1999c) with respect to increasing health funding; (d) drafting national legislation to regulate aspects of the public health system, such as access to the termination of pregnancy, the medical aid industry and pharmaceutical registration; (e) international health liaison with international organisations, departments of health of other countries etc; and (f)

providing technical support to the provinces; and (g) monitoring and evaluating policy implementation.

The provinces, on the other hand, are responsible for rendering health services within nationally determined guidelines. These guidelines, though centrally conceptualised and developed, are also discussed and approved at intergovernmental forums in the public health sector. The provinces are also expected to determine provincial policies, norms and standards. One issue of current contestation is the extent to which the provinces can develop policies, norms and standards different from those of the central government.

According to Pillay (2000), the implementation of the central government's transformation responsibilities has often occurred by political fiat through actions such as the announcement of free health care for pregnant women and children under six years of age and the primary school nutrition programme. This included decisions to establish a clinic-building and upgrading programme in 1994 and the announcement by the Minister of Health in 1996 of free primary health care for all. These policy pronouncements are not only indicative of a health service delivery paradigm shift, but also of a mixture of strong controlling governance in policy design and implementation in the public health sector. The policy announcements have also signalled the beginning of a conscious and strong central government policy direction to ensure policy interests of access and redress in public health care. According to the *2001 Intergovernmental Fiscal Review (*National Treasury, 2001b:41):

> The challenge to the public health sector in 1994 was to restructure service provision, providing access to appropriate services at the right locations. This necessitated a shift towards primary health care with a large clinic-building programme, the introduction of free primary health care services and the establishment of a district-based health system. Priority health programmes such as maternal and child health, tuberculosis (TB), sexually transmitted infections, HIV and Aids and mental health have been reinforced.

However, to ensure that primary health care (PHC) services are prioritised, resources in the provinces needed to shift from tertiary health care services to DHS, providing for the expansion of primary health care. This shift also implied a rationalisation of tertiary hospital services, which has led to major problems in rationalising and redistributing tertiary hospital services (Pillay 2000), such as the closing or down-grading of certain hospitals and the difficulties that have accompanied the country's national and public health budget restructuring and reprioritisation. This rationalisation of hospitals, Pillay (2000) argued was complicated by insufficient flexibility in and control over personnel structures. These factors

have resulted in the inability of institutions to respond to the rationalisation process. Over-expenditure on tertiary hospitals has, as a result, become a major problem for both the health sector and the provincial treasuries.

The *2001 Intergovernmental Fiscal Review* (National Treasury, 2001b: p42) maintains that there are a number of pressures on public health provision, such as an "escalation of HIV and Aids, squeezing out of non-personnel expenditure, such as medicines and maintenance, and inadequate management decentralization". Although the *Intergovernmental Fiscal Review* acknowledges these pressures as perceptions, it rebuts these perceptions by stating that (National Treasury, 2001b: p42):

> While these problems are often attributed to the stringent fiscal environment in the period after 1996, financing is not necessarily the dominant factor. Pressures in the system were compounded by remuneration increases, such as rank and leg promotions that escalated personnel costs, management and institutional transformation and increased demand as a result of HIV and Aids.

This study is of the opinion that the stringent fiscal environment is symptomatic of tough choices made by the central government between competing economic and social service policies and priorities, competing spending service delivery responsibilities and pressures within and between the social services sectors.

The government-sanctioned *Provincial Review Report* (Department of Public Service and Administration, 1997) was of the view that different central government departments formulated public policies without exploring how the different provinces would implement these policies. The report holds that the "unwritten expectation is that provinces will make the necessary financial and organisational arrangements. There appears to be an assumption at a national level that policy will automatically become activity" (1997:p14). The remuneration levels of medical personnel are an example of how central government sets the national policy framework, while the provinces are responsible for its delivery, administration and financing. This policy practice where decisions are taken at one level and implemented at another has, in many instances, contributed to tensions and potential disarticulation between policy mandates, functions and financing obligations, leading in various ways to mandate drift. Greenstein (1997) eloquently asserts that central government hardly plays any role in implementation and delivery of services and it does not carry its own policies. It thus bears no responsibility for seeing them translated into concrete programmes

of action, nor is it accountable for its failures. This practice could suggest an unequal role in policy design and could give rise to the perception that, because the provinces implement policy, they are de facto conveyor belts of central government policy implementation.

Post-apartheid policies in the transformation of the public health system and expansion of services

The introduction of *free health care* in May 1994 by Nelson Mandela, South Africa's first democratically elected president, led to a widespread increase in service utilisation during a period in which support systems were still being established or consolidated at the provincial and district levels. While the provinces were required to reprioritise expenditure for health care services, the real financial and implementation implications did not seem to have been considered by the central government decree declared by the President. Schneider et.al. (1997: p7) note that:

> Free health care resulted in deep frustrations on the part of frontline providers, who saw themselves being squeezed between rising patient numbers and a decline in support functions.

The introduction of free health care included services for children under the age of six years, for pregnant women up to six weeks after birth, the elderly, the disabled, and certain categories of people with chronic ailments. Free health care covered services such as preventative and promotive activities, school health services, nutrition support, curative care for public health problems and community care. Free health care was provided in terms of *Government Gazette Notice 657 of 1994: Rendering of Free Services* (Department of Health 1994*)*:

(a) at State health care facilities, including hospital, community health centres, clinics, mobile clinics, satellite clinics;
(b) at State aided hospitals of which more than half their expenditure is subsidised by the State; and
(c) by district surgeons.

The Government Gazette (Department of Health 1994*)* also states that:

> Free health services include the rendering of all available health services to persons … including the rendering of free health services to pregnant women for conditions that are not related to pregnancy.

As a further response to these constitutional mandates, the national Department of Health has increased access to services through a number of interventions such as:

- Elimination of fees for primary health care for all;
- Elimination of fees for all health services for children under 6 years of age and pregnant and lactating women;
- The provision of increased access to save the termination of pregnancies (1996 Choice of Termination of Pregnancy Act);
- FeedING Programme at both clinics and primary schools;
- The building and upgrading of PHC facilities, such as clinics; and
- The expansion of health care services through the introduction of community service for medical doctors to deliver services in rural and under-served areas; and
- Expansion of health care through the introduction of community service for pharmacists

As part of its fiscal policy commitment to expenditure for nutrition, the central government introduced its Integrated Nutrition Programme Conditional Grant in 1998 (National Treasury, 2000a:p63) to feed children in primary schools. Accordingly, the Integrated Nutrition Programme is "targeted at poor provinces with a high population of school children" and funded from the allocated conditional grant. Most of the conditional grants were given to historical and rural provinces; i.e. the Eastern Cape, Northern Province [Limpopo Province, as it is now known] and KwaZulu-Natal received about 63 per cent of the allocation (National Treasury 2000a: p63).

The *2003 Medium-Term Policy Statement* (National Treasury, 2003a) commits the central government, in conjunction with the provinces, to further expand the Integrated Nutrition Programme by stating that baseline budgets also provide for significant growth in the Integrated Nutrition Programme. *The 2003 Intergovernmental Fiscal Review* indicates that "planning for the transfer of the school nutrition component of the Integrated Nutrition Programme grant to the Department of Education from 1 April 2004 is also at an advanced stage" (National Treasury, 2003b: p67). During 2005 the nutrition programme shifted to the

education sector, leading to a significant scaling down of the nutrition programme in the public health sector as a conditional grant from the central government.

Hospital Strategy Project, 1996

The joint policy decision of both the central and provincial governments to prioritise PHC services has, by implication, necessitated the shifting of resources within the provinces from tertiary health care hospitals to DHS. In order to do this, both the policies on DHS and the hospital strategy project have obliged the provinces to rationalise tertiary health care services.

In the hospital sector, which covers both secondary and tertiary levels of health, a joint project between the Department of Health and the European Union was initiated to "develop a strategy to improve the equity and efficiency of the South African public hospital system" (Department of Health, 1996a: p1). This strategy, called the *Hospital Strategy Project in South Africa, 1996,* notes there was recognition of (Department of Health, 1996a: p1) the serious problems of inefficiency and inequity which had been inherited in the hospital system, and which were manifested by: serious budgetary crises; widely varying levels in the quality of patient care; breakdown in the referral chain; maldistribution of resources, and many other problems.

The Hospital Strategy Project (HSP) recognises (Department of Health, 1996a: p10) that despite a growing demand for health services as a result of population growth, urbanisation and epidemiological factors:

> Tight fiscal policy has led to very slow real growth in the overall health budget, despite growing demand for health services. The situation has been made worse by the rapid pace of reallocation of health budgets, both between provinces and between hospitals and primary health care services. This has left large parts of the hospital system facing substantial budget deficits and without time or resources to adjust to these resource constraints in a rational and controlled way. The size of the hospital funding gap and the speed at which hospitals are being forced to adjust to it are having extreme negative effects on the hospital system. In the absence of rational planning approaches and tools, provinces are being forced to be crude – across the board budget cuts – without regard to particular needs of individual institutions. This undermines staff morale and quality of care, and reduces public confidence in the hospital system.

The HSP promotes a new vision for the public hospital system with major implications for the provincial governments. The overall HSP "strategic approach" seems to seek to improve

equity and efficiency in the public hospital system, ostensibly through financing, service delivery and management. The HSP (Department of Health, 1996a: p13) foresees that the public health system will create and support a national network of dynamic, efficient, responsive and accountable hospitals, which will deliver high quality, affordable and accessible health services to all South Africans and will act as the supportive backbone of the national health system.

The new vision articulated in the HSP for the public hospital system furthermore suggests that the rationalisation of the system is based on equity in access to hospital services. It claims that all citizens should have equal access to adequate standards of hospital care for equal need, regardless of income, place and residence. It also indicates: a) the decentralization of all hospitals with as much delegation of authority and responsibility as possible for each hospital; b) maximum efficiency in the distribution and use of hospital resources; c) accountability to the community and responsiveness to the needs of patients and their families; d) full integration and support of the district-based primary health care system and the wider health care system; e) responsible stewardship of public funds; and f) the creation of a safe, just and stimulating working environment for all hospital workers.

In order to achieve these objectives, the HSP proposed in 1996 the strategic interventions set out in the paragraphs that follow.

a) The restructuring of the hospital system (Department of Health, 1996a: p16) entails defining different roles for various hospitals in the public health system through a consistent classification method for hospitals and the relative role of each hospital type; the development of a referral map to cover referrals within and between the provinces, and the development of an effective referral system, which includes clinical and referral guidelines.

b) On ensuring adequate funding. The HSP (Department of Health, 1996a: p14) acknowledges that while the

> …total share of public health spending currently allocated to hospitals is clearly too high in relation to spending on primary health care services, making sure that the extent of reallocation and the pace at which this is done do not damage the already precarious hospital system is vital, especially given the tight fiscal policy environment and its impact on overall health budgets.

On the rationalisation and reallocation of hospital resources the HSP mentions that financial, human and physical resources should be rationalised and reallocated, so as to ensure equitable and efficient distribution between geographical regions, hospital types, and levels of care. The HSP specifically proposes that the "rationalisation and reallocation will have to be undertaken on the basis of detailed nationally acceptable and affordable guidelines, covering such items as bed population and staff to workload ratios". The HSP suggests that "difficult decisions will need to be taken over the extent of shifts of resources from the hospital sector to primary health care…" and that (Department of Health, 1996a: p15-16):

> …specifically, district and regional hospital services should be developed and strengthened prior to any attempts to devolve services away from central hospitals. Failure to follow this sequence will undermine central hospitals prior to lower-level hospitals being ready to manage increased patient flows.

c) On developing a system for rational planning and future resource allocations (Department of Health, 1996a: p16 -17), the HSP insists that before hospitals can be rationalised and restructured, resource planning is required by: preparing service provision and staffing guidelines; preparing planning, procurement and maintenance guidelines; and by developing of capital plans.

d) On ensuring efficient resource use at hospital level (Department of Health, 1996a: p 17). The HSP states that major changes are required to attain efficiency in resource use at the hospital level and that various strategies must be considered to strengthen the hospital management capacity, structures and systems. It also suggests that detailed clinical guidelines for district, regional and central hospitals will be necessary.

e) On developing an efficient and accountable hospital management (Department of Health, 1996a: p 17). The HSP proposes that a national policy on decentralized management in hospitals is required to: address delegating authority over personnel, finances, procurement and other critical functions to the hospital management level; establish hospital boards, the design of appropriate structures and systems; and recruit skilled and motivated hospital managers.

It is with the last strategic intervention in mind that the *2002 Medium-Term Budget Policy Statement* unambiguously mentions that in the "health sector additional spending will provide for both improved compensation of health personnel and expanding employment" (National Treasury, 2002c: p63). The *2003 Budget Review* (National Treasury, 2003c:p166) confirms the recruitment of skilled personnel, stating including additional allocations have been made to attract and retain health professionals in the public service. The review mentions (National Treasury, 2003c: p166) in particular, that:

> shortages of skilled health professionals in some provinces and hospitals have been identified as a major obstacle to improving health care. In certain areas of the profession, shortages in medical specialists, physiotherapists, psychologists and pharmacists are particularly acute. A range of interventions has been designed to make serving in rural areas more attractive, as part of a broader rural health strategy. In 2003/04 a rural allowance for doctors, specialists and dentists will increase significantly. Furthermore, the allowances will, for the first time, be extended to a wider range of categories of skilled professional personnel where inequities exist.

The 2003 Budget Review also states that (National Treasury, 2003c: p167):

> The 2003 Budget marks the launch of scarce skills strategy, which sees a significant upward adjustment in salaries for a range of health professionals, who are currently difficult to attract and retain in the public sector. Criteria have been developed to identify appropriate categories of professions. Once implemented, these incentives should help to impact positively on the ability of the public service to retain skilled professionals.

Other HSP strategic interventions are set out below:

f) The presence of an effective labour relations policy and management (Department of Health, 1996a:p17-18) must be ensured. The HSP indicates that an integrated, coherent labour relations policy framework for the health sector is required. It also proposes that the principles of co-operative governance should be implemented within collective bargaining and other labour relations processes, including an effective communication strategy, the introduction of alternative dispute resolution procedures, and the development of capacity to manage labour relations.

g) Several changes to government policy and regulations are required if the robust and growing private health sector is to make a positive, and much needed, contribution to the public health system (Department of Health, 1996a: p18-19). The HSP asserts that "changes will need to address the current perverse subsidies from the public to the

private sector" and work towards creating an effective relationship between the public and private sectors (Department of Health, 1996a: p18-19). The HSP recommends the following measures: a) controlling the expansion in the supply of private hospital beds in order to minimise the negative impact on the public health system; b) having the public hospital system compete with private hospitals to attract paying patients and private practitioners back into the public hospital system; c) enacting regulations to prevent the "dumping" of private patients on public hospitals when their benefits have been exhausted; and d) to exploring creative public-private partnerships in all aspects of hospital service delivery.

Implementation of Hospital Restructuring through Public Financing

As mentioned earlier in this chapter, health services were predominantly hospital based and dominated public health financing relative to other health services, thus reflecting greater support and financing of tertiary and specialised services. By all accounts, hospital services, particularly tertiary and specialised services, are relatively more expensive in order for them to be equitable and redistributive between the different provinces. Also, given the geographical distribution of hospitals, especially tertiary hospitals and the spillover effect of tertiary and specialised health services for people living outside the provinces where these services are delivered, conditional grants, as a fiscal policy financing and expenditure option, were introduced (National Treasury 2000a: p61). According to the National Treasury (2000a: p61), most of the conditional grants are "likely to continue for a long period, if not indefinitely, as the services and functions involved are permanent".

This study is an analysis of the policy content and argues that given the purpose of conditional grants to achieve national policy options, the introduction of certain conditional grants in the health sector was specifically geared towards achieving the HSP policy intentions. According to the Treasury, conditional grants were introduced in the 1998 Division of Revenue Act (National Treasury, 2000a: p56-57) in order to: provide for national priorities in the budgets of provincial and local spheres; promote national norms and standards; compensate the provinces for cross-border overflows and specialised services of a national benefit, such as the training of medical professionals; effect the transition by supporting capacity-building and structural adjustments in recipient administrations; and address backlogs and regional disparities in social infrastructure.

Some of the conditional grants were recurrent grant funding, which funded services that existed before the introduction of the equitable share funding formula. The National Treasury (2000a: p15) argues that:

> For reasons of economies of scale, it may not be feasible to redistribute them to other provinces. In particular, the central hospital and professional training grants were introduced because provinces that inherited these services required more funding than the equitable share formula could provide. Recurrent grants address, among other things, spillovers that would lead to suboptimal service provision by the respective provinces.

The conditional grants make the provinces "responsible for actual expenditure and financial accountability" while the national [central] departments "are responsible for monitoring compliance with the conditional grants" (National Treasury, 2000a:57). The different conditional grants introduced in fiscal policy expenditure during 1998: were

> *Central hospitals* – The largest in the system, this grant is a mechanism to fund the provinces that support central hospitals, provide specialised health care services. The aim is to make these services available to all South Africans, irrespective of where they live. The grant has been allocated to four provinces – The Free State, Gauteng, KwaZulu-Natal and the Western Cape – which together have ten hospitals. The grant is conditional on the non-discrimination of residence (National Treasury 2000a: p59).
>
> *Health professional and training* – This grant compensates the provinces for higher service costs associated with the training of health professionals and supports the research and training of all categories of health professionals. About 90 per cent of this grant is allocated to the four provinces that have medical schools and is based on the number of final-year medical undergraduates. The other provinces share the remaining 10 percent equally to fund health training in provincial tertiary, regional and district facilities (National Treasury 2000a: p59).
>
> *Hospital infrastructure grants* – The hospital rehabilitation grant was established after the 1996 audit of hospital facilities indicated a need for a major hospital reconstruction and rehabilitation programme. It is through this grant that the provinces can rebuild and rearrange hospital facilities and restructure the hospital sector. Since the grant is allocated on the basis of infrastructural backlogs, the poorer provinces benefit more (National Treasury 2000a: p63).
>
> The grant for the *redistribution of specialised health services* also has a significant capital component. It was introduced to improve access to specialised care in provinces lacking such services and to reduce the number of referrals for specialist and subspecialist care to provinces with CHS. The grant is used for the acquisition of specialist equipment and training, and as an incentive for specialists to relocate to these provinces (National Treasury 2000a: p67).

Since 1998, the central government's health department (National Treasury, 2000a: p58) "administers more [conditional] grants than any other department", growing from R4,7 billion

in 1998/99 to more than R5,9 billion in 2002/03. During 2000/01 the conditional grants amounted to "about 43 per cent of all budgeted transfers to provinces" (National Treasury, 2000a: p58). The National Treasury also indicates that (National Treasury, 2000a: p58):

> The central hospital and professional training and research grants, which are targeted at provinces with academic and specialised health facilities, are two of the largest grants. Other health grants support the redistribution of specialised health services, the rehabilitation of hospitals and the upgrading of hospital facilities in the Eastern Cape (Nelson Mandela Academic Hospital) and KwaZulu-Natal (Nkosi Albert Luthuli Academic Hospital).

This fiscal policy intention was further supported by the 2002 Budget Review (National Treasury, 2002b:p140), which mentioned that "budgeted expenditure on the national health vote increases from R7,2 billion in 2002/03 to R8,2 billion in 2004/05. Furthermore, this Budget Review (National Treasury, 2002b:p140) states that:

> This includes a redesigned grant to provinces to support tertiary hospitals and grants for professional training, hospital management and nutrition programmes. Additional allocations over the 2001 baseline estimates are largely directed towards the enhanced response to HIV and Aids.

Moreover, based on the HSP's strategic intentions, the *2003 Medium-Term Budget Policy Statement* (National Treasury, 2003a:p67) suggests that:

> Health expenditure estimates provide for improvement in the remuneration of medical professionals and adjustments of rural allowances. Baseline budgets also provide for significant growth in the Hospital Revitalisation Programme.

The 2003 Budget Review confirms the fiscal policy commitment to revitalize hospitals, stating that (National Treasury, 2003c:p146):

> Substantial additions to the Health vote are proposed over the MTEF period. These include inflation-related adjustments to transfers to provinces for tertiary hospital services and professional training, a further R848 million for rehabilitation and revitalisation of provincial hospitals and replenishing medical equipment.

The 2004 Medium-Term Budget Policy Statement reflects consistency in the fiscal policy approach towards achieving some of the intentions of the HSP, confirming (National Treasury, 2004a:p58):

> In addition to the Hospital Revitalisation-programme, which will see ten of the original 27 targeted hospitals completed over the next two years, the health sector has also prepared a plan for modernization of the tertiary health sector. Proposals for accelerating the rate of

hospital revitalisation and the financial and resource implications of building the tertiary sector are currently being considered.

The policy content analysis of the HSP, with different statements on fiscal policy positions relative to the HSP, indicates a strong link between the HSP and the macro-fiscal policy intentions. However, the next chapter assesses whether this link is actually translated in the budgetary and expenditure allocations. This link is assessed at both an aggregated and disaggregated level in the hospital services budget programmes. It is also here where a link is formed between the policy content analysis and revenue and expenditure analysis. This link in the two analyses is possible between the articulated policies - HSP and fiscal - and what is actually implemented through province-specific spending trends. While the analysis shows synchronization between the HSP and the fiscal policy stance on hospital services, the conditional grant-funding mechanism is the best option to finance and support the HSP intentions, especially the revitalisation of hospitals. By considering the conditional grant as the best funding mechanism, the central government acknowledges its responsibility and authority for the overall macro-policies, and also accepts that to implement the HSP, conditional funding is required from the central revenue funds. This policy attitude not only enhances the link between the HSP and the fiscal policy, but also confirms that in terms of implementing the HSP, the provincial governments are, de facto, the implementers of central government's policies and strategies. On the other hand, the conditional grants also give the central government a quasi-implementing responsibility and authority. Conditional grants, in this instance, serve as a policy implementing leverage.

In further analysis of the HSP, the researcher adapted and applied the decision-making space tool to the HSP. Table 5a below shows an adaptation and application of the decision-space to the HSP. The table allows for an evaluation of the specific policy based on it content in order to determine the nature of decision making the policy provides from a provincial government perspective. In the table narrow means limited decision making authority, whereas wide operates at a level of devolved decision making authority. The outcome of the adaptation and application of the decision-making tool are set out in the paragraphs that follow.

a) The decision-making space tool shows a significant degree of technical efficiencies though relatively smaller that allocative efficiencies. The degree of technical efficiency demonstrates that at an implementation level of the policy process

recognition of the comparative advantage of provinces over the central government in the implementation of public policy. This degree of technical efficiencies also shows that provinces have greater autonomy in the implementation of public policies, especially in decision regarding on revenues and expenditures, human resources, access and governance functions.

b) An expanded form of devolution of authority exists on strategic and operational matters regarding the implementation of the policy reform as articulated through the HSP. This expanded devolution is not only between central and provincial governments, but also within the hospital services programme between the provincial governments and their hospitals.

c) The greater allocative efficiencies embedded within the public policy is indicative of the South African central government's approach towards ensuring equity between hospital services and geographical areas as hospital care services impacts on the population.

Table 5a: Adaptation and Application of the Decision-making Space Functions in the Hospital Strategy Project

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Finance and Expenditure *Revenue Sources* Choices about origin of sources: i.e. Will the provincial governments be allowed to assign their own source of revenue to health?			Provincial Government (Province)	Allocative (Province) Technical (Province)
Allocations of Expenditure Choices about how to allocate funds: i.e. Will the central and provincial governments be allowed to assign funds to different priority programmes? Hospital vs. primary care?			Central Province	Both Allocative
Income from Fees Choices about provincially controlled charges: i.e. Will the central and provincial governments be allowed to set fees? If so, are they allowed to determine the levels and change them?	Province		Central	Allocative (Central) Technical (Province)
Service Organisation Functions *Payment mechanisms* Will the central and provincial governments be allowed to select different means of paying providers? E.g. *per capita*, salary or fee-for-service?		Province	Central	Allocative (Central) Technical (Province)
Insurance Plans Will central and provincial governments be allowed to create, manage and regulate provincially controlled health insurance plans?	Province		Central	Technical (Province) Allocative (Central)
Hospital Autonomy Will central and provincial governments be allowed to grant hospitals autonomy and select the degree of autonomy allowed?		Province	Central	Technical (Province) Allocative (Central)
Required Programmes and Norms To what degree will the central and provincial governments define what programmes and services the provincially controlled health facilities provide?		Province	Central	Technical (Province) Allocative (Central)
Service Standards To what degree will the central authority be allowed to define service standards, such as quality for facilities?		Province	Central	Technical (Province) Allocative (Central)

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Vertical Programmes and Supplies and Logistics Are vertical programmes continued under the control of the central government or are they transferred to provincial control? Are drugs and other supplies provided by the central government or do they become the responsibility of provincial governments?		Central	Province	Technical (Central) Allocative (Province)
Human Resource Functions *Salaries* Will the central and provincial governments be allowed to set different salary levels? Will they be allowed to determine bonuses?	Province		Central	Technical (Province) Allocative (Central)
Contracts Will the central and provincial governments be allowed to contract short-term personnel and set contract terms and payment levels?			Central Province	Both Allocative
Civil Service Will the central and provincial governments be allowed to hire and fire permanent staff without higher approval? Will staff be able to be transferred by the central and provincial governments?			Central Province	Both Allocative
Access Functions *Access Rules* Will the central and provincial governments decide who has access to facilities and who is covered by insurance?	Province		Central	Technical (Province) Allocative (Central)
Governance Functions *Governance Rules* Are provincial officials accountable to the electorate? Will the central and provincial governments have choices about: size and composition of hospital boards? Size and composition of provincial health offices? Size, number, composition and rule of community participation?		Central Province		Both Technical
Total Decision-making Space • Central • Province	2 4	3 3	11 7	Minimal Technical, but Maximum Allocative

White Paper for the Transformation of the Health System in South Africa, 1997

The national Department of Health's (1997) *White Paper for the Transformation of the Health System in South Africa* (The White Paper) was the first health policy framework document released by the post-apartheid government. According to The White Paper, the department must "provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary health care approach" (Department of Health, 1997: p1).

The White Paper's objective is to "present to the people of South Africa a set of policy objectives and principles upon which the Unified National Health System of South Africa is built (Department of Health 1997: p1). Although White Papers such as this one do not necessarily identify health-function and service-delivery obligations for provincial governments, this White Paper directly sets the broad policy paradigm for future policy on shared health function by determining five strategies.

The five strategies, in conjunction with the different objectives and goals identified in the White Paper, effectively outline the policy terrain and regulate public health policy and service delivery priorities for the public sector:

> (a) The health sector must play its part in promoting equity by developing a single, unified health system; (b) The health system will focus on the districts as the major locus of implementation and emphasise the PHC approach; (c) The three spheres of government, NGOs and the private sector should unite in the promotion of common goals; (d) The national, provincial and district levels should play distinct, but complementary roles; and (e) An integrated package of essential PHC services should available to the entire population at the first point of contact (Department of Health 1997: p12).

A strategic policy output obligation that the White Paper (Department of Health, 1997: p46-48) raises for the provinces relates to the establishment of the *district health system* and, in particular, the roll-out of a PHC approach in this system. The obligation on the provinces is expressed in terms of increasing access to PHC services, setting the goal of 2.8 and 3.5 consultations per person per year by 2000/01 and 2005/06 respectively. Chapter Three of the White Paper asserts that revised procedures for budgeting, including strategies for budgetary controls and criteria for budgetary reprioritisation,

should not only promote the optimal utilisation of resources, but also an equitable distribution of financial resources at the level of policy implementation.

Chapter Four of the White Paper deals with human resources. It suggests that *a national framework for the training and development of health personnel* must be established to ensure maximum coverage and cost-effectiveness, including an equitable distribution of health personnel and the provision of training for personnel in the primary health care approach. The White Paper also introduces a three-prong strategy for provincial *nutrition programmes* comprising: a) a health facility-based nutrition programme; b) a community-based programme; c) nutrition promotion including communication; and d) advocacy and legislation. The White Paper leans strongly towards *maternal, child and women's health* by indicating that maternal, child and women's health (MCWH) services should be accessible to mothers, children, adolescents and women of all ages, especially the rural and urban poor and farm workers.

The White Paper by promoting the *National AIDS Control Programme* (Programme) in eighth chapter acknowledges that HIV and Aids and other sexually transmitted diseases (STDs) are major problems. The White Paper suggests that programmes should focus on the: (a) prevention of the disease spreading by promoting safer sexual behaviour, adequate provision of condoms and controlling of STDs; (b) protection and promotion of the rights of people living with HIV and Aids by ensuring that discrimination against them is outlawed; (c) care and support, including social welfare services, of people with HIV and Aids, their families and communities; (d) use of the mass media to popularize key prevention concepts and the development of life skills education for the youth; and (e) the mobilisation and unification of local, provincial, national and international resources to prevent and reduce the impact of HIV and Aids.

In support of the mobilisation of national resources the *2002 Budget Review* (National Treasury 2002b:p63-64) mentions that:

> It is anticipated that expenditure on the Enhanced Response to HIV and Aids, launched last year, will be stepped up by about R3,3 billion over the next three years. This includes targeted funding on the national department's budget, increased conditional grant amounts as well as increased provincial spending funded through the equitable share. Additional funds will also go towards the rollout of the prevention of mother-to-child transmission, post-exposure prophylaxis and further expansion of appropriate treatment regimes in line with Cabinet's Statement of 17 April 2002.

The White Paper and the policy statement for increased funding for HIV and Aids with either conditional grants or equitable share allocations indicate a definitive separation and location of responsibility for different parts of the HIV and Aids programme between the central and provincial governments. While the White Paper acknowledges dual responsibility, which is embedded in the shared health function, it mandates the provincial governments to both fund and implement these programmes. The White Paper also explicitly influences the budgetary and expenditure allocation processes in the provincial governments, entrenching a strong articulation of policy to be implemented at the provincial government level.

Chapter Eight of the White Paper is particularly strong on *decreasing morbidity and mortality rates* with strategic interventions, such as accelerating the delivery of an essential package of PHC services in the district health system; revitalising hospital services; improving resource mobilisation and management without neglecting the attainment of equity in resource allocation; reorganising certain support services; improving human resource management; and improving the quality of care. Lastly, another major policy implication for the provincial governments reflected in the White Paper is the *provision of hospital services* (Department of Health, 1997). The White Paper notes that the role of hospitals will be redefined in line with the PHC approach and that plans will be developed to rationalise public hospital services, facilities, staffing and capital investment. The White Paper refers furthermore that:

a) Decentralized hospital management will be introduced to promote efficiency and cost-effectiveness;
b) Hospital boards will be established to increase local accountability and power;
c) A targeted, efficient and equitable user fee system will be introduced and facilities will retain part of the revenue generated to encourage efficient collection and improve services; and
d) Hospitals providing unique or highly specialised services will be treated as a national resource.

The White Paper also gives additional provincial government implementation responsibilities to provincial governments that include e*nvironmental and occupational*

health, including the development of appropriate human resources and the equitable distribution of environmental officers. Other additional responsibilities for provinces are set out in the paragraphs that follow.

Mental health, covering a community-based mental health and related services are to be planned and co-ordinated at the national, provincial, district and community levels and integrated with other health services. Human resources for mental health services need to be developed in order to ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health services based on the PHC approach.

Oral health services are to prioritise service delivery by focusing on prevention, the equitable distribution of services and the integration of oral health care with other health services, based on a basic package of oral health services.

Academic health service complexes (AHSCs) are to be linked to similar facilities for the benefit of communities. AHSCs should be accountable to both the national and provincial health authorities. AHSCs should maximise benefits from available resources and adopt cost-effective approaches. The curricula of AHSCs will be “revised, with greater emphasis placed on the needs of communities in accordance with primary health care principles” (Department of Health 1997: p153).

A centrally controlled or coordinated national health laboratory service (NHLS) is to be established to provide services such as pathology, environmental health services like food and water, occupation health, forensic services, and other laboratory-based services.

The White Paper advocates a PHC approach in the public health sector so that it becomes the dominant health service delivery paradigm. In this way, the central government confirms its strong controlling and supervisory role, which is based on its drive to ensure overall equity in health service provision. PHC is consequently perceived as the appropriate and primary policy option to ensure that all citizens, especially historically marginalised groups and communities have access to basic health services. Therefore, through the PHC approach as the central pillar of the public health system,

the White Paper promotes integrated and comprehensive public health services, thus ostensibly driving towards a single public health sector with different complimentary parts. The White Paper also confirms the relative responsibilities between the central and provincial governments in the governance, management, financing and delivery of public health services, particularly in for hospital services. This is a strong interconnectedness with the intentions of the HSP.

The analysis of the White Paper for the Transformation of the Health System through an adaptation and application of the decision-making space tool as shown in Table 5b below, demonstrates

a) The dominance of attaining allocative efficiencies through the process of reforming the South African health system in accordance with the government's programme of equity; and

b) A clear expression of deconcentrated and narrow decision-making authority in the implementation of the transformation programme on the part of provinces, while the decision-making authority of central government is far more extensive than that of the provinces with regard to all of the functions.

Table 5b: Adaptation and Application of the Decision-making Space Functions in the White Paper for the Transformation of the Health System

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Finance and Expenditure *Revenue Sources* Choices about origin of sources: i.e. Will the provincial governments be allowed to assign their own source of revenue to health?		Province	Central	Technical (Province) Allocative (Central)
Allocations of Expenditure Choices about how to allocate funds: i.e. Will the central and provincial governments be allowed to assign funds to different priority programmes? Hospital vs. primary care?	Central		Province	Technical (Central) Allocative (Province)
Income from Fees Choices about provincially controlled charges: i.e. Will the central and provincial governments be allowed to set fees? If so, are they allowed to determine the levels and change them?	Province		Central	Technical (Province) Allocative (Central)
Service Organisation Functions *Payment mechanisms* Will the central and provincial governments be allowed to select different means of paying providers? E.g. *per capita*, salary or fee-for-service?			Province	Allocative (Central)
Insurance Plans Will central and provincial governments be allowed to create, manage and regulate provincially controlled health insurance plans?	Province		Central	Technical (Province) Allocative (Central)
Hospital Autonomy Will central and provincial governments be allowed to grant hospitals autonomy and select the degree of autonomy allowed?	Province		Central	Technical (Province) Allocative (Central)
Required Programmes and Norms To what degree will the central and provincial governments define what programmes and services the provincially controlled health facilities provide?	Province		Central	Technical (Province) Allocative (Central)
Service Standards To what degree will the central authority be allowed to define service standards, such as quality for facilities?		Province	Central	Technical (Province) Allocative (Central)

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Vertical Programmes and Supplies and Logistics Are vertical programmes continued under the control of the central government or are they transferred to provincial control? Are drugs and other supplies provided by the central government or do they become the responsibility of provincial governments?	Province		Central	Technical (Province) Allocative (Central)
Human Resource Functions *Salaries* Will the central and provincial governments be allowed to set different salary levels? Will they be allowed to determine bonuses?	Province		Central	Technical (Province) Allocative (Central)
Contracts Will the central and provincial governments be allowed to contract short-term personnel and set contract terms and payment levels?			Central Province	Both Allocative
Civil Service Will the central and provincial governments be allowed to hire and fire permanent staff without higher approval? Will staff be able to be transferred by the central and provincial governments?			Central Province	Both Allocative
Access Functions *Access Rules* Will the central and provincial governments decide who has access to facilities and who is covered by insurance?		Province	Central	Technical (Province) Allocative (Central)
Governance Functions *Governance Rules* Are provincial officials accountable to the electorate? Will the central and provincial governments have choices about: size and composition of hospital boards? Size and composition of provincial health offices? Size, number, composition and rule of community participation?	Central		Province	Technical (Province) Allocative (Central)
Total Decision-making Space • Central • Province	2 6	3	11 4	Allocative is dominant

A Policy for the Development of a District Health System in South Africa, 1996

According to Gilson, Doherty, McIntyre, Thomas, Brijlal, Bowa and Mbatsha (1999:p35):

> …although the establishment of a District Health System was identified as a key policy of the new government, the further decentralisation of the responsibilities to the district level progressed very slowly over its first term. One important reason was that the demarcation of the health districts occurred at the same time that new local boundaries were being negotiated under the terms of the Constitution.

According to the draft document *Restructuring of the National Health System for Universal Primary Health care*, which forms part of the Report of the Committee of Inquiry into a National Health Insurance System (Department of Health, 1995:p1):

> The comprehensive primary health care approach incorporates a broad definition of health, of the nature and role of health services, and of the relationship between health services and other interventions which improve health status. Health is seen as more than simply the absence of disease; health services encompass promotive, preventive and curative services; and the crucial role of environmental factors, such as clean water and sanitation, housing and education are recognised as fundamental to the improvement of the health status of individuals and populations.

The Department of Health (1995:p11) indicates that it does not believe that a comprehensive PHC package should be defined in terms of detailed interventions, but rather that:

> …the publicly funded PHC system should provide a comprehensive package of PHC services, including district hospital services, environmental health services and other preventative, promotive and monitoring services, and comprehensive personal ambulatory services, including access to essential medicines for PHC.
>
> The actual scope of the PHC package will in practice be determined by resource constraints, and may change over time. Policy decisions over constraints could take several forms. The package could be constrained both in terms of the range of services to be delivered, and/or in terms of personnel categories included in the delivery model. Because of the difficulties with defining a package in terms of specified interventions or services, it is considered more likely that constraints in this instance would emerge in the form of a reduced range or reduced numbers of personnel or some combination of these.

This proposition of delivering PHC through a range of service-delivery networks is also supported by the FFC (2000:p42), indicating in its *2000 Recommendations 2001-2004 MTEF Cycle* that:

> Even basic health services, broadly defined as Primary Health Care, include a complex bundle of different types of services. This range of basic services is, in turn, delivered by

> a number of different providers – community health centres, clinics, district hospitals and even provincial hospitals.

The FFC (2000:p42) further states that:

> The costs of providing PHC services may vary in terms of which public institution delivers these services. Costs are also likely to be influenced by the degree of ruralness in a province, the incidence of poverty, various disease profiles and the extent to which provinces can exploit economies of scale in service provision.

The *Policy for the Development of a Policy District Health System in South Africa, 1996* (DHS Policy), quoting the World Health Organisation (WHO), states the following about the District Health System (Department of Health, 1996b: p6-7):

> A District Health System … consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces and communities, through the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, other diagnostic, and logistical support services.

The DHS Policy (Department of Health, 1996b:p7) mentions that the "health district needs to be large enough to have the financial and management capacity to provide essential care, including environmental health services, emergency services and first-level hospital care. It must contain all elements required for comprehensive primary health care services". The elements include comprehensive community health care services and non-specialist district hospital services. The DHS Policy (Department of Health, 1996b:p7) indicates that within each health district there should be "one or more district hospitals, community health centres, clinics and smaller facilities such as mobile units and visiting posts". The clinic building programme mentioned earlier as part of the transformation of public health system on page 137, was a critical public health priority to ensure that the different facilities were available. Capital and goods and services expenditures were some of the main cost drivers originating from the District Health Systems Policy.

The DHS Policy sets a number of goals which from a policy content analysis perspective became cost drivers within the DHS for the transformation of the public health sector that required provincial implementation. These goals are set out below.

a) The establishment a single health service and health management team for each district;

b) The determine of a uniform salary and uniform service conditions to be phased in for all public sector health personnel and the principle of equal pay for equal work and responsibilities.

c) Allocating to the health team the responsibility for providing comprehensive health services in the district up to and including the district hospital level.

By identifying different levels of support in the district health system, the DHS Policy (Department of Health, 1996b:p8) confirms that:

> The national Department of Health is responsible for the overall co-ordination and determination of policy for the country's health system, and for monitoring and support of the provinces. The provincial Departments of Health are responsible for the co-ordination of the health system within each province, for the provision of specialist health services, and support for monitoring and support of districts. The district health authorities are responsible for the provision of non-specialist health services within each district.

The provinces are required by the DHS Policy to "set up regional sub-offices responsible for the establishment, monitoring, evaluation and support of the district health authorities". The DHS Policy (Department of Health, 1996b:p9) argues that at a micro-level, districts should be divided into community service delivery areas. At this service delivery point, the notion of primary health care, through the district health system, becomes more concrete:

> The community health services to these areas will be managed by a multi-professional team (employed by the district health authority), usually based at a Community Health Centre and at several smaller clinics, or at a District Hospital. The Health Centre provides a comprehensive 24-hour service, and provides effective support to clinics in its area through regular visits of various members of the team, and through referrals from the clinics.

The DHS Policy (Department of Health 1996b: p10) asserts:

> Clinical support to the districts is provided by secondary specialist referral hospitals, managed by the provincial Health Department. These hospitals will receive patients referred from District Hospitals, and they will provide effective outreach services, support and in-service training to staff at the district facilities through regular visits of specialists and registrars.

On governance structures at district level, the DHS Policy proposes three options to be considered by the provinces (Department of Health, 1996b:p19-23). However, it sets a preconditions on the three options:

> The structures that the provision of health services will need to respond to the structures of political governance in such a way that they can form an interface that will be flexible enough to adapt to the inevitable changes to come. This approach takes into account the need for a coordinating structure at the district level of the management that will have adequate power and functions, and allows for the development of a relationship to local government and communities that takes into account the existing disparities.

With the provincial option, provincial Departments of Health take full responsibility for DHS. This option is rooted in the assumption that there is insufficient independent capacity and infrastructure at the district level. As such, this option prefers the establishment of District Health Councils, with specified power in relation to the district health manager, who is a provincial health department employee at district level.

The statutory district health authority option is established by legislation, makes the district health authority (DHA) responsible for all health services. This option assumes that there will be capacity to devolve responsibility to the district level. Within this option, a statutory district health authority is established for each health district, with a District Health Council assuming devolved responsibility for all DHS from the provincial MEC for Health.

Content analysis of the Policy of the District Health System shows that the decision-making space for the provinces falls between the deconcentrated (narrow) and delegated (moderate) categories. This indicates that technical efficiency will not necessarily be significant for the required level of decentralization in the co-operative governance system, given the location of the policy implementation responsibility. The decision-making space further confirms the wider control span of the central government to determine policy implementation imperatives.

The adaptation and application of the decision-making space tool to the Policy for the Development of a District Health System as shown in Table 5c below, indicates that

a) The policy approach limits the technical efficiency influence of the central government, though it allows an increase in its role to attain the necessary allocative efficiencies.

b) The policy recognises the comparative advantage of provinces in the implementation and administration of the policy. It is through the process of implementation that provinces have extensive authority over the interpretation of the policy, thus also determining the approach and the roll-out of the different responsibilities as articulated through the policy.

Table 5c: Adaptation and Application of the Decision-making Space Functions on the Policy for the Development of a District Health System

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Finance and Expenditure *Revenue Sources* Choices about origin of sources: i.e. Will the provincial governments be allowed to assign their own source of revenue to health?	Central		Province	Technical (Central) Allocative (Province)
Allocations of Expenditure Choices about how to allocate funds: i.e. Will the central and provincial governments be allowed to assign funds to different priority programmes? Hospital vs. primary care?	Central	Province		Technical (Central) Technical (Province)
Income from Fees Choices about provincially controlled charges: i.e. Will the central and provincial governments be allowed to set fees? If so, are they allowed to determine the levels and change them?	Province			Technical (Province)
Service Organisation Functions *Payment mechanisms* Will the central and provincial governments be allowed to select different means of paying providers? E.g. *per capita*, salary or fee-for-service?			Province	Allocative (Province)
Insurance Plans Will central and provincial governments be allowed to create, manage and regulate provincially controlled health insurance plans?	Province		Central	Technical (Province) Allocative (Central)
Hospital Autonomy Will central and provincial governments be allowed to grant hospitals autonomy and select the degree of autonomy allowed?	Province		Central	Technical (Province) Allocative (Central)
Required Programmes and Norms To what degree will the central and provincial governments define what programmes and services the provincially controlled health facilities provide?		Province	Central	Technical (Province) Allocative (Central)
Service Standards To what degree will the central authority be allowed to define service standards, such as quality for facilities?		Province	Central	Technical (Province) Allocative (Central)

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Vertical Programmes and Supplies and Logistics Are vertical programmes continued under the control of the central government or are they transferred to provincial control? Are drugs and other supplies provided by the central government or do they become the responsibility of provincial governments?			Central Province	Both Allocative (Central)
Human Resource Functions *Salaries* Will the central and provincial governments be allowed to set different salary levels? Will they be allowed to determine bonuses?	Province		Central	Technical (Province) Allocative (Central)
Contracts Will the central and provincial governments be allowed to contract short-term personnel and set contract terms and payment levels?		Province	Central	Technical (Province) Allocative (Central)
Civil Service Will the central and provincial governments be allowed to hire and fire permanent staff without higher approval? Will staff be able to be transferred by the central and provincial governments?	Province		Central	Technical (Province) Allocative (Central)
Access Functions *Access Rules* Will the central and provincial governments decide who has access to facilities and who is covered by insurance?		Province	Central	Technical (Province) Allocative (Central)
Governance Functions *Governance Rules* Are provincial officials accountable to the electorate? Will the central and provincial governments have choices about: size and composition of hospital boards? Size and composition of provincial health offices? Size, number, composition and rule of community participation?	Central Province		Central	Technical (Province) Allocative (Central)
Total Decision-making Space • Central • Province	 3 6	 5	 10 4	Limited Technical Maximum Allocative for Centre Maximum Technical, Limited Allocative for Provinces

National Health Act, No. 61 of 2003

The introduction of the National Health Act, No. 61 2003 (Department of Health 2003a) reconfirms the principal–agent policy formulation and implementer roles and responsibilities of the central and provincial governments. The principal-agent roles and responsibilities are articulated in its national purpose, thereby setting the national health policy and service delivery agenda and location of different responsibilities related to the health function. The National Health Act (NHA), 2003 confirms:

a) The central government's policy- and legislation-setting and adoption responsibilities; and

b) The provincial governments' policy- and legislative-implementing responsibilities, regarding health service delivery, financing and management and supervisory interaction with 'health establishments'.

The legislative responsibilities, captured in the National Health Act, make particular reference to the central government's competency in setting norms and standards on a range of health services, the organisation and management of health services, the financing and regulatory interaction between the central and provincial governments. Contrary to previous policies and legislative approaches, the NHA confirms in some instances and reconfigures in other instances the role of both the central government and the provinces. This is done by the NHA (a) setting the policy and regulatory framework for health service delivery and management; (b) reorganising health functions and responsibilities; (c) setting the policy framework for the subsidisation of health services through not-for-profit organisations; and (d) influencing, and at times strongly exerting, the role of the central government in financing the health function in the provinces.

The National Health Act, No.61, 2003, comprises 12 chapters, covering: the objectives of the Act; responsibilities for health; eligibility for free health services; the rights and duties of users and health care personnel; definitions of the functions for the different spheres of government in the delivery of health care; the establishment of health

authorities to determine policy and provide governance in the different spheres; regulations for the services that are provided by health establishments, including private institutions; provide co-ordination of training through academic health complexes; and the control of human tissues and organs. The NHA also establishes organisational mechanisms to direct health research, such as the National Health Research Committee, and to control ethic committees at research institutions, such as the National Health Ethics Committee. At a provincial government level, the NHA instructs the MEC (Clause 77 of NHA) to establish an Inspectorate for Health Establishments to monitor compliance with provisions of the Act. The provincial MECs are required to submit annual reports on the activities and findings of the Provincial Inspectorate to the National Minister. In this way, the study contends, the political role of the MEC in Health is predetermined.

The *preamble* within the NHA strongly confirms an alignment with different clauses of the South African Constitution. The NHA intends to

> Provide for a system of co-operative governance and management of health services, with national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and the delivery of quality health care services; Establish a health system based on decentralized management, principles of equity, efficiency, sound governance and internationally recognised. Promote a spirit of cooperation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

The functions of the different spheres of government are defined in Chapters 3 to 5 of the NHA. Chapter 3 confirms that the central government is among other things, responsible for: national policy and legislation; determining norms and standards; and participating in the equitable share allocation of financial resources by developing formulas and methods. The key questions that arise at this juncture from a policy content analysis perspective are whether this policy directive and intention of the NHA is in conflict with the overall responsibility of the National Treasury, in terms of the Public Finance Management Act, 1999, or just a reflection of an intended or confirmed partnership or basic statement, indicating the health sector 'turf' and competing interests with the public finance sector, especially the National Treasury.

The NHA establishes a National Health Council (NHC), consisting of, among others, the national Minister and the nine provincial MECs responsible for Health, local government representatives and the technical heads of the central and provincial Departments of Health. The NHC mandate is to advise the Minister on policy concerning any health matter that will protect, promote, improve and maintain the health of the population (Clause 23 (1) (a)), including health responsibilities by individuals and the public and private sectors (Clause 23 (1)(a)(i)) and on targets, priorities, norms and standards relating to the equitable provision and financing of health services (Clause 23 (1)(a)(ii)) and on setting, according to (Clause 23 (1)(a)(vi)), equitable financial mechanisms fund health services.

Currently, the determination of the equitable distribution of nationally collected revenue for public expenditure such as on public health is that of the National Treasury at a technical level and the Budget Council to Cabinet (as the final decision-making political structure). All policies, therefore, in relation to the division of revenue and equitable distribution of fiscal resources fall in the ambit of the public financial sector; that is the central and provincial government treasuries. The financing decisions – what gets financed and the level or amount of the budget allocation, for public health services and establishments – are made by the provincial governments via the treasuries and health departments.

While the National Treasury sets, in “consultation”, uniformed budget structure and strategic planning formats (see Chapter Six), the NHA shifts this responsibility and accountability to the National Health Council. The NHA states, in Clause 23 (2) that the National Health Council may determine the timeframes, guidelines and the format for preparation of national and provincial health plans.

This shows that, through the NHA, the public health sector, led by the National Health Council seeks to remove this policy responsibility from the public financial sector. In this way, the National Health Council intends to assert its policy influence on the public health sector, as opposed to being a recipient of treasury-driven policy initiatives, which have a determining effect on the nature and scope of the health sector. This policy stance of the health sector is a clear indication of its exertion of authority on the policy, strategic planning and budgetary format of the health sector. The policy content analysis

of this section of the NHA also shows that no reference is made in the establishment and composition of the National Health Council to include the public finance sector.

In addition to various other public health responsibilities, Chapter 4 on Provincial Health, covering provincial health services and the general functions of the provincial departments, reconfirms that provincial MECs must ensure the implementation of national policy, norms and standards in their specific provinces. Chapter 4 further regulates, in Clause 25 and its subsections, the role and responsibilities of the provincial departments. The following are provincial government policy implementation responsibilities originate from the NHA, which are to provide specialised hospital services; coordinate the funding and financial management of district health councils; plan, co-ordinate and monitor health services; control and manage the cost and financing of public health establishments and health agencies; plan the development of public and private hospitals, other health establishments and health agencies; facilitate and promote the provision of port health services, comprehensive primary health services and community hospital services; provide and coordinate EMS and forensic pathology, forensic clinical medicines and related services, including the provision of medico-legal mortuaries and medico-legal services; control the quality of health services and facilities; provide health services contemplated by specific provincial health service programmes; provide and maintain equipment, vehicles and health care facilities; and provide for services for the management, prevention and control of communicable and non-communicable diseases.

Similar to central government structures and functions, such as the National Health Council, a Provincial Health Council is established in each province by the NHA (Clauses 26 and 27). The Provincial Health Council, according to (Clause 27 (1) (vii) is responsible for policy matters, such as:

> …the design of and implementation of programmes within the province to provide for effective referral of users between health establishments or health care providers or to enable integration of public and private health establishments.

In addition to the financing matters mentioned under the National Health Council functions, the Provincial Health Council is responsible for “efficient co-ordination of

health services within the province and between neighbouring provinces" (Clause 27 (1) (iii), including advising the provincial MEC on "norms and standards for the establishment of health establishments" (Clause 27 (1) (c). Chapter 5 of the NHA, covering the district health system, provides in Clause 29 (1) for the establishment of a district health system; division of health districts into sub-districts; establishment of district health councils; municipal health services and the preparation of district health plans. In conjunction with the DHS Policy, it sets the legislative and functional framework much more firmly for a configuration of the district health system, including administrative, management and services planning.

The classification of health establishments, previous a provincial responsibility, is now placed squarely the policy responsibility of the central government. The NHA, in Chapter 6, makes the National Minister responsible for the *classification of hospital establishments* (Section 35 of NHA). This includes, among other things, their role and function in the national health system; the size and location of communities they serve; the nature and level of health services they are able to provide; and the need to structure health service delivery in accordance with national norms and standards in an integrated and coordinated national framework. This shift or reorganisation of responsibilities absolves the provinces from the regulatory and administrative burden of classifying health establishments. It also limits the role of the provinces in relation to classifying private health establishments, and thereby their ability to assess future planning and provision of health services in different establishments. The limitation placed on provincial governments could perversely influence province-specific health facility planning and financing. More specifically, splitting the location of the decision making to classification of health establishment and the determination of the types of health services to be delivered raised serious financing and other resourcing obligations. The researcher is of the opinion that this split between the location of the policy decision and the location of financing decisions influence the planning of different levels of health care. The researcher's opinion is also that the location of the different types of decisions raises equity and geographical location of the health facilities concerns, including concerns about health care provision between high- and low-income earners. This split in decision making also compromises technical efficiencies to be gained through hospital services.

In the *provision of health services at public health establishments* (Section 41 of the NHA) both the National Health Minister and provincial Health MEC's responsibilities are regulated. Although the Minister's responsibilities relate to central hospitals and those of the MECs to only provincial public health establishments, the NHA requires them to determine the range of health services that may be provided at the relevant public health establishments. These responsibilities include prescribed procedures and criteria for admission and referral to public health establishments. Clause 41c of Section 41 allows the Minister and MECs to prescribe: a schedule of fees, including penalties for not following the rules of admission and referral in respect of different categories of users; various forms of treatment; and various categories of public health establishments. Under this section of the NHA, provision is also made for consultation with the relevant Treasury to determine the proportion of revenue generated by a particular public hospital that may be retained and used. While this policy intention of retention of funds augurs well for a hospital, and possibly serves as an incentive for it to collect user fees and other costs, it ignores the need for a possible policy requirement from each hospital to prepare a solid revenue-collection and retention policy and strategy. The NHA is, however, silent on the need for requisite policy, administrative skills and systems to implement such a strategy. Moreover, it ignores the design of an implementation plan for the strategy.

In the absence of revenue collection and retention policies and strategies approved by provincial Treasuries, the overall revenue collection intentions of the provinces could be determined, as well as the revenue collection, distribution and management responsibilities of provincial hospitals. The NHA basically requires provincial Treasuries to provide a proportion of revenue raised at a health establishment to a particular hospital. The NHA stipulates that: "a province whose residents make use of another province's services must compensate that province for health services provided to such residents in a manner and to the extent prescribed by the Minister in consultation with, in the case of the central hospital, the National Treasury and, in the case of any other hospital, the relevant Treasury" (Clause 41 (3)). The NHA presupposes that there is a solid billing system in provincial health departments.

The NHA makes both the Minister and the MECs responsible for determining the range of health services, procedures and criteria for admissions and referrals and the setting of

fees at all public health establishments, in consultation with the relevant Treasuries. This type of joint responsibility is clearly a classical case of intentional ambiguity, being deliberately non-specific about the location of the regulatory competencies or mandates of the central government relative to the provinces. The researcher's view is that the intentional ambiguity also means that the previous responsibility of the provincial government, with the health department determining different types of health establishments and services to be provided, is no longer that of the province alone. Provincial government decided during the first five years of the public health transformation (from 1994 to 1999) as an output of the rationalisation and restructuring of hospitals policy. This policy not only directed the restructuring and rationalisation of hospitals services but also reallocating of hospital resources, the closing of certain hospitals, the rationing of public health services within certain geographical areas driven by equity considerations, and the upgrade certain health services in certain geographical areas. It is through the implementation of this policy that reclassifying certain health establishments took place.

However, by means of the clauses discussed above, joint responsibility between the central and provincial Minister and MECs, demonstrates a well co-ordinated and regulated move in the NHA towards integrated decision making between the two spheres of government. The National Health Act provides almost exclusive responsibility for health service delivery and policy implementation at the provincial level, including comprehensive PHC and secondary and specialised health care services. Although the delivery of health services through the different levels of health care remains the responsibility of the provincial departments, the determination of the type of health establishments to deliver these services becomes the responsibility of the central department of health. The NHA also removes almost all responsibilities for central hospitals, including determining the type of health services to be provided by these health establishments, to the central government. By stating that the Minister will determine the range of health services to be provided by central government hospitals, as opposed to what is currently provided by these establishments, effectively removes decision making of the provincial government and the hospital management decide on the type of health service determination. This determination by the Minister also signals the start of the central government determining appropriate levels of staffing and financing of these hospitals from provinces.

The NHA regulates the health service delivery responsibilities of the provinces without indicating how they will be financed. The role and responsibility analysis of the NHA, for intergovernmental relations between the provinces, indicates that other than referring to equitable distribution and financing of health services, the fiscal impact of the intended decentralized competencies to the provinces has not been quantified. Accordingly, the NHA intends to establish budgetary and financing requirements for health services and other policy implementation, as well as for determining a possible review of the current fiscal and expenditure arrangements regarding public health. It is also the view of the researcher that the legislative references in the NHA to "targets, priorities, norms and standards relating to the equitable provision and financing of health service" and "equitable financial mechanisms for the funding of health services" directly challenge the current public financing policy arrangements, in the form of division of revenue and provincial equitable share allocation. These legislative and obligatory challenges are also directed at the distribution of public resources at the provincial government level. According to the *2004 Medium-Term Budget Policy Statement (*National Treasury, 2004a:p57-58):

> The National Health Act of 2003 will be implemented in 2005/06 and aims to consolidate fragmented primary health services under a single level of government. The new framework locates responsibility for the primary health service function at provincial government, with local government only responsible for the narrowly defined environment health service. Provincial governments may choose to take over primary health care services, but also have the option to assign the function to local governments. Increases on the equitable share will be partly utilised to replace portions of what local government has been spending on this function while metropolitan councils are likely to maintain delivery of these services.

The NHA also establishes a range of health governance institutions, regulatory structures and enforcement mechanisms, such as Inspectorates, without determining the resource implication for the provinces. Moreover, regarding the different governance arrangements, the NHA raises direct and indirect additional health service implementation responsibilities for the provinces, such as requirements for additional personnel and organisational implications. Given that these obligations have not been costed, the resourcing of these implications seems to be in conflict with the PFMA. Section 35 of the PFMA mandates the central government and its line departments to fully cost all legislation that has a fiscal obligation on the provinces. The perspective of this study is that the mere fact that the NHA has not been costed, conflicts with Section

35 of the Public Finance Management Act, 1999, and creates unfunded mandates or insufficient funding levels requirements for certain programmes relative to the overall funds required to implement NHA programmes. The central government determined unfunded policy mandates on provinces have the potential to crowd-out funding for existing programmes relative to the authoritative nature of the programmes, stemming from the implementation of the NHA. In order to avoid unfunded mandates and to facilitate appropriate costing and financing of a public policy, the PFMA recommends in Section 35 that:

> …legislation that assigns an additional function or power to, or imposes any other obligation on a provincial government, in a memorandum that must be introduced in Parliament with that legislation, give a projection of the financial implications of that function, power or obligation to the province.

A critique of the conceptualization of the governance arrangements and related functions suggests that the location of power between the Minister and the MECs, both the NHC and Provincial Health Council, may become terrains of contestation in future between the different authorities. The responsibility for policy is located at both the central and provincial government political levels. While the NHC must make policy decisions by recommendations through consensus to the Minister, it seems to have inordinate powers that usurp some of the Minister's powers and consequently those of Cabinet. A similar situation could result between the different structures, including the provincial line departments of health. The NHA give rise to concerns related to the role of the Provincial Executive Council, given that it assigns policy-making, regulatory and different implementing roles to the Minister, MECs, NHC and Provincial Health Council.

The approach taken by the NHA, in locating responsibilities in the public health sector governance structures, seems to disregard the existing powers and functions of the provinces in determining health service delivery priorities, targets and financing obligations. The mere fact that the provinces are required to apply to the national Director-General to alter bed numbers and for changes to the range of health services to be provided at existing facilities appears to reduce provincial autonomy and independence. While the Minister allows for the establishment of academic health complexes, the provision of health services in these establishments seems to be the responsibility of the provinces.

The adaptation and application of the decision-making space tool to the NHA as shown in Table 5d below, indicates:

a) An expansion and consolidation of the strength of the central government through both the central Ministry and Department of Health; with the widening authority of the central government further enforcing its grip on allocative efficiency intentions through the National Health Act; and

b) Greater involvement of central government in finance and expenditure functions within the health system, including human resources and access functions. The researcher is of opinion that an expansion of the central government, through the health ministry and department, has the potential to interfere in what is constitutional and also as per the intergovernmental relations legislation provincial autonomous competencies.

c) The decision-making space shows that there is a marginal difference in allocative and technical efficiency intentions of the policies. However, both these policy intentions demonstrate a greater dominance of the central government.

Table 5d: Adaptation and Application of the Decision-making Space Functions in the National Health Act, 2003

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Finance and Expenditure *Revenue Sources* Choices about origin of sources: i.e. Will the provincial governments be allowed to assign their own source of revenue to health?	Central		Province	Technical (Central) Allocative (Province)
Allocations of Expenditure Choices about how to allocate funds: i.e. Will the central and provincial governments be allowed to assign funds to different priority programmes? Hospital vs. primary care?	Central		Province	Technical (Central) Allocative (Province)
Income from Fees Choices about provincially controlled charges: i.e. Will the central and provincial governments be allowed to set fees? If so, are they allowed to determine the levels and change them?	Province		Central	Technical (Central) Allocative (Province)
Service Organisation Functions *Payment mechanisms* Will the central and provincial governments be allowed to select different means of paying providers? E.g. *per capita*, salary or fee-for-service?			Province	Allocative (Province)
Insurance Plans Will central and provincial governments be allowed to create, manage and regulate provincially controlled health insurance plans?	Province		Central	Technical (Province) Allocative (Central)
Hospital Autonomy Will central and provincial governments be allowed to grant hospitals autonomy and select the degree of autonomy allowed?	Province		Central	Technical (Province) Allocative (Central)
Required Programmes and Norms To what degree will the central and provincial governments define what programmes and services the provincially controlled health facilities provide?	Province		Central	Technical (Province) Allocative (Central)
Service Standards To what degree will the central authority be allowed to define service standards, such as quality for facilities?		Province	Central	Technical (Province) Allocative (Central)

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Vertical Programmes and Supplies and Logistics Are vertical programmes continued under the control of the central government or are they transferred to provincial control? Are drugs and other supplies provided by the central government or do they become the responsibility of provincial governments?	Province		Central	Technical (Province) Allocative (Central)
Human Resource Functions *Salaries* Will the central and provincial governments be allowed to set different salary levels? Will they be allowed to determine bonuses?	Province		Central	Technical (Province) Allocative (Central)
Contracts Will the central and provincial governments be allowed to contract short-term personnel and set contract terms and payment levels?			Central Province	Allocative (Central) Allocative (Province)
Civil Service Will the central and provincial governments be allowed to hire and fire permanent staff without higher approval? Will staff be able to be transferred by the central and provincial governments?			Central Province	Allocative (Central) Allocative (Province)
Access Functions *Access Rules* Will the central and provincial governments decide who has access to facilities and who is covered by insurance?		Province	Central	Technical (Province) Allocative (Central)
Governance Functions *Governance Rules* Are provincial officials accountable to the electorate? Will the central and provincial governments have choices about: size and composition of hospital boards? Size and composition of provincial health offices? Size, number, composition and rule of community participation?	Central		Province	Technical (Central) Allocative (Province)
Total Decision-making Space • Central • Province	 3 6	 2	 10 6	Limited Technical Maximum Allocative for Central Marginal difference in Technical/Allocation

2000-2005 HIV/AID/STDs Strategic Plan for South Africa, 2000

It is generally accepted that the spread and impact of HIV, Aids and Sexually Transmitted Diseases (HIV/AID/STDs) will increasingly affect the public health system and will over time demand greater public health services. This demand has the potential to increase constraints on the supply side of the health system. The *2000-2005 HIV and Aids/STD Strategic Plan for South Africa, 2000 (Department of Health,* 2000) indicates that those infected by Aids-related diseases will increased public health establishment admissions and also lead to an increase demand for outpatient and bed daycare. While a number of public health interventions were previously considered unaffordable, new interventions have been introduced in the public health sector since 2001. Different treatment and prevention programmes, such antiretroviral therapy (ARV), prevention of mother-to-child transmission, isoniazad use to prevent tuberculosis (TB) and co-trimoxazole to prevent opportunistic infections have been considered to curtail the spread of HIV, Aids and STDs (Department of Health, 2000).

Some of the interventions that were articulated for implementation in either provinces public health establishments, different provincial health programmes or in not-for-profit organisations show that there are geographical disparities in the distribution of the HIV and AIDS epidemic in South Africa (Department of Health 2000). The interventions also reveals that the HIV epidemic in South Africa is one of the fastest growing epidemics in the world: young women aged 20-30 have the highest rates of prevalence; and young women under age 20 had the highest percentage increase compared to other age groups in 1998 and 1999 compared to 1997 (Department of Health 2000:p7-8*).* The 2004 Medium- Term Budget Policy Statement notes in particular that the "caseloads of public hospitals and clinics reflect, among other factors, the rising burden of HIV- and Aids – related diseases" (National Treasury, 2004a:p5).

The department's *2000-2005* HIV/AID/STDs *Strategic Plan for South Africa* (the Strategic Plan) serves as the overall policy and implementation strategy for HIV, Aids and STDs. Accordingly, the Strategic Plan is a "broad national strategic plan designed to guide the country's response as a whole to the epidemic" (Department of Health 2000:p8). The Five-year Strategic Plan focuses on prevention, treatment; care and support; legal and human rights; and monitoring research and evaluation. The strategic plan notes that (Department of Health, 2000:p8):

> Closely linked to the HIV and AIDS epidemic is a tuberculosis (TB) epidemic which is fuelled by HIV infection and which is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

The Strategic Plan (Department of Health, 2000:p8-9) asserts that:

> There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5 million of these managed by private practitioners. Even without the HIV epidemic, STDs pose an important health problem.

Both the 1992 National AIDS Coordinating Committee of South Africa (NACOSA) and the 1997 South African National STD/HIV and AIDS Review identify specific provincial responsibilities to prevent and treat HIV/AID/STDs. The strategic plan indicates that, following a review of both the strengths and weaknesses in addressing the HIV/AID/STDs epidemic, recommendations were made, which effectively direct the principal-agent relation between the central and provincial governments. The recommendations from the Strategic Plan to be implemented by provinces are:

a) Increasing resources and building capacity at the provincial and district levels to manage, organize and implement the HIV/AID/STDs Programme, thereby dealing with prevention and improving the management and control of STDs.

b) Providing treatment, care and support to health establishments or facilities, communities and developing and expanding the provision of care to children and orphans; and

c) An increasing collaboration between the HIV/AID/STDs and TB Programmes.

The Strategic Plan (Department of Health, 2000:p26) does, however, acknowledge that while it should be used in developing provincial operational plans on HIV/AID/STDs:

> [t]hese should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each province. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the provinces.

With regard to financial resources, the Strategic Plan (Department of Health, 2000:p27) indicates that:

> It is important to ensure that adequate funding is available at national and provincial levels within the health care environment to ensure delivery. One method is to establish agreed resource standards for all provinces to directly place financial resources into HIV/AID. This is currently (in 1999/2000 prices) set at R10,00 a person a year or a total of R400 million a year for the whole country.

The *2003 Budget Review* (National Treasury, 2003c) commits the fiscal policy to enhance the response to HIV/AID/STDs Programme as a key priority, mentioning that:

> The HIV and Aids and Tuberculosis programme, which includes grants to provinces for the prevention of mother-to-child transmission, distribution of condoms, contributions to the Global Fund for HIV and Aids and partnerships with non-governmental organisations, increases from R666 million in 2003/04 to R903 million in 2005/06.

In support of the policy intentions of the HIV/AID/STDs Programme, the 2003 Medium-term Budget Policy Statements, points out that in health, the rollout of the antiretroviral therapy (ARV) programme dominated allocations (National Treasury, 2003a:p65). It further states that (National Treasury, 2003a:p67):

> The 2004 MTEF will continue to strengthen health funding to deal with the impact of HIV and Aids. Baseline increases in the health conditional grant for HIV and Aids will accommodate extending appropriate treatment programmes. Planning for implementation of a national anti-retroviral programme is at an advanced stage, and procurement teams are exploring mechanisms to reduce the unit costs of treatment further. The new treatment programme complements the ongoing prevention and treatment activities under the Enhanced Response to HIV and Aids.

The above fiscal policy stance is further supported by the 2004 Medium-Term Budget Policy Statement (National Treasury, 2004b), which says that:

> Budgets also accommodate building the capacity of the national Department of Health to support and monitor the implementation of the comprehensive programme for HIV and Aids, delivered mainly through provinces and non-governmental organisations.

With regard to human resources, the strategic plan indicates that the prescribed intervention must include the designation by provincial authorities of coordinators responsible for the HIV/AID/STDs Programme in every province and district. In broader terms it confirms that (Department of Health, 2000:p27):

> It is vital to the success of this Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current standard suggested is one dedicated employee per 100,000 the population. To evaluate the availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and district levels.

According to the *2002 Budget Review* commits fiscal policy on the expenditure side towards improving HIV/AID/STDs provincial capacity building (National Treasury, 2002b:p134):

> Provincial priorities and spending pressures are dominated by the need to strengthen both human and physical capacity in the health system to address the impact of communicable diseases, such as HIV and Aids, tuberculosis and malaria.

According to the *2001 Intergovernmental Fiscal Review* (National Treasury, 2001b:p52), with special reference to the relationship between the central and provincial governments, this intergovernmental fiscal review mentions that both spheres of governments fund the fight against HIV and Aids, through at least five channels:

- Provincial health budgets;
- The Government Aids Action Plan, whose aim is mostly preventative by distributing condoms and by piloting the prevention of mother-to-child transmission projects in the provinces;
- A special allocation for an integrated strategy aimed primarily at children and youths, which focuses on the rollout of life-skill training at primary and secondary schools, including expanding capacity to provide voluntary counselling and testing at health clinics, and piloting home-based care;
- Allocations from the provincial equitable share to deal with prevention and information; and
- Spending by individual government departments, which are intended to inform employees and support them.

The Strategic Plan (Department of Health, 2000:p28) confirms that:

> The National DOH [Department of Health] has overall responsibility for the implementation of the Strategic Plan within provincial structures. Specific, measurable targets and indicators will be developed for each objective and reported in yearly operational plans.

As a result of the perceived tardiness of the central government's response to HIV/AID/STDs, the National Health Department directed all the provinces on 16 April 2002 to provide Nevirapine where no PMTCT programme existed. According to the *Circular Minute on Prevention of Mother-To-Child Transmission of HIV (*Department of Health, 2002) which was issued in terms of the South African Constitutional Court's Interim Order, Nevirapine must be provided for the prevention of Mother-To-Child Transmission of HIV (PMTCT) in government health services where there is no PMTCT programme. This circular was valid until the Judgment of the Constitutional Court on 2 and 3 May 2002.

According to the court order, as explained by the circular (Department of Health 2002: p1):

> The first to ninth respondents [central and provincial government departments of health] are ordered to make Nevirapine available to pregnant women with HIV who give birth in the public sector and to their babies, in the public health facilities to which the respondents' present programme for the prevention of mother-to-child transmission of HIV has not yet been extended, where in the opinion of the attending medical practitioner, acting in consultation with the medical superintendent of the facility concerned, this is medically indicated, which shall at least include that the woman concerned has been appropriately tested and counselled.

The Constitutional Court (Department of Health, 2002: p2) confirmed:

> This order does not require the wholesale extension of the prescription of nevirapine outside the pilot sites established by the government. It requires only that government make nevirapine available in public facilities where, in the opinion of the attending medical practitioner in consultation with the medical superintendent of the clinic or hospital, it is medically indicated and the preconditions for its prescription already exist.

The Government circular (Department of Health, 2002) further stated that

> It is important to note that the Court order is designed to cater for individual cases only: this is to cater for what the High Court referred to as "missed opportunities". Each request shall be dealt with on a case-by-case basis. This means that the attending medical practitioner must, in relation to a specific pregnant woman, who has been appropriately counselled and tested, determine (in consultation with the medical superintendent of the facility) that it is medically indicated to prescribe nevirapine for the woman and her baby. To ensure the highest quality of care and to comply with nationally endorsed minimum standards on PMTCT, all medical superintendents are requested to ensure that the provision of nevirapine is consistent with the three attachments to this circular. Where the necessary preconditions for prescribing nevirapine exist (as described in the order) the medical

superintendent shall in writing request the Head of Health in the province to provide nevirapine.

This researcher argues that policy implementation and the associated expenditure obligation on HIV, Aids and STDs require higher aggregate levels of expenditure, which definitely have an impact on the division of revenue. As a consequence of these possible changes, adjustments may be required to the provincial equitable share formula. The adaptation of the decision-making space based on interviews and the policy content analysis further illuminates the implications of the Strategic Plan. This is discussed in Table 5e: Adaptation and Application of the Decision-making Space Functions in the 2000-2005 HIV/Aids/STD Strategic Plan for South Africa, 2000.

The adaptation and application of the decision-making space tool to the 2002-2005 HIV and Aids/STD Strategic Plan for South Africa, as shown in Table 5e below, indicates:

a) Contrary to previous policies discussed above, and increase in allocative efficiency responsibilities to provinces, and the public policy also ensures that maximum technical implementation authority is given to provinces relative to the central government; and

b) Widening of authority for both the central and provincial government, particularly in the arena of finance and expenditure functions, ostensibly to enable both central and provincial governments to augment or match each other's financial inputs into the financing, budgeting and delivery on this Strategic Plan.

Table 5e: Adaptation and Application of the Decision-making Space Functions in the 2000 -2005 HIV/AID/STDs Strategic Plan for South Africa, 2000

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Finance and Expenditure *Revenue Sources* Choices about origin of sources: i.e. Will the provincial governments be allowed to assign their own source of revenue to health?			Central Province	Allocative (Central) Allocative (Province)
Allocations of Expenditure Choices about how to allocate funds: i.e. Will the central and provincial governments be allowed to assign funds to different priority programmes? Hospital vs. primary care?		Central	Province	Technical (Central) Allocative (Province)
Income from Fees Choices about provincially controlled charges: i.e. Will the central and provincial governments be allowed to set fees? If so, are they allowed to determine the levels and change them?	Province		Central	Technical (Province) Allocative (Central)
Service Organisation Functions *Payment mechanisms* Will the central and provincial governments be allowed to select different means of paying providers? E.g. *per capita*, salary or fee-for-service?			Central Province	Allocative (Central) Allocative (Province)
Insurance Plans Will central and provincial governments be allowed to create, manage and regulate provincially controlled health insurance plans?	Province		Central	Allocative (Central) Technical (Province)
Hospital Autonomy Will central and provincial governments be allowed to grant hospitals autonomy and select the degree of autonomy allowed?		Province	Central	Allocative (Central) Technical (Province)
Required Programmes and Norms To what degree will the central and provincial governments define what programmes and services the provincially controlled health facilities provide?		Province	Central	Allocative (Central) Technical (Province)
Service Standards To what degree will the central authority be allowed to define service standards, such as quality for facilities?		Province	Central	Allocative (Central) Technical (Province)

Types of Decentralization				
Functions	**Deconcentration Narrow**	**Delegation Moderate**	**Devolution Wide**	**Efficiency**
Vertical Programmes and Supplies and Logistics Are vertical programmes continued under the control of the central government or are they transferred to provincial control? Are drugs and other supplies provided by the central government or do they become the responsibility of provincial governments?			Central Province	Both Allocative (Central)
Human Resource Functions *Salaries* Will the central and provincial governments be allowed to set different salary levels? Will they be allowed to determine bonuses?	Province		Central	Technical (Province) Allocative (Central)
Contracts Will the central and provincial governments be allowed to contract short-term personnel and set contract terms and payment levels?		Province	Central	Allocative (Central) Technical (Province)
Civil Service Will the central and provincial governments be allowed to hire and fire permanent staff without higher approval? Will staff be able to be transferred by the central and provincial governments?			Central Province	Allocative (Central) Allocative (Province)
Access Functions *Access Rules* Will the central and provincial governments decide who has access to facilities and who is covered by insurance?		Province	Central	Allocative (Central) Technical (Province)
Governance Functions *Governance Rules* Are provincial officials accountable to the electorate? Will the central and provincial governments have choices about: size and composition of hospital boards? Size and composition of provincial health offices? Size, number, composition and rule of community participation?		Province	Central	Technical (Province) Allocative (Central)
Total Decision-making Space • Central • Province	2 3	1 6	11 5	Maximum Allocative for Central Maximum Technical with increase in Allocative for Provinces

Conclusion

The different approaches to and the location of decision making competencies for policy and practice between the public finance and health sectors, in addition to the location and responsibility for revenue and spending decision-making, have contributed to complex and varied policies and competencies. These policy content and interview analyses showed that the central government has used its authority to systematically enlarge its responsibility within the processes of policy design and implementation. The central government has used a range of co-operative government instruments and tools at its disposal such as control, supervision, influence and interference to enhance its influence over the design and implementation of public health policies that intend to push equity and efficiency. The central government has also increased policy responsibilities and obligations for service delivery, implementation and resourcing onto provinces through the different policies discussed earlier.

However, provinces as the implementing agents of public health policies have not been passive recipients of national policies and programmes and have actively engaged the central government about the nature, extent and obligations of these policies. This policy design and implementation process has contributed to separation of different responsibilities and accountability for the health function between the central and provincial governments. The policy content analysis has also demonstrated a gradual expansion of public health services and programmes juxtaposed against requisite provincial government capabilities. Depending on the policy content and, by implication, the obligations it conferred, including out of annual official budget cycle public policy statements, on the provinces, the relationship between the different locations of policy design and implementation led national public health policies either being imposed or voluntary coordinated policy solutions within the shared health function. This chapter shows, especially during the discussion on the National Health Act, 2003 that it is these differences for policy responsibility and accountability in practice that have led to varied interpretations of policy content and its associated obligations, thus leading to the undermining of the intentions of co-operative governance.

This chapter examined the nature and extent of interactions between the central and provincial governments, regarding the interpretation of shared responsibilities for public health. Within this context, an examination was undertaken of policy as formulated and the consequential implications for the provincial governments and its departments of health, at both a level of implementation and identification of financing and budgetary obligations. The policy content analysis also focused on the different cost drivers of these policies for provincial governments. It further explored the nature of the relationship between the central and provincial governments in the public health and finance sectors, given the different domains of public finance and health policies. This chapter identified specific policies, which have had specific service delivery and financial implications on the provinces, especially policies that promote the central government policy intention to establish a two-tier public health system, ostensibly consisting of strong and expansive PHC and a contained public hospital system.

The intention was not to present a typology of the different policies that have emerged in the 1997/08 to 2004/05 period but rather, an analysis of major selected polices, with a view to determine the location of the different health functions and responsibilities, and associated service delivery requirements that are articulated in the policies. Given that national policies and priorities are often discursive in nature, the analysis was specific to understanding the commonalities and separation of responsibilities between the central and provincial governments. It looked at how the functions are allocated and shared between the central and provincial governments.

The policy content analysis showed that the different policies were aligned with the central government's key policy imperative of implementing a primary health care approach in a district health system. The vertical split of policy responsibility between the central and provincial governments impacts differently on various provinces, especially with regard to equity in service delivery. The policy process and content analysis confirmed that the public policy process continued to be a contested terrain, particularly in the domain of the provinces, as "independent, autonomous" spheres of government.

The content analysis confirms that with different policies, the central government maintains a dominant role in the policy design-to-implementation process. The literature review on policy process demonstrated the importance of policy content analysis in order

to determine the nature, scope and complexity of decentralized co-operative governance within policy as practice.

Different public health policies and programmes were designed to not only strongly steer but also to develop a primary health care approach that assures equity and efficiency in the public health system. The content analysis of the different policies and programmes shows that the policies are strongly driven and influenced by the central government, though through a co-operative and partnership arrangement. The public policies and programmes also not only direct the fiscal structure of the public health sector and services, but also set a framework for the administrative and organisational configuration of health services and programmes. Notwithstanding this influence, the split between policy formulation and implementation gives the central government further impetus to direct its policies towards equity and efficiency. Given the commentary of different policy actors, the central government has an added comparative advantage to camouflage the policy design process as a national co-operative policy-making process.

The policy content and documentary analyses showed that the policy processes as it affects the public health system reflects both a voluntary and an imposed cooperation policy design and implementation process between and within the central and provincial governments. This researcher's view is that the policy design and implementation processes epitomise a mix of strong influence, supervision and control of the policy model and process to achieve a unitary policy design and implementation process within the public health system. This strong mix of different governance models combined with an overzealousness to reach equity within a short space of time, has been interpreted in this study as *de facto* centralised control, influence and supervision of the policy formulation. In this way, the policy process reflects the central government's role of strong control, supervisory and inference over policy design and implementation in the provinces. In this manner, the central government uses its policy competence to not only reflect an active interest but also participate in the management of national policy priorities that are implemented provincially. This activity makes the central government a quasi-implementer of policies and programmes. This augurs well for policy process synergy and has the potential to avoid a classical disjuncture between policy design and implemented policy. This type of policy paradigm requires, as its foundation, policy uniformity in both design and implementation across all the provinces. It has, however, in

many ways, contradicted the principle of devolving authority and responsibility that provided the *raison d'etre* for provinces. This researcher agrees with Barberton (1998) that, as a result, this type of policy process undermines the incentive structures of contestability, comparative competition, benefit savings, and the risk of overspending inherent in a decentralized co-operative governance system.

Given the provincial governments' comparative advantage in the implementation arena, the policy practice acceptance is that the central government's responsibility begins and ends with policy design and drafting, and, thereby, the setting of norms and standards in the different health functions. These policies are given to the provinces to implement and finance, with limited capabilities to make adjustments for implementation. It is at this point of handing over of policy responsibility to the provinces where policy could become the glue for holding the responsibilities of the central and provincial governments together. Alternatively, the different interests and responsibilities, combined with competing new and existing policy priorities and existing health programme obligations between the central and provincial governments, contribute to a creep and, at times, mandate a shift in the policy implementation process. This is without the requisite resources for the provinces. It is also at this point of policy off-load that co-operative governance and collegial management in the link between policy design and implementation is forged between the central and provincial governments.

Although there seems to be a clear responsibility determination and execution between the central and provincial governments in the nature and form of policy off-loading, most policies show an implicit and explicit continued role for the central government in implementing and financing public health policies. A closer reading and analysis of the different policies also indicate that it is within this principal-agent relationship, or put differently, in this collegial policy designer and implementer relationship that the central government's influence in reality ought to have substantially reduced. However, it is through the policy-formulation process that the central government sets the norms and standards of what ought to be delivered. In practice, this type of involvement of the central government definitely leads to a creep not only into the policy implementation process, but also the resource allocation within provincial government. Although this process of policy creeps is a gradual process where central government slips policy changes, by overt or covert activities, it mostly happens at an implementation level under

the pretext of customizing policies for implementation purposes by the provinces. This may, happening through a set of concrete policy directives from the central government given the relative strength in authority of the provincial government in determining the level of resourcing these public policies. The public health policy creep from both the central and provincial governments can potentially lead to policy variation between provinces and a deviation from the original policy intention agreed to in terms of the norms and standards, expected deliverables originating from the policy, with unintended costs and other requisite (such as human capital and service administration) obligations across and within provinces.

While uniformity in policy implementation is critical, given the considerations of equity, the centralized policy approach seems to ignore the inherent historical weaknesses in certain provinces. The centralized unitary approach is a policy implementation approach that all provinces must implement as a 'one size fits all' irrespective of the level of its different capabilities. This approach contradicts the principle of choice and variation based on the service conditions and resource capabilities in the policy. Indeed, the centralized decision-making policy-implementation approach undermines incentives that spurred better provinces to adopt measures that have resulted in significant gains. It ignores differences that exist between the provinces and the need to adopt a varied and appropriate strategy for provinces experiencing difficulties – a strategy that would require asymmetric policy obligation and responsibilities on the provinces. In this approach, explicit recognition is then given to the provincial capabilities, thereby maintaining the incentive structure of co-operative governance and decentralized delivery in the public health system.

Conversely, the implicit argument in central government-driven policies is the recognition that the location of responsibility for policy implementation and accountability for service delivery is integral to co-operative governance. This understanding requires both the central and provincial governments to weigh up whether protocol, policies and procedures outweigh responsibility and accountability. The key to this proposition is that as a result of the separation between policy formulation and implementation, those responsible for deciding policy should not decide how it should be implemented. This is because the policy implementer in the public health system – the province – has a comparative advantage to the central government in terms of information about the level

of services to be provided. The argument is, therefore, that the provinces should be accountable for the implementation and management of inputs, outputs and outcomes of public health policies. National policy processes should, therefore, be organised in such a way as to provide for co-responsibility in some areas. The split in the public health process assumes that the provinces will, as a result of their involvement in the policy process, provide adequate funding to meet their policy implementation obligations, including maintaining the delivery of quality health services, administration and management.

From the interviews with the different policy actors, it is also clear that, given that the majority of public health policies, including those discussed in this research, were not costed and that there is no financial framework for some of the policies, it becomes difficult for the provinces to ascertain the financial structure and resource allocation for a policy. Similarly, the central government will experience difficulty in supervising or interfering with the levels of resource allocation to specific policies relative to other policy priorities. The process of supervision or interference in the resource-allocation process, if the policies were costed, should not be arbitrary but should be objectively aligned to baseline service administration and delivery, previous financial expenditures and the levels of health service delivery. If the policies were costed, it could contribute to adequate distribution of public health responsibility, accountability and authority between the central and provincial governments and its implementation assurors and financing responsibilities and obligations. The adaptation and application of the decision-making space tool is particularly illustrative.

Although the combined effect of the different policies reproduces tensions between the central and provincial governments, it contributes to modifying the health system within the context of decentralization within a system of co-operative governance. The different public health policies also apply a derivation principle, which essentially identifies the different competencies of the central government relative to those of the provincial governments. The different competencies originating from the policies also create competition between policy priorities for resources. Given the nature and intensity of the HIV/Aids/STDs policy and programme debate in South Africa, for example, this policy programme can potentially become the nexus of setting policy priorities in the provinces. On the other hand, this policy programme has the potential to undermine other policy

priorities or health programmes in the provinces for resource allocations, leading to implementation shirking on other policies. Such a possible avoidance of policy implementation originates from a situation where the provincial departments of health, for cogent public health service reasons, agree to a policy in the co-operative governance collective, but at implementation level may choose certain aspects of the policy for implementation, given their own health service considerations and obligations. This clearly leads to a practice of priority choice within an overall policy, which leads to partial implementation of policy.

The policy content analysis showed that the policies and their associated priorities are the cause or foundation for not only a shift in resource allocation but also an expansion of public health services. Both the shift and expansion have a major impact on provincial budgetary allocations, including earmarked funds from the central government for certain health programmes. The shift and expansion also have the potential to create unfunded mandates, thus leading to fiscal risks at a provincial level, including the potential to create moral hazard. It is inevitable that such a state of affairs has the ingredients to create tensions between the central and provincial governments in policy design to implementation. Moreover, it contributes to a situation where the provinces, given the expansionary nature of the policies relative to the resource envelope, could ‘pick and choose’ which policies or elements within a policy or priorities to implement. However, to mitigate such a state of affairs, the NHA proposes a strong fiscal role for the central government via different institutional arrangements.

While a strong role is advocated to deal with different policy intentions, including policy renegade provinces in resource allocation and policy implementation the central government has different levers, such as norms and standards, including a strong state controlled governance role to coerce the provinces into implementing policies as intended. In addition, even if and when there was joint agreement on policy intentions about what should be implemented, the nature of the policy process and the location of varying mandates do not necessarily bind any particular sector or sphere to the policy discussion outcome. Given that policy decisions, in the final analysis, rest with the central government, the public policy process provides the opportunity for those vertical and horizontal policy differences to resurface, leading to the possible undermining of the co-operative governance system. Obviously, a different policy decision made will have to be considered against the political imperatives, how the policy decision is aligned to

other macro-economic decisions, which was not of necessity considered within the interaction between the public health and finance sectors.

This interaction will not only be necessary to promote co-operative governance between central and provincial governments and the line functions in the policy and the budgeting processes, but to enforce consistency and uniformity in policy implementation across the spheres of government. However, given the different responsibilities of public health policy implementation and, consequently, differing policy orientations and different interests the system of co-operative governance within the public health policy domain can be summed up as follows:

a) Common and varied public health policy and implementation interests between central and provincial governments and its line functionaries that are within the sector;

b) Common and varied public finance policy and implementation interests between central and provincial governments and its line functionaries within the sector; and

c) Common and varied interests between line functionaries at both central and provincial government levels that are between health and treasuries.

Concretely, within the public health system, the central and provincial Departments of Health might for national policy uniformity and health priorities form an alliance to ensure that both the national and provincial fiscal policy make adequate provision for health policy implementation and other health service delivery priorities. On the other hand, stakeholders in the public finance sector could ensure that public health policy does not contradict the fiscal and finance policy outlook. However, between the spheres, provincial government through its line functionaries (department of health and treasuries) could work through its exclusive and joint co-operative governance responsibilities by lobbying for particular policy implementation responsibilities and additional resources for its province. Given the vertical, horizontal and transversal interactions, the researcher believes that the possible policy outputs and outcomes have often been deliberate sectoral collusion co-operative within governance settings.

However, the policy processes, though contested, have incentives of building and strengthening the policy design and implementation partnership between the central and provincial governments. This is achievable through a set of conditionalities, originating from a specific policy, which have the potential to create privileged partnership and mutual interests about the public health system among the central and provincial governments and the public finance and health sectors.

This policy process partnership is possible in spite of the divergent policy views and practices, especially regarding those intentional ambiguous policy questions as indicated in the NHA. There is also broad public policy process agreement between the central and provincial governments and the sectors that it is in the interest of all sides the central government should continue to steer the public health system reforms. Closer interaction between the public finance and health sectors and among the central and provincial governments led by the central government would strengthen nominal control, supervision and influence over the nature and form of the policy processes and the different obligations on provinces.

Chapter Six: Decentralized Co-operative Governance of Public Financing of Policies: Principal-Agent Relations

Introduction

Public expenditure in the health sector has achieved important health, political and social goals: a) improving health outcomes; b) promoting non-health aspects of well-being, for example by insuring that individuals are not at risk; and c) financing redistribution to the poor (Gertler and Hammer 1997:1). These goals are achieved by mobilising private resources such as medical insurance and user fees, which are either paid at the service delivery point or by taxation. Public health expenditure in South Africa is financed by both private and public resources and by resources provided by donor organisations. Public resources are transferred from the central tax-raised revenue fund. This chapter is link to conceptual framework through a discussion and analysis of the principal-agent relationship as contained within the policy content (as discussed in Chapter 5) and public financial policies and practices.

The financing of the public health system by both the central and provincial governments is a powerful phenomenon in both testing levels of commitment and the scope and scale of public health policy implementation. This chapter argues that the identified national public health policies discussed in the previous chapter have predetermined the budgetary and resource-allocation process within provinces. This policy design and implementation practice, which is articulated through different public health expenditure programmes, has pushed overall budgets and expenditure. This chapter also argues that the overall intentions of the different public health policies discussed have systematically steered the proportional distribution of power and authority between the central and provincial governments, thus enabling internal finance and fiscal shifts between different health services and programmes within the public health system.

While at an aggregate level the national public health polices have pushed expenditure, at a disaggregate level, however, data categorisation and classification have made it difficult to determine the nature and impact of these policies. This chapter also argues that given the dominant role of the central government public finance sector embodied

within the National Treasury, it has pushed for a uniform, rule-based and coordinated public finance policy practice. The practice has led to a hard-budget-constraint approach within the public finance sector, which has contributed to simmering tensions within the public health sector as a result of its expansionary and equity orientated policy approach. This chapter also argues that further tensions are added to the policy process practice discussed in Chapter 3 as an outcome of: differing policy design and implementation practices within and between the public finance and health systems; and the implementation of different financing mechanisms such as transfers and policy creep of central government within the policy-implementation domain of the provincial government. These tensions have led to differing forms of policy design and implementation between and within the public finance and health sectors at both the vertical and horizontal levels of governments to an extent that pushes uniformity and inclusivity on the one hand and on the other, separates and creates exclusivity in responsibilities and accountability. The varied finance and fiscal policy-implementation responsibility and accountabilities between the sectors and central and provincial government, this chapter argues, have added to a undermining of the intentions of co-operative governance and have also contributed to a co-operative government becoming co-operative management of expenditure within public health.

Background on the financing of public health

The South African public finance and fiscal decentralization system is a hybrid of provincial decision-making and central government control. There are wide disparities between the fiscal bases of the provinces and, as such, this dissertation holds that provincial expenditure responsibilities outstrip their own revenues. The Committee of Inquiry into a Comprehensive System of Social Security for South Africa (cited in the Department of Health 2003b) is of the view that in many developed countries budgeting for the public services requires major regional redistribution which is more centralized than public services in general. The argument is that it is easier to redistribute resources according to different provincial needs if one guiding hand controls the allocation process. In 1995, the allocation of the health budget was the responsibility of the function committee, which developed a formula to redistribute resources. The Department of Health (2003b) argues that, since 1997, South Africa does not have one

national public health budget but, rather, ten (10) comprising the nine provinces and the central health budget, which are determined separately by the relevant treasuries.

The debate about appropriate levels and mechanisms of public health financing and fiscal arrangements has increased tensions between the spheres of government. An inappropriate funding mechanism, unfunded mandates, over expenditure on health and uncosted policies have become buzz words as part of the discourse of public finance arrangements within the public health sector. The Department of Health (2003b) argues that it is difficult to effect the overall transformation of public health according to defined government policy. The Department of Health (2003b:p13) goes further by categorically stating on the public financing and fiscal arrangements for the public health system that:

> It also makes it more possible for total public health expenditure to fall imperceptibly and unwittingly behind the country's needs. A return to the central system of provincial health allocation would undoubtedly facilitate the structural reforms needed in the South African public health sector.

What follows is not only a description of the functional and structural arrangements of the co-operative governance public finance and fiscal system between the central and provincial governments, but also a critical assessment of the links among public financial decisions, central government priorities, and public health policy implementation. While the previous chapter provided an analysis of the link between national public health policies and what ought to be implemented by the provincial governments, this section focuses on the implementation of these public health policies and programmes through the looking glass of public finance and fiscal policy. Multi-year budgets, funding arrangements and funding mechanisms, transfers and overall expenditure are critical features of this analysis.

Similarly to the previous chapter, this chapter also considers, from a public finance perspective, whether there is an emerging inverse relationship between the central and provincial governments and between the public health and finance sectors. It examines the nature and levels of budgets, the type of funding mechanism, the inter- and intra-governmental transfers and the overall expenditure. The existence of both under and over expenditure are segments of a barometer to measure policy implementation and the degree of fiscal policy decision making in the provinces. By analysing the internal dynamics of these different modalities, the public finance and fiscal system assisted in

measuring whether the central and provincial governments' policies and programme decisions have had an impact on budgets and expenditure, and also where these policies intersect. Such an analysis ought to show how national public health policies and programmes have been used to maximise either the size of the public health budgets and consequently, expenditure or have served as a means to 'force' budget allocations. Alternatively, where there is an inverse relationship between national budgetary decisions such an analysis should show those revenues and expenditures determined at the provincial levels. Built within this dynamic is an acceptance, whether publicly articulated or not, that new public health policies and programmes either contribute to a decline or an increase in public health expenditure budgets or expenditure.

Overview of revenue and expenditure data collection

This chapter draws on: national and provincial data of health financing and expenditure; documentary analysis of financing and expenditure for public health services delivered by the nine provinces; sourcing and expenditure trends analysis and their connections with policy decisions and statements; and interviews with senior policy and finance officials within health departments and treasuries.

The research question directed the study towards a method of tracking the flow of funds within the health system, from sources of funding programmes and services that originate not only from public health policies. The study also explored service delivery priorities determined by central government, by focusing on the flow of funds, composition of funds, and an alignment between policy and funding trends over a multi-year period. The theoretical exposition points towards determining measures of inputs, costs and the financial trends in order to estimate how central government policies and priority-setting pressures have impacted on the nature of decentralized co-operative governance.

The revenue sources and expenditure data on budget allocations and expenditure from 1997/08 to 2007/08 were utilised to measure the effects of the public health policy on the financial decision-making capabilities of the provinces. As a result, the research approach in this chapter is one of a PER with the primary objective to track the public

health policy implementation or to measure the “commitment” by the provinces to adhere to the national public health service delivery policies, programmes and priorities.

The revenue and expenditure data are presented in tables, graphs and diagrams. The tables, graphs and diagrams depict overall trends within revenue allocation and expenditure and the funding mechanism – that is, equitable share or conditional grants. The data is also presented through the public health uniform budget structure programme as regulated by the National Treasury guidelines. The uniform and standardised budget structure for health comprises programmes and sub-programmes. The data is also presented through an analysis of financial data at an economic classification and standard-expenditure-item level. The expenditures at the levels of both the programme and classification are then linked and analysed in relation to the policy content discussed in Chapter 3. The intention here is to determine the linkages between the mandatory and discretionary cost drivers within the policies and growth patterns in revenue and expenditures. The mandatory cost drivers refer to the financing of the health policies and priorities, interests of government debt and payments required under government-guaranteed loans. Discretionary cost drivers, in turn, include personnel and capital expenditure. The expenditure on wages, interests, inflation and exchanges are all part of discretionary cost drivers.

Public Health Financing

In addition to the overall structural and organisational reforms within the public health system, another key aspect of the process of transformation of the health system is equity in resource allocation within the public sector and between urban areas and rural areas of the country. The new government inherited a system that was hospital based, curative in orientation, and which favored the urban areas and the white population (Pillay 2000). McIntyre (1995) mentions, for example, that in 1993, 76 per cent of the total public health budget was spent on the provision of hospital services, with tertiary and academic hospitals accounting for 44 per cent of the 76 per cent total budget for provision of hospital services. In contrast, primary health care expenditure amounted to 11 per cent of total public health expenditure. In addition, the per capita public health expenditure in the richest magisterial districts was 3, 6 times higher than in the poorest districts.

In 1994 a political decision was taken by the national Minister and the nine members of the provincial executive committee responsible for the public health care to achieve equity in resource allocation among the nine newly demarcated provinces within five years. In order to achieve a more equitable distribution of funds a 'Functions Committee' with representation from all provinces was constituted by the national Department of Health to determine financial allocations to each province health department. According to Pillay (2000), although constrained by a lack of accurate data, a formula for resource allocation was adopted that took into account population size and relative poverty. This formula was later modified to take into account percentage of the population covered by private health insurance. In terms of the formula, provinces that were previously advantaged (urban and well resourced in terms of health facilities and services) has to give up part of their budgets to those provinces that were persuaded to accept the formula in the spirit of the need for horizontal equity in allocation.

In order to continue to protect tertiary and academic hospitals the Cabinet decided during 1997 to fund teaching and research (largely at medical schools) from a top slice of the national budget. In addition, highly specialised services (largely tertiary and quaternary care) that were used by residents of provinces outside those in which the facilities were located were to be funded by a conditional grant from the top slice. This was done to remove the need for inter-provincial transfers in reimburse provinces in which these services were located and to acknowledge that these institutions were national resources. According to an interviewee from the public health sector, a respondent reading from her draft paper notes:

> The intention was ensure that historically disadvantaged areas, especially those provinces with large rural populations and those which now had the bulk of the previous homeland residents, were not disadvantaged and that provinces could shift resources from the hospital sector to primary health care.

The radical reform in the financing of public health and the associated changes in the intergovernmental transfers and flow of funds in 1997 mandated by the constitution and implemented by the National Treasury had a major impact on the allocation of public health funds. According to Pillay (2000), the use of the national Functions Committee in public health to allocated resources ceased at the beginning of the 1997/8 financial year when the Department of Finance decided to change funding flows from going to

provincial health departments via the national health departments. The changes effected transfer of global budgets from the National Treasury directly to provincial treasuries. This meant that provincial health departments had to bid within the province for the bulk of their budgets. This process of bidding however, excluded the national conditional grants for hospital rehabilitation, specialised hospital services, teaching and research and the primary school nutrition programme.

Thomas and Muirhead's (2000) review on public health sector expenditure and the equitable share formula as a funding mechanism found that: (a) inter-provincial inequities in health budgets have grown large and (b) that the previously under-resourced provinces have not been able to leverage sizeable budget increases due to lack of capacity and negotiation skills (Thomas and Muirhead 2000). An interview respondent argued that this approach to the finance of public health "has resulted in the reversal of early gains made with respect to inter-provincial equity". Thomas, Mbatsha, Muirhead and Okorafor (2004:p3) also note that:

> Interestingly, and prior to the formulation of the conditional grants, the Financial and Fiscal Commission proposed ring-fencing of funds to support Primary Health care and the District Health System, in terms of a "Minimum Standards Grant" … Further, there was an attempt by the National Department of Health to obtain a conditional grant for PHC activities in 1997. Nevertheless, neither proposal succeeded. Instead, the National Treasury sanctioned the protection of higher levels of hospitals.

Schedule 4 of the Constitution determines the concurrent responsibilities of the central and provincial governments. According to the National Treasury's (2006:p2) *Provincial Budgets and Expenditure Review 2002/03 -2008/09:*

> Concurrent functions include policy-making, legislation, implementation, monitoring and performance management. Functions such as school education, health services, social welfare services, housing and agriculture are shared between national [central] and provincial governments. For these functions, national [central] is largely responsible for providing leadership, formulating policy, determining the regulatory framework including setting norms and standards and monitoring the overall implementation by provincial governments. Provinces are mainly responsible for implementation in line with the nationally determined framework. Provincial departments therefore have large budgets for the diverse implementing services, while the national [central] departments have relative small share for their functions.

Schedule 5 of the South African Constitution sets out the areas of exclusive provincial legislative competence. The funding arrangements in South Africa to meet these

responsibilities are determined through the annual budgetary process within the context of the 3-year Medium Term Expenditure Framework (MTEF). According to Section 227 (1) of the Constitution, a province is: *entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it; and may receive other allocations from national government revenue, either conditionally or unconditionally.*

Once estimates of the national revenue have been decided, the vertical division in the budgetary process involves identifying the amount needed for debt servicing. The national Budget Council Minutes of 11-13 May 2000 indicates that the remaining balance is allocated among the central, provincial and local spheres of government (National Treasury, 2000b). The vertical division process further takes into account allocations of conditional and unconditional grants from the national share to the provinces and the municipalities (National Treasury, 2000b). The system of financing the different levels of government comprises first considering a division of revenue followed by an equitable share allocation.

The national and provincial fiscal policies are key features in a decentralized co-operative government system and directing the analysis of public health financing. The division of revenue or vertical split of revenue policy sets the fiscal context for analysis. The division of revenue serves as an initial measure to assess the relative strength of the central government regarding the distribution of fiscal resources. In practice, the central government, through various technical and political process and structure, first top slices the nationally collected revenues and, afterwards, divides the remainder between the provincial and local spheres taking into consideration Section 214 (2) of the Constitution. This section of the Constitution makes provision for an equitable share of revenue raised among the central, provincial and local governments. It also requires a determination of each province's share of the equitable share of the revenue, the horizontal division. It also requires an articulation of any conditions attached for any other allocations to the provinces. The division of revenue has been at the epicentre of contestation between the central and provincial governments. The argument is that provincial obligations and financing responsibilities do not only look at marginal public expenditure allocations, such as new policy and programme budget bids. The argument

extends further in that neither do the provinces look only at existing programmes or average public expenditure allocations, but rather at overall competencies.

Any existing or new national policy that must be implemented, according to this argument, should therefore be measured against the overall responsibility for different functions and services. This study holds that the overall provincial responsibility for public health comprises hospital services, primary health care, including provision for the prevention and treatment of HIV/AID/STDs, capital expenditure responsibilities for health facilities, emergency and medical services, health sciences and training, and health care support. There are also corresponding differences in the fiscal capacity of the provinces to deliver and finance these functional responsibilities and priorities.

Provincial equitable share

The Constitution entitles the provinces to a share of nationally raised revenue, which is divided among the provinces on the basis of a redistributive provincial equitable share formula. According to the National Treasury (2003a), the provincial equitable share allocation finances the bulk of public services rendered by provinces. The provincial equitable share allocation is the main fiscal source for financing provincial expenditure. The *2002 Budget Review* (National Treasury 2002b:253) mentions that the equitable share formula comprises seven components that attempt to capture the relative demand for services between the provinces and for particular provincial circumstances. The Treasury also maintains that "[a]lthough the formula has components for education, health and welfare, the share 'allocations' are intended merely as broad indications of relative need." (National Treasury 2002d:253). The National Treasury insist, that the "Provincial Executive Committee have discretion regarding provincial allocations for each function." According to the *2005 Budget Review*, the division of equitable share allocation among the provinces is done through an objective redistributive formula (National Treasury 2005a:p244). The National Treasury indicates that the components of the equitable share allocations formula are:

a) *An education component (41 per cent) based on the size of the school-age population (ages 5-17) and the average number of learners enrolled in ordinary public schools as a proxy for the demand for educational services;*

b) *A health component (19 per cent) based on the proportion of the population with and without access to medical aid to capture the demand for health services;*

c) *A social security component (18 per cent) based on the estimated number of people entitled to social security grants – the elderly, the disabled and children – and weighted by using a poverty index derived from the Income and Expenditure Survey to reflect provincial responsibility to provide social security grants;*

d) *A basic component (7 per cent) derived from each province's share of the total population of the country;*

e) *A backlog component (3 per cent) based on the distribution of capital needs as captured in the schools register of needs, the audit of hospital facilities and the distribution of the rural population;*

f) *An economic output component (7 per cent) based on the distribution of total remuneration in the country; and*

g) *An institutional component (5 per cent) divided equally among the provinces.*

(National Treasury 2005a:p244).

Table 6a shows the values, changes to these values, components and elements within the equitable share formula over a multi-year period. According to Table 6a, the health component weight remained constant at 18 per cent during the late 1990s, increasing to 19 per cent during the first half of the 2000s. In the *2004 Intergovernmental Fiscal Review*, the Treasury argues that the percentage increase in the weight since 1999/00 reflects increased health care access to people without medical aid, growth in and the changing demographic patterns including and increase in overall medical costs (National Treasury 2004b).

Table 6a: Equitable Share Formula

Components	Elements	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Education	Education		39	40	41	41	41	41
Education	*Enrolment*			*1*	*1*	*1*	*1*	*1*
Education	*School age (6-17)*			*2*	*2*	*2*	*2*	*2*
Health	Health		18	18	19	19	19	19
Health	*With medical aid*			*1*	*1*	*1*	*1*	*1*
Health	*Without medical aid*			*4*	*4*	*4*	*4*	*4*
Social Development	Social Development		16	17	17	17	18	18
Social Development	*Old age*			*65*	*65*	*65*	*65*	*65*
Social Development	*Disability*			*25*	*25*	*25*	*25*	*25*
Social Development	*Child care*			*10*	*10*	*10*	*10*	*10*
Social Development	*All grants*			*75*	*75*	*75*	*75*	*75*
Social Development	*Income adjustment*			*25*	*25*	*25*	*25*	*25*
Basic share	Basic share		15	9	7	7	7	7
Economic activity	Economic activity		8	8	8	8	7	7
Institutional	Institutional		4	5	5	5	5	5
Backlog	Backlog		0	3	3	3	3	3
Backlog	*Health*			*18*	*19*	*18*	*18*	*18*
Backlog	*Education*			*40*	*41*	*40*	*40*	*40*
Backlog	*Rural*			*42*	*40*	*42*	*42*	*42*

Note: National Treasury Reports (1998/99 to 2003/04) - Budget Reviews & Intergovernmental Reviews

Note: National Treasury Reports (1998/99 to 2003/04) - Medium Term Budget Statements

Table 6b shows an overall higher weighting for education at 41 per cent, followed by health at 19 per cent and social welfare services, which includes social assistance grants at 18 per cent. Table 6b below shows the current structure and distribution of shares by component, including each province-specific share in the equitable share. The health distribution within the equitable share among provinces shows higher percentage distribution with KwaZulu-Natal (KZN) at 21.7 per cent, followed by the Eastern Cape at 17 per cent, and Gauteng at 14.7 per cent. Table 6b shows a higher weighting for education at 41 per cent, followed by health at 19 per cent, and social welfare services at 18 per cent. Education, health, and social welfare are the major competencies of provincial governments. According to the *2005 Budget Review* (National Treasury, 2005b), the formula is reviewed and updated every year for new data, taking account the recommendations of the Financial and Fiscal Commission (FFC). The Treasury indicates that the review covers “the structure of the formula, weights of components and other economic development and poverty-related policy considerations” (National Treasury, 2005a:p245).

Table 6b Distributing the equitable share, percentages by province

	Education	Health	Social welfare	Basic share	Economic activity	Institu-tional	Backlog	Target shares
Weighting	*41.0*	*19.0*	*18.0*	*7.0*	*7.0*	*5.0*	*3.0*	*100.0*
Eastern Cape	18.4	17.0	19.6	15.5	6.5	11.1	20.6	17.0
Free State	6.3	6.5	7.1	6.5	5.3	11.1	5.7	6.6
Gauteng	12.6	14.7	13.9	18.1	41.6	11.1	5.1	15.4
KwaZulu-Natal	22.0	21.7	19.6	20.7	17.0	11.1	22.9	20.6
Limpopo	15.4	13.3	13.7	12.1	3.0	11.1	22.9	13.6
Mpumalanga	7.3	7.2	6.5	6.9	4.9	11.1	8.5	7.2
Northern Cape	1.9	2.0	2.2	2.1	1.7	11.1	1.3	2.4
North West	8.0	8.6	8.7	8.3	5.7	11.1	9.4	8.3
Western Cape	8.0	8.9	8.8	9.7	14.4	11.1	3.7	8.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

National Treasury database 2005.

The National Treasury maintains that the elements of the formula are neither indicative budgets nor guidelines as to how much should be spent on which functions by provinces. The National Treasury strongly argues that the equitable share formula is not a proxy for funding the different competencies, but rather an indication of the relative need for the purpose of allocating funds. However, a respondent interviewed within the provincial public health sector during June 2004 argued that:

> [e]ven though what the National Treasury indicates is true for a policy on paper, in reality or practice the components are weighted according to expenditure patterns and service delivery pressures.

Another interview provincial public health sector respondent during May 2003 mentioned that

> [t]he equitable share is compounded by national policy priorities for provincial service delivery and that it rather render the equitable share as an unconditional fund to provinces, a 'national conditional grant allocation in disguise'.

The Head of the Western Cape Provincial Government Treasury echoes this by stating on page 4 of a South African Weekly newspaper, *Mail and Guardian, September 30 to October 2005*, that there is already:

> … a sharp move to conditionality on provincial transfers. National government wants us to achieve certain things, so there is an increase in conditions. You need a strong centre to ensure lesser inequality and a higher growth path. ….The equitable share

> takes into account neither where we are [n]or where we need to be. More conditionality would require a focus on circumstances and the outcomes.

However, a central public finance sector interview respondent in August 2004 acknowledges that

> The equitable share formula is only an instrument that attempts to allocate resources and not a replacement for policy and decision making at a political level within both the central and provincial governments.

Furthermore it can be argued that there are no clear and objective bases to which the weights are allocated to the other four components of the formula. In particular the formula does not seem to consider different policy imperatives in a specific sector or adequately the overall cost associated to the delivery of a specific function and service, including the ability of the formula to fund constitutionally mandated basic services. The conflicts in the public policy processes that were discussed in the previous chapter on policy content analysis not only spill over, but are also more acute within the public finance system.

The conflict in the policy processes and policy product is particularly because of the public health sector's consistent approach to increase its controlling responsibilities and authority not only in the health sector and also to manage the influences of the public finance system on the public health system. It is the view of the researcher that the public health sector, at least the central government's Department of Health, is increasingly preferring to legislate its role in order to ensure a stronger influence and control over policy processes and practice that influence inputs into and outputs of the public health system. The departments of health find it especially difficult, at least from a public health sector perspective, to comprehend and accept the policy practice of the public finance system, particularly as it constrains overall public health policy intentions. The public health sector especially argues that the 'fiscal federalist system' practice by the public finance sector coalesces with a constitutionally decentralized but unitary government and, as a result, compromises and constrains access and equity considerations of the health system. The Department of Health (2002:p8) also states that in the: "1997/98 financial year the public sector officially switched over to a fiscal federal system whereby budgets for health were determined by provincial legislatures and not advised by national policy". The argument from public health sector is also that instead of allowing the expansion of health services in terms of policy and legislation, the

public finance system has constrained structural reform of the health system. The researcher strongly believes that control and management of the public finances and fiscal resources is the vexing issue within this conundrum.

In its criticism of the public finance system that is operable within the health system and sector, the national Department of Health strongly draws on the National Health Accounts Review claiming that there has been a systematic overall and per capita decline in public health expenditure since 1996/1997. This Review, according to the Department of Health (2002: p8) mentions that:

> …expenditure decline is in part attributable to the peculiarities of the fiscal federal system rather than to any explicit national policy decisions. Various studies as well as the NHA review have pointed out the inability of the health system to achieve national policy objectives with respect to equity as a consequence of the fiscal federal environment, appear to have reversed in the years since 1996/97. However, a significant contributor to the decline in health budgets appears due to the decline in the overall allocations to provinces.

The Department of Health (2002: p8-10) mentions unequivocally in is report: *Inquiry into Various Social Security Aspects of the South African Health System, based on the Health Subcommitttee Findings of the Committee of Inquiry into a Comprehensive System of Social Security – Policy Options for the Future, May 2002* that various problems appear pervasive and impact significantly on the performance of the health-delivery system. The arguments advanced by the Department of Health (2002: p8-10) are generally that

- Policy decisions concerning health care at national level cannot be backed by resource flows as the provincial governments are responsible for budget setting for health services.
- The conditional grants allocated for teaching and research and supra-regional services (highly specialised services that are only available in a few provinces) are not linked to any specific services, and are apparently being reduced in real terms without any clearly defined policy framework.
- Conditional grant allocations to provinces are undermined by provincial treasuries, who dominate resource allocation decisions. As such, the primary motivation for a “conditional” grant is substantially undermined.
- As yet no specific norms and standards that can be used for budget motivation and resource allocation have been satisfactorily developed.

- In recent years there has been a tendency for an increased level of funding for normal capital expenditure to be made available at a national level. Access to these funds is uncertain, difficult and bureaucratic.

- All funds raised in additional revenue from medical scheme and other private patients is not retained by the relevant cost-centre (i.e. hospital). As such hospitals lose out financially when they treat private patients.

- The Treasury Department is not applying a consistent approach with respect to mixed financing options within the public sector generally. This has particular relevance for the Health system, as a degree of flexibility between alternative revenue sources for public health institutions is a characteristic of all successful health systems.

- The current system of public finance for the health system is inflexible and inefficient. Institutions are generally uncertain about future budget allocations, despite the Medium-Term Expenditure Framework (MTEF).

- The budgeting system appears to involve an inconsistent mix of centralization and decentralization with respect to the public health. Firstly, budget allocations are decentralized to provinces resulting in a weakening of equity and other national policy objectives. Secondly, key aspects of the budget which are more appropriately managed with a high degree of decentralization are at a national or provincial level.

Costed norms approach in public financing of provinces

In responding to the equitable share formula, the FFC (2000) recommendS a costed norms approach to allocate funds to the provinces. According to this approach, estimates will be made of the actual cost of providing basic services in education, health and welfare. The approach attempts to identify the specific policy norms or goals in each sector and then to develop an expenditure model to estimate the cost of achieving these policies. The basis of the approach is that costing of the norms and standards for a sector serves as a benchmark to determine baseline provision of services. By doing this, the service delivery baseline in turn serves as benchmarks for determining appropriate levels of public health financing and, hence, provincial health allocations.

In terms of the setting of norms and standards, the FFC (2000) argues that it could also potentially direct attention to where improvements are required in the health and identify areas where health services continue to be inequitable. Provincial allocations would then be the aggregation of the cost estimates across the different expenditure categories in the provincial budgets. The cost estimates would therefore reflect the national norms

and standards in each sector. The costed norms approach, it is argued, could be used to determine not only the horizontal division between the provinces, but also inform the vertical division between the national and provincial spheres. However, the National Treasury has rejected the FFC's proposals on a costed-norm approach, arguing that appropriate information is needed to develop the cost estimates, which is simply unavailable. The Treasury (National Treasury 2005b:p3), however, disagrees by indicating that in sectors such as public health:

> National norms have been set for implementation by the provinces. Sectors tend to collude to bypass the budget allocation process by setting such norms and standards – the over expenditure problems in the three sectors [education, health and social development] in 2003/04 attests to the fact that this problem is actually getting worse.

Then again, the Department of Health (2003b: p30) has argued that:

> The definition of service packages with associated norms and standards for the public health system would set a theoretical floor for health services in all parts of the country. Used as benchmarks towards which provincial health services would be working over time, norms and standards would assist in the provincial strategic planning process and guide progressive improvement of public health care. They would act as yardsticks against which progress in service provision could be judged.

The Department of Health (2003b: p30) does, however, acknowledge, for different reasons, that the definition of norms and standards for a health sector as technically complex as health care is a daunting and complex undertaking. It mentions that:

> Many of the definitions of service provision developed so far are more qualitative than quantitative. The reason is that quantification of the service norms and their associate resource requirements is difficult. Defining the 'needs' of health services in quantitative terms is something like asking 'how long is a piece of string'. Any amount of ideal health care can be imagined. In practice service, 'needs' and resource availability have an interactive relationship: definitions of 'minimum' service provision are used to attract resources from funding authorities, but at the same time they are always set with likely resource ceilings in mind. That is why service 'norms' rise over time with economic development.

In addition, the Department of Health (2003b, p30 - 31) emphasises that:

> Quantification is often easier for preventative interventions than for many treatments and easier for primary health care than for (much more complex) hospital care, especially at specialised levels. …. Normative utilisation rates are even more difficult to define, especially curative care, and estimates of 'expected' rates often have to be used based on empirical 'best practice' experience in the country or in comparable countries. Any definition of normative health expenditure is thus relative to place and

> time and is not a completely scientific exercise. …Nevertheless, because of technical complexities, a norms and standards approach may prove less effective in ensuring the adequate and equitable funding of provincial health services than a simpler system of central financial allocation based on relative needs.

Health component of the provincial equitable share

The health component addresses the need for the provinces to deliver primary and secondary health care services, but excludes tertiary or academic health services delivered by provinces because they are mainly funded through conditional grants. The assumption of the equitable share is that all citizens are eligible for health services as such, the provincial share of the total population forms the basis for the health share. Given this proposition, the health component ought to predict demand, such as population distribution, age distribution (older people need more health care), gender (women of child-bearing age are more expensive), HIV (hospitalisation and other costs), and other types of mortality or morbidity.

The formulation of the health component recognises that people without medical aid support are more likely to use public health facilities and are therefore weighted four times more than those with medical aid (National Treasury, 2005c).

Table 6c: Calculation of health component

Thousands	With Medical Aid	Without Medical Aid	Weighted Share (%)
Weighting	*1*	*4*	
Eastern Cape	510	5,793	17.0
Free State	467	2,166	6.5
Gauteng	2,958	4,390	14.7
KwaZulu-Natal	1,103	7,314	21.7
Limpopo	376	4,554	13.3
Mpumalanga	392	2,409	7.2
Northern Cape	175	665	2.0
North West	457	2,897	8.6
Western Cape	1,127	2,830	8.9
Total	**7,566**	**33,018**	**100.0**

National Treasury database 2005.

Table 6c shows the calculation of the health component where people without medical aid are weighted four times more than those with medical aid. This higher weighting of people without medical aid is a clear indication of making provision for the pro-poor spending that could inevitably lead to increasing access and improving equity within

public health care. The distribution of the weight share shows KwaZulu-Natal at 21.7 per cent followed by the Eastern Cape at 17 per cent. The lowest of the total share is in the Northern Cape at 2 per cent. Although the health care funds in the main are distributed through the equitable share health component, an interview respondent from the provincial public health sector is of the opinion that:

> It is not necessary for public health, provincial priorities or the different roles and functions to be fulfilled by the province. This is so because a preponderance of national priorities comes through from central government and that the national Department of Health and the National Treasury determine policy and the funding environment, which finds expression within the President's State of the Nation Address.

The argument goes further that while policies regularise service inputs and outputs to be provided, they do not necessarily address the funding levels required. This is because a majority of public health policies are not costed in terms of Section 35 of the PFMA. The PFMA referring to unfunded mandates states in Section 35 that:

> Draft legislation that assigns an additional function or power or power to, or imposes any other obligation on, a provincial government, must, in a memorandum that must be introduced in Parliament with that legislation, give a projection of the financial implications of that function, power or obligation to the province.

This view is supported by an interview respondent within the public finance sector:

> In almost all instances financial implications for provincial departments, especially those around human resource capacity and additional clinics have not been calculated. However, these are basic services and provinces should provide them.

The mere fact that different policies have not been costed for their financial implications contravenes the PFMA. The researcher is of the view that the contravention of this Act, has in different ways contributed to tensions within the division of revenue and budget programme allocations within and among the central and provincial government departments and treasuries. This practice of non-compliance with the Act to determine appropriate cost drivers and, thereby, the appropriate levels of a programme or policy to be funded have led, according to this study, to inappropriate levels of funding and unfunded mandates. The non-compliance with the policy costing requirements of the PFMA has also contributed to levels of funding that are not commensurate with the real costs of a policy. This has led to a practice of malicious compliance of a province in its funding practice on a policy or programme. As a result, service delivery pressures are

not necessarily addressed at appropriate funding levels or at the levels of norms and standards articulated by the FFC. Another interview respondent from the public health sector argues that:-

> Previous years funding remains the basis for future years and that it is more by serendipity in terms of what provincial health priorities get implemented.

In support of this statement though from a different angle, a public finance sector interview respondent mentioned that

> Only the antiretroviral policy for those infected by HIV was costed in order to indicate provincial-specific obligations.

The study argues that, given that a majority of polices were not costed before implementation by the public health sector, these uncosted policies have contributed to the inability of the central government and the provinces to measure the appropriate levels of funding for a particular policy to be implemented. This situation has also led to a disjuncture between the funding and the implementation of different national policies, given the lack of determining appropriate baseline financing requirements to implement policies. However, questions have been raised by both the health and finance sectors as to whether medical aid or insurance coverage is the appropriate measure to determine the demand of public health funding in the equitable share. As stated above, the formula has benefited previously disadvantaged areas such as Mpumalanga and resulted in significant decreases for the largely urban provinces of Gauteng and the Western Cape. According to Segall (1999), the Western Cape, with the highest per capita expenditure in 1995, spent three times more on a person than Mpumalanga did, but this decreased to 2.5 times in 1996/97 and two times by 1997/98. Public health, as an expenditure component in provincial budgets, is also placed under insurmountable pressures as a result of factors such as those listed below:

a) If the resource base for health is measured against the increasing need, fuelled by increasing patient loads and public expectations, it would in all probability require the expenditure component to be increased;

b) Reduction in the overall national and province-specific disease burden is a strategy which, at best, provides medium-term results;

c) Choice remains with respect to curtailing certain services, largely of a specialised nature in certain provinces because of the principal policy that PHC must be made a priority; and

d) The costs of drugs and specialised medical equipment are mostly influenced by inflation and foreign exchange rates, and costs associated with staffing, the provision of hospital beds and emergency services, controlling certain disease burdens, infrastructure, maintenance, support services and training.

Contesting the equitable share

According to the national Department of Health, any system of devolved health financial allocations must assume that the pot of money from which provincial governments make their health allocations genuinely represents the province's equitable share of the nationally available government finance (Department of Health, 2003b). Furthermore, this department's investigation indicates that the provincial equitable share formula needs to be revisited in a number of respects:

a) It requires an annual adjustment for population growth. Also, the weighting in the formula for medical scheme membership (uninsured people count four times more than those within schemes) is problematic as an indicator of need;

b) The formula does not adjust for the large variation of health services used and cost of different groups or the two sexes;

c) The size of the health component should take into account the higher rate of medical inflation compared to general inflation;

d) "Crowding out" of other social expenditure can occur due to an inaccurate calculation of the need for social security; and

e) The backlog component is calculated on the basis of and infrastructural needs and does not take into account human developmental backlogs.

The Department of Health (2003b: p33) argues strongly that:

> A central allocations system would be the best means to reduce inter-provincial health inequalities, as well as ensure the adequacy of public health finance within the bounds of economic constraints. Within the existing devolved fiscal system, establishment of minimum norms and standards for public health care would set the floor for health services in all parts of the country. However, generating norms and standards, and monitoring provincial compliance with them, would be technically demanding tasks. The provincial equitable share is in need of revision in a number of respects that influence the size and distribution of the health component.

The implementation of a devolved fiscal system has constrained both the central government health department and the combined public health sector's decision-making capabilities in the budgeting process of the provinces. Although norms and standards seem to be cited as the means to maintain both the central government's health department and the health sector's control and influence on allocative decisions, determination of these norms and standards has, by the health sector's own acknowledgement, been more complex. However, it is clear that because of the different dynamics in the provincial budgeting process, including the policy creep effect of the central government within the provincial processes, the final fiscal resources allocations are quite contested. Nevertheless, the researcher is of the view that a central allocation process would, in effect, constrain resource allocation decision making at a provincial level and could inversely correlate to the public health needs in a province; and could also adversely affect the gains made in improving access, equity and quality. Moreover, such a central allocation process would undermine the constitutional and legislation-based provincial decision-making mandate, rendering the provinces the administrative implementers of nationally determined programmes with limited decision-making powers.

Annually, through the provincial equitable share baseline allocations, upward adjustments are made that consider: expenditure trends within the public health sector as a direct outcome of a growing demand for a particular service; the introduction of new policies, priorities and programmes; and the possibly growing fiscal resources within the national fiscus. The adjustments to provincial baseline allocations are communicated to provinces through annual allocation letters. The new amounts are included in the equitable share or vertical division to provinces. The determination of the resource allocation is also linked to both national policies and priorities. With reference to the

allocation letter processes, an interview respondent from the provincial public finance sector during August 2004 mentions unequivocally that:

> No, we [provincial treasuries] don't make our own [budgetary] decisions. We make our own decision at the margins. In the allocation letter they [central government and specifically, National Treasury with the line department] have decided on what ought to be funded. We [provinces] are administrators.

This form of equitable share allocation, especially taking the content of the allocation letter into consideration constrains the provincial government to execute its budgetary responsibilities through treasuries. While the fiscal tension exists between the central government's and the provincial governments' treasuries, this study contends that it has fostered during the budgetary processes an alliance between the provincial treasuries and health departments against the central government. The top-down nature of the unconditional allocation, the study contends has adversely affected the provincial budgetary processes to the extent where claims are made by well-resourced provinces such as Gauteng and Western Cape Provinces that the equitable share allocation is ignorant to province-specific service-delivery needs. Put differently, allocation ignores the principles of allocative efficiency which is built a central pillar of a fiscal decentralization system where provinces are responsible for implementation of policies and jointly-agreed priorities matched with what gets determined by the provinces. This fiscal policy practice shows that by implication that the provinces have the right to make a claim that they cannot be held accountable for the management of financial inputs.

The logical outcome of these allocation letters is that the provinces use the equitable share percentage allocation in terms of the component to make relevant allocations to specific departments to budget for a policy priority. The allocation letter, by implication, not only regulates the budgetary allocation process within the province, but also becomes the invisible hand in resource allocation. Given the institutional autonomy of the provinces, should the resource allocation letters indicate amounts allocated in the provincial equitable share to fund national policies? Interview respondents from the different sectors and provinces argued differently about this matter. For example, an interviewee from the public health sector comments that "the equitable share is a conditional grant in disguise". On the other hand, within the same province, a respondent from the public finance sector argued that the "additional allocation to provinces should

cover all national policies to be funded by the province as stated in the National Treasury allocation letter and more".

The two responses on the resource allocation process shows that depending on the institutional and service delivery capacity of provinces and requisite resource requirements relative to provincial needs, differences about the rationale behind both the equitable share and allocation letter do exist between provincial treasuries. On the one hand, it seems that certain provinces prefer an allocation letter from central government which 'effectively predetermines' the allocation and distribution process in provinces. This practice obviously helps the province to ensure overall stability in the budgeting process relative to nationally determined policies and priorities and that the annual allocations to different sectors are thus marginal and concurrent to what is determined by the central government. This researcher is of the view that the utilisation of the allocation letter from National Treasury in the funds-distribution process in provinces gives the provincial treasuries evidence and an element of mitigation with its provincial counterparts if and when any tensions arise with regard to the funding allocation. The researcher is also of the view that the allocation letter also helps to create a level of provincial concerns contributing to a provincial government alliance against the national process of the division of revenue shares. The alliance is especially formed because of a collective provincial view that the division of revenue between the levels of government and the fiscal resource allocation per province do not comprehensively look at the service-delivery obligations and public policy pressures on the provincial governments.

This form of alliance, the researcher contends, which is an outcome of the public resource allocation process has the potential to turn in to a collusion by either the provinces or the public service sectors against the National Treasury. The National Treasury is technical responsible for the macroeconomic and fiscal policy of the central government. On the other hand, provinces with better developed institutional and service delivery capabilities want to have greater decision-making authority on the allocation so as to determine how national priorities, policies and programmes fit with the province-specific priorities, policies and programmes, instead of the fit being the other way round.

The strong and supervisory role of the National Treasury is apparent in its determination of policy priorities and assumptions underpinning provincial budgets. Over and above

the regular intergovernmental forums held between the central and provincial treasuries, the National Treasury also convenes annual benchmark bilateral meetings with each provincial treasury. It is within these forums that the provincial budgets are assessed by the National Treasury. The National Treasury, in consultation with the provincial Treasuries, determine in these forums the extent to which provincial treasuries give effect to national priorities and how provincial treasuries take assumptions about personnel growth rates and inflationary adjustments into account. It is during these forums where the level of fiscal resourcing of different functional competencies and new policy programmes such as, public health policies and programmes gets confirmed. It is also in these forums where pressure of both a technical and political nature is place on provincial treasuries by the National to do adjustments to their allocation in order to adequately address national policy priorities. The outcome of this process potentially has an impact on the implementation of public policies given that in most cases these adjustments or shifting of funds occur within the resource envelop as per the allocation letter. As such, this process of adjustment or shifting of funds within the allocated resources, and the full or partial implementation of a particular public health policy, might be constrained by the fiscal policies of the central government. Moreover, the National Treasury mentions with specific reference to the equitable share (National Treasury2005d:p3) that the policy adjustments are for the "provision of anti-retroviral treatment, the impact of HIV and Aids on the health system, primary health care in non-metropolitan municipalities and a special salary dispensation to recruit and retain health professionals with scarce skills". This practice is essentially about what gets funded, which is could lead to unfunded mandates.

The National Treasury (2005d:p2-3) acknowledges in its *Preliminary Observations on the 2005 Provincial Budgets* that annual changes to the equitable share allocations are based on a number of factors. Although the adjustment is indicative of the influences into the equitable share allocation, it is also tantamount to a 'pre-emptive determination' of the wage budget of the provinces, thus removing all autonomy from provinces to determine salaries and the types of annual increases. According to the National Treasury's (2005g) *Preliminary Observations on the 2005 Provincial Budgets on the Equitable Share Adjustments*:

- General inflation of 5.1 per cent for 2005/06 and 2006/07, and 5.0 per cent in 2007/08;
- Salary increase of 5.5 per cent for 2005/06, 5.5 per cent for 2006/07 and 5 per cent for 2007/08 effective from 1 July of the year in which the budget is tabled;
- Provision of pay progression of approximately 1 per cent of the wage bill;
- Phased approach to extend the non-pensionable housing allowance to R403,00 by 2009;
- Reduction of employers' contribution to the Government Employment Pensions Fund (GEPF) from 15 per cent to 12 per cent; and
- Surpluses arising from this reduction to be used to fund additional personnel costs, arising from the 2004 three-year wage agreement.

The regulatory effect of the resource allocation letter, including the Medium-Term Expenditure Framework (MTEF) allocations and annual baseline adjustments to the equitable share allow for provincial funding distribution among health programmes, as long it does not compromise the financing of national priorities. During the process of resource allocation, the provinces make priority funding choices within programmes. This practice of provinces maneuvering within their financial decision-making space further constrains the autonomy as it has no say or insight into total revenue and the division of revenue.

The Division of Revenue – The Vertical Division Policy Practice

The division of revenue consists of the distribution of funds among the central, provincial and local governments. The provincial allocation comprises equitable share allocations, conditional grants, and specially earmarked funds. The 1997 MTEF (Department of Finance, 1997a) provides the overall MTEF for all three spheres of government. The MTEF, shown in Table 6d below, indicates both actual expenditure and estimated expenditure and budget outcomes over a ten-year fiscal period since the introduction of the equitable share in 1997/08 to the outer years ending in 2007/08. In addition Table 6a provides further data on:

a) Specific allocations for national [central], provincial and local governments; b) The debt service costs of government, which annually serve as the first call to the

national revenue fund; c) The percentages of shared total allocations, i.e. the percentage share of the amounts to the total allocation for the different spheres; and d) The actual expenditure for the years before 2004/05, revised estimates for 2004/05, which refers to a revision of the original allocation for that year, and medium-term estimates from 2005/06 to 2007/08.

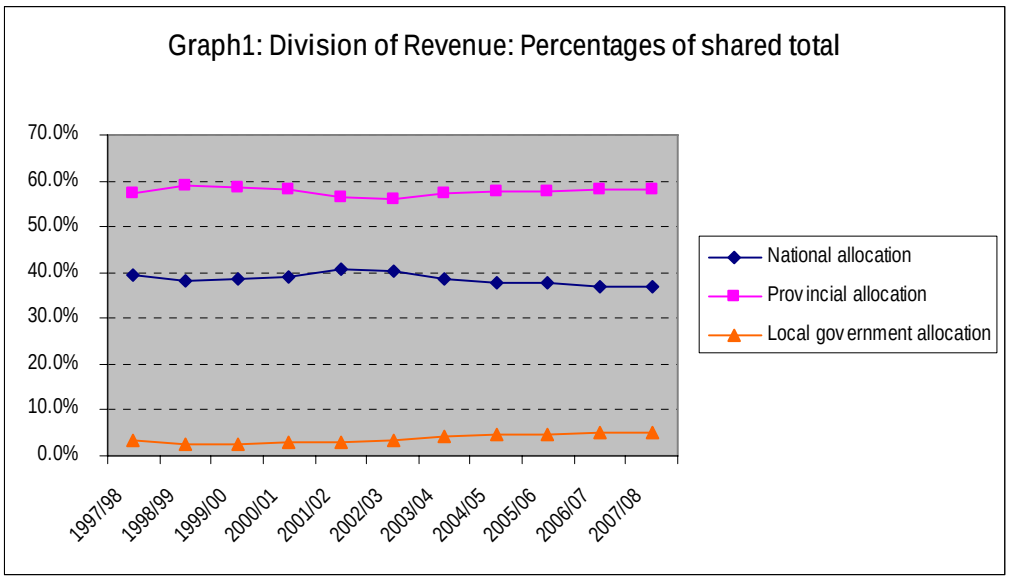
The MTEF and the division of revenue, as shown in Table 6d, indicate that the consolidated government expenditure for all three spheres of government was R151billion in 1997/98. The MTEF increased by an annual average of R27,6billion from its 1997/98 level to an estimated total expenditure of R427,5billion in 2007/08. From the end of the 2000/01 fiscal year adjustments on the years going forward are above R27billion on the total annual expenditure, which range from R27,7billion in 2000/01; R29,3billion in 2002/03; to R37,6 billion in 2003/04; R38,8 billion in 2004/05; R41,4 billion in 2005/06, which is the highest over the period; with declines in annual additions to R33 billion in 2006/07, declining further to R31,7 billion in 2007/08.

Table 6d: Medium term expenditure framework and division of revenue

R million	1997/98 Actual	1998/99 Actual	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Actual	2003/04 Actual	2004/05 Revised Estimate	2005/06 Medium term estimates	2006/07	2007/08
National allocation	59,780	60,912	65,715	73,142	87,705	99,091	108,459	121,101	136,262	146,800	157,817
Provincial allocation	86,538	93,457	99,263	108,904	121,099	136,873	161,494	185,354	209,273	229,282	248,236
of which											
Equitable Share	*81,883*	*84,342*	*89,095*	*98,398*	*81,670*	*93,827*	*110,004*	*122,426*	*134,706*	*146,757*	*157,678*
Conditional Grants	*4,655*	*9,115*	*10,168*	*10,506*	*39,429*	*43,046*	*51,490*	*62,928*	*74,567*	*82,525*	*90,558*
Local government allocation	4,811	4,377	4,627	5,576	6,520	8,759	12,396	14,757	17,159	19,708	21,461
Allocated expenditure	151,128	158,747	169,605	187,621	215,324	244,722	282,349	321,212	362,694	395,789	427,513
Plus:											
Debt service cost	38,819	42,669	44,290	46,321	47,581	46,808	46,313	48,901	53,125	56,603	59,381
Contingency reserve	–	–	–	–	–	–	–	–	2,000	4,000	8,000
Total expenditure	189,946	201,416	213,895	233,942	262,904	291,530	328,662	370,113	417,819	456,392	494,894
Percentages of shared total	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*
National allocation	*39.6%*	*38.4%*	*38.7%*	*39.0%*	*40.7%*	*40.5%*	*38.4%*	*37.7%*	*37.6%*	*37.1%*	*36.9%*
Provincial allocation	*57.3%*	*58.9%*	*58.5%*	*58.0%*	*56.2%*	*55.9%*	*57.2%*	*57.7%*	*57.7%*	*57.9%*	*58.1%*
Local government allocation	3.2%	2.8%	2.7%	3.0%	3.0%	3.6%	4.4%	4.6%	4.7%	5.0%	5.0%

National Treasury databases.

Graph 1 indicates that the central government share declined slightly from 39.6 per cent in 1997/98 to 39 per cent in 2000/01. This is over a three-year period according to the MTEF.



However, over this period, the central government share grew by 1.6 per cent and 1.4 per cent from its 2000/01 share to 40.6 per cent in 2001/02 and 40.4 per cent in 2002/03 respectively. While the central government share increased for these two years, the provincial share declined from about 58 per cent in the years 1998/99, 1999/00 and 2000/01 by 1.7 per cent to 56.3 per cent in 2001/02 and by 2.0 per cent in 2002/03 from a 58 per cent in 2000/01. This decline comparatively meant an additional allocation for the central government to fulfil its responsibility, which grewing from R73,1 billion in 2000/01 to R87, 3 billion in 2001/02 and to R98,7 billion in 2002/03.

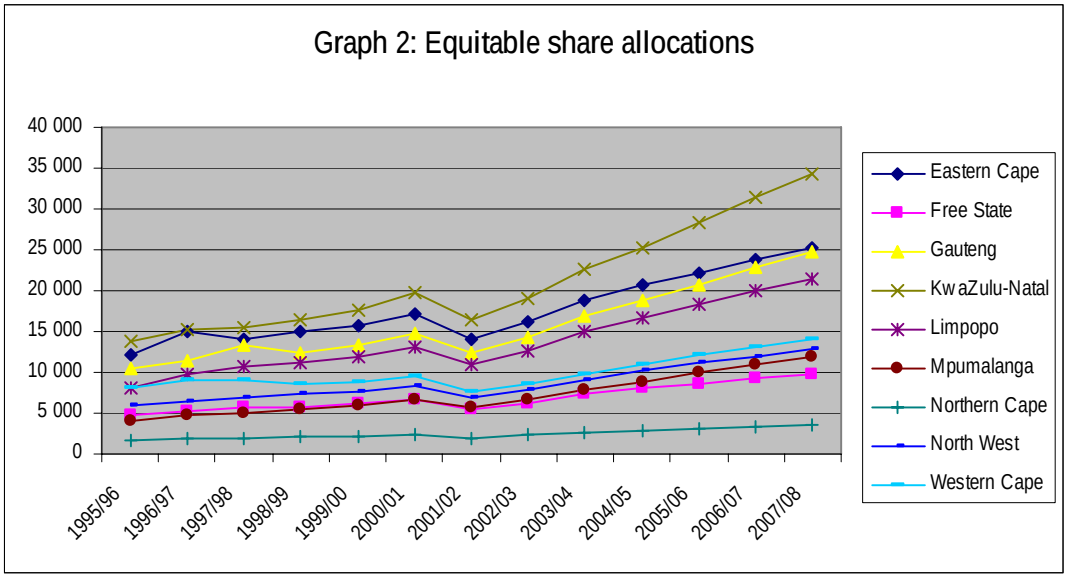
Graph 1 shows an increase of 1.6 per cent in percentage share of the provincial allocation between 1997/98 and 1998/99. The provincial allocation declined, however, from 1998/99 to 2001/02. This share declined by 0.4 per cent in 1998/99 to 1999/2000, by 0.5 per cent in 2000/01, by 1.7 per cent in 2001/02, and by about 0.3 per cent in 2002/03. Over the next three years ending in 2004/05 it gained 0.2 per cent (2003/04); 0.4 per cent (2004/05) and 0.6 per cent (2005/06) as a percentage of the consolidated budgets of the central, provincial and local governments.

The local government share of the division of revenue remained relatively flat, moving from a 3.2 per cent in 1997/98 and ending at 3.6 per cent in 2002/03. Over the period ending in 2005/06 the local government share increased by 0.7 per cent in 2003/04 and 2004/05 respectively, and by 0.8 per cent in 2005/06 from the 3.6 per cent in 2002/03. The division of revenue shares for the provincial governments remained above the 56 per cent mark, while the central government share flattened out at 39 per cent in 2005/06.

The consolidated provincial equitable share allocation introduced in 1997/98 shows that fiscal resource allocation grew from an initial R81, 8 billion to around R98, 3 billion in 2001/02. This is an increase of about R16, 5 billion over that period. The equitable share allocation declined by R11, 6 billion during 2001/02 to its 1997/98 level of R81.6 billion. This decline in the equitable share allocation had an equivalent impact on the overall specific equitable allocations in all the provinces, with drops occurring between 2000/01 and 2001/02.

The provincial equitable share (PES) allocation increased in nominal terms from its 2001/02 allocation by R12, 1 billion to R93, 8 billion in 2002/03. Although inconsistent, there are sharp nominal increases in the overall PES allocation for the next years ending in 2007/08. Increases to the PES were around R16,1billion, moving the allocation to R110billion in 2003/04; a further R12,4billion increasing the allocation to R122billion in 2004/05; approximately R12,2billion in 2005/06 increasing the allocation to R135 billion with a further increase of R12billion taking the provincial equitable share to around R147billion in 2006/07. However, at the end of the financial year 2007/08 the annual increase in provincial equitable share allocation is expected to decline to an estimated R10,9 billion reaching an overall estimated provincial equitable share allocation of approximately R158 billion.

Graph 2 below shows the equitable share allocation for each province and the corresponding growth levels. The line graph indicates a similar growth trajectory for each province, similar to the overall consolidated provincial equitable share growth pattern. The line graph also shows the lion’s share of the provincial equitable share allocation going towards the Eastern Cape, Gauteng, KwaZulu-Natal, Limpopo and Western Cape.



The accelerated upward increases in the Eastern Cape, KwaZulu-Natal and Limpopo provinces, as opposed to the two most urbanised provinces of Gauteng and Western Cape, are a direct outcome of the redistributive bias of the PES towards the more poor and rural provinces. In the South African context, the poorer and rural provinces are considered to be the provinces of the Eastern Cape, Free State, Limpopo, Mpumalanga, Northern Cape and North West. The National Treasury (2003b:16) observed that a "negative bias" exists towards urban provinces such as Gauteng, KwaZulu-Natal and the Western Cape, and charges that:

> The bias towards the more poorer and rural provinces ranges from 0.1 per cent in KwaZulu-Natal to 4.4 per cent in Gauteng. It should be noted that the provinces with a negative bias are provinces that gain substantially from conditional grants, especially in health. This trend, however, is coincidental and was not anticipated at the time when the equitable share formula was crafted.

Clearly, the overall equitable share formula considers poverty levels, demand for specific services, expenditure pressures on particular services, infrastructural backlogs, and the cost of running administrations. The outcome of the formula is also mostly biased towards rural and poor provinces. However, the equitable share allocation increases in Gauteng and Western Cape can be ascribed to increasing population numbers as a result of inward migration within South Africa; that is, the movement of people across provinces. These provinces are historically better resourced, from the perspective of both a fiscal capabilities and overall social and physical infrastructure.

Role of conditional grants as a funding mechanism for public health

Although conditional grants were formally introduced within the South African budget process and public finance system in the 1998/99 financial year, a policy framework on conditional grants was introduced only in 2001. This *Policy Framework on Conditional Grants* (National Treasury, 2001c) confirmed that conditional grants were introduced to meet pressing needs and ensure that the oversight role of central government departments in policy areas is shared concurrently with provinces. The policy states more specifically that conditional grants have been used to generally realise national policy objectives involving access and improving provision of the norms and standard of government services; compensate provinces for inter-jurisdictional spillovers resulting from services provided by certain provinces; effect transition within the service delivery systems, administration and other institutional arrangements having an adverse impact on the realisation of norms and standards; and address backlogs and both inter and intra-provincial disparities. A direct challenge to this has been the response from the Department of Health (2003:p38) noting that

> The use of the conditional grant is intended to maintain central control on certain allocation decisions and can effect some change in health resource distribution. However, the grants only account for 20% of expenditure, and are complex to manage and monitor. They apply a useful plaster to the wound of resource inequity but do not heal it.

The Department of Finance, however, maintains in its *1997 Summary of Sectoral Team Report: Health* that conditional grants were proposed in recognition of the national referral and medical training functions provided by provinces (Department of Finance, 1997b). It further argues that the conditional grant will go to the provinces from the national revenue share, but will initially be created out of the conditional grant amounts set aside in the allocation to provinces. More specifically, according to the Department of Finance, the main aims of the conditional grants are to stabilise the funding of these services so that realistic budgets are possible; ensure that services that are of benefit beyond the boundaries of provinces are sufficiently funded to provide an agreed minimum level of service; and enable national planning and co-ordination of the CHS and thereby facilitate the transformation of the health system as envisaged by the *White Paper for the Transformation of the Health System in South Africa Transformation* (Department of Health, 1997).

The Department of Finance (1997c:p61) insists that the conditional grants cover three elements:

a) Health professional training and research – this grant will compensate provinces for additional costs associated with training professionals.

b) CHS – this grant will compensate provinces which provide tertiary level care and other referral services to patients originating from provinces; the grant will initially be calculated as 75 per cent of the budgets of the central hospitals and will reduce over the period of the MTEF in line with the intended rationalisation of tertiary services.

c) Redistribution of tertiary services – this element of the grant will facilitate the redistribution of tertiary services to other provinces; the total allocation for tertiary services will not be increased but will more equitably spread throughout the country.

Table 6e shows the number of conditional grants and trends between 2000/01 to 2007/08 within the public health sector. The total expenditure on health conditional grants range from R5billion in 2000/01 to R9,4billion in 2006/07. As shown in Table 6e the largest conditional grant is National Tertiary Services Grant (NTSG), which grew from R3,3billion in 2000/01 to close to R5billion in 2006/07. The NTSG, which funds tertiary care services, is focused on supporting reforms within the tertiary health care within hospitals and it is designed (National Treasury, 2003b:p92):

> …to replace the Central Hospitals, Redistribution of Specialised Services and part of the Health Professionals Training and Research grants. … The first phase of the grant reform was based on actual expenditures in the designated units. The second reform phase, known as the Modernization of Tertiary Services, focuses on a future desirable pattern of tertiary services and will more explicitly link service outputs to funding.

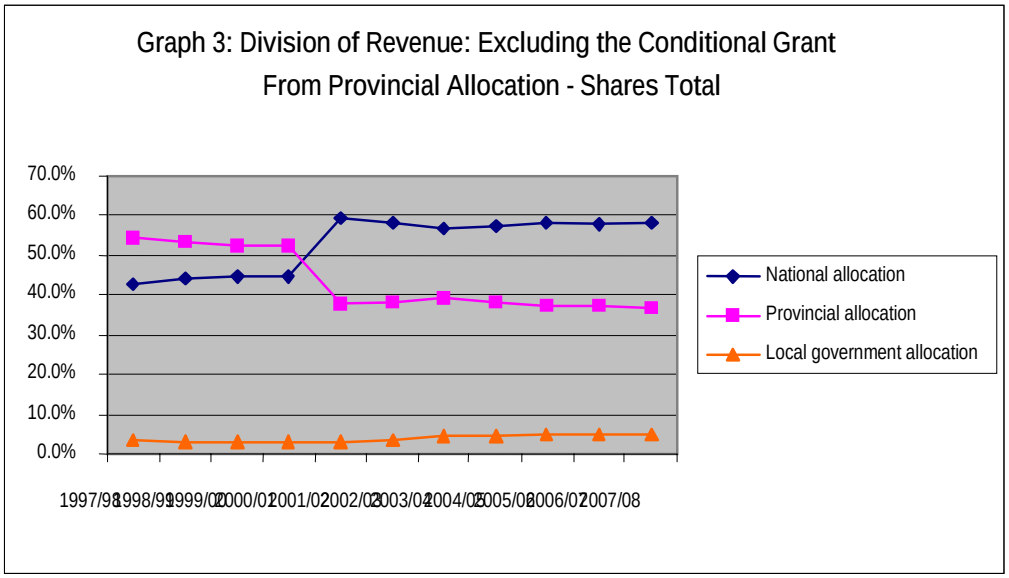
Table 6e: Trends in health conditional grants, 2000/01 to 2007/08

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
		Actuals			Prelim.	Medium-term estimates		
R million								
National tertiary services grant	3,319	3,451	4,285	4,209	4,214	4,709	4,981	5,221
Comprehensive HIV and Aids grant	10	37	288	402	770	1,135	1,567	1,646
Hospital revitalisation grant	323	563	702	567	680	1,027	1,180	1,239
Integrated nutrition programme grant[1]	64	59	77	100	97	123	–	–
Hospital management and quality improvement grant	–	120	114	113	135	150	159	167
Hospital construction grant	169	348	70	168	–	–	–	–
Health professions training and development grant	1,174	1,222	1,315	1,321	1,381	1,520	1,520	1,596
Medico-Legal	–	–	–	1	–	–	–	–
Other	-0	8	147	-0	18	-0	–	0
Total health conditional grants	**5,060**	**5,809**	**6,998**	**6,880**	**7,294**	**8,666**	**9,408**	**9,870**

1. Includes the primary school nutrition programme.
2. Information not available prior to 2000/01.
Source: National Treasury databases.

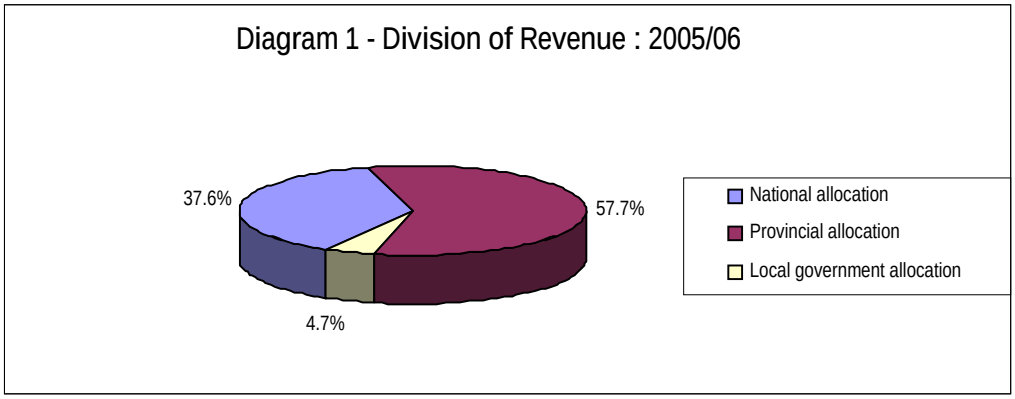
The Health Professions Training and Development Grant not only finances but also facilitates the redistribution of medical specialists (National Treasury, 2003b:p93). The exponential growth in expenditure on this grant has resulted, according to the National Treasury (2003b), in a widespread roll-out of several aspects of the central government's comprehensive response to HIV and Aids, leading to treatment programmes being initiated in all 53 districts in 2004, with around 42 367 persons on treatment before December 2004. While the grants on tertiary care and specialist trainers have significantly augmented provincial expenditure on hospital services – that is central and PHS programmes – the HIV and Aids grant, which grew at a rapid rate following from 2001/02, led to a substantial augmentation of provincial HIV and Aids spending within the district health service programme (see discussion later on provinces in chapter 7). What is clear from the consolidated expenditure on conditional grants is that the respective conditional grants have not only augmented provincial expenditure in the different programmes, but also served as a leverage for central government interventions as a means to assure that national policy priorities are financed and implemented by provinces.

The *2005 Intergovernmental Fiscal Review* (National Treasury, 2005c) shows that problems experienced since the introduction of the conditional grant include confusion over accountability, poor design and planning, inadequate transparency in the allocations, poor monitoring and a proliferation of small grants into the system. Conditional grants are also provided to provinces with specific conditions that regulate expenditure, the type of services to be supported, public finance administration regulations and the required processes of monitoring and supervision of programmes by the specific central government line department. Graph 3 provides a different outcome of the division of revenue if the conditional grant is calculated as part of the national allocation. Graph 3 also shows the fiscal gap between the national and provincial allocations.

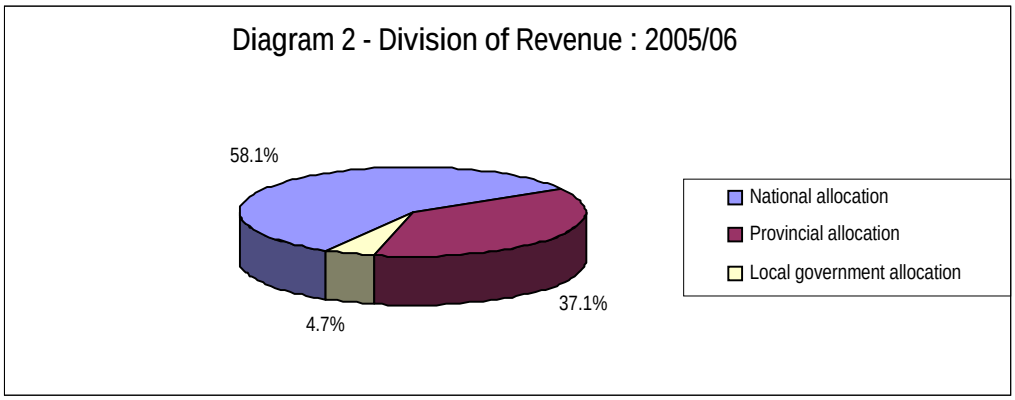


Graphs 3 shows that the national allocation controlled by the central government grows consistently from 1997/8 to 2007/08 as a share of total government expenditure. Provincial allocation declines over the period with increases only in the last three financial years of the 10-year period. However, when the conditional grant is removed as part of the provincial allocation, the provincial allocation drops significantly as a share of total consolidated government budgets. The sharp decline happens from above 50 per cent between 1997/8 and 2000/01 to below 40 per cent from 2001/02 to 2007/8. The significance of the decline, as shown in Graph 3, is that the provincial share drops from 52.4 in 2000/01 to between 37 per cent and 39 per cent, with the lowest percentage of 36.9 per cent in 2007/08.

Conversely, the national allocation share of the central government grows rapidly from slightly below 45 per cent between 1997/8 and 2000/01 with 44.6 per cent in 2000/01. It is from 2000/01 to 2007/8 that the national share grows exponentially to above 56 per cent, 59 per cent in 2001/02, 58.1 per cent in 2002/03, 56.6 per cent (2003/04), 57.3 (2004/05), 58.1 per cent (2005/06), 57.9 per cent (2006/07), and 58.1 per cent in 2007/08. This significant increase in the central government allocation share relative to provinces is symptomatic of the relative strength of central government. The pie – Diagram 1 below shows that for 2005/06 the provincial share was at 57.7 per cent and the national allocation at 37.6 per cent. This distribution includes the conditional grant funding as part of the provincial share.



Contrary to this lion's share that provinces have in total budgets during 2005/06 financial year, Diagram 2 below shows that for the same year with the conditional grant included in the national allocation as opposed to it being part of the provincial share, that the provincial share shrinks to 37.1 per cent, while the national allocation grows to 58.1 per cent.



Provincial and National Public Health Expenditure

Table 6f shows total public health expenditure consisting of central and provincial government budgets. Overall, public health budgets – that is, for central and provincial governments – amounts to R22,4 billion in 1997/98, growing to R24,1 billion in 2000/01, an annual average growth rate of 4.9 per cent. The overall expenditure grow rapidly to an annual average of 12.5 per cent between 2000/01 to 2003/04, increasing effectively from R24,1 billion to R36,9 billion – growth of R12,8 billion. While this growth shows consolidated public health expenditure, at a provincial level public health expenditure was at an annual average of 12, 5 per cent between 2000/01 and 2003/04. Annual year-on-year average percentage expenditure was in particular at

a relatively low percentage of 9. 1. Table 6f further shows that the percentage growth of consolidated central and provincial government public expenditure between 1996/97 and 2004/05 was at an annual average of 8.8 per cent. All provinces, except the Eastern Cape, at 6.8 per cent, were above the 8 per cent mark.

This below annual average expenditure in the Eastern Cape is similar as in the province's expenditure as a percentage of the total public health budget. The total public health expenditure in this province as seen in Table 6f declined from 14.4 per cent in 1996/97 to 13.2 per cent in 1997/98 and with further declines to 10.8 per cent (1998/99), 11.7 per cent (1999/00), 11.5 per cent (2000/01), 10.7 per cent (2001/02), 11.0 per cent (2002/03 and 2004/05) and 11.4 per cent (2003/04). Notwithstanding this decline in the Eastern Cape health expenditure, all provincial budgets over the same period show a moderate decline in provincial expenditure. The sharp growth in provincial budgets from R20, 6 billion in 1996/97 to R22, 4 billion in 1997/98 was largely due to the wage negotiations of 1996 and rank and leg promotions of public health personnel.

The national share of the consolidated central and provincial government public health expenditure increased by R5,4 billion from R656million in 1996/97 to R6,1 billion in 2000/01, at an annual average growth of 128.9 per cent. The expenditure of the national share grew further by R1, 5 billion from 2000/01 to 2003/04 at an annual average of 7.6 per cent. Table 6f shows that between 2003/04 and 2004/05, the year on year expenditure grew by an annual average of 14.5 per cent. This sharp upward growth in the national share of consolidated public health expenditure amount to 38.2 per cent annual average growth over a nine-years period. The central government public health expenditure share at 19.5 per cent in 1999/2000 and 19.2 per cent in 2000/01 is as a percentage share more than all provinces. The closest to this level of percentage share is Gauteng at 18.7 per cent in 1999/2000 and 18.4 in 2000/01.

Table 6f shows that from 1998/99 to 2004/05 Gauteng, KwaZulu-Natal and the central government expenditure together amounts to more than 50 per cent of total budgets. The level of expenditure in the Gauteng and KwaZulu-Natal provinces seems to be not only in line with demographic and socio-economic trends, but also in KwaZulu-Natal as a result of redress and access. In Gauteng expenditure also included possible financing of interjurisdiction spillovers resulting from tertiary health care services.

The growing budget of the central government indicates a consistent expansion of central government fiscal leverage within consolidated public health budgets. A comparison of total consolidated expenditure during 1999/00 and 2000/01 for the provinces of Mpumalanga, Northern Cape, North West and Western Cape is less than the central government health budget of R230million and R363million respectively for these two financial years. Contrary to this trend of year-on-year higher expenditure in Gauteng and KwaZulu-Natal, the average annual percentage growth in the central and provincial government budgets shows expenditure to be below the national annual average in most provinces except Eastern Cape, KwaZulu-Natal, Limpopo, KwaZulu-Natal, Northern Cape and Western Cape. Public health expenditure was particularly far below the national annual average of 4.9 per cent between 1997/98 and 2000/01 in Free Sate at 1.7 per cent, Gauteng at 3.6 per cent, Mpumalanga at 1.3 per cent, and North West at 3.6 per cent.

Table 6f: Provincial and national health expenditure, 1996/97 to 2004/05[1]

R million	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05 Main appropria	2004/05 Prelim. outcome
				Actuals						
Eastern Cape	3,066	3,031	3,048	3,496	3,699	3,808	4,374	5,090	5,410	5,173
Free State	1,470	1,659	1,692	1,589	1,743	1,927	2,165	2,503	2,731	2,797
Gauteng	4,643	5,299	5,478	5,605	5,900	6,792	7,625	8,129	8,731	8,597
KwaZulu-Natal	4,234	4,806	4,900	5,110	5,662	6,913	7,392	8,042	8,767	8,950
Limpopo	1,999	1,954	2,081	2,221	2,431	2,596	3,062	3,627	3,976	4,196
Mpumalanga	817	1,047	1,058	1,147	1,087	1,425	1,652	1,953	2,302	2,263
Northern Cape	330	376	392	433	459	509	599	817	815	832
North West	1,276	1,375	1,342	1,384	1,528	1,675	1,973	2,207	2,599	2,595
Western Cape[2]	2,780	2,937	3,032	3,125	3,444	3,703	3,951	4,547	4,937	5,172
Total provincial	**20,616**	**22,483**	**23,025**	**24,110**	**25,953**	**29,347**	**32,794**	**36,916**	**40,268**	**40,575**
National	**656**	**513**	**5,119**	**5,859**	**6,155**	**6,224**	**7,059**	**7,672**	**8,788**	**8,715**
Total	**21,272**	**22,996**	**28,144**	**29,969**	**32,108**	**35,571**	**39,853**	**44,588**	**49,055**	**49,289**
Percentage of total health expenditure										
Eastern Cape	14.4%	13.2%	10.8%	11.7%	11.5%	10.7%	11.0%	11.4%	11.0%	10.5%
Free State	6.9%	7.2%	6.0%	5.3%	5.4%	5.4%	5.4%	5.6%	5.6%	5.7%
Gauteng	21.8%	23.0%	19.5%	18.7%	18.4%	19.1%	19.1%	18.2%	17.8%	17.4%
KwaZulu-Natal	19.9%	20.9%	17.4%	17.1%	17.6%	19.4%	18.5%	18.0%	17.9%	18.2%
Limpopo	9.4%	8.5%	7.4%	7.4%	7.6%	7.3%	7.7%	8.1%	8.1%	8.5%
Mpumalanga	3.8%	4.6%	3.8%	3.8%	3.4%	4.0%	4.1%	4.4%	4.7%	4.6%
Northern Cape	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%	1.5%	1.8%	1.7%	1.7%
North West	6.0%	6.0%	4.8%	4.6%	4.8%	4.7%	5.0%	4.9%	5.3%	5.3%
Western Cape[2]	13.1%	12.8%	10.8%	10.4%	10.7%	10.4%	9.9%	10.2%	10.1%	10.5%
National	3.1%	2.2%	18.2%	19.5%	19.2%	17.5%	17.7%	17.2%	17.9%	17.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Percentage growth (average annual)	**1997/98 – 2000/01**	**2000/01 – 2003/04**	**2003/04 – 2004/05**	**1996/97 – 2004/05**
Eastern Cape	6.9%	11.2%	6.3%	6.8%
Free State	1.7%	12.8%	9.1%	8.4%
Gauteng	3.6%	11.3%	7.4%	8.0%
KwaZulu-Natal	5.6%	12.4%	9.0%	9.8%
Limpopo	7.6%	14.3%	9.6%	9.7%
Mpumalanga	1.3%	21.6%	17.9%	13.6%
Northern Cape	6.9%	21.2%	-0.2%	12.2%
North West	3.6%	13.0%	17.7%	9.3%
Western Cape	5.5%	9.7%	8.6%	8.1%
Total provincial	**4.9%**	**12.5%**	**9.1%**	**8.8%**
National	**128.9%**	**7.6%**	**14.5%**	**38.2%**
Total	**11.8%**	**11.6%**	**10.0%**	**11.1%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Includes capital works in respect of health voted on public works.
Source: National Treasury databases.

Consolidated expenditure grew rapidly between 2000/01 and 2003/04 with most provinces except Eastern Cape (11.2 per cent), Gauteng (11.3 per cent), and KwaZulu-Natal (12.4 per cent) and Western Cape (9.7 per cent) below the annual average of 12.5 per cent. Table 6f shows a rapid increase in annual average percentage growth between 1997/98 and 2000/01 and 2000/01 and 2003/04 in all provinces, with the highest at 14.3 per cent in Limpopo, 21.6 per cent in Mpumalanga, and 21.2 per cent in Northern Cape. The year on year expenditure between 2003/04 and 2004/05 shows the majority of provinces below the average of 9.1 per cent, with disturbing expenditure trends of minus 0.2 per cent in the Northern Cape. See later discussion on this province for analysis of expenditure level IN Chapter 7.

Gross Domestic Product and Real Expenditure of Public Health

According to Table 6g overall provincial public health expenditure as a percentage of gross domestic product (GDP) ranged from 0.1 per cent in both Mpumalanga and Northern Cape in 1996/97 to 0.8 per cent in Gauteng. Provincial health expenditure to GDP remained relatively stable for all provinces, with fluctuations of 0.1 per cent. Expenditure in Northern Cape was particularly low at 0.0 per cent to GDP in 2000/01 and 2001/02.

Table 6g: Provincial and national health expenditure as percentage of Gross Domestic Product (GDP), 1996/97 to 2007/08

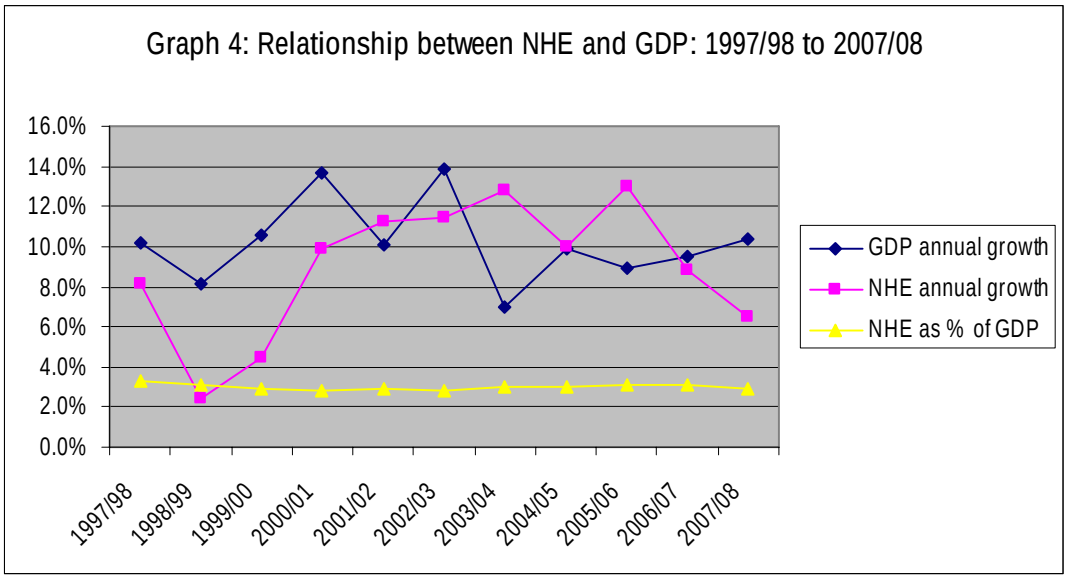
	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
					Actuals						MTEF	
Percentage												
Eastern Cape	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Free State	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Gauteng	0.7%	0.8%	0.7%	0.7%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
KwaZulu-Natal	0.7%	0.7%	0.6%	0.6%	0.6%	0.7%	0.6%	0.6%	0.6%	0.7%	0.7%	0.7%
Limpopo	0.3%	0.3%	0.3%	0.3%	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Mpumalanga	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%
Northern Cape	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
North West	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Western Cape	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%
Total provincial	**3.2%**	**3.2%**	**3.0%**	**2.9%**	**2.7%**	**2.8%**	**2.7%**	**2.9%**	**2.9%**	**3.0%**	**3.0%**	**2.9%**
National	**0.1%**	**0.1%**	**0.7%**	**0.7%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**
Total	**3.3%**	**3.3%**	**3.7%**	**3.6%**	**3.4%**	**3.4%**	**3.3%**	**3.5%**	**3.5%**	**3.6%**	**3.6%**	**3.5%**

Source: National Treasury databases.

Although the Eastern Cape expenditure declined from 0.5 per cent in 1996/97 to 0.4 per cent in 1997/98, it remained flat at 0.4 per cent as a percentage of GDP to and including 2004/05. Both Gauteng Province and KwaZulu-Natal had comparatively to other provinces, a greater percentage growth to GDP. From a 0.8 per cent in 1997/98 expenditure in Gauteng Province dropped to 0.7

per cent in 1998/99 and 1999/2000. It further declined to but remained at 0.6 per cent from 2000/01 to 2004/05. Expenditure in KwaZulu-Natal is at 0.7 per cent in 1997/98, but declined to 0.6 of GDP for the next three years. While there was a 0.1 percentage growth from 0.6 per cent in 2000/01 to 0.7 per cent in 2001/02, the percentage growth declined back to the level of 0.6 per cent of GDP.

Total public health expenditure was at 3.3 per cent for 1996/97 and 1997/98 as a percentage of the gross domestic product (GDP), declining slightly by 0.1 per cent to 3.6 per cent in 1999/2000. It further declined by 0.2 per cent to levels of 3.4 per cent of GDP for 2000/01 and 2001/02 respectively and gained ground in 2003/04 and 2004/05 to levels of 3.5 per cent of GDP. Clearly, the total public health expenditure as a percentage to GDP lowered since 1996/97, but with trends fluctuating over time. This resource availability and expenditure pattern was largely affected by levels of public health expenditure, overall GDP trends and fiscal constraints on public expenditure placed by the macro-economic policy framework. Graph 4: Relationship between National Health Expenditure (NHE) and Gross Domestic Product (GDP) below shows annual GDP growth, annual growth in public health expenditure and public health expenditure as a share of GDP.



According to Graph 4, annual growth in gross domestic product (GDP) declined around 10.2 per cent in 1997/1998 to 8.2 per cent in 1998/99, a year-on-year decline of 2 per cent. However, annual growth in GDP accelerates to 10.6 per cent in 1999/2000 to 13.9 per cent in 2002002/03, up significantly from 8.1 per cent in 1998/99.

National health expenditure, measured as a percentage of GDP remained constant much of the period around 3.3 per cent for the years 1996/97 and 1997/98. However, national health expenditure declined by 0.2 per cent in 1998/99 to 3.1 per cent, with further decline to 2.9 per cent in 1999/2000 and to 2.8 per cent in 2000/01. The 0.2 percentage point increase in the proportion of GDP being spent on public health to 3.0 per cent in 2003/04 reflects slower health expenditure growth coupled with a slowdown in GDP growth, as compared to the 1997/98 to 2003/04 levels, when the percentage of GDP remained steady. According to the Graph 4, annual nominal national health expenditure dropped dramatically from 8.1 per cent to slightly above 2 per cent in 1998/99 and above 4 per cent. While the growth in nominal expenditure dropped and slowed to below 5 per cent for 1998/99 and 1999/2000, it has accelerated during the first part of the 2000s. Expenditure increased during this period from 4.5 per cent in 1999/2000 to 9.9 per cent in 2000/2001, a year on year increase of 4.4 per cent. Over the period 1999/2000 and 2005/06 it has increased to between 11 per cent and 13 per cent, with a slight dip to 10 per cent in 2004/05 growing to a high of 13 per cent in 2005/06. This accelerated growth in nominal public health expenditure reflects a faster growth as opposed to a slower GDP growth.

Furthermore, the researcher's view is that the flat growth in public health expenditure as a percentage of GDP and the very low increases in real expenditure have exerted collective pressure on public health expenditure. The claim can, therefore, be made that the very low real expenditure increase has been unable to absorb the growth drivers such as inflation; structural factors such as population growth, increased demands for access to public health services and programmes to historical disadvantaged communities, increasing demands placed by the HIV and Aids pandemic and other communicable diseases and changes in how services are organised and delivered as a result of the public health reconstruction and development programme.

Table 6h: Provincial health expenditure in real terms (2004 prices), 1996/97 to 2004/05[1]

R million	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05 Main appropriati	2004/05 Prelim. outcome
					Actuals					
Eastern Cape	5,315	4,865	4,563	4,895	4,803	4,600	4,811	5,305	5,410	5,173
Free State	2,549	2,663	2,532	2,225	2,263	2,327	2,381	2,609	2,731	2,797
Gauteng	8,049	8,505	8,201	7,847	7,661	8,205	8,387	8,472	8,731	8,597
KwaZulu-Natal	7,339	7,713	7,335	7,155	7,353	8,351	8,131	8,382	8,767	8,950
Limpopo	3,466	3,136	3,116	3,109	3,156	3,136	3,368	3,780	3,976	4,196
Mpumalanga	1,416	1,680	1,584	1,606	1,411	1,721	1,817	2,035	2,302	2,263
Northern Cape	572	603	586	606	596	614	659	851	815	832
North West	2,212	2,207	2,009	1,937	1,984	2,023	2,171	2,300	2,599	2,595
Western Cape[2]	4,819	4,713	4,539	4,376	4,472	4,473	4,346	4,739	4,937	5,172
Total provincial	**35,737**	**36,087**	**34,465**	**33,755**	**33,700**	**35,452**	**36,069**	**38,474**	**40,268**	**40,575**

Percentage growth (average annual)	**1997/98 – 2000/01**	**2000/01 – 2003/04**	**2003/04 – 2004/05**	**1996/97 – 2004/05**
Eastern Cape	-0.4%	3.4%	2.0%	0.2%
Free State	-5.3%	4.9%	4.7%	0.9%
Gauteng	-3.4%	3.4%	3.1%	1.0%
KwaZulu-Natal	-1.6%	4.5%	4.6%	2.2%
Limpopo	0.2%	6.2%	5.2%	1.7%
Mpumalanga	-5.7%	13.0%	13.1%	6.3%
Northern Cape	-0.4%	12.6%	-4.3%	4.5%
North West	-3.5%	5.0%	13.0%	2.0%
Western Cape[2]	-1.7%	2.0%	4.2%	0.3%
Total provincial	**-2.3%**	**4.5%**	**4.7%**	**1.5%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.

2. Includes capital works in respect of health voted on public works.

Source: National Treasury databases.

Compared to the strong nominal growth of public health expenditure shown in Table 6h real expenditure in public health has declined significantly at provincial level. This table shows that public health expenditure has declined from around R36 billion in 1997/98 to R33, 7 billion in 2000/01, an annual average decline of minus 2.3 per cent. However, over the period to 2003/04 real expenditure grew to R38, 4 billion, an annual average increase in real expenditure of 4.5 per cent. The highest growth in real terms was in Mpumalanga moving from a minus 5.7 per cent growth between 1997/98 to 2000/01 to 13 per cent real growth from 2000/01 to 2003/04. This is followed by the Northern Cape which was at minus 0.4 per cent during 1997/98 to 2000/01 and increased to 12.6 per cent in real terms from 2000/01 to 2003/04. While real expenditure in Mpumalanga increased by 0.1 per cent to 13.1 per cent, in the Northern Cape expenditure in real terms dropped excessively to a minus 4.3 per cent between 2003/04 and 2004/05. Overall, expenditure in real terms increased by 0.2 per cent from 4.5 per cent to 4.7 per cent from 2003/04 to 2004/05.

Table 6i: Provincial health expenditure, 1996/97 to 2004/05

R million	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05 Main appropriation	2004/05 Prelim. outcome
	Actuals									
Eastern Cape	3,066	3,031	3,048	3,496	3,699	3,808	4,374	5,090	5,410	5,173
Free State	1,470	1,659	1,692	1,589	1,743	1,927	2,165	2,503	2,731	2,797
Gauteng	4,643	5,299	5,478	5,605	5,900	6,792	7,625	8,129	8,731	8,597
KwaZulu-Natal	4,234	4,806	4,900	5,110	5,662	6,913	7,392	8,042	8,767	8,950
Limpopo	1,999	1,954	2,081	2,221	2,431	2,596	3,062	3,627	3,976	4,196
Mpumalanga	817	1,047	1,058	1,147	1,087	1,425	1,652	1,953	2,302	2,263
Northern Cape	330	376	392	433	459	509	599	817	815	832
North West	1,276	1,375	1,342	1,384	1,528	1,675	1,973	2,207	2,599	2,595
Western Cape	2,780	2,937	3,032	3,125	3,444	3,703	3,951	4,547	4,937	5,172
Total provincial	**20,616**	**22,483**	**23,025**	**24,110**	**25,953**	**29,347**	**32,794**	**36,916**	**40,268**	**40,575**
Year-on-year percentage growth										
Eastern Cape		-1.2%	0.6%	14.7%	5.8%	2.9%	14.9%	16.4%	6.3%	-4.4%
Free State		12.8%	2.0%	-6.1%	9.7%	10.6%	12.4%	15.6%	9.1%	2.4%
Gauteng		14.1%	3.4%	2.3%	5.3%	15.1%	12.3%	6.6%	7.4%	-1.5%
KwaZulu-Natal		13.5%	2.0%	4.3%	10.8%	22.1%	6.9%	8.8%	9.0%	2.1%
Limpopo		-2.3%	6.5%	6.7%	9.5%	6.8%	17.9%	18.4%	9.6%	5.5%
Mpumalanga		28.2%	1.1%	8.4%	-5.3%	31.1%	15.9%	18.2%	17.9%	-1.7%
Northern Cape		13.9%	4.2%	10.5%	6.1%	10.8%	17.8%	36.4%	-0.2%	2.1%
North West		7.8%	-2.4%	3.1%	10.4%	9.6%	17.8%	11.8%	17.7%	-0.2%
Western Cape		5.6%	3.3%	3.1%	10.2%	7.5%	6.7%	15.1%	8.6%	4.8%
Total		**9.1%**	**2.4%**	**4.7%**	**7.6%**	**13.1%**	**11.7%**	**12.6%**	**9.1%**	**0.8%**

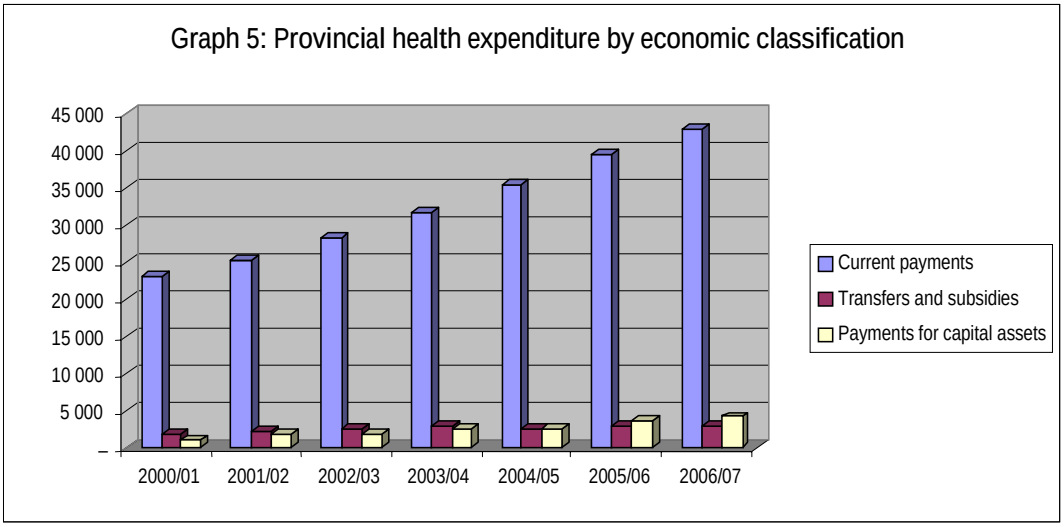
1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Includes capital works in respect of health voted on public works.
Source: National Treasury databases.

Expenditure grew (Table 6i) at 9.1 per cent from 1996/97 to 1997/98. The highest percentage growth was in Mpumalanga at 28.2 per cent, with the lowest in the Eastern Cape at minus 1.2 per cent. All provinces except the Eastern Cape, Limpopo, North West and Western Cape were below the year-on-year average of 9.1 per cent. Table 6i shows that the year on year growth declined to below the 9.1 percentage mark set in 1997/98 to 2.4 per cent in 1998/99, 4.7 per cent in 1999/2000, and 7.6 per cent in 2000/01. Year-on-year percentage growth was experienced in 2001/02 to a level of 13.1 per cent, but declined again to 11.7 per cent, 12.6 per cent in 2003/04, with a very steep decline of 9.1 per cent in 2004/05.

The drastic decline in year on year percentage expenditure in 1998/99 was a result of a below national average year-on-year expenditure in the Eastern Cape at minus 1.2 per cent, a 2.0 per cent in the Free State at minus 2.3 per cent in Limpopo, at 7.8 per cent in North West and at 5.6 per cent in the Western Cape. Table 6j also shows that for each of the financial years from

1996/97 up to and including 20004/05, not a single province's health expenditure is consistently above the year-on-year percentage growth. Clearly these fluctuations in year-on-year percentage growth have not only had consequences for the stability in provincial budgets, but have also had implications for the public health and finance policy priority choices made by the both the central and provincial governments. On the other hand, these fluctuations could also be a result of increased expenditure in the other competencies of provinces, which led to a shifting around of funds between different competencies for a particular year.

Further to the overall provincial health expenditure, Graph 5 shows provincial health expenditure by economic classification. The economic classification allows an analysis within budgets on what activities are funded and possible linkages of expenditure with public health policies. According to the Graph 5 there is a consistent growth in the expenditure on current payments ranging from an increase of R2, 2 billion between 2000/01 to 2001/02 within further increases of R3 billion to 2002/03, R3, 1 billion in 2003/04, R3, 8 billion in 2004/05, R4, 0 billion in 2005/06 and R3, 4 billion in 2006/07. The consistent growth in current payments over the same period was at an annual average growth at 10.9 per cent. By far the greatest cost driver in current payments was compensation of employees. Expenditure on compensation of employees grew by R1, 3 billion between 2000/01 and 2001/02 with further increase of R1, 2 billion in 2002/03, R1, 8 billion in 2003/04, R2, 4 billion in 2004/05, R2, 5 billion in 2005/06 and a R1, 9 billion in 2006/07. Over a three-year MTEF cycle in 2000/01, expenditure of compensation of employees grew from R16, 4 billion to R20, 8 billion in 2003/04.



The overall expenditure on compensation is definitely influenced by national policy decisions, which are in all probability outcomes of the Labour Health and Welfare Central Bargaining Council and policy decisions made between central and provincial governments. Given the public policy decisions on compensation of employees, it seems that different cost drivers have contributed over time to an increased expenditure on compensation of employees. While some of these policy decisions are before the 2000/01 period, factors such as voluntary severance packages (VSP), equalisation of employee benefits across gender groups, overtime payment schemes, rank promotions, and notch and salary (annual) increases have contributed to the growth of provincial expenditure on employees. However, the spike in expenditure on employees could also be because of conscious funding practices within provinces – those effected, not only to address the human resources requirements, but also to attract and retain personnel public health personnel who have scarce skills. On the other hand, the overall growth in expenditure could also be because of policy implementation requirements to address the unequal and inadequate public health human resources distribution between and within provinces.

Goods and service as an economic classification grew at a rate of 14.8 per cent from 2000/01 to 2006/07. The increase in goods and services is as a result of costs of medicine, medical and surgical consumables, laboratories and purchasing of highly technical medical equipment. The financial data reflected in Graph 5 show strong growth in expenditure on payments for capital assets. Payments on capital assets grew by R3, 1 billion from R1 billion in 2000/01 to R4, 1 billion in 2006/07 – an annual average of 26.1 per cent for this period. By far the strongest growth in the payment of capital assets was expenditure on building and other fixed structures. Expenditure on

this grew from R395 million in 2000/01 to R2, 5 billion in 2006/07, an annual average growth of 36.4 per cent. This strong growth, according to this study, is understood during the analysis of provincial health expenditure and specifically within each of the functional programmes. Notwithstanding the need to further analyse provincial health expenditure, the growth in both these economic classifications – that is, *goods and services and payments on capital assets* – could signal a recovery from previous years after declines as a result of fiscal constraint when compensation of employees squeezed non-personnel non-capital expenditure.

Table 6j above shows a distribution of conditional grants and equitable share funding, including a breakdown of the different conditional grants within the provincial health budgets. The consolidated provincial budgets consist of an equitable share of 80, 5 per cent, with the 19.5 per cent consisting of the different conditional grants in 2000/01. The equitable share allocation to the provincial health budgets declined to 80.2 per cent and 78.7 per cent for 2001/02 and 2002/03, respectively. During the same two years, the conditional grant transfers to provinces increased to 19.8 per cent and 21.3 per cent for 2001/02 and 2002/03, respectively. The conditional grant increases show that provinces decided to allocate less from their equitable share allocation, which is an unconditional grant, to fund their public health budget programmes.

This increase in the conditional grants and a decline in funding from the equitable share allocation also meant that instead of funding public health programmes at a consistent level as the previous years baseline expenditure, more importance was attached to the conditional grant allocations as a means to address national public health priorities and inter-jurisdictional spillovers. This funding could also mean that provinces used conditional grants as a form of “budget health programmes double dip” where, instead of a conditional grant only funding a specific national policy objective or programme parts, the funds could have been used to deal with inter-programme spillovers created by health care service demands, including the management and administration of programmes. For example, the conditional grant could also have funded the administrative and service delivery management of a grant, thereby inadvertently providing additional funds for the administration programme. Although this might be the case, such a practice as a result of indirect policy outcome of the conditional grant, it does, however, enhance public policy and public health programmes resource-allocation and expenditure synergies in the public health system.

Table 6j: Provincial health: Conditional grants and equitable share percentage share, 2000/01 to 2006/07

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
	Actuals					Medium-term estimates	
Percentage							
National tertiary services grant	12.8%	11.8%	13.1%	11.4%	10.4%	10.3%	10.0%
Comprehensive HIV and Aids grant	0.0%	0.1%	0.9%	1.1%	1.9%	2.5%	3.1%
Hospital revitalisation grant	1.2%	1.9%	2.1%	1.5%	1.7%	2.2%	2.4%
Integrated nutrition programme grant[1]	0.2%	0.2%	0.2%	0.3%	0.2%	0.3%	–
Hospital management and quality improvement grant	–	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%
Hospital construction grant	0.7%	1.2%	0.2%	0.5%	–	–	–
Health professions training and development grant	4.5%	4.2%	4.0%	3.6%	3.4%	3.3%	3.0%
Medico-Legal	–	–	–	0.0%	–	–	–
Other	-0.0%	0.0%	0.4%	-0.0%	0.0%	-0.0%	–
Total conditional grants	**19.5%**	**19.8%**	**21.3%**	**18.6%**	**18.0%**	**18.9%**	**18.8%**
Equitable share	**80.5%**	**80.2%**	**78.7%**	**81.4%**	**82.0%**	**81.1%**	**81.2%**
Total provincial	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

1. Includes the primary school nutrition programme.

2. Information not available prior to 2000/01.

Source: National Treasury databases.

Regulatory Framework for Budgeting and Expenditure

The Constitution (Republic of South Africa, 1996) provides the legislative framework for national legislation on budgets. Section 215 (2) of the Constitution requires that national legislation must prescribe “the form of national [central], provincial and municipal budgets” and “that budgets in each sphere of government must show the sources of revenue and the way in which proposed expenditure will comply with national legislation”. The Constitution also requires that budgets in each sphere must contain “estimates of revenue and expenditure, differentiating between capital and current expenditure”.

Furthermore, sections 213 and 226 with regard to central and provincial governments, require that all funds received must generally be paid into a national or provincial revenue fund and that such funds may only be withdrawn in terms of the Constitution or an Act of the appropriate legislature, either through a Direct Charge Act or an Appropriation, which are both money bills. It is especially with regard to expenditure that detailed legislation is required, given sections 213 and 226 of the Constitution. Expenditure per main division or budget programme must be appropriated or dealt with through a direct charge act. With regard to revenue, the budget legislates the power to impose the tax or levy and not the amounts projected from each tax. No charges are made on user charges, macro-projections on growth and or inflation; however, the power to impose a user

charge is not a money bill and can be dealt with through ordinary legislation. The budget only legislates (National Treasury, 2005b:p3) the power to collect funds from a specific tax or levy; specific allocations for expenditure through an appropriation act; and specific payments or transfers of a direct charge in terms of the Constitution and yearly Division of Revenue Act.

The Republic of South Africa (1999) *Public Finance Management Act* also provides the legislative framework on budgets in the way that it regulates the budget processes, determines treasury norms and standards, and empowers the Minister of Finance to issue regulations on the formats of budgets. Section 27 of the Public Finance Management Act (PFMA) specifies that the annual budget must be in accordance with a format as may be prescribed and must contain:

a) Estimates of current expenditure for that financial year per vote and per main division with that vote (Sections 27 (3)(b))

b) Estimates of capital expenditure per vote and per main division within a vote for that financial year, and the projected financial implications of that expenditure for future financial years (Sections 27 (3)(d)).

The public health budget programme for the central government department comprises administration, strategic health programmes, health service delivery and human resources. This budget programme structure is not similar to the provincial budget structures and, as such, obscures the ability to determine the interaction between the central and provincial budget programmes. For example, the budget programme Health Service Delivery intends to strengthen the delivery of Primary Health Care (PHC) through DHS (DHS). This is to be achieved through the revitalisation of hospital services by either upgrading or replacing hospitals and by way of health quality and management improvements (National Treasury, 2005f:p339). The central health budget programme, is therefore, differently structured from the way it is structured in various provinces.

The uniform budget structure for public health approved in 2004 by the central and provincial government treasuries and health departments identifies a number of budget programmes that are generic across provinces. During 2003/04 the new budget programme structure was implemented with the view that it would enhance planning and monitoring of service delivery (National Treasury, 2003b). The Treasury, however, acknowledges that although the “quality of provincial budget documents has improved substantially over the last number years” there is still very little service delivery information or analysis of departmental budgets” (National Treasury, 2005c:4).

According to the National Treasury, “the advantages of the new structure are the separation of different components of primary health care services, hospital services and emergency services” (2003b:p83). In terms of the new budget structure “[p]rimary health care services includes clinics, community health care services, community based services, HIV and Aids and nutrition. While hospital services include district, provincial and tuberculosis hospitals”. Emergency service, on the other hand, consist of emergency transport and planned patient transport (National Treasury, 2003b:p83). The programmes, which exclude the administration, provide a means to measure the performance of public health policy implementation through the budget programmes. The programmes are DHS, EMS, PHS, CHS, and HFM.

The budget reforms undertaken were aligned to the PFMA section 27 (3) which highlights the minimum requirements of an annual budget and allows the Minister of Finance to prescribe the format of the annual budget (National Treasury, 2003d:p1). The Treasury further highlights in its *Reference Guide to the New Economic Reporting Format, Version 2 (November 2003)* that the overall objective of its budget reform programme (National Treasury, 2003d:p1):

> … was to improve accountability and modernize the accounts of government by bringing reporting in line with best practice. The ultimate aim of this reform process is to provide better quality information to legislatures to assist in the policy-making process and reinforce Parliament’s oversight role.

The above reforms were followed by a process of reclassification of expenditure items in line with the requirements of the Government Finance Statistics (GFS) classification developed by the International Monetary Fund (IMF). This was to ensure compliance with the requirements of the Special Data Dissemination Standard (SDDS), a minimum reporting standard set by the IMF to which South Africa is signatory.

However, many inconsistencies were and are still being experienced in the application of economic reclassification within and between budget programmes and within provinces. According to the National Treasury (2003d:p3) before the introduction of the economic classification format:

> …disposal baby nappies were sometimes classified as capital expenditure and major school rebuilding projects as current expenditure. This was mainly due to classification rules being inconsistently applied and limited control over the application. Furthermore departments were allowed to create their own accounting codes on the systems, leading to a vast number codes and hundreds of applications.

In addition to the introduction of a new provincial budget structure, the national Department of Health in collaboration with the National Treasury has developed a uniform strategic plans format to enhance strategic planning processes (National Treasury 2003e). The National Treasury furthermore claims that through the uniformed budget structure and strategic planning format, it anticipates achieving greater alignment between budgets and strategic plans. While both the new budget structures and strategic plans allow for uniformity and consistency across the nine provinces, they ensure comparability across provinces between policy implemented and the financial inputs. The researcher, therefore, argues that just as annual GDP growth is a good measure of the performance of the economy, the level and trends of finance for public health are a measure of commitment through resources for policy implementation.

Given the prescriptive nature and rule-bound nature of the budget structure and strategic formats to assure uniformity originating from public finance regulations, variation across provinces is not accommodated. The National Treasury (2003e:p4) mentions that to introduce a degree of 'standardisation' between programmes, a set of principles have been developed in conjunction with provincial line-function or with departments' chief financial officers. These principles for budget formatting and programme structure are set out below:

- Inter-provincial comparability is vital (to demonstrate the effective use of resources and to inform allocations);
- Services delivered to communities should determine departmental structures;
- Programme and budget structures do not always 'mirror' departmental structures, but accountability can be achieved through the internal management budget;
- Capital expenditure must be split over programmes (as per the PFMA 29 of 1999);
- Programme 1 'administration' should be as small as possible, as administration costs should be spread between programmes;
- Programmes such as 'auxiliary and support services' ought to be discontinued and the expenditure shifted into 'delivery programmes';
- Clear definitions for programme content need to be agreed, then consistently applied supplementary programmes and subprogrammes, which are additional to be defined programme structure, can be allowed; and
- Formats must be consistent with Government Financial Statistics (GFS).

The introduction of uniform budget structure formats and programmes, according to an interview respondent from the public finance sector, has almost led to a 'tolerant consensus" about the budget structure programme and the strategic planning formats. According to the interview respondent:

> It has lead to many tensions between the central government departments e.g. National Treasury and Department of Health (DoH) on the one part and between the health sector and treasuries on the other.

Moreover, an other interview respondent within the central government public finance sector mentions that:

> The health sector in the design of uniform budget structures and strategic plans was more complicated and tensions existed as a result of arguments about: 1) variations in budgets structures and strategic plans within the health sector which for particular reasons linked to focus of emerging national health programmes and priorities in provinces; 2) the gathering of both financial and non-financial data were at the time not available or non-existent as required by the strategic plans; 3) health leadership [public health sector] preferred the public health sector to be driver of both the conceptualization and design of both budget structures and strategic plans.

Provincial health expenditure by selected programmes

What follows is an analysis based on the major, but selected, programmes. These health budget programmes were selected because it is through these programmes that the public financing of the different public health policies occurs. It is also through these programmes that different national and provincial health policies and health priorities are implemented. The different programmes also serve as an identification of where the appropriate public health service delivery responsibilities are located within the overall budget structure format of the provincial health departments. While these programmes are both funding- and service-delivery orientated, they serve as the regulatory context through which the decentralized implementation of public health happens. Put differently, national and appropriate provincial health policies and priorities for service delivery implementation get firstly dragged through a specific programme and then afterwards through the appropriate sub-programme. It is within these programmes that it possible to observe the different financial inputs delivered to implement a policy or set of priorities.

In addition to the health programme expenditure revenue and expenditure review, the analyses will also deal with the sub-programmes and economic classifications of the different

programmes. This analysis not only allows for an overall review of the budgets and expenditure within a programme, but also for an analysis of the budget and spending inputs within each programme. Public expenditures are from a economic classification perspective divided into three broad categories: current payments; transfers and subsidies; and payments for capital assets. Current payments allows for a distinction between funds directly spent by a department and funds transferred to other institutions and individuals. Current payments comprise of compensation employees; goods and services; and interest and rent on land. According to the National Treasury (2003b:p13) regarding current payments,

> [f]or direct departmental spending, detail is provided on personnel-related expenditure in the item, *compensation of employees.* In this item there is a clear distinction between normal salary costs and government contributions to pensions and provident funds. This is required for economic reporting purposes. The item, goods and services, will in most instances be the second largest spending item for departments. It is proposed that specific details of the purchase of each department be included as further sub-divisions of this item in the detailed departmental tables. It is envisaged that at least the four largest spending items of the department be listed. … This allows the classification to be adapted for the particular data needs of each department, thereby facilitating oversight and policy analysis. The item, interest and rent on land would for most departments be very small, … This item is of particular interest for the calculation of the government's contribution to South Africa's national income.

According to the transfers and subsidies classification, transfers are sub-divided into various sectors receiving funding from government with the intention to "provide clear information about the targeted recipients or beneficiaries of departmental spending …" (National Treasury, 2003b:p14). Subsidies are considered to be "provided to public enterprises as these payments usually have direct policies outcome, either by subsidizing the price of goods and services or by influencing the level of production. The payment of capital assets classification identifies "capital expenditure as a separate item, because it shows the government's contribution to capital formation in South Africa as well as the government's spending on infrastructure". Within this classification special care is taken to distinguish between "assets of a fixed nature, such as building and other fixed structures and movable assets" (National Treasury 2003b: p15).

The specific budget structure for public health, the different broad economic classification categories, and the different expenditure items within each of the classifications get captured within the Standard Chart of Accounts (SCOA). The SCOA, according to an interview respondent from the public finance sector:

> ..is the economic reporting format providing a combination of around 6000 financial inputs to more than two million line detailed spending items of possible combinations.

The SCOA comprises "the coding of items used for classification, budgeting, recording and reporting of revenue and expenditure within the accounting system" (National Treasury 2003b: p16).

This study intended to do an analysis of expenditure trends to lower levels – for example, "posting of staff". It was, however, not possible to move beyond the second level of economic classification. The study was not able to look at *compensation of employees* within current payments, given the implementation problems associated with the new economic classification such as:

a) Reclassification problems experienced in the standardisation of expenditure items for example services procured from institutions still being recorded in certain budget programmes and provinces as transfer payments, instead of being recorded as goods and services, which leads to incorrect classifications within departments;
b) Confusion between capital and current transfers;
c) Capacity within departments on the use of the financial systems;
d) Lack or non-existent asset evaluations and asset management procedures and systems; and
e) Alignment problems with historical expenditure data and standard items prior to 1 April 2004, which are not yet at the level of financial data required within the economic classification.

These problems regarding the expenditure review make comparability difficult, if not impossible, within and between provinces, programmes, and at the primary level of economic classification. Given that at the second level of economic classification, the classification is more financial input drive, that is standard item expenditure coding, the measurement of the impacts of the different policies was not possible. What the researcher opted for instead, was an assessment of the broad categories of the financial inputs at this level within each programme and economic classifications till the second level thus allowing for inferences to be drawn. Within this context, broad but relevant transaction categories will be considered within

the economic classification of each programme. These transaction categories will further be considered in terms of the expenditure items where possible.

The transaction categories are followed in the Chapter 7 by a comparison of the macro-level expenditure with that at a micro-level within each province. While a macro-level expenditure analysis provides a national assessment of public health financing for each programme, it might distort interpretation of expenditure patterns and create difficulties for tracking public health policy and priority through expenditure. This is so particularly where funding of a programme might show upward overall annual average growth in expenditure, but a deeper analysis by province indicates that growth in the programme expenditure as an annual average is pushed up not because of a higher expenditure in all provinces, but rather as a result of expenditure in a province like KwaZulu-Natal as opposed to a province like Northern Cape. However, the macro-level analyses do provide a statement of the nature of policy priority implementation and the growing fiscal commitment to such programme.

The Table 6k below reflects expenditure patterns of the major health programmes in provincial departments. These programmes not only provide an indication of both the responsibility for full or partial location of the health function, but also help to distill the elements of the public health service and financing responsibilities. It is the view of the researcher that the health programmes also provide provinces with a vehicle to locate the different health policies within the context of operation for implementation. It is also within these budget programmes where an analysis could be made of the linkages between public health policies and the financing of these policies and associated programmes. It is through these budget programmes that realisation of public health policy implementation is assessed.

Expenditure by Health Programme

The programmes chosen for the analysis are: DHS (DHS), emergency health services (EMS), provincial health services (PHS); CHS (CHS); and HFM (HFM). The selected budget programmes provide within the South African context an unbundling of the overall public health function, which includes administration, EMS, facilities (which is capital expenditure), health care support, health sciences and training, hospitals, and primary health services (including HIV and Aids and nutrition). Each programme will be analysed at a macro-level with a view to determine or track public policy choices through expenditure trends.

Revenue and expenditure trends within these functional classifications through the budget structure programmes, coupled with economic classification of expenditure, ought to be the most valid and reliable elements for tracking the relationship between national priorities and policy implementation and to analyse expenditure rationales. This study analyses the standard expenditure items of the economic classification per health programme per province in order to further inform expenditure rationales with a view to tracing these to possible linkages with the implementation of public health policies within provinces.

Expenditure Trends in Health Programmes – connecting with public health policies and national priorities

Table 6k shows the proportional share of the different health programmes within the total health budget programmes. The selected programmes consolidated as a percentage share of the total programmes are above the 92 per cent mark from 1999/00 to 2001/02 but decline slightly to above 91 per cent with the highest share at 91.3 per cent in 2003/04 and 2004/05. The consolidated programmes decline to 91 per cent by 2007/08. The overall highest percentage share expenditure is on DHS, which was above 35 per cent growing to around 41 per cent at the beginning of the 2000s, with moderate declines over the years to a level of 39.9 per cent in 2007/08.

Table 6k: Provincial health percentage share by programme, 1996/97 to 2004/05

	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2004/05	2005/06	2006/07	2007/08
	Actuals								Main appropriation	Prelim. outcome	MTEF		
Percentage													
Administration	7.3%	4.0%	3.5%	3.9%	3.7%	4.1%	3.8%	4.3%	4.1%	4.3%	3.9%	3.6%	3.7%
District Health Services	35.2%	37.9%	38.9%	41.0%	40.8%	39.0%	38.4%	38.1%	39.9%	39.4%	39.4%	40.0%	40.1%
Emergency Medical Services	–	–	–	2.9%	2.8%	2.7%	2.8%	3.5%	3.3%	3.3%	3.7%	3.6%	3.5%
Provincial Hospital Services	27.8%	28.9%	29.4%	24.9%	25.9%	25.1%	26.9%	27.0%	25.2%	25.8%	24.9%	24.3%	24.4%
Central Hospital Services	22.0%	22.9%	22.2%	19.9%	20.8%	19.7%	18.9%	17.1%	16.3%	17.1%	15.8%	15.6%	15.4%
Health Sciences and Training	2.3%	1.8%	2.0%	2.0%	1.8%	2.2%	2.4%	2.7%	2.9%	3.0%	3.4%	3.3%	3.3%
Health Care Support Services	2.0%	1.5%	1.4%	1.4%	1.4%	1.4%	1.5%	1.7%	1.8%	1.6%	2.1%	2.0%	2.1%
Health Facilities Management	3.6%	3.1%	2.8%	3.8%	2.6%	5.8%	5.4%	5.6%	6.6%	5.6%	7.0%	7.7%	7.6%
Other	-0.2%	-0.2%	-0.2%	0.2%	0.2%	-0.1%	-0.1%	–	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
Total programmes	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: National Treasury databases.

DHS followed by PHS, moving from 28.9 per cent in 1997/8 to above the 25 per cent mark. CHS declined from 22.9 per cent in 1997/8 to around 15 per cent in 2007/08, while HFM grew from 3.1 per cent in 1997/8 to a high of 7.6 per cent in 2007/08. EMS, on the other hand, grew from 2.9 per cent to 3.5 per cent in 2007/08.

Consolidated expenditure on selected public health budget programmes (see Table 6l) grew from R24,1 billion in 2000/01 to R48,4 billion at an annual average of growth of 10.5 per cent. HFM grew at an annual average rate of 28.7 per cent from 2000/01 to 2007/08. This growth rate was followed by EMS at 14.8 per cent, DHS at 10.6 per cent, PHS at 9.9 per cent, and CHS at 6.1 per cent. The largest increase in the provincial health budgets occurs in the HFM programme. This could be as a result of public health policies such as the District Health Policy and the Hospital Revitalisation Programmes, which gave rise to conscious public health infrastructure investment within provinces.

The White Paper on the Transformation of Health (ibid) discussed earlier in chapter 5, served as the stimulus to the building of numerous clinics in rural and urban areas by provincial governments. The expenditure distribution analysis shows huge investments in hospitals through the Hospital Revitalisation Grant, the Hospital Rehabilitation Grant, the Central Hospitals Grant and the Provincial Infrastructure Grant. The grants according to the trends, have all contributed to the increase of funding and expenditure within the HFM Programme. An interview respondent mentions that:

> However, although large sums of funds are spent on refurbishments and infrastructure, maintenance is still lagging in hospitals.

Although the HFM Programme expenditure grew faster than expenditure for other programmes, DHS dominated overall expenditure. The level of expenditure on DHS as a proportion of overall provincial health expenditure ranged between 42 per cent and 44 per cent of total expenditure over the period 2000/01 to 2007/08. The dominance of DHS seems to epitomise the policy decision to shift greater resources to primary health care (PHC) through DHS. DHS has been a major driver in the provincial sphere and the expenditure growth pattern confirms the national policy articulation as the core competency of provincial public health services.

The relatively strong growth in DHS expenditure compared to the expenditure on the other programmes is a result of strengthening of the primary health care services, as well as, the expansion of the HIV and Aids expenditure. This strong growth in expenditure was, however, from a low base of R57million in 2000/01 to R2, 4 billion in 2007/08. The accelerated growth in this programme also appears to be a direct output of a public policy priority to expand the provision of health care, through anti-retroviral treatment, home care, and programmes related to the prevention and treatment of the public infected and affected by the HIV and Aids. The increased growth in expenditure levels confirms the strong influence of the PHC policy and programmes.

It is through this level of funding that the HIV and Aids Comprehensive Policy and Plan adopted in 2003/04 received a huge step up in funding, which to a large extent contributes to the increase in the expenditure for the programme as a whole. Over the 2005 MTEF funds an amount of R200 million, R300million and R400million were also allocated to fund the eventual takeover of public health services previously delivered by the municipalities. This funding was a direct result of the change in policy, where provinces became comprehensively responsible for all primary health care services, thereby shifting or transferring the function to provincial government.

When hospital services – that is, CHS and PHS are computed together as a key service within the public health function – CHS and PHS grows between 44 per cent and 50 per cent over the period. This growth either equals or exceeds DHS expenditure. DHS is, for example, at 44 per cent for both the 1999/00 and 2000/01 fiscal years, compared to a consolidate hospital expenditure at 48 per cent and 50 per cent in the respective years. Consolidated hospital expenditure further exceeds DHS expenditure at percentages of 49 per cent in 2001/02, 50 per cent in 2002/03, and 48 per cent in 2003/04. This compares to a flat growth rate of 42 per cent for each of these for DHS. The annual average percentage growth between DHS and consolidated hospital services of between 6 per cent and 8 per cent confirms, contrary to the national policy decision to shift funds to primary health care, that public hospital services continued dominate expenditure.

This picture, however, changes between 2005/06 and 2007/08, with the annual average percentage gap becoming narrow between DHS and consolidated hospital expenditure.

The gap between DHS (at 43 per cent) and consolidated hospital expenditure at (45 per cent) is a meagre 2 per cent in favour of hospitals in 2005/06, with equal annual averages of 44 per cent for both consolidated hospital expenditure and DHS for the 2006/07 and 2007/08 fiscal years.

While Table 6l below shows the emerging dominance of DHS in reality, consolidated hospital expenditure continued to dominate, with downward year-to-year fluctuations to levels equal to DHS over the outer years. Consolidated hospitals' share of total health expenditure fell, but still represented the largest single category of health expenditure in South Africa from 1999/2000 to 2007/08. Following a dip from 2004/05 expenditure levels, the outer years saw steady expenditure growth. The continued strong growth within hospital services was a result of a continued central government commitment through the conditional grants.

Overspending on health budgets declined significantly from 22.21 per cent in 1996/7 to 5.3 per cent in 1998/9. The reasons for the decline in overspending are varied and numerous, ranging from a direct outcome of poor budgeting to central government policy creating unfunded mandates on the delivery and spending side of these policies and poor financial management and systems. Segal (1999:p17), in particular, mentions that:

> The public sector wage agreement of 1996 resulted in significant real salary increases for health personnel and a rise in health personnel costs. Much of the overspend on health budgets from 1996/97 onwards is probably due to an increase in personnel costs … not fully funded by central allocations for improvement in conditions of service. … In addition, health departments have had to finance from existing allocations, rank and leg promotions for nurses and other health personnel, as well as some of the costs of voluntary severance packages. Un-funded increases in personnel costs have been beyond the control of health managers, especially in the absence of a retrenchment tool to facilitate the downsizing of staff.

Table 6I: Provincial health expenditure by selected programmes and their sub-programmes, 1999/2000 to 2007/08

R million	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
			Actuals			Prelim. outcome	Medium-term estimates		
District Health Services	**9,884**	**10,581**	**11,443**	**12,591**	**14,071**	**15,978**	**18,096**	**19,976**	**21,358**
District Management	611	724	802	936	910	988	1,161	1,254	1,336
Community Health Clinics	1,680	1,881	2,212	3,055	2,997	3,520	4,058	4,493	4,828
Community Health Centres	833	991	892	809	1,681	1,760	2,061	2,238	2,400
Community-based Services	282	365	271	595	600	671	725	778	840
Other Community Services	268	274	380	243	286	422	439	505	537
HIV/Aids	57	60	80	283	618	1,181	1,744	2,218	2,471
Nutrition	464	61	187	134	131	184	167	77	81
Coroner Services	–	–	–	1	1	6	3	3	3
District Hospitals	5,688	6,225	6,619	6,535	6,846	7,245	7,737	8,410	8,862
Emergency Medical Services	**704**	**719**	**793**	**907**	**1,285**	**1,340**	**1,679**	**1,784**	**1,888**
Emergency Transport	689	702	773	899	1,187	1,194	1,492	1,556	1,639
Planned Patient Transport	15	18	20	8	99	145	188	228	249
Provincial Hospital Services	**6,008**	**6,723**	**7,367**	**8,826**	**9,963**	**10,484**	**11,420**	**12,144**	**12,990**
General (Regional) Hospitals	4,658	5,220	5,759	6,910	7,940	8,193	8,760	9,305	9,976
Tuberculosis Hospitals	163	186	205	332	400	394	556	608	652
Psychiatric/Mental Hospitals	985	1,102	1,161	1,217	1,310	1,543	1,666	1,764	1,870
Sub-acute, Step down and Chronic Medical Hospitals	45	50	54	182	107	108	199	211	222
Dental Training Hospitals	129	139	155	154	169	204	194	204	215
Other Specialised Hospitals	25	26	32	30	36	42	46	51	54
Air Services (LIM)	2	–	–	–	–	–	–	–	–
Other	2	–	–	–	–	–	–	–	–
Central Hospital Services	**4,787**	**5,392**	**5,791**	**6,210**	**6,325**	**6,938**	**7,233**	**7,795**	**8,176**
Central Hospital Services	1,767	1,953	4,950	5,036	5,122	5,554	5,577	5,929	6,212
Provincial Tertiary Hospital Services	3,020	3,439	841	1,174	1,203	1,384	1,655	1,865	1,963
Other	Other	Other	Other	Other	Other	Other	Other	Other	Other
Health Facilities Management	**918**	**686**	**1,691**	**1,763**	**2,061**	**2,270**	**3,195**	**3,836**	**4,022**
Community Health Facilities	72	33	146	216	305	414	596	702	737
Emergency Medical Rescue Services	0	0	4	2	6	13	20	30	23
District Hospital Services	268	272	382	493	780	830	1,322	1,524	1,728
Provincial Hospital Services	140	128	284	362	540	645	719	931	832
Central Hospital Services	202	89	425	57	367	168	226	215	250
Other Facilities	216	62	450	633	63	199	312	434	453
Buildings and Infrastructure from Public Works	19	102	–	–	–	–	–	–	–
Other	235	164	–	–	–	–	–	–	–
Total selected programmes	**22,300**	**24,101**	**27,084**	**30,297**	**33,705**	**37,010**	**41,623**	**45,534**	**48,433**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

The *2003 Intergovernmental Fiscal Review* (National Treasury, 2003b:p78) indicates that:

> [a]fter the 1996 wage agreement, personnel expenditure absorbed increasing proportions of health budgets and crowded out other health expenditure. In the context of these personnel cost pressures and the need to remain within budgets, health sector personnel numbers declined substantially in the late 1990s as departments strove to remain within budgets.

Ultimately, the levels of spending could be a demonstration that the required fiscal discipline had been ineffective in public health spending, in this way being unable to keep the provinces to hard budget constraints. It is also possible that the demands for health care provision and resource implications for health departments are not commensurable with revenue transfers to the provinces. Also, the current practice and policy directions are not synchronised with the resource envelope of the provinces, creating allocative efficiency problems. This has the potential to lead to both policy implementation and service delivery drift, which, at worst, could lead to potentially unintended policy outcomes at the provincial level. Then again, the resources handed to the health departments to achieve their health care service objectives may not have been correctly distributed across health programmes, leading to possible operational efficiency problems. The resource distribution could also mean that the current formula for central revenue allocation to public health could be wrong or inappropriate to ensure that the provinces deliver on their health responsibilities.

In order to cushion spending overshoots on provincial public health budgets and their overall impact on economic policy forecast and medium-term budget, the central government has intervened according to Ahmed (n.d) with deficit grants and coverage of specific expenditure shortfalls and bailouts. Such interventions have been in defiance of annualised fiscal discipline and hard budget constraints for the provinces. Ahmed (n.d) therefore argue, therefore, that expenditure problems are could be a result of budgetary games between the central and provincial governments. Such practices further contribute to an ambiguity in revenue allocation and expenditure responsibilities.

Transfer allocations to the provinces are generally through the equitable share formula and conditional grants. One could argue, therefore, that one could argue that spending problems at the provincial level could be due to over- or under-resourcing. Recently,

central government implemented a national HIV and Aids policy. Additional resources were provided to the provinces through the equitable share to provinces to address this problem in the public health sector. However, the mere fact that the provinces have discretion in allocating the funds may result in the funds not being earmarked for a particular policy. Furthermore, the departmental resource bidding process during the Medium-Term Expenditure Framework (MTEF) could have an impact on budgetary resource allocation, especially where a health department's bid for resources is weaker than the education department's bid. In this instance, funds could be channelled from public health to public education.

The disproportionate location of certain health facilities – for example some provinces have tertiary health facilities – while others do not, complicates public health financing. The benefits of delivering tertiary health care tend to spill over into other provinces, where the delivery of these services is also more expensive. These benefit spillovers or externalities occur when services provided and financed by a provincial government within its geographical jurisdiction also benefit members of another provincial government that do not contribute to the provision of such a service. Such a provision of public health service and its financing is sometimes corrected through central government subsidisation, and with the "extent of spillover determining the degree of subsidy, or the matching ratio" (Shah 1994:p26).

The growing inter- and intra-provincial disparities suggest that the reform has may have induced various allocative distortions in health. In this instance, decentralized decision making could require more effective national budgetary controls to safeguard macro-economic stability and vigorous redistribution to prevent further inequality between the provinces. At the provincial level, better financial controls and management may be needed, if expected allocative benefits in the form of more responsive provincial services are to be realised.

Increased resources, powers, functions and service-delivery competencies of the provinces have not contributed to an inverse relationship between the central and provincial governments on the social service delivery and expenditure side, such that the expansion of provincial responsibilities has meant a reduction of the service-implementing role of central government. On the contrary, the increase in fiscal

resources coupled with an increase in service-delivery competencies have contributed to the emasculation of the central government, especially through its Department of Health and its National Treasury.

Central government has remained dominant within the domain of policy and fiscal governance, particularly with regard to revenue raising and distribution, setting fiscal policies that identify norms and standards, and determining the macro-economic framework. This dominance has led to a high degree of fiscal dependence on central government. A study undertaken by Gilson et al. (1999:p24) suggests that within the South African context

> …centralizing tendencies predominate over decentralizing tendencies, and that the balance of power is consequently skewed more in favour of national government which tends to view the other two spheres of government – provinces and local governments - as spheres of 'implementation' rather 'representation'. In effect, provinces often have little latitude to apply national policies to their specific circumstances, this being true especially for the budgeting process, which in any case is not conducive to effective consultation.

All provincial governments in South Africa are dependent on the sharing of centrally collected revenue unlike in sub-national governments in other countries, especially in the financing of social service programmes. Around 5 per cent of provincial revenue can be described as the provinces's own budgetary resources. There are also wide disparities in the fiscal bases of the provinces (horizontal imbalances) and the provinces' spending responsibilities far outstrip their own revenues (vertical imbalances). This situation creates the fiscal dependency of provincial governments on central government fiscal transfers. The Department of Finance (1998) acknowledges that although the provinces have significant expenditure requirements, they have only limited revenue resources.

According to Kolehmainen-Aitken (1999:p17) "it is often stated that decentralization reduces costs by decreasing bureaucracy", but there is no evidence to support this statement. In fact, the more devolution of power and authority that takes place, the higher the level of effort required, which implies the potential for increased costs.' Burki et al. (1999:36) suggest that decentralization tends to increase total and sub-national spending, creating central government deficits as a result of a serious mismatch between the allocation of responsibilities and resources. The argument is that, for decentralization to succeed, policy makers must guarantee a balance between revenue

and spending assignments. Estache and Sinha (1995) suggest that a good way to offset the impact of decentralization on spending is to increase revenue relative to spending assignments. However, an imbalance between revenue resources and expenditure assignments inevitably threatens to reduce the performance of the provincial governments.

Conclusion

This chapter examined whether the claim of a contested policy-implementation process leads to different and incompatible public health and finance policy outputs within and between the central and provincial governments and between the public finance and health sectors. This chapter also analysed the context of decentralized co-operative governance in public finance; the composition of public health financing; the structure of budget programmes and sub-programmes, budget programme structural alignment with certain public health policies; financial inputs and outputs; and the implications of the transfer system and expenditure trends in relation to the policy priorities set by the central government for implementation.

In this chapter it has been strongly argued that:

a) The different policy-design and implementation orientations between the public finance and health sectors at a central government level contribute to the undermining of decentralized co-operative governance system within the health system. In many instances the decentralized co-operative governance system has enabled a situation where the relative strength of the treasuries through their fiscal policy responsibilities consciously undermines policy intentions of the health sector.

b) The public finance sector, especially through the National Treasury uses its regulatory and oversight authority within the public finance administration and management to impose co-ordinated solutions to ensure uniformity and standardisation in health programmes and expenditures.

c) While treasuries design and implement a rule-bound system, their intentions are to regulate both the behaviour of provinces from a central government perspective and to regulate the service delivery, budgets and expenditure behaviour of health departments from a provincial treasury perspective. All this policy practice is ostensibly to maintain hard budget constraints and thereby instill fiscal discipline.

d) The different policy initiatives between the public finance and health sectors policy are essentially a battle for policy design authority as opposed to implementation authority, which ought to lead to the proportional distribution of power and authority between the sectors and the levels of government. While on the one hand, the policy design authority discourse allows for a constructive dialectical discourse on public finance and health policies, it has also managed to chip away the fundamental aspects of mutual trust and respect between the spheres and sectors.

e) There is a classical disjuncture between public finance and health sector policies where the former requires strong fiscal discipline and hard budget constraints while the other argues legitimately for health service expansion and arguably a softer budget constraint or a greater expansionary public health expenditure budget to realise equity considerations. A strong argument in this instance has been the public health sector's incessant argument that public health service policy and service delivery obligations outstrips its resource envelope.

f) There is indeed an inverse relationship between the central and provincial government and between the public finance and health sectors. This chapter demonstrates the strength of the central government in relation to provinces and the relative strength of the public finance sector to the health sector. This is true at both the policy and fiscal-resource levels.

g) While the National Treasury strongly argues that the equitable share allocation is not a proxy for the different provincial competencies, in practice, the nature of central government allocation to provinces and explicit referral to different fiscal and social policy options, including the off-setting of these policy obligations against the equitable share allocation, pre-determines the resource allocation process within

provinces. This is a strong element of imposed co-ordination on the part of the central government.

h) Even though there are strong arguments that the resource envelope of provinces is far less than its expenditure obligations, in reality the true expenditure has never been adequately determined given that public health policies were never costed. This situation has led to not only to uncertainty regarding the appropriate level of resource required relative to the policy cost drivers, but also to a disjuncture between the policy as intended and its resource inputs and outputs. This is also a further demonstration of how provinces are driven into a particular policy direction without the requisite resources, thus contributing to take undermining of the provincial competencies and, consequently, the system of decentralized co-operative governance.

Chapter Summary

The focus of this chapter, principal-agent relations through public financing, explored the background of financing of the public health system, public policies that regulate the health system and financing regime. Within this exploration, review and analysis, emphasis was placed on how the regulatory nature of the different public policies determines the varying competencies and fiscal resource-allocation between the central and the provincial governments. The chapter also reviewed and commented on the funding mechanisms for the public health system and how these funding mechanisms either increase or reduce the competencies and policy design and implementation authority of either the central or provincial governments. The chapter also argued the public financing regime and the implementation of the different financing mechanisms – the conditional grant and the equitable share – have confirmed the strong principal and weak agent role and responsibilities between the central and provincial governments.

The broad macro-policy thrust of the principal-agent relationship between the central and provincial governments is further analysed through the revenue, budgets and expenditure policy practice with the nine provinces. Chapter Seven provides this review.

Chapter Seven - Decentralized Co-operative Governance at Provincial Level: Revenue, budgets and expenditures

Introduction

This chapter continues with the public finance discussion started in Chapter 6. It argues through the tracing of budget and expenditure trends that public finance and health policies have had an influence on provincial budgets and expenditures within the nine provinces. The tracing of revenue and expenditures are done through a review and an analysis of financing and expenditure trends of major selected public health programmes. These were carried out to assess the influence that central government policies and programmes exert onto the budget-allocations process within the provincial public health sector. The intention was also to assess the nature and extent of the interaction between the public finance and health sectors in the determination of resource allocations and how revenue, budgets and expenditure patters are influencing the decentralized co-operative governance approach. The chapter presents a provincial budget and expenditure data analysis. The analysis presented is both province-specific and programme-specific.

Eastern Cape Province - Health Service Expenditure

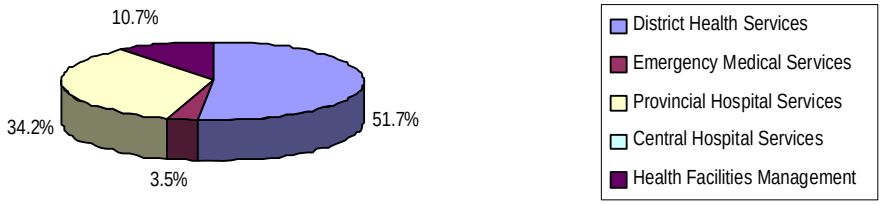
Overall expenditure for the main health programmes in the Eastern Cape Province, the poorest province within South Africa, was projected to grow at 9.3 per cent from 1999/00 to 2007/08. Consolidated expenditure also grew over the three-year MTEF cycle from R3, 3 billion in 1999/2000 to R4 billion in 2002/03, an increase of slightly more than R785 million. Expenditure increased more than double from 2002/03 to 2005/06, by R1, 3 billion. Expenditure was further expected to increase year-on-year from 2005/06 by R550 million respectively for 2006/07 and 2007/08.

Expenditure by health programme

Diagrams 5a and 5b on the Eastern Cape show health expenditure by major selected programmes. The proportional distribution of the share of the different health

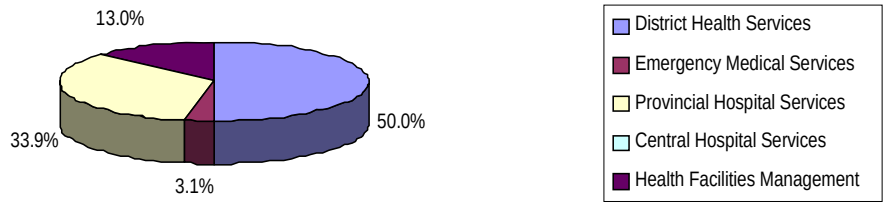
expenditure to total expenditure shown in the diagrams indicates the dominance of DHS within this province, which was a 51 per cent share of total expenditure on selected programmes in 2005/06. The share for provincial hospitals services (PHS) was at 34.2 per cent, EMS at 3.5 per cent, and HFM at 10.7 per cent in 2005/06. The dominance of the DHS expenditure in total provincial health expenditure can be ascribed to a direct output of the national district health system policy and the implementation of PHC.

Diagram 6a: Eastern Cape health expenditure by selected programmes: 2005/06



A difference is observed, indicated in Diagram 5b, in the proportional shares in total expenditure between financial years 2005/06 and 2006/07. This difference shows a step up in the share of HFM from 10.7 per cent in 2005/06 to 13 per cent in 2006/07. This could be a direct expected output of the clinic-building programme that has continued since the introduction of free primary health care. Diagram 5b shows decreases of 1 per cent reaching 50 per cent for DHS, a decline of 0.4 per cent in EMS to 3.1 per cent, and a decline of 0.3 per cent in HFM. HFM shows increases in expenditure in goods and services from R110 million in 2005/06 to R170 million in 2006/07. This shift in shares also makes provision for substantial increases in buildings and fixed structures within the payments of capital. This shift in shares demonstrate from both a public policy and finance perspective the continued commitment by the provincial government to equity and access within health service and this by coincidence implementation of national health policies.

Diagram 5b: Eastern Cape health expenditure by selected programmes: 2006/07



Graph 5a above demonstrates the growth trajectory of spending within the different programmes. While growth in EMS and HFM seems to have been moderate over the period, overall accelerated upward growth was experienced within DHS and Central Hospitals, reflecting consistent growth patterns. The expenditure pattern indicates accelerated growth in DHS, which is a result of increased spending on primary health care services and the further decentralization of overall public health services as a means to improve access to health care. The very strong upward growth in DHS is indicative of a policy choice and commitment to the provision of PHC.

Graph 5a: Eastern Cape health expenditure by selected programmes

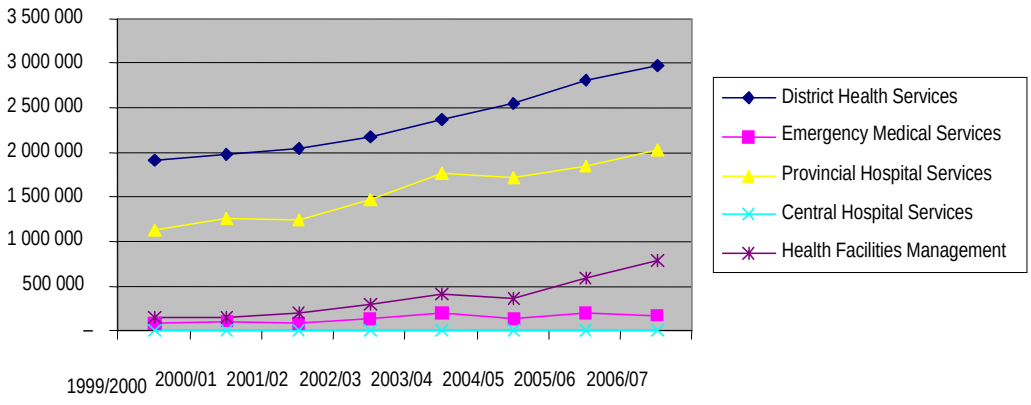


Table 7a shows an analysis of health expenditure by selected programmes and sub-programmes from 1999/2000 to 2007/08 within the Eastern Cape. The overall impression produced by this table is that DHS and PHS were the main cost drivers within the total provincial health expenditure and also made up a combined expenditure of far more than half of the total expenditure for any given year. It is observed that DHS was expected to grow at 7.2 per cent from between 2000/01 and 2007/08, followed by 7.4 per cent in EMS, PHS at 8.9 per cent, and HFM at 27.8 per cent.

DHS

DHS expenditure in the Eastern Cape was expected to grow by 7.2 per cent from 1.98 billion in 2000/01 to R3.2 billion in 2007/08. Although the highest percentage growth was in the sub-programmes district management at 35.4 per cent followed by other community services at 52.2 per cent, the lion's share of the combined expenditure making up DHS is in community health clinic services, community health centres and district hospitals. After declining from R828 million in 2002/03 to R548 million in 2003/04, the sub-programme community health clinics services (CHS) grew by R156 million to an amount of R705 million in 2004/05. Over the medium term, as indicated in Table 7a, DHS was estimated to be at R827 million. The highest expenditure in the DHS programme, district hospitals, is expected to grow at an annual average growth of 2.8 per cent from 2000/01 to 2007/08. The growth in DHS indicates an annual average growth of 8.4 per cent within current payments, 5.2 per cent in transfers and subsidies and a 16.8 per cent growth in payment for capital assets. The growth in payment of capital assets confirms an investment in DHS infrastructure as an expected output of the PHC implementation and DHS policy requirements.

Expenditure in current payments specifically for compensation, grew R553 million from R1,4 billion in 2001/02 to an estimated R1,9 billion in 2007/08. Goods and services also grew by R493 million from R291 million to an estimated R789 million in 2007/08. These levels of expenditure and the consistent nominal increases in DHS show an increasing push of DHS policy articulation aligned to the national priorities and objectives set within this programme.

Table 7a: Eastern Cape health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome		Medium-term estimates		
District Health Services	**1,910,873**	**1,983,386**	**2,040,610**	**2,181,159**	**2,365,725**	**2,551,020**	**2,794,563**	**2,982,760**	**3,220,700**	**7.2%**
District Management	23,936	17,925	33,346	84,717	79,034	140,479	140,000	143,988	149,397	35.4%
Community Health Clinic Services	396,394	491,020	532,066	828,105	548,977	704,942	771,488	781,486	827,646	7.7%
Community Health Centres	105,218	133,888	87,290	–	361,779	253,061	315,869	320,751	339,996	14.2%
Community Based Services	7,213	9,111	5,984	–	10,810	57,228	57,668	50,017	53,018	28.6%
Other Community Services	381	498	316	–	6,011	9,825	8,464	8,869	9,401	52.2%
HIV/Aids	–	–	–	–	72,729	142,176	177,580	237,543	249,420	–
Nutrition	108,372	15,902	47,696	18,568	20,461	32,248	26,316	–	–	-100.0%
Coroner Services	–	–	–	–	–	1,077	–	–	–	–
District Hospitals	1,269,360	1,315,042	1,333,912	1,249,769	1,265,924	1,209,983	1,297,178	1,440,106	1,591,822	2.8%
Emergency Medical Services	**93,004**	**117,032**	**87,314**	**122,464**	**194,488**	**124,938**	**186,846**	**182,180**	**192,329**	**7.4%**
Emergency Transport	93,004	117,032	87,314	122,464	159,650	73,795	132,531	126,366	133,166	1.9%
Planned Patient Transport	–	–	–	–	34,838	51,143	54,315	55,814	59,163	–
Provincial Hospital Services	**1,132,472**	**1,250,272**	**1,237,957**	**1,470,194**	**1,764,282**	**1,711,957**	**1,850,037**	**2,019,097**	**2,269,971**	**8.9%**
General (Regional) Hospitals	976,921	1,104,315	1,052,854	1,294,392	1,520,871	1,449,016	1,524,961	1,657,706	1,875,688	7.9%
TB Hospitals	–	–	–	–	80,760	48,907	96,279	120,818	139,276	–
Psychiatric/Mental Hospitals	155,551	145,957	185,103	175,802	162,578	214,034	228,797	240,573	255,007	8.3%
Chronic Medical Hospitals	–	–	–	–	70	–	–	–	–	–
Dental Training Hospitals	–	–	–	–	3	–	–	–	–	–
Other Specialised Hospitals	–	–	–	–	–	–	–	–	–	–
Central Hospital Services	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Central Hospital Services	–	–	–	–	–	–	–	–	–	–
Provincial Tertiary Hospital Service	–	–	–	–	–	–	–	–	–	–
Health Facilities Management	**155,269**	**151,190**	**189,962**	**303,218**	**404,875**	**370,048**	**578,242**	**777,283**	**842,617**	**27.8%**
Community Health Facilities	–	–	–	–	–	76,409	122,413	193,601	215,395	–
Emergency Medical Rescue Servic	–	–	–	–	–	–	–	–	–	–
District Hospital Services	91,551	100,190	100,962	199,645	304,337	204,522	392,329	389,816	411,550	22.4%
Provincial Hospital Services	63,718	51,000	89,000	103,573	100,506	89,116	63,500	193,866	215,672	22.9%
Central Hospital Services	–	–	–	–	32	–	–	–	–	–
Total selected programmes	**3,291,618**	**3,501,880**	**3,555,843**	**4,077,035**	**4,729,370**	**4,757,963**	**5,409,688**	**5,961,320**	**6,525,617**	**9.3%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

The increasing expenditure in compensation of employees is also indicative of an investment in greater numbers of personnel. Transfers and subsidies to provinces and municipalities also more than doubled within the DHS, increasing from R110 million in 2001/02 to R232 million in 2007/08. While expenditure in transfers and subsidies for non-profit institutions declined from R230 million in 2001/02 to R201 million in 2007/08, this movement of funds away from NGOs is a result of internal shifts within the programme towards capital assets and increased spending on compensation.

EMS

Table 7a shows a rollercoaster expenditure pattern within *EMS.* Expenditure declined from a R117 million in 2000/01 to R87 million in 2001/02. Although there is nominal growth in expenditure for the years to 2003/04 to R194 million, expenditure declined again to its 2002/03 level of around R124 million in 2004/05. Expenditure is, however expected to increase to an estimated outcome of R192 million by 2007/08. Current payments as captured in Appendix A: Eastern Cape grew strongly at 76.7 per cent mainly due to increase expenditure on compensation of employees and goods and services. The National Treasury (2005d:11) notes in its *Preliminary Observations on 2005 Provincial Budget*s that the provincial budget for compensation of employees to be insufficient over the 2005/06 to 2007/08 MTEF periods It further states that:

> Given that the health sector is faced with the challenge of appointing more specialists (doctors and nurse for example) and the restructuring of remuneration of certain categories of professional health personnel to cater for scarce skills and rural allowances, the current growth in the personnel [compensation of employees] is not sufficient, with a possible shortfall of R140 million, R135 million and R114 million in 2005/06, 2006/07 and 2007/08 respectively. … The medicine budget sharply decreases by 34.1 per cent year on year and continues to decline by 9.5 per cent over the MTEF period. The shortfall under “goods and services” budget amounts to R36 million in 2005/06.

The increase in compensation of employees between 2000/01 and 2007/8 is mainly due to the implementation of a national policy approach and priority to provincialise EMS and the provincial decision to purchase new ambulances. This reflects, firstly, an interdependence between the national and provincial policy decisions and, secondly, the budgetary outcome – thus, a policy implementation synergy of different policy decisions between the spheres.

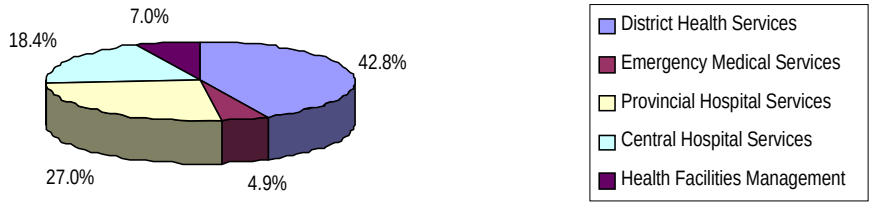
Free State Province - Health Service Expenditure

The expenditures in selected health programmes in the Free State are shown in Diagrams 5c and 5d, and Table 7b and in Annexure B – Economic Classification for Free State. While Table 7b shows both health-programme and sub-programme historic expenditure and medium expenditure estimates trends, the different Appendices E provides the expenditure trends within the programmes by economic classification.

Expenditure by health programme

The Diagram 5c above shows that during 2005/06 00 the DHS proportional expenditure share was at least more than 15 per cent higher than PHS, which was at 27 per cent. PHS expenditure as a proportional share is followed by CHS, which was at 18.4 per cent of total expenditure for the selected programmes. HFM was a 7 per cent, while EMS was at 7 per cent. The proportional share trends, according to this study, seem to be in line with the location of major health service delivery and policy implementation.

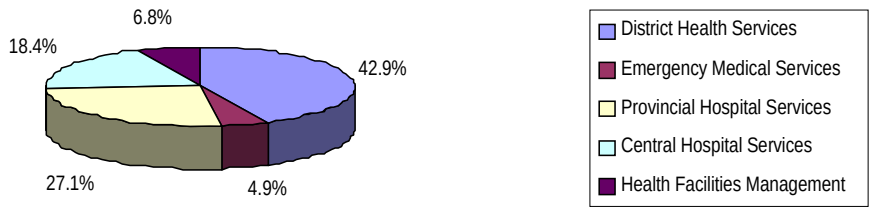
Diagram 5c: Free State health expenditure by selected programmes: 2005/06



A comparison of the proportional share of expenditure for 2005/06 to 2006/07 shown in Diagram 5c and Diagram 5d, shows that in Diagram 5d there was a slight shift in the proportional shares. The shift led to an increase of 0.1 per cent in both DHS and PHS, with a 0.2 per cent decline in HFM. Although small in percentage terms, the proportional increase is a clear signal by the provinces to ensure not only an increase in budget, revenue and expenditure on major health care service delivery responsibilities, but also to ensure stability in expenditure planning and consistency in it fiscal policy approach

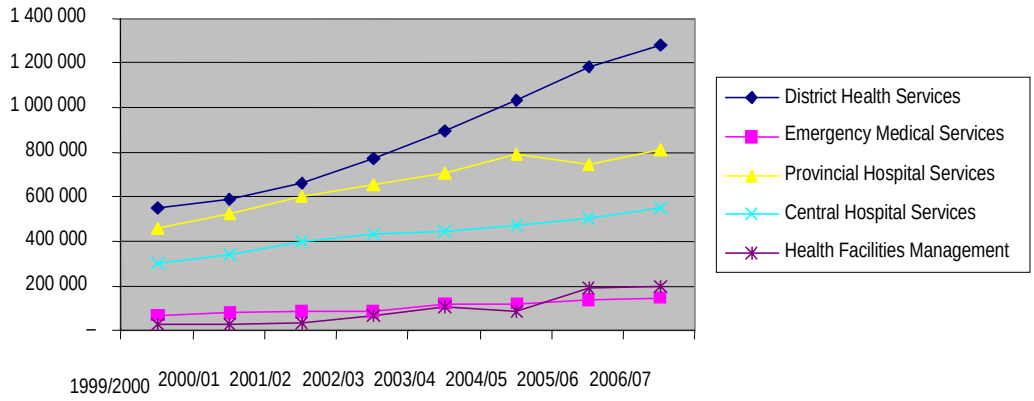
within public health, including a policy commitment towards maintaining the shift of resource towards a district health system. The commitment in revenue, budgets and expenditure going forward could, however, also be as a result of relative stability in the provision of facilities and their maintenance.

Diagram 5d: Free State health expenditure by selected programmes: 2006/07



Line Graph 5c confirms a consistent, but strong upward expenditure in DHS, PHS, and moderate increases in CHS and EMS. It also shows a close but stable growth pattern in both EMS and HFM.

Graph 5b: Free State health expenditure by selected programmes



DHS

According to Table 7b, the increase in expenditure for DHS amounted to R441 million from R592 million in 2000/01 to R1 billion in 2004/05. The expenditure grew further by at least R334 million to R1, 4 billion in 2007/08. The District Management expenditure within the DHS programme grew the fastest within the DHS from a low of R23 million to about around R224 million in 2007/08, an annual average growth rate of 35.8 per cent. This growth not only reflects a conscious expenditure policy on district management, but also an overall increase in expenditure towards support of district health system through the management and development of structures, which is a direct result of the provinces commitment to the development of the district health system. There are, however, declines in expenditure of close to R30 million in DHS between 2002/03 and 2003/04, which is an indication of funds shifting between the different programmes and it seems from Table 7b that the benefactors were the sub-programmes of community health centres, CHS and other community services, all benefactors within the DHS. Revenue over this period for expenditure was, therefore, not lost to this programme.

The DHS expenditure is particularly boosted by expenditure in the HIV and Aids sub-programme. The expenditure in this sub-programme grew from an initial expenditure of R12, 8 million in 2000/01 to R128,3 million in 2007/08. This is not only an increase by ten times, but also an increase by 35.4 per cent. The direct investment of central government in this sub-programme through the HIV and Aids Conditional Grant augmented the expenditure on this programme contributing towards the upward growth. The conditional grant funding in this programme thereby ensures that expenditure in this programme addresses not only national policy decisions on HIV and Aids, but also national priorities set through the conditional framework by the central government.

A further commitment by the provinces to the roll-out of primary health care through the implementation of the DHS policy is demonstrated through a steady growth in expenditure in the community health clinics, community health centres, and community-based-services sub-programmes, each growing over the period from 2000/01 to 2007/08 by 18.3 per cent, 21.4 per cent, and 10.1 per cent, respectively.

The additional expenditure to the roll-out of primary health care sees growth in expenditure of 5.9 per cent on district hospitals, while expenditure on nutrition sharply declined by minus 204.3 per cent as an outcome of a national policy decision to transfer the nutrition programme to the public education sector in order to augment the public school feeding programme. An assessment of the economic classification shows a strong growth in expenditure on compensation of employees within the DHS, with only a decline of R103 million in expenditure between the 2004/05 adjusted budget and the revised estimate expenditure for the same fiscal year. The growth in expenditure for the compensation of employees is according to 2005/06 fiscal year projections above the inflation rate, thus demonstrating that adequate account has been taken of the rural and the scarce skills allowances, an additional national policy and funding obligatory priority. The National Treasury (2005d) notes that:

> [t]he growth in the compensation of employees in aggregate appears to be adequate and in line with what has been the proposed growth rate in the allocation letter to provinces. Provinces were informed that they needed to assume salary growth rates of 5.5; 5.5 and 5.0 per cent for 2005/06, 2006/07, and 2007/08.

The expenditures on transfers and subsidies, according to Appendix B – Economic Classification: Free State, reflects an unstable expenditure pattern showing a percentage growth of minus 18.5 per cent. These declines denote a reduction in transfers and subsidies to municipalities in the delivery of primary health care or an upward shift in the primary health care services in synergy with the national policy of provincialisation of primary health care. A similar pattern is experienced in payments for capital assets after declining from R21, 8 million in 1999/00 to R4,7 million in 2000/01, a drastic cutback in capital payments. This decline was a result of a completion of the province's district-clinic-building programme, a national policy priority which was implemented to increase access to primary health care facilities and programmes started during the second part of the 1990s.

The expenditure in current payments on the EMS programme grew from R76, 6million in 2001/02 to R87, 1million in 2007/08, annual average growth of about 1.7 per cent. The bulk of expenditure was on 'goods and services; which remained above R70million between 2001/02 and 2003/04. During 2004/05 expenditure on goods and services declined to a revised estimate of R67million reaching an estimated amount of above R70million in 2006/07 and 2007/08. 'Compensation of employees' grew by more than

R9million from R443 thousand in 2001/02 to R9.6 million in 2007/08, reflecting an expansion of EMS to appoint additional critical skilled staff.

Public health expenditure in the major selected health programmes within the Free State grew at an annual average of 10.8 per cent between 2000/01 and 2007/08, as shown in Table 7b. The growth amounts to an increase in expenditure from R1, 5 billion in 2000/01 to R3,2 billion in 2007/08. By far the greatest growth in health programme expenditure is in the HFM programme growing from R22 million in 2000/01 to R182 million in 2007/08, which amounts to an increase of 35.2 per cent. However, the bulk of expending is on DHS, which grew by 12.7 per cent between 2000/01 and 2007/08, followed by PHS growing at 7.5 per cent, and CHS at 8.3 per cent. While expenditure on EMS (EMS) grew relatively faster at 11 per cent than some of the major spending programmes, its growth is from a small expenditure base.

Table 5b: Free State health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**546 328**	**592 679**	**657 143**	**774 943**	**893 590**	**1 033 759**	**1 179 002**	**1 273 989**	**1 368 526**	**12.7%**
District Management	23 010	26 378	56 136	49 184	29 532	82 746	195 960	210 690	224 123	35.8%
Community Health Clinics	40 365	48 371	46 401	–	126 700	212 426	136 885	147 174	156 557	18.3%
Community Health Centres	11 196	13 416	12 870	–	40 921	42 706	45 527	48 949	52 070	21.4%
Community Based Services	84 674	101 468	94 147	382 833	255 034	173 189	164 943	180 524	198 690	10.1%
Other Community Services	479	574	551	–	3 393	1	–	–	–	-100.0%
HIV/AIDS	12 815	15 356	14 731	–	34 227	82 358	112 237	120 674	128 367	35.4%
Nutrition	20 458	-10 151	–	–	7 603	28 673	11 951	12 850	13 669	-204.3%
Coroner Services	–	–	–	–	–	1 029	–	–	–	–
District Hospitals	353 331	397 267	432 307	342 926	396 180	410 630	511 499	553 128	595 050	5.9%
Emergency Medical Services	**69 708**	**74 422**	**89 143**	**90 941**	**118 966**	**123 904**	**135 079**	**145 233**	**154 492**	**11.0%**
Emergency Transport	64 135	68 468	82 012	90 941	114 374	113 541	128 734	138 410	147 235	11.6%
Planned Patient Transport	5 573	5 954	7 131	–	4 592	10 363	6 345	6 823	7 257	2.9%
Provincial Hospital Services	**463 212**	**519 939**	**596 122**	**648 436**	**705 210**	**792 354**	**745 026**	**805 050**	**864 789**	**7.5%**
General Hospital	402 133	445 824	526 830	555 449	597 101	664 911	621 412	672 145	723 410	7.2%
Psychiatric/Mental Hospitals	61 080	74 115	69 292	92 987	108 109	127 443	123 614	132 905	141 379	9.7%
Central Hospital Services	**306 204**	**335 549**	**398 035**	**432 971**	**446 425**	**468 832**	**506 619**	**547 435**	**588 058**	**8.3%**
Universitas Hospital	306 204	335 549	398 035	432 971	446 425	468 832	358 712	385 676	410 265	2.9%
Central Hospital Services	–	–	–	–	–	–	147 907	161 759	177 793	–
Health Facilities Management	**24 466**	**22 085**	**35 359**	**71 533**	**104 709**	**84 667**	**191 846**	**201 038**	**182 124**	**35.2%**
Community Health Facilities	6 204	–	14 567	26 734	28 073	30 006	31 946	34 348	36 537	–
District Hospital Services	13 739	11 613	20 644	25 511	33 832	23 397	49 551	53 276	56 673	25.4%
Provincial Hospital Services	4 464	10 472	8	19 288	41 037	30 092	110 349	113 414	88 914	35.7%
Central Hospital Services	60	–	140	–	1 767	1 172	–	–	–	–
Total selected programmes	**1 409 918**	**1 544 674**	**1 775 802**	**2 018 824**	**2 268 900**	**2 503 516**	**2 757 572**	**2 972 745**	**3 157 989**	**10.8%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

EMS

The EMS (EMS) grew by 11 per cent from 2000/01 to 2007/08 from R69, 9million, increasing to R154,4 million over the period. Strong growth is particular observed within emergency transport sub-programme, which could be for the purchasing of vehicles, such as ambulances by the province. Further investment in emergency transport has however been slow growing at only 2.9 per cent from R5.6 million to R7,2 million between 2000/01 and 2007/08. The current payments according to Appendix B show an increase in expenditure of 9.2 per cent from R81.6million in 2001/02 to R138million in 2007/08, a growth rate of 9.2 per cent. The bulk of the expenditure in current payments was on compensation of employees growing from R50million in 2001/02 to R90million. The increase shows a growing expenditure towards compensation of employees, which is aligned to the central government's overall policy of "making sure that service delivery is not compromised by shortages of skilled and productive individuals in the public service.." (National Treasury, 2005c:119). All expenditure on capital assets within EMS, which grew by 12.7 per cent, from R7, 4 million to R15, 3 million was on machinery and equipment. This expenditure was channeled to the purchasing of ambulances, which is a provincial-department-determined priority.

PHS

The PHS expenditure shows a growth of 7.5 per cent (Table 7b), with the bulk of expenditure on the general hospitals' sub-programme. Similar to DHS expenditure, the largest expenditure item in PHS is compensation of employees; this grew from R448 million in 2001/02 to R628 million in 2007/08. PHS (PHS) budget in HFM grew by 27.3 per cent from R4, 4 million to R56million in 2007/08. This is a direct expenditure resulting from a national policy priority to revitalise hospitals through the National Tertiary Service Grant.

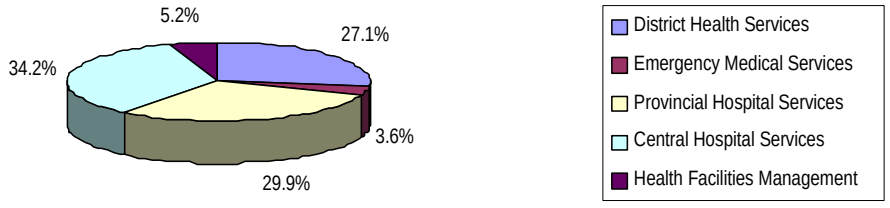
A slightly higher growth was observed in CHS, growing at 8.3 per cent from R355million in 2000/01 to R588 million in 2007/08. The bulk of expenditure was for the Universitas Hospital in Bloemfontein. The expenditure on this hospital also grew by 2.9 per cent over the same period. As it is to be expected, the lion's share of expenditure was for the compensation of employees, growing from R448million in 2001/02 to R628million in 2007/08. According to the National Treasury, the Free State's central hospital sub-programme expenditure healthy growth (National Treasury, 2005c).

Transfers and subsidies in this programme were at R865million in 2004/05, growing only by R396million to an estimated expenditure outcome of R1, 2 billion in 2007/08. Payments of capital assets in CHS (CHS) were mostly for machinery and equipment declining from R6.5 million in 2001/02 to R2,7 million in 2007/08. This decline could be as a result of the economic reclassification in payments of capital assets under the HFM programme. While payments for capital assets declined in the CHS programme, within the HFM programme expenditure on CHS, as a sub-programme within HFM grew from R19, 2 million in 2002/03 to R89 million in 2007/08. The expenditure on capital assets in CHS confirmed the financial data classification problems within the health data. This is a substantial increase that amounts to around R70 million. Community Health Facilities, ostensibly a programme for primary health care facilities as indicated in Table 7b, for DHS was at R36,5 million by 2007/08. This further demonstrates a further increase in the implementation of primary health care services as priority services and the enhancement of the district health system.

Gauteng Province - Health Service Expenditure

The Diagrams 5e and 5f shows that compared to both the Eastern Cape and Free State provinces, the proportional share of central hospitals dominates the health programmes expenditure within the Gauteng Province. CHS (CHS) is at 34.2 per cent as a proportion of total health programme expenditure. The proportional share of DHS was 27.1 per cent, PHS was at 29.9 per cent, EMS at 3.6 per cent, and HFM at 5.2 per cent during the 2005/06 financial year.

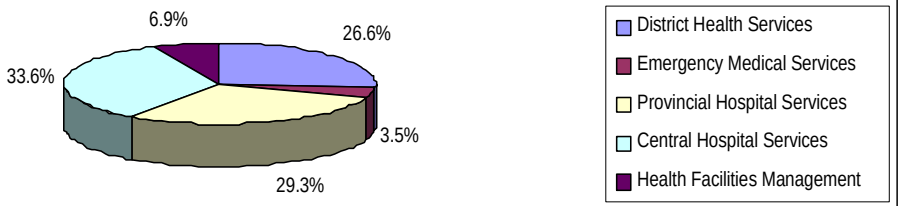
Diagram 5e: Gauteng health expenditure by selected programmes: 2005/06



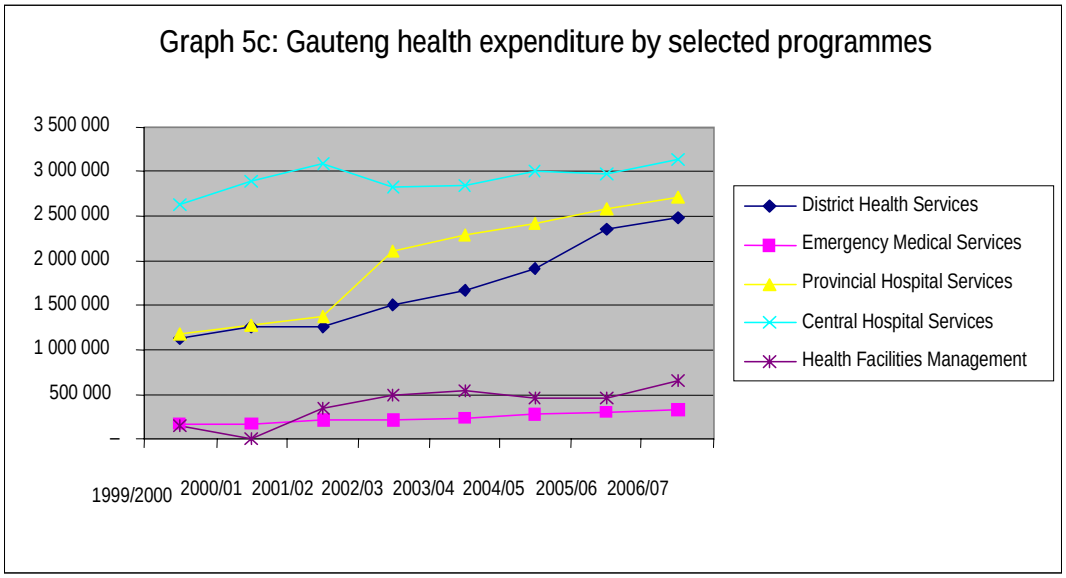
Expenditure by health programme

However, over the 2006/07 financial year there were major shifts in the expenditure pattern within the selected health programmes. There were overall declines in the proportional share of expenditure in major programmes, with declines observed in CHS by 0.6 per cent, DHS by 0.5 per cent, PHS by 0.6 per cent, and EMS by 0.1 per cent. The HFM was the benefactor from the declines in these programmes, growing by 1.7 per cent to 6.9 per cent as a proportional share of total expenditure in 2006/07.

Diagram 5f: Gauteng health expenditure by selected programmes: 2006/07



The Line Graph shows an upward expenditure trend between 1999/2000 and 2001/02 in CHS, declining sharply to below expenditure levels in 2002/03 and 2003/04. While there was a decline in CHS, there was a sharp increase in expenditure in PHS and DHS from 2001/02 to the 2007/08 financial years. As a result of the shifting of fiscal resources between the major programmes from 2000/01, expenditure in the HFM increased moderately, but remained stable from 2002/03 in 2005/06. A slight increase in growth is observed to 2006/07.



Growth in expenditure as shown Table 7c in health programmes within the Gauteng Province indicates an overall annual average growth of 8.2 per cent from 2000/01 to 2007/08. The annual average growth rate ranges from 11 per cent for DHS, EMS at 10.9 per cent, and PHS at 12.1 per cent. The only expenditure far below the overall annual average was CHS at 1.6 per cent. The percentage growth of HFM, which was also far below the annual average growth seems to have been affected by the budget structure reform and the reclassification of economic expenditure data.

DHS

Table 7c shows that within the *DHS* (DHS) programme, expenditure growth between 2000/01 to 2007/08 was the highest in community health clinics at 29.8 per cent. Expenditure on community health clinics grew from R102 million in 2000/01 to R634 million in 2007/08, an estimated increase that amounts to around R532million. The sharp increase in community health clinics and HFM expenditure could be ascribed to a direct output of the national policy priority of the clinic building programme. According to a public health interview respondent “over the period a more than 30 clinics were built”.

The district management sub-programme grew at an annual average rate of minus 7.2 per cent. The growth rate translates into a decline of expenditure from R522million in 2000/01 to R310million in 2007/08, a decline in expenditure of R241million. Another expenditure to grow at

an accelerated pace was community health centres – from R174 million in 2000/01 to R329 million in 2007/08, growing by R15, 5 million over the period. This is growth of 9.5 per cent. The HIV and Aids sub-programme starting in 2002/03 grew from R65million to R480milion in 2007/08, growing by around R415 million over the period. This growth in the sub-programme is a direct result of the impact of the HIV and Aids conditional grant allocation. Clearly the national policy implementation driven through the conditional grant has had a dominant impact on the growth of expenditure. This connection between expenditures demonstrates a close synergy between central government funding and provincial government matching in expenditure.

The nutrition sub-programme grew at a negative rate of minus 30 per cent, declining from R63 million in 2000/01 to R5million in 2007/08. This is a direct outcome of the shift of the nutrition programme to the education sector in 2003/04. District hospitals grew by around R190 million from R391 million in 2000/01 to around R581 million in 2007/08. The growth in district hospital expenditure is particularly high between 2004/05 and 2005/06, growing by R128 million from around R394 million in 2004/05 to R522 million in 2005/06. The expenditure growth trajectory remained above R500 million in the outer years.

Overall consolidate expenditure in the DHS for current payments grew from slightly more than R1billion in 2001/02 to R2 billion in 2007/08. This is an annual average growth of 11.5 per cent. The bulk of expenditure in the current payments is for compensation of employees, ranging from R667 million in 2001/02 to R1,1 billion in 2007/08. Expenditure in goods and services also grew by more than double from R376 million in 2001/02 to R889 million in 2007/08, an annual average increase of 236 per cent. Expenditure within this economic classification was especially geared towards medicines and drugs to support the further roll-out of DHS.

Transfer and subsidies grew at 18.5 per cent from R204 million in 2001/02 to R567million in 2007/08. Transfers and subsidies for provinces and municipalities and the non-profit institutions makes up the bulk of expenditures. Payments for capital assets expenditure grew at 14.3 per cent from R14 million in 2001/02 to R30,8 million in 2007/08. The expenditure in particular on machinery and equipment has more than doubled, starting at around R14million in 2001/02 to R31million in 2007/08.

EMS

Expenditure on EMS, as shown in Table 7c, is above the total selected health programmes expenditure of 8.2 per cent at 10.9 per cent between 2000/01 and 2007/08. The bulk expenditure in this programmes is on emergency transport, at 10.2 per cent, growing from R165million in 2000/01 to R326million in 2007/08. The growth is particularly ascribed to a provincial policy decision to purchase ambulances and other forms of transport services.

Table 7c: Gauteng health expenditure by selected programmes and their sub-programmes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**1,140,385**	**1,251,754**	**1,260,835**	**1,510,430**	**1,676,623**	**1,911,057**	**2,351,981**	**2,474,906**	**2,602,500**	**11.0%**
District Management	470,661	522,377	550,813	566,553	446,062	353,643	279,930	295,000	310,000	-7.2%
Community Health Clinics	164,484	102,108	272,945	524,063	324,627	391,329	572,000	603,000	634,000	29.8%
Community Health Centres	113,591	173,860	85,147	–	233,126	265,504	277,000	313,000	329,000	9.5%
Community Based Services	–	–	–	–	168,991	227,179	238,000	250,000	264,000	–
HIV/AIDS	–	–	–	64,725	118,043	266,843	435,048	457,000	480,000	–
Nutrition	55,826	62,692	18,859	7,448	15,240	11,923	27,403	5,106	5,000	-30.3%
District Hospital	335,823	390,717	333,071	347,641	370,534	394,636	522,600	551,800	580,500	5.8%
Emergency Medical Services	**163,075**	**165,053**	**206,787**	**214,480**	**247,900**	**277,899**	**309,772**	**325,100**	**341,100**	**10.9%**
Emergency Transport	163,075	165,053	206,787	214,480	244,537	277,805	306,772	315,100	326,100	10.2%
Planned Patient Transport	–	–	–	–	3,363	94	3,000	10,000	15,000	–
Provincial Hospital Services	**1,165,154**	**1,288,405**	**1,368,349**	**2,115,906**	**2,292,408**	**2,417,069**	**2,591,850**	**2,723,402**	**2,865,700**	**12.1%**
General Hospitals	766,115	840,411	906,466	1,639,179	1,753,596	1,830,396	1,986,900	2,085,202	2,195,200	14.7%
Psychiatric/Mental Hospitals	284,997	327,286	322,557	341,840	388,692	426,347	428,650	450,200	472,500	5.4%
Other Specialised Hospital	25,465	26,229	31,836	30,444	35,832	41,793	45,500	51,000	54,000	10.9%
Dental Training Hospitals	88,576	94,479	107,490	104,443	114,288	118,533	130,800	137,000	144,000	6.2%
Central Hospital Services	**2,625,046**	**2,892,627**	**3,092,936**	**2,831,224**	**2,857,212**	**2,992,767**	**2,970,988**	**3,119,950**	**3,239,710**	**1.6%**
Chris Hani Baragwanth Hospital	630,202	681,269	3,092,936	2,831,224	2,857,212	2,992,767	2,970,988	3,119,950	3,239,710	25.0%
Johannesburg Hospital	593,964	673,040	–	–	–	–	–	–	–	-100.0%
Pretoria Academic Hospital	485,434	534,168	–	–	–	–	–	–	–	-100.0%
Other	915,446	1,004,150	–	–	–	–	–	–	–	-100.0%
Health Facilities Management	**155,304**	**–**	**354,120**	**493,361**	**547,941**	**461,927**	**453,085**	**645,351**	**663,166**	**–**
Community Health Facilities	–	–	–	–	69,461	72,006	35,167	40,731	38,625	–
Emergency Medical Rescue Servic	–	–	–	–	616	3,516	500	500	500	–
District Hospital Services	–	–	–	–	35,574	75,680	69,862	172,377	165,365	–
Provincial Hospital Services	–	–	–	–	127,438	109,846	121,884	118,343	129,883	–
Central Hospital Services	–	–	–	–	293,272	125,566	162,852	149,666	162,263	–
Other Facilities	155,304	–	354,120	493,361	21,580	75,313	62,820	163,734	166,530	–
Total selected programmes	**5,248,964**	**5,597,839**	**6,283,027**	**7,165,401**	**7,622,084**	**8,060,719**	**8,677,676**	**9,288,709**	**9,712,176**	**8.2%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

Overall spending on transfers and subsidies grew by 10.4 per cent in 2001/02 from R128million to R231million in 2007/08. Expenditure in this category was mainly on transfers to households, with expenditure only in 2004/05 towards 'provinces and municipalities'. All expenditure in payment for capital assets was towards machinery and equipment with revised estimates of expenditure towards software and other tangible assets in 2004/05. Overall expenditure on payment of assets grew by 158.9 per cent from R73million in 2001/02 to R22million in 2007/08.

Within the PHS (PHS) programme, expenditure on the sub-programmes grew by 14.7 per cent for general hospitals, 5.4 per cent for psychiatric/mental hospitals, 10.9 per cent for other specialised hospitals, and dental training hospitals at 6.2 per cent from 2000/01 to 2007/08. These expenditures on PHS not only show consistent growth in expenditure, but also reflect the provincial constraints on choice and manoeuvrability in shifting funds to other programmes. The expenditure on PHS grew from R1.3billion to R2.9billion, an increase in expenditure of about R1.6billion from 2000/01 to 2007/08. The bulk on expenditure in this programme is on general hospitals, which grew from R850 thousand in 2000/01 to R2, 2billion in 2007/08. Psychiatric/mental hospital expenditure increases from R327million in 2000/01 to R472million, an annual average growth of 5.4 per cent.

Expenditure on dental training hospitals increase from R94.4million in 2000/01 to R144million in 2007/08, an annual average growth of 6.2 per cent over the period. Within PHC the greatest share of spending was on current payments which grew from R1,2billion in 2001/02 to R2,6billion in 2007/08 (Table 7c), an annual average expenditure growth of 13.4 per cent over the period. Compensation of employees, which is the major expenditure item under current payments, grew from R915million in 2001/02 by around R894million to R1,8billion in 2007/08. Goods and services grew by more that 2.5 times from its expenditure level of R297million in 2001/02 to R764million in 2007/08.

Transfers and subsidies expenditure on PHS grew from R125million in 2001/02 to R197million in 2007/08, an annual average increase of 7.9 per cent. Expenditure from 2001/02 to 2003/04 on the transfers and subsidies is mostly for departmental agencies and accounts, which is diversified over the period 2004/05 to 2007/08, including funding towards provinces and municipalities and households. The expenditure growth on 'payments for capital assets' grew by 20 per cent over the 2001/02 to 2007/08 period,

from R31, 5million to R94million. The majority of expenditure was for machinery and equipment, with only R122 thousand going towards software and tangible assets during 2004/05.

CHS

CHS (CHS) expenditure grew by 1.6 per cent from R2, 9billion in 2000/01 to R3, 2billion in 2007/08. Most of the expenditure on 'current payments' within the CHS programme was allocated to compensation of employees and goods and services. Current payments grew by 0.7 per cent from R3billion in 2001/02 to R3, 1 billion in 2007/08. Compensation on employees grew from R1, 8 billion in 2001/02 to R1,9billion in 2007/08. The high level of spending for compensation of employees is to be expected, given the specialist health service delivery nature of CHS, especially in a province like Gauteng, as well as the scarce skills requirements of the this province. The researcher, therefore, argues that the expenditure trend on compensation of employees within this programme is closely aligned to the policy expectation of retaining and employing specialist skilled health personnel. Payments for capital assets is all on machinery and equipment growing from R56, 5million in 2001/02 to R62million, increasing by around R5million. This is growth was also at an annual average of 1.5 per cent.

Expenditure on towards Chris Hani Baragwanath Hospital (CHB) as a sub-programme of CHS grew the fastest at 6.1 per cent relative to Johannesburg Hospital, which had a growth of 4.2 per cent. Expenditure on Pretoria Academic Hospital was 3.1 per cent. The expenditure trends within the CHB sub-programme amounts to an increase of R351million, moving from R681million in 2000/01 to R1billion in 2007/08. This amounts to an annual average increase of expenditure in CHB of around R50million. This is the highest annual average increase relative to the other sub-programmes within the CHS programme.

Johannesburg Hospital expenditure increase from R673million in 2000/01 to R900million in 2007/08, increasing annually by an average of around R32million, while expenditure on Pretoria Academic Hospital increased from R534million in 2000/01 to R661million in 2007/08. The annual average increase of R18million for Pretoria Academic Hospital was the lowest, relative to the other hospital sub-programmes. This low level of annual

average increase reflects the declines in the nominal baseline expenditure within this hospital, particularly the decline from R660million in the 2004/05 preliminary outcome to R603million in 2005/06. While there is a moderate growth in nominal terms, expenditure in this sub-programme only reaches close to the 2004/05 preliminary outcome expenditure level by 2007/08 at R661million.

While there was a particularly strong growth in expenditure in Johannesburg Hospital between 2003/04 and 2004/05, reflecting a growth in expenditure of R42million between these financial years, expenditure declined by R34million in the 2005/06 financial years. Over the next year it grew moderately by moving above its 2004/05 preliminary outcome to R866million in 2006/07 and R900million in 2007/08.

The overall expenditure trend in CHS is not only reflective of a historical bias in expenditure towards hospital services, but also indicative of higher medium estimates in expenditure towards CHB compared to those for the other hospitals. This expenditure bias towards CHB, the researcher argues, could be as a result of wanting to reach equity in health services and expenditure inputs between the different hospitals within this programme, noting, of course that, historically, Johannesburg Hospital and Pretoria Academic Hospital mostly directed their health services towards the white population group. The increase in expenditure is also attributable to the National Tertiary Service Grant (NTSG). According to the National Treasury (2005c:39):

> Compared to primary health care funding, hospital expenditure has been virtually constant over this period and has declined in real per capita terms. This applies particularly to the large central hospitals. At the same time the proportion of patients admitted for HIV and Aids related illnesses has increased significantly as demonstrated in a range of surveys. Hospitals appear to have dealt with this increased pressure within a constant real funding envelope, by raising thresholds for admission and reducing length of stay. While efficiency gains have been and continue to be necessary, some increases in future hospital budgets will be necessary for improving quality and making sure that they remain accessible.

According to the economic classifications on expenditure within CHS, most expenditure is on current payments followed by expenditure on payments for capital assets. Within current payments, expenditure on compensation of employees is the major cost driver. Expenditure on current payments increased by R135million from R3billion in 2001/02 to around R3.2billion in 2007/08. This increase is particularly noticeable within the expenditure on compensation of employees, increasing by R102million from R1, 9billion

to R2billion between 2001/02 and 2007/08. This increase in expenditure on compensation seems to be a direct output of the scarce skills and remuneration and retention policy on personnel. It is particularly in programmes such as the CHS where this policy is more applicable because of the kind of specialist skills required within tertiary hospital care. However, despite this increase in nominal terms, the expenditure on compensation of employees grew by less than 1 per cent at 0.88 per cent. The National Treasury (2005e) states in its *Summary Report - Outcome of the 2005 Provincial Benchmark Exercise, 3 February 2005,* that the growth in overall health personnel expenditure is "adequate to fund inflationary adjustments on salaries as well as the need to provide allowances for scarce health skills' (National Treasury, 2005e:p12).

Goods and services expenditure grew by 0.47 per cent on the CHS programme from R1.14billion in 2001/02 to about R1,18billion in 2007/08. Expenditure on payments for capital assets grew at 1.53 per cent from R57million in 2001/02 to R62millioin in 2007/08. All expenditure on payments for capital assets was allocated to machinery and equipment. Accordingly, the National Treasury (2005e) observed that the provincial expenditure trajectory on CHS is "not adequately funded as well as goods and services under which provision is made for drugs and medicines with a decreased by 0.9 per cent which is over R26million". The funding levels are substantially lower than historical allocations. The National Treasury report (2005e:p16) also observed that:

> [g]iven some of the evidence of spending pressures in central hospitals in the current financial year, the current declining growth rate of 2.6 per cent from 2004/05 to 2005/06 and recovering slightly at 2.1 per cent over the MTEF in Gauteng is of concern.

HFM

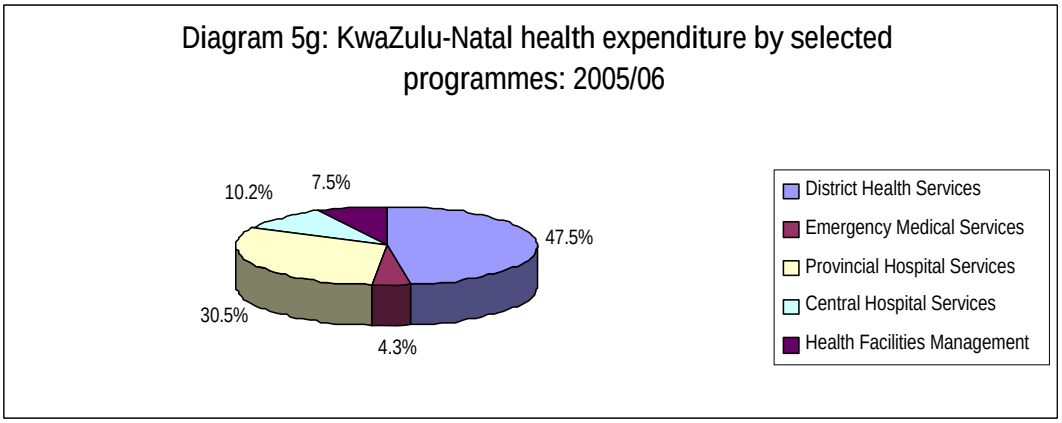
Expenditure on the HFM programme, though not indicated for 2000/01 due to reclassification of financial data, grew, according to Table 7c from R354million in 2000/01 to R663million in 2007/08. Table 7c shows that the bulk of expenditure went towards hospitals – that is, on district, provincial and CHS. Expenditure reflected shows that the majority of an expenditure is on goods and services, which increased by 48 per cent from 2001/02 to 2007/08. This increase amounts to an expenditure growth of R293million from R31million in 2001/02 to R324million in 2007/08. The second significant expenditure was buildings and fixed structures, even though this expenditure

grew by less that 0.52 per cent between 2001/02 to 2007/08 from R323million to R332million.

KwaZulu-Natal Province - Health Service Expenditure

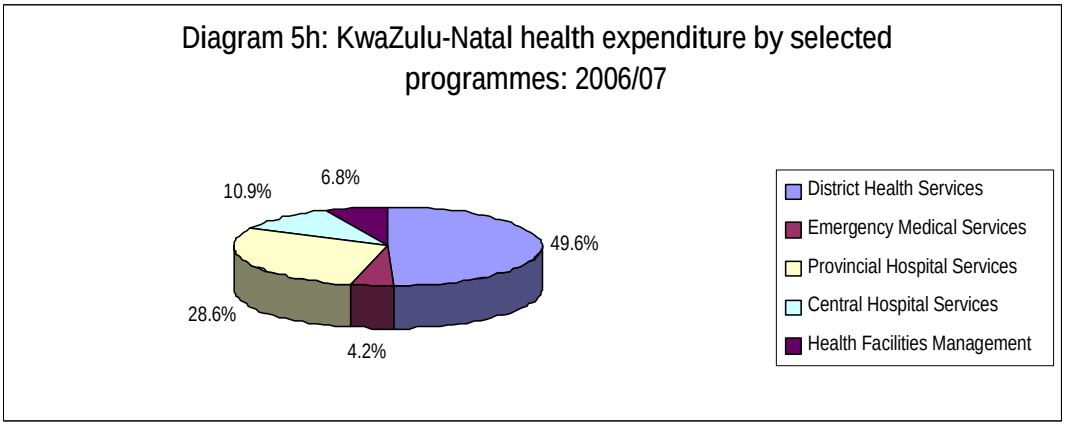
Diagrams 5g and 5h below show KwaZulu-Natal's health expenditure for the chosen selected programmes for 2005/06, indicating that the proportional share of district health expenditure was by far the greatest, at 47.5 per cent.

Diagram 5g: KwaZulu-Natal health expenditure by selected programmes: 2005/06



The second highest proportion in programme expenditure was PHS at 30.5 per cent, followed by CHS at 10.2 per cent, HFM at 7.5 per cent, and EMS at 4.3 per cent.

Diagram 5h: KwaZulu-Natal health expenditure by selected programmes: 2006/07

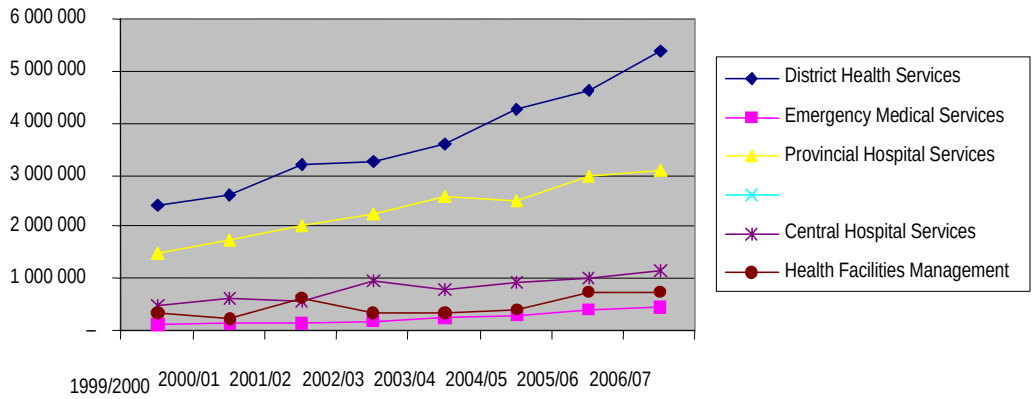


Expenditure by health programme

Diagrams 5g and 5h above shows that there were significant shifts in the funding levels between programmes from 2005/06 to 2006/07. The shift in expenditure especially results in a reduction in funds to EMS of minus 0.1 per cent, PHS of minus 1.9 per cent, and to HFM of minus 0.1 per cent. The benefactors of these declines in the proportional share of expenditure are DHS by 2.1 per cent and CHS by 0.7 per cent. The increase in expenditure as a proportional share of selected programme expenditure is a demonstration of the provinces' intentions to strengthen DHS and the overall system.

The expenditure in selected health programmes in KwaZulu-Natal is also shown in Table 7d and in Annexure D – Economic Classification for KwaZulu-Natal. The growth in the health expenditure for the selected programmes in KwaZulu-Natal (KZN) is at an annual average of 11.5 per cent between 2000/01 to 2007/08. This translates into a growth of R6, 2billion from R5,4 billion in 2000/01 to R11billion in 2007/08 (see Table 7d). Most expenditure in KZN was on DHS, growing at 12.2 per cent, PHS at 9.4 per cent, and CHS at 9.8 per cent over the same period.

Graph 5d: KwaZulu-Natal health expenditure by selected programmes



DHS

As indicated in Table 7d, expenditure on DHS grew from R2, 6billion in 2000/01 to R5, 8billion in 2007/08. The bulk of expenditure in this programme was for community health clinics, which grew from R630million in 2000/01 to R1, 4billion in 2007/08, an increase of 11.8 per cent. The increase in expenditure levels on HIV and Aids grew from R30million in 2000/01 to R991million in 2007/08, representing a growth of 64.5 per cent. This growth of more than R960million, the researcher argues, is definitely a direct output of an interplay between a provincial-national determined policy priority to address the HIV and Aids pandemic, with additional fiscal support from the central government through a conditional grant. The HIV and Aids conditional grant grew from about R13million in 2001/02 to R362million in 2007/08.

The growth in district management expenditure seems to be aligned to the overall policy requirement for the establishment and operationalisation of the district management system. Expenditure on district management grew more than thrice as much as its expenditure level of R26million in 2000/01 to R89million in 2007/08. Significant growth also took place in district hospitals, growing from R1,5billion in 2000/01 to R2,6billion in 2007/08, an increase of 7.7 per cent. The increase in expenditure in district hospitals also signifies a greater financial commitment to the establishment of DHS in terms of the stated national policy. Other than nutrition, expenditure in all programmes is increasing, demonstrating overall expansion of DHS within KZN.

Expenditure on community health clinics and community health centres grew by 11.8 per cent and 12.5 per cent, respectively. The level of expenditure on community health clinics grew from around R630 million in 2000/01 to about R1,4billion in 2007/08, while expenditure on community health centres grew from around R115million in 2000/01 to R262million in 2007/08. Expenditure on community based services grew faster than both community health clinics and health centres at 17.7 per cent over the same period. Community-based services, however grew from a lower base which was at R48million in 2000/01 to R400million in 2007/08. Expenditure growth in district hospitals is from about R1,5billion in 2000/01 to R2,6billion, an annual average growth of 7.7 per cent.

Table 7d: KwaZulu-Natal health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**2,419,435**	**2,625,273**	**3,206,593**	**3,254,212**	**3,578,147**	**4,249,928**	**4,630,789**	**5,352,526**	**5,882,880**	**12.2%**
District Management	23,051	26,056	31,689	42,178	50,409	70,022	76,662	85,495	89,519	19.3%
Community Health Clinics	541,767	629,744	732,585	753,037	845,016	961,623	1,074,345	1,228,140	1,377,854	11.8%
Community Health Centres	100,157	114,683	136,224	144,650	146,254	185,845	217,476	240,197	261,957	12.5%
Community Based Services	44,969	47,743	64,911	81,669	46,566	89,060	112,557	129,121	149,827	17.7%
Other Community Services	205,393	204,137	310,401	183,896	211,105	304,933	318,827	375,087	400,225	10.1%
HIV/Aids	31,841	30,403	49,364	123,401	246,701	348,484	543,304	808,390	991,292	64.5%
Nutrition	118,558	15,412	48,443	63,657	39,793	25,721	26,954	–	–	-100.0%
Coroner Services	–	–	–	–	65	962	–	–	–	–
District Hospitals	1,353,699	1,557,095	1,832,976	1,861,724	1,992,238	2,263,278	2,260,664	2,486,096	2,612,206	7.7%
Emergency Medical Services	**124,741**	**154,158**	**158,336**	**196,428**	**272,046**	**305,713**	**418,995**	**453,380**	**485,614**	**17.8%**
Emergency Transport	115,778	142,958	147,081	193,691	268,074	296,243	393,114	424,535	454,577	18.0%
Planned Patient Transport	8,964	11,200	11,255	2,737	3,972	9,470	25,881	28,845	31,037	15.7%
Provincial Hospital Services	**1,497,607**	**1,758,694**	**2,020,760**	**2,242,949**	**2,570,991**	**2,513,238**	**2,978,262**	**3,086,580**	**3,295,652**	**9.4%**
General Hospital	1,201,634	1,403,577	1,634,424	1,614,437	2,000,181	1,918,146	2,194,722	2,254,941	2,410,421	8.0%
Tuberculosis Hospital	107,171	123,923	144,556	267,065	251,263	268,609	376,448	397,679	418,168	19.0%
Psychiatric Hospital	171,756	211,018	219,254	214,985	258,547	264,840	322,214	343,547	371,444	8.4%
Chronic Medical Hospital	11,650	13,889	15,297	139,622	53,730	53,591	75,740	80,462	85,170	29.6%
Dental Training Hospital	5,395	6,287	7,229	6,840	7,270	8,051	9,138	9,951	10,449	7.5%
Central Hospital Services	**477,181**	**639,022**	**556,323**	**969,210**	**765,370**	**915,055**	**994,735**	**1,173,060**	**1,229,168**	**9.8%**
Central Hospital Services	95,436	127,816	111,265	295,290	211,704	285,879	311,689	366,638	383,699	17.0%
Provincial Tertiary Hospital Servi	381,745	511,206	445,058	673,920	553,666	629,176	683,046	806,422	845,469	7.5%
Health Facilities Management	**342,832**	**234,770**	**624,071**	**324,009**	**347,492**	**426,031**	**728,609**	**731,465**	**726,510**	**17.5%**
Community Health Services	16,040	12,288	27,895	61,243	66,081	80,950	141,323	161,185	137,844	41.2%
District Hospital Services	29,361	29,300	44,254	43,306	86,619	140,857	310,487	265,021	275,000	37.7%
Emergency Medical Services	362	472	435	–	786	2,091	12,200	21,210	21,210	72.2%
Provincial Hospital Services	51,548	56,677	72,459	108,051	117,599	157,552	151,315	160,000	173,961	17.4%
Central Hospital Services	200,069	86,956	414,245	48,509	58,708	8,396	18,000	19,049	19,775	-19.1%
Other Services	45,451	49,077	64,783	62,900	17,699	36,186	95,284	105,000	98,720	10.5%
Total selected programmes	**4,861,797**	**5,411,917**	**6,566,083**	**6,986,808**	**7,534,046**	**8,409,965**	**9,751,390**	**10,797,011**	**11,619,824**	**11.5%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

Current payments on the DHS programme were the strongest cost driver. Within current payments, compensation of employees grew from R2billion in 2001/02 to R3, 8billion in 2007/08. The strong growth in compensation of employees is not only as a result of national policy on salary improvements for personnel, but also because of the restructuring and redeployment process within Gauteng Province since 2001/02 to enhance the district health system. Goods and services also grew fast, reaching unprecedented levels of more than R1billion from a R760million in 2001/02 to R1,7billion in 2007/08. The expenditure on compensation in the DHS programme during 2004/05 was for salaries and wages where the major expenditure items were basic salaries, service bonuses, non-pensionable allowances and overtime. The other major expenditure item in terms of compensation of employees was on social contributions, comprising employer contributions on medical aid payments and pension contributions.

The major cost drivers in the goods and services classification were: consultancy, contract and specialised services, at R134million; inventory at R751million; medical services at R84million; maintenance, repair and running costs at R36million; operating leases at around R7million; owned and leased property expenditure at R52,6milion, which included major expenditure on municipality buildings; travel and subsistence at R22million; training and staff development at R14million; personnel agency fees of about R3,3million; and protective and specialised clothing at R6,6million.

Transfers and subsidies grew from R58million in 2001/02 to approximately R85million in 2007/08. The expenditure on transfers and subsidies supported the expansion of primary health care services through municipalities. The majority of funds was spent on machinery and equipment, declining from R68, 2million to R66million. Major expenditure on transfers and subsidies during 2004/05 were mostly for consultation, contract and specialised services, households social benefits, inventory such as stationery and printing materials, and transfers to more than 29 municipalities for primary health care services and RSC levies, including subsidies to non-profit organisations and owned and leasehold property expenditure.

EMS

EMS grew from R165million in 2000/01 to R341million in 2007/08, growing at an annual average of 10.9 per cent. By far the greatest expenditure as indicated in Table 7d was for emergency transport which grew by 18 per cent over the same period. While emergency transport grew from around R143million in 2000/01 to R454million in 2007/08, the other sub-programme – planned patient transport – grew from R11million to R31million over the same period, an annual average growth rate of 15.7 per cent. The largest expenditure in terms of the economic classification on the EMS was current payments. Within this classification, compensation of employees is growing at an annual average rate of 28.7 per cent between 2001/02 and 2007/08. Most of the expenditure on compensation of employees was allocated to the same expenditure items as indicated in DHS within the EMS programme. Overall expenditure on salaries and wages amounted to 85 per cent, while social contribution was around 14.9 per cent. Salaries and wages is about R151million with the bulk of spending comprising basic salaries, overtime and service bonuses. Expenditure on social contributions was around R27million.

Goods and services grew from R62,5 thousand in 2001/02 to R119,5 thousand, an annual average of 11.4 per cent. Expenditure on goods and services comprises items such as inventory at R30, 4million which includes cost drivers such as fuel, oil and lubricants at R17million, maintenance material around R7million, and oxygen for patients at R2, 3million. Another huge expenditure item was maintenance, repair and running costs at R14,5million, comprising spending on emergency vehicles at around R12million and radio equipment at R1, 7million. Other expenses included: communication such as telephone and faxes at R7million; equipment at R5million; consultancy, contracts and specialised services at R3million; personnel agency fees at R834 thousand; transport for departmental activities at R3, 2million; and travel and subsistence at around R2, 7million.

PHS

PHS expenditure grew from R1, 7billion in 2000/01 to R3, 2billion in 2007/08, an annual average growth of 9.4 per cent. The fastest growth in expenditure on PHS programme is found in the chronic mental hospital programme, growing at 29.6 per cent between

2000/01 and 2007/08. Table 7d also shows that growth in the tuberculosis hospital sub-programme was at 19 per cent, growing from R124million in 2000/01 to around R418million in 2007/08, while expenditure in the psychiatric hospitals grew from R211million to R371million at an annual average growth rate of 8.4 per cent over the same period. By far the greatest expenditure, which is above 70 per cent of the total expenditure on PHS, was incurred in the sub-programme general hospitals. Expenditure on general hospitals grew from R1, 4billion in 2000/01 to R2, 4billion in 2007/08, an increase in expenditure of R1billion.

Most of the expenditure within the PHS as per the economic classification is on compensation of employees and goods and services within current payments. Expenditure on compensation of employees grew from R1, 4billion in 2001/02 to around R2, 3billion in 2007/08, an annual average increase of 7.86 per cent. Expenditure on compensation of employees for 2004/05 is neatly split 85:15 per cent between salaries and wages and social contributions. Salaries and wages expenditure is approximately R1, 4billion to cover costs on basic salaries which are R1, 1billion, followed by service bonuses at R92million; overtime at R83million; home owners allowance at R19million and periodic payments at R5million. The greater share of expenditure for social contribution of the total expenditure of around R256million was pensions at R173million and medical aid contributions at approximately R82million.

The goods and services component of current payments grew by 11.63 per cent from R426million in 2001/02 to around R824million in 2007/08. Expenditure for goods and services for 2004/05 comprises approximately R462million on inventory which includes around R181million on medicines; around R28million for food supply; and more than R250million on other medical supplies. Other major expenses for goods and services are consultancy, contract and specialised services at R25,9million; medical services at around R52million; computer services at approximately R19million; communication at R16million; maintenance, repairs and running costs at approximately R16million; owned and leasehold property expenses at R36million and plant and flower decoration at about R9million.

The expenses on transfers and subsidies during 2004/05 comprise major payments to nonprofit organisations of about R121million; expenses to municipalities of

approximately R777 thousand; household social benefits of R7million; and about R2million for medical services. Within the PHS programme, payments for capital assets have declined significantly from R44,6million in 2001/02 to R20million in 2007/08, at an annual average of minus 12.37 per cent. Payments for capital assets are mostly for purchasing of medical and allied equipment, office equipment and office furniture, all amounting to approximately R158million. The bulk of expenses within this category is for machinery and equipment at R9million of which R5million was spent on the purchasing of medical and allied equipment. The other significant expense is transport equipment at R5million for motor vehicles during 2004/05.

CHS

The expense on the CHS programme, consisting only of two broad sub-programmes – CHS and provincial tertiary hospital services – grew from R639million in 2000/01 to R1, 2billion in 2007/08, a growth of approximately R590million. As indicated in Table 7d, expenditure on the CHS as a sub-programme grew from R128million in 2000/01 to R384million in 2007/08, an annual average growth rate of 17 per cent compared to a 7.5 per cent growth rate on the provincial tertiary hospital services programme.

According to the economic classification, the major share of expenditure is for current payments, an overall annual average share of more than 80 per cent per annum. As in the other health programmes expenditures, most of the expenses are on compensation of employees and goods and services, which grew by 5.60 per cent and 18.73 per cent, respectively. The other major expense is payments for capital assets, which grew significantly from R9million in 2001/02 to R207million in 2007/08, an annual average growth rate of 67.14 per cent. Out of the expenditure for compensation of employees for 2004/05 which is around R300million, approximately R253million was spent on salaries and wages with a social contribution of R40, 7million. Goods and services expenditure is at approximately R461million, which included expenses at around R177million for inventory, comprising mostly medical equipment and supplies; around R257million for consultancy, contracts and specialised services; and R13,5 million towards owned and leasehold property expenses.

HFM

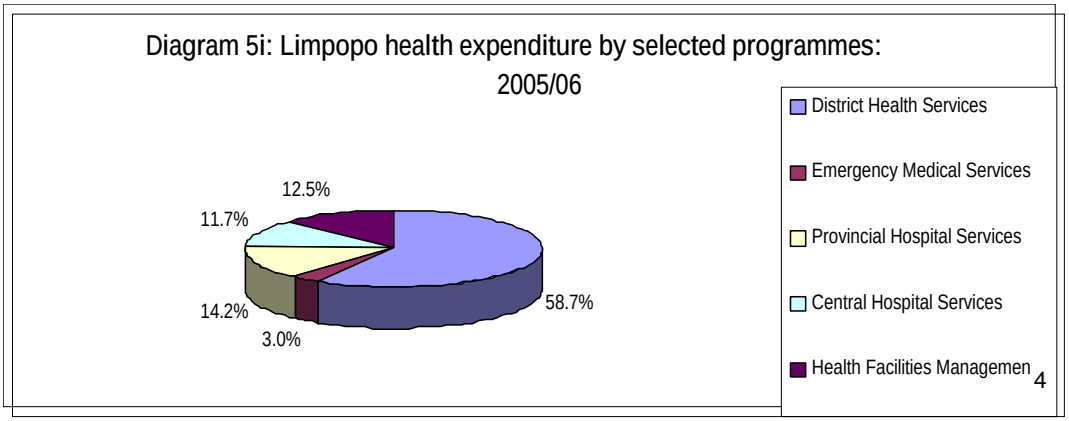
The HFM programme grew by 17.5 per cent, according to Table 7d. The highest growth in this programme is in facilities towards EMS, growing at 72.2 per cent, followed by community health services at 41.2 per cent, district hospital services at 37.7 per cent, and PHS at 17.4 per cent. While other services as a sub-programme grew at 10.5 per cent, CHS facilities management grew by minus 19.1 per cent. Current payments on the HFM programme grew by 15.82 per cent from R85million in 2001/02 to R205million in 2007/08. Most expenditure reflected in goods and services are towards inventory; consultancy; contracts and specialised services; maintenance, repairs and running costs. These expenditures are reflected in goods and services because of classification problems in the other economic categories. The expenditures on capital assets in the economic classification for 2004/05 are mostly for other machinery and equipment such as: the purchasing of medical and allied equipment; computer hardware and systems; telecommunications; and buildings, which include the purchasing of capital assets for clinic and community health centres, hospitals and ambulance stations, mobile homes and office buildings.

Limpopo Province – Health Service Expenditure

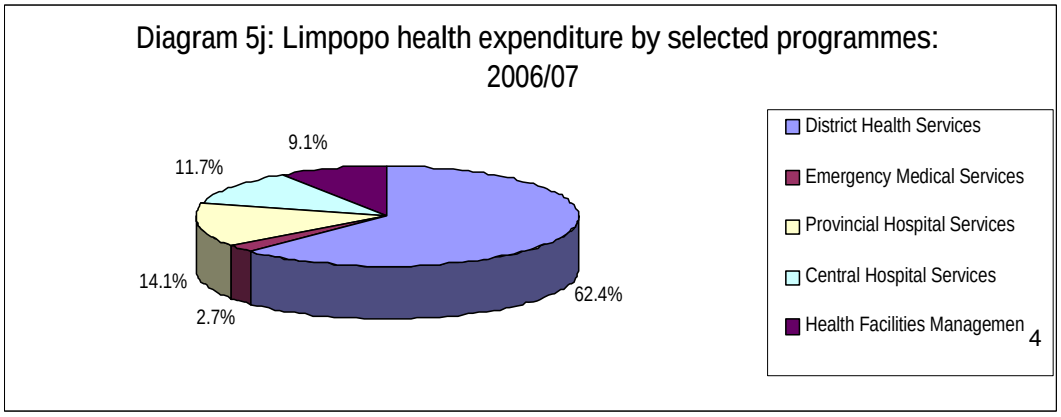
Expenditure in the selected health programmes in the Limpopo Province is shown in Table 7e. While Table 7e shows health programme and sub-programmes historic expenditure and medium-term expenditure estimate trends, Appendix E provides the expenditure trends within the programmes by economic classification.

Expenditure by health programme

Diagram 5i below shows that during 2006/07 DHS took up a proportional share of expenditure of 58.7 per cent, PHS 14.2 per cent, HFM 12.5 per cent, CHS 11.7 per cent and EMS 3 per cent. Over the 2006/07 financial year, expenditure was projected to shift increasingly towards DHS, propelled by a decline in projected expenditure in EMS of 0.3 per cent; in PHS of at least 0.1 per cent, and about 3.40 per cent in the HFM programme. These declines led to an increase in the proportional expenditure share of DHS from 58.7 per cent to 62.4 per cent.



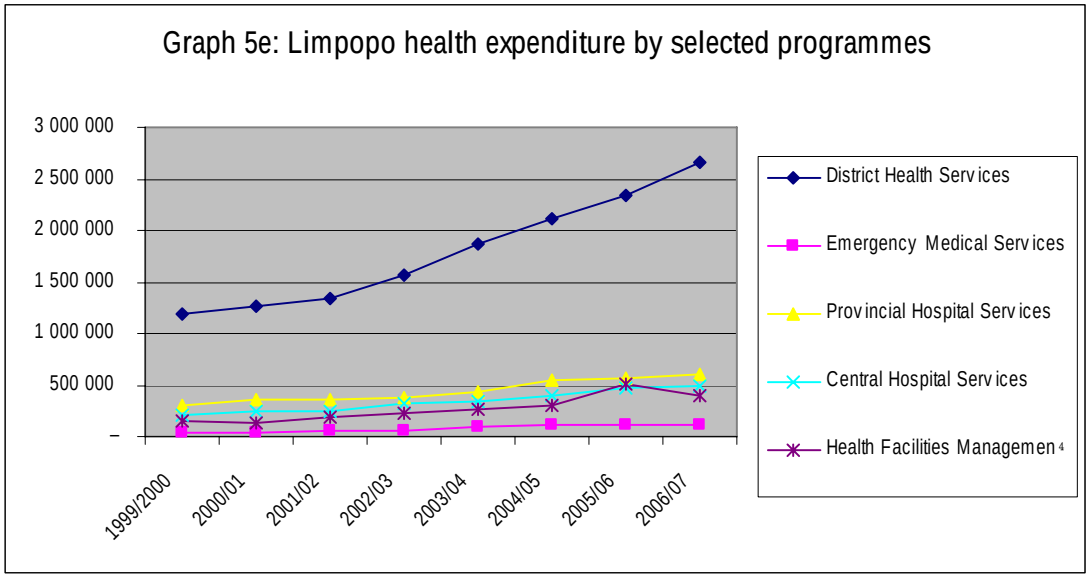
According to Table 7e, the lion's share of expenditure was on DHS, which grew from R1,2billion to R2,7 billion between 2000/01 to 2007/08, an annual average of 11.8 per cent. The second highest expenditure over the same period was on the PHS which grew by 8.6 per cent, from R351million in 2000/01 to R624million in 2007/08. However, the highest growth rates are on EMS at 18 per cent and HFM at 17.1 per cent.



DHS

Within DHS, expenditure on district management grew exponentially from a very low base of R7million in 2000/01 to more than R177million in 2007/08. This represents an annual average growth rate of 58.1 per cent. The increase in expenditure definitely signifies the strengthening of DHS management and the further building of the district health system within this province. The strong overall growth in expenditure within all the sub-programmes of the DHS not only contribute towards the further roll-out of PHC and

of the district health system, but also the continued expansion of primary health care services. There is also significant growth in expenditure on the HIV and Aids sub-programme, growing by 59.3 per cent. District hospitals are other key facilities within the overall district health system. The increased expenditure within the community health clinics, community health centres and community based services are key financial investments by the provinces towards the strengthening of the primary health care and overall district health system, which is clearly aligned to the national policy imperatives. The nutrition sub-programme declined drastically between 1999/2000 from R85million to an overspending on a zero budget of R1,4 million, but increases to R37million in 2007/08. This increase is not only contrary to what happens in other provinces, but is also not aligned to the national policy, which policy imperative was to reduce funding on this programme through the progressive shift of the function to the public education sector.



EMS

Within the EMS programme, which grew by 18 per cent, almost all expenses were for emergency transport. This sub-programme grew from R36million in 2000/01 to R116million in 2007/08, an annual average growth rate of 18.3 per cent. Current payments on the EMS programme comprise compensation of employees which grew from approximately R30million in 2001/02 to an estimated R73million by 2007/08.

Expenditure on this item was split 86:14 per cent between salaries and wages and social contributions. Expenditure on goods and services, which covers expenditure on major expenditure standard items, includes travel and subsistence allowances; communication; consultancy, contract and specialised services; maintenance, repair and running costs. Payment of capital assets is mostly for transport equipment and was around R24million in 2004/05.

PHS

The bulk of funding within the PHS programme, which grew from R351million in 2000/01 to R624million in 2007/08 was spent within the general (regional) hospitals sub-programme. Expenditure on this sub-programme grew by almost R200million from R299million in 2000/01 to R494million in 2007/08. Table 7e also shows that psychiatric/mental hospitals as a sub-programme grew from R47million to around R130million, not only indicating increased investment in psychiatric hospital services, but possibly an increased commitment to implement different policy requirements originating from the Mental Health Care Act, 2002. The only significant expenditure items on the PHS programme were for compensation of employees and goods and services, which grew between 2001/02 and 2007/08 by 9.83 per cent and 3.29 per cent, respectively. The expenditure growth on compensation of employees was particularly large, increasing from R291million in 2001/02 to approximately R510million in 2007/08, while goods and services grew from R69million in 2001/02 to R84million in 2007/08. Payments on capital assets grew from R5million in 2001/02 to approximately R18million in 2007/08.

CHS

According to Table 7e, provincial tertiary hospital services were the only expenditure and funding sub-programme in the CHS programme. Expenditure on this programme grew by 11.4 per cent from R249million in 2000/01 to R529million in 2007/08, although declines were experienced of close to R10million between 2000/01 and 2001/02. Expenses on the CHS are mostly on current payments growing from R233million in 2001/02 to approximately R460million in 2007/08, which represents an annual average growth rate of 14.48 per cent. Within this classification, compensation of employees

grew from R164million in 2001/02 to approximately R368million in 2007/08, while goods and services grew from R69million to R92million over the same period.

Growth in expenditure within HFM was from R141million in 2000/01 to an estimated R425million in 2007/08. The fastest growing expenditure within this programme was community health facilities, growing at 69.8 per cent, which was followed by tertiary hospitals at 39.8 per cent and district hospital services at 6.4 per cent. The only two expenditures within the economic classification (see Appendix E) in this programme were current payments for goods and services and the payments of assets for buildings and other fixed structures. Spending on goods and services covers mostly costs, and associated with maintenance, repair and running costs; inventory that includes food and medical supplies. Payments on capital assets deals with costs associated with maintenance and repairs to buildings.

Table 7e: Limpopo health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02 Actuals	2002/03	2003/04	2004/05 Prelim. outcome	2005/06 Medium-term estimates	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
District Health Services	**1,182,117**	**1,255,638**	**1,345,515**	**1,561,611**	**1,862,646**	**2,105,045**	**2,348,512**	**2,655,782**	**2,734,830**	**11.8%**
District Management	4,505	7,161	3,364	5,066	22,306	136,318	152,085	171,983	177,102	58.1%
Community Health Clinics	172,495	199,967	203,006	458,099	481,359	517,020	576,817	652,288	671,701	18.9%
Community Health Centres	54,930	60,300	68,025	71,808	95,544	97,948	109,277	123,574	127,253	11.3%
Community-based Services	60,185	70,413	70,189	88,617	79,085	84,136	93,867	106,148	109,308	6.5%
Other Community Services	–	–	–	–	–	24,223	27,025	30,560	31,470	–
HIV/Aids	3,265	4,299	3,329	33,008	32,919	86,035	95,986	108,544	111,775	59.3%
Nutrition	84,916	-1,418	39,346	14,219	17,419	28,477	31,770	35,927	36,996	-259.3%
District Hospitals	801,820	914,916	958,256	890,794	1,134,014	1,130,888	1,261,685	1,426,758	1,469,225	7.0%
Emergency Medical Services	**36,128**	**36,568**	**47,833**	**50,262**	**95,253**	**105,550**	**118,370**	**114,860**	**116,349**	**18.0%**
Emergency Transport	35,874	35,974	47,833	48,387	95,253	105,550	118,370	114,860	116,349	18.3%
Planned Patient Transport	254	594	–	1,875	–	–	–	–	–	-100.0%
Provincial Hospital Services	**306,588**	**351,214**	**365,022**	**380,145**	**438,964**	**548,434**	**568,121**	**599,029**	**624,573**	**8.6%**
General (Regional) Hospitals	258,202	299,101	308,119	312,375	394,625	434,069	449,651	474,114	494,331	7.4%
Psychiatric/ Mental Hospitals	46,665	52,113	56,903	67,770	44,339	114,365	118,470	124,915	130,242	14.0%
Air Services	1,721	–	–	–	–	–	–	–	–	–
Central Hospital Services	**209,270**	**248,995**	**239,890**	**323,786**	**346,870**	**397,437**	**466,213**	**497,098**	**529,586**	**11.4%**
Central Hospital Services	–	–	–	–	–	–	–	–	–	–
Provincial Tertiary Hospital Service	209,270	248,995	239,890	323,786	346,870	397,437	466,213	497,098	529,586	11.4%
Health Facilities Managemen	**142,937**	**141,240**	**192,681**	**226,661**	**261,188**	**294,142**	**500,569**	**387,347**	**425,167**	**17.1%**
Community Health Facilities	3,206	3,168	4,322	34,371	21,922	89,353	152,060	117,666	129,155	69.8%
District Hospital Services	121,905	122,664	162,125	168,157	220,820	130,642	222,325	172,038	188,836	6.4%
Provincial Hospital Services	–	–	–	–	15,277	11,274	19,187	14,847	16,296	–
Private Hospitals	12,048	12,921								-100.0%
Tertiary Hospitals	2,319	2,487	2,931	3,360	3,169	17,947	30,542	23,634	25,942	39.8%
Other Facilities	3,458	–	23,303	20,773	–	44,926	76,455	59,162	64,938	–
Total selected programmes	**1,877,039**	**2,033,655**	**2,190,941**	**2,542,465**	**3,004,921**	**3,450,608**	**4,001,785**	**4,254,116**	**4,430,505**	**11.8%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

Mpumalanga Province – Health Service Expenditure

Table 7f and Appendix F provides the expenditure trends for Mpumalanga within the different programmes as per the economic classification and standard item expenditure.

Expenditure by health programme

HFM and PHS, as shown in Table 7f, grew above the consolidated annual average expenditure for selected health programmes of 16.1 per cent from 2000/01 to 2007/08, growing at 65.6 per cent and 26.2 per cent, respectively. However, spending on DHS dominated the programme funds in Mpumalanga Province, growing from R856million in 2000/01 to approximately R1,47billion in 2007/08, an annual average expenditure growth rate of 8.0 per cent. Diagram 5k below shows the dominance of DHS as a proportion of overall programme expenditure.

Diagram 5k: Mpumalanga health expenditure by selected programmes: 2005/06

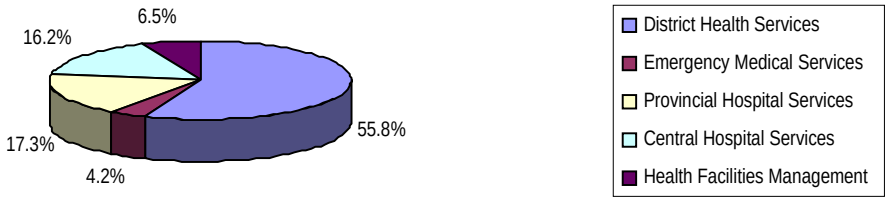
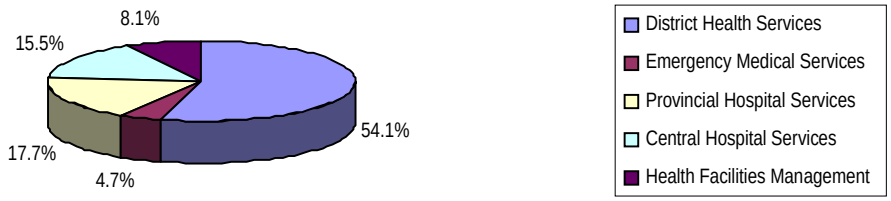


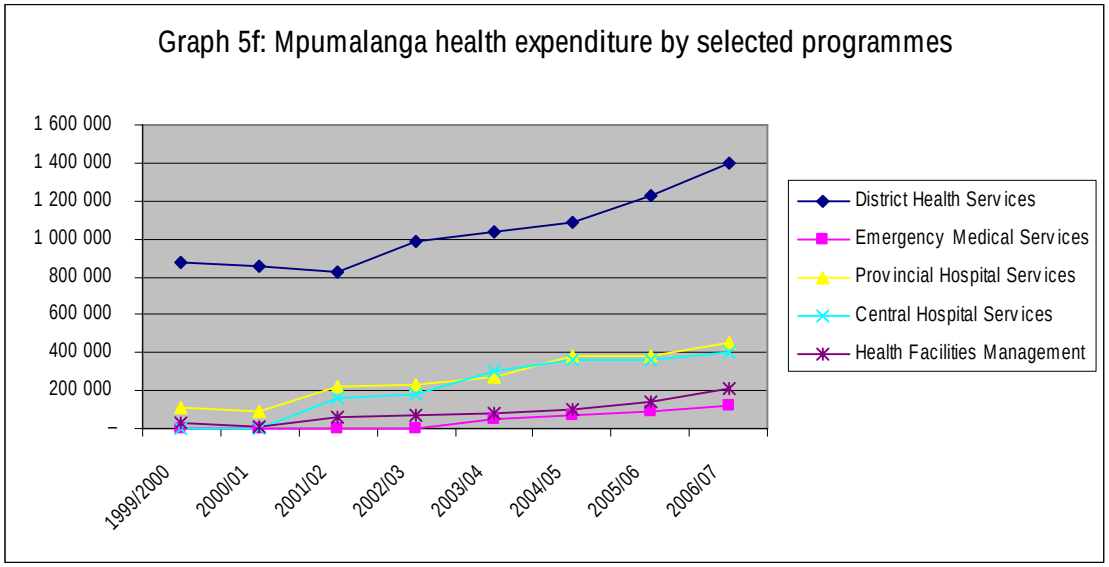
Diagram is also shows that: expenditure on central hospitals service is at 16.2 per cent; PHS at 17.3 per cent; HFM at 6.5 per cent; and EMS at 4.2 per cent during the 2005/06 financial year. The expenditure projected over the 2006/07 financial year indicates, similarly to the expenditure patterns in other provinces, a slight shift in funding. However, in Mpumalanga, projected expenditure over the 2006/07 reduced by 1.7 per cent for DHS, declining from 55.8 in 2005/06 to 54.1per cent in 2006/07. Declines in expenditure also occurred on the CHS programme by minus 0.7 per cent leading to increases in expenditure of 1.6 per cent in the HFM programme, 0.5 per cent in EMS and a 0.4 per cent in PHS.

Diagram 5l: Mpumalanga health expenditure by selected programmes: 2006/07



The increase in expenditure on the EMS programme was targeted at the planned patient transport sub-programme, which grew from R46, 7million in 2003/04 to approximately R130million in 2007/08. the sharp upward increases in expenditure took place within the general hospitals sub-programme within the PHS, especially between 2005/06 and 2006/07 with an increase of approximately R50million from R336million to R406million. Overall, the general hospital sub-programme expenditure grew by 24.9 per cent from R87million in 2000/01 to an estimated expenditure of R411million.

A similar pattern is observed in Mpumalanga Province to other provinces regarding the economic classification of expenditures on the EMS. The compensation of employees and goods and services on the current payment classification and machinery and equipment comprise almost all expenditure on the EMS programme. The compensation of employees grew by 6.98 per cent from 2001/02 to 2007/08, while goods and services grew from 17.35 per cent over the same period. In nominal terms, the compensation of employees grew from R44million in 2003/04 to R58million in 2007/08, while goods and services grew over the same period from R2,3 million to R9,8 million.



All the expenditure on the CHS programme was to defray costs on the provincial tertiary hospitals services, growing from an expenditure of R156million in 2001/02 to approximately R410million in 2007/08 – an increase in expenditure that amounts to around R254million over the period. The current payments on the CHS programme grew from R153million in 2001/02 to R384million in 2007/08, an annual average of 16.47 per cent. Out of this expenditure the compensation of employees grew by 25.67 per cent while goods and services grew by 10.47 per cent.

EMS

Payments on capital assets within the EMS programme grew rapidly from R110 thousand in 2003/04 to about R62,3million in 2007/08. Most of the expenditure on payments for capital assets was to defray spending on transport equipment and the purchasing of capital assets such as medical and allied equipment and emergency and rescue equipment during 2004/05.

Table 7f: Mpumalanga health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**874,705**	**855,773**	**824,219**	**985,225**	**1,039,009**	**1,086,995**	**1,231,086**	**1,397,771**	**1,465,557**	**8.0%**
District Management	3,475	1,295	6,501	27,672	65,523	56,389	106,203	114,614	138,570	94.9%
Community Health Clinics	10,622	11,690	12,143	45,432	160,323	157,221	201,169	281,375	303,085	59.2%
Community Health Centres	–	–	–	21,186	104,282	131,747	146,243	191,137	198,161	–
Community Based Services	65,407	114,394	–	–	–	–	–	–	–	-100.0%
Other Community Services	–	–	–	–	–	–	–	–	–	–
District Hospitals	795,201	728,394	804,849	874,849	678,849	661,602	669,130	684,929	693,556	-0.7%
Malaria Control	–	-30,565								-100.0%
Coroner Services	–	–	–	–	–	979	–	–	–	–
Nutrition	–	30,565	726	4,915	7,301	14,744	11,655	2,178	2,309	-30.9%
HIV/ Aids	–	–	–	11,171	22,731	64,313	96,686	123,538	129,876	–
Emergency Medical Services	**–**	**–**	**–**	**–**	**46,729**	**68,299**	**92,549**	**120,393**	**130,024**	**–**
Emergency Transport	–	–	–	–	–	–	–	–	–	–
Planned Patient Transport	–	–	–	–	46,729	68,299	92,549	120,393	130,024	–
Provincial Hospital Services	**112,117**	**91,339**	**224,546**	**232,951**	**269,611**	**378,425**	**382,764**	**456,759**	**464,439**	**26.2%**
General Hospital	108,269	86,845	220,405	226,689	262,186	334,102	335,664	405,773	411,903	24.9%
Tuberculosis Hospital	3,849	4,494	4,141	6,262	7,425	7,973	10,806	12,514	13,140	16.6%
Psychiatric / Mental Hospital	–	–	–	–	–	10,110	10,094	10,700	11,235	–
Chronic Medical Hospital	–	–	–	–	–	–	26,200	27,772	28,161	–
Dental Training Hospital	–	–	–	–	–	26,240	–	–	–	–
Central Hospital Services	**–**	**–**	**156,080**	**176,775**	**302,377**	**357,591**	**358,013**	**399,982**	**410,215**	**–**
Provincial Tertiary Hospital Services	–	–	156,080	176,775	302,377	357,591	358,013	399,982	410,215	–
Health Facilities Management		**6,876**	**63,763**	**72,401**	**81,148**	**104,187**	**143,198**	**208,157**	**235,249**	**65.6%**
Health Facilities	31,483	6,876	63,763	72,401	81,148	24,427	46,205	62,802	66,136	38.2%
District Hospital Services		–	–	–	–	54,682	57,018	101,032	117,071	–
Provincial Hospital Services		–	–	–	–	25,078	39,975	44,323	52,042	–
Total selected programmes	**986,823**	**953,988**	**1,268,608**	**1,467,352**	**1,738,874**	**1,995,497**	**2,207,610**	**2,583,062**	**2,705,484**	**16.1%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

HFM

The expenditure on HFM grew from R6, 9million in 2000/01 to R235million in 2007/08. The expenditure on the health facilities sub-programme declines from R81million in 2003/04 to R46million in 2005/06. The expenditure increased, however, over the outer years, ending at R63million in 2006/07 and R66million in 2007/08. The dominant expenditure on the health facilities programme was on district hospital services, which grew from R54, 7million in 2004/05 to R117million in 2007/08. This expenditure augmented the overall spending and the strengthening of the district health system. The other expenditure within this programme was on PHS, which grew at around R27million from a preliminary outcome of R25million in 2004/05 to R52million in 2007/08. The expenditure on goods and services within the current payments economic classification declined by minus 10.56 per cent from R54million in 2001/02 to R27, 7million in 2007/08.

The revenue and expenditure analysis discovered that because of economic classification problems within Mpumalanga budgets as a result only expenditures on compensation are reflected which is different of the other provinces economic classification. The expenditure on compensation is associated with HFM and is covered in the different hospital services and emergency medical service programmes. The expenditure on payments for capital assets during 2004/05 paid for costs linked to the purchasing of capital assets for clinics and community health centres, hospitals and ambulance stations, and universities and colleges of nursing. The expenses in the economic classification cover machinery and equipment such as laundry equipment, medical and allied equipment, and office furniture.

DHS

The expenditure on district health management grew the fastest within the DHS programme by 94.5 per cent, though from a low expenditure base of R1million in 2000/01 through to a rapid expenditure growth to approximately R139million in 2007/08. The expenditure on the community health clinics also accelerated from its spending level of R11,6million in 2000/01 to R303million in 2007/08, an exponential annual average growth of 59.2 per cent. Although expenditure on the district hospital sub-programme declined by minus 0.7 per cent, ostensibly as a result of the new budget programme

structure and the standardisation in programmes and standard expenditure items, spending shifted to HFM on capital expenditure as a result of reclassification. The expenditure on district hospitals remained close to the R700million mark by the end of the 2007/08 financial year. As a result of compliance with the national policy objectives to shift the function to the education sector, the nutrition sub-programme expenditure declined drastically from R30,5 million in 2000/01 to R2,3million in 2007/08, a annual average decline in growth of minus 30 per cent. As a result of the expenditure augmentation through the conditional grant allocation for the expenditure on the HIV and Aids sub-programme, expenditure grew rapidly from R11million in 2002/03 to close to R130million in 2007/08.

The bulk of expenditure within the DHS according to the economic classification for this programme is for current payment, especially compensation of employees and goods and services. The expenditure on the compensation of employees grew by 6.98 per cent from R574million in 2001/02 to R861mbillion in 2007/08. Most expenditure during 2004/05 was on salaries and wages and for social contribution, which was about a 85:15 percentage split between these two standard expenditure items. The expenditures on goods and services during 2004/05 were mostly for: consultancy, contract and specialised services at an estimated R6,2million; inventory at R237million, which included major estimated spending of an amount of about R125million on medicines; more than R25million on food supplies; and close to a R1billion on pest control. Payments on capital assets were mostly directed to off-set spending pressures on the purchasing of machinery and equipment, in the form of office furniture, workshop equipment and motor vehicle expenses.

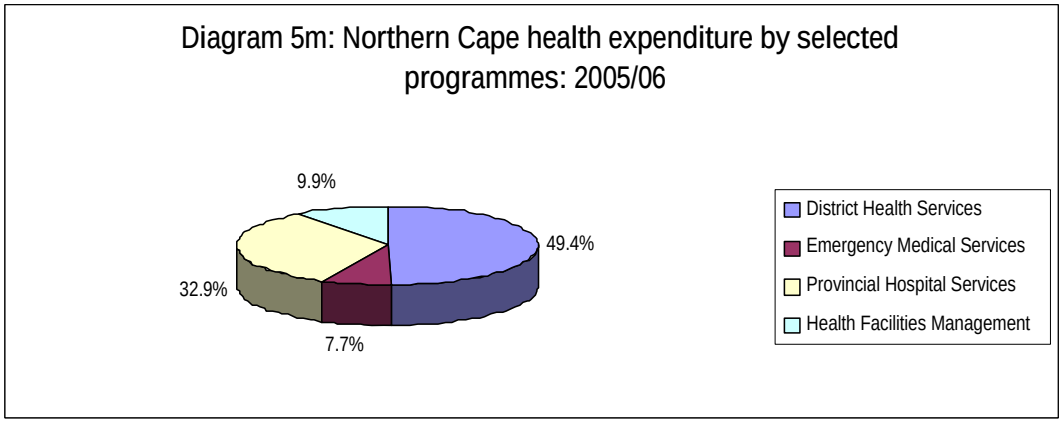
Northern Cape Province – Health Service Expenditure

Expenditure in selected health programmes in the Northern Cape Province is shown in Table 7g and in Annexure G – Economic Classification for Northern Cape Province.

Expenditure by health programme

The main health programmes in the Northern Cape Province are DHS, EMS, PHS and HFM. Diagram 5m shows district health service at 49.4 per cent; PHS at 32.9 per cent;

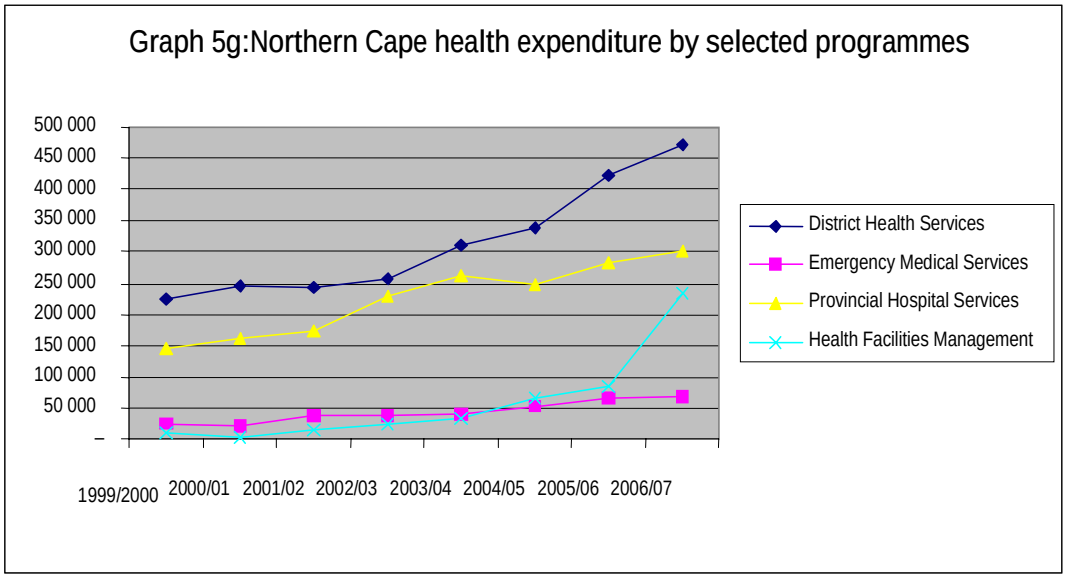
HFM at 9.9 per cent and EMS at 7.7 per cent as a proportional share of total health programme expenditure during 2005/06.



Over the 2006/07 period drastic shifts in the proportional expenditure share of each programme were projected. The declines are projected for DHS were 5.4 per cent, thus reducing from 49.4 per cent to 44 per cent; a 5 per cent decline in provincial health services to 27.9 per cent; and EMS declining by 1.3 per cent, to 6.4 per cent as proportional shares of total expenditure in 2006/07.

HFM

The HFM programme benefits directly through the gradual reduction in the proportional share of the different programmes, increasing from 9.9 per cent in 2005/06 to 21.7 per cent as a share of total expenditure on the selected programmes. Graph 5g confirms this sharp upward growth in the HFM programme from above R84, 6million in 2005/06 to about R232,8million in 2006/07.This level of growth in the HFM programme has particularly contributed to its accelerated upward growth from a meagre R1,7million in 2000/01 to R257,5million in 2007/08, representing an annual average growth rate of 104.2 per cent over the period.



DHS

The overall expenditure on the *DHS* programme, according to Table 7g grew by 10.7 per cent from R245million in 2000/01 to R501million in 2007/08. This is an increase on the DHS programme of more than 100 per cent. The largest expenditure on this programme is within the district hospitals sub-programme, which grew from R113million in 2000/01 to approximately R192million in 2007/08, an annual average growth rate of 7.8 per cent. The second largest expenditure programme is community health services, which grew from R52, 5million in 2000/01 to R105,6 million in 2007/08, providing an annual average increase of 10.5 per cent. The nutrition, a sub-programme grew against expectations at a fast annual average rate of 25.7 per cent from R1.1million in 2000/01 to R5, 9million in 2004/05. This high growth rate suggests that the Northern Cape Province continues to include the nutrition sub-programme in the district health service programme, which could be interpreted as a policy approach against the overwhelming national policy movement of the other provinces and central government to shift this programme to the education sector. The analysis shows that the provincial department of health prefers to provide the nutrition programme through clinics.

HIV and Aids Programme

The HIV and Aids sub-programme grew from R252thousand in 200/02 to R72million in 2007/08, which clearly is a strong and dominant augmentation of the funding level provided by the HIV and Aids conditional grant. The strong role of the conditional grant has also contributed to the enhancement of expenditure towards the roll-out of primary health care services and the strengthening of funding to the overall district health system. The other significant increases in expenditure on the DHS programme were for community health clinic services, which grew from R33,5million in 2000/01 to R75million in 2007/08, an annual average growth rate of about 12.2 per cent over the period. The overall consistent and strong growth rate in previous expenditure and estimated expenditures on the DHS programme signifies continued implementation of a district health system and the continued preference within the province towards roll-out of the primary health care services.

Current payments comprising compensation of employees and goods and services grew by 13.15 per cent from R224million in 2001/02 to R470million in 2007/08. Within the economic classification of expenditure, compensation grew by more than R120million from R164,6million in 2001/02 to R284,7million in 2007/08, an annual average growth rate of 9.57 per cent. The expenditure on salaries and wages is about R189, 7million, while social contribution amounts to R31, 8million, providing a percentage split of 86:14 percentage items on the compensation of employees' economic classification.

Goods and services grew at a rapid growth annual average rate of 20.86 per cent from R60million in 2001/02 to an estimated expenditure outcome of R187, 7million in 2007/08. Smaller economic classification expenditure trends show transfers and subsidies growing by 2 per cent from R17,3 million in 2001/02 to about R19,5million in 2007/08. Payments for capital assets, though the growth in percentage terms is high, expenditure on this economic classification grew from R988 thousand to around R10,5million. The only significant spending item on the payments of capital assets was to defray costs on machinery and equipment, which includes medical and allied equipment, and computer hardware systems.

Major spending on goods and services within the DHS programme during 2004/05 was to cover costs related to communication of about R4, 3million; consultancy, contract and specialised services that amounted to R1,8million; inventory that amounted to around R37million; maintenance, repair and running cost at about R2,1million; medical services amounting to R22million; operating leases, which included renting aircrafts at R5,6million; owned and leased property at expenditure at R20,4million; and travel and subsistence totaling around R5million.

EMS

The main expenditure sub-programme (see Table 7g) on the EMS programme was to defray expenditure on emergency transport. Expenditure on emergency transport grew from R20, 5million in 2000/01 to around R71, 4million, an annual average growth rate of 19.5 per cent. The fast growth over the medium-term cycle in expenditure on this programme was between the expenditure level of R39million in 2003/04 and the preliminary outcome of R51, 2 million in 2004/05. The expenditure during 2004/05 on salaries and wages is about R21, 4million, while social contribution amounted to R3,8million providing a percentage split of 85:15 on the compensation of employees' economic classification. The major costs drivers on the goods and services expenditure item were expenses on inventory, which include maintenance material supplies, fuel and oil, medical equipment supplies, maintenance, repair and running costs towards motor vehicles, radio equipment, and hospital and ambulance station. All expenditure on payment of capital assets covered the purchasing of emergency vehicles.

Table 7g: Northern Cape health expenditure by selected programmes and their subprogrammes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**222,092**	**245,446**	**242,512**	**256,687**	**312,091**	**339,922**	**422,681**	**472,799**	**500,560**	**10.7%**
District Management	15,596	21,438	14,076	13,494	13,979	12,175	17,156	18,457	19,655	-1.2%
Community Health Services	45,566	52,526	51,233	47,723	57,040	78,019	91,631	99,197	105,602	10.5%
Community Health Clinic Service	26,325	33,535	26,409	53,830	39,577	35,552	66,481	71,065	75,015	12.2%
Community Based Services	–	–	–	–	1,628	1,421	1,900	2,000	2,100	–
Other Community Services	19,709	23,340	21,540	22,387	22,316	28,200	22,582	24,186	25,647	1.4%
HIV/Aids	111	–	252	1,967	11,255	28,323	48,050	68,603	72,033	–
Nutrition	8,477	1,191	344	1,323	2,828	7,248	5,281	5,508	5,917	25.7%
Coroner Services	–	–	–	612	793	1,148	1,843	1,991	2,113	–
District Hospitals	106,308	113,416	128,658	115,351	162,675	147,836	167,757	181,792	192,478	7.8%
Emergency Medical Services	**25,550**	**20,536**	**37,643**	**37,239**	**39,187**	**52,965**	**66,136**	**68,727**	**71,483**	**19.5%**
Emergency Transport	25,550	20,536	37,643	37,239	39,187	51,267	66,136	68,727	71,483	19.5%
Planned Patient Transport	–	–	–	–	–	1,698	–	–	–	–
Provincial Hospital Services	**147,010**	**162,166**	**172,591**	**228,729**	**261,626**	**248,788**	**281,333**	**300,355**	**319,362**	**10.2%**
General Hospital	133,437	146,403	157,446	212,579	244,743	229,299	261,958	279,783	297,714	10.7%
TB Hospital	6,789	8,172	7,288	7,637	6,545	8,736	8,597	9,197	9,716	2.5%
Psychiatric/Mental Hospital	6,784	7,591	7,857	8,513	10,338	10,754	10,778	11,375	11,932	6.7%
Health Facilities Management	**8,124**	**1,737**	**16,764**	**24,548**	**33,372**	**64,149**	**84,644**	**232,857**	**257,524**	**104.2%**
District Health Services	–	–	–	6,425	30,469	21,876	49,909	167,922	250,589	–
Provincial Hospital Services	8,124	1,737	16,764	18,123	2,903	42,273	34,735	64,935	6,935	21.9%
Total selected programmes	**402,777**	**429,885**	**469,510**	**547,203**	**646,276**	**705,824**	**854,794**	**1,074,738**	**1,148,929**	**15.1%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

PHS

The expenditure on the PHS programme grew from R162million in 2000/01 to R319million in 2007/08, an annual average growth rate of 10.2 per cent. The largest expenditure on this programme is the general hospital sub-programme, which grew from R146million in 2000/01 to R298million in 2007/08. This is followed by a moderate though consistent increase in expenditure on the psychiatric/mental hospital sub-programme, which grew from R7, 6million in 2000/01 to R12million in 2007/08, an annual growth rate of 6.7 per cent. This moderate increase can be interpreted as a progressive financing of the realisation of the 2002 Mental Health Care Act. The expenditure on the tuberculosis hospital sub-programme also grew by 2.5 per cent from R8million in 2000/01 to about R10million in 2007/08.

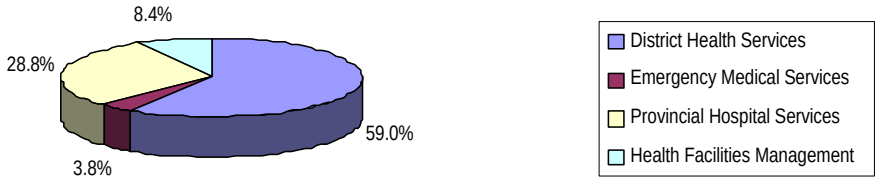
The expenditure on current payments within PHS grew from R168million in 2001/02 to R314, 5million in 2007/08. The expenditure on compensation of employees, comprising salaries and wages and social contributions, grew from R121million in 2001/02 to R217million, an annual average growth of 10.18 per cent. The expenditure between the spending items within the compensation of employees consisted of a percentage split of 86:14 between salaries and wages and social contributions. The expenditure on salaries and wages was about R156, 3million, while social contribution amounted to R17, 6million. Goods and services grew by 13 per cent from R46, 8million in 2001/02 to R97, 5 million in 2007/08. During 2004/05, the expenditure on goods and services covered expenses associated with inventory that amounted to R27,2 million, which included medical supplies; medical services amounting to R13million, such as the expenses on medical laboratory services; and owned and leasehold property expenses that included payments to municipalities.

Transfers and subsidies as expenditure items grew from R366thousand in 2001/02 to R790 thousand in 2007/08, an annual average growth rate of 12.86 per cent. The expenditure of this period covers costs linked to transfers and subsidies towards provinces and municipalities. Payments on capital assets, however, grew at a negative rate of minus 0.37 per cent because of expenditure declining over the period, levelling at about R4million in 2001/02; declining sharply to R755 thousand in 2002/03; growing to R8, 1million in 2003/04; but declining sharply again to R4million in 2007/08.

North West Province - Health Service Expenditure

The expenditure in selected health programmes in North West Province is shown in Table 7h and the different Appendices H provides the expenditure trends within the programmes by economic classification.

Diagram 5n: North West health expenditure by selected programmes: 2005/06

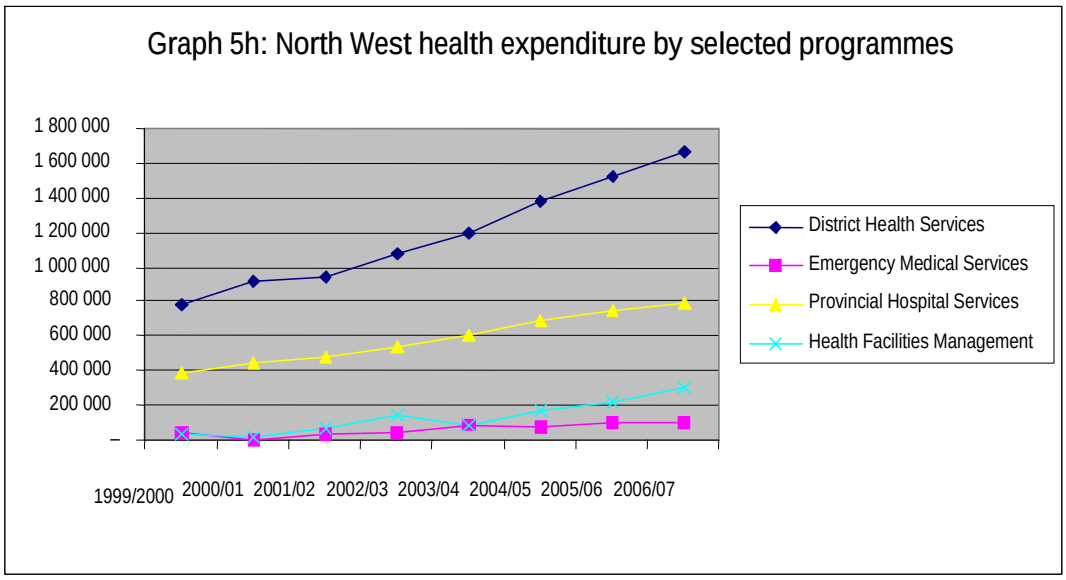


Expenditure by health programme

The economic classification expenditure items in terms of the classification at a lower level are not available for the North West. This is because the province it runs a different financial system from that of the other eight provinces. According to an interview respondent currently no detailed financial mapping exists in the central governments Vulindlela Management Information System and Walker Financial System used by the North West province. This makes comparative expenditure assessment difficult, but also creates uncertainty whether financial data used in the system is similar to that used in the national standards chart of accounts (SCOA). This also allows for a potential manipulation of financial data, given the lack of central government access to the system.

However, similarly to other provinces, the largest proportional share of expenditures during 2005/06 by selected health programmes went towards financing DHS. The proportional expenditure shares, as indicated in Diagram 5n above, for the different selected health programmes within North West were 59 per cent for DHS, 28.8 per cent for PHS, 8.4 per cent for HFM and 3.8 per cent for EMS. During 2006/07 a shifting of

funds for projected expenditure took place through a decline of the different proportional shares such as: a reduction in the percentage share of 0.9 per cent of the DHS to 58.1 per cent; a decline in EMS by 0.2 per cent to 3.6 per cent; a decline of 0.9 per cent to 27.9 per cent of the PHS. HFM was the only programme that grew, by 2.0 per cent to 10.4 per cent as a result of the declines.



DHS

Graph 5h shows that out of all the selected health programmes, DHS grew the fastest from around R800million in 1999/2000 to about R1, 8billion. This upward spending trajectory is followed by progressive growth in expenditure in the PHS programme. The expenditure, as indicated in the line graph, grows moderately on the HFM programme, assisted by the shift of funds from the different programmes, while there is slow growth in expenditure on the EMS programme from 20032/03. Graph 5h and Table 7h show a slightly moderate growth in expenditures on DHS and HFM. Table 7h shows that the growth in the expenditure on the *DHS* (DHS) programme is about 10 per cent, growing from R918million in 2000/01 to around R1,8 million in 2007/08. The expenditure on community health clinics and community health centres is particularly above the national annual average of 11.9 per cent, being at 12.5 per cent for community health clinics and 17.9 per cent for community health centres. There is definitely, according to this study,

internal budget shifting within the programme to off-set expenditure pressures from other functions within the larger health budget programme.

The expenditures in the community health centres sub-programme are not only the fastest growing in terms of expenditure but are also the second largest within the DHS programme, growing from R139million in 2000/01 to R439million in 2007/08. The expenditure on this sub-programme has grown rapidly since from its level of R155million in 2002/03 and increased to around R275million in 2003/04. Community health clinic sub-programme expenditure, though declining between 2000/01 and 2001/02, increased to more close to R300million from about R139million in 2000/01 to an amount of approximately R439million. The expenditure on the HIV and Aids sub-programme primarily financed through the HIV and Aids conditional grant grew from R29million in 2002/03 to R149million in 2007/08. It is clear that within this sub-programme no manoeuvrability is allowed on the part of the province to determine the level of expenditure. As in other provinces, the conditional grant framework further allows for the roll-out of the HIV and Aids programme through the DHS. It is also through this policy that both the district health system and the roll-out of the primary health care programme within the North West Province are strengthened.

The district hospitals sub-programme, which is the largest on the DHS programme, though declining in expenditure between 2002/03 and 2003/04 and between 2004/05 preliminary outcome and the 2005/06 medium estimates, grew by 3.3 per cent from R516million in 2000/01 to a medium-term estimated expenditure of R647million in 2007/08. Although the expenditure level on the year-on-year expenses is unstable, declines over the years to the level of zero budgets over the medium term ending in 2007/08, is line with the national policy decision to shift the nutrition sub-programme to the education sector in this province.

In terms of the economic classification, of the expenditure for DHS, current payments grew by 10.48 per cent from R907million in 2001/02 to about R1, 6billion in 2007/08. Expenditure particularly on compensation of employees grew from R727million in 2001/02 to R1, 1billion in 2007/08 – an annual average growth rate of 7.36 per cent. Goods and service as the other expenditure item in current payments grew from R180million in 2001/02 to R536million in 2007/08 – an annual average growth rate of

19.92 per cent. Transfers and subsidies and payments for capital assets also grew substantially on the DHS programme, by 32.1 per cent and 21 per cent. The expenditures on transfers and subsidies were payments to municipalities and non-profit organisations.

EMS

EMS programme expenditure, according to Table 7h, was channelled mostly to the emergency transport sub-programme, growing from R32, 5million in 2001/02 to R110million in 2007/08. The expenditure on this sub-programme increased substantially between 2002/03 and 2003/04 by more than R42, 5million. The current payments comprising only expenditures for compensation of employees and goods and services on the EMS programme grew from R15, 5million in 2001/02 to R107million in 2007/08. The compensation of employees as a share of expenditure on the current payments grew from R8, 2million in 2001/02 to R75, 7million in 2007/08, an annual average growth rate of 44.8 per cent, compared to goods and services, which grew 27.5 per cent from R7, 3million to R31, 3million over the same period. Payments of capital assets covering only expenses on machinery and equipment grew by 11.35 per cent from R1, 5million in 2001/02 to around R3million in 2007/08. Expenditure on transfers and subsidies decline sharply from R16, 8million in 2001/02 to R134 thousand in 2007/08. There was zero expenditure for 2002/03 to the end of the 2004/05 financial years.

Table 7h: North West health expenditure by selected programmes and their sub-programmes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02 Actuals	2002/03	2003/04	2004/05 Prelim. outcome	2005/06 Medium-term estimates	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
District Health Services	**782,663**	**918,396**	**935,666**	**1,072,979**	**1,198,442**	**1,377,409**	**1,525,408**	**1,661,246**	**1,788,220**	**10.0%**
District Management	25,580	78,395	88,000	125,019	170,192	113,615	124,875	141,381	150,478	9.8%
Community Health Clinics	149,296	170,063	153,142	193,978	188,524	227,875	311,680	357,793	389,037	12.5%
Community Health Centres	123,305	138,674	141,846	154,822	274,736	309,702	369,596	383,699	438,648	17.9%
Community Based Services	–	–	–	2,555	4,166	5,685	6,095	6,461	6,848	–
Other Community Services	8,571	9,145	11,050	–	–	5,187	5,561	5,895	6,248	-5.3%
HIV/Aids	–	–	–	29,070	41,392	72,104	119,241	142,316	149,432	–
Nutrition	33,246	6,048	14,734	8,854	7,642	18,047	10,981	–	–	-100.0%
Coroner Hospitals	–	–	–	–	–	–	–	–	–	–
District Hospitals	442,665	516,071	526,894	558,681	511,790	625,193	577,379	623,701	647,529	3.3%
Emergency Medical Services	**45,043**	**–**	**33,898**	**42,407**	**85,204**	**82,574**	**97,099**	**103,354**	**110,131**	**–**
Emergency Transport	45,043	–	32,350	38,554	81,144	78,423	97,099	103,354	110,131	–
Planned Patient Transport	–	–	1,548	3,853	4,060	4,151	–	–	–	–
Provincial Hospital Services	**393,171**	**445,767**	**479,798**	**532,072**	**606,468**	**697,736**	**746,244**	**796,132**	**848,591**	**9.6%**
General (Regional) Hospitals	321,454	363,005	393,588	441,828	501,586	580,932	607,673	649,364	693,136	9.7%
Tuberculosis Hospitals	–	–	–	–	–	–	–	–	–	–
Psychiatric/Mental Hospitals	71,717	82,762	86,210	90,244	104,882	116,804	138,571	146,768	155,455	9.4%
Health Facilities Management	**38,891**	**26,250**	**70,821**	**146,614**	**84,055**	**165,423**	**218,211**	**297,433**	**309,536**	**42.3%**
Community Health Facilities	15,556	10,500	26,152	14,808	25,850	22,048	47,587	71,000	86,900	35.2%
Emergency Medical Rescue Serv	–	–	–	–	–	–	–	–	–	–
District Hospital Services	11,668	7,875	19,615	25,147	20,776	105,829	98,056	125,493	106,495	45.1%
Provincial Hospital Services	11,667	7,875	19,614	52,824	17,205	–	–	–	–	-100.0%
Central Hospital Services	–	–	–	–	–	–	–	–	–	–
Other Facilities	–	–	5,440	53,835	20,224	37,546	72,568	100,940	116,141	–
Health Maintenance	–	–	–	–	–	–	–	–	–	–
Total selected programmes		**1,390,413**	**1,520,183**	**1,794,072**	**1,974,169**	**2,323,142**	**2,586,962**	**2,858,165**	**3,056,478**	**11.9%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.
2. Information not available prior to 1999/2000.
Source: National Treasury databases.

PHS

PHS programme expenditure was at 9.6 per cent, growing from R446million in 2000/01 to approximately R849million in 2007/08. Table 7h also shows that the largest expenditure on the PHS budget is for the general (regional) hospitals sub-programme, which grew from R363million in 2000/01 to R693million in 2007/08 – an annual average growth of 9.7 per cent, reflecting a consistent year on year growth expenditure pattern in this programme, though below the national annual average expenditure of about 1.4 per cent. The current payments on the PHS grew by 9.97 per cent from R456million in 2001/02 to R810million in 2007/08. The expenditures on compensation of employees and goods and services within the current payments classification grew by 6.97 per cent and 17.14 per cent, respectively. The other significant expenditure was payments of capital assets, which grew from around R24million in 2001/02 to R37, 2 million in 2007/08 – an annual average growth rate of around 7.7 per cent.

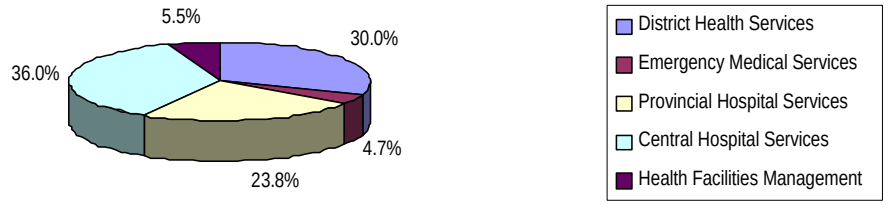
The overall fastest growing health programme as indicated in Table 7h is expenditure for HFM. The consolidated HFM expenditures which are towards improving and strengthening the DHS through the sub-programmes community health facilities and district hospital services far exceeds the other expenditures associated with the DHS. This growth shows an increased roll-out of the district health building programme within the North West Province. The growth in expenditure of community health facilities at an annual average rate of 35.2 per cent and about 45.1 per cent on district hospitals not only accelerates expenditure on DHS facilities in percentage growth terms but also in nominal and real expenditure terms relative to other health programmes. Such an increased level of expense further enhances the establishment and operationalisation of the DHS and the roll-out of primary health care services, clearly aligned to the national policy objectives on both the district health system and the primary health care programme. The only expenditures incurred and estimated on the economic classification of expenditure on the HFM programme is in current payments on goods and services, growing at 43.9 per cent from R5, 4million in 2001/02 to R48, 2million in 2007/08. The transfers and subsidies towards municipalities grew from an adjusted appropriation of R57, 2million in 2004/05 to R30million in 2006/07. It seems that other expenditures on both these classifications – that is, current payments and transfers and subsidies – are covered in the different sub-programmes expenditures associated with

HFM. This confirms the financial data classification programme discussed earlier in the North West Province. The payments of capital assets on the HFM programme comprising expenditures for buildings and fixed assets and machinery and equipment, grew from R65, 3million in 2001/02 to R261million in 2007/08.

Western Cape Province - Health Service Expenditure

The expenditure in selected health programmes in Western Cape Province is shown in Table 7i and Appendices I provide the expenditure trends within the programmes by economic classification.

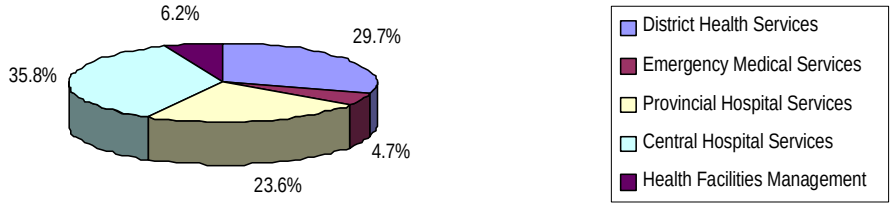
Diagram 5o: Western Cape health expenditure by selected programmes: 2005/06



Expenditure by health programme

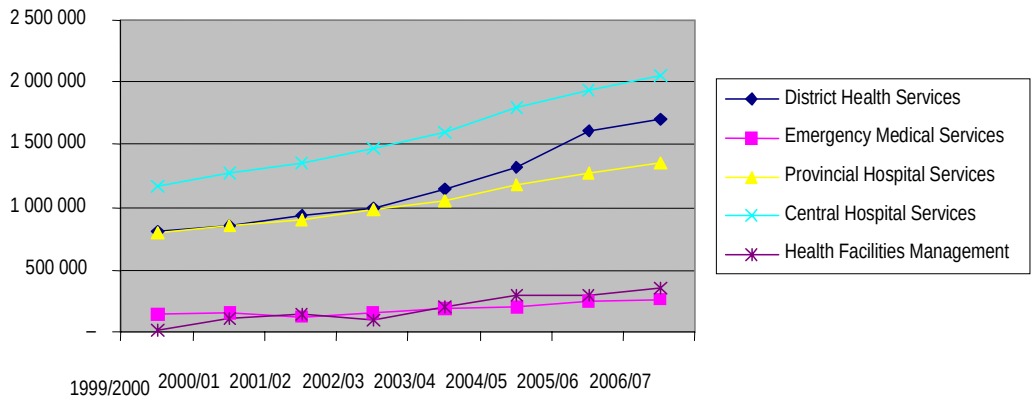
Diagram 5o shows the expenditure on CHS programme is at 36 per cent the largest proportion of total expenditure of the selected health programme. The second largest proportion of expenditure is taken up by DHS at 30 per cent, PHS at 23.8 per cent, building and infrastructure at 5.5 per cent, and EMS at 4.7 per cent. Further analysis of projected estimates for the 2006/07 expenditure, in terms of Diagram 5p, shows that there are slight shifts in percentage terms, such as: a reduction by 0.2 per cent in the proportion of CHS to 35.8 per cent in 2006/07; a 0.3 per cent decline in DHS to 29.7 per cent, a 0.2 per cent decline in PHS to 23.6 per cent. While the building and infrastructure programme within the Western Cape Province health programmes gained by 0.7 per cent, the proportional share of expenditure for EMS remained constant between 2005/06 and 2006/07.

Diagram 5p: Western Cape health expenditure by selected programmes: 2006/07



Graph 5i shows a consistent and rapid increase in the revenue allocation and expenditure on the DHS. Overall, the strong growth in CHS expenditure is maintained relative to PHS and DHS. The expenditures by the selected health programmes within the Western Cape (see Table 7I) grew by an annual average of 9.4 per cent. This expenditure grew 2000/01 by more than R3, 2billion to R6billion in 2007/08. The annual average expenditure over the period 2000/01 to 2007/08 in DHS is at 11.2 per cent, EMS at 9.5 per cent and on the HFM programme at 20.7 per cent, which are all above the overall annual average expenditure are indicated in Table 7I. The annual average growth in expenditure on PHS are at 7.7 per cent and central hospitals are, however, below the overall annual average. This shows a clear push of expenditure towards DHS.

Graph 5i: Western Cape health expenditure by selected programmes



Central Hospital Programme

The central hospital programme in the Western Cape Province spends the largest amount of funds, growing from R1, 2billion in 2000/01 to R2, 1billion in 2007/08. All expenses are incurred only the different central hospitals within this province. The only sub-programme reflected within this programme is CHS, which grew from around R1, 3billion in 2000/01 to R2, 1million, providing an annual average growth rate of 7.9 per cent. The growth in expenditure in this sub-programme is consistent over the years between 2000/01 and 2007/08, regarding the expenditure on goods and services within the current payments economic classification, which grew from R341million in 2001/02 to around R723million – an annual average of 13.35 per cent. Although it shows an inconsistent year-on-year growth, compensation of employees within the CHS programme grew from R949million in 2001/02 to around R1, 3billion in 2007/08. Within the transfers and subsidies, the largest expenditure within the CHS programme is on universities and technikons, which grew from R32million in 2001/02 to R48, 6million in 2007/08 – an annual average growth rate of 7.24 per cent. Other expenses in the transfers and subsidies are payments towards provinces and municipalities, growing by 8.2 per cent between 2001/02 and 2007/08 and the transfers to households, which grew from R236 thousand to R2million over the same period.

DHS

Within the DHS programme, the expenditures on community health centres are the largest, growing from R303, 5million in 2000/01 to R578million in 2007/08, representing an increase in the annual average growth of 9.6 per cent. The highest growth period on this sub-programme is the expenditure growth of R75million between 2004/05 preliminary outcome of R438million and 2005/06 in R513million.

The annual average expenditure growth rate within the community health centre programme grew by 9.6 per cent, which exceeds the provincial annual average over the period for this DHS programme. The compensation of employees and goods and services within the current payment economic classification in DHS grew by 12.15 per cent and 15.20 per cent, respectively. These annual growth levels in both economic

classification expenditure items reflect the relative strong growth towards further expansion of the district health system.

The HIV and Aids sub-programme grew the fastest over the 2000/01 to 2007/08 period at an annual average rate of 48.8 per cent. The expenditure on this sub-programme grew from R9, 8million in 2000/01 to R158, 5million in 2007/08. The growth in expenditure is also strong on the community based services sub-programme, which grew from R21, 4million in 2000/01 to R56, 4million in 2007/08, an annual average growth rate of 14.8 per cent. Table 7I shows that expenditure in the other sub-programmes grew from 2000/01 to 2007/08 by 18.8 per cent in district management; community health clinics by 9.3 per cent; other community services by 8.4 per cent; and district hospitals by 9.7 per cent. The nutrition sub-programme grew by 3.4 per cent from R13million in 2000/01 to R16, 6million in 2007/08. The increase expenditure growth in this sub-programme seems to be not aligned to the national policy decision to shift the nutrition sub-programme and budget to the education sector.

The expenditure annual average growth rate within the community health centre programme also grew by 9.6 per cent, which exceeds the provincial annual average over the period for this DHS programme. Compensation of employees and goods and services within the current payment economic classification in DHS grew by 12.15 per cent and 15.20 per cent, respectively. These annual growth levels in both economic classification expenditure items reflect relatively strongly on further expansion of the district health system.

The expenditures by the selected health programmes within the Western Cape (see Table 7I) grew by an annual average of 9.4 per cent. This is expenditure grew from 2000/01 by more than R3, 2billion to R6billion in 2007/08. The annual average expenditure over the period 2000/01 to 2007/08 on DHS are at 11.2 per cent, EMS at 9.5 per cent, and on the HFM programme at 20.7 per cent which are all above the overall annual average expenditure as indicated in Table 7I. The annual average growth in expenditures on PHS is 7.7 per cent and central hospitals are, however, below the overall annual average. This shows a clear push of expenditure towards DHS.

Central Hospital Programme

The central hospital programme within the Western Cape Province spends the largest amount of funds, growing from R1, 2billion in 2000/01 to R2, 1billion in 2007/08. All expenses are incurred by the different central hospitals within this province. The only sub-programme reflected within this programme is CHS, which grew from around R1, 3billion in 2000/01 to R2, 1million, providing an annual average growth rate of 7.9 per cent. The growth in expenditure in this sub-programme is consistent over the years between 2000/01 and 2007/08 regarding the expenditure on goods and services within the current payments economic classification, which grew from R341million in 2001/02 to around R723million, an annual average growth of 13.35 per cent. Although it shows an inconsistent year-on-year growth, compensation of employees within the CHS programme grew from R949million in 2001/02 to around R1, 3billion in 2007/08. Within the transfers and subsidies, the largest expenditure within the CHS programme was on universities and technikons, which grew from R32million in 2001/02 to R48, 6million in 2007/08, an annual average growth rate of 7.24 per cent. Other expenses in the transfers and subsidies were payments towards provinces and municipalities, growing by 8.2 per cent between 2001/02 and 2007/08 and the transfers to households, which grew from R236 thousand to R2million over the same period.

Table 7i: Western Cape health expenditure by selected programmes and their sub-programmes, 1999/2000 to 2007/08

R thousand	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Average annual growth 2000/01 - 2007/08
			Actuals			Prelim. outcome	Medium-term estimates			
District Health Services	**805,156**	**852,185**	**929,594**	**993,592**	**1,144,686**	**1,322,416**	**1,611,684**	**1,704,433**	**1,793,938**	**11.2%**
District Management	21,215	23,100	18,108	21,636	32,955	22,462	68,537	72,855	77,153	18.8%
Community Health Clinics	178,437	194,293	208,943	204,653	264,879	269,591	322,480	342,751	362,973	9.3%
Community Health Centres	278,819	303,595	334,084	362,374	384,819	438,416	513,430	545,775	577,975	9.6%
Community Based Services	19,710	21,461	35,748	39,644	33,443	32,956	50,178	53,339	56,488	14.8%
Other Community Services	33,352	36,316	36,353	37,140	43,527	49,917	56,636	60,204	63,754	8.4%
HIV/Aids	9,024	9,826	12,121	19,678	38,146	90,458	116,023	150,954	158,502	48.8%
Nutrition	34,619	13,179	16,625	15,378	12,896	16,573	14,811	15,744	16,674	3.4%
Coroner Services	–	–	–	–	304	927	775	824	873	–
District Hospitals	229,979	250,415	267,612	293,089	333,717	401,115	468,814	461,987	479,546	9.7%
Emergency Medical Services	**146,254**	**151,481**	**131,673**	**152,910**	**185,695**	**197,688**	**254,470**	**270,501**	**286,461**	**– 9.5%**
Emergency Transport	146,254	151,481	131,673	152,910	184,441	197,687	248,976	264,661	280,277	9.2%
Planned Patient Transport	–	–	–	–	1,254	1	5,494	5,840	6,184	–
Provincial Hospital Services	**790,266**	**855,444**	**901,601**	**974,273**	**1,053,048**	**1,176,384**	**1,276,765**	**1,357,199**	**1,437,268**	**– 7.7%**
General Hospitals	489,766	530,160	558,626	613,307	665,389	752,145	776,762	825,698	874,412	7.4%
Tuberculosis Hospitals	45,522	49,277	49,065	51,154	54,269	59,911	64,124	68,163	72,182	5.6%
Psychiatric/Mental Hospitals	186,241	201,602	214,322	225,209	232,790	258,171	285,273	303,244	321,136	6.9%
Chronic Medical Hospitals	33,535	36,301	38,934	42,078	53,228	54,603	96,859	102,961	109,038	17.0%
Dental Training Hospitals	35,201	38,104	40,654	42,525	47,372	51,554	53,747	57,133	60,500	6.8%
Central Hospital Services	**1,169,571**	**1,275,645**	**1,348,157**	**1,476,202**	**1,607,089**	**1,806,534**	**1,936,056**	**2,057,004**	**2,177,830**	**– 7.9%**
Central Hospital Services	1,169,571	1,275,645	1,348,157	1,476,202	1,607,089	1,806,534	1,936,056	2,057,004	2,177,830	7.9%
Health Facilities Management	**18,793**	**101,689**	**143,375**	**100,794**	**196,176**	**299,523**	**296,805**	**354,745**	**379,770**	**– 20.7%**
Community Health Facilities	–	–	9,188	6,459	12,572	19,194	19,020	20,765	26,130	-17.6%
Emergency Medical Rescue Ser	–	–	3,493	2,455	4,779	7,297	7,230	8,250	1,000	–
District Hospital Services	–	–	34,807	24,470	47,625	72,715	72,055	76,848	156,212	–
Provincial Hospital Services	–	–	86,161	60,572	117,892	179,999	178,365	221,070	147,866	–
Central Hospital Services	–	–	7,246	5,094	9,914	15,137	15,000	22,387	42,382	–
Other Facilities	18,793	101,689	2,480	1,744	3,394	5,182	5,135	5,425	6,180	–
Total selected programmes	**2,930,039**	**3,236,444**	**3,454,400**	**3,697,771**	**4,186,694**	**4,802,545**	**5,375,780**	**5,743,882**	**6,075,267**	**9.4%**

1. Adjusted for the primary school nutrition programme shift to the Department of Education.

2. Information not available prior to 1999/2000.

3. Includes capital works in respect of health voted on public works.

Source: National Treasury databases.

Conclusion

In this chapter I have proven that both intentions of the co-operative governance system practice are operational within the social and financing policy decision between central and provincial government. Although central government strongly relies on the conditional grants funding mechanism to push its policy objectives through provincial budget, provinces have in certain policy areas also matched or added additional funding. This is evident in the expenditure within the HIV/Aids programme.

Moreover, in this chapter I demonstrate that there is a much stronger expression through the provincial budgets and expenditure of the central government's public finance and health policies. In the instance of conditional grants, the public finance and health policy practice reaffirms the overall policy dominance and allocative efficiency responsibility of the central government to achieve equity and health programme and service redress. On the other, the public finance and health policy practice acknowledges the provincial government's technical advantage in the public health sector in the determination of service delivery and, hence, funding levels.

In this chapter I have shown that:

a) As a result of a conscious district health system policy to achieve equity, but also to implement a primary health care system, provincial resource allocation has systematically shifted from certain health programmes such as EMS to DHS. The overall increases in DHS are in most instances, not a result of real additional revenue allocation from both the central and provincial governments but, rather, an internal shift in funding from one programme to the other. It is the opinion of this research that this internal shift is indicative of the provinces succumbing to the strong policy pressure from central government, but also an indication of the provinces' intent to maliciously comply with central government's policy directives. This policy directive and practice at a provincial government level within the health system clearly undermines the fundamentals of decentralized co-operative governance discussed earlier.

b) The practice occurs regarding hospital services, where funding has not really shifted from hospitals to PHC services through the district health system. The shifting of funds to PHC is still a requirement of the DHS policy and the White Paper for the Transformation of the Health System in South Africa. In fact, provinces with PHS consciously chose to ignore the policy directive from central government and preferred to increase the maintenance of the hospital services and also improve or invest in either additional resources or expand hospital services. While this augurs well for the arguments of technical efficiency, it does create a chasm between the policy directive and what gets practised. This clearly undermines the intentions of co-operative governance between the central and provincial government regarding health service delivery and management through policy directives.

c) The shifts in expenditure levels in health programmes made provision for the erection of buildings as directed through the district health service policy's clinic building programme. This policy practice proves the synergy in policy orientation between the central and provincial government and the public finance and health sectors.

d) Imposed policy implementation and co-ordination took place within provincial budgets and expenditures, particularly as a result of wage negotiations over which provinces have no power. Compensation of employees grew consistently over the financial years discussed within this chapter. The salary proposals as agreed between central government and different stakeholders such as labour unions are indeed tantamount to 'pre-emptive determination' of the wage budget of the provinces, thus removing all autonomy from provinces to determine salaries and the types of annual increases. This excludes a practice of province-specific negotiations of salaries in relation to fiscal capacity, because the negotiations take place through a centralised collective bargaining council. This practice is also a classical example of how the intent of the decentralized co-operative governance system's operation between the central and provincial government is undermined. In fact, in this instance of wage negotiations proves in many ways that provinces are de facto implementers or administrators of central government policies and that the constitutional ideal of an independent autonomous sphere of government is more apparent than real.

e) Although there are increases in consolidated budgets and expenditures on the health programmes in provinces, these are rather nominal and constrain the expenditure manoeuverability of provincial governments in the face of increasing health priorities and increasing medical costs. In fact, this practice strongly asserts that, irrespective of new public health policy directives or central government expenditure priorities within the public health sector, provinces should finance these policy directives or priorities within the existing fiscal resource envelope.

Chapter Eight – Conclusion: Interaction between different public policies - Imposed Co-ordination or Inclusivity through within the Public Health System

Introduction

The purpose of this chapter is to conclude the study by briefly revisiting the methodological approach, conceptual framework, and the outcomes of chapters that present data. Also considered in the chapter are implications for policy and practice, and suggestions for future research.

The chapter concludes the dissertation by arguing that from the perspective of public policy design and implementation, and revenue allocation and distribution, and public finance expenditure the constitutional imperatives of co-operative governance are under threat. Moreover, the chapter argues that the existing features, components and elements of co-operative governance practice within the public health system are not able to hold the system together. The chapter raises a number of observations and conclusions that demonstrate the inability of the co-operative governance system to enforce and hold together uniformity and standardisation at both a vertical and horizontal level within the public health system between the public finance and health sectors. It argues for a new system of co-operative co-ordination or management within the public health system between the public finance and health sectors, which speaks to integration rather than a different form of governance. The chapter further argues for tailored universalism on policy responsibility and accountability at an implementation level relative to overall provincial capabilities, resource allocation and the distribution of the public health function. The premise of this argument is the diminishing policy influence and resourcing roles at the implementation level of the provincial governments. Furthermore, it is argued that given the empirical evidence and analysis that emerged from the study, provinces are de facto provincial administrations of central government policies. This deposition is strengthened by the argument that the increasing strong role of the central government within the unitary decentralized governance system has led to a systematic revoking of the devolved authority to either a delegated or deconcentrated system within the public health system.

The original conceptualization of this research study was to review the relationship between the central and provincial governments in a decentralized unitary state within the context of co-operative governance. However, as one tried to understand and design the scope, nature and extent of the intergovernmental relationship within and between the public health and finance sectors and within and between the central and provincial governments, it became apparent that a review of the governance and decentralization theories was required. The design of the study was further compounded by the research study objectives, which required locating both the public health and finance policies within an understanding of: a) a concurrent or shared public health function between the central and provincial governments; b) the governance relationships between the central and provincial governments and between the finance and health sectors; c) the emerging policy practice context, which started to articulate differential responsibilities and competencies between the central and provincial governments within the public health sector; and d) the interdependent policy design and practice vertical and horizontal relationships between the central and provincial health and finance (treasury) departments.

In order to review and analyse the decentralized co-operative governance system between the public finance and health sectors and between the central and provincial governments the theoretical and practical construction of the research drew strongly on Stephen Ball's (1993:10) notion of a "toolbox of diverse concepts and theories rather than a pure one." The use of such a toolbox allowed not only for a mix of theories but for a connectivity between the different features and assumptions of these theories. This mix of theories has led to a number of theoretical and practical considerations. However, instead of privileging any of Kooiman's (1993) three models of governance - state control, state supervision and state interference the study preferred to consider all three as prisms for an analysis of the co-operative governance system. Furthermore, the connectivity of these models was found to be not only varied, but had similar assumptions and elements with the different approaches to decentralization. Chapter 2 of the study shows close links at a theoretical level, as well as, tensions that could emerge between the governance models and the decentralized approaches of delegation and devolution of functions, responsibilities and authority.

This initial theoretical journey towards the construction of a governance and decentralized orientation led to a conscious exploration of the orientations of the public policy process in government institutions. This exploration led to the formation of linkages between approaches to governance and the decentralization of the macro-economic and political processes in the country. Furthermore, this theoretical exploration included varied and different components of macro and micro political considerations; economic and fiscal considerations, and administrative and institutional considerations. These considerations have had an influential and regulatory effect on co-operative governance practices. They have also created conditionality in the public policy processes of both the public finance and health sectors and their determining influences on the public health system. These combinations of concepts, theories and international experiences, including debates about public finance and health decentralization, led to different compartments in the toolbox of analysis.

This toolbox of analysis was not only developed and utilised to review and analyse the operability and the nature of co-operative governance between the central and provincial governments but also to analyse the public finance and health policy processes, the responsibilities and obligations associated with central and provincial government responsibilities, and how these are resolved within the decentralized co-operative governance system. Public policies were considered as the terrain of investigation but also as the looking glass for the analysis of co-operative governance within the public health system.

This theoretical justification, serving as the backdrop to the research, provided a context for the exploration of the problem statement. The problem statement is that the functional and structural decentralization of policy making and implementation within the co-operative governance system has contributed to the undermining of the co-operative governance relationship between the public finance and health sector and central and provincial governments. The contention explored was that the central government is using its overriding powers to “impose coordinated solutions” to problems within the co-operative governance system, which have led to situations where ‘imposed co-ordination’ is considered as ‘co-operative governance’. As a means to further probe the primary problem statement, the study also explored the following subset of propositions:

a) The tensions between central and provincial government, which originate from central and provincial governments and their associated interpretations of the concurrent or shared responsibilities for public health;

b) The notion of a contested policy implementation process that leads not only to different but also incompatible public health and finance polices outputs; and

c) The perception of an emerging inverse relationship between central and provincial governments within the public health and finance sectors.

The exploration and analysis of the problem statement was undertaken through a case study approach, which allowed for an in-depth, multi-method account of the scope, nature and extent of co-operative governance within the public health system. The case study approach to co-operative governance was further strengthened through a deployment of the decision-space tool (Bossert, 2000), which allowed for an application of the decentralization and governance theories combined with the arguments of allocative and technical efficiency. The combination of different research tools and methods allowed for a variety of data collection and data analysis techniques such as in-depth individual interviews, assessment and analysis of reports and documents and budget and expenditure data analysis. Through this study one sought to develop deeper insights into the co-operative governance within a decentralized unitary system and into how structural and functional factors in this system influence, determine and constrain policy implementation.

While conducting the study, the researcher discovered that both the extent and character of co-operative governance and the decentralized policy practices differ within and between the central and provincial governments and within and between the public finance and health sectors. Within the public finance sector, significant expenditure responsibility and authority have been transferred to the provinces from the central government. This has taken place as a result of both constitutional requirements and the introduction of intergovernmental finance legislation and best practices on fiscal decentralization.

However, while the expenditure assignment for the fiscal construction of public health services was located with the provinces, revenue mobilisation was located within the central government. This dislocated revenue and expenditure assignment, which contributed to the health administration and service delivery planning in the provinces in the absence of revenue mobilisation knowledge and responsibility. Policy implementation planning thus relied heavily on fiscal transfers from central government - a post ante policy practice.

Therefore, it can be seen that this policy practice has contributed to an inverse relationship between the responsibility and authority for the fiscal resources and the distribution of these resources (between central and provincial governments and public health policy priorities and programmes). Consequently, the means to achieve allocative efficiencies and the technical efficiencies within and between the different spheres of government and within and between the sectors have differed from each other in the setting of public policies, strategies, finance and administration. This clearly has led to different orientations within and between the spheres of government and sectors. It also contributed to the achievement of the imperatives of co-operative governance. Moreover, it has created a co-operative governance system that has a combination of elements of state control, supervision and interference. These elements are at the exposure of central government, which provides the central government with a leash on provinces in finance and health arenas.

The public health policy analysis in chapter 5 and 6 the public finance analyses also covered in chapters 6 and 7, combined with the above observations confirm that:

a) The functional and structural decentralization of policy making and implementation within the co-operative governance system contributes to the undermining of the co-operative governance relationship between the public finance and health sectors and between central and provincial governments;

b) The central government is using its overriding powers to “impose coordinated solutions” to problems within the co-operative governance system, which leads to situations where ‘imposed co-ordination’ is considered as ‘co-operative governance’;

c) The tensions exist between central and provincial government, which originate from differing interpretations of the concurrent or shared responsibilities for public health;

d) As a result of variation in the policy design and implementation processes, policy implementation is contested at central and provincial government levels between the finance and health sectors within the public health system, given competition for the resources and weaknesses in provincial capacities, which have led to not only different but also incompatible public health and finance polices outputs; and

e) There is a perception of an emerging inverse relationship between central and provincial governments within the public health and finance sectors.

Implications for decentralized co-operative governance within unitary public health system

The evidence that emerged from this study shows that unitary and federal elements co-exist in the public health and financing system as indicated in Table 8 below. However, this is more so in the public finance system. The dissertation confirms that South Africa has a unitary system of government, but with strong decentralized features. Some of the functions, as indicated in Table 8, are exclusively performed by the central government. There are however, those functions such as health that are shared between the central and provincial governments. The shared functions are mainly with regard to, as Table 8 indicates, the federal system elements, co-operation and co-ordination on policy design and implementation, legislation and monitoring. This interaction between the central and provincial government is also referred to as co-operation federalism. The strong centralized features of the public finance and health systems, as discussed earlier in this dissertation, include decisions on revenue sharing and public administration. The Constitution, in particular, makes the South African system a revenue-sharing one, dominated by a single tax system. The Constitution also provides for one public service for employees in the central and provincial government spheres.

As seen in Table 8 these features impact directly on the competencies and the authority of provinces. This research, therefore, maintains that where the responsibility for any function is shared between two spheres of government, there is a continual need for central government to strongly manage and co-ordinate policy design and

implementation, legislation, and monitoring. As such, any gaps in the co-ordination and management between the processes lead to co-ordination failures and real or alleged unfunded mandates. Table 8 also confirms the overall strength of the provincial government on the expenditure side relative to the central government as a result of the federal system elements within the co-operative governance system. It also confirms that, although there is a strong principal (central government) in terms of policy-decision and revenue-distribution capabilities, the agents (provincial governments) are still responsible for making implementation decisions. The South African co-operative governance system thrives on the importance of it being a hybrid between unitary and centralized decision-making features on the one hand and strong decentralized and federalist features on the other. Given that the governance system is really emerging in practice, the co-existence of both these sets of features enforces the co-operative governance conundrum.

The co-operative governance structures established by the public finance and health sectors operating in the public health system have had a powerful effect on public policy design and implementation processes. These structures have not only contributed to an overt emasculation of the central government authority and responsibilities, but also constrain political authority for policy and fiscal decisions and choices in provincial governments. The structures have also shaped the way in which co-operative governance policy decisions are put into practice. The result is that the implementation of the public health policies is often not necessarily consistent with the intentions of these policies. Also, the public health policy may have required substantial public finance and other resources to produce the policy as intended within the context of practice but, instead, provinces have, as a result of limited resources, only focused on those components of public health policies that fit within their fiscal resources and expenditure plans.

Table 8: Unitary and Federal Elements Co-existing in Public Health System: The Conundrum of Decentralized Co-operative Governance

Unitary System Element of Governance System	Federal System Elements of Governance System
• Inclusive centralized national public policy making in consultation provinces	• Policy implementation responsibility with authority to make adjustments to policies on margins, but not to alter overall policy intentions • Authority to determine the degree and level of services and programmes to be delivered, including financing of national social services policies
• Centralized policy sets norms and standards underpinned by equity and access	• Provinces obligated to deliver service and programmes in terms of centralized sets of norms and standards underpinned by equity and access • Provinces have power to determine appropriate levels of services delivery and choice of which norms and standards to priorities – given competing priorities and revenue envelop (including the baseline requirements for services, institutional and financing arrangements) • Deciding on financing level of policy obligations, thus privileging its choices (technical and allocative efficiency decision)
• Centralized macro-economic and fiscal policy making	• Authority to craft provincial fiscal policies within the regulatory framework set by the centralized/national macro-economic and fiscal policy framework • Determined resources, however, provincial microeconomic policy inconsequential given the dominance of the overall macro-policy stance and sourcing
• Centralized tax system and revenue collection system given serious disparate fiscal capacity and economic and growth capabilities and opportunities	• Very limited taxing resources, thus expenditures outstrip own revenue in provinces • Curtailment of independent and autonomous fiscal policy decision-making in provinces • Provincial disparities
• Centralized process, with appropriate and regulatory forms of participation in national revenue distribution	• Provinces are recipient of centrally raised revenue in terms of an equitable share formula and through conditional grants allocations • Though provincial expenditure decisions, revenue allocation from central government has the effect of either influencing or imposing a nationally determined priorities • Provinces are recipient of revenue shares based on macro-economic growth and development and conditionalities created by the national fiscal policy
• Monitoring of provincial implementation of fiscal and social policy decisions	• Spending powers are with provinces within the ambit of revenue allocated. • Provinces required to apply hard budget constraints (fiscal stability)

Operational versus constitutional public policy processes within the conceptual framework

The literature review approach deals with decentralization and co-operative governance from an operationalised and constitutional perspective, but does not deal with the complexities of the decentralized co-operative governance system in a South African context and government system. What the conceptual framework on decentralized co-operative governance offers is a means to analyse these processes from a number of areas. The conceptual framework brings together the public policy, service-delivery and financing approach and elements together as a framework to consider governance and decentralization processes. The framework provides also a definition of decentralized co-operative governance within the public finance and health context in South Africa. Furthermore, it combines policy and decision making in order to determine not only the nature and extent of decentralization, but also to determine whose the principal and the agent of policy implementation and resourcing.

Findings from the Study

The main findings from the study are set out in the paragraphs that follow.

First and foremost, provinces are constitutional, autonomous, decision-making governments as well as its administrative departments of central government. This autonomy is, however, compromised and constrained because of the location of the overall policy-making responsibility within the public health sector. The location and design of public policies happens through an acclaimed process of partnership and co-operative governance that regulates and influences “what ought to be” a national policy that attests to key considerations of equity and efficiency across the public health sector. The outcome of this new policy process, controlled by the central government, consequently sets the health service organisation and delivery priorities to be implemented by provinces.

Push-pull activity within public policy process

Second, there is a push-pull activity and effect within the co-operative governance approach and within the public health system. This happens as the central government pushes for vertical integration within both finance and health policy process. In this manner it demonstrates that there is a strong link between responsibility for policy design and implementation. Consequently, both central and provincial governments are jointly responsible and accountable for policies. However, when policies and the associated programs are not implemented or there are no sufficient resources, either by design or default, central governments pull away and through this behaviour declare that provinces are responsible and accountable for policy implementation and service delivery. This, conversely, is a practice of vertical separation within the policy design and implementation process.

Horizontal and vertical separation and integration of public policies

Third, the co-operative governance approach within the public health system requires a horizontal integration of public finance and health policies at a provincial level. This in itself not only creates a scramble for resources between the health sector and other provincial responsibilities but also elevates the role of the public finance sector as the mediator between different policy priorities within a province. This mediator role of the provincial finance sector (provincial treasury) is influenced by a comparative information advantage about the key components of the macro-economic and fiscal policy within a given year but is also influenced by the dominant role the provincial treasury plays in resource allocations. The pull effect here is that fiscal policy considerations dominate, determine and regulates the nature and level of financial support for the implementation of nationally determined policies. This confirms that there is only one single government at a provincial level that consists of different sectors, thus allocating collective responsibility for setting and implementing service-delivery policies and priorities.

However, the converse is also true. This happens when a policy is not implemented, over expenditure occurs in relation to annual budgetary allocations, and where policies are approved without determining the level of public finances required. In these instances, both the central and the provincial governments treasury departments would

declare the health sector as being delinquent as it does not uphold due diligence on policy processes or costing of policies (including being ill-disciplined in the management and administration of public finance). As a result, treasury departments engineer a reinterpretation of collective responsibility and accountability between the finance and health sectors as central and provincial governments in order to absolve them from practices that do not contribute to either fiscal prudence or good public finance management and administration practice. This practice is synonymous with a pull-out activity and effect within the co-operative governance process, thus a horizontal separation between sectors.

In both these instances of separation and integration at the horizontal and vertical levels, the relative strength and comparative advantages of the central and provincial governments and the different sectors are exposed. This illustrates tensions between the central and provincial governments but also between the public health and finance sectors. As way of illustration, one can explore the policy articulation of public financing and expenditure responsibilities within the National Health Act. This policy stance, as discussed in Chapter 5, provides a legislative role for the Minister of Health in the determination of both resource mobilisation and allocation, including expenditure responsibilities within the public health system. This policy not only interferes with, but also contradicts the existing expenditure assignment responsibilities of the provincial government. It also has the potential to fuel policy design and implementation tensions between the central government ministries of finance and health, given the location of competency for macro-economic and fiscal policy within South Africa.

Diversity and varying capacity within public policy process

Fourthly, the wide diversity and varying degrees of capacity within the public health system resulting from historical, political, economic and organisational conditions have led to an explicit policy consideration of achieving equity and efficiency across and within provinces. As a direct outcome of allocative and technical efficiencies and also equity considerations, significant policy implementation and spending responsibilities have been given to provinces. This has clearly led to an over zealousness in policy production and articulation in order to reform the public health system and to ensure uniformity in norms and standards. This happened at the expense off weak administration, public

finance and service delivery capabilities, which means that policy implementation obligations exceeded provincial governance competencies. This created an inverse relationship between policy responsibilities – that originated either from the shared health function or national policies – and the existing financial service delivery and administrative abilities of provinces. The pre-occupation with uniformity and the application of norms and standards within the public health system ignores the relative capabilities of provinces to implement these policies. It further ignores in the context of equity and allocative efficiencies the need for possible asymmetry in the allocation of policy and public health care service-delivery obligations to provinces.

Vertical integration and expenditure authority, but constrains through fiscal transfers

Fifth, the intergovernmental transfers – in the form of the provincial equitable share of nationally raised revenue and conditional grants – are indeed the glue that serves to bind at both a horizontal and vertical level the co-operative governance system. The design and levels of the fiscal transfers system have had a varying impact on the decentralized co-operative governance system. The claim that the equitable share allocation to provinces, which is in theory an unconditional block grant, is a "conditional grant in disguise" resonates with the policy design of this fiscal transfer. In fact, the preliminary and final resource allocations to provinces indicate the different priorities to be considered when the budgetary allocations are made to health programmes. This contradicts fiscal and public finance theory and international best practices regarding unconditional block grant allocations to provinces. This form of resource-allocation also restricts provincial autonomy in the allocation of resources, thus leaving provinces with a relatively marginalised role. On the other hand, the resource-allocation process and mechanisms confirm the off-policy practice that within a unitary state the central government ought to be responsible for spending, particularly where it concerns production of efficiency.

Public policy decisions pre-determining resource-allocation

Sixth, although central government sets the policy, norms and standards for service-delivery provision it also provides decision-making space for provinces to detail the

practical measures required for the implementation and financing of policies. Whilst this ought to be considered against efficient management and administration of programmes and policies of national interest (that match both economic political and social conditions) it has contributed to increased fiscal pressures placed on provincial government. This has in many instances led to unfunded policy mandates on the part of provinces. It is therefore conceivable that public finance and fiscal capacity and the location of responsibility must accompany each other. The mere fact that the majority of policies have not been priced has contributed to arbitrary levels of financing. As a result it becomes difficult from the perspectives of both public health and finance policy to make a compelling statement that health, but particularly health policies and programmes, are either over funded or under funded.

Interaction between public policies and budget and expenditures

Seventh, at an aggregated level there is a strong interaction between policy and programmes on the one side and budgets and expenditure on the other. This interaction demonstrates the impact that the different public health policies have had on the public health system – particularly, the shift in resource mobilisations and allocations towards a primary health care approach within a district health system. The aggregate assessment at a health-expenditure program level strengthens the perception of strong integration at both the vertical and horizontal levels within the decentralized co-operative government approach. However, at a disaggregated level health expenditure assessment becomes problematic. The lack of uniformity in financial data within and between health programmes does not assist in the analysis at a disaggregated level. It complicates an analysis to determine whether the health policies and priorities have indeed contributed or influenced budgetary allocation within and among public health programmes. Furthermore, from a supervisory and management perspective, it undermines the central government's ability to assure comparability between policy and programme implementation within and across provinces. It also does not contribute to measuring uniformity and standardisation between policy and programmes at a national level, thus leading to inconsistencies in financial analysis and a lack of uniformity in approach.

Lack of public policy costing to determine financing obligations

Eighth, the lack of pricing of the different public health policies and programmes conflicts with current public finance legislation. It is a requirement of the Public Finance Management Act, 1999 that all policies that have a direct financial burden for provinces must be costed. These conflicts exist at an implementation level because the public health sector imposes the public health policy on provinces by using its political leverage within the co-operative governance system. As a result, these uncosted policies destabilise budgetary and resource certainty within provinces. It also determines budgetary allocation through policies on a provincial level. It is therefore conceivable that such a costing outcome would not only strengthen the budgetary process in provinces but also allow for technical choices in the implementation of the policies relative to a need. This contributes towards attaining technical efficiencies during the implementation of public health care policies and services.

Separate, but equal public policy authority between public sectors?

Ninth, the co-operative governance approach in the context of a unitary decentralized government encourages the evolution of separate, but different and equal, policy design and implementation. This means that the policy process and the involvement of provinces in the public health sector are considered to be inconsequential to the process that happens within the finance sectors. Both the public finance and health sector policy and budgetary processes are considered to carry equal weight but, in practice, the policy processes increases competition between the sectors and consequently exacerbates potential conflict between finance and health policies operating within the public health system. Thus depending on either the strength of the fiscal and the political considerations or the level of joint policy decision making or the nature of persuasion embedded in decentralized co-operative governance, the approach followed to resolve tensions and conflicts have the potential to become a contested terrain.

Conditional transfer as a means to increase central government competency within the policy process

Tenth, the current manner in which conditional grants are used could be perceived by provinces as an intervention by the central government in their constitutional mandate. This might be seen, to a certain extent, as undermining the authority of the provincial governments and legislatures in the policy implementation processes and its expenditure-assignment responsibilities. However, there is acknowledgement on the part of provincial government health departments that conditional grants were ostensibly introduced to address national public health policy priorities and to expand the oversight role of central government in the shared health function. There is, however, a perception that the use of conditional grants could be an acknowledgement that the provincial equitable share formula is not an appropriate mechanism for assuring that national public health policy priorities are financed and implemented. Moreover, conditional grants could also be viewed as a vote of no confidence in the ability of the provincial budget process to align provincial health priorities with those of national interest.

Conflicting public policy intentions between the public sectors

Eleventh, the public finance sector, through its vertical integration approach and consistent introduction of different policies in the form of legislation and regulations, such as the Standard Chart of Accounts, strongly pushes for uniformity in the application of public finance good governance and administration practices. The introduction of these policies creates a strong rule-bound system and sets the basis for decentralized co-operative governance between the central and provincial governments. In the public health sector, the introduction of policies was more geared towards the expansion of public health services and the realisation of equity within and across the provinces. The policies contribute to priority setting and allocation of funds within the public health sector at a provincial government.

Hard budget constraints versus off-budget policy making

Twelfth, there is a continuing fragile and uncomfortable relationship between the public finance sector's policy approach of hard budget constraints versus the off-budget policy

priorities and programmes introduced during a financial year. From a public health sector perspective, it's policy-making processes and setting of priorities and norms and standards have the multiple goals of ensuring equity across the provinces and ensuring sufficient and adequate health facilities and services and appropriate interventions, with the objective of an expansion of public health services. What compounds the push against the hard budget constraints is sometimes the making of policies through either public announcements or media statements that have not been included within the national and or provincial budget processes. In fact, these statements not only push for soft budget constraints, but also introduce an "unofficial" or "parallel" ad hoc budget process.

Central government as a strong and controlling principal

Thirteenth, the evidence show that fiscal transfers, both conditional and unconditional, are based on central government's policy intentions and projected inputs and outputs determined through nationally identified health needs, public health programme designs, multi-year strategic health plans, and multi-year term expenditure projections. These all contribute to the argument set out in this dissertation that the total resolve of the authority and power in terms of governance resides with the central government, with implementation responsibility at a provincial level. This dissertation argued that the overall public policy process – from design to implementation – take place in a highly centralized unitary government and state. The public policy processes comprise both deconcentrated and delegated features of policy making within the decentralized co-operative governance system of government. This is definitely opposed to the constitutional ideal of a unitary state with a devolved system of government. Finally, current and potential tensions that exist within the central government level and between public finance and health sectors are reproduced at a provincial-government level. On the one hand, the public policy tensions contributed to clarifying differential responsibility within the public health system. The policy process and practice tensions also contributed to confirming that central government is the principal of public policies and is responsible and accountable for ensuring that the national health public interest is upheld and that provinces are de facto implementing agents of these policies and programmes. This not only contributes to a difference in policy decision-making processes between the public health and finance sectors between the central and

provincial governments, but has also created the potential to undermine co-ordination and, as such, decentralized co-operative governance between policy decisions, budgeting and planning.

Although the existence of provinces is constituently guaranteed, the functioning of provinces only exists in as much as the central government allows it to exist within provincial power and authority. In the context of the public health sector, both provincial departments of health and finance are only responsible for the implementation and financing of a national set of health priorities and programmes. This policy practice translates into provincial governments and their associated finance and health departments being the implementers of central government national policies.

Those disconnections make it fanciful to suppose that the nascent policy design and implementation dialogue, and the revenue allocation and expenditure practice, will lead to uncontested national policy and programme implementation within the system of co-operative government. It is in the interest of central government, according to this study, that the intention of a strong central government relative to the provincial government is to ensure damage limitation. It is the contention that within the context of a unitary decentralized government, both the central and provincial governments will ensure uniformity and standardisation within public health system but, given the informational comparative advantage at a implementation level of the provincial governments, provinces will particularly take a different route to achieve better health inputs and outcomes for their citizens.

Primary and secondary arguments of the dissertation

The dissertation argued that the tensions originate from differing responsibilities and authority within the shared health services and that the tensions have comprehensively: a) led to policy shirking; b) enhanced the emasculation of the central government relative to provinces; c) increased the policy and finance mandate drifts and scope creep; and d) increased a level of malicious compliance on the spending side as a consequence of nationally pronounced policies and programmes within the public health system.

The overall contention of this study is, therefore, that the functional and structural decentralization of policy making have contributed to the undermining of the decentralized co-operative governance relationship between the public finance and health sectors and central and provincial governments. Moreover, the functional and structural decentralization of the policy process has contributed to central government using its overriding powers to 'impose coordinated solutions' to problems, leading to situations where 'imposed co-ordination' is considered as 'decentralized co-operative governance'. As a result, pressures have been building to change the governance arrangement. These pressures have led to three sets of dynamics and outcomes between the spheres and sectors: a) tensions between central and provincial government regarding an interpretation of shared responsibilities for public health; b) a contested policy implementation process that not leads to different and even incompatible public health and finance polices outputs; and c) an emerging inverse relationship between central and provincial governments within the public health and finance sectors. These sets of dynamics and outcomes are discussed below.

a) Tensions between central and provincial government regarding an interpretation of shared responsibilities for public health

The contention here is that the horizontal and vertical articulation of common and varied policy interests between the spheres of government and within and between the sectors gives rise to the notion and practice of co-operative governance becoming a contested terrain. This study argued that the common and varied policy outlooks of different sectors and that government levels produces a system of the functional (public finance and health) and structural (between the different spheres) decentralization. Given the functional and structural decentralization process operable within the co-operative governance system and the prevalence of both common and varied policy considerations and interests, the functional and structural decentralization has also produced alliances, which vary from strong to fragile depending on the policy intentions, despite the 'intention and spirit' of the constitution given the nature of a unitary state. The functional and structural decentralization has in many instances led to central and provincial departments of health openly revolting against the treasuries fiscal and finance policy positions on hard budget constraints on public expenditure. In other instances, functional and structural decentralization led to a provincial government – as

the collective entity for both the health and treasury – in a specific instance protesting against a national policy decision taken by the central government departments, that is health and treasury – without consultation – which has financial implications for a province. It is therefore conceivable that alliances on certain policy design and implementation might exist within functional areas (public health or finance), but not exist across the sectors at a central and provincial governments level.

b) A contested policy implementation process that not only leads to different, but incompatible public health and finance polices outputs

The contention is that national policy decisions take place at a central government level for implementation at provincial level. This has contributed to variations in the outputs of implementation processes that intersect public finance and health policy decisions. This study argued in chapter 5, 6 and 7 that the policy design and implementation processes or practices have contributed to the financing of public-policy decisions for implementation that do not necessarily contribute to the strengthening of co-operative governance within the public health system.

c) An emerging inverse relationship between central and provincial governments within the public health and finance sectors

Given the location of fiscal responsibility and authority and compliance requirements within the context of macroeconomic stability and hard budget constraints on the part of central government, it is the contention of this study that an unequal relationship favouring the public finance sector exists between the central and provincial government. This, the dissertation argued, has undermined the fiscal policy decision making and autonomy of provinces in the distribution of budgetary allocations in the overall scheme of public financing. Moreover, the decentralized co-operative governance system in conjunction with the decentralised government strategy confirms that a stronger link exist between the kind of macroeconomic policy pursued by the central government and the fiscal resource space undertaken to implement both public finance and health policies. The dissertation also argued that this has contributed to an uneasy relationship between sectors – that is, those responsible for public finance policy and

expenditure allocations, essentially treasuries; and those responsible for public health policy making and implementation, that is, the health departments.

This dissertation leads me to conclude that the South African practice of co-operative governance in the health system is actually imposed co-ordination and that provinces are de facto administration outposts of central government policies, programmes and service delivery responsibilities. Therefore, in reality, there is no autonomy and independence of the provinces from the central government as envisaged in the Constitution of the Republic of South Africa. In fact, provinces only exist, in terms of their constitutional competencies as far the central government allows them to exist given its plenipotentiary powers over both micro and macro matters affecting institutions, fiscus, and social policies.

Implications for future research

The South African co-operative governance system's intention is to keep the decentralized co-operative governance public health sector together and this way drives overall uniformity. In this type of governance approach, the central government will retain certain functional responsibilities in public health. Uniformity combined with the policy intention and practice of standardisation, serves as the binding characteristic of co-operative governance. It would, however, be naïve to accept that within a unitary public health system, like that in South Africa, central government would not retain functions that have spillover effect on certain provinces. It is for this reason that central government exerts a strong and determining influence in the terrain of policy, financing and administration of tertiary health services. This has also been a bone of contention between the central and provincial governments, where the one determines policy and the other carries the fiscal and resourcing burden. The parallel policies of restructuring the health system and expanding the provision of health care to the historically disadvantaged groups have had a strong dependence on adequate health funding. Health funding is therefore critical to the restructuring, reshaping and the achievement of increased efficiencies in the public health system.

It is through the conceptual framework of co-operative governance within the public policy implementation context that the dissertation contributes to knowledge and

empirical evidence of policy design and implementation, governance and public financing within a co-operative governance and decentralized system. The study also considers the ways in which policy implementation could be strengthened between central and provincial governments in a system of co-operative governance.

It is assumed that public policies are made to address national policy and service-delivery imperatives, but that these do not of necessity correspond to provincial service-delivery needs, priorities and budgets. In this study a number of functional and structural matters regarding co-operative governance in a decentralized unitary public health system were highlighted that can provide opportunities for further research. Such research could include:

a) An investigation into the administrative and constitutional role of provinces in the efficient provisioning of a unified comprehensive public health care service in a unitary system of government;

b) An investigation into how the budgetary and public policy processes that ensure incentives and required capacities within the public health system contribute to the setting of prioritization of both aggregate and disaggregated spending in order to achieve technical and allocative efficiencies; and

c) An investigation into how the input mix between the central and provincial governments; in the implementation of policies; contributes to a single unified public health system.

This study is of the view that the most pressing long-term question for the co-operative governance system is whether the strong interference, supervision, and control regime by the central government can manage the challenges created by the separation, but also integration of policy design and implementation. The management of these challenges also requires a degree of consistency to avoid the practice of central government vacillation between the deconcentrated, delegation and devolved models of decentralization. Moreover, decentralized co-operative governance system, further requires stability in the location of resourcing responsibility and authority for policies and service delivery priorities.

The question also arises as to whether central government has, and is prepared to use, the political, economic and technical capabilities to deal with the growing demand by provinces for more power and authority in the public policy process. Moreover, the question is whether this demand will break the decentralized co-operative governance system.

References

Ahmed, J (n.d) Creating Incentives for Fiscal Discipline in the new South Africa. http://www1.worldbank.org/publicsector/decentralization/cd/safrica.pdf.

Ajam, T (1997) *Intergovernmental Fiscal Transfers*, Budget Watch, Idasa, South Africa.

Ansell C. and Gingrich J. (2006) "Trends in Decentralization". Cain B.E., Dalton R.J., and Scarrow S.E. (eds) *Democracy Transformed: Expanding Political Opportunities in Advanced Industrial Democracies.* Oxford: Oxford University Press.

Araujo, J.L.A. (1997) "Attempts to Decentralize in recent Brazilian Health Policy: Issues and Problems, 1988-1994". *International Journal of Health Services, 27, 1, 109-124.*

Ashleigh D.A. (2005) A study of successful implementation and management of educational technology in Three South Wales Primary Schools. A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Education. School of Educational Leadership, Faculty of Education, Australian Catholic University, Australia.

Bahl, R. (1996) "Fiscal Decentralization: Lessons for South Africa" in Helmsing B., Mogale T., and Hunter R. (eds) *Restructuring the State and Intergovernmental Fiscal Relations in South Africa.* Johannesburg: Friedrich Ebert Stiftung and Graduate School of Public and Development Management, University of Witwatersrand.

Bahl, R (1999) "Implementation Rules for Fiscal Decentralization". *Working Paper 10, International Studies Program*, School of Policy Studies; Georgia State University, Atlanta.

Ball, S. (1990) *Politics of Policy making in Education*. London: Routledge,

Ball, S. (1993) "What is Policy? Texts, trajectories and toolboxes". *Discourse, 13(2)10-17.*

Barker, C. (1996) *The Health care Policy Process.* London: Sage Publication.

Berman, P. (1996) “National Health Accounts in Developing Countries: Appropriate Methods and Recent Applications”. Forthcoming in Health Economics, 1997 January – February; 6(1):11-30.

Bird, R. and Vaillancourt (1998) “Fiscal Decentralization in Developing Countries: An Overview” in Bird R. and Vaillancourt, eds (1998) *Fiscal Decentralization in Developing Countries*. Cambridge

Bird, R.M. (2000a) *Rationale and Forms of Decentralization*. Rotman School of Management, University of Toronto.

Bird, R.M. (2000b) Intergovernmental Fiscal Relations: Universal Principles, Local Applications. Rotman School of Management, University of Toronto.

Bossert, T. (2000) Methodological Guidelines for Applied Research on Decentralization of the Health System. Latin America. LAC Health Sector Reform Initiative, Harvard School of Public Health, June 2000.

Bossert, T. and Beauvais, J. (2002). “Decentralization of the Health System in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision-space”. Health Policy and Planning; 17 (1):14-31.

Bossert, T.; Chitah, M.B.; Simonet, M; Mwansa, L; Daura, M; Mabandhala, M; Bowser, D; Sevilla, J; Beauvais, J; Silondwa, G; and Simatele, M (2000). Decentralization of the Health System in Zambia. Major Applied Research 6 Technical Report, 2. Partner for Health Reform, Abt Associates, Maryland.

Bowe, R; Ball, S and Gold, A (1992). Reforming education and changing schools. London: Routledge.

Brown, S., and Folscher, A. (2004) Introduction. *Economic Transformation Audit 2004 – Taking Power in the Economy: Gains and Directions. An Annual Publication*. Cape Town: Institute for Justice and Reconciliation, South Africa.

Burki, S.J., Perry, G.E., and Dillinger, W.R. (1999) "Beyond The Center: Decentralizing The State." World Bank Latin American and Caribbean Studies. Washington D.C: World Bank.

Cameron, R. (1991) "Implementing Devolution" in Cloete, F., Schlemmer, L., and van Vuuren, D (eds). *Constraints and Possibilities-Policy Options for a New South Africa*. Pretoria: Human Sciences Research Council.

Cheema, G.S. and Rondinelli, D.A. (1983*) Decentralization and Development: Policy Implementation in Developing Countries*. Beverley Hills: Sage.

Chellian, R. J. (1999) "Taxes suitable for Assignment to Provinces". Midrand: Financial and Fiscal Commission.

Chhibber, A. (1997) "The State in a Changing World". *Finance and Development*, September.

Cibulka, J.G. (1994) "Policy analysis and the study of politics of education". *Journal of Education Policy.* 9 (5&6). p.105-25. September to December.

Cloete, N., Moja, T. and Muller, J (1995) "Towards New Forms of Organization in Higher Education." Submission to the National Commission on Higher Education.

Cohen, L. and Manion, L. (1997) *Research Methodologies in Education*. New York: Routledge.

Collins, C. (1994) *Management and Organization of Developing Health Systems*. Oxford: Oxford University Press.

Collins, C. and Green, A. (1994) Decentralization and primary health care: Some negative implications in developing countries. International Journal of Health Service 24,3, 459-475

Corry, D. (1997) Public Expenditure - Effective Management and Control. Institute for Public Policy Research (IPPR), London. The Dryden Press, Harcourt Brace & Company Limited KPMG.

Dale, R. (1999) Specifying globalization effects on national policy: A focus on mechanisms. Journal of Education Policy, 14(1).

Das Gupta, M. and Rani, M. (2004) "India's Public Health System – How Well Does It Function at the National Level?" Washington D. C: World Bank. World Bank Policy Research Working Paper 3447. November.

De Mello, L. (2000) 'Fiscal Decentralization and intergovernmental fiscal relations: a cross-country analysis.' *World Development*. 28 (2). February. p.365 –380.

Department of Finance (1997a) *1997 Medium-Term Expenditure Framework.* Pretoria: Department of Finance.

Department of Finance (1997b) *1997 Summary of Sectoral Team Report: Health.* Unpublished.

Department of Finance (1997c) "Intergovernmental Fiscal Framework Review". Pretoria: Department of Finance.

Department of Finance (1998) *Budget Review 1998.* Pretoria: Department of Finance.

Department of Finance (1999a) "Intergovernmental Fiscal Framework Proposals". Budget Office, Department of Finance, Pretoria. (unpublished).

Department of Finance (1999b) "Draft: Intergovernmental Fiscal Framework". Budget Office, Department of Finance, Pretoria (unpublished).

Department of Finance (1999c) *Intergovernmental Fiscal Review 1999.* Pretoria: Department Finance. September 1999.

Department of Health (1994) *Government Gazette Notice 657 (1994): Rendering of Free Services.* Pretoria: Department of Health.

Department of Health (1995) Report of the Committee of Inquiry into a National Health Insurance System - Restructuring the National Health System for Universal Primary Health care, Main Report. June. Pretoria: Department of Health.

Department of Health (1996a) *Hospital Strategy Project – Overview and Final Report. Monitor Company, Health Partners International.* Pretoria: Department of Health.

Department of Health (1996b) *A Policy for the Development Of A District Health System for South Africa.* Pretoria: Department of Health.

Department of Health (1997) *White Paper for the Transformation of the Health System in South Africa.* Notice 667 of 1997, Government Gazette no. 17910. Pretoria: Government Printers.

Department of Health (1999) *Health Sector Strategic Framework 1999 -2004*. Pretoria: Department of Health.

Department of Health (2000) *HIV and Aids/STD Strategic Plan for South Africa 2000-2005*. Pretoria: Department of Health.

Department of Health (2002) "*Circular Minute on Prevention of Mother-To-Child Transmission of HIV".* Pretoria. Department of Health (unpublished).

Department of Health (2003a) *National Health Act, Number 61 of 2003. Government Gazette*. Vol. 469, No. 26595. Pretoria: Government Printers.

Department of Health (2003b) *Essential Health care for South Africans – An investigation into public health financing and provincial health resource distribution*. Pretoria: Department of Health.

Department of Provincial Affairs and Constitutional Development (1998) "Co-operative Governance and Intergovernmental Relations". Discussion Document. Pretoria. (unpublished)

Department of Public Service and Administration (1997) *Provincial Review Report*. Pretoria. Department of Public Service and Administration.

di Gropello, E. (2002) Decentralization Systems of Health Care Delivery and the Role of Large Cities – A Comparative Analysis. *HNP Discussion Document*, Health Nutrition and Population, Washington D.C: World Bank.

Dillinger, W. and Fay, M. (1999) "From Centralization to Decentralized Governance". *Finance and Development*. A Quarterly Magazine of the International Monetary Fund. 36 (4). December. http://www.imf.org/external/pubs/ft/fandd/1999/12/dillinge.htm

Dillinger, W. and Webb, S.B. (1999) "Decentralization and Fiscal Management". The World Bank -Latin American and Caribbean Region, Poverty Reduction and Economic Management Sector Unit. Policy Research Working Paper 2122. Washington D. C: World Bank.

Donaldson, A.P. (1991) "Competition and cooperation in the education and health sectors: non-racial services in a democratic South Africa" in Beukes E.P.; Davies W.J.; van der Kooy R.J.W; and van Wyk L.A (eds) *Development Employment and the new South Africa* . Proceedings of the biennial conference of the Development Society Southern Africa, 5-7 September 1990, University of Witwatersrand, Johannesburg. Published in Johannesburg by Development Society Southern Africa.

Estache, A and Sinha, S (1995) Does Decentralization Increase Spending on Public Infrastructure? World Bank Policy Research Working Paper 1457. Washington DC: World Bank.

Filmer, D, Hammer, J.S. and Pritchett, L.H. (2000) “Weak Links in the Chain: A Diagnosis of Health Policy in Poor Countries”. *The World Bank Research Observer*. 15 (2). p199 – 224. Washington DC: World Bank.

Financial and Fiscal Commission (2000). *Financial and Fiscal Commission Recommendations 2001-2004 MTEF CYCLE.* Midrand: Financial and Fiscal Commission. May 2000.

Financial and Fiscal Commission (2001) *Financial and Fiscal Commission Preliminary Recommendations for 2001 – A Costed Norms Approach for the Division of Revenue.* Consultation Document. Midrand: Financial and Fiscal Commission

Firestone, W.A. (1987) “Meaning in Method: The Rhetoric of Quantitative Qualitative Research”. *Educational Researcher.* Vol.17. p16 – 21.

Fourie, F.C. v N., and Burger, P. (2003) “Fiscal Sustainability and the South African Transformation Challenge”. *South African Journal of Economics* 17 (4). p806 – 829. December.

Furniss, N. (1974) “The Practical Significance of Decentralization.” Journal of Politics 36 (4): p958-982.

Freinkman, L. and Yossifov, P. (1999) “Decentralization in Regional Fiscal Systems in Russia – Trends and Links to Economic Performance”. World Bank Policy Research Working Paper 2100. Washington DC: World Bank.

Gertler and Hammer (1997) “Financing and Allocating Public Expenditure in the Health Sector.” Draft (January 1). Haas School of Business and School of Public Health, University of California at Berkley, and Public Economics Division of the World Bank.

Gilson, L., Doherty J., McIntyre, D., Thomas, S., Brijlal V., Bowa, C., and Mbatsha, S. (1999). *The Dynamics of Policy Change: Health Care Financing in South Africa, 1994 – 1999. Analysing the Process of Health Financing Reform in South Africa and Zambia,*

South Africa Country Report. Johannesburg: Centre for Health Policy, University of Witwatersrand.

Gilson, L., Kilima, P. and Tanner, M. (1994) "Local government decentralization and the Health sector in Tanzania". *Public Administration and Development.* Vol. 14. p451-477.

Green, A. (1992). An Introduction to Health Planning in Developing Countries. Oxford Medical Publications, Oxford University Press, Oxford.

Greenstein, R. (1997) "New Policies and the Challenges of Budgetary Constraints" in *Wits EPU Quarterly Review of Education and Training in South Africa*, 4,4.

Hatcher, R. and Troyna, B. (1994) "*The "policy cycle": A Ball by Ball account*". *Journal of Education Policy*. 9 (2). p155 - 170.

Helmsing, B., Mogale, T., and Hunter, R. (1996) *Restructuring the state and intergovernmental fiscal relations in South Africa*. Johannesburg: Friedrich Ebert Stiftung and Graduate School of Public and Development Management, University of Witwatersrand.

Hubbard (2001) "Notes on Fiscal Decentralization". Unpublished

Jack W. (2000) "Dcentralizaing the Provision of Health Services"- An Incomplete Contracts Approach. World Bank Policy Research Working Paper 2395. Washington DC: World Bank. July.

Jupp, V. and Norris, C. (1993) *Traditions in Documentary Analysis in Social Research: Philosophy, Politics and Practice*. London: Sage.

Kalaycioglu, E. (2000) "Politics of Fiscal Decentralization." www1.worldbank.org/wbiep/decentralization/library1/Politics%20of%20Fiscal%20Decentralization.pdf.

Khaleghian P, and Das Gupta M. (2004) “Public Management and the Essential Public Health Functions”. World Bank Policy Research Working Paper 3220. Washington DC: World Bank. February.

Kolehmainen-Aitken, R.L. (1999) *Myths and Realities about Decentralization of Health Systems*. Boston: Management Sciences for Health.

Kooiman, J. (1993) *Modern Governance: New Government – Society Interactions*. London: Sage.

Lauglo, J. (1995) “Forms of Decentralization and their implications for education”. *Comparative Education*. 31(1). p5- 29.

Lee, P.R.; Silver L.; and Benjamin A.E. (1992) “Health Policy and Politics of Health” in Maxcy-Rosenan-Last (1992) *Public Health Preventative Medicine.* 13th Edition. Connecticut/San Mateo, California: Appleton and Lange, Norwalk.

Lethbridge, J. (2004) “Public sector reform and demand for Human Resources for Health (HRH)”. *Human Resources for Health*. 2:15.

Litvak, J. and Seddan, J. (eds) (1999) *Decentralization Briefing Notes*. World Bank Institute Working Papers. Washington, D.C: World Bank.

Ma, J. (1997) *Intergovernmental Relations and Economic Management in China.* London: Macmillan.

Magnoli, A. (2001) “National Health Accounts in Latin America and Caribbean: Concepts, Results and Policy Issues”. Harvard University, IADB/INDES – Joint Program INDES/EU. September.

May, J. (1998) “Poverty and Inequality in South Africa”. http://www.polity.org.za/html/govdocs/reports/poverty.html

Miles, M.B., and Hiberman A.M. (1984) Qualitative data analysis. A sourcebook of new methods. Beverley Hills. Sage Publications.

McIntyre, D., (1995) “Financing and Expenditure”. *South African Health Review 1995.* Durban: Health Systems Trust/Henry J. Kaiser Family Foundation.

Mills, A., Vaughan, J.P., Smith, D.L. and Tabibzadeh, I. (1990) *Health System Decentralization – Concepts, issues and country experience*. Geneva: World Health Organization.

Mokoro Ltd (1999) “Draft Public Expenditure Review Manual. Prepared for the Bureau of Budget, Government of Thailand. England: Mokoro Ltd.

Musgrave, R.A. (1976) “Devolution, Grants, and Fiscal Competition”. *Journal of Economic Perspectives.* 4. p.65-72.

National Treasury (2000a) *2000 Intergovernmental Fiscal Review*. Pretoria: National Treasury.

National Treasury (2000b) Budget Council Minutes. Pretoria: Unpublished.

National Treasury (2001a) *2001 Budget Review*. Pretoria: National Treasury.

National Treasury (2001b) *2001Intergovernmental Fiscal Review*. Pretoria: National Treasury.

National Treasury (2001c) “Policy Framework on Conditional Grants”. Pretoria. Unpublished.

National Treasury (2002a) “Some thoughts on economic growth in South Africa”. Economic Policy and International Finance Relations Division”. Pretoria. Unpublished.

National Treasury (2002b) *2002 Budget Review*. Pretoria: National Treasury.

National Treasury (2002c) *2002 Medium-Term Budget Policy Statement*. Pretoria: National Treasury.

National Treasury (2002d) *2002 Intergovernmental Fiscal Review*. Pretoria: National Treasury.

National Treasury (2003a) *2003 Medium-Term Budget Policy Statement*. Pretoria: National Treasury.

National Treasury (2003b) *2003 Intergovernmental Fiscal Review*. Pretoria: National Treasury.

National Treasury (2003c) *2003 Budget Review*. Pretoria: National Treasury.

National Treasury (2003d) *Reference Guide to the New Economic Reporting Format, Version 2*. Pretoria: National Treasury, November.

National Treasury (2003e) "Technical Committee for Finance: 2003 Budget Documents and Formats". Pretoria. Unpublished.

National Treasury (2004a) *2004 Medium-Term Budget Policy Statement*. Pretoria: National Treasury.

National Treasury (2004b) *2004 Trends in Intergovernmental Finances: 2000/01-2006/07*. Pretoria: National Treasury.

National Treasury (2005a) "A Partnership for Growth and Empowerment: accelerating economic development, 2005 -2014". Pretoria. Unpublished. July.

National Treasury (2005b) *2005 Budget Review*. Pretoria: National Treasury.

National Treasury (2005c) *2005 Intergovernmental Fiscal Review*. Pretoria: National Treasury.

National Treasury (2005d) *Preliminary Observations on 2005 Provincial Budgets.* Pretoria: Unpublished. February.

National Treasury (2005e) *Summary Report: Outcome of Provincial Benchmark Exercise, 2005.* Pretoria: Unpublished.

National Treasury (2005f) *Estimates of National Expenditure.* Pretoria: National Treasury.

National Treasury (2005g) *Preliminary Observations on the 2005 Provincial Budgets on the Equitable Share Adjustments*. Pretoria: Unpublished.

National Treasury's (2006) *Provincial Budgets and Expenditure Review 2002/03 - 2008/09.* Pretoria: National Treasury.

Neuman, W.L. (1994) Social Research Methods – Qualitative and Quantitative Approaches. London: Allen and Bacon.

Oates, W. (ed) (1998) *The Economics of Fiscal Federalism and Local Finance*. Northampton, MA: Edward Elgar Publishing.

Partners for Health Reformplus, (2002) "Insights for Implementers – Decentralization and Health System Reform". Maryland, USA: PHRplus, September.

Pillay, Y. (2000) Managing the transition – Reflections on the past five years and next steps for the National Department of Health, Draft 2. Unpublished.

Pimstone, G. (1998) "The Constitutional Basis of Local Government in South Africa" in (eds) Atkinson, D. & Reitzes, M. *From a tier to a sphere in the new South Africa constitutional order*. Sandton: Heinemann.

Poullier, J-P., Hernandez, P. and Kawabata, K. (2002) *National Health Accounts: Concepts, Data Sources and Methodology*. Geneva: World Health Organization.

Pradhan, S. (1996) *Evaluating Public Spending – A Framework for Public Expenditure Reviews.* World Bank Discussion Paper, 323. Washington D.C: World Bank.

Prud'homme, R. (1995) “The dangers of decentralization". World Bank Observer 10, 2: 201-220.

Republic of South Africa (1996) Constitution of the Republic of South Africa, Act 108 of 1996. Pretoria: Government Printers.

Republic of South Africa (1999) Public Finance Management Act, Act 29 0f 1999. Pretoria: Government Printers.

Rondinelli, D.A. (1983) “Implementing decentralization programmes in Asia: A Comparative Analysis”. *Public Administration and Development*, 3:p181-207.

Schneider, H., Cabral, J., Gilson, L., Cele, M., Laubser, S and Magongo, B. (1997) *District Health Systems and Transformation in South Africa – questions for national, provincial and local policymakers and managers.* Johannesburg: Centre for Health Policy.

Segall, M. (1999) *Review of Public Health Service Delivery- “The Bottle is Half Full”- Policy Oriented Overview of the Main Findings.* University of Sussex, England: Institute of Development Studies. May.

Shah, A. (1994) “Perspectives on the Design of Intergovernmental Fiscal Relations in Developing Transition Economies”. in S.P. Gupta *et.al* (eds): *Intergovernmental Fiscal Relations and Macro-economic Management in Large Countries.* New Delphi: Allied Publishers.

Shah, A. (1999) *The Reform of Intergovernmental Fiscal Relations in Developing and Emerging Economies*. Washington D.C: World Bank.

Silver, H. (1990) *Education, Change and the Policy Process*. London: Falmer.

Simeon, R. (1998) “Considerations on the Design of Federations: The South African Constitution in Comparative Context”. Working Paper (2). Queens University: Institute for Intergovernmental Relations (IIGR).

South African Health Review (1999) *South African Health Review*. Durban: Health Systems Trust.

Statistics South Africa, Mid-Year Population Estimates, 2006. http://www.statssa.gov.za/publication/P03022006 (Accessed 22 November 2006).

Tapscott, C. (1998) “Intergovernmental Relations in South Africa – A Comparative Analysis”. *Intergovernmental Relations: An International Comparative Study*. Bellville: Department of Constitutional Development and Provincial Affairs in collaboration with the National Democratic Institute for International Relations and the School of Government, University of the Western Cape.

Ter-Minassian, T. (1997) “Decentralizing Government”. *Finance and Development*, September, p36-39. Washington D.C: International Monetary Fund.

Thomas, S., and Muirhead, D. (2000) *National Health Accounts Project -The Public Sector Report*. November. Cape Town: Department of Health.

Thomas S., Mbatsha S., Muirhead D., Okorafor O. (2000) *Primary Health care Financing and Needs Across Health Districts in South Africa.* An output of the Local Government and Health Consortium, funded by Health Systems Trust and comprising Health Systems Trust, Centre for Health Policy and Health Economics.

Turnbull G.K. (2002) “Local Tax Base Sharing: An Incentive for Intergovernmental Cooperation”. *FRP Report No. 75.* October. Atlanta: Andrew Young School of Public Policy, Georgia University.

van Rensburg, H.C.J., Fourie, A., Pretorius, E. (1992) *Health Care in South Africa – Structure and Dynamics*. Pretoria: Academia.

Wallace M. (1996) “Guided by the Unseen Hand: The Mass Media and Education Policy” in (*eds)* Watson, K. Modgil, C. and Modgil, S. *Educational Dilemmas: Debate and Diversity Power & Responsibility in Education*. Volume Three. London: Cassell.

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*. London: ZED Books.

Watts R. (1998) “Introduction”. *Intergovernmental Relations: An International Comparative Study.* Bellville: Department of Constitutional Development and Provincial Affairs in collaboration with the National Democratic Institute for International Relations and the School of Government, University of the Western Cape.

Whitty G and Edwards T (1994) “Researching Thatcherite education policy.” Walford G (ed) *Researching the Powerful in Education.* London: UCL Press Limited.

World Bank (1994) *World Development Report 1994: Infrastructure For Development – World Development Indicators*. New York: World Bank, Oxford University Press.

World Bank (1999) “Public Expenditure Reviews: Progress and Potential”. The World Bank Prem Notes 20, Public Sector, April.

World Bank (2000) *Entering the 21st Century - World Bank Report 1999/2000.* Washington D.C: World Bank, Oxford University Press.

World Bank (2006) “World Development Indicators online”.

Yin R. (1994) *Case Study Research: Design and methods*. (2nd edition). Thousand Oaks, CA: Sage.

APPENDICES