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**Fiscal Federalism, Equity and Governance in the Financing of
Primary Health Care: the case of South Africa**

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIH	Autorização de Internação Hospitalar (Permission to Hospitalise)
CHST	Canada Health and Social Services Transfer
DHS	District Health System
DM	District Municipality
E.Cape	Eastern Cape
FFC	Financial and Fiscal Commission
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GHS	General Household Survey
HIV	Human Immunodeficiency Virus
HPDT	Health Professions Training and Development Grant
HRF	Health Reform Fund
KZNatal	KwaZulu Natal
LG	Local Government
LGHD	Local Government Health Department
MM	Metropolitan Municipality
MTEF	Medium Term Expenditure Framework
NDoH	National Department of Health
BOR	Basic Operating Rule
PCA	Principal Components Analysis
PDoh	Provincial Department of Health
PHC	Primary Health Care
SES	Socio-economic Status
SMOH	State Ministry of Health
SNG	Sub-National Government
SPG	Specific Purpose Grant
SUS	Sistema Unico de Saude (Unified Health System)
TFF	Territorial Formula Financing
VAT	Value Added tax
W.Cape	Western Cape

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Executive Summary

South Africa is one of the most unequal societies, largely as a result of apartheid policies that were instituted. These policies advocated the provision of different services and created unequal opportunities to each racial group, resulting in large disparities in socio-economic status. At the time, the health system was fragmented and there were huge inequities in the provision and access to public health services. The first democratic government in 1994 was determined to pursue a unified health sector with the fundamental goal of equity. Within the first two years of democratic governance, considerable progress was made in the reallocation of health budgets between provinces. However, with the adoption of a new constitution and the introduction of fiscal federalism in 1996, the progress towards equity in budgetary allocations to health slowed down considerably. With the introduction of fiscal federalism and substantial autonomy given to provinces, they could then determine allocation between sectors and functions under their jurisdiction. Health care is one of them.

This study investigates the implications of fiscal federalism in South Africa for the equitable distribution of Primary Health Care (PHC) resources and how equity can be promoted in a fiscal federal context. The study evaluates processes and criteria for intergovernmental and sector budgeting that determines the budget for PHC, the influence of key stakeholders, community involvement in PHC budgeting, and policy objectives of the health sector to assess how they impact on the realisation of an equitable distribution of PHC resources.

A combination of qualitative and quantitative analysis was used to achieve the stated objectives. Literature on intergovernmental relations, theory on fiscal federalism and international experience of other countries operating a fiscal federal system provided a point of reference for the analysis of collected data. They informed the design of the questionnaire used in data collection. Also, reviewed literature formed the basis for the conceptual framework used in analysis. Data on the budgeting processes, criteria for allocations and strategies and constraints for achieving equity in PHC allocations was collected through interviews with government officials involved in determining PHC budgets and or providing PHC services. Government officials interviewed were from four out of the nine provinces in South Africa and the National Government. Government officials from Nigeria were also interviewed on similar issues. Data from the Nigerian experience was used for comparative analysis with the South African system.

Data on demographic and socio-economic variables from South African household surveys done in 2001 and 2005 were used to construct deprivation indices for health districts. The deprivation indices were constructed using Principal Components Analysis and were used as indicators of health need. These indices were compared with per capita PHC expenditure for districts in 2001 and 2005 to assess the trend in PHC expenditure patterns with respect to equity. Regression and correlation analysis was used for the analysis.

Analysis of collected data shows that in recent years, there has been a considerable shift in PHC allocations between districts and provinces towards a more equitable distribution. While there is no consensus from district managers or provincial officials

on 'who' is driving the shift, this has occurred alongside increased national influence on the budgeting process for sectors at the province. The National Department of Health has been successful in getting equity in PHC allocations onto the national agenda. With the intervention of the National Treasury in fiscal arrangements between national and provincial departments, (to promote better coordination between them), expenditure behaviour of provinces have been more in line with national priorities, thus fostering a more equitable distribution of PHC expenditure outlays. The National and Provincial Treasuries are increasingly involved in monitoring of provincial expenditure to ensure that their expenditure patterns reflect nationally identified priorities; effectively increasing the level of accountability of provinces to the national government. In Nigeria, Local Governments are responsible for PHC provision and financing. A major difference between Nigeria and South Africa is the lack of accountability of local governments to any other authority. This has created greater scope inequities in PHC budgetary allocations between Local Governments and States.

Currently, in South Africa, the intervention of the National Government and the support given to PHC and equity by health officials at national, province and district levels are key facilitators for promoting equity in the distribution of PHC resources. The major constraints identified are the predominance of budgeting based on historical expenditure within provinces, and the lack of adequate support and guidance from the National Department of Health to provinces for the provision of PHC services. Also, the poor level of interaction in relatively less funded provinces between the provincial Departments of Health and their provincial Treasuries may be a constraint to securing more funds for PHC. The poor level of interaction between them has the potential to limit their level of cooperation. Lastly, based on the study's results, the single most important constraint is the lack of requisite human resources in rural districts and provinces where PHC is less well-funded. As health care is human resource driven, areas that fail to attract the right mix and quantity of human resources generally spend less on PHC. Also, the lack of managerial capacity in such areas limits the ability of districts and provinces to adequately utilise funds allocated to them.

The study recommends that to promote equity in PHC resources, the influence of the National Government on provincial expenditure patterns be maintained, although not to the extent of 'ring-fencing' PHC budgets. Secondly, the National Department of Health should provide more support to provinces in developing their capacity to effectively utilise health care funds, and to give clear guidelines and targets for PHC and the overall health sector. Thirdly, provincial Departments of Health need to engage more with their provincial Treasuries with the aim of fostering a more cooperative relationship. Finally, while efforts should be made to follow through on the recommendations above, it is critical that capacity to utilise PHC funds where they are most needed is developed.

Section 1: Background

South Africa has been referred to as one of the world's most unequal societies. This is largely as a result of apartheid policies that were instituted in South Africa. These policies advocated the provision of different services to each racial group (Bloom and McIntyre, 1998). These policies also created unequal opportunities for different racial groups, resulting in large disparities in socio-economic status. The first democratic government elected in 1994 in South Africa set out to reduce geographic inequities in the provision and financing of all public services entrenched by the apartheid regime. At that time, the public health sector was fragmented, and there were huge inequities in provision and access to public health services. This was alongside massive disparities in health status. The South African Government, as outlined in the White Paper for the Transformation of the Health System, was determined to pursue a unified health sector with the fundamental goal of equity (Gilson et al., 1999, Okorafor et al., 2003, Thomas et al., 2003). Considerable progress was made in reallocating health budgets between provinces during the first two years after the 1994 elections when provincial budgets were determined by the Health Function Committee. With the move to fiscal federalism resulting from adoption of a new constitution in 1996, provinces were allocated global budgets using a population based formula and could themselves determine the allocation between different sectors/functions. Since this occurred, there has been somewhat less progress in addressing inter-provincial inequities in health budgets (McIntyre et al., 1998).

Currently, South Africa operates a fiscal federal system with three spheres of government and significant decentralisation of powers and functions, including budgeting. There are nine provinces, each with their own legislatures and executive committees, as well as administrative structures. There are 284 local municipalities, categorised according to whether they are metropolitan, district-wide or local structures, and comprised of political and administrative components. Provinces are accountable to provincial legislatures and local governments to councils. National and provincial governments are concurrently responsible for functions like school education, health, welfare and housing. In practice, national government's role is primarily to determine policy, while provincial governments shape some policy and have a considerable role in implementation. Most local government functions involve

services such as electricity, water and sanitation, but they also provide public goods such as municipal and household infrastructure, streets, street lights and refuse collection. The South African fiscal system is based on a revenue-sharing model¹, with provinces largely dependent on transfers² from the national government, while municipalities are only partially dependent on such transfers (National Treasury, 2001).

1.1 The Structure of the South African Health System

Initially, following the adoption of a fiscal federal system in 1996, the structure of the health system followed the three spheres of government; a National Department of Health (NDoH), Provincial Departments of Health (PDoH), and a department of health in each Local Government. Much of the operational decision-making in health care delivery was decentralised to the provincial level, with the National Department of Health (NDOH) retaining responsibility only for national policy making and the development of norms and standards to ensure equitable and affordable health care provision across provinces. The NDoH does have some power over resource allocation through conditional grants, which address the funding of tertiary hospitals, human resource training and specific programmes, such as nutrition (Doherty et al., 2002).

Recently, the National Health Act has narrowly defined municipal health services (health services provided by the local governments) to encompass only environmental health services (Republic of South Africa, 2004). Provinces now assume responsibility for providing the bulk of PHC services. This is yet to be fully implemented, although most provinces have fully assumed this responsibility. The public health sector has also adopted a District Health System (DHS), which is a lower level of provincial health authority. Currently, there are 53 health districts in South Africa. The DHS is the vehicle through which PHC is to be delivered. Under the DHS system, there are three types of districts. The type A districts are metropolitan districts, while the rest are type C districts. Each of these district

¹ Full detail of revenue sharing and expenditure responsibilities in Section 3

² These transfers refer to nationally collected revenue that is split between the three tiers of government. Full details of this process are also discussed in Section 2.

municipalities (A and C) are sub-divided into type B municipalities (Barron and Asia, 2001), also referred to as sub-district municipalities.

1.2 Inequities in Health Care Financing

Although the government is committed to reducing disparities in provision and access to health services, research in the area has shown that there still exist gross inequities in the financing of health care across and within provinces (McIntyre, 1994, McIntyre et al., 1995, Doherty and van den Heever, 1997, Thomas et al., 2003, Brijlal et al., 1997, Daviaud et al., 2000). For example, in the fiscal year 2003/04, budgeted per capita provincial health care expenditure was R627 in Limpopo Province compared to R1,261 and R1,668 in the Western Cape and Gauteng Provinces respectively (National Treasury, 2003). Although, this is of great concern, this study looks at a more specific aspect of health care: Primary Health Care. The reason for focusing on PHC is because the PHC approach³ is one of the key means, as stated in the White Paper, for the transformation of the public health system. Also, communicable diseases, which contribute significantly to the burden of ill-health in South Africa (Bradshaw et al., 2003) are potentially preventable and could be effectively treated at a PHC level.

Table 1 below provides a snapshot of the level of inequities in PHC funding by provinces during the 2002/03 financial year. There is a wide variation of provincial PHC expenditure from the national average – ranging from R70 per capita in Limpopo province to R238 per capita in Gauteng. The problem with this distribution of PHC expenditure is that those provinces with the greatest burden of ill-health and the highest level of social and material deprivation have the lowest PHC expenditure per-capita (McIntyre and Okorafor, 2003). Research has shown that although the variation in per capita PHC expenditure has reduced consistently since the 1997/98 financial year, the rate of convergence appears to be too slow to achieve equity within an ‘acceptable’ time frame (Okorafor et al., 2003).

³ The PHC approach is discussed in detail in Section 2

Table 1.1 Out-of-Hospital Primary Health Care Expenditure by Provinces (2002/03)*

Province	PHC expenditure per capita
Eastern Cape	91
Free State	183
Gauteng	238
KwaZulu Natal	163
Limpopo	70
Mpumalanga	122
Nothern Cape	199
North West	145
Western Cape	213
National Average	148

*Figures from Intergovernmental Fiscal Review 2003

Thus, in addition to the challenges to PHC services arising from the restructuring of health service administration (particularly the ‘provincialisation’ of PHC services), a key challenge is that of inequities in budget allocations to PHC across provinces. Within a fiscal federal context, where provinces have considerable autonomy in determining budget allocation to health services and within that, to PHC services, the question of how to influence provincial level decision-making is a key one. The South African Government proposed a nationwide PHC package (National Department of Health, 2002, National Department of Health, 2003). The concept of a PHC package has the potential to promote a more uniform level of PHC service provision across provinces. It is seen as an important tool for Provincial Departments to strengthen their negotiations with provincial treasuries for appropriate budget allocations to the health sector. This has implications for the equitable distribution of PHC resources between and within provinces.

1.3 Objectives and Justification

As we have shown, there are huge inequities in PHC funding between provinces. More critically, research has shown that the provinces with greater need for additional PHC resources have lower PHC expenditure per capita than provinces that have less need (Thomas et al., 2003). There also exist similar inequities in PHC financing within the different provinces: districts with relatively higher health needs also receive less PHC funding per capita than districts with lower health needs (Thomas et al., 2003, McIntyre and Okorafor, 2003). The current PHC funding pattern is clearly inequitable and unfair, because the losers are the poorer households, who are supposed to be the targeted beneficiaries of public PHC provision. With the adoption

of a new constitution and the move to fiscal federalism, there has been less progress in reducing the inequities in health budgets across provinces. This movement to fiscal federalism serves as a good point of reference to investigate the inequitable distribution of PHC resources.

The overall aim of this study is to investigate the implications of fiscal federalism in South Africa for the equitable distribution of PHC resources and how equity can be promoted in a fiscal federal context. More specifically, the study aims to achieve the following:

1. A critical evaluation of governance in PHC resource allocation by investigating the processes of fiscal transfers and the autonomy of sub-national levels of government, and how they impact on equity in PHC expenditure.

To achieve this, the study will critically evaluate the following transfer processes:

- The process of vertical split of nationally collected revenue (division of revenue) across the three tiers of government
- The process of horizontal split of revenue between provinces and local governments, and the process of budget allocations to departments within provinces.
- The process of transfers within the Provincial Department of Health to different health programmes, with special emphasis on PHC

The evaluation of these processes will include identifying (1) who is involved in the various processes and who has the most influence in decision making, and why; (2) what criteria are used for allocating resources and to what extent equity is a consideration (3) what information is utilised by decision-makers to identify areas of greatest need; and (4) explore the relationship between the size of overall provincial budgets and allocations to PHC. Such analyses will help investigate the level of autonomy of provincial and local authorities in determining the budget for PHC and the effect this has on the equitable distribution of PHC resources. To assist this it will also be important to:

- a. Identify any guidelines or structures in place to ensure that provincial and local authorities adhere to national guidelines on resource allocation; and assess the extent to which such guidelines influence resource allocation at the provincial and local level
 - b. Explore the likely impact of different types of centrally defined incentives (to achieve a more uniform PHC expenditure) on equity in PHC and autonomy of provincial and local authorities
 - c. Investigate the mechanisms to ensure that the priorities of the communities within provincial and local jurisdictions feed into decision making on PHC resource allocation.
2. A review of the ‘equity’ objectives of the health sector, particularly as they relate to PHC and against current PHC expenditure patterns. Such equity objectives and the current resource allocation criteria and patterns will be evaluated to assess the extent to which they target the geographic areas with higher health needs.
3. An analysis of the factors that constrain or facilitate the realisation of a more equitable distribution of PHC resources.
4. Documentation of Nigeria’s experiences in the equitable financing of health and PHC activities, for comparative analysis with South Africa
5. The study will then propose recommendations and strategies for addressing the identified problems.

Investigating the problem of inequities in resource allocation of PHC through the lens of fiscal federalism is critical as it not only looks at resulting inequities, but reviews the entire decision making process that leads to such inequities. The research will prove particularly useful to developing countries operating fiscal federal systems (including those with decentralised health systems), as it will highlight the constraints and facilitating factors for equitable financing within any sector in a system with decentralised decision making.

In most African countries, the transfer of power and authority to lower levels of the health sector has been motivated by the potential for increased efficiency, better quality of care and accountability (Gilson and Mills, 1995). Although it is recognised that decentralisation can have a positive influence on equity if it encourages the preferential allocation of resources to remote, and usually rural areas, decentralisation can also have a negative influence on equity. Factors such as : (1) inappropriate organisational and institutional arrangements (e.g. in Ghana); (2) poor capacity at lower levels (e.g. in Cote D'voire); and (3) inappropriate resource allocation to PHC activities (e.g. in Uganda) (Dugbatey, 1999) have rendered the health systems unable to effectively establish a more effective and equitable distribution of health services. The problem of inappropriate resource allocation to PHC is common for most countries in Sub-Saharan Africa. Inappropriate financing of PHC usually arises from: (1) resource allocation for PHC being based on existing capacity rather than need; and (2) continued centralised control of hospital funding, protecting this portion of the national health budget at the expense of PHC (ibid)

This study not only serves as a review process for decision making processes for resource allocation to PHC in South Africa, it raises key issues that are relevant to other developing countries, especially where the provision and financing of a public good/service is the responsibility of sub-national governments (SNGs), and there is concern for equity.

Section 2: Methods

This section describes the methods used in carrying out this study. The process for data collection, sampling, identification of study sites, and analysis are outlined in detail.

2.1 Data Collection

The main sources of information for this study were document reviews, stakeholder interviews, and secondary data. The following documents were reviewed:

- Government publications on the nature of intergovernmental fiscal arrangements in South Africa. These included budget reviews, intergovernmental fiscal reviews, health bills, and other government publications on budgeting and resource allocation guidelines. A review of these documents provided an understanding of the nature of intergovernmental relations in South Africa, the basis for intergovernmental transfers to provinces and resource allocation to health and PHC in South Africa. Similarly, government publications on the Nigerian fiscal federal system were reviewed.
- Theoretical literature on fiscal federalism. These provided the study with a good understanding of the tenets of fiscal federalism, including the nature and effect of intergovernmental transfers on SNG autonomy and equity in the financing and provision of services.
- International literature on the experiences of other countries operating a fiscal federal system in financing health and PHC. Review of international experience provided a valuable reference point for exploring the equity implications of different intergovernmental arrangements, including forms of transfers for funding PHC activities.

In South Africa, government officials involved in intergovernmental transfers and budgeting for PHC expenditure at the national, provincial and district levels were interviewed. Semi-structured questionnaires (designed according to interviewee position) were used. Copies of questionnaires are attached in appendix A. Semi-structured questionnaires are used to allow the researcher to probe into areas that needed further clarification. A total of 34 officials were interviewed in South Africa. Government officials interviewed were from the following offices:

- National Department of Health
- Provincial Departments of Health
- National Treasury
- Provincial Treasury
- Health Districts

For Nigeria, officials interviewed were from:

- Local Government Departments of Health
- State Ministries of Health; and
- Advisers to the Federal Ministry of Health

In total, 12 officials were interviewed.

In order to assess the extent of equity in the distribution of PHC resources between district and provinces in South Africa, data on health care expenditure and indicators of need were collected. District and provincial PHC expenditure data for 2001/02 and 2005/06 financial years, obtained from the District Health Barometer (Barron et al., 2005, Barron et al., 2006) was used. This comprised of non-hospital per capita expenditure by districts and provinces. Per capita expenditure calculations are based on the population within each district that do not have access to private health insurance (called medical schemes in South Africa). This adjustment is to capture the population within each district or province that are dependent on publicly funded PHC services. Unfortunately, similar data could not be accessed for the years between 2001/02 and 2005/06 financial years.

The 2001 South African census data and the 2005 South African General Household Survey (GHS) were used to derive information on health needs. These were the household surveys that collected comparable information on variables needed for this study, and disaggregated to province and district levels. A detailed explanation of how need at the district and provincial level is measured, including the assessment of equity in the distribution of PHC funds, is discussed in section 2.4.

2.2 Study Sites for Interviews

Four of the nine provinces in South Africa were visited. These were Gauteng, Western Cape, Limpopo and Eastern Cape provinces. These provinces were chosen

because they provide the study with an even split between provinces with relatively high PHC per capita expenditure and those with relatively low PHC per capita expenditure. Gauteng and Western Cape have relatively higher PHC per capita PHC expenditure. For example, in the 2002/03 financial year their per capita PHC expenditure was R238 and R213 respectively. In the same year per capita PHC expenditure for Limpopo and Eastern Cape were the lowest: R70 and R91 respectively⁴. In each of these provinces, two districts were selected for district-level interviews.

Districts selected for site visits are based on nominal changes in non-hospital PHC expenditure from 2001/02 to 2005/06 financial years. Within each of the selected provinces, districts with the highest and lowest nominal increase in non-hospital PHC expenditure were selected. The rationale behind this selection criterion is that since the study investigates the impact of fiscal federalism on equity in PHC allocations, it is important to find out what factors prevent or facilitate changes in PHC expenditure across districts. Based on this criterion, the districts presented in table 2.1 below were selected for site visits.

Study sites for Nigeria were selected based on geographic location. One state and one local government area in the eastern part of the country was selected, while one state and one local government in the western part of the country was selected. At the request of the officials in Nigeria, the states or the local governments visited will not be identified in this study.

Table 2.1 Districts selected for site visits

Province	District	PHC per capita 2001/02 (Rand)*	PHC per capita 2005/06 (Rand)*	Difference (Rand)
W. Cape	West Coast DM	275	307	32
	Overberg DM	240	201	-39
Gauteng	Sedibeng DM	151	225	74
	Ekurhuleni MM	389	270	-119
Limpopo	Vhembe DM	124	237	113
	Gr. Sekhukhune DM	87	115	28
E.Cape	Ukhahlamba DM	48	207	159
	Nelson Mandela MM	129	201	72

* Note that PHC per capita refers to “per capita non-hospital PHC expenditure” calculated using the population within districts without access to any form of medical scheme cover. All are measured in South Africa Rands (ZAR)

⁴ Note that these figures are from the National Treasury’s Intergovernmental Fiscal Review of 2003.

2.3 Qualitative Analysis

Data from interviews were coded according to broad themes. These themes formed the basic outline for the framework for analysis. Also, the analysis considered differences in results between the relatively well funded provinces and those that were not very well funded. The themes are:

1. Process and criteria for vertical split of revenue between the three levels of government. The size of the equitable shares to provinces places a limit to some extent on how much a province can commit to health and therefore PHC.
2. The process for allocations to sectors within provincial governments
3. Influence of key stakeholders: This focuses on identifying key players in determining equitable shares to provinces, budgetary allocations to sectors within provinces and allocations to PHC
4. Community participation and health policy
5. Financing options for PHC
6. Expenditure capacity and sufficiency of funds for PHC
7. Understanding equity: this focuses on assessing the views of officials on what an equitable distribution means, their views on the current distribution of PHC funds and what definition of equity should guide resource allocation to PHC

Although the analysis is structured around the themes listed above, a common thread running through the analysis is the assessment of the impact of processes, actors, systems and regulations on the achievement of equity in the financing of PHC. Also, accountability and transparency in governance is evaluated.

2.4 Quantitative Analysis

This part of the analysis focused on assessing the extent of equity in the distribution of PHC finances between provinces and districts. Also, the trend in allocations to districts and provinces with respect to equity is assessed. PHC expenditure per capita for districts and provinces in the 2000/01 and 2005/06 financial years were used to measure expenditure levels for PHC. Deprivation indices were used as measures of health needs. These indices were constructed from socio-economic and demographic variables contained in the 2001 census data and the 2005 GHS, using principal

components analysis (PCA). The 2001 census data contains a sample of 3,725,655 individuals and 948,592 households. The 2005 GHS data contains a sample of 107,987 individuals and 28,129 households. Full explanation of the use of PCA in generating the index of deprivation is described in the next sub-section. The index measures social and material deprivation, from a set of variables that are individually associated with social and material deprivation.

2.4.1 Principal Components Analysis and the Deprivation Index

Principal components analysis (PCA) is a technique that reduces the information contained in a large number of variables to a smaller number of variables, by summarising the patterns of correlation among observed variables. PCA creates a set of mutually uncorrelated components of the data (Filmer and Pritchett, 1999). These components are supposed to reflect underlying processes that have created the correlations among variables (Tabachnick and Fidell, 2001). PCA has been used to construct asset indices (Gwatkin et al., 2000) in measuring household economic welfare, and in constructing deprivation indices (McIntyre et al., 2002, McIntyre and Okorafor, 2003) to measure geographic social and material deprivation.

To construct a deprivation index, we apply PCA to a set of variables that are indicators of material and social deprivation. The choice of variables used is guided by international literature on the subject and the South African context. There is general consensus that variables included in the construction of a deprivation index should be additive; and that the weighting assigned to each variable reflects the relative contribution of the variable to deprivation (McIntyre et al., 2002). Having an additive set of variables means that an individual (household or geographic area, depending on unit of analysis) with any two of the characteristics reflected in the variables is likely to experience greater deprivation than an individual with only one of the characteristics. For this study, our unit of analysis is the health district. The choice of variables used for generating a deprivation index will be guided by this principle. PCA assigns weights to each variable based on the level of correlation (contribution) of the variable with the generated components. Therefore this method satisfies the second condition above.

As previously mentioned, PCA produces several components that are mutually uncorrelated. These are linear combinations of observed variables (Tabachnick and Fidell, 2001). The first principal component is the linear index of variables with the highest amount of information common to all of the variables (Filmer and Pritchett, 1998); and therefore explains the most variation in the set of observed variables. Based on the selection criteria for the variables used, the first component, which explains the most variation in the set of observed variables, will be used to construct the index. The result of the principal component should be an index, which is linear combination of the observed variables that reflects the underlying process responsible for correlations among the variables – deprivation. The index for each health district (D_j) is calculated based on the formula below:

$$D_j = f_1 \times \left(\frac{d_{j1} - d_1}{s_1} \right) + \dots + f_n \times \left(\frac{d_{jn} - d_n}{s_n} \right)$$

Equation 2.1

Where f_1 is the ‘scoring coefficient’ assigned to the first observed variable, d_{j1} is the district’s value for the first variable, d_1 and s_1 are the mean and standard deviation of the first variable over all observations respectively. This operation is repeated for all n observed variables, and then summed up to give the deprivation index for the district.

2.4.2 Variables used for the Construction of the Deprivation Index

The variables included in the PCA are listed in Table 2.2 below. These variables were chosen based on criteria discussed in section 2.4.1. The first column shows the variable name. Definitions of the variables are provided in the second column.

These are selected variables from the South African 2001 census data and the 2005 GHS data that are indicators of social and material deprivation. Demographic variables such as the proportion of the population that are children below the age of 5, proportion of the population that are females, and the proportion that are elderly are also included. In South Africa, women and children have been targeted (as vulnerable groups) for improved health service provision (McIntyre and Gilson, 2002). The elderly are more prone to chronic illnesses and other illnesses associated with old age, and therefore require more health care. These variables are therefore indicators of

relative health need across populations. As a result of racial discrimination during the apartheid era, the black African population are still the most disadvantaged group (Woolard, 2002). The variable measuring the proportion of the population that is black African therefore provides another indicator for social and material deprivation. All variables, as listed above, were used to construct deprivation indices from the two data sets.

Table 2.2 Variables for Constructing the Deprivation Index

Variable Name	Definition
<i>p_child</i>	The proportion of the population below the age of 5
<i>p_black</i>	The proportion of the population that are black Africans
<i>p_unemp</i>	The proportion of the population between 25yrs and 59yrs old not working and looking for work or not working and not looking for work
<i>p_shacktrad</i>	The proportion of the population living in traditional (informal) dwelling or shacks
<i>p_nocloseaccess</i>	The proportion of the population that do not have piped water in the house or on site
<i>p_pitbucketnone</i>	The proportion of the population that use a pit latrine, bucket latrine or have no toilet facility
<i>p_headnoeduc</i>	The proportion of the population that are from households headed by an uneducated individual
<i>p_femhhhead</i>	The proportion of the population that are from households headed by a female
<i>p_noenergy</i>	The proportion of the population that do not use either electricity or solar energy as their main source of energy.

2.4.3 Assessing Equity in PHC Allocations across Districts

The deprivation indices generated for each district was compared with PHC per capita allocations in each district. So, the index from the 2001 census data was compared with the 2000/01 PHC per capita expenditure, while the index from the 2005 GHS was compared with the 2005/06 PHC per capita expenditure. This comparison was done with the aid of regression analysis. In each case, the deprivation index was the independent variable and PHC per capita expenditure was the dependent variable. The model is specified this way as we assume that need determines the amount of resources committed to any district. The unit of analysis was the district level. To calculate the per capita allocations to district, the population of the district without access to medical scheme cover was used. This was to capture more accurately, the

population in each district dependent on publicly provided PHC services. The analysis was carried out using STATA 9.

2.5 Limitations of the Study

A major limitation of this study is that due to time and resource constraints, interviewed government officials in Nigeria were from only two states and two local government areas. Although officials from the federal government were interviewed, information from the interviews with state and local officials may not be fully representative of what obtains in other states and local governments in the country.

The definition of PHC expenditure for analysis (quantitative) is a narrow definition as it does not account for PHC activities carried out in district hospitals. Discussions with government officials revealed that district hospitals in some provinces also provide PHC services. The implication for this is that in some of the provinces, PHC expenditure may be underestimated. Previous research (Okorafor et al., 2003) identified these provinces as KwaZulu Natal and Eastern Cape. This is acknowledged in the analysis.

Lastly, because of interviewees request in Nigeria, states and local governments visited cannot be revealed; this restricts the project from making any recommendations that are specific to any local government or state in Nigeria.

Section 3 Literature Review

In this section, literature on the definition and conceptual understanding of key concepts such as equity, governance and need are reviewed. This is to give the reader a clear perspective on the guiding principles of the research paper. Literature on fiscal federalism, including the nature of fiscal federalism in South Africa is explained. A detailed account of resource generation and expenditure responsibility in South Africa, including the process of intergovernmental transfers and allocation process for health care is outlined. The section then concludes with a review of international experience of selected countries in the financing of health and primary health care.

3.1 Governance

The use of the term “governance” is applied in various contexts, with as many meanings. The term has been used synonymously with government (state institutions), although most recent definitions of governance are broader than the government (Kjaer, 2004). Review of literature on the subject reveals much debate around the definition of the term, and such debates are outside the scope of this paper. Rather we highlight components of definitions of governance, and attempt to draw out a conceptual understanding that is suitable for this paper.

Some of the definitions are narrower than others. Governance has been defined as: “...*the institutional capacity of public organisations to provide the public and other goods demanded by a country’s citizens or their representatives in an effective, transparent, impartial, and accountable manner, subject to resource constraints*” (World Bank, 2000).

In a broader sense, “*governance is the setting, application and enforcement of rules of the game*” (Kjaer, 2004).

A more traditional definition of governance explains the concept as “*the capacity of government to make and implement policy, in other words, to steer society*” (Pierre and Peters, 2000).

These are but a few definitions of governance. What is clear is that governance refers to the **decision making process** of an **empowered authority** that **enacts policies and enforces rules** concerning the public life of the society. This paper focuses more on the public sector allocations for a publicly provided service/good, and so the definition by the World Bank most closely represents the view of governance that guides this paper. Therefore this paper adopts a definition of governance that refers to the decision making process and capacity of the government to set rules and regulations that guide the provision of public services in a manner that is effective, efficient, equitable, accountable and responsive to the needs and demands of the citizens. Such processes, rules and policies that define a fiscal federal state and how they impact on the equitable allocation of PHC capture the focus of this paper.

3.2 Equity Defined

The concept of equity refers to a fair distribution of something across different individuals and/or groups in society (Mooney, 1983). In most societies, there is in one form or another, a concern that health care resources and benefits should be distributed in some fair manner (Donaldson and Gerard, 1993); (Culyer and Wagstaff, 1993). While the concept of equity in the field of health care has been judged to be important, there is no clear consensus on what is meant by equity in health (Whitehead, 1992). What is clear however, is the distinction between equity and equality. Equality is concerned with equal shares, which may not necessarily be a fair distribution. In health care, an equal distribution of access to services (for example) may not be a fair distribution of access as socio-economically disadvantaged groups should perhaps be given greater access to achieve a distribution that is considered equitable (Mooney, 1983).

The different definitions of equity put forward by different authors reflect the varied views around the concept. A brief review of theories of justice on the subject provides some insight into different perspectives of equity. The *libertarian* perspective emphasizes a respect for natural rights (the rights to life and possessions); and consumer sovereignty and market forces in the distribution of health care resources and benefits (Donaldson and Gerard, 1993). As long as people acquire and transfer their holdings without violating the rights of others, their holdings are regarded as just. In the distribution of most economic goods, this view would receive support

from most schools of thought. However, the distribution of health care resources on the basis of non-medical merits (that would obtain for other economic goods⁵) is regarded as repugnant by most (Gilson, 1998).

The *Utilitarian* perspective seeks to maximise total social welfare (Wagstaff and van Doorslaer, 1993), and therefore if current patterns of distribution of health care resources increase overall health status within a population, then it is equitable. With respect to equity in health, the utilitarian view is criticised for not allowing for special consideration of the poorest and most vulnerable (Gilson, 1998). Overall increases in health status for any given population can be achieved with little or no improvement in the health status of the most needy. Indeed, overall health gains can be experienced, even with declines in the health status of the poorer members of the population.

The *Rawlsian* notion of equity requires that the worst-off in society are provided with a decent basic minimum of health care, and therefore distribution of health care resources that promote a minimum standard of health care is thus equitable (Gilson, 1998). This view allows for more consideration of the poor than the utilitarian perspective although it is also criticised (by egalitarians) on the basis that achieving an absolute minimum of health services for the poor is not enough. The richer members of the population still have the opportunity to maintain and even increase their relatively better access to and utilisation of health services.

The *egalitarian* perspective advocates for distribution of health care resources according to need (also a Marxist view). In the egalitarian view, access to health care is the right of every citizen, and that the distribution of health care should not be influenced by income and wealth. Egalitarians would judge equity by assessing the extent to which health care in practice, is distributed according to need and financed according to ability to pay (Gilson, 1998, Wagstaff and van Doorslaer, 1993). There is consistent evidence showing that socio-economically disadvantaged groups carry a heavier burden of ill-health, have poorer survival chances and have less access to good quality health care (Power et al., 1991, Phillimore et al., 1994, Davey and Bartley, 1990, Wilkinson, 1986, Townsend and Davidson, 1982), (Braveman and

⁵ 'Other economic goods' represents other goods that are not generally regarded as a right for very member of the population

Tarimo, 2002), (Wagstaff, 2001). It is because of such evidence that the egalitarian perspective has gained popularity. Considering the huge socioeconomic inequalities within South Africa (McIntyre and Gilson, 2002) (Bloom and McIntyre, 1998), this perspective seems most appropriate for assessing equity in the South African health system. It is this (egalitarian) perspective that therefore guides this paper.

Whether any of these perspectives or values forms the guiding principles underlying any health system, the problem of identifying an appropriate operational definition of equity based on measurable criteria remains (Braveman and Gruskin, 2003). In addressing this issue, a starting point would be to identify “what” is to be distributed fairly. Are health systems to be concerned with a fair distribution of “health” (equal health) or “health care”? Literature supports the view that a fair distribution of health care is a more realistic objective of health systems. This is based on the argument that there are numerous factors that affect health status that are outside the locus of control of health systems (Donaldson and Gerard, 1993, Whitehead, 1992). Some of these factors are

1. Genetically inherited conditions and natural deterioration of health over time
2. It is still not known what is meant by “good health”
3. Freely chosen health damaging behaviour such as extreme sports, smoking etc
4. Exposure to unhealthy, stressful living and working conditions (*ibid*).

There is therefore some consensus in the literature that health differences determined by factors such as points 1 and 3 above should not be classified as inequities since such differences are unavoidable (Whitehead, 1992)

Literature on equity in health identifies two major principles of equity: horizontal equity and vertical equity (Mooney, 1983) (Donaldson and Gerard, 1993). Horizontal equity refers to the “equal treatment of equals”; such that individuals with similar characteristics in all respects (including health status) are treated equally. On the other hand, vertical equity refers to the “unequal treatment of unequals”. This suggests that those with different health status should be treated differently. It may be extremely difficult to put the ‘horizontal equity’ definition into practice as this presents the problem of deciding what ‘equal treatment’ and ‘equals’ means. Vertical equity on the other hand seems easier to put into practice because it is easier to identify who has

greater health needs than another, and therefore (hopefully) provide health care discriminately in favour of the person(s) with greater health needs⁶. A key problem in the application of vertical equity is to determine “how unequal health conditions (disease conditions for example) are” and “how unequally the health system should respond”?

In the financing of health care, the bulk of health care expenditure for most countries comes from two or more of four sources: taxation, social insurance contributions, private insurance premiums and out-of-pocket payments (van Doorslaer and Wagstaff, 1993). A key consideration of equity in the financing of health care is how actual payments for health care across individuals and groups are related to ability to pay. While this is a key aspect of equity in the field of health care, this study focuses on equity in the distribution of health care resources across geographic areas. Operational definitions reviewed for equity are thus limited to those that refer to the allocation of health care resources across populations.

A number of definitions of equity have been put forward for practical purposes. Some of the more common definitions are:

- a. *Equality of expenditure per capita*: An equitable allocation of health care resources is achieved if the available budget is allocated to different regions pro rata with the size of the regional population.
- b. *Equality of inputs (resources) per capita*: Equity in resource allocation to different regions is achieved if all resources (labour, land, capital, etc.) are distributed pro rata with the regional population. The major difference with this definition and the previous one is that this second definition takes into consideration the different prices of health care resources in different regions.
- c. *Equality of input for equal need*: This definition suggests going beyond population size as the basis for resource allocation. The health needs of the different regions (could be defined by health status, demographics, socio-economic levels etc) should be considered also. So, given equal population sizes, one region should receive more resources, if it is deemed to be in greater need of health care.

⁶ The concept of need in health is discussed in more detail in subsequent sections of the literature review

- d. *Equality of (opportunity) of access for equal need*: Based on this definition, all individuals with similar need for health should face the same cost (transport, time, financial, etc.) of utilising health services.
- e. *Equality of utilisation for equal need*: This takes the definition of equity further than the previous one. If everyone had the same tastes and preferences for health and health care, then equality of access would automatically translate into equal utilisation. However, this is generally not the case. In practise therefore, this definition advocates for positive discrimination in favour of those less willing to utilise health care. While the previous definition focuses only on supply side factors of health care, this definition also considers demand-side factors of the health care market.
- f. *Equality of marginal met need*: Equity is achieved if all regions are given an extra sum of money (given ranking of health needs by order of priority) all regions would spend it on treating the same health needs. In other words, the quantity of health benefits gained from an extra allocation of resources is the same.
- g. *Equality of Health*: Equity is achieved when all members of the population have the same health status. This is a very ambitious aim, and would be extremely difficult to achieve because of unavoidable differences in genetic make-up of each individual. While other definitions refer to equity in the distribution of resources, this definition focuses on equity in health status (Mooney, 1983).

Whatever operational definition used by a health system will depend on how equity is viewed. In this paper, equity is viewed from a more egalitarian perspective: equity in resource allocation refers to the allocation of resources according to health needs, such that those with greater health needs are given more preference in the allocation of health care resources. Our perspective on equity in allocation of health care resources is best described by Whitehead's definition of equity. According to Whitehead, "equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided" (Whitehead, 1989) . Using this definition as a guide implies that the more disadvantaged, those of lower socio-economic status (SES), should receive disproportionately more resources than the rich because the richer members of the population inherently have a higher capacity for achieving their full health potential.

3.3 Need

The meaning of “need” in health has been a subject of debate in many academic papers, especially in relation to the equitable allocation of health care resources. Equity in health care distribution (and resource allocation in health) is generally associated with or based on need. It is common to find need in this context to be equated to ill-health. This view therefore suggesting that persons with similar health status have the same need, and that persons with different health statuses have different needs. The problem with this definition of need as observed by Culyer and Wagstaff (1993) is that it is difficult to see why a person who is sick can be said to need health care. According to them, they may, fundamentally, need health, but not health care. Another problem with this definition is that ineffective health care cannot be needed. If a person is in a state of ill-health, but cannot benefit from health care, then the person does not have a need for health care; therefore need as capacity to benefit may be a more useful concept of need. In this sense, a person may need health care but may not be ill (as in the case of preventive measures); also, a person may be in a state of ill-health but not need health care because no effective health care is available (Culyer and Wagstaff, 1993).

A problem with this definition of need is that it does not provide the answer to the question: how much health care does a person need? (Culyer and Wagstaff, 1993). A third definition that addresses this problem is: need for health care as the “minimum amount of resources required to exhaust a person’s capacity to benefit”. This definition incorporates ‘capacity to benefit’ but also, quantifies the amount of necessary resources. This definition is most relevant at the macro-planning level (Culyer, 1995). Identifying the necessary resources for potential health gain is critical for resource allocation in the health sector, especially to different geographic regions. Understanding need in this way may be ideal for guiding the process for equitable allocations (more resources for areas with greater need); however, it will be difficult to quantify the amount of resources that exhausts the capacity to benefit for large populations.

This paper focuses not on individual needs but on the needs of populations in different geographic areas. We shall assume that populations within defined geographic boundaries that carry a heavier burden of ill-health (or have the potential to do so)

will be referred to as areas with greater needs. There is consistent international evidence that those of lower socioeconomic status (SES) carry a heavier burden of ill-health, and are least able to afford health care. They are therefore caught in a vicious circle: poverty breeding ill-health and ill-health maintaining or leading to poverty (Braveman, 2003, Wagstaff, 2002). In this paper therefore, 'need' will be measured by proxy: using a composite measure that incorporates variables that indicate levels of socioeconomic status.

3.4 Governance and Public Sector Provisioning of Health Care

In the past, prior to the 1970s, economic literature held the view that rapid economic growth within any country would ultimately trickle down to the masses in the form of jobs and economic opportunities that will create the necessary conditions for the wider distribution of improvements in overall welfare. However, evidence from countries that experienced rapid economic growth but with little improvements in the welfare of the poor has brought this view under heavy criticism (Todaro and Smith, 2003). One of the reasons given for the failure of this theory is that as markets spread, large sections of the population become even more vulnerable to poverty. People become more dependent on the workings of the market and therefore become more vulnerable to factors such as price and quantity changes in volatile markets and natural disasters such as droughts. The market responds to demand backed up by cash. So peoples' ability to provide for themselves is limited by their assets. Those with fewer assets (poorer) are more vulnerable to changes in the market environment. Any change that increases the prices of necessary goods and services (such as food) reduces their real income and can potentially render them unable to purchase goods and services necessary to maintain an acceptable standard of living. This has the potential to increase inequities in socio-economic status and therefore health inequalities. As markets by default do not protect the poor and vulnerable, it has become important that the governments step in to intervene in the operations of the market in order to protect the poor.

Government involvement in the financing and provision of health care is partly as a result of the failure of the market to efficiently allocate resources in the health sector;

because of the nature of the market for health care. Some of the characteristics of health care that make it an exceptional good (as opposed to other normal goods such as peanuts and bicycles) and thus necessitate public intervention in its provisioning, financing and regulation are:

- The demand for health care is unpredictable and unsteady (Rashid et al., 2005); it depends on illness. It is difficult for one to plan their expenditure on health care. The costs of treating ill-health can be catastrophically high and not everyone can afford it.
- The provider of health care (physician) cannot act like a normal businessman because his objective is to cure the patient (buyer); reducing the demand for health care (ibid). The provider should not act as a normal businessman by trying to increase the demand for the product he/she sells because it is unethical.
- The vast asymmetry of knowledge about the products between the patient and doctor (ibid). Patients usually do not have sufficient knowledge/information about the health product they are purchasing to make a rational decision at the point of purchase. Also, the asymmetry of information can lead to supplier-induced demand – distorting the price mechanism.
- There are relatively high restrictions to enter the market for health care (ibid). Labour is relatively immobile, and thus cannot respond adequately to changes in the market conditions; making the market inadequate in the efficient allocation of health care resources.
- Health care is generally regarded as a merit good, such that all members of the population have access to good quality basic health care. Then, income levels and ability to pay should not determine the distribution of health care resources, as in the market for other ‘normal’ goods. There is little incentive for the private sector to provide ‘merit’ goods.

For such reasons as listed above, in most countries, the state⁷ has taken up the responsibility of providing certain services (such as health and education) to protect the more vulnerable members of the society. Public provision of health care protects

⁷ referring to the government and its subsidiaries

poorer families against the (sometimes) catastrophic costs of ill-health. The public provision of services such as health and education, increases the opportunities of the socio-economically deprived to provide a better livelihood for themselves. In some countries, this has worked well to reduce destitution, but it has not for others (Wuyts, 1997). Governments do not exist just to cater for the poor and vulnerable. In fact, the well functioning of the market depends on the presence of (and the enforcement of) laws and regulations instituted by the government, which protect the rights of economic agents. Governments determine how well markets function (Brautigam, 1991). Indeed, the significant influence of government activities on overall economic performance of a country, the interaction of economic agents within and the welfare of the vulnerable in society is such that the nature of governance (how good or bad) still maintains a prominent place in discussions on politics, economics and management.

3.5 Fiscal Federalism and Equity in Health

Fiscal federalism can be defined as the devolution of spending responsibilities to sub-national levels of government. This has become a global trend in the past few years (Ter-Minassian, 1997, de Mello JR, 2000). This is partly a reflection of the political evolution towards more democratic societies. Also, the economic literature has presented the view that fiscal decentralisation can entail substantial gains in terms of both efficiency and welfare. According to this view, such gains are best achieved by assigning responsibility for each type of public expenditure to the level of government that most closely represents the beneficiaries of these outlays (Musgrave and Musgrave, 1989, de Mello JR, 2000) (Bird and Vaillancourt, 1997, de Mello JR, 2000, Ter-Minassian, 1997). However, the literature also indicates that fiscal decentralisation can entail significant costs in terms of distributional equity (McIntyre *et al* 1998). Theoretical efficiency gains from decentralisation can be significantly undermined by institutional constraints such as:

- Weak administrative capacity in sub-national governments (SNGs), poor technical skills at lower levels, and the existence of corruption;
- Sub-national governments may not have developed modern and transparent public expenditure management systems; and

- The size of the local jurisdiction (which is often a result of historical developments or political factors) is not always consistent with the full realisation of potential efficiency gains from decentralisation (Ter-Minassian, 1997).

Although many countries have substantially devolved expenditure responsibilities to lower levels of government, the form of decentralisation taken by any country reflects its particular context (Bird and Vaillancourt, 1997, de Mello JR, 2000). The amount of autonomy given to sub-national governments therefore varies. In most countries operating a fiscal federal system, large expenditure responsibilities are decentralised to sub-national levels of government while most of the major taxes are assigned by the central government. This usually results in large funding gaps (called *vertical imbalances*) at sub-national government level. This is because SNGs rarely have the capacity to raise sufficient revenue to fund the activities they are required to carry out. There are generally four solutions to this problem. The first is to increase revenue at the sub-national level by transferring more revenue raising power to lower levels of government. A second is to reduce local expenditure. A third option is to transfer expenditure functions up to the government level with more revenue. The fourth option is to transfer some centrally collected revenues to lower levels of government; and this last option usually prevails (Bird and Vaillancourt 1997). Fiscal decentralisation can also lead to inequities in the distribution of resources across SNGs (called *horizontal imbalances*). Sub-national governments usually have differential capacity to generate their own revenues (Ter-Minassian, 1997), leading to unequal capacities to carry out similar functions.

3.5.1 Intergovernmental Transfers

In most countries, these imbalances (vertical and horizontal) are addressed through inter-governmental transfers, which refer to the transfers of funds from the central government to lower levels of government such as provinces, states and local governments. The key issues in intergovernmental transfers are around deciding on the type of transfers and the criteria for the size of transfers made to sub-national governments. The type of transfers utilised to correct both vertical and horizontal imbalances has varying impacts on the results which they aim to achieve. The results of such transfers, whether good or bad, will depend on the incentives (built into the

transfer system) they create for central and local governments and, indirectly, for residents of the different regions of the country (Bird and Smart, 2002). Inter-government transfer mechanisms can be grouped into two broad categories: **revenue sharing** and **grants**. Whether transfers are in the nature of revenue sharing or grants, there are basically three ways to determine how much is to be distributed:

1. As a fixed proportion of government revenues;
2. On an ad hoc basis, in response to specific claims, and
3. On a formula-driven basis (Bird and Vaillancourt 1997).

Revenue sharing arrangements are usually geared towards correcting vertical imbalances. Sharing of tax revenues can be on a tax-by-tax basis, with different coefficients of distribution among levels of government for each tax or on the entire pool of central government tax revenues. Tax-by-tax sharing is practiced in countries such as Argentina, Brazil, Hungary and Russia. However, a major disadvantage of such sharing is that it provides an incentive for tax administration at central government to concentrate its collection and enforcement on the taxes that are not shared or are shared to a lesser degree (Ter-Minassian 1997). Furthermore, tax-by-tax sharing provides the central government with incentives to concentrate increases in rates (for instance for stabilisation purposes) on the shared taxes. Therefore, revenue sharing based on the entire pool of government revenues may be preferable (Fjeldstad, 2001).

In general, grants can be grouped into two:

- **General purpose grants:** unconditional transfers aimed at addressing vertical and horizontal imbalances;
- **Specific purpose grants (or conditional grants):** grants that carry conditions regarding the use of the funds and/or the performance achieved in the programme(s) financed through them. Some conditional grants may require matching elements by recipient authorities.

Most countries use a combination of revenue sharing and grants. In general, the former forms the basic revenue for sub-national governments. Grants are additional

transfers made to certain (or all) sectors of sub-national governments either to increase the overall expenditure capacity of certain jurisdictions (usually in the form of general purpose grants) or to influence the level and distribution of particular services across all jurisdictions (usually in the form of specific purpose grants).

The choice between conditional and unconditional transfers should be based on a number of considerations. On the one hand, the imposition of conditions clearly reduces the level of autonomy at lower levels with respect to decisions around “how much” to spend and on “what”. This is contrary to the welfare and efficiency arguments in support of decentralisation. On the other hand, the imposition of conditions may be justified by distributional considerations. For example, it may be necessary to attach conditions to funds to realise uniform or minimum expenditure on issues of national concern, such as PHC⁸ (*ibid*). The design of grants to sub-national levels/sectors/programmes has significant implications for effective and efficient use of the resources and for the achievement of the stated goals for which the funds are disbursed. The result of transfers depends on the incentives they create for the different levels of government (Bird and Smart, 2002).

If any grants are used, some choices can be identified:

- Whether the transfers should be made on a conditional or unconditional basis. It is to be noted that an unconditional grant simply increases the SNG’s income without altering their spending priorities, which are dictated by local preferences. The main justification for conditional grants over unconditional grants therefore must be that local decision-making fails to produce the socially optimal outcome. However, many developing countries have relatively weak capabilities in expenditure management at the SNG level. The use of conditionality and performance criteria for a special purpose grant may then generate confusion and pro forma fulfilment of the needed criteria (Ahmad and Craig 1996). Conditional/specific purpose grants are more appropriate where SNGs lack the capacity to manage resources, as the conditions attached to the funds dictate the terms of how the money is to be spent. However, where the conditions for use (and performance) are such that they require a high level of managerial capacity to

⁸ Possibly also to support specific standards or levels of service provision.

fulfil stated criteria, managing conditional grants at lower levels could become very difficult. Therefore, unless SNGs possess the capacity to monitor and manage the conditionality for grants, it may be better if central governments simplify the design and conditionality of special purpose grants, and/or supplement these with lump-sum transfers, which could then be seen as ‘own’ resources by recipient governments (ibid).

- Second, within the category of conditional transfers, whether the central government should require sub-national governments to undertake some matching of funding of programmes by lower level governments. This might be done to ensure that SNGs spend resources on this priority activity, and not on other activities. It may also be done to pave the way for the transfer of the activity to SNGs, by gradually decreasing the proportion of funding paid by central government.
- Third, whether there is to be some redistribution in the transfer mechanism or whether the transfers will be made based on efficiency (or other) criteria to each member of the defined population in each region.
- Finally, within both conditional and unconditional transfer mechanisms, whether the grants should be open-ended or subject to caps i.e. limits placed on the amount of spending (Ahmad and Craig, 1997).

3.5.2 Intergovernmental Transfers and Autonomy

The nature of intergovernmental transfers to SNGs may depend on the public good/service that they finance. For certain public services, their outcomes are of national interest and therefore the central government may see a need to intervene in fiscal operations at lower levels to realise a more ‘desired’ outcome. For example, in Australia, in pursuit of national policy objectives, sectors such as health, education, social welfare and housing are largely funded through specific purpose grants. In Canada, the major general purpose grants are transferred to provinces with below average tax capacity, while specific purpose grants are employed to fund health and,

more broadly, the social sector. In Italy, conditional grants have been used to influence the level and distribution of sub-national expenditure on health and public transport, which are deemed to be of national concern. In Bulgaria, specific purpose grants are given to municipalities for capital expenditure purposes only; while general-purpose grants are the dominant form of transfers to municipalities (Bogetić, 1997).

As already mentioned the outcome of some publicly provided services may be of central concern. In these cases, the central government may intervene in fiscal operations to achieve a more equitable, uniform or contextually optimal (to achieve some national objective) distribution of expenditure and/or provision of these services. Whether the central government intervenes in fiscal operations directly by attaching conditions to transfers or indirectly by laying down norms and standards (or any such regulation), such interventions reduce the level of autonomy enjoyed by SNGs.

3.5.3 Fiscal Federalism and the Health Sector

A major concern for the health sector is that the introduction of fiscal federalism can lead to inequities in the distribution of health care resources between geographic areas (Thomas et al., 2003). With increased autonomy at lower levels, sub-national governments have greater influence on the budgetary allocations to sectors (health, education, transport, etc). Differential capacity to generate and utilise resources coupled with different local preferences will most likely yield different levels of financing and provision of health care services across SNGs. However, the type of transfers to lower levels for the health sector can significantly influence the distribution of resources for the health sector across areas covered by different SNGs.

The outcome of the health sector is of central interest for most countries. Health is generally regarded as a merit good, such that all citizens within the country have an “acceptable” (which usually translates into minimum or uniform) level of access and utilisation. In this regard, central governments (in most countries operating a fiscal federal system) influence fiscal operations to achieve a desired distribution of

resources, expenditure and provision of health services within the country. There are different ways in which central governments have influenced these within health systems. In some cases higher levels of government retain expenditure responsibilities for health services with the central government maintaining overall control of activities in health sector financing and provision, as in Australia and Canada (Craig, 1997, Krellove et al., 1997). In other cases, all tiers of government share the responsibilities for financing and delivery of health care, as in Argentina (Schwartz and Liuksila, 1997) and Nigeria (Ayodele, 2003). Also, where financing and provision of health services are decentralised to lower levels, the central government transfers funds for health as a specific purpose grant with conditions on how the funds are to be used. In other cases, specific purpose grants are used to finance only certain programmes within the health sector. For all options outlined, the central/national government still retains some control over expenditure responsibilities, or at least participates in the spending on and providing of health services.

3.6 Fiscal Federalism in South Africa

Apartheid policies of the pre-1994 era left a legacy of severe socio-economic disparities in South Africa (Yemek, 2005). Between 1948 and 1994, South Africa was governed by the National Party (elected into power by a whites-only electorate). Under this regime, a policy of racial segregation and discrimination was systematically implemented. The country's political and administrative system was structured along racial lines into ten 'homelands' where the majority of Black Africans lived, and four provinces for 'white' South Africa. Most of the 'whites' lived in cities that had modern infrastructure, with well funded schools and modern hospitals. Most urban African (Black) localities had much poorer services, and large numbers living in informal squatter settlements. Although there were approximately 800 local governments across the country and administrative structures at the province level, South Africa remained in practice a highly centralised state. Major decisions on policy, planning, budgeting and resource allocation were controlled by the central government (Gilson et al., 1999); (National Treasury, 1999).

The first democratic government instituted in 1994 set out to face the immense task of resource redistribution and to ensure the provision of a range of social services to

meet prevailing socio-economic challenges within resource constraints (Okorafor et al., 2003, Yemek, 2005). In 1996, South Africa adopted a new constitution that established three separate, independent and interrelated spheres of government: a national government, nine provincial governments and 284 local governments. Each sphere is assigned its own powers, functions and responsibilities, with the national government responsible for managing the country's affairs while sharing the responsibility for providing basic social services with the sub-national governments. The provinces are mandated to deliver most basic services including education, health and welfare. Local governments are responsible for certain local services and infrastructure such as water, sanitation and electricity. The national government's intervention in provincial and local government decisions is defined and limited by the constitution. Fiscal decentralisation although largely politically driven in South Africa (National Treasury, 1999) aims to provide a framework for the efficient provision of public services by aligning expenditure with regionally based priorities (Yemek, 2005).

South Africa's fiscal system is based on a revenue-sharing model, with provinces largely dependent on transfers from the national government, while local governments are only partially dependent (National Treasury, 2001). The constitution stipulates that nationally raised revenue be distributed equitably between the three spheres of government, and the provincial share must be divided equitably between the nine provinces, and that other allocations may be made from the national share with or without conditions. Despite their significant expenditure responsibilities, provinces have limited sources of own revenue. While the constitution confers significant autonomy on provincial governments, it creates a monitoring and coordination role for the national government to ensure macroeconomic stability, achievement of national policy goals and obligations, and a consistent standard of services so that citizens are not prejudiced based on their place of residence. The government achieves this through framework legislation or setting norms and standards. Provinces are responsible for implementing national policies affecting concurrent functions (National Treasury, 1999).

Even though the new provinces were established under the Interim Constitution⁹ of 1993, the flexibility to allocate their own budgets did not materialise until 1997/98. Prior to this, allocations were made through Function Committees for education, health and welfare amongst others (National Treasury, 1999). The Financial and Fiscal Commission (FFC)¹⁰ originally established in the 1993 Interim Constitution is to play a leading role in the development and maintenance of inter-governmental fiscal and financial relations in South Africa (Financial and Fiscal Commission, 1999). Since then, and also based on recommendations of the FFC, intergovernmental fiscal relations in South Africa have evolved over the years, although still maintaining the general framework adopted by the 1996 constitution.

3.6.1 Revenue Generation

Based on the Constitution, revenue raising powers still remain highly centralised in the national government. The most productive taxes such as the value added tax (VAT), personal and corporate income tax are reserved for the national government (Ajam, 2005). This is because collection is easier to administer at the national level; also this avoids duplication associated with a more decentralised system (Ajam, 2005). Provincial own revenue is from road traffic fees, hospital patient fees, gambling levies, and other once-off revenues, which amount to less than 5% of their total revenue (National Treasury, 2001, Ajam, 2005).

Local governments have a higher revenue generating capacity. They are entitled to impose rates on property and surcharges on fees for services provided by or on behalf of the municipality (e.g. electricity or sewage). For example, in 2003/2004, only about 17% of total local government revenue was due to national transfers (National Treasury, 2003).

⁹ Interim Constitution refers to the constitution of 1993, the foundation for establishing a system of intergovernmental relations. A new constitution was adopted in 1996.

¹⁰ The Financial and Fiscal Commission is an independent constitutional institution. It is required to give advice and make recommendations to matters affecting intergovernmental fiscal relations, mainly regarding the equitable sharing of nationally collected revenues between the national, provincial and local spheres of government.

3.6.2 Expenditure Responsibilities

The functions allocated to the national government generally include expenditures related to defence, tertiary education, justice, correctional services, water affairs and foreign affairs. Pensions and unemployment compensation are also the responsibility of the national government (Yemek, 2005).

The constitution assigns certain responsibilities for the delivery of goods and services to provinces and local governments with or without national government. Schedule 4 of the constitution lists the functional areas concurrent national and provincial legislative competence (complete list in Appendix B). These include agriculture, disaster management, education at all levels (excluding tertiary education), environment, health services, housing, road traffic regulation and tourism. Part B of schedule 4 lists local government responsibilities, including air pollution, building regulations, local tourism, municipal health services, trading regulations etc (complete list also in Appendix B).

Schedule 5 (Part A) of the constitution lists functional areas of exclusive provincial legislative competence, such as abattoirs, ambulance services, liquor license, etc; while Part B lists local government matters such as beaches, cemeteries, markets, noise pollution etc.

The responsibilities of provincial governments include primary and secondary education, health and welfare services, provincial roads and local economic development. Local governments are responsible for municipal services such as housing water, electricity and sanitation (Yemek, 2005).

In the following section we look at allocations to provinces and local governments. The section focuses heavily on transfers to provinces, as these are the transfers that finance the health sector and therefore PHC.

3.6.3 Revenue Sharing

As previously mentioned, provinces generate less than 5% of their provincial budget. Given the significant responsibilities allocated to them, there exists a large vertical imbalance between assigned expenditure responsibilities and own revenue. A similar situation is observed for local government, although to a lesser extent. These vertical imbalances are corrected in the form of national transfers called equitable shares. The constitution entitles provincial governments to an equitable share of the revenue collected nationally, in line with their expenditure responsibilities and functions (Ajam, 2005). A second form of transfer from the national government to sub-national governments is conditional grants. Conditional grants are meant to support national priorities, particularly in the social sectors. These grants are used in order to:

- Enable national priorities to be provided for in the budgets of other spheres of government
- Promote national norms and standards
- Compensate provinces for cross border flows and inter-provincial benefits
- Effect transition by supporting capacity-building and structural adjustments
- Address backlogs and regional disparities in social infrastructure (National Treasury, 2003).

Both provinces and local governments receive funds through conditional grants and equitable shares. Since we are more interested in the financing of health care, we focus on the description of intergovernmental transfers to provinces, as they are jointly responsible (with the national government) for the provision of health care services.

3.6.3.1 Conditional Grants to Provinces

Conditional grants to provinces in the 2005/06 financial year are in the following sectors: Agriculture, Education, Health, Housing, Land Affairs, National Treasury, Provincial and Local Government, Sport and Recreation South Africa and Transport. Conditional grants to provinces for the health sector are:

- Comprehensive HIV and Aids Grant
- Forensic Pathology Services Grant
- Health Professionals Training and Development Grant

- Hospital Revitalisation Grant
- National Tertiary Services Grant (National Treasury, 2006)

The Comprehensive HIV and AIDS Grant is to enable the health sector to develop a specific response to the HIV and AIDS epidemic. The grant also supports (in addition to other HIV and AIDS prevention programmes) specific interventions such as voluntary counselling and testing, prevention of mother to child transmission, post exposure prophylaxis and home based care.

The Health Professions Training and Development Grant (HPDT) compensates provinces for their role in supporting teaching and training of health science students. It enables the shifting of teaching activities from central to regional and district hospitals. The largest portion is distributed to provinces according to a formula based on the number of current medical students. A further component provides for a phased increase in the number of medical specialists and registrars in historically under-served provinces to address inter-provincial inequities in post-graduate training capacity.

The Hospital Revitalisation Grant is meant for transforming and modernising infrastructure and equipment in hospitals. It focuses on projects in which an entire hospital is upgraded. The Hospital Management and Quality Improvement Grant which facilitates management development initiatives including personnel, procurement delegations and financial management capacity is phased into the Hospital Revitalisation Grant (See review of previous conditional grants to health sector in table 3.1).

The National Tertiary Services Grant is to fund national tertiary services delivered in 27 hospitals across the nine provinces and ensure the equitable access to basic tertiary services in the country. Given the specialised nature of the services, they tend to be concentrated in large cities such as Cape Town, Johannesburg, Pretoria, Durban and Bloemfontein (National Treasury, 2005).

Programmes in the health sector funded by conditional grants have changed in the past years. Table 2.1 below provides a brief description of conditional grants to health

in the past 5 years. Over time, the number of conditional grants to health has reduced, as has the overall number of conditional grants to provinces (National Treasury, 2003, National Treasury, National Treasury, National Treasury, National Treasury).

Table 3.1 Conditional grants to the health sector in South Africa: 2000 - 2005

Financial Year	Conditional Grants to the health sector
2004/05 (National Treasury, 2005)	<ul style="list-style-type: none"> ▪ Comprehensive HIV and AIDS ▪ Health Professionals Training and Development ▪ Hospital Management and Quality Improvement ▪ Hospital Revitalisation ▪ Integrated Nutrition Programme ▪ National Tertiary Services
2003/04 (National Treasury, 2004)	<ul style="list-style-type: none"> ▪ Comprehensive HIV and AIDS ▪ Health Professional Training and Development ▪ Hospital Revitalisation ▪ Integrated Nutrition Programme ▪ National Tertiary Services ▪ Hospital Construction – Academic Hospitals ▪ Medico-legal
2002/03 (National Treasury, 2003)	<ul style="list-style-type: none"> ▪ HIV/AIDS ▪ Health Professionals Training and Development ▪ Hospital Management and Quality Improvement ▪ Hospital Revitalisation ▪ Integrated Nutrition Programme ▪ National Tertiary Services ▪ Cholera Epidemic – KwaZulu Natal ▪ Pretoria Academic Hospital
2001/02 (National Treasury, 2002)	<ul style="list-style-type: none"> ▪ HIV/AIDS ▪ Health Professionals Training and Development ▪ Hospital Revitalisation ▪ Integrated Nutrition Programme ▪ National Tertiary Services ▪ Nkosi Luthuli Academic Hospital ▪ Pretoria Academic Hospital
2000/01 (National Treasury, 2001)	<ul style="list-style-type: none"> ▪ HIV/AIDS ▪ Integrated Nutrition Programme ▪ Professional Training and Research ▪ Hospital Rehabilitation ▪ Central Hospital ▪ Redistribution of Specialised Health Service ▪ Construction

3.6.3.2 Equitable Shares

The second type of transfer to provinces is the equitable shares. This transfer allows the provinces to provide services and perform functions allocated to them (targets the problem of vertical imbalances). Equitable shares to provinces are determined by an equitable shares formula that is updated annually, taking into account the recommendations of the FFC. For the 2006 budget, the equitable shares formula has three main components and three smaller components. The components of the

formula are designed to capture the relative demand for services between provinces, while taking into account particular provincial circumstances. The table below provides a summary of the components of the equitable shares formula for 2006, and the resulting proportion of total funds for equitable shares are distributed across provinces.

Table 3.2 Equitable shares formula in South Africa

Percentage	Education	Health	Basic share	Poverty	Economic activity	Institutional	Target shares
Weighting	51.0	26.0	14.0	3.0	1.0	5.0	100.0
Eastern Cape	17.4	15.3	14.4	21.0	8.1	11.1	16.1
Free State	5.8	6.1	6.1	7.1	5.5	11.1	6.2
Gauteng	13.8	17.7	19.8	11.2	33.0	11.1	15.6
KwaZulu Natal	22.8	21.7	20.9	23.1	16.5	11.1	21.6
Limpopo	15.1	12.7	11.8	17.1	6.5	11.1	13.8
Mpumalanga	7.6	7.2	7.0	6.6	7.0	11.1	7.5
Northern Cape	1.7	1.8	1.8	2.1	2.4	11.1	2.2
North West	7.7	8.4	8.2	8.0	6.5	11.1	8.1
Western Cape	8.2	9.2	10.1	3.8	14.5	11.1	8.8
Total	100	100	100	100	100	100	100

Source: Budget Review 2006, National Treasury, Republic of South Africa

A more detailed explanation of each component is given in the Box 2.1 below.

Box 3.1 Components of the Equitable Shares formula

- The **education share** (51%) is based on the size of the school-age population (ages 5-17) and the average number of learners (Grade R to 12) enrolled in public ordinary schools for the past three years.
- The **health share** (26%) is based on the proportion of the population with and without access to medical aid
- A basic share (14%) derived from each province's share of the national population
- An institutional component (5%) divided equally between provinces
- A poverty component (3%) reinforcing the redistributive bias of the formula
- An economic output component (1%) based GDP by region

Source: Budget Review 2006, National Treasury, Republic of South Africa

The weighting for the education share and health share are derived from average provincial expenditure on the respective sectors (in total provincial expenditure) for the past three years excluding conditional grants. Within the health component, people without medical scheme cover are assigned a weight four times the weight of those with medical scheme cover. This is on the grounds that those without medical

scheme cover are more likely to use public health care facilities. The poverty component provides for some redistribution within the formula. This component is based on the proportion of the population residing in a province that is considered poor. The poor population is defined as those whose incomes fall within quintiles 1 and 2 (quintiles with lowest income groups) based on the 2000 Income and Expenditure Survey. The economic activity component is a proxy for provincial tax capacity. The institutional component is distributed equally across all provinces on the grounds that there are costs associated with running a provincial government and providing services that are not directly related to the size of the population (National Treasury, 2006).

Equitable shares were first introduced in the 1998 budget and have been updated every year. The formula for the horizontal division of revenue included consideration of the recommendations and submissions of the FFC. The FFC recommended that the provincial grants formula was to have 5 components:

1. A **Minimum National Standards Grant**: to ensure that each province can provide a minimum national standard of basic human capital. This is specifically to provide primary and secondary education; and primary and district health-care to their residents
2. **Spillover Grant**: which provides for the financing of service that have inter-provincial spillover effects
3. **Fiscal Capacity Equalisation Grant**: to ensure that provincial functions are financed from an equitable provincial taxing capacity and to encourage accountability and democratic institutions associated with the establishment of a provincial legislature
4. **Institutional Grant**: for each province to finance the core of its legislature as required by the Constitution
5. **Basic Grant**: to support provincial functions; establishing and maintaining institutions necessary for the fulfilment of their constitutional obligations according to their own priorities.

The FFC proposed that the value of the health care component be determined by calculating the costs of providing within 10 years an average of 3.5 visits per year to a primary health care clinic by people who do not have access to medical schemes, and

0.5 visits by those with access to medical schemes. Also this component includes the cost of providing services by district hospitals (Financial and Fiscal Commission, 1996). This formula as presented by the FFC was to be phased in over a 5 year period (National Treasury, 1998)

The Government amended the equitable share formula as proposed by the FFC; the first equitable shares formula to provinces (for the 1998/99 financial year) had 6 components:

1. An education share based on average size of school age population and number of learners enrolled
2. A health share based on proportion of the population without private health insurance, weighted in favour women, children and the elderly
3. A social security component, based on the estimated number of people entitled to social security grants
4. A basic share, based on total population with a 50% weighting in favour of rural communities
5. An economic output share based on the estimated distribution of gross domestic product (GDP)
6. An institutional grant divided equally among provinces (National Treasury, 1998).

The components and their respective weightings have changed over the years. Table 2.3 below shows a summary of the components of equitable shares to provinces from 1998 to 2006.

Table 3.3 Weighting of the Equitable Shares 1998 - 2006

Weights of Components by Financial Years								
Components	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
Education	39.0	40.0	41.0	41.0	41.0	41.0	41.0	51.0
Health	18.0	18.0	19.0	19.0	19.0	19.0	19.0	26.0
Social Welfare	16.0	17.0	17.0	17.0	18.0	18.0	18.0	-
Basic	15.0	9.0	7.0	7.0	7.0	7.0	7.0	14.0
Economic Activity	8.0	8.0	8.0	8.0	7.0	7.0	7.0	1.0
Institutional	4.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
Backlogs	-	3.0	3.0	3.0	3.0	3.0	3.0	-
Poverty	-	-	-	-	-	-	-	3.0
Total	100	100	100	100	100	100	100	100

Figures sources from the National Treasury's Budget reviews of 1998 to 2006

For the 1999/00 financial year, weightings for some of the components were revised; also, an additional component was included in the equitable share formula. The weightings for education and social welfare were increased to reflect actual expenditure trends. The institutional component was increased by one percentage point. The basic share component was split into basic share and a backlog component. The combined weighting was reduced to make allowance for increases in other components. The backlogs component was introduced to address criticisms of the previous formula (failing to account for significant backlogs faced by some provinces). The backlogs component was to finance capital spending on rural infrastructure and facilities in the health and education sectors (National Treasury, 1999). Only minor changes to the weightings of the formula were made until 2005. For the 2005/06 financial year, the education and health components were increased substantially (51% and 26% respectively). These revisions are based on expenditure patterns and indications of relative need for the purpose of allocating funds. This increase in the education and health components is largely because ‘social welfare’ component was removed and a huge reduction in ‘economic activity’ component; therefore strengthening redistribution. Provincial Executive Committees have discretion regarding the determination of departmental allocations for each function. The welfare and backlog components were removed from the formula, but a poverty component was introduced to retain some degree of redistribution within the formula. This follows the shift of the social grant function from the provincial to the national government. The social security grant is now to be administered as a conditional grant (National Treasury, 2005). This is the current formula in use. The new formula does not produce any radical changes in the proportions of the equitable shares received by each province. Table 3.4 below shows the proportions of the equitable shares that are targeted for each province based on the 2004/05 and 2005/06 equitable share formulae.

Table 3.4 Target shares based on Equitable Shares formula

Percentage	Target shares based on Equitable Shares Formula for 2004/05	Target shares based on Equitable Shares Formula for 2005/06
Eastern Cape	16.6	16.1
Free State	6.5	6.2
Gauteng	15.3	15.6
KwaZulu Natal	20.9	21.6
Limpopo	13.7	13.8
Mpumalanga	7.4	7.5
Northern Cape	2.3	2.2
North West	8.3	8.1
Western Cape	9.0	8.8
Total		100

3.6.4 The Budgeting Process and Health Budgets

Since 1997/98, the National Department of Finance (NDoF) has been allocating block grants (equitable shares) to provinces on the basis of differential need. Total provincial budgets comprise of conditional grants, equitable shares and own revenue (forms a very small portion). Conditional grants are tied to specific programmes and therefore outside negotiations for budgets for the various sectors at the level of the province. The remaining funds (equitable shares plus own revenue) are divided up amongst various sectors (health, transport, education etc) through negotiations with the representative departments. Thus, provincial departments of health have to negotiate their budget in competition with other departments. This means that provincial departments of health have the freedom to determine spending on health care, with little control from the national department of health. The budgeting and allocation process allows for some of the health budget to be protected at the national level in the form of conditional grants (Doherty and van den Heever, 1997).

Health programmes currently funded through conditional grants are listed in Table 3.1. Funds for PHC activities are not funded through conditional grants and so are at the mercy of budgetary negotiations at the provincial level (for the health sector budget). Since the NDoH has little influence over resource allocation with provincial departments of health, resulting funds available for PHC activities are further dependent on decisions made at the provincial Department of Health. Interestingly, the FFC prior to the formulation of conditional grants had proposed strict conditionality on grants for supporting PHC and the district health system (Financial and Fiscal Commission, 1996). This proposal was not successful. Instead, funds for

higher levels of hospitals are protected through conditional grants as can be seen in Table 3.1.

3.7 Summary of Fiscal Federalism and Health in South Africa

The South African fiscal federal system has three spheres of government: The national, provincial and local governments. Each sphere of government is charged with revenue raising and expenditure responsibilities. Provincial and local governments raise a proportion of their budgets, and are dependent (more so, the provinces) on transfers from national governments. These transfers are aimed at solving the vertical imbalances arising from the gap in revenue generating capacity and expenditure responsibilities at different levels. There are essentially two types of transfers from the national government to the sub-national governments (provincial and local government) governments. Equitable shares are transferred to both provinces and local governments to support them in providing goods and services for which they are responsible. Conditional grants are also transferred to sub-national governments (SNGs) to promote national priorities and to ensure certain standards of service provision among other reasons.

Budgets for various departments in the provinces are determined through budgetary negotiations. Within the health department, further negotiations are carried out to determine budgets for the different programmes within the health department (such as PHC). Essentially, the National Department of Health has little control/influence over budgetary negotiations, and resulting programme budgets within provincial health departments. PHC has been considered a priority area by the national department, but previous research has shown that there still remain huge differences in public PHC allocations across and within provinces. Funds available for public PHC activities are dependent on three rounds of budgetary activities. First the funds for PHC depend on how much money is allocated to provinces as equitable shares. Secondly, the funds are dependent on how much money is allocated to the provincial department of health; and thirdly on budgetary/resource allocation processes within the provincial departments of health.

Recommendations by the FFC to protect funds for PHC activities were not successful. It is therefore not very surprising that previous research has identified huge

differences in inter- and intra-provincial allocations to PHC. In the next part of this section, experiences of other countries in financing national priorities (with a focus on health and PHC) operating a fiscal federal system are reviewed. This is done with a view to inform discussions and analysis around achieving a more equitable allocation process for PHC funds in South Africa. Fiscal federal systems are generally dependent on the history and geography of countries, and so it may not be appropriate to make generalisations based on successes of different countries. However, the experiences of other fiscal federal systems may be an important guide in informing recommendations for the South African case.

3.8 Fiscal Federalism and the Financing of Health Care: International Experience

As previously mentioned, many countries have adopted a fiscal federal system (for varying reasons). We shall now review, in more detail, the experiences of select countries operating a fiscal federal system, in financing health and primary health care. The countries selected are Australia, Canada, India, Nigeria, and Brazil. Canada and Australia are selected because they are among the countries with the oldest fiscal federal systems. Nigeria, Brazil and India are selected because they are large (in size and population) developing countries, and therefore comparable in at least some respects to South Africa. Also, they are from different continents, thus providing information from varied contexts.

For each of these countries, we outline the nature of fiscal federalism in operation, the level of vertical imbalance, sub-national government autonomy, nature of intergovernmental transfers (in general and for health and PHC), the level of government responsible for health care expenditure and provision and mechanisms in place to ensure the equitable financing and provision of health and PHC services.

3.8.1 Australia

Australia has one of the oldest fiscal federal systems; lasting for over a century (Warren, 2006). Australia has three tiers of government, The Commonwealth, State and Local governments (Institute On Governance, 1998). The provision of health services is the joint responsibility of the Commonwealth and the States; and is shared

almost evenly (Warren, 2006). Australia has a centralised tax system, with the broadest tax bases such as personal income, corporate profits, and goods and services held by the Commonwealth (the national government). Subsequently, there is a large vertical fiscal imbalance, considering the expenditure responsibilities of the States¹¹. The states are responsible for provision of services such as health, education, policing and transport. States' own revenues account for only 40% of their expenditure outlay, and are therefore substantially dependent on fiscal transfers from the Commonwealth (*ibid*). Transfers to State governments are in two forms: Specific Purpose Payments (conditional grants) and General Purpose Grants. Over 50% of the transfers to States are in the form of specific purpose grants, while approximately 45% of the transfers are in the form of general purpose grants (Institute On Governance, 1998).

Responsibility for funding health services is shared almost evenly between the Commonwealth (52%) and the States (48%). Interestingly, the health system is the constitutional responsibility of the State, but the Commonwealth has significant overlapping responsibilities. The States and Territories have their own health authorities and are responsible for hospital services, mental health programmes, dental health services, home and community care, child, adolescent and family health services, women's health programmes, health promotion, rehabilitation systems, regulation, inspection, licensing, and monitoring of premises and personnel. The local governments are responsible for immunisation services, community based services for people with disabilities and a variety of environmental services that contribute to good health (Liu and Lee, 1998). Health services that fall under our definition of PHC are clearly provided by the States/Territories. Transfers for the health sector from the Commonwealth to the States are in the form of specific purpose grants, allowing the Commonwealth to influence expenditure on health at the State level. The Commonwealth uses the specific purpose grants (SPGs) to steer the policies of sub-national governments. These SPGs are also used as a vehicle for the extension of the Commonwealth's policies into areas for which the States are held accountable. It has been noted that in some cases, SPGs are little more than a mechanism for directing funds towards the Commonwealth's areas of priority rather than pursue matters of higher priorities to a particular State (Warren, 2006).

¹¹ There are 6 States and 2 Territories that have similar expenditure responsibilities as the States. Territories.

3.8.2 Canada

The Canadian Federal system is characterised by three tiers of government: the Federal, Provincial/Territorial¹² and the Municipal governments (Henceforth we use provincial government to include both provincial governments and territorial governments). The federal and provincial governments have concurrent jurisdiction on the same tax bases, and both tiers collect personal, corporate income taxes as well as taxes on goods and services (VAT). However, customs duties and some excise tax are used exclusively by the central government. Provinces therefore have access to considerable financial resources (Rangarajan and Srivastava, 2004).

Provincial responsibilities include education, health, municipal institutions, social welfare, police, natural resources and highways. Other responsibilities handled by provinces with the federal government are pensions, immigrations, agriculture and industry. Given that a majority of the resource intensive expenditure responsibilities rest with the province, there is a vertical imbalance between revenue capacity and provincial expenditure responsibilities. In recent years however, provincial expenditure has been almost fully covered by provincial own revenue. Different revenue generating capacities across provinces results in horizontal imbalances. These imbalances are corrected through fiscal transfers from the federal government to the provinces. There are three main avenues of transfers to provinces: Equalisation grants, Canadian Health and Social Services Transfer (CHST) and Territorial Formula Financing (TFF). Recently a small facility called the Health Reform Fund (HRF) has been introduced. These equalisation grants are aimed at equalising fiscal capacities – to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. Equalisation grants are mandated by the constitution (*ibid*).

The Federal and Provincial governments are jointly involved in the financing and provision of universal publicly insured and administered health care to Canadians. The federal government's primary role in the health services has developed through

¹² There are ten provinces and three territories

financial transfers to provincial governments. (Lazar et al., 2002). Transfers from the federal government to the provinces for health services are done through the CHST (also including the recently created Health Reform Fund). The CHST is the largest federal transfer to the provincial governments (comprising about 72 – 74 percent of total transfers from the federal government to the provincial governments). The CHST is meant to support health care, boost education and support social assistance. It is a general purpose grant and therefore allows the provincial governments flexibility to allocate funds among the social programmes according to their own priorities (Rangarajan and Srivastava, 2004). However, for province to receive this transfer from the federal government, conditions as set out in the Canada Health Act must be adhered to. These conditions among other include:

- Accessibility of medically necessary services without being impeded by financial or other barriers,
- Universal coverage
- Comprehensive provision of all medically necessary services
- Provincial governments to provide the federal government with information about how the conditions set out in the Canada Health Act are met as well as how the federal government's financial contribution to health services has been recognised (Li, 2006).

3.8.3 India

India's federal system comprises central government; 28 states, 7 union territories (two with legislatures), over 3,500 urban local bodies and 234,078 rural local bodies (Srivastava, 2003, Fjeldstad, 2001). The central government is responsible for functions required to maintain macroeconomic stability, international trade and relations. Responsibilities assigned to the states include public order, public health, agriculture, irrigation, land rights etc. The tax system in India is based on a principle of separation. Tax categories are exclusively assigned either to the centre or the states. Most broad based taxes have been assigned to the centre, including taxes on income and wealth from agricultural sources, corporation tax, taxes on production and customs duty. A long list of taxes is assigned to the states, however, only the tax on the sale and purchase of goods has been significant for the state revenues. The tax

assignment and expenditure assignment arrangements (between the central government and the states) in India have resulted in substantial vertical imbalances. In 2002-2003, the states on average raised about 38 percent of government revenues, but incurred about 58 percent of expenditures (Singh, 2004).

India has multiple channels for transfers from the central governments to the states to address vertical and horizontal imbalances. One channel of transfer is tax sharing: shares of personal income tax and union excise duty to states. The criteria for general tax sharing among the states are based on: population size, distance from the highest per-capita income state (equity), area and infrastructure deficiency, tax effort and fiscal discipline¹³. A second is a general purpose grant called the grants-in-aid. These are unconditional grants meant to fill the gap between assessed expenditures for each state and the sum of projected own revenue and shares in central taxes (Srivastava, 2003). Both are made under the recommendations of the Finance Commission. A third channel is the dispensation of funds (for development purposes) by the Planning Commission to states by way of grants and loans. In addition to these, various central ministries give specific purpose transfers with or without matching requirements (Rao, 2004).

Provision of primary health care is the responsibility of the states. The central government's role in the provision of health has been to fund centrally sponsored schemes, to develop policies and guidelines and to provide statutory grants or general transfers to the states. The central government makes all the decisions regarding new investments and programmes, such as the financing of new primary health care facilities. States account for approximately three-quarters of total health care expenditure, and this is generally dominated by recurrent expenditure. In practice, states plans for the health sector in any one year are updates and revisions of the plans of the previous year. It is therefore not surprising that the quality and quantity of health care provision varies widely across states, reflecting their varying levels of economic development, their health sector priorities and their current and past

¹³ More detailed discussion of tax sharing in India can be found in: Srivastava D.K. (2003) India; In: Intergovernmental Fiscal Transfers in Asia: Current Practice and Challenges for the Future. Edited by Paul Smoke and Yun-Hwan Kim. Asian Development Bank

investments in health. Similarly, there are wide variations in health outcomes, across states, socio-economic groups and across urban and rural areas.

States with the poorest health status tend to have the poorest health infrastructure in place. Even when additional funds are made available to address these gaps, the practice of the states have been to use the funds in a manner that does not address poor health care infrastructure and delivery. The launch of the centrally sponsored scheme for the universalization of elementary education has prompted Bajpai and Goyal to suggest a similar drive towards joint provision and financing of health by the central and state governments (Bajpai and Goyal, 2005). Although states are heavily reliant on central transfers for the financing of primary health care, they appear to have significant autonomy in deciding how these funds are used.

3.8.4 Nigeria

Nigeria operates a fiscal federal system with the assignment of government functions among three tiers of government: The federal, state and local governments. There are 36 states, a federal capital territory (FCT) and 774 local government areas (Federal Ministry of Health, 2007). Expenditure responsibilities for matters of national interest such as defence, foreign affairs, currency, aviation, price control, etc are assigned to the federal government. The states are responsible for primary education (post-primary is shared with the federal government), health and social welfare, culture, commerce and industry, etc. Local governments are responsible for land use, markets, primary health care, social welfare, sewage and refuse disposal etc (Ayodele, 2003). The provision of health care is the joint responsibility of the federal, state and local governments. The federal government is responsible for tertiary health services, the states are responsible for secondary health services (specialised services for patients referred from primary health care level) and the local governments are responsible for the provision of primary health care services, with the support of the state government (National Population Commission, 1999).

The federal government has the rights to revenue from import duties, excise duties, export duties, mining rents and royalties, petroleum profit tax, companies-income tax,

etc. The states collect capital gains tax, personal income tax (other than personal income tax for armed forces, police and residents of the FCT – collected by federal government), motor vehicle licenses, etc. The local governments collect revenue from taxes such as market and trading license and fees. The federal government has chosen the mix of tax revenue to ensure that it collects a significantly large share of tax revenue. More than 90 percent of total tax revenue is collected by the federal government. A small portion of the federally collected revenue is retained by the federal government as its independent revenues. The balance is paid into the federation account (Ayodele, 2003). Subsequently, local (Khemani, 2004) and state governments are heavily dependent on transfers from the federation account. Vertical revenue sharing of funds from the federation account to the federal, state and local levels has been a controversial issue even in the pre-independence era. The formula for vertical allocations has been modified several times in the past. Currently, the revenue sharing formula gives the federal government 52.68%, States 26.72% and local governments 20.6% (Ekpo, 2004). The horizontal allocations to the states are based on the following criteria outlined below:

Table 3.5 Revenue sharing to states and local governments in Nigeria

Criterion	Percentage
Equality	40
Population	30
Social development	10
Land mass and terrain	10
Internal revenue effort	10

Source: Udeh J. (2002) Petroleum Revenue Management ¹⁴

Nigeria operates a three-tier health system. The Federal Ministry of Health (FMOH), State Ministries of Health (SMOH) and Local Government Health Departments (LGHD) broadly have responsibilities for tertiary, secondary and primary health care respectively. While the 1998 health policy (revised in 1996 and 2004) lists the functions of the different government levels, there exists no legal framework that articulates the roles and responsibilities of the tiers of government. All tiers of government are involved to some extent in stewardship, financing and service provision (Federal Ministry of Health, 2007). This lack of clarity in the roles and

¹⁴ Full reference in the reference section

responsibilities of the different tiers of government has resulted in overlaps and neglect in service delivery, and is identified as the major weakness of the health system (Federal Ministry of Health, 2004).

Transfers to the federal, state and local governments are in the form of general purpose grants (not ear-marked or tied to any conditions). Each tier of government then decides how to allocate their budget to the various sectors under their jurisdiction. States and local governments are not required to provide budget and expenditure reports to the federal government, thus the federal government does not have any influence on the size of funds allocated to secondary and primary health care. Similarly, the state government cannot influence the allocations to PHC at the local government level (Federal Ministry of Health, 2007).

In effect, the local governments have full autonomy in deciding PHC budgets, without any guidelines from the federal or state government. Theoretically, this should result in better response to the needs of the community. However, as literature on decentralisation in the health system indicates, this may result in huge inequities in the public financing of PHC. Detailed analysis of the process for budgeting, resource allocation within the local government for PHC is presented in a later section of the paper.

3.8.5 Brazil

The Brazilian federation has a federal government, 27 state governments (including a federal district) and numerous local governments (municipalities). The history of federalism in Brazil has been characterised by cycles of decentralisation and centralisation of taxation and amount of financial resources shared by each level of government. The Constitution of 1988 produced a significant decentralisation of revenue and power to SNGs (Castanhar, 2003). Interestingly, Brazil's fiscal system is not decentralised based on political and economic policies formulated/implemented by the federal government. Intergovernmental relations cannot be established or modified by the federal political and economic authorities according to their own arbitrary wishes. Under the national Constitution, the states and municipalities enjoy broad autonomy with regards to levying their taxes, deciding expenditure, hiring public employees and determining salaries (Afonso, 2004).

Tax assignment is defined by the federal Constitution, and proceeds of most taxes are transferred to SNGs according to non-discretionary constitutional rules. The federal government is responsible for import, export and income taxes, tax on rural properties, tax on financial operations, a VAT on industrialised products and a tax on general fortunes. The states are responsible for VAT on goods and services, tax on property transfers due to inheritance, legacy and donation and tax on vehicles. The municipalities are responsible for urban property tax, tax on real estate transactions and the tax on services (Guardia and Sonder, 2004). In 2002, own revenue generated by municipalities was approximately 35% of total revenue (65% was due to transfers). On average, states' own revenue covered three-quarters of their total expenditure. These figures vary significantly across units and the dependence of each unit on transfers from the federal government is directly related with its level of development (Afonso, 2004).

There are, in general, five types of intergovernmental transfers in Brazil. There are:

1. Tax Devolution
2. Tax Compensation
3. Intra-State Redistributive Transfers (from states to municipalities)
4. Inter-State Redistributive Transfers
5. Voluntary Transfers

Tax devolution and tax compensation have no horizontal redistributive effects. These transfers are to rebalance centrally collected taxes on behalf of lower levels. Therefore they are made strictly according to each SNG's tax base and reflect spatial allocation of tax sources across the country. Intra-state redistributions are resources reallocated among municipalities within a state, based on criteria other than tax collection capacity. Inter-state redistributions are resources from richer states to poorer states (with the federal government as an intermediary). A proportion of the revenues from richer states' tax bases are sent to the federal government, and these are transferred to poorer states (with smaller tax bases) – thus reducing regional disparities in spending capacity. The central government also has the ability to do voluntary transfers to states, which fluctuate according to the yearly budget (Guardia and Sonder, 2004).

Brazil's health care system consists of a complex network of providers and purchasers of services, which are interrelated, complementary and competitive. The sections of this system are the public sector, which comprises publicly financed and provided services; the privately contracted sector, financed by the public sector through reimbursement systems; and free choice (private sector) financed by personal or corporate medical insurance schemes. The Unified Health System (Sistema Unico de Saude –SUS), created in 1990 integrates all public health care services and is supplemented by private facilities (Buss and Gadelha, 1996). The three levels of government are mandated by law to participate in the SUS. The federal government is responsible for formulating national health policies and guidelines, participates in financing the SUS, coordinates, monitors and evaluates the health system's operations, amongst other functions. It is also responsible for regulating health service delivery by the private health sector (Pan American Health Organisation, 2005).

The municipality is defined as the sole federal entity assigned the constitutional mission of providing health care services to the population. The federal and state governments are responsible for providing technical and financial cooperation necessary to accomplish this task. Decentralisation of health services has been boosted and regulated through specific Basic Operating Norms. These are specific and negotiated guidelines, emanating from the Ministry of Health and approved by the national representatives of municipal and state health offices, which contemplate the budget share between the government levels, the assignments for the management and organisation of the health care model. These Basic Operational Norms were introduced in 1991 and have been modified in 1993 and 1996. These guidelines were introduced to assess the managerial capacity of municipalities to effectively deliver health services, as a basis for assignment of health care provision. These requirements are that, municipalities are committed to:

- Amplify the management capacity to plan, evaluate and control health services
- Establish a Health Council
- Create a Health Fund
- Elaborate a Management Report for the auditor that should contain the balance sheets of the health fund, minutes of the Health Municipal Council's meetings, and data concerning appropriate fiscal expenditures allocated to health

- Provide information on local organisational resources for auditing expenditures on contracted out-patient and hospitalisation service

Municipalities that have the capacity to meet these requirements achieve autonomy in health care delivery. These municipalities obtain

- The entitlement to authorise, control and evaluate out-patient and hospital services, private or philanthropic
- The management of all the quotas of AIH (permission to hospitalise)
- The management of the out-patient network
- The incorporation of epidemiological and health inspection actions to service networks, etc (Center for Public Policies Studies, 2004).

Based on these criteria, municipalities are able to apply for one of only two levels of management autonomy (Lobato and Burlandy, 2000). Municipalities with the higher grade (referred to as “full management of the municipal system”) possess full responsibility for municipal health services. Second grade municipalities (referred to as “full management of basic care”) have restricted responsibilities - responsibility for all primary health care. Municipalities not able to do any of these remain SUS services providers under the control of the state government (Collins et al., 2000, Lobato and Burlandy, 2000).

There are three sources of income for health care expenditure. The first is from municipality own revenue. Municipalities are expected to allocate approximately 10% of the municipal budget to health. This is not obligatory, but recommended, and so is not always realised. The second source is federal transfers. These are made through SUS for payments to providers for care provided, and are done so on a monthly basis. The recipients of the transfers depend on the “grade” of municipalities. In municipalities not registered under the BOR (Basic Operating Rule) of 1996, these transfers go directly to the provider institutions of outpatient and hospital care. For municipalities registered as “full management of basic care”, the funds are transferred directly only to the private provider institutions for hospital care. For municipalities classified as “full management of the municipal system”, their transfers are made to the Municipal Health Fund, and the municipalities have significant autonomy on how the money is spent. For these municipalities the sum of their transfer is calculated by

the federal level by up-dating previous sums formerly transferred under the SUS payments. The third source is through monthly transfers from the National Health Funds to the Municipal Health Funds. This transfer has a fixed and a variable component. The fixed component is based on a fixed per-capita value to cover basic care. The variable component is made up of five sub-programmes which establish their own specific areas of activity and criteria for allocation of funds. They are designed as an incentive for municipal action in the specific areas set out in the programmes. Both fixed and variable components come with conditions, and are deposited in special accounts to maintain transparency and ensure that the funds are not used for other purposes (Collins et al., 2000).

Although the SUS emphasises universalism and equity, Collins et al (2000) observe that there are still concerns regarding the impact of the decentralisation process of the health system on equity. First, the devolution of responsibility for health service provision could exacerbate inequities in the health system. Local revenue collection for financing municipal health services favours the well-off areas. Secondly, transfers through the SUS for hospital and out-patient care are made directly to the Municipal Health Fund for the first grade municipalities (referred to as “full management of the municipal system”). These are calculated based on previous SUS transfers. This allocation tends to be based on where hospital and out-patient institutions are located, which historically tend to be the richer areas. This type of transfer potentially reinforces the unequal allocation of resources in the country. On the other hand, the fixed element of PAB has meant that poorer municipalities have experienced an increase in funds for financing health care. The variable element of PAB is not specifically designed for correcting inequities, and the sub-programmes they fund are limited in the amount of funds and impact they have. Nevertheless, there are significant inequities in the services offered by the SUS. Access to health care in Brazil varies with income, irrespective of region; while there are regional disparities in the availability of health services and utilisation thereof (Buss and Gadelha, 1996).

3.9 Summary

The provision of health and PHC services in South Africa rests with the provincial governments. Unconditional grants to the provinces comprise over 60% of total transfers to provinces (National Treasury, 2005). So, although provincial own-revenue is less than 5% of their expenditure budget, they generally have substantial autonomy in deciding budgets for health programmes outside the few that are funded through conditional grants. Transfers to provinces in the form of conditional grants form a relatively high proportion of total provincial revenue. However, PHC is not one of those programmes financed through conditional grants, and so this disadvantages the equitable financing of PHC. Previous research has shown that decision making and criteria for allocations to PHC are largely done on a historical basis (Thomas et al., 2005). It is not very surprising that allocations to PHC are much higher in richer provinces/districts.

In Australia, the state and the federal government share the responsibility of financing health services. Although the state raises approximately 40% of own revenue, they are still dependent on federal transfers for expenditure on health. Transfers to the state for health are in the form of specific purpose grants, giving the federal government (commonwealth in Australia) significant control over the distribution of health care resources across all of Australia. In the Canadian system, the provinces' contributions to health care expenditure are even higher. Also, transfers from the federal government are in the form of unconditional grants, giving the provinces autonomy in prioritising health care expenditure as they see fit. With respect to autonomy, this is similar to the South African scenario. However, the set of horizontal equalisation transfers and constitutional mandates, ensure that each province provides health services that are reasonably comparable at reasonable levels of taxation. The Indian case is similar to that of South Africa. Primary health care is the responsibility of the state, and there is little intervention from the federal government on the size of the budget for PHC. With the historical approach to budgeting, health service quality and quantity reflect the level of socioeconomic development of the states, as in South Africa. Similarly, in Nigeria, local government authorities are responsible for financing and providing PHC without any intervention from the state or federal government. Of all the countries reviewed, this is the most extreme case as the local governments have complete autonomy in deciding the size of PHC budgets and,

“how” and “what” to spend their PHC budget on. Brazil differs from all other countries reviewed. Health and PHC services are the responsibility of the municipalities. The level of autonomy in providing and managing these services depends on the managerial capacity of the municipalities. Although municipalities are encouraged to commit a percentage of their own revenue to health, this is not generally adhered to. As in India and South Africa, the quality and quantity of health services are better in richer states and poorer in poorer states. Differences in levels of service delivery and expenditure on health and PHC have been attributed to the nature of transfers to the municipalities and states. The implications for the level of autonomy enjoyed by local governments in Nigeria on the equitable financing of PHC are explored in later sections of this report.

Section 4: Conceptual Framework

In this section a conceptual framework that will guide our research is developed. The conceptual framework is based on the literature review in the previous section. Figure 4.1 below provides a diagrammatic representation of the inter-relationship between the concepts, variables and factors that influence the equitable allocation of financial resources for PHC activities. The conceptual framework developed below applies to the financing and provision of public services by SNGs for which their outcomes are of national concern. Although the framework is used as a guiding framework for analysis of the South African and Nigerian contexts, it should be applicable to other contexts operating under a fiscal federal system

4.1 Theoretical Framework

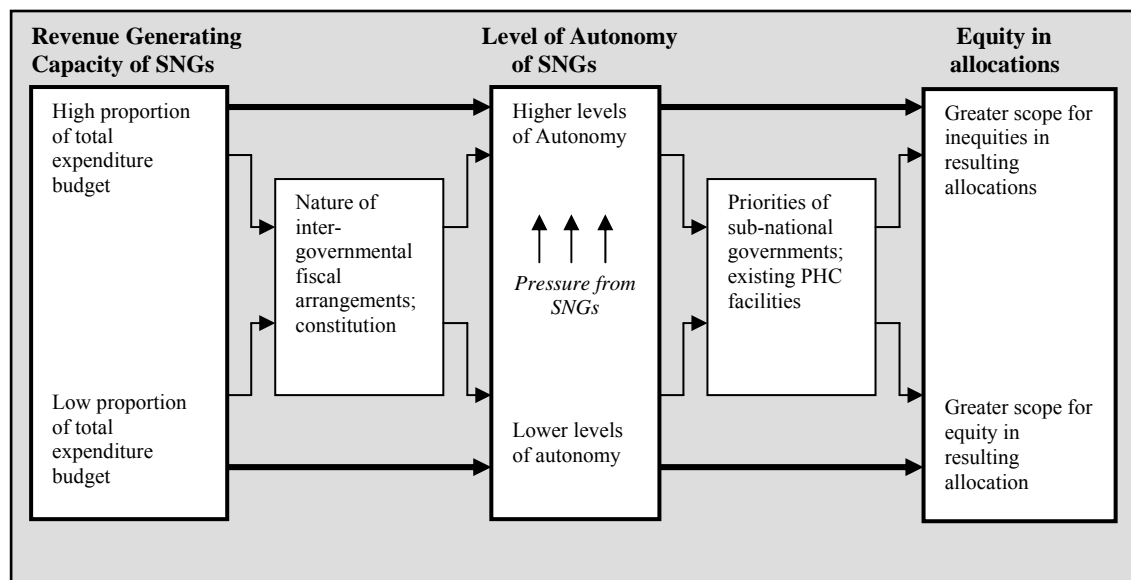
Fiscal federalism involves the devolution of revenue raising and expenditure responsibilities to sub-national levels of government. With the devolution of these responsibilities, there is a major concern around the level of autonomy enjoyed by sub-national governments in carrying out the functions they are assigned. How much decision making authority do the sub-national governments have regarding revenue generation (e.g. setting the rates for taxes assigned to them) and spending (e.g. deciding budgets for sectors/programmes within their constitutionally defined jurisdiction)? This concern is more pronounced around the financing and provision of goods and services, for which their outcomes and geographic distribution are of national interest and the responsibility of their provision and financing lies with the sub-national governments. Often, sub-national governments are partly or fully responsible for the financing and provision of these good/services (henceforth referred to as ‘national priorities’ in the rest of this section), such as health care, education, and transport.

Equity in the financing of these ‘national priorities’ can be influenced by the extent of horizontal and vertical imbalances, the proportion of sub-national expenditure budget generated by own revenue and the nature of fiscal policies and intergovernmental transfers that define intergovernmental relations. These factors, by virtue of their levels or nature in turn define the level of autonomy enjoyed by sub-national

governments. We start our description of the conceptual framework with levels of autonomy and equity in resource distribution. Where sub-national governments generate a high proportion of their expenditure budget from own revenue, they are less dependent on transfers from the federal government, and therefore have more autonomy in deciding how their budget is spent. In this case, even where conditions are tied to a significant proportion of transfers from the federal government, the SNGs still have authority in deciding how to spend a large portion of their total expenditure budgets. In this scenario, the federal government can only significantly influence the financing of ‘national priorities’ if it has been given constitutional authority to set guidelines for SNGs in financing national priorities.

In a second scenario where SNGs generate a small portion of their expenditure budget, they must depend on transfers from the federal government to carry out their functions. The level of autonomy enjoyed by SNGs in this scenario depends on the nature of the transfers from the centre. The level of autonomy enjoyed by SNGs will depend in part on the proportion of the transfers that are unconditional (with the effect of only increasing the SNGs revenue).

Figure 4.1 Conceptual Framework



The higher this proportion is, the more autonomy the SNGs are likely to enjoy. Autonomy enjoyed by SNGs will also depend on whether the constitution gives the federal government authority to set guidelines for the SNGs in the financing of

‘national priorities’, and the extent to which the federal government decides to exercise this authority.

The federal government could decide to relieve SNGs of authority in financing a national priority. In this case, there are two possibilities for the provision of the good/service. First, the federal government could assume the provision of the service in question. The second possibility is for the SNGs to act as agents of the federal government and provide the services under conditions defined by the federal government. In this second scenario, the SNGs do not enjoy any autonomy in the financing of the good/service.

The effect of levels of autonomy of SNGs on equity can be illustrated. If SNGs enjoy a greater level of autonomy¹⁵, then there is a greater possibility for inequalities in financing of any particular national priority. This clearly stems from the tenets of fiscal federalism – different local preferences will most likely yield different levels of financing and provision. This is based on the assumption that the SNGs make their decisions based on revealed preferences of the community. Different local decision making processes for budgeting and resource allocation across SNGs could also result in different levels of financing for any given national priority. Thirdly, differential capacity to generate and utilise own-revenue will most likely yield different levels of financing and provision of services. All these are likely to have adverse effects on the equitable distribution of funds across SNGs, as priorities, capacities, processes and perceptions of need may vary at the local levels. Therefore, the more autonomy SNGs enjoy, the more likely there are to be inequities in the distribution of finances for national priorities. Nevertheless, if the SNGs’ priorities are in line with national priorities (with respect to equity), equity can still be promoted with minimal federal intervention. Where SNGs have limited autonomy for the financing of a national priority, the federal government can influence the levels and quality of services throughout the country. If the equitable distribution of the outcomes of the good/service is a priority for the federal government, it can exercise its authority to achieve this. Since decision making at the SNG level plays a limited role in the

¹⁵ SNGs generate a high proportion of expenditure budget, with minimal intervention from the federal government or SNGs generate small proportion of expenditure budgets with largely unconditional transfers and minimal intervention from federal government.

outcome of the distribution of finances, there is greater scope for achieving a more equitable distribution of finances for the provision of the good/service.

Based on our framework, it may be necessary for the federal government to intervene in the financing of national priorities, to achieve a more equitable distribution of the services. Whether the SNGs generate a higher or lower proportion of their total expenditure budget, the nature of intergovernmental fiscal arrangements in place could significantly determine the extent of equity in the distribution of finances for the provision of national priorities. The constitution guiding intergovernmental relations could however limit the extent to which the federal government can intervene in fiscal matters regarding the financing of specific services. Whatever the case is, SNGs in a fiscal federal context generally prefer to have greater autonomy in planning, financing and providing good/services under their jurisdiction. Subsequently, any intervention from the centre is likely to meet with some resistance from SNGs.

Finally, budgetary allocations to geographic areas are to a significant extent dependent on the available facilities and human resource in the areas. This is especially the case in the context of the health sector. In areas (districts for example) with more PHC facilities and personnel, the recurrent expenditure is generally higher. So, areas with more facilities and personnel are likely to continue receiving higher budgetary allocations. One way of reducing their budgetary allocations to achieve a more equitable expenditure outlay could be to close some of the facilities. However, this will depend on whether such areas are over-resourced.

What is clear is that the more autonomy SNGs enjoy, the higher the possibilities for inequitable geographic distribution of PHC funds. It may be necessary for the federal government to intervene in fiscal arrangements to achieve a more equitable distribution of PHC funds. However, any form of intervention from the national government in fiscal arrangements, to promote equity in PHC financing will reduce SNG autonomy, and this will most likely meet with resistance from the SNGs.

The conceptual framework developed in this section provides a broad framework for appreciating the inter-relationship between intergovernmental fiscal arrangements,

autonomy and equity. This framework will serve as a guide in analysis of collected data.

Section 5 Results of Quantitative Data Analysis

In this section, the results of the PCA are presented and explained. Also, data for per capita primary health care (PHC) expenditure and results for the assessment of equity in PHC allocations between health districts and provinces are presented and discussed.

5.1 Results of the Principal Components Analysis

Principal components analysis was applied to the variables listed in the methods section for the two data sets (GHS 2005 and Census 2001 data sets). For the Census data, the sample size of the data was 21,094. Each sample observation represents a sub-place, which is a combination of a few coterminous enumerator areas, and is a geographic area that is small enough for the population to be homogeneous, yet large enough to allow for statistical analysis. The average number of observations per sub-place was 2,121 observations. These sub-places constitute health districts. A total of 107,987 individuals were included in the GHS 2005 sample. For the two data sets, the unit for analysis was the district level.

The results of the PCA on all the variables for the 2001 Census data are presented below. Table 5.1 below shows the first part of the result. The first column lists the various components derivable based on the variation of all 9 variables, ordered from the component that accounts for the most variance from the 9 variables, to the component that accounts for the least variance. The second column shows the eigenvalues¹⁶ of each component. The third column shows the difference between the eigenvalue of each component and the eigenvalue of the next component. A sharp drop in eigenvalues suggests that subsequent eigenvalues are just sampling noise (StataCorp, 1999). There is a sharp drop from the eigenvalue of the first component to the eigenvalue of the second component. This value is equal to 4.661, whereas the differences in eigenvalues for the rest of the components are all below 0.26. This therefore suggests that only one identifiable underlying process influences the values of these variables, and this is captured by the first component. Following the criteria

¹⁶ This is a standardized measure of the proportion of total variation explained by each component.

for selecting the variables, this underlying process is deprivation. Further confirmation of this is presented in Table 5.2.

Table 5.1 Components of the Principal Components Analysis on 2001 Census

Component	Eigenvalue*	Difference	proportion	Cumulative
1	5.511	4.661	0.612	0.612
2	0.851	0.250	0.095	0.707
3	0.601	0.100	0.067	0.774
4	0.501	0.063	0.056	0.829
5	0.438	0.079	0.049	0.878
6	0.359	0.042	0.040	0.918
7	0.317	0.031	0.035	0.953
8	0.286	0.150	0.032	0.985
9	0.136	-	0.015	1.000

*All eigenvalues have been rounded to three decimal places

The fourth column shows the proportion of total variance of the variables accounted for by each component. As can be seen, the first component accounts for just over 61% of total variance of all variables. The last column shows the cumulative of variance accounted for by the components. The first component is retained for construction of the deprivation index.

Table 5.2 below displays the second part of the results. The first column lists the variables, while the second column displays the scoring coefficients associated with each variable that is used to calculate the deprivation index. Scoring coefficients are the weights attached to each variable in the calculation of the deprivation index. There are denoted as f_I in equation 2.1 in section 2. The results show that all variables included in the PCA have similar weights.

Table 5.2 Scoring Coefficients for the Deprivation Index on 2001 Census

Variable	Component 1
Proportion of the population that are children below the age of 5	0.2973
Proportion of the population that are Africans (Black)	0.3523
Proportion of the working age population that are unemployed	0.2738
Proportion of the population that live in a shack or traditional dwelling	0.3340
Proportion of the population with no close access to safe water	0.3807
Proportion of the population that use a pit latrine, bucket latrine or have no toilet facility	0.3808
Proportion of the population that are from households headed by a female	0.3251
Proportion of the population that do not use either electricity or solar energy as their main energy source	0.3285
Proportion of the population that are from households headed by an uneducated individual	0.3122

The calculated deprivation index ranged from -3.129 to 1.824. Lower deprivation index scores represent lower levels of deprivation and vice versa.

Tables 5.3 and 5.4 below show the results of the PCA on the same variables from the 2005 GHS. The results are similar, however in this case, the component explains just over 66% of the total variation of the 9 variables. For the GHS 2005 data, the deprivation index ranged from -4.3397 to 4.6038. The deprivation indices for all districts using the 2001 census data and the 2005 GHS are in appendix C.

Table 5.3 Components of the Principal Components Analysis on 2005 GHS

Component	Eigenvalue*	Difference	proportion	Cumulative
1	5.966	5.059	0.663	0.663
2	0.907	0.226	0.101	0.765
3	0.681	0.216	0.076	0.839
4	0.465	0.079	0.052	0.891
5	0.386	0.149	0.043	0.934
6	0.237	0.055	0.026	0.960
7	0.182	0.070	0.020	0.980
8	0.112	0.048	0.012	0.993
9	0.064	-	0.007	1.000

*All eigenvalues have been rounded to three decimal places

Table 5.4 Scoring Coefficients for the Deprivation Index on 2005 GHS

Variable	Component 1
Proportion of the population that are children below the age of 5	0.3011
Proportion of the population that are Africans (Black)	0.3148
Proportion of the working age population that are unemployed	0.3672
Proportion of the population that live in a shack or traditional dwelling	0.2490
Proportion of the population with no close access to safe water	0.3753
Proportion of the population that use a pit latrine, bucket latrine or have no toilet facility	0.2758
Proportion of the population that are from households headed by a female	0.3780
Proportion of the population that do not use either electricity or solar energy as their main energy source	0.3791
Proportion of the population that are from households headed by an uneducated individual	0.3315

5.2 Descriptive Statistics for the Deprivation Index

Table 5.5 below provides some of the results of the deprivation index. The table lists the 5 most deprived districts and the 5 least deprived districts from the two data sets.

Table 5.5 Most Deprived and Least Deprived Districts in South Africa

Census 2001			GHS 2005		
Province	District	Dep_index	Province	District	Dep_Index
E Cape	O. R. Tambo	1.8240	E Cape	O. R. Tambo	4.6037
E Cape	Alfred Nzo	1.6311	E Cape	Alfred Nzo	4.4341
KZNatal	Umkhanyakude	1.5892	KZNatal	Umkhanyakude	4.2539
KZNatal	Umzinyathi	1.5876	KZNatal	Umzinyathi	3.7304
KZNatal	Zululand	1.2120	Limpopo	Bohlabela	3.5096
W Cape	West Coast	-3.2192	W Cape	West Coast	-4.3397
W Cape	Overberg	-3.0637	W Cape	Overberg	-4.0157
W Cape	Boland	-3.0124	W Cape	Boland	-3.7806
W Cape	Eden	-2.7900	N Cape	Namakwa	-3.3069
W Cape	Central Karoo	-2.775	W Cape	Central karoo	-2.9760

From the table above, there has been little change in the order of the most and least deprived districts from 2001 to 2005. The least deprived districts are from the Western Cape (except Namakwa), while the most deprived districts are mainly from the Eastern Cape and KwaZulu Natal provinces.

5.3 Assessing Equity in Primary Health Care Allocations Across Districts

To investigate the extent of equity in PHC allocations, per capita non-hospital PHC expenditure is compared with deprivation indices for all districts. Data on per capita non-hospital PHC expenditure (henceforth referred to as per capita PHC expenditure) for only two financial years were available. These are for the 2001/02 financial year and the more recent 2005/06 financial year. Data for these years are available in Appendix C. Correlation analysis and regression analysis are used to compare per capita PHC expenditure and deprivation indices. The deprivation indices from the 2001 census data and the 2005 GHS are compared with PHC expenditure per capita for 2001/02 and 2005/06 respectively.

Table 5.6 Results for Correlation Analysis at the District Level

	Per capita PHC expenditure 2001/02	Per capita PHC expenditure 2005/06
Deprivation Index [census 2001]	-0.4963	
Deprivation Index [GHS 2005]		-0.1126

As is displayed in the above table, there is an inverse relationship between deprivation and per capita PHC expenditure across districts (values are negative) for the two years. Essentially, this suggests that less deprived districts are spending more on PHC than more deprived districts. The absolute value of the correlation coefficient for the census 2001 deprivation index and the 2001/02 per capita PHC expenditure is higher, than the coefficient for 2005/06 per capita expenditure and the deprivation index for the 2005 GHS. This suggests a change in expenditure pattern, favouring the more deprived; although in general, more deprived districts are still spending less on PHC. A positive correlation coefficient would suggest a positive relationship between deprivation and expenditure (districts that are more deprived are spending more on PHC per capita than districts that are less deprived). This is what should obtain if PHC resource allocation was equitable - those in greater need for health care receiving disproportionately more resources. Regression analysis is also used to compare deprivation across districts and per capita PHC expenditure for the same years. The results are presented below.

Table 5.7 Result for Regression Analysis

Model 1: Dependent Variable: 2001/02 per capita PHC expenditure	
	Coefficient (<i>t-value</i>)
Deprivation Index 2001 Census***	-29.116 (-4.10)
Constant***	140.194 (12.22)
Adjusted R ² = 0.2463; n = 53	
Model 2: Dependent Variable: 2005/06 per capita PHC expenditure	
Deprivation Index 2005 GHS	-2.905 (-0.81)
Constant***	229.038 (26.37)
Adjusted R ² = -0.0067; n = 53	
* = significant at 10% level	
** = significant at 5% level	
*** = significant at 1% level	

Note: Complete results are displayed in Appendix D

Results from the regression analysis are in line with the results from the correlation analysis. The first part of the result is the regression model with the deprivation index from the 2001 census data (as independent variable) and per capita PHC expenditure for 2001/02 (as dependent variable). The model is specified in this way, based on the assumption that health needs should determine the amount of resources allocated to

districts. For this first model, the coefficient for the deprivation index is negative and statistically significant at 1% level. This means that there is an inverse relationship between the two variables. Across all districts, per capita PHC expenditure was lower in districts with higher levels of deprivation. The adjusted R^2 value of 0.2463 indicates a weak linear association between the two variables.

The second part of the result is for the model using the 2005/06 per capita PHC expenditure and deprivation index from the 2005 GHS data. The sign of the coefficient of deprivation index is also negative, but in this case the coefficient is not significant. Consequently, no conclusion can be drawn about the direction of the relationship between the two variables. The adjusted R^2 (-0.0067) is much lower than the R^2 for the previous model, suggesting an even weaker linear association between deprivation index and per capita PHC expenditure in 2005/06. However, we can still draw some inferences from the above results concerning how equitable PHC allocations are, and how this has changed over time. For the model using 2001/02 per capita PHC expenditure the relationship between deprivation and PHC expenditure was an inverse relationship. For the model using 2005/06 PHC expenditure, the coefficient for the deprivation index is negative, though not statistically significant. This suggests that the more recent expenditure outlay is more equitably distributed than what existed four years previously.

The graphs (Figures 5.1 and 5.2) below confirm that there has been a shift towards a more equitable distribution PHC expenditure between districts. As one can observe, the fitted values (linear prediction of PHC expenditure based on values of the deprivation indices) is flatter in the second graph.

Fig 5.1 Deprivation index from Census 2001 and 2001/02 PHC per capita expenditure

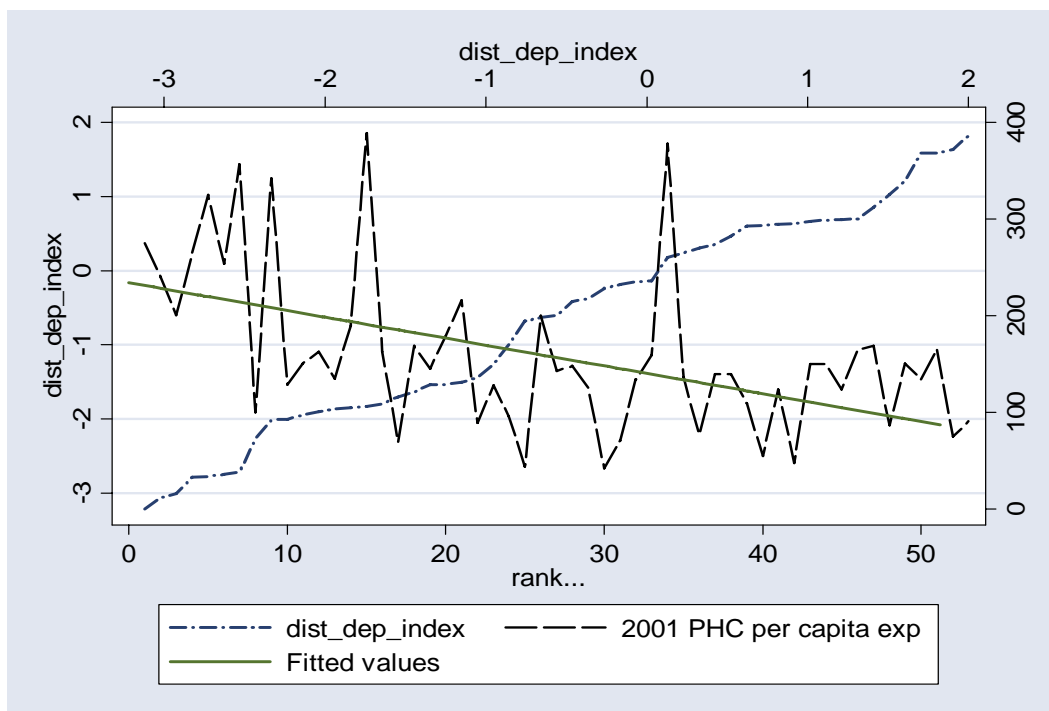
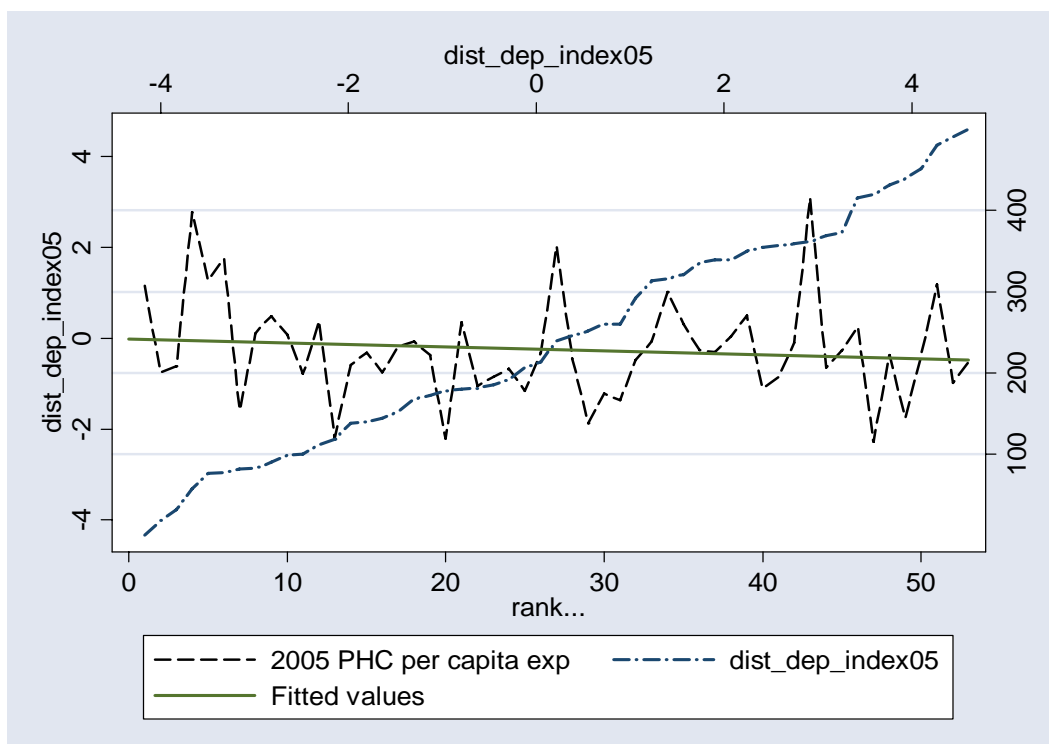


Fig 5.2 Deprivation index from GHS 2005 and 2005/06 PHC per capita expenditure



In order to explain the change in the coefficient for the deprivation index, further investigation is carried out on the data. Closer examination of the data on per capita PHC expenditure for the two years shows that there has been a substantial difference in the distribution of funds for PHC across districts. Districts that had relatively low levels of expenditure in 2001/02 had a significantly higher level of expenditure in 2005/06. Table 5.9 shows the changes in per capita PHC expenditure between 2001/02 and 2005/06 financial years for selected districts.

Column three in the table lists the ranking of the districts based on the 2001 census deprivation index. The ranking starts from 1 (the least deprived district) to 53, which is the most deprived. The other columns are self-explanatory. From the table it is clear that the 10 least funded districts in 2001/02 are among the most deprived districts, while the 10 most funded districts are relatively less deprived (with one or two exceptions). This is in line with the findings of the correlation and regression analysis. In 2005/06, per capita PHC expenditure increased significantly for the least funded districts. A look at the table shows that these districts experienced more than a 135% increase in per capita PHC expenditure with the exception of Greater Sekhukhune DM. On the other hand, 6 out of the 10 most well funded districts experienced a reduction in per capita PHC expenditure. Only one of them (Namakwa DM) experienced an increase in per capita expenditure of more than 50%. It is important to note that Northern Cape is very sparsely populated so that although some of its districts may not be very deprived, they require more money per person to provide accessible PHC services. This clearly shows a move towards a more equitable distribution of PHC expenditure outlays.

Table 5.8: Changes in per-capita PHC expenditure 2001/02 to 2005/06, for selected districts

Province	District	Ranking by dep. index	2001/02 per capita PHC exp.	2005/06 per capita PHC exp.	Absolute change	Change (%)
<i>10 least funded districts in 2001/02</i>						
MP	Gert Sibande DM	30	42	138	96	227.5
MP	Nkangala DM	25	44	175	131	298.7
EC	Ukhahlamba DM	46	48	207	159	330.9
LP	Bohlabela DM	39	55	145	90	162.9
EC	Cacadu DM	18	69	195	126	182.3
FS	T. Mofutsanyana	33	71	228	157	221.3
EC	Alfred Nzo DM	52	75	188	113	150.9
LP	Capricorn DM	35	77	181	104	135.4
LP	Gr. Sekhukhune DM	48	87	115	28	32.4
FS	Fezile Dabi DM	22	89	210	121	136.0
<i>10 best funded districts in 2001/02</i>						
NW	Southern DM	20	216	262	46	21.2
WC	Overberg DM	2	240	201	-39	-16.1
NC	Namakwa DM	5	254	398	144	56.6
WC	Eden DM	4	265	247	-18	-6.8
WC	West Coast DM	1	275	307	32	11.7
WC	Central Karoo DM	7	325	314	-11	-3.4
GT	Johannesburg MM	9	342	249	-93	-27.0
WC	Cape Town MM	6	357	341	-16	-4.4
NW	Bophirima DM	34	378	416	38	10.0
GT	Ekurhuleni MM	12	389	270	-119	-30.5

Results of correlation analysis between the 2001/02 per capita PHC expenditure and the absolute changes in expenditure between 2001/02 and 2005/06, shows that the correlation coefficient is -0.67. Similar analysis using the 2001/02 per capita PHC expenditure and percentage change gives a correlation coefficient of -0.71. Clearly, changes in per capita PHC expenditure between these years disproportionately favoured districts that were previously less well funded.

5.4 Discussion and Further Analysis

Analysis of available quantitative data shows that in 2001/02, PHC expenditure favoured districts that were potentially in less need for primary health care. By the 2005/06 financial year, substantial changes in expenditure outlays had occurred such

that the distribution of PHC expenditure became more equitable. This is confirmed by regression and correlation analysis. The coefficient of the 2005 GHS deprivation index in the second regression model and the correlation coefficient (between 2005/06 expenditure and 2005 GHS deprivation index) suggests that the current expenditure outlays may still favour districts with relatively less need. If the expenditure outlays were equitable, the coefficient for the deprivation index should be positive and statistically significant. This would mean that districts that are in greater need are spending more on PHC than districts with less need. The challenge with assessing equity in this way is that there is no objective method for identifying a benchmark value for the coefficient of deprivation in such regression analysis that defines the point from which the expenditure outlays are equitable. In other words, it is difficult to say “*how much more expenditure should district A with X level of need aim for, over and above the expenditure of district B with Y level of need*”, for outlays to be equitable. Nevertheless, achieving a positive (and significant) value for the coefficient of a measure of need and expenditure (using regression analysis in this case) should be a starting point.

Introduction of a fiscal federal system in South Africa in 1996 was associated with a ‘slow-down’ in the movement towards a more equitable distribution of health care expenditure. However, the results above are evidence of commitment to reduce existing inequities in PHC expenditure over the past five years. A major concern for the health sector is that the introduction of fiscal federalism can lead to inequities in resource allocation across geographic areas. These inequities arise from factors such as differential revenue generating and resource utilising capacity at lower levels of government and autonomy in decision making for expenditure. In South Africa, provinces only generate approximately 5% of their overall expenditure budget. The rest of their expenditure budgets are funded through centrally collected revenue in the form of conditional grants and equitable shares. Equitable shares form the major part of the revenue to provinces. Equitable shares are allocated to provinces based on a formula that is supposed to take into consideration the relative needs (for health, education etc) of each province. Essentially, the effect of differential revenue generating capacity on equity in health care expenditure is minimised. Differences in expenditure across provinces are therefore more likely to be as a result of differential resource utilisation capacity and/or high levels of autonomy enjoyed by provincial

government in making budgetary allocations across sectors. Quantitative analysis provides little information on whether the equitable allocation of resources to PHC is impacted more by any one of these factors or a combination of them. However it does shed some light on current trends in PHC expenditure outlays, that form a platform from which further analysis is carried out. Analysis of quantitative data shows a shift towards a more equitable distribution of PHC expenditure between districts from 2001/02 to 2005/06 financial years. This is an indication that under South Africa's fiscal federal system, progress towards a more equitable distribution of PHC resources is possible. Data on per-capita PHC expenditure and deprivation provide sufficient information to identify provinces and districts for which further investigation can yield answers to what the constraints and facilitating factors for achieving equity in PHC outlays are. In the next section, results of analysis of qualitative data from interviews with government officials from these provinces and districts (including officials from National Treasury, National Department of Health and Provincial Treasury) in South Africa are presented and analysed.

Section 6: Analysis of Qualitative Data

In this section, data collected from interviews with government officials in South Africa and Nigeria are analysed. As stated in the methods section, this will be done according to seven broad themes. For each theme, the central focus is to assess the impact of processes, actors and structures on the equitable distribution of PHC finances. The analysis begins with data from South Africa and in the second part of this section, data from Nigeria will be analysed. The third section provides a comparative analysis of the two systems.

6.1 South Africa

6.1.1 The Vertical Division of Revenue

Revenue for provinces is from 3 financing streams, their own revenue, conditional grants and the equitable shares. The amount of funds transferred to provinces in the vertical split depends largely on the broad expenditure priorities of the government. These are influenced by the spending pressures of different sectors of government. The weighting given to any sphere is then a reflection of the priority given to the functions that are the responsibilities of the government sphere. As an official from the National Treasury commented:

“For example, if the government puts a lot of emphasis on buying submarines... that will be at the national sphere ... The vertical weighting must also reflect some sort of differential weighting of priority across spheres (government levels)”

These spending pressures are generated from sector processes such as the 10x10s, and 4x4s¹⁷. These meetings set different sector pressures and policy priorities. Despite these processes, the budget process begins with a soft division of revenue based on historical divisions across spheres as a starting point. Conditional grants are viewed as money from the national government, so in essence these processes determine the size of the equitable shares to all provinces from which health and PHC is funded. The rest of the analysis will focus on resource allocation and budgeting within the equitable

¹⁷ The 10x10s are forums that comprise all nine provincial treasuries, all nine provincial health departments in addition to the National Treasury and the relevant national department. The 4x4s are forums that comprise of representatives from the National Treasury, three provincial treasuries, the respective national department and three of its provincial counterparts.

share grant. Equitable share allocations to provinces are then based on the equitable share formula (discussed in section 3). The process using nationally identified priorities for determining the vertical split of revenue thus promotes a consultative process which allows for input from different sectors and spheres of government in determining the overall government priorities and therefore the size of funds transferred to each sphere. In principle, this process is transparent and should result in a division of revenue that reflects the relative level of priority of different sectors within each sphere. However, process of vertical transfers may have other constraints to achieving equity as a result of provincial and sector budgeting processes that feed into this process. These are discussed in the next sub-section.

6.1.2 Budgeting for Health and the Horizontal Division of Revenue

Based on interview data, the size of PHC budgets within provinces depends on the relative priority of the health sector (relative to other sectors); the relative priority of PHC within the health sector, and the relative priority of PHC to other programmes in other sectors within the province. Therefore the size of health and PHC budgets in any province will depend on how well the Departments of Health (province and national) present their policy priorities at sector forums that determine the overall government expenditure priorities.

A concern with the equitable shares formula is that although it is supposed to promote an equitable distribution of funds between provinces, based on general indicators of health needs, educational needs, etc has been cited as a flawed process. A government official from a provincial department of health pointed out that the equitable shares formula uses out-dated population figures that do not reflect the actual population sizes of province and also does not properly estimate the number of patients that cross provincial boundaries to seek health care.

Budgeting for sectors (including health) at the province level involves submissions of spending priorities and budget proposals by all provincial sectors to the provincial treasury. These bids are evaluated by the provincial treasury to see if they are in line with the three-year fiscal framework, national priorities (as agreed in 10x10s), and the indicative budget available for the province. There are series of negotiations back and forth (between provincial sectors and the provincial treasury) where sectors rank their

priorities based on agreed criteria. Allocations to sectors are then based on the relative level of priority of sector policies and programmes. Essentially, there is a collective bidding process by national departments (in consultation with their provincial counterparts), which is a national bid for funds that informs the size of equitable share transfers, and a local bid at the level of the province by provincial sectors. The bids at the provincial level are usually in line with nationally agreed priorities, but they also address any needs peculiar to a sector within the province. As commented by a provincial treasury official:

“You may have a local requirement for some other thing that is a local anomaly, then you get a bid at the province level”

Interestingly, this province-level bidding process, which should lead to priority-led allocations to sectors within provinces (the hallmark of an ideal fiscal federal system), is becoming increasingly constrained because more and more of the equitable shares are being transferred with instructions from National Treasury on what these funds are meant for. In recent years more pressure has been applied by National Treasury on the provincial budgeting process for equitable shares to ensure that expenditure budgets reflect nationally identified priorities. In effect, national priorities driven by the NDoH have a better chance of being adequately funded by provinces. This pressure from the National Treasury is confirmed by an official at a provincial treasury office:

“..the equitable shares is becoming less unconditional ... the whole system has changed significantly in the past years; 3 years ago, the equitable share was unconditional and there were probably some broad priorities that were outlined in the MTEF [Medium term Expenditure Framework]. 2006, you started to get the budget council memorandum and allocation letters saying we have allocated X amount additional to your equitable shares and the expectation is not only will it go to these priorities but that this percentage of it will go to this priority and that’s something completely new element. Its one thing to say that generally we think the province should spend their money on job creation and social development and poverty alleviation, its another thing to say that we are giving you this equitable share money and we expect that 50% of it is going to go to the following 5 priorities. That’s what started happening in 2006, what happened in 2007 was even more so”

In recent years, the National Treasury has become more involved in deciding budgets for the different sectors. According to an official of the National Treasury, the rationale has been to ensure that national priorities are funded at provincial levels, and to promote better coordination between national and provincial departments. These national priorities for health, for example, are developed by the NDoH together with the Provincial Departments of Health. Previously, the equitable shares were completely unconditional grants to provinces, and the provinces, through their provincial budgeting process determined how much of the equitable shares were allocated to the various provincial sectors. This had the potential to, and frequently resulted in a disjuncture between nationally identified priorities and the actual funds allocated to the priorities by the provinces. The amount of funds allocated to these priorities in some cases did not reflect the level of priority placed on them by the national government.

The recent developments in the budgeting and resource allocation practice to provinces guarantees that that the pattern of allocations to health programmes are a better reflection of nationally identified priorities. Under this dispensation, the realisation of a more equitable distribution of health and PHC resources between and within provinces stands a better chance, as equitable shares are no longer completely at the mercy of provincial budgetary negotiations. Of course this will depend on whether PHC is considered a priority in the national prioritisation process. The “enforcement” of national priorities on provincial budgetary allocations has had implications for the level of autonomy enjoyed by provinces, and their capacity to address specific PHC or health care issues peculiar to the provinces. A national treasury official said that:

“Now this has had both positive and negative effects. The positive effect is that when for example national has articulated a particular priority ... there has been very strong support (financially) for that priority. The negative effect has been that provincial specific priorities are being squeezed out”

However, an official from a provincial treasury confirmed that the provincial government still has authority to (and in some cases does) refuse to allocate their

funds according to national priorities but rather according to their own priorities. This is also confirmed by an official from the NDoH.

Nevertheless, under this current budgeting and resource allocation dispensation, an official of the National Treasury identified some limitations to the equitable financing of PHC. First, while the amount of funds allocated to PHC across provinces has increased in the last 3 years, there has been a deterioration of performance indicators in certain areas such as maternal health and tuberculosis control in certain provinces. These poor performance indicators have negated NDoH bids for additional funds to health and PHC, as National Treasury is concerned that funds already allocated are not being effectively utilised. Although the National Treasury is keen to assist the health sector in securing adequate funds to carry out its functions, the performance of the health sector has been a draw back in this regard. As commented by a treasury official:

“...I think there’s a strong sense by many that the NDoH needs to be more active in its norms and standards and support role ... we are not talking about NDoH interfering in delivery but we are talking about NDoH setting much clearer norms and standards and supporting provinces to deliver on those”

Secondly, the National Treasury is of the view that NDoH does not adequately articulate, with “real hard information” the collective bid for the health sector. This has also reduced the effectiveness of the NDoH to secure additional funds that could be used to support a more equitable distribution of resources. A provincial health official commented that:

“...in terms of the dynamics of increasing the funding to the health sector, our perception is that they (NDoH) have not done profoundly enough work to convince Treasury (National Treasury). I don’t think Treasury needs convincing. I do speak to (Treasury official), they are waiting for us to present the case: why should we get more money? I think that is my biggest concern at the moment is that NDoH does not have a strong enough economic unit to present a strong enough argument to Treasury as to why we should get more”

Within provincial departments of health, budgeting for health requires submission of budget proposals by health districts. These budget proposals are aggregated to generate a provincial budget proposal. Most district managers believe that the budget proposals (district plans) they submit to their respective provinces do not influence their allocations. For example, a district manager commented that:

“...we submit our budget tools ... we do almost something like zero-based budgeting... we submit it to our head office in X and then basically that’s the last we hear of it until we are told here’s your budget for the year...”

This response on the use of district plans by provincial health authorities was generally the same for most interviewees at the district level. However, in a few districts, the managers felt that although the provincial departments considered their budget proposals, the amount of money the district eventually received was dependent on the total health budget and historical expenditure of districts. This was confirmed by a provincial official:

“...we give each hospital and each clinic the budget they had in the previous year in real terms – so we add inflation. And then we ask them: what are the real critical needs that they have? We would consider those if additional funds are available”

In the Eastern Cape, the process of aggregating district budget proposals apparently does not work at all. Some districts actually do not send in budget proposals. As commented by a provincial official:

“Districts are required to submit what we call EC documents [budget plans] ...but that becomes a farce in itself because they submit the EC documents and some of them don’t”

All district managers confirmed that they never receive exactly what they proposed. In all cases, the budget they eventually receive is lower than what they had proposed.

With the “conditionalisation” of equitable share grants to the health sector, provincial budgeting processes have less influence on the total health budget and in certain cases

no influence on the size of the budget for specific health programmes. Similarly, district budget proposals have very little influence, if at all, on the size of the PHC or overall provincial health budget. Interviews with officials did not reveal any form of “conditionalisation” of funds for PHC. What is true is that priorities as developed by all provincial departments of health and the NDoH take preference over individual provincial priorities. This has significantly reduced the autonomy enjoyed by the provinces and the provincial departments of health in determining the overall health budget and PHC expenditure outlays. A key point to note though, is that provincial Departments of Health are part of the decision making process for defining national health priorities. In essence, if a province(s) has health priorities that need more funding it stands a better chance to get increased funding if this health priority gets onto the national agenda and is identified (by consensus with other provinces and NDoH) as a national priority.

Clearly, nationally determined priorities now have more influence on the division of equitable share revenue between provincial sectors. The implication for the equitable distribution of PHC funds between and within provinces depends on whether the NDoH has the ability and commitment to drive this initiative in the national prioritisation processes. An official of the NDoH stated that the NDoH has been successful in getting the equitable distribution of PHC allocations on to the national prioritisation process. He also explained that the shift towards a more equitable distribution of PHC funds across districts and provinces was initiated by the NDoH; and also, the health component of the equitable shares allocated to provinces is done according to the cost of providing a comprehensive PHC package, determined by utilisation rates and unit costs.

Nevertheless, achieving equity would most likely necessitate extra funds as reallocation of funds would meet with considerable pressure from provinces that are relatively well-funded. In any case, reallocation may not be possible since the bulk of health care expenditure is on personnel, and this would require the termination of appointments of health personnel in some provinces (or at least a relative redistribution of personnel across provinces). In the current dispensation, National Treasury is aware that the health sector needs more funds, and so is open to releasing more funds. The onus therefore lies with the NDoH to articulate good evidence for

extra funds and ensure that provinces are providing high quality care with good indicators of performance. Only when the NDoH can do this would National Treasury be open to releasing more funds to the health sector or specifically, PHC.

The budgeting process from the district level seems to contribute little to the overall provincial health budget. Also the use of the historical-led approach to budgeting at the province level further limits the possibilities for shifts in PHC funds to achieve a more equitable outlay between districts. However, district managers in general have the authority to decide on how much of PHC funds are allocated to cost centres such as clinics and community health centres, within certain limits. For example funds for personnel cannot be reallocated from one sub-district to another, or used for any other activity apart from personnel remuneration.

6.1.3 Influence of key stakeholders

The key stakeholders involved in the financing of publicly provided health and PHC services are the national and provincial Treasuries, the national and provincial Departments of Health and the districts (part of the provincial health authority). Based on the current process for determining health budgets, the NDoH has substantial influence in determining health budgets. This is because they are the ones who coordinate the national prioritisation process. Provincial Departments of Health should also exert considerable influence on the outcomes of budget processes, as they have the authority to determine the actual expenditure budgets for PHC. National Treasury's role in ensuring that provincial expenditure outlays reflect nationally determined priorities strengthens National Government's role in provincial budgetary processes.

Currently, and based on interview data, the NDoH has played a major role in the progress towards a more equitable distribution of PHC expenditure. However, because of poor output indicators (cure rates for TB for example) especially in previously less funded provinces and districts, and that the NDoH is not able to (from the National Treasury's view) properly articulate the need for additional funds, the influence of the NDoH and provincial Departments of Health is substantially limited by the National Treasury. Provincial Treasuries essentially work within broad guidelines as defined by National Treasury. Within provinces, the provincial

Departments of Health also submit budget bids to their provincial Treasuries. While operating within the guidelines as defined by national health priorities, provincial Departments of Health are able to influence the size of their budget depending on the strength of their bids. This process is discussed in a later part of this section. Within each province, district managers have very little (if at all) influence on the health budget. Their submissions in many cases are not considered in the budgeting process. They only have some influence in deciding how provincially-determined PHC budgets are allocated to various cost centres.

In summary, it appears that NDoH and the National Treasury wield considerable influence over the outcome of budgeting processes for health. Provincial Departments of Health have less control over budgetary outcomes in more recent years. The NDoH is now in a better position to influence allocations to health and PHC than it was in previous years. The NDoH is potentially the single most influential stakeholder in promoting a more equitable distribution of PHC funds, and will continue to be, if it can provide substantiated reasons for additional funds to be allocated to PHC in areas that have been previously less well funded. Further constraints to the NDoH's ability to achieve this are discussed later.

6.1.4 Community Participation and Health Policy

All interviewees confirmed that there was some mechanism or the other to elicit community preferences and views regarding the provision of PHC services. All districts acknowledged that constitutionally established structures such as clinic committees and hospital boards were operational in their districts and provinces. District managers said that these structures were not working very well. Major reasons for this were the lack of attendance of committee members and lack of understanding of members' roles. In their opinion, these structures are not effective in drawing community views, preferences or complaints into the policy agenda. In cases where the communities have the opportunity to air their views, they do not see the desired change in the provision of health care. A district manager commented that:

“The good thing is that we do have these meetings with the communities so that at least we're not hiding away or anything like that – so that does help. But the community say that you keep saying that you can't improve the service here because

you don't have money to appoint staff, and what are you doing about it? And all you can say is that we are asking X [provincial authority] and X says you can't fill posts because there is no money"

However an exception was a district in Limpopo where the district manager stated that these structures work very well. However, the manager was quick to say that their major limitation was adequacy of funding to respond to the revealed needs of the community. Interestingly, all provincial officials were of the opinion that their mechanisms for eliciting community views and preferences work very well. For example a provincial health official commented that:

"We have a complaints and compliments system in place in each and every facility. People do not have to expose themselves, and these are monitored on a monthly basis. We are lucky, currently we get more compliments than complaints. We also do annual waiting time surveys. We try to reduce waiting time. At the governance level we have Provincial Health Council, an advisory body to the Minister and acts in accordance with the Act... Also there are individual health committees and health forums at the local level, and all these are working very well; we don't have a problem. We have created enough space for people to air their views... our Standing Committee is very open, our Chairperson opens the doors of the government to the people, and they tell us whatever they want to".

Closer examination of interview data revealed that the provincial authority has alternative means for eliciting community such as health summits and "Imbizos"¹⁸, where top ranking provincial health officials met with community members.

On whether community views influence health policy and budgets, officials at the district level thought that community views were not taken into consideration. However, provincial officials believed that communities' views were well represented in the policy agenda. With respect to the provision of PHC, the districts are responsible for service delivery and are closer to community members. Based on this

¹⁸ Imbizos are gatherings between government officials and community members held periodically to elicit community views and preferences. Government officials would move from one district to another to interact with the community members.

assumption, it is therefore more likely that health districts are more aware of any changes made with respect to service delivery based on communities' inputs. Also, the historical-incremental approach to budgeting within the province, does not ideally allow for any radical changes in service delivery based on community preferences. A key question then is that if communities' views are not incorporated into health policy, how does the province or the district respond to the health needs of the people? More specifically, how does the province decide which district has greater needs than others? On the issue of equity, most officials cited equal expenditure per capita and expenditure based on disease burden as a basis for allocating PHC funds to achieve equity. None of these in essence captures the specific needs of community members. Equal expenditure per capita does not take account of relative need of different districts. The use of disease burden may be a better criterion but the statistics on disease burden may well depend on the availability and use of facilities. The absence of community preference in determining relative need for PHC services potentially compromises the reliability of any mechanism for assessing relative need and promoting equity.

6.1.5 Financing Options for PHC

PHC activities are financed from equitable shares, through inter-sector negotiations and intra-sector (within the provincial health authority) budgetary negotiations. Provincial PHC budgets and PHC allocations were largely determined by the provinces, with the National and provincial treasuries playing a stronger monitoring role on overall expenditure. Interviewees were asked if the funds for PHC should be transferred through another mechanism that protected the budget for PHC to ensure adequate and equitable funding. Most respondents did not see the necessity for the funding of PHC through some protected mechanism like conditional grants or having the funds for PHC ring-fenced. From a National Treasury perspective, financing PHC as a conditional grant is not necessary considering the significant growth in PHC expenditure per capita experienced in recent years.

“...I think if it (PHC expenditure) hadn't been growing strongly, we would have been much more receptive to mechanisms to ring fence but because it's growing so strongly, we haven't felt the need to do it. In fact, ... we're a little concerned at some

of the constraints in hospital budgets, you know, because there are some things in health that are being funded, there are some things that are not being funded and, for example, some of the hospital budgets have been constrained for a decade and the services in some hospitals are really, we think, woefully inadequate. So, I'm not really that worried about the growth in provincial primary health care budgets, what I'm more worried about is the limited progress on district level allocation [referring to improving equity in allocations between districts]”.

An official from the NDoH also maintained that it is not necessary to protect PHC as a conditional grant. The official argued that the same goals (increased budgets for PHC) could be achieved with implementing norms and standards. Use of norms and standards pose fewer problems for financial management. Using norms and standards gives the provinces an objective to aim for; using a conditional grant sets a definite amount that should be spent on PHC in a financial year. Unfortunately, those provinces that have greater health needs are those that are least able to utilise additional funds. Failure to use up PHC budgets from conditional grants would attract budget cuts and other financial management disciplinary actions.

“Well, I think there are different ways of doing it, you know obviously if you can make it a conditional grant you are making it conditional upon a number of things. The question is what will it be conditional upon? The second thing to say is if you have a norms and standards approach it reaches the same goal. The problem with mandating that in a way that a conditional grant might do is absorptive capacity, so you might get the same result. You are getting more money but you are not able to spend it because 60% of the funds will be human resources. These are the same provinces that have difficulties in retaining and attracting personnel, so it might not give you the intended aim because of these other barriers, supply...issues....”.

“I think there are two things here, one is that I think provinces can do more to strengthen primary health care. Secondly, national can provide more guidance to provinces around primary health care even without changing the financing....I think that's missing. So even without changes to fiscal federalism we can do better”

The view that provinces should be able to ensure that PHC is adequately and equitably funded is held by some other interviewees. They believe that since PHC has been identified as a priority programme, budgetary allocations within the PDoH should reflect this. Provincial Departments of Health, they felt, should be “mature” enough to adequately fund PHC without national prodding. One official commented that national and provincial treasuries did not “like” conditional grants. Specifically, the official said that conditional grants reduce the amount of control that provincial treasuries have within the province, and so are opposed to them. Interestingly, no official (who commented on options for financing PHC) proposed some form of protection for PHC funds.

Interviewees were asked whether there were any guidelines from the NDoH or the provincial Departments of Health that influenced the size of PHC budgets or expenditure. One official at the district level mentioned a “national utilisation rate” for PHC facilities as a guide. All the other interviewees were not aware of any guideline from the NDoH on PHC. In fact an official from a provincial Department of Health said:

“...That is also a problematic situation; I think I will expect the NDoH to give us more guidance in that; to tell us like we should have ZAR10 per member of the population for PHC. Now we don't receive that guideline”

Interestingly, an official of the NDoH admitted that they (NDoH) had set the cost of the PHC package at ZAR300 per capita, and this was used as a benchmark to see how provinces were funding PHC. None of the provincial or district officials interviewed seemed to be aware of this benchmark. It would seem that the NDoH has not been effective in communicating this guideline to provincial Departments of Health or health districts. This lends credence to statements made by some officials that the NDoH has not been “pulling its weight” in terms of monitoring and supporting the provision of health care. This is potentially a weak link in the drive for achieving any adjustments if PHC financing between provinces and districts.

6.1.6 Expenditure Capacity and Sufficiency of Funds for PHC

A key issue in the progress towards a more equitable distribution of PHC funds is the ability of districts and provinces¹⁹ that are less well funded to utilise extra funds adequately. Also, for these provinces, it is important to assess whether the provincial authority and the district management system have sufficient autonomy to allow them make the necessary decisions regarding capacity development. Interviewees were asked if the provincial Departments of Health (head office) and the districts had sufficient capacity to manage health and PHC funds (and any extra funds for achieving equity) that were allocated to them.

Most officials thought that the provincial authorities in general had sufficient capacity to manage and utilise any extra funds allocated to them. However, they thought that most districts did not have sufficient managerial capacity to adequately manage finances allocated to them. All interviewees who responded to this question cited the lack of skilled personnel in financial management, and in some cases, a general lack of management level personnel. One provincial Department of Health official commented that:

“...in the Eastern Cape the big problem is turnover of staff. So you have staff, you train them, they are enthusiastic, they start learning things and then they move, then you have to start from scratch”

Another PDoH official related the lack of capacity to equity-driven financing initiatives between districts in his province:

“No, I don’t think the capacity is there. You know, a few years ago there was a concerted effort to move money to areas that were previously disadvantaged, but they were not able to spend it, which meant a reverse in equity”

¹⁹ Although the district is an administrative part of the province, we make a distinction here to allow for assessing these two administrative structures. Provincial authorities will therefore refer to the provincial head office.

These results are interesting in the sense that with respect to management of PHC funds, the districts' lack of capacity is seen as a provincial lack of capacity by National Treasury and NDoH.

The lack of personnel in many rural districts and provinces (that are largely rural) has reduced their capacity to use extra funds allocated to them. In addition, such districts and provinces find it difficult to attract staff to work in those areas. The health sector is largely human resource driven, and so areas that are under-staffed generally have lower per capita PHC expenditure since personnel costs take up a large proportion of health care expenditure. This is a major constraint to achieving an equitable distribution of PHC resources in South Africa. In general the more urban provinces (Gauteng and Western Cape) and districts have no problems in attracting the right mix of personnel, and these areas in general have relatively lower health needs and lower levels of deprivation than the more rural areas (districts and provinces). Their expenditure on PHC is generally higher because they are relatively well staffed and have the requisite managerial skills to make good use of any extra funds allocated to PHC. On the other hand, the more rural provinces and districts fail to attract staff, are generally under-staffed and so have lower expenditure. Now the lack of managerial skills in these areas reduces their capacity to utilise any extra funds allocated to them to improve on the quality or quantity of health services delivered. As an official mentioned:

"...so the key thing, really, in all of these initiatives is human resource management. If we can't fix that up, you can't throw money at the initiative"

All officials at the province and district level said that funds for PHC and health in general was not sufficient to adequately deliver PHC services to their populations. Only one district manager in Gauteng believed that the funds allocated to PHC was sufficient if the district used the money allocated to them efficiently. These assertions by officials from Western Cape and Gauteng provinces are consistent with their financial reports, as they are over spending on their budgets. Nevertheless, an official from the NDoH said that province and districts always claim that they do not have enough funds. From the data on PHC per capita expenditure by districts, average nominal district expenditure increased from ZAR160.49 in 2001 to ZAR229.04 (more than a 40% increase). In real terms (base year = 2001), average district per capita

expenditure increased from ZAR160.49 in 2001 to ZAR189.1 in 2005²⁰. Clearly, there has been a substantial increase in allocations to PHC across the country. A NDoH official stated that:

“..if you go to provinces and districts, they will always say that they are under funded for the whole range of services that they are providing, but at the same time, they are not able to spend the money that has been given to them”

6.1.7 Perceptions on Equity and Criteria for PHC Allocations

In general, interviewees agreed that PHC was a priority. This was a unanimous perception. The strengthening of the district health system in providing PHC is a priority policy goal in all provinces and districts visited. Some of the respondents cited specific disease programmes as the major health priorities. These were HIV/AIDS, tuberculosis and lifestyle diseases such as diabetes, hypertension and cardiovascular diseases. Concerning the distribution of PHC funds between districts, interviewees admitted that allocations were not entirely distributed based on health needs. Budgeting based on historical expenditure still prevails, although indicators such as disease burden increasingly influence allocations. In general, interviewees thought that allocations between districts were not equitable, but was increasingly becoming more equitable.

Government officials' views on equity and the level of priority placed on PHC services are encouraging. The implication of this is that they will be less resistant to changes in the financing pattern of PHC in support of equity. On the other hand, the use of a budgeting process that is based on historical expenditure limits the progress in the shift of PHC finances for achieving equity. Importantly, an official raised a concern that equity is not the only concern for the provision of PHC services. It is important that districts and provinces are able to use resources allocated to PHC efficiently, effectively and the services should be provided in an appropriate manner.

²⁰ Using the Consumer Price Index from Statistics South Africa, with base year of 2001, the index for 2005 is 121.09

“ quality cannot be measured by equity alone ... efficacy, efficiency, equity, affordability, accountability and appropriateness. If you bring all these into equity then we can talk”

Officials were asked to comment on the convergence of PHC expenditure per capita between districts in South Africa. Most of the officials were aware of these shifts but did not know who was responsible for them. In the Eastern Cape, officials attributed shifts in PHC to areas of greater need to the provincial health authority.

6.1.8 Comparisons Between Relatively Higher and Lower Funded Provinces

Comparison of interview data from the historically higher funded provinces (Gauteng and Western Cape) and lower funded provinces (Eastern Cape and Limpopo) revealed that information from the two groups were similar with the exception of two areas. These areas are: personnel and the relationship between the provincial Departments of Health their Treasury counterparts.

Gauteng and Western Cape officials admitted that although they still needed skilled personnel in management positions, they were coping very well with the number of management staff they had. For Limpopo and Eastern Cape, they acknowledged shortage of staff in the areas of administration, financial management and health personnel. They essentially have a more acute shortage of human resources than Gauteng and Western Cape. This is not surprising as Gauteng and Western Cape are more urban provinces, while Limpopo and eastern are more rural. It may well be that higher PHC expenditure per capita experienced in the Western Cape and Gauteng could be partly attributed to personnel cost.

Interview data revealed that the provincial departments of the Western Cape and Gauteng engage with their provincial Treasuries very often. Their Treasury departments were always aware of their key priorities, problems and plans in as much as they relate to budgeting and resource allocation. It appears that there is a good deal of cooperation and understanding between them. As commented by a provincial Treasury official in the Western Cape:

“...provincial Treasury has a tight relationship with provincial health and they all go up to the 10x10s and 4x4s together...”

On the issue of interaction and cooperation between the provincial Treasury and the provincial Department of Health in Western Cape another provincial Treasury official said:

“It’s on a whole number of different levels, so I couldn’t say. It’s everything from informal to HOD level. Some of the interactions, for example in the budget office, we have an economist who is assigned to the health department and she will be in regular contact with them. Both with their budgeting side and their CFO, HOD, and their programme managers... So for instance, a good example (of cooperation) is before we have the ten-by-ten, we got together with them here back in the province and said what are we going to put on the table? What are the key issues that we want to take to the national level about this. I think most of the provinces did not do that; you could tell because once they come to the meeting, their Treasury is saying something different from their provincial departments. We had a conference beforehand and talked about what they wanted to put on the table and how we could support them putting it on the table, and what did not make sense as well. Even if we don’t agree, at least we would have had that conversation before the national meeting”

With this kind of relationship, the provincial Departments of Health get support from their Treasury counterparts in bidding for additional resources. Unlike the Western Cape and Gauteng, the provincial Treasury and provincial Departments of Health in Limpopo and Eastern Cape do not have this kind of relationship. This is confirmed by a statement from a provincial Treasury official in the Eastern Cape:

“...look, I must be frank with you; we do interact [with provincial Department of Health] but not as often as one would want it to be ...in summary there is a weak link between Treasury [provincial] and departments ... you know the problem with the intergovernmental relation is that when departments outline their policy areas, when they embark on their strategic plans, provincial Treasuries are left behind”

The official attributed this weak link to the fact that the provincial Treasury is under staffed and so cannot afford to engage with the various departments as regularly as they should.

6.1.9 Discussion

The process of vertical split of revenue to the different levels of government allows for a consultative process that promotes financing of sectors based on overall government priorities. This on its own is a good foundation for promoting an equitable distribution of resources for any priority, be it PHC or some other programme. A few years ago, provinces had much more autonomy in deciding sector budgets such as health and education. In more recent years the increased role of the national and provincial Treasuries in monitoring provincial expenditure to ensure that they are in line with nationally identifies priorities has significantly reduced their autonomy. Under this current dispensation, there is greater potential for the realisation of more funds for PHC in areas that are relatively less well funded. However, this depends on whether PHC and the equitable distribution of its funds are considered a national priority. With increased accountability of provinces to national and provincial Treasuries (on nationally identified priorities) in overall expenditure, this presents a good opportunity for the NDoH to promote national priorities as the provinces are more likely to align themselves to these.

Protecting PHC funds by financing it as a conditional grant or as a ring-fenced budget is deemed to be unnecessary. Also, most officials involved in the budgeting process for health and PHC agree that equity is an important goal to pursue. The implications of these two points are that it may not be necessary to further reduce the autonomy of provinces to ensure that PHC funds are adequately funded through conditional grants. Also, there is likely to be very little resistance by district managers and provincial Departments of Health to initiatives to promote a more equitable distribution of PHC funds.

While there is now greater influence from the national government on provincial budgeting and spending behaviour, and a more conducive atmosphere for promoting equity in financing PHC, there is still a system constraint. This is around the capacity

of districts and provinces that have been relatively less well funded to effectively utilise additional funds allocated to them. This capacity constraint is largely as a result of the lack of requisite personnel and managerial capacity in those areas.

6.2 Nigeria

This section reviews the data collected from interviews with Nigerian officials in the local, state and at the federal government level.

6.2.1 Vertical Division of Revenue

Vertical allocations of federally collected revenue is allocated to the state and local government based on a formula that considers factors such as population size and revenue generating effort for example. The allocations to states and local governments (LGs) have no conditions attached to them and essentially form part of their revenue. The states and local governments determine how much they spend on secondary and primary health care respectively, without any intervention from the federal government. Therefore the local government has full autonomy in deciding the budget for PHC.

Revenue allocation to the local government is done on a monthly basis. The funds are transferred through the state governments. The state has no influence on how much is allocated to each local government, and does not have the authority to redistribute local government allocations. They simply serve as a conduit to the local governments. With such autonomy, it is very unlikely that the distribution of PHC allocations between local governments will be equitable, as each LG authority makes decisions concerning the financing of PHC independent of other LGs, the state or the federal government.

6.2.2 Budgeting for PHC

Within the local government, the budgeting process for PHC funds starts with the Department of Health at the local government. The department sends proposals to the local government executive on the activities it intends to carry out. Release of funds to the Department of Health is subject to approval from the local government

executive. In the two local governments visited, the staff of the Department of Health revealed that the local government chairperson had the final say in deciding the PHC budget. The chairperson could do absolutely whatever he or she wanted to do with funds transferred to the local government. This was confirmed by officials from the states visited. Interviewees revealed that in some cases, the state had to advocate on behalf of the local government Department of Health to get funds allocated to PHC.

6.2.3 Influence of Key Stakeholders

Information from interviews suggest that the local government chairperson has complete authority in deciding PHC budgets and budgets for any other sector that is under the jurisdiction of the local government authority. Local government chairpersons are not accountable to any one. Responses from interviewees suggest that only gentle persuasion or advocacy from the State Governor may change the chairperson's mind concerning the way he/she may want to allocate funds to PHC. The states are supposed to provide support to the local government authority. The support provided by the state in support of PHC has been the training of health personnel and providing logistical support to campaigns for programmes such as immunisation. The Department of Health at the local level, though appreciative of the support, are of the opinion that this support is not enough. An adviser to the Federal Ministry of Health (FMOH) explained the reason for poor accountability of the LG authority to the state or federal government. The roles of the federal, state and local government in the provision of health are not clearly defined constitutionally, so higher levels of government have no legal mandate to insist on any form of accountability from the local government with respect to PHC. Also on the issue of accountability and discipline, he commented that: *“if good examples come from federal and state, then LGs may change, but this is not the case”*

6.2.4 Community Participation

Interviewees at the local government level revealed that they had structures in place to interact with the community members such as facility health committees. These structures worked well in the sense that the Department of Health gets relevant information about how the community views the services provided and what their

preferences are. However, one interviewee commented that they had been experiencing problems with these committees because they were not paid.

“...but a problem we have is the committee members are not paid, so they may be nonchalant...”

Based on the budgeting process for PHC, it would appear that funding of PHC based on the revealed preference of the community (and according to need) depends solely on the level of priority placed on PHC by the LG chairpersons. In a situation where a LG chairperson considers PHC as a priority, this would lead to better funding for PHC; otherwise the reverse will be the case.

6.2.5 Financing Options for PHC

With regards to strategies for influencing the size of PHC budgets, respondents commented that there are certain cases where a state, with money from donor agencies offers financial support for specific PHC activities on the condition that the LG contributes a certain percentage. This form of arrangement, called “counterpart funding”, is used to draw more money into PHC from the local government. For more sustained adequacy of PHC funds, respondents at the Department of Health (LG) felt that PHC should not be left at the mercy of the LG chairperson, but protected. They suggested that the funds for PHC be “deducted at source” – essentially as a specific purpose grant.

6.2.6 Expenditure Capacity and Sufficiency of Funds for PHC

Respondents believed that Departments of Health at the local government level do not have the capacity to adequately manage PHC funds. One respondent felt that the major reason was the lack of managerial staff. Officials were asked questions regarding sufficiency of funds and over or under spending. All officials claimed that PHC funds were inadequate. A local government official commented that:

“There is no money to speak of over spending or under spending”

A state official explained that in many cases proposals for PHC to the LG were unsuccessful because the chairperson said there was no money.

“I have had personal experience; the chairman says there is no money”

6.2.7 Perceptions of Equity and Criteria for Resource Allocation

In response to questions on whether equity is a priority, respondents from both the state and local Departments of Health confirmed that equity is not a priority. One official commented that health was not seen as a priority in his local government area, but was a priority for the state. *“Health is not seen as an investment”*. Officials felt that PHC funds were not allocated equitably. An official commented that the constraints to achieving equity or adequacy in the financing of PHC are: *“poor policy design, poor implementation, and lack of discipline ... there is no planning or strategy”*

6.2.8 Summary

The nature of revenue sharing in Nigeria, allows states and local governments complete autonomy in deciding their budgets for sectors under their jurisdiction. The local government is responsible for providing PHC, although this is not clearly stated, constitutionally. As a result, local governments decide on PHC budgets independent of any state or federal influence. The resulting lack of accountability has created a situation where local government chairpersons are free to allocate resources to PHC as they wish. Based on the results of the interviews in Nigeria, state governments often lobby the local government to finance PHC, as they have no legal mandate to influence budgetary processes at the local government level. Based on our conceptual framework, this is an ideal situation that promotes the inequitable distribution of resources for any programme or sector between SNGs. Equity is not a key priority for PHC as revealed by interviewees. It is not surprising that from interview data, the distribution of PHC funds between local governments is not equitable. Officials concerned about the lack of accountability and size of PHC budgets suggest that PHC should be funded as a specific purpose grant.

6.3 Comparative Analysis: South Africa vs. Nigeria

The table below provides a summary of the difference and similarities between the structures and processes between the two federal systems in the financing of PHC.

Table 6.1 Financing PHC in Nigeria and South Africa

Theme	South Africa	Nigeria
Level of government responsible for providing PHC	Districts, which are administrative structures within the province	Local governments, autonomous from state and federal government
Vertical split of revenue	Based on spending pressures from sectors and overall government policy priorities	Fixed based on set criteria
Accountability	Provinces are responsible for determining PHC budgets, but are accountable to their provincial Treasuries and national Treasury on their overall expenditure	Local governments are responsible for determining PHC budgets and are not accountable to any other authority
Influence of stakeholders	Sector processes involving NDoH, National Treasury and provincial Treasuries influence the size of the health and PHC budget in each province. Provinces determine how much is spent on PHC at the districts	The local government decides how much is spent on PHC. States lobby local governments to influence PHC expenditure. LG Chairperson particularly powerful
Financing Mechanism	PHC finances are funded through general purpose grants to provinces.	PHC finances are funded through general purpose grants to local governments
Expenditure Capacity	Lacking in more rural districts and provinces, largely as a result of a lack of staff	Lacking at local government level due to lack of staff. Although this does not affect the size of PHC budget
Priority level of PHC	High priority	Not a priority for local government but a priority for the state
Equity in financing of PHC	Not equitable, but moving towards a more equitable distribution. General agreement that equity is a priority at all levels of government	Not equitable. Equity not seen as a priority
Guidelines for PHC financing	Nationally defined but not effectively communicated to provinces	No guidelines
Community Participation	Mechanisms in place but not effective in influencing PHC budgets	Mechanisms in place but they do not function very well and do not influence PHC budgets

The major differences between the South African and Nigerian systems are that in the case of South Africa, PHC is the responsibility of the province (the second tier of government) and provided by the districts. In Nigeria, the local governments, which are the lowest level of government, are responsible for providing PHC. The vertical

split of nationally collected revenue (in Table 3.4) is determined annually through a consultative process that allows for spending pressures within sectors to influence vertical split. This is more conducive for shifts in financing based on priorities. This is not the case in Nigeria. The vertical split is based on basic indicators of relative need and do not allow for consideration of specific needs within sectors.

In both cases, PHC funds are financed through general purpose grants. In South Africa, provinces are accountable to the national and provincial Treasury with regards to their budgetary allocations. Their expenditure behaviour is monitored based on nationally prescribed priorities. Therefore there is some influence from the national government on the distribution of PHC allocations between districts and provinces. This is not the case for Nigeria; local governments are not accountable to any other authority. The lack of accountability at LG levels creates greater incentive for mismanagement of funds. There is therefore a greater scope for inequities in PHC allocations between local governments and between states.

In South Africa and Nigeria, lack of personnel is a major constraint to the effective provision of PHC services. The key difference between the two sites is that while this affects the amount of funds that is allocated to PHC at districts, it does not in any way determine the amount of resources allocated to PHC at local governments in Nigeria.

Finally, in South Africa, PHC is viewed as a priority by government officials; equity in the distribution of PHC allocations is a goal that all officials ascribe to. Guidelines on PHC expenditure set by NDoH are however not effectively communicated to provinces. On the other hand, in Nigeria, PHC is not considered to be a priority by the level of government responsible for its provision, achieving equity is not a priority and there are no guidelines for LGs on expenditure patterns for PHC. Also, the fiscal arrangement does not provide any mechanism for accountability to or influence from higher levels of government.

Section 7 Conclusion and Recommendations

This study has reviewed the South African fiscal federal system to assess the impact of fiscal federalism on the equitable distribution of PHC. Previous research revealed that progress towards achieving equity in the distribution of PHC funds between provinces and districts slowed down considerably with the introduction of a fiscal federal system in South Africa. Within the new fiscal federal system, local governments were responsible for providing PHC services. This responsibility has since been moved to the province. Based on the nature of the intergovernmental relations, provinces have had autonomy in deciding their health budgets and PHC allocations between districts, with little intervention from the national government, although PHC has been of national concern.

In recent years, there have been considerable shifts in PHC allocations between districts, leading to convergence in PHC expenditure per capita throughout all districts – resulting in a more equitable distribution of PHC funds. From interviews with provincial and district officials, there was no consensus on who drove this process. NDoH officials acknowledge that the NDoH is responsible for driving this process. It is of interest to note that this convergence in PHC expenditure per capita coincides with greater influence of the national government on provincial spending patterns. It would appear that the combination of NDoH drive for equity in PHC allocations and National Treasury enforcement of national priorities in provincial spending are central to achieved progress in the equitable distribution of PHC allocations. National influence on the budgeting process has effectively reduced the level of autonomy enjoyed by provincial governments and created greater scope for alignment between nationally identified priorities and provincial spending patterns. Comparisons with the Nigerian system reveals that local governments have significantly higher levels of autonomy and are not accountable to any authority. This is probably the single most important factor for the inequitable distribution of PHC funds between local governments²¹.

²¹ Actual data on PHC expenditure by local governments were not available; this conclusion is based solely on interview data.

A major conclusion reached by this study is that within any fiscal federation, the extent of autonomy enjoyed by SNGs that are responsible for providing public service has a huge impact on the distribution of finances for the provision of the service between SNGs. The more autonomy given to SNGs, the more scope there is for inequity in financing. While SNG spending levels may differ in response to differential need, the financing of public services such as PHC, where the outcome of the service is of national interest, a balance has to be sought between the amount of autonomy SNGs are allowed and national influence in financing these services. In such cases, SNGs should have enough autonomy to respond to the needs of the population they serve, and the national government should be able to exert just enough influence to realise a desired distribution of the service.

Perceptions on the level of priority of PHC and equity amongst key government officials is encouraging and creates less resistance to initiatives for promoting equity in PHC funding. This is a crucial enabling factor for the move towards equity.

In this study, identified constraints to achieving a more equitable distribution of PHC funds are as follows:

1. Budgeting based on historical expenditure: The predominance of historical budgeting within provinces limits progress in shifting resources to areas of greater need.
2. Weak support from the NDoH on provision of PHC services. Poor performance indicators for certain provinces and districts reduce the effectiveness of any arguments from the Departments of Health for increased funding to areas of higher need. Also the lack of guidance from NDoH on expenditure levels for PHC leaves provinces with no benchmark to work towards.
3. A possible constraint is the poor interaction between provincial Departments of Health and their provincial Treasuries in less well-funded provinces. Provinces such as Gauteng and Western Cape have a good relationship with their provincial Treasuries. They have frequent engagements that afford the

Treasuries a better insight into the problems faced by the provincial Departments of Health. The level of cooperation fostered by this relationship encourages the Treasuries to support the health departments.

4. Based on the results of this study, the single most important constraint to achieving equity in the distribution of PHC funds is a lack of human resources in areas of greater need. Lack of managerial skills in rural areas (generally have greater need) limits the ability of districts and provinces to effectively utilise funds allocated to them, further increasing the reluctance of the Treasury to release more funds to these areas. In addition, the lack of personnel (administrative, medical and managerial) in these areas further reduces the amount spent on personnel for these areas. This is the most important factor because even if the budgeting process (criteria and key stakeholders) work in favour of achieving equity, additional money allocated to areas of greater need will have little impact on the welfare of the population.

This study recommends that the influence of the national government on provincial spending be maintained, whether from the NDoH or National Treasury (also through the provincial Treasuries); but not to the extent of ring-fencing PHC budgets. As has been seen in Nigeria, allowing provinces complete autonomy potentially reduces any scope for an equitable distribution of PHC funds.

Secondly, the NDoH should provide more support to provinces in the delivery of health services, to ensure that money allocated to health and to PHC is used effectively and more efficiently. Clearly, and correctly, the National Treasury does not intend to reward inefficient use of resources by increases in budgets. Also, national targets, norms or standards for a priority like PHC should be effectively communicated to provinces. Only when provinces know what their targets are will they be able to assess how well they are doing and what constraints they face in achieving the targets. These targets could be used to negotiate more effectively with their provincial Treasuries.

Thirdly, provincial Departments of Health need to engage more with their provincial Treasuries. The objective should be to foster a more cooperative relationship. The

provincial Departments of Health need to work more closely with their provincial Treasuries to get a better understanding of the “rules of the game” when it comes to sourcing of extra funds. Provinces like Gauteng and Western Cape have been benefiting from their close relationship with their Treasury departments.

Finally and most importantly, while efforts should be made to follow through on recommendations made above, it is critical that the capacity to utilise funds for PHC be developed in areas of greater health needs. The first three recommendations made above focus on shifting resources to areas of greater need. These will not make much of a difference to the lives of the more vulnerable population if there is no capacity to effectively utilise the additional resources channelled to these areas.

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Appendix A

Questionnaires

Interview Schedule for the National Department of Health (NDoH)

1. Is equity in the allocation of PHC finances across provinces and districts a priority for the NdoH?
2. Do you think equity in the allocation of PHC finances is a priority for the provinces?
3. Are there any existing mechanisms / initiatives / guidelines driven by the NDoH to promote equity in PHC allocations across geographic areas?

[If yes, probe for description of the initiative and how well the initiative performed. Also, find out what the constraints and facilitators to success have been.]

4. Have there been other initiatives to promote equity in PHC allocations in the past?

[If yes, probe for description of the initiative(s) and how well the initiative(s) performed. Also, find out what the constraints and facilitators to success have been.]

5. Are there any other strategies that could be used to promote equitable distribution of PHC resources?
6. Previous research has identified the lack of capacity (managerial, technical and human resources) to benefit as a key constraint to increasing allocations to poorly funded districts. What measures are being taken to solve this problem?
7. In general, many provinces and districts believe that they are underfunded. However, it appears that they usually underspend on their budget. Are there any strategies you (national / province / district) are considering to ensure that you fully utilise all the money you are given, so as to justify increases?
8. Does NDOH have strategies in place to assist provinces that constantly under-spend? Any mechanism in place to ensure that provincial health departments who under-spend still receive fair share from provincial equitable share.
9. What are the major causes of underspending?
10. Is the NDoH involved in negotiations for the provincial health budgets? And how? Who and why?
11. The NDoH submits bids for changes (increases) in the health budget to National Treasury, however, decisions taken at this level are generally undermined by provincial level budgetary negotiations. What is the PDoH or NDoH doing about this?
 - a. Are there bids for increased funding for specific health programmes? Are there any mechanisms to ensure that these funds are used for the intended programmes?

12. Is the NDoH involved in negotiations for the PHC budget? And how? Who and why?
13. Is the NDoH involved in defining the criteria for allocation of PHC finances across districts?
14. Are you aware of any guidelines used by provinces for the allocation of PHC finances across districts? If there are – what are they?
15. Do you think that the current budgeting and resource allocation system results in an equitable distribution of PHC finances? If yes (why?); If no (why not?)
16. Do you think that the NDoH should have more involvement in deciding the budgeting and resource allocation system within the provinces?

[If yes, what type of involvement?]

Questions around feasibility

17. Do you think that these strategies for involvement will meet any resistance?
18. Where would the resistance come from?
19. Are there any factors that could facilitate the success of this strategy?
20. What definition of equity do you think should guide the allocation of resources to PHC across geographic areas?
21. Are there any monitoring and evaluation system in place to ensure that equity in PHC allocations is achieved? If there are – what are they, and who is doing the monitoring and evaluation?
22. There has been considerable progress in the past 5 years towards a more equitable distribution of PHC funds across districts.
 - a. Who initiated this?
 - b. How was this achieved?
 - c. Are districts that are receiving more funds able to fully utilise the funds? Why? Why not?

Interview schedule for officials of the National Treasury

1. What is the process for determining provincial budgets?
2. Is the National Treasury involved in any way in budgetary allocations to different sectors within the province? – What is the nature of this involvement?
3. Is the National Treasury involved in any way in decision making for provincial health budgets? Who is involved? In what way?
4. Is there any structure in place for interactions with the Department of Health around issues of priority setting and financing?

If Yes:

5. Who does the National treasury interact with?
6. What kinds of decisions are taken in these meetings?
7. What impact do such decisions have on budgeting and resource allocation to health and PHC?
8. NDoH submits bids for changes (increases) in the health budget to National Treasury, however, decisions taken at this level are generally undermined by provincial level budgetary negotiations. What are is being done to resolve this issue?
9. Given that PHC is considered a priority, have there been any discussions with the Department of Health regarding the protection of PHC budget?

If Yes:

10. What forms of protection have been suggested?
11. Were these implemented? Were they successful? [*Probe questions on what factors influenced the success or failure of the form of protection foe PHC budgets*]
12. In not implemented, why not?

[Interviewer can list forms of protection such as conditional grants, norms and standards etc to prompt discussion]

13. What form of protection for PHC budgets (to promote equity) will the National Treasury be in support of?
14. What type of services should be protected (the funds)?
15. Are conditional grants a “separate” source of revenue to various departments from budgeted equitable shares to departments? Is it considered as part of departmental revenue in the process of budgeting from equitable shares?
16. To what extent is the health sector seen as a priority? Why? Why not?
17. What is the relative importance of different health programmes? PHC?
18. Are you aware of any DoH policy on PHC?

19. There are a lot of provinces and districts that under-spend on their health budgets (even those with relatively high levels of need). What is being done to resolve this problem?

20. There has been considerable progress in the past 5 years towards a more equitable distribution of PHC funds across districts.
 - a. Who initiated this?
 - b. How was this achieved?
 - c. Are districts that are receiving more funds able to fully utilise the funds? Why? Why not?

Interview schedule for officials of the Provincial Department of Health

1. What are the priority areas for health in the province?
2. Are there any financial constraints in achieving the goals set for the priorities?
3. Are you involved in deciding the health budget for the province?
4. Who else is involved in this process?
5. Who has makes the final decisions on the budget for health? Why?
6. Can you describe the process for deciding the health budget?
7. [Probes] Do you usually get the amount you ask for? Are there any strategies you can employ to influence the size of your budget? What are there? Do you get reasons for budget cuts? What are they? [all these depend on the response of the interviewee]
8. Are there any guidelines that influence the health budget? What are they?
9. Are conditional grants a “separate” source of revenue to various departments from budgeted equitable shares to departments? Is it considered as part of departmental revenue in the process of budgeting from equitable shares?
10. Once you have received the health budget, how do you decide the budgets for different health programmes?
11. Are there any guidelines that influence the budgets for health programmes? And PHC?
12. NDoH submits bids for changes (increases) in the health budget to National Treasury, however, decisions taken at this level are generally undermined by provincial level budgetary negotiations. What are is being done to resolve this issue?
13. Are there any mechanisms in place to ensure that these guidelines are adhered to?
14. Are you involved in the distribution of PHC budgets to the districts? Who is involved?
15. On what basis/criteria are PHC allocations to districts made? What measure of relative need is used for allocating PHC funds?
16. Do you think that the current allocation process achieves an equitable distribution of PHC finances across districts?
17. Are there any mechanisms in place to elicit community preferences/priorities with respect to their needs? How does this information feed into decision making?

18. What definition of equity do you think should guide PHC allocations to districts?
19. Do you think you have the capacity to manage the allocation of the PHC budget across all districts?
20. There has been considerable progress in the past 5 years towards a more equitable distribution of PHC funds across districts.
 - a. Who initiated this?
 - b. How was this achieved?
 - c. Are districts that are receiving more funds able to fully utilise the funds? Why? Why not?
21. Are some districts under-spending? Why? What is being done to resolve this?

Interview schedule for officials at the Districts

1. As a district manager what are your roles and responsibilities?
2. Do you have any involvement in deciding the provincial budget for health?
3. Do you have any involvement in deciding the provincial budget for PHC?
4. Are there any guidelines that influence the size of the overall provincial PHC budget? What are they?
5. Are there any guidelines / criteria for allocating PHC budgets across districts? What are they?
6. Are you expected to prepare a budget for your district? If so, do you get what you asked for?
7. Do you think that the PHC allocation to your district is sufficient to provide the required services? Why do you think this is so?
8. Do you think that the distribution of PHC budgets based on the current allocation is equitable?
9. If no; what criteria should be used in allocating PHC budgets across districts?
10. Are there any mechanisms in place to engage with communities to elicit their views on service delivery of PHC?
11. What are these mechanisms?
12. Do they work properly?
13. Does the voice of the community influence service delivery? Amount of PHC allocations committed to the district?
14. Do you have the authority to decide on how much of the PHC budget is spent on the various cost centres? Or are they decided at the province?
15. If decided at the province; would you prefer if the district had the authority to decide the amount of funds allocated to different PHC cost centres?
16. If yes: does the district have the capacity to manage the allocation of PHC budgets across cost centres?
17. What definition of equity do you think should guide the allocation of PHC budgets across districts?
18. There has been considerable progress in the past 5 years towards a more equitable distribution of PHC funds across districts.
 - a. Who initiated this?
 - b. How was this achieved?

- c. Are districts that are receiving more funds able to fully utilise the funds?
Why? Why not?

19. Is this district under-spending on its budget? Why? What is being done to resolve this?

Interview schedule for officials at Provincial Treasury

1. Are you involved in budgetary allocations to different sectors within the province?
2. What are your roles and responsibilities regarding allocating budgets for different sectors within the province?
3. Please describe the process for allocating budgets to different sectors within the province.
4. What is the extent of interaction with sectoral departments?
5. Are there any guidelines from National Treasury on how these allocations should be made?
6. Are there any guidelines developed by the Provincial Treasury on how these allocations should be made?
[Probe: are there any mechanisms in place to ensure that these guidelines are adhered to?]
7. Is 'Equity' a consideration in deciding budgets for sectors? How?
8. Who is involved in these budgetary negotiations?
9. Who would you say has the final say on allocations to different sectors? Why is this so?

Involvement in deciding the health budget

10. Do you have any specific involvement in deciding the health budget?
11. What is the nature of your involvement?
12. What kind of input does the Provincial Department of Health (PDoH) make in deciding the health budget?
13. Assuming that the PDoH wants to secure a significantly larger budget, what are the procedures for this? What are the strategies available to them?
14. What strategies have the PDoH used in past to secure larger budgets? Success? Failure?
15. NDoH submits bids for changes (increases) in the health budget to National Treasury, however, decisions taken at this level are generally undermined by provincial level budgetary negotiations. What are is being done to resolve this issue?
16. Does the PDoH usually use up all its budgetary allocations?

17. If 'no' what reasons have been given for under-spending?
18. What strategies have been initiated to address the problem of under-spending?
19. To what extent is the health sector seen as a priority in this province? Why? Why not?
20. What is the relative importance of different health programmes? PHC?
21. Are you aware of any DoH policy on PHC?

Involvement in PHC Allocations

22. Are you involved in budgetary allocations to PHC/District Health Services?
23. What is the nature of your involvement?

If the Provincial Treasury is involved in PHC allocations, probe to find out whether they monitor PHC allocations across districts, if they are aware of inequities in allocations across districts, if they know whether some districts under-spend, and what they do about these.

24. There has been considerable progress in the past 5 years towards a more equitable distribution of PHC funds across districts.
 - a. Who initiated this?
 - b. How was this achieved?
 - c. Are districts that are receiving more funds able to fully utilise the funds? Why? Why not?

Interview Schedule for Officials at Local Government Level in Nigeria

1. How are PHC funds determined and allocated to LGs?
2. Are you involved in deciding the budget for PHC in the LG?
[If yes] Are you also involved in deciding overall PHC budget for the State?

[If no: probe] Why are you not involved?

Would L.G. officials prefer to be involved? How?

Are there any problems experienced in the financing and provision of PHC because the L.G. is not involved?

Are there any benefits/advantages from State/Federal controlled process for deciding the PHC budgets?

3. Briefly describe the process for determining PHC budgets for the LG?
4. Are there any guidelines that influence the overall PHC budget for Nigeria?
5. Are there any guidelines/criteria used for allocating PHC budgets between L.G.As, or States?
6. Is the L.G. expected to prepare a budget proposal for PHC expenditure? Who do you submit this bid to? Do you usually get what you ask for?
7. Is equity a priority for the Ministry of Health? L.G. level / State / Federal
8. Do you think that the PHC allocation to your L.G.A. is sufficient to adequately provide the required PHC services? Why do you think this is so?
9. Do you think that the distribution of PHC allocations across L.G.A. in the State is equitable? Why?
10. Are there any constraints to achieving a more equitable distribution of PHC finances across L.G.A.s? What are they?
11. Have there been any initiatives (from L.G., State or Federal Government) to deal with this?
12. What criteria do you think should be used in allocating PHC finances across L.G.A.s?
13. What definition of equity do you think should guide the allocation of PHC budgets?

14. Are there any mechanisms in place to engage with community members to elicit their views on PHC service delivery? What are these mechanisms? Do they work properly?
15. Does the voice of the community influence PHC delivery or the amount allocated to PHC in the L.G?
16. Do you have the authority to decide how much of the PHC budget is spent on the various cost centres? If not, who does?

If yes: does the L.G. have the capacity to adequately manage the allocation of PHC budgets across cost centres? [explain answer]
17. Is equity a priority in the allocation of funds to cost centres within the LG? How is this reflected in financial allocations within the LG?
18. Does the L.G. under-spend or over-spend on its PHC budget? Why? Any strategy in place to deal with this?
19. The National health Policy stipulates that States are to provide support to L.G.s in providing PHC services. What kind of support does the State give L.G.s in the financing and provision of PHC services?
20. Do you think this support is necessary?
21. Do you think that the L.G. has sufficient autonomy in the determination and use of PHC allocations to adequately provide PHC services in response to the health needs of the L.G.?
22. What mechanism is there for monitoring PHC expenditure (accountability)?
23. Assuming that you need more money for PHC services, what options are available to the L.G. to secure a larger budget for PHC services?
24. Is equitable access for communities to PHC services a priority for the L.G?
25. Have there been any initiatives / policies / strategies in place to promote equitable access to PHC services? What are they? Have they worked well? Why? [keep in mind the deferral and exemption schemes]
26. Is the size of Local Government revenue from user-fees in health facilities taken into account in the amount of funds allocated to PHC?

Interview Schedule for Officials at State Government Level in Nigeria

1. What is the State's role in the financing and provision of PHC services?
2. Are you involved in deciding the PHC budget for L.G.s within your state?
3. Are there any guidelines that influence the size of the overall State / L.G. PHC budget?
4. Are there guidelines /criteria for allocating PHC budgets between L.G.A.s? What are they?
5. Briefly describe the budgeting process that determines the PHC budget for L.G.A.s / States.
6. Are you expected to submit budget proposals for PHC? Do you usually get what you ask for?
7. Do you think that PHC allocations to the L.G.s are sufficient for them to adequately provide required PHC services? Why do you think so? [If no: ask what has been done to increase PHC allocations]
8. Do you think that the distribution of PHC allocations across L.G.A.s is equitable? Why?
9. What are the constraints to achieving a more equitable distribution of PHC allocations between L.G.A.s? Have there been any initiatives / strategies employed to deal with this?
10. In your opinion, what criteria should be used in allocating PHC funds between L.G.A.s?
11. Do you think equity should be a major criterion for allocating PHC funds to Local Governments? If so...
12. What definition of equity do you think should guide the allocation of PHC budgets?
13. Is equity in the allocation of PHC budgets across L.G.A.s and States a priority for the Ministry of Health?
14. Do you think that L.G.s have sufficient managerial capacity to adequately manage PHC funds allocated to them? Explain why
15. Do L.G.s over-spend or under-spend on their PHC budgets? Why does this occur? Any initiatives / strategies to deal with this?
16. Assuming that PHC allocations to L.G.s are not sufficient, what options are available to the L.G or State in securing a larger PHC budget?

17. PHC is considered as a priority area for health in Nigeria, to what extent is this reflected in PHC allocations?

Interview Schedule for Officials at Federal Government Level in Nigeria

1. Are you involved in the budgeting process for PHC expenditure across States / L.G.A.s?
2. Briefly describe the process that determines the national PHC budget?
3. Are there any guidelines that influence the size of the national PHC budget?
4. What are the sources of funds for PHC (donor? LG? fee revenue? Federal government?)? Debt relief funds?
5. What is the relative importance of each source in funding PHC? [size]
6. Are there any guidelines /criteria that determine the size of PHC budgets across States / L.G.A.s
7. Is equity in the distribution of PHC budgets across States and L.G.A.s a priority for the federal government?
8. Do you think that the current budgeting and resource allocation process results in an equitable distribution of PHC resources? Why?

If no: Has there been any strategies / initiatives put in place to promote more equitable PHC expenditure outlays?

9. What are the constraints to achieving a more equitable distribution of PHC funds across States / LGAs?
10. What does the Ministry of Health consider as an equitable distribution of financial resources?
11. Are funds for PHC allocated to L.G.s as an unconditional transfer from the federal government, or are they conditions attached to PHC allocations?
12. Do you think that the PHC budgets allocated to LGs are enough for them to adequately provide PHC services – considering their relative needs?
13. If LGs or States need to secure larger budgets for PHC, what are the options open for them? Do these options work? Why?
14. Do you think that the LGs have sufficient managerial capacity to effectively finance and deliver PHC services?
15. Do you think that the federal or state government should have more involvement in financing and providing PHC services? Why?

Appendix B

Schedules 4 & 5 from the South African Constitution

Schedule 4 - Functional areas of concurrent national and provincial legislative competence

Part A

- Administration of indigenous forests
- Agriculture
- Airports other than international and national airports
- Animal control and diseases
- Casinos, racing, gambling and wagering, excluding lotteries and sports pools
- Consumer protection
- Cultural matters
- Disaster management
- Education at all levels, excluding tertiary education
- Environment
- Health services
- Housing
- Indigenous law and customary law, subject to Chapter 12 of the Constitution
- Industrial promotion
- Language policy and the regulation of official languages to the extent that the provisions of section 6 of the Constitution expressly confer upon the provincial legislatures legislative competence
- Media services directly controlled or provided by the provincial government, subject to section 192
- Nature conservation, excluding national parks, national botanical gardens and marine resources
- Police to the extent that the provisions of Chapter 11 of the Constitution confer upon the provincial legislatures legislative competence
- Pollution control
- Population development
- Property transfer fees
- Provincial public enterprises in respect of the functional areas in this Schedule and Schedule 5
- Public transport
- Public works only in respect of the needs of provincial government departments in the discharge of their responsibilities to administer functions specifically assigned to them in terms of the Constitution or any other law
- Regional planning and development
- Road traffic regulation
- Soil conservation
- Tourism
- Trade
- Traditional leadership, subject to Chapter 12 of the Constitution
- Urban and rural development
- Vehicle licensing
- Welfare services

Part B

The following local government matters to the extent set out in section 155(6)(a) and (7):

- Air pollution
- Building regulations
- Child care facilities
- Electricity and gas reticulation
- Firefighting services
- Local tourism
- Municipal airports
- Municipal planning
- Municipal health services
- Municipal public transport
- Municipal public works only in respect of the needs of municipalities in the discharge of their responsibilities to administer functions specifically assigned to them under this Constitution or any other law
- Pontoons, ferries, jetties, piers and harbours, excluding the regulation of international and national shipping and matters related thereto
- Stormwater management systems in built-up areas
- Trading regulations
- Water and sanitation services limited to potable water supply systems and domestic waste-water and sewage disposal systems

Schedule 5 - Functional areas of exclusive provincial legislative competence

Part A

- Abattoirs
- Ambulance services
- Archives other than national archives
- Libraries other than national libraries
- Liquor licences
- Museums other than national museums
- Provincial planning
- Provincial cultural matters
- Provincial recreation and amenities
- Provincial sport
- Provincial roads and traffic
- Veterinary services, excluding regulation of the profession

Part B

The following local government matters to the extent set out for provinces in section 155(6)(a) and (7):

- Beaches and amusement facilities
- Billboards and the display of advertisements in public places
- Cemeteries, funeral parlours and crematoria
- Cleansing
- Control of public nuisances
- Control of undertakings that sell liquor to the public

- Facilities for the accommodation, care and burial of animals
- Fencing and fences
- Licensing of dogs
- Licensing and control of undertakings that sell food to the public
- Local amenities
- Local sport facilities
- Markets
- Municipal abattoirs
- Municipal parks and recreation
- Municipal roads
- Noise pollution
- Pounds
- Public places
- Refuse removal, refuse dumps and solid waste disposal
- Street trading
- Street lighting
- Traffic and parking

Appendix C

Deprivation Indices and PHC per capita Expenditure by Districts

Deprivation Indices for Health Districts in South Africa: Census 2001

Province	District	Deprivation Index	PHC per capita 2001	Rank
W.CAPE	West Coast DM	-3.21925	275	1
W.CAPE	Overberg DM	-3.06368	240	2
W.CAPE	Cape Winelands DM	-3.01237	201	3
W.CAPE	Eden DM	-2.79	265	4
W.CAPE	Central Karoo DM	-2.77544	325	5
NORTH CAPE	Namakwa DM	-2.74831	254	6
W.CAPE	City of Cape Town	-2.71355	357	7
NORTH CAPE	Siyanda DM	-2.27395	100	8
GAUTENG	City of Johannesburg	-2.01524	342	9
E.CAPE	Nelson Mandela Metropolitan Municipality	-2.00425	129	10
GAUTENG	Sedibeng DM	-1.9518	151	11
NORTH CAPE	Karoo DM	-1.90131	163	12
NORTH CAPE	Frances Baard DM	-1.86938	135	13
NORTH WEST	City of Tshwane Metropolitan Municipality	-1.85134	190	14
GAUTENG	Ekurhuleni Metropolitan Municipality	-1.83629	389	15
GAUTENG	West Rand DM	-1.79614	163	16
E.CAPE	Cacadu DM	-1.70192	69	17
GAUTENG	Metsweding DM	-1.63837	169	18
FREE STATE	Xhariep DM	-1.54088	145	19
KZN	eThekweni Municipality (Durban)	-1.53655	179	20
NORTH WEST	Southern DM	-1.50513	216	21
FREE STATE	Northern Free State	-1.44245	89	22
FREE STATE	Motheo DM	-1.26778	128	23
FREE STATE	Lejweleputswa DM	-0.98669	96	24
MPUMALANGA	Nkangala DM	-0.68332	44	25
KZN	uMgungundlovu DM	-0.63265	200	26
NORTH WEST	Bojanala Platinum DM	-0.60245	143	27
KZN	Amajuba DM	-0.41922	148	28
LIMPOPO	Waterberg DM	-0.37427	125	29
MPUMALANGA	Gert Sibande DM	-0.2384	42	30
FREE STATE	Thabo Mofutsanyana	-0.18726	71	31
MPUMALANGA	Ehlanzeni DM	-0.14583	134	32
NORTH WEST	Central DM	-0.13892	159	33
NORTH WEST	Bophirima DM	0.183052	378	34
E.CAPE	Amathole DM	0.238216	137	35
LIMPOPO	Capricorn DM	0.306604	77	36
NORTH CAPE	Kgalagadi DM	0.354167	140	37
LIMPOPO	Mopani DM	0.466654	140	38
E.CAPE	Chris Hani DM	0.600198	109	39
LIMPOPO	Bohlabela DM	0.606219	55	40
KZN	Ilembe DM	0.626324	124	41
E.CAPE	Ukhahlamba DM	0.634059	48	42

KZN	uThungulu DM	0.666524	150	43
KZN	uThukela DM	0.682727	150	44
LIMPOPO	Vhembe DM	0.690505	124	45
KZN	Ugu DM	0.693579	165	46
KZN	Sisonke DM	0.853005	169	47
LIMPOPO	Greater Sekhukhune DM	1.027324	87	48
KZN	Zululand DM	1.211906	151	49
KZN	uMzinyathi DM	1.587639	134	50
KZN	uMkhanyakude DM	1.589184	166	51
E.CAPE	Alfred Nzo DM	1.631172	75	52
E.CAPE	O R Tambo DM	1.824015	91	53

Deprivation Indices for Health Districts in South Africa: GHS 2005

Province	District	Deprivation Index	PHC per capita 2005	Rank
W.Cape	West Coast District Municipality	-4.33972	307	1
W.Cape	Overberg District Municipality	-4.01569	201	2
W.Cape	Boland District Municipality	-3.78062	208	3
North Cape	Namakwa District Municipality	-3.30689	398	4
W.Cape	Central Karoo District Municipality	-2.97601	314	5
W.Cape	City of Cape Town	-2.96147	341	6
Gauteng	West Rand District Municipality	-2.87515	154	7
Gauteng	City of Johannesburg Metropolitan Municipality	-2.86533	249	8
Gauteng	Ekurhuleni Metropolitan Municipality	-2.73034	270	9
W.Cape	Eden District Municipality	-2.57377	247	10
Gauteng	City of Tshwane Metropolitan Municipality	-2.55138	199	11
KZN	Ethekwini Municipality	-2.3486	264	12
North Cape	Siyanda District Municipality	-2.2246	120	13
Free State	Northern Free State District Municipality	-1.86652	210	14
Gauteng	Sedibeng District Municipality	-1.84511	225	15
E.Cape	Nelson Mandela	-1.76347	201	16
Free State	Motheo District Municipality	-1.60968	232	17
North Cape	Karoo District Municipality	-1.3423	239	18
KZN	UMgungundlovu District Municipality	-1.25303	222	19
Gauteng	Metsweding District Municipality	-1.15797	119	20
North West	Southern District Municipality	-1.12396	262	21
Free State	Lejweleputswa District Municipality	-1.10068	184	22
E.Cape	Cacadu District Municipality	-1.02251	195	23
North Cape	Frances Baard District Municipality	-0.90654	205	24
Limpopo	Waterberg District Municipality	-0.65519	178	25
North West	Bojanala District Municipality	-0.5165	225	26
Free State	Xhariep District Municipality	-0.05748	356	27
Mpumalanga	Ehlanzeni	0.056734	217	28
Mpumalanga	Gert Sibande District Municipality	0.156581	138	29
Mpumalanga	Nkangala	0.312834	175	30
KZN	Amajuba District Municipality	0.317492	166	31
KZN	iLembe District Municipality	0.88666	216	32
KZN	Uthungulu District Municipality	1.264339	239	33
North West	Central District Municipality	1.312398	300	34
North Cape	Kgalagadi District Municipality	1.408351	260	35
Free State	Thabo Mofutsanyane District Municipality	1.655178	228	36
KZN	Ugu District Municipality	1.724339	226	37
E.Cape	Amatole	1.732225	245	38
KZN	Sisonke District Municipality	1.922967	271	39
Limpopo	Capricorn District Municipality	1.999115	181	40
KZN	Uthukela District Municipality	2.048629	195	41
Limpopo	Vhembe District Municipality	2.077491	237	42
North West	Bophirima District Municipality	2.127184	416	43
E.Cape	Ukhahlamba District Municipality	2.26335	207	44
Limpopo	Mopani District Municipality	2.334091	227	45
E.Cape	Chris Hani District Municipality	3.097776	257	46
Mpumalanga	Sekhukhune Cross Boundary District Municipality	3.161837	115	47

KZN	Zululand District Municipality	3.379342	222	48
Limpopo	Bohlabela District Municipality	3.509576	145	49
KZN	Umzinyathi District Municipality	3.730372	221	50
KZN	Umkhanyakude District Municipality	4.253882	309	51
E.Cape	Alfred Nzo District Municipality	4.434091	188	52
E.Cape	O.R.Tambo	4.603675	213	53